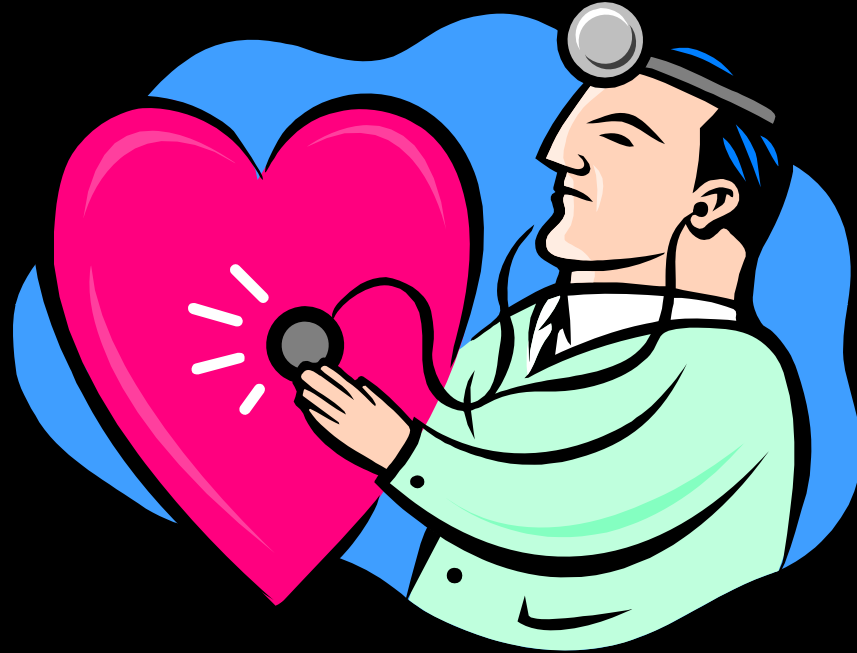


# Using Appropriate Perioperative Governance Structures to Implement Better Block Scheduling

Randy Heiser, BA, MA  
President and CEO

Sullivan Healthcare Consulting, Inc.

# Patient Scheduling

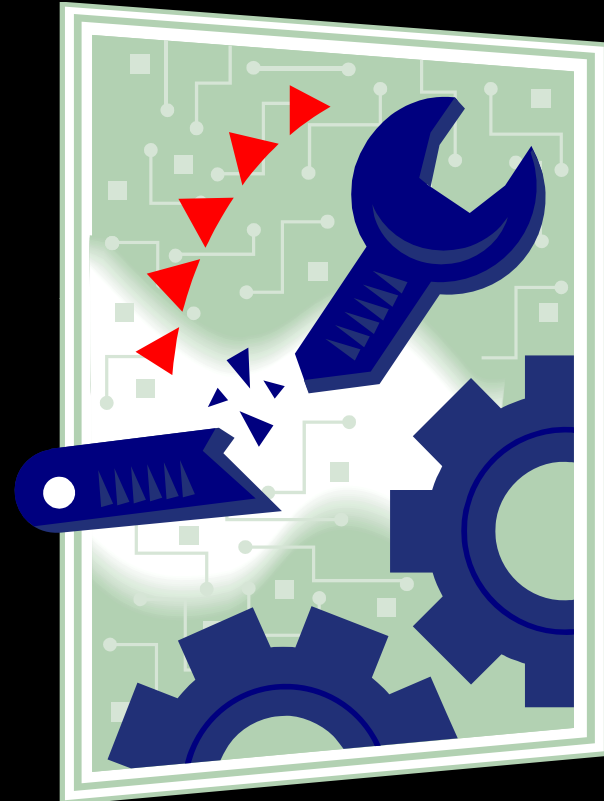


THE HEART OF THE OR

# Ineffective Scheduling

Increases surgery  
cost

Reduces effective  
utilization of all  
resources



# Symptoms of a Poor or Inaccurate Schedule

- Late surgeons, anesthesiology, and nursing
- Day-of-surgery crisis management (e.g., continual case juggling)
- Holes in the schedule/poor utilization
- Extended pre- and postoperative patient length of stay
- Excessive overtime
- Poor employee morale
- Bottlenecked patient volume

# An Effective Scheduling Program Should:

- Provide an achievable plan
- Allow elective case starts to occur as planned
- Preplan room time and coverage for urgent/emergency cases
- Provide accurate schedules so that all staff members involved can effectively plan their days
- Maintain effective utilization of resources
  - Surgeons
  - Anesthesiologists
  - Nursing
  - Supply chain
  - Facility
  - Interdepartmental

# An Effective Scheduling Program Will:

- Allow surgeons to manage daily activity and increase their productivity and revenues
- Improve facility utilization and the number of cases that can be scheduled each day
- Improve nursing and anesthesiology productivity/utilization/morale
- Decrease cost-per-case

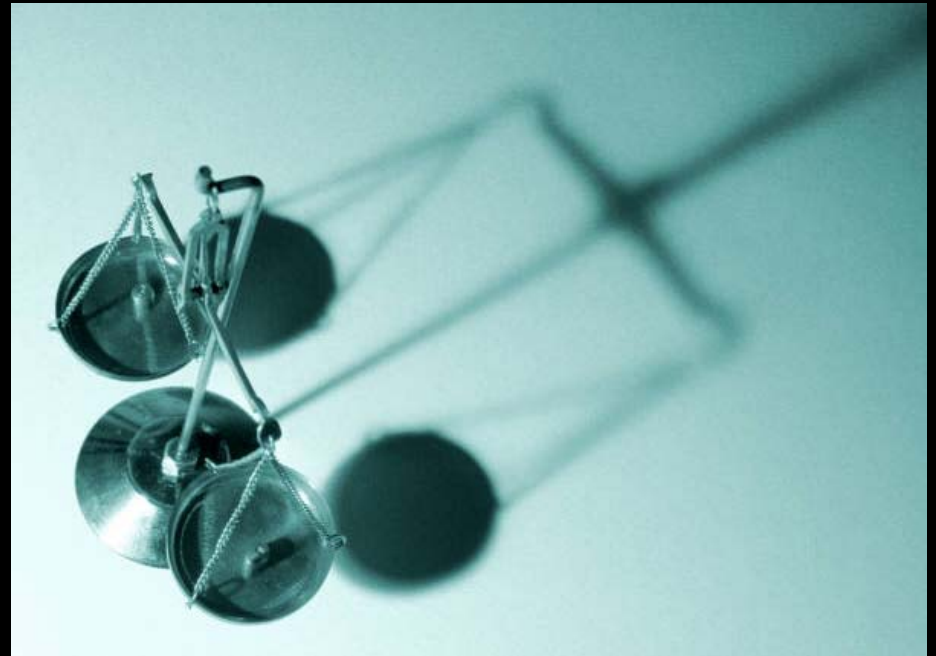
# The Best Programs Balance the Needs and Demands of:

Surgeons

Anesthesia providers

Nurses/nursing  
management

Administration



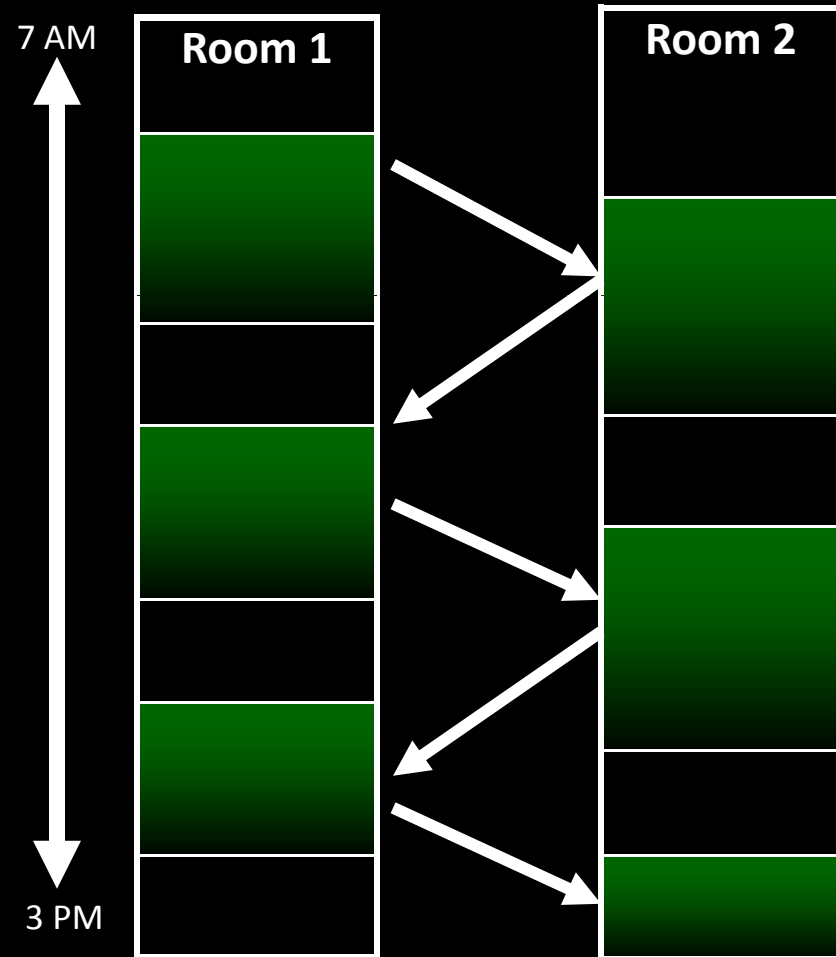
# Ideal Scheduling Program for Surgeons

- Individual room
- Specialty-trained handpicked staff
- Adequate equipment
- Specific anesthesiologist
- Available 7 days a week for each surgeon
- All staff ready and available on demand



# Ideal Scheduling Program for Anesthesiologists

- Two or more rooms
- Two sets of nursing staff
- Anesthesiology, room support staff, and surgeons always waiting in the lounge for the next case – NO DELAYS
- Achieve 100% billable time during scheduled hours – home by 3:30 PM
- Minimal or no weekend and after-hours volume

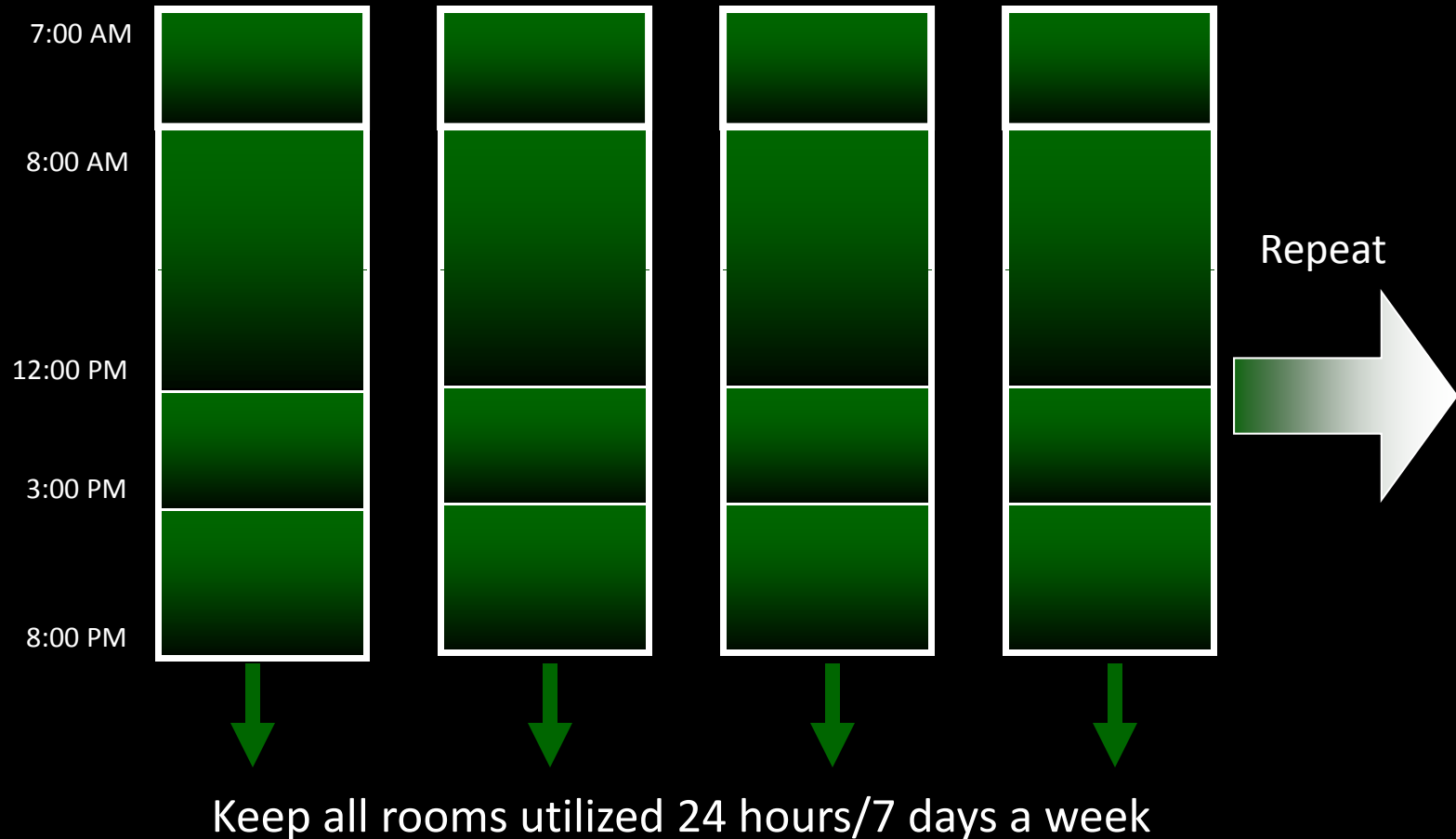


# Ideal Scheduling Program for Nursing

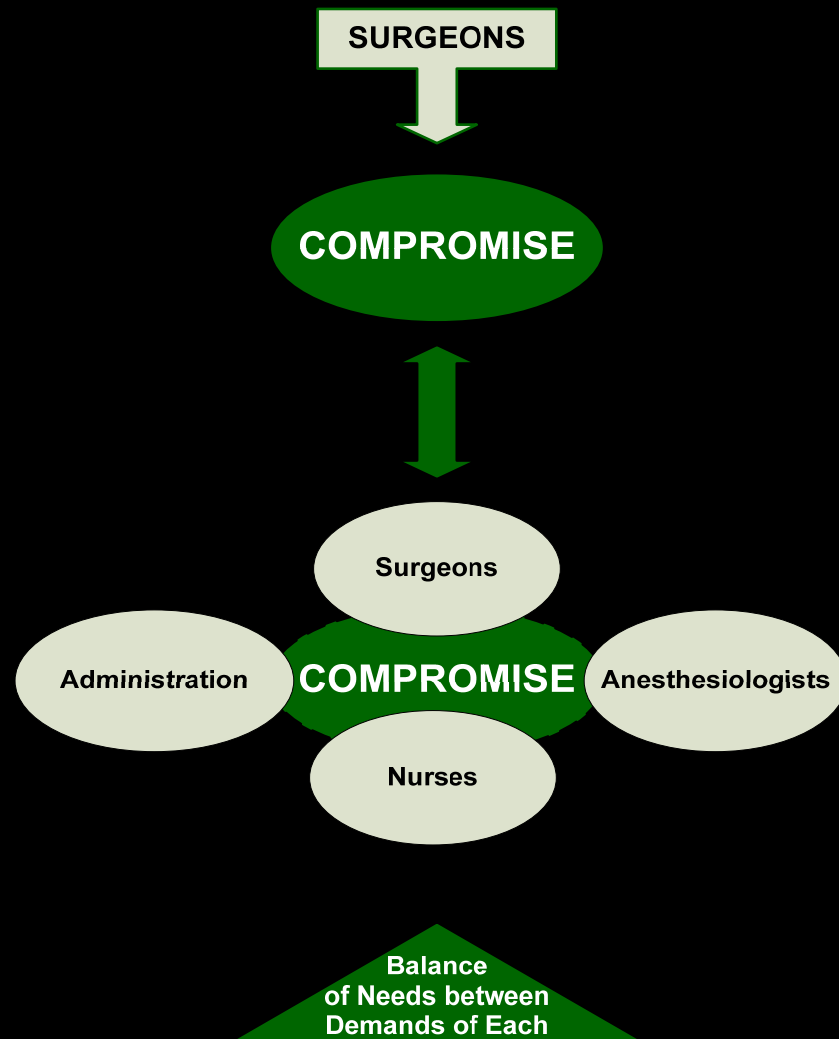


- One team per room
- Scheduled lunch and breaks
- Surgeons and anesthesiologists waiting in lounge for case starts

# Ideal Scheduling System for Administration



# A Successful Scheduling Program Requires Compromise, which Requires a Governance Structure



# What is Good Perioperative Governance?

- The primary responsibilities of a best practice governance structure are:
  - Balancing the needs of each group with the resources available
  - Strategic planning
  - Direction setting
  - Decision making
  - Policy development
  - Enforcement

# What Kinds of Models Currently Exist?

- No model
- Traditional surgery/OR committee
- Department of surgery groups
- Hybrid operational/medical staff groups
- All one stakeholder groups

# Traditional Surgery Committees Are Not Up to the Task

Problem	Result
Composed of large number of surgeons	Unable to come to decisions; Becomes “complaint forum”
Has inadequate representation from other key groups (e.g., anesthesiology, nursing)	Discussions slanted; can become political, personal in nature
Lacks clout necessary for change	Ideas generated do not result in change
Meets infrequently	Cannot engage in pressing issues
Poor attendance, tardiness common	No quorum for decision; starts vicious downward spiral



# Failure of Typical Governance Models

- Overestimation of opportunities
- Focus on symptoms
- Pollyanna perspective
- Inadequate metrics
- Conservative culture
- Not invented here
- “It’s fine for everyone else but me”



# Competing Agendas

## Service to Surgeons

- Securing surgeon participation
- Ensuring convenient scheduling
- Readily accommodating add-ons
- Guaranteeing timely turnover and start times
- Accommodating urgent/emergent volume
- Meeting new equipment requests
- Building and maintaining skill mix of OR staff
- Retaining/recruiting scarce clinicians

## Service to the ORs

- Maintaining OR volumes
- Managing OR costs
- Limiting staff overtime expense
- Managing waitlists
- Controlling adoption of new technologies/devices
- Standardizing supply utilization/vendors
- Re-engineering materials acquisition process

**The Surgery Committee  
Should Be the Board of  
Directors  
for the Surgery Program**

# **Information and the “Will to Act” Are the Foundation**

# Key Elements of the Plan

Surgery executive  
committee

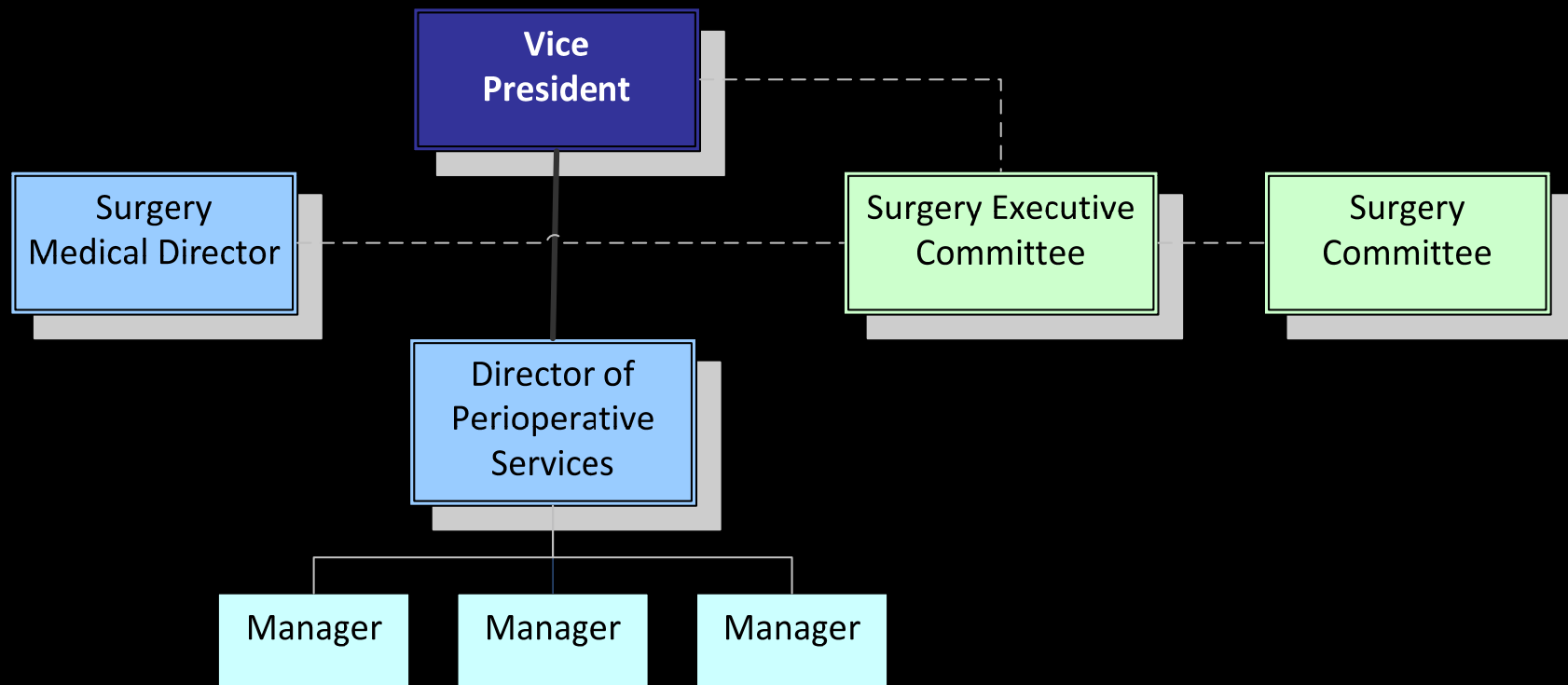
Surgery medical  
director

Revised surgery  
committee

# Scheduling Governance

- Continued management of daily scheduling activities/data input activity
- Continued coordination with materials managers
- Well-defined OR rules and regulations
- Administration of well-defined scheduling policies based on OR rules and regulations
- Continued block scheduling management
- Close coordination with the surgery committee

# Successful Perioperative Organization Governance Plan



# Surgery Executive Team

- Business analogy – management committee of the board of directors
- Smaller membership
- Frequent meetings
- Dedication to the overall program
- Enforcement of policies
- Receives data and acts on it



# Ideal Surgery Executive Team

- Perioperative director
- Medical director of the OR or:
  - Chief of surgery
  - Chief of anesthesiology
- Senior administration representative

# Surgery Executive Committee Objectives

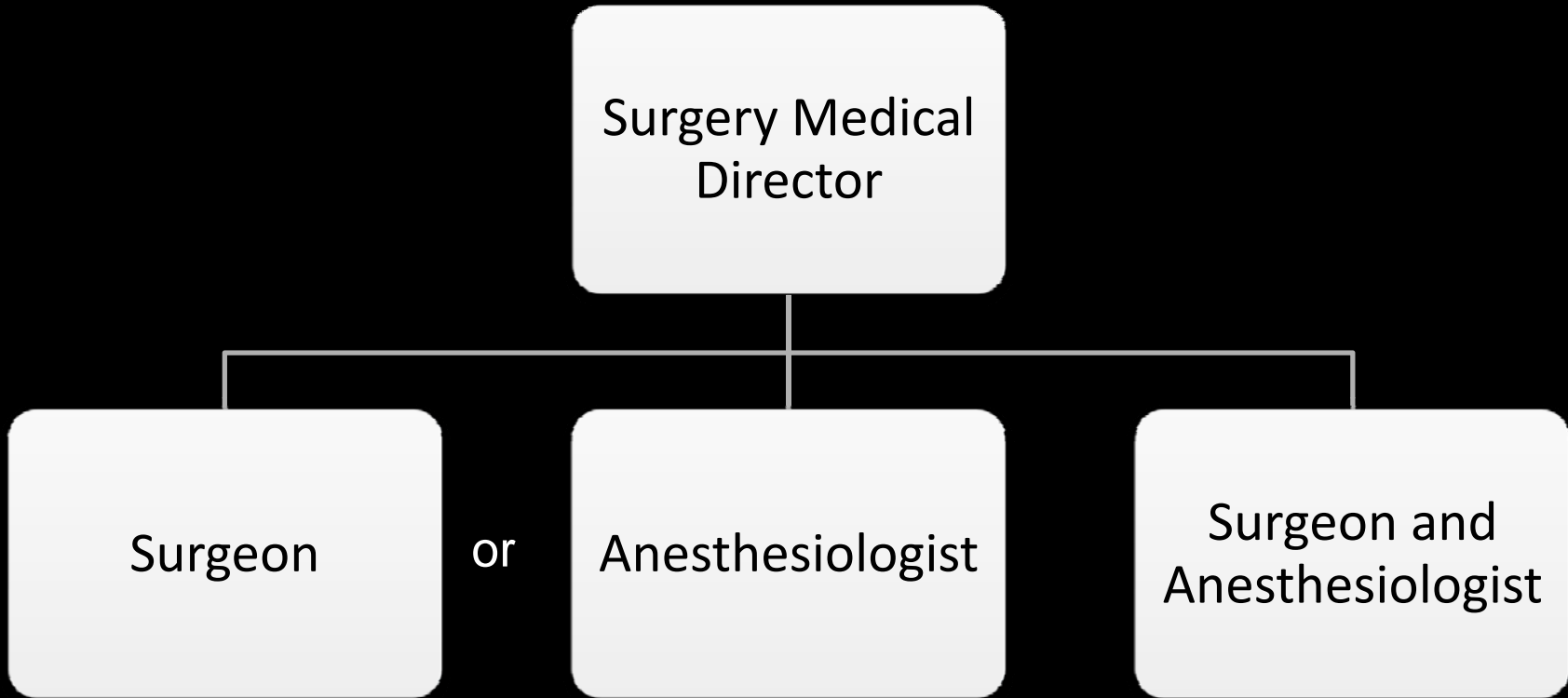
1. Provide a best practice operationally effective perioperative program
2. Provide an operationally marketable program and meet patient and surgeon client needs
3. Increase OR case volume revenue and margins to assure monies are available for new technology, medical staff expenses, and competitive wages
4. Provide input into development of:
  - Surgery medical staff plan
  - Surgery strategic plan

# Surgery Executive Committee Responsibilities

- Budgets
  - Expense
  - Revenue
  - Materials
  - Capital
  - Labor
- Block scheduling management
- Operational and cost-effective program
- Operational marketing program
- Operational policies and procedures
- Medical and clinical quality patient care

# Physician Leadership is Critical

- Serves as the overall physician leader of the perioperative program
- Ability to function as the “OR czar”
- Enforces policy “in the moment”
- Serves as primary “board runner”
- Must have dedicated time
- Should be a hospital position with evaluation criteria and compensation



# Surgery Medical Director Role and Position Summary

- Ideally displays the following attributes:
  - Respected by physicians and personnel involved in perioperative services and in the department of anesthesiology
  - Possesses excellent interpersonal skills
  - Team-oriented
  - Contributes to the improvement of processes/systems in the operating room

# Surgery Medical Director Role and Position Summary

- A member of the surgery committee and surgery executive committee
  - Makes medical and operational policy recommendations to these and other committees
- Takes physician lead in all OR changes and involves surgeons and/or anesthesia providers to assure the physicians' part of the change has been successfully made

# Surgery Medical Director Role and Position Summary

- Works to assure the OR will be customer-friendly to:
  - Patients
  - Patients' families
  - Surgeons
  - The community at large
- Serves as direct communication line for all surgeons to:
  - Assure surgeons' needs are understood and reasonably met
  - Assure surgeons' needs and OR program needs are reasonably balanced



# Surgery Medical Director Role and Position Summary

- Serves as a direct line of communication to anesthesiology leadership and anesthesia providers to:
  - Understand anesthesiology needs
  - Assure both anesthesiology needs and OR program needs are being reasonably balanced and that anesthesia needs, surgeons' needs, and hospital/OR needs are reasonably balanced

# Surgery Medical Director Roles

- Running the daily schedule
  - Sequencing add-ons based on the clinical priority established by services
  - Determining “bumping” priorities
  - Final authority on how the schedule will run each day
  - Ensuring the elective schedule is protected

# Surgery Committee

- Final piece of the puzzle
- Advise and consent role – not problem solving
- Communications with medical staff is key responsibility
- Serve as input for the executive

# Surgery Committee

## Committee Members

- Medical Director (s) Chairperson/Co Chairs
- Chairperson/Chief, department of surgery
- Chairperson/Chief, department of anesthesiology
- Section chairs, chiefs, or lead surgeons for each surgical section
- Other department of anesthesiology managers; director of perioperative services
- Administrator in charge of OR/surgery

# Implementing a New Paradigm for OR Access

- Access is a right, not a privilege
- Blocks are special rights available to surgeons who contribute
- Mixture of blocks, open, and urgent/emergent is required to meet the needs of all surgeons
- Must have rules and transparency

# Key Elements of an Effective Scheduling System

- Defined coverage plan correlated with demand
- Variable schedule access
  - Planned urgent and emergency case access
  - Elective block access
  - Elective FCFS access
- Block scheduling policies, monitoring and ongoing management

# OR, Anesthesiologist, and Nursing Coverage Plan

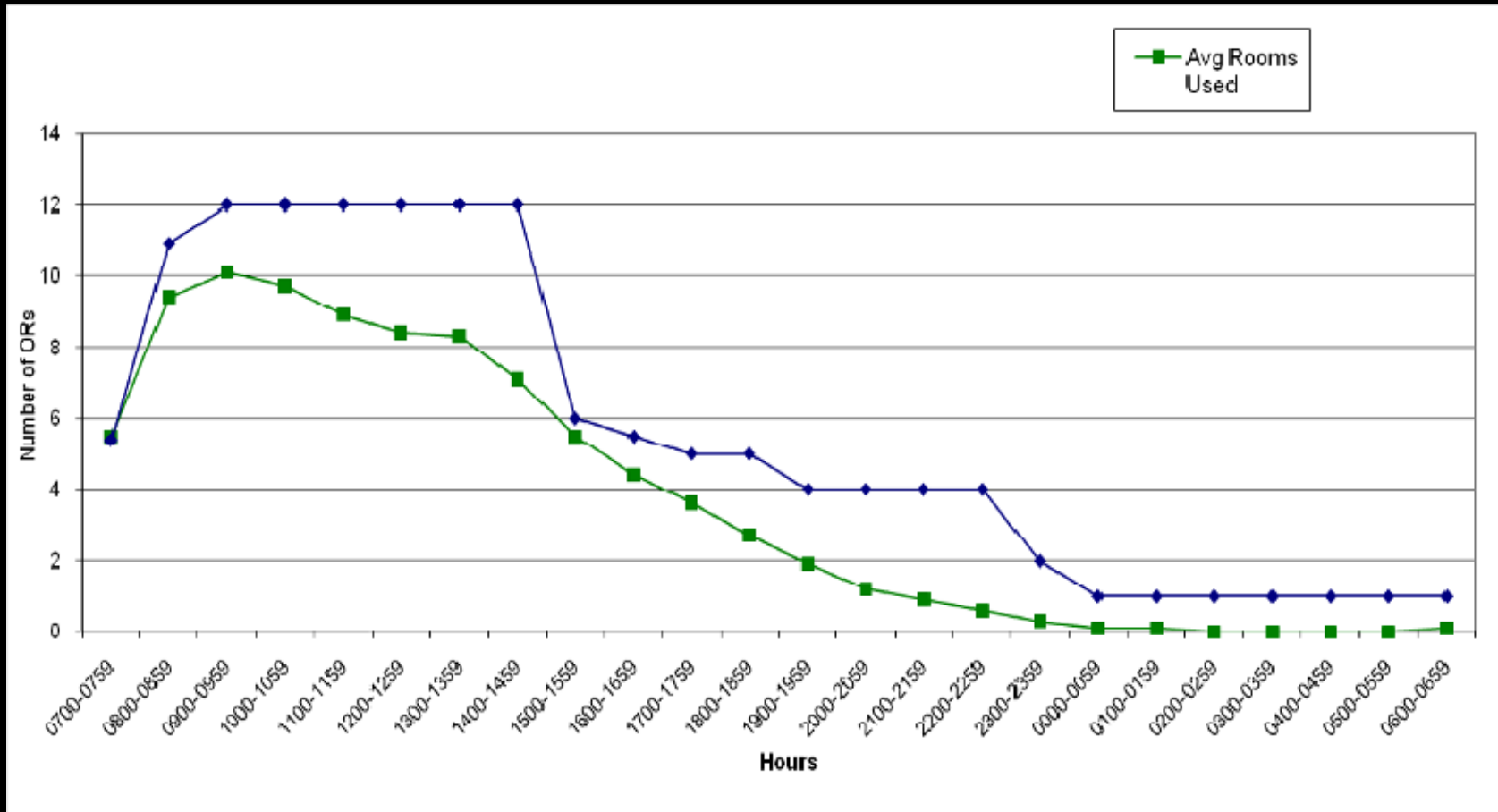
- A coverage plan based on historical daily demand is the starting point to developing an effective scheduling system.

# Coverage Plans

- Based on historical volume and demand
- Founded on the mission and vision of the surgical program
- Require agreement and balance between nursing and anesthesiology
- Do not open what cannot be covered every day
- Keep open regardless of daily volume fluctuations – guaranteed availability

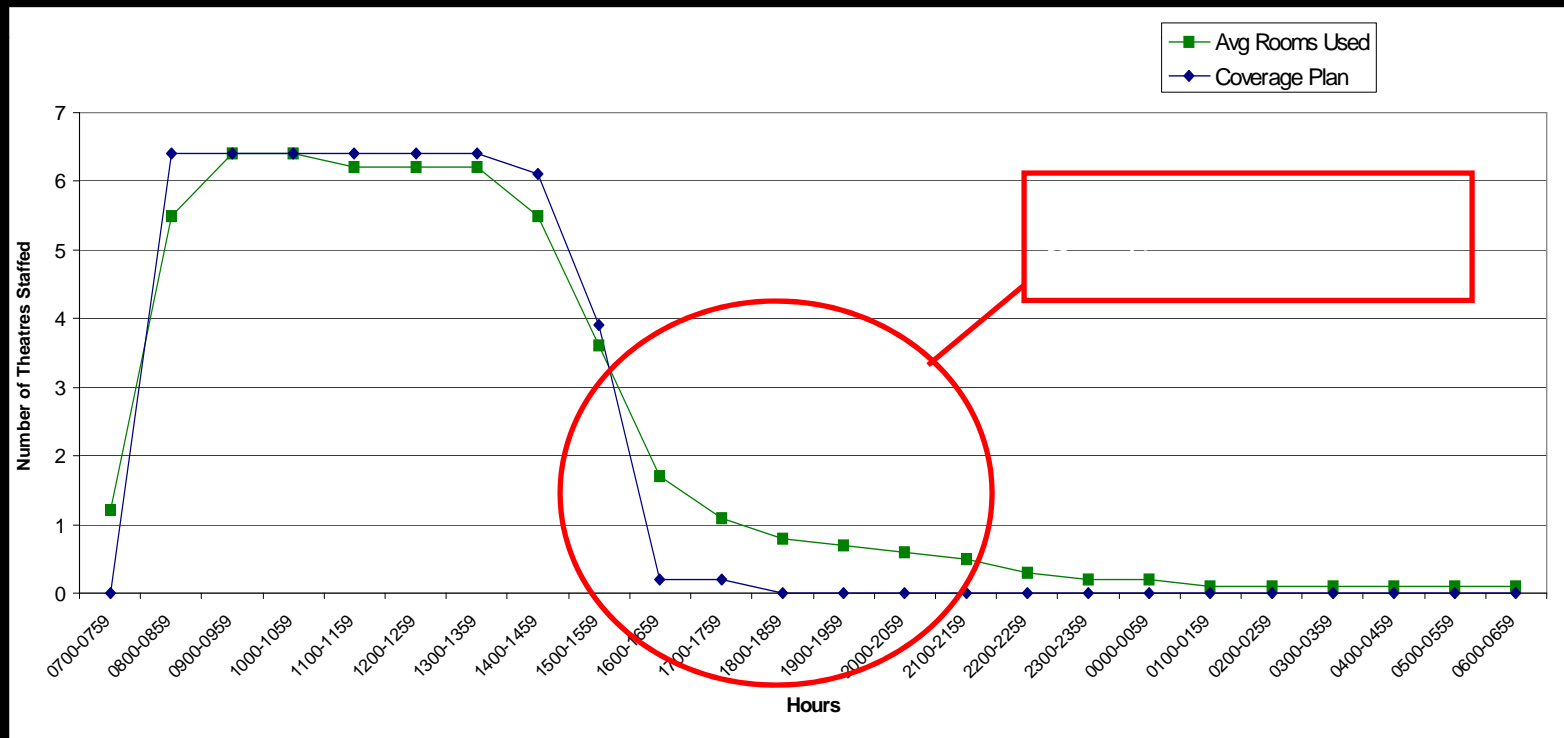


# Historical Utilization Monday-Friday



# Utilization Indicators

Performance Indicator	Client Value	Client Quartile	Comparison Group Values		
			75th	Median	25th
Overtime Percent of Worked Hours					
Direct Patient Care	4.2%	1	0.8%	1.9%	3.3%
Time Critical Support Staff	2.8%	1	0.2%	0.5%	2.2%
<b>Subtotal for Functional Area</b>	<b>3.7%</b>	<b>1</b>	<b>0.7%</b>	<b>1.6%</b>	<b>2.9%</b>

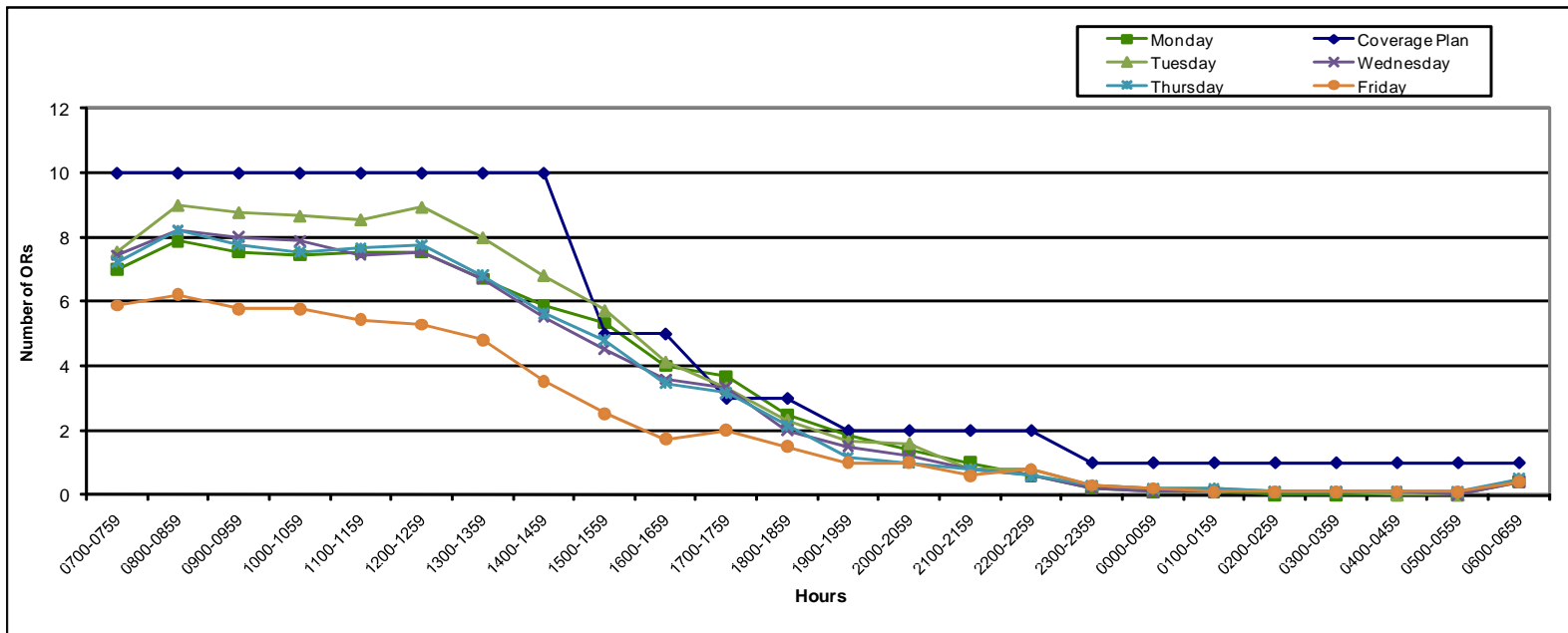


# Coverage Plan

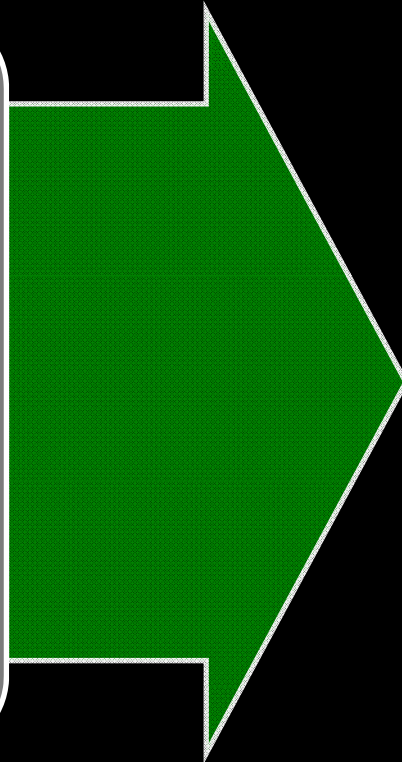
- Not cast in stone
  - Review and evaluate every 3-6 months
  - Use target utilization rates to open/close coverage based on a 3-6 month average
- Understand that you must open it before you can fill it
- Does not have to be a cookie-cutter approach
- Use targets to increase or decrease coverage plan

# Consider a Different Coverage Plan by Day of Week

Coverage Utilization	Coverage Plan	Avg Rooms Used at Target Utilization
0800-1159 68%	10.0	0800-1159 7.6
1200-1459 55%	10.0	1200-1459 6.5
1500-1659 60%	5.0	1500-1659 3.9
1700-1959 50%	2.7	1700-1959 2.3
2000-2259 23%	2.0	2000-2259 0.9
2300-0759 42%	2.0	2300-0759 0.9
0800-1459 63%	10.0	0800-1459 7.1



**Recommended  
Utilization  
Targets**



**Coverage Plan Utilization**  
*Monday through Friday*

<b>Time of Day</b>	<b>Coverage Plan Utilization</b>
7:00 AM-12:00 PM	90%
12:00 PM-3:30 PM	70%
3:30 PM-7:00 PM	65%
7:00 PM-11:00 PM	60%

# Coverage Plan Requirements

- Anesthesiology and nursing coverage must match
- Non-OR anesthesiology demands must be isolated from OR coverage whenever possible
  - Endoscopy
  - L&D
  - Pain
- Coverage changes must be communicated 1-3 months in advance
- Separate coverage that is scheduled from call coverage

# Variable OR Access Plan

A variable OR access plan should be developed based on historic urgent, emergency, and elective demand

# Elective, Urgent, and Emergency Schedule Access Plan

<i>Location</i>	<i>Site 1</i>	<i>Site 2</i>	<i>Site 3</i>	<i>Cardiac</i>	<i>Site 4</i>	<i>Site 5</i>
7:30-8:00	Green	Green	Green	Grey	Green	Green
8:00-8:30	Green	Green	Green	Grey	Green	Green
8:30-9:00	Green	Green	Green	Grey	Green	Green
9:00-9:30	Green	Green	Green	Grey	Green	Green
9:30-10:00	Green	Green	Green	Grey	Green	Green
10:00-10:30	Green	Green	Green	Grey	Green	Green
10:30-11:00	Green	Green	Green	Grey	Green	Green
11:00-11:30	Green	Green	Green	Grey	Green	Green
11:30-12:00	Green	Green	Green	Grey	Green	Green
12:00-12:30	Green	Green	Green	Grey	Green	Green
12:30-13:00	Green	Green	Green	Grey	Green	Green
13:00-13:30	Green	Green	Green	Grey	Green	Green
13:30-14:00	Green	Green	Green	Grey	Green	Green
14:00-14:30	Green	Green	Green	Grey	Green	Green
14:30-15:00	Green	Green	Green	Grey	Green	Green
15:00-15:30	Green	Green	Green	Grey	Green	Green
15:30-16:00	Green	Light Green	Green	Grey	White	White
16:00-16:30	Green	Light Green	Green	Grey	White	White
16:30-17:00	Green	Light Green	Green	Grey	White	White
17:00-17:30	Green	Light Green	Green	Grey	White	White
17:30-18:00	Green	Light Green	Green	Grey	White	White
18:00-18:30	Green	Light Green	White	Grey	White	White
18:30-19:00	Green	Light Green	White	Grey	White	White
19:00-19:30	Green	Light Green	White	Grey	White	White
19:30-20:00	White	Grey	White	Grey	White	White
20:00-20:30	White	Grey	White	Grey	White	White
20:30-21:00	White	Grey	White	Grey	White	White
21:00-7:30	White	Grey	White	Grey	White	White

Protect Elective Schedule



# Block Scheduling

- 100% blocks or 100% FCFS results in daily crisis management in the OR
- A combined block, FCFS, and urgent/emergency program is the only schedule infrastructure that allows for development of a daily planned schedule process in which scheduled case times can happen as planned

# Components of a Good Block System

- Individualized – not one size fits all
  - Variable block sizes
  - Variable block release times
- Block allocation based on surgeon's contribution to the hospital
  - Utilization of existing blocks
  - Historical volume
  - Service to the hospital
  - Compliance with policy
  - Contribution to mission (teaching, research, critical service, etc.)

# Components of a Good Block System

- Transparency – no backroom deals
- Ability to increase/decrease/modify blocks
- Utilization should include reasonable turnover time
- Surrender time for vacation far enough in advance so that time can be used by others

# Block Management Requires Reports to Objectively Make *Data-Driven* Change

# Block Utilization

## Key Columns:

Block Utilization  
Percentage

Surrender  
Release (time  
given back to  
the OR with 4 or  
more weeks  
notice)

Out of Block  
time

# What Are You Looking For?

- What is the utilization?
  - Is it at the target or not?
- Is the block the right size?
  - Excessive surrender time
  - Low utilization
  - High utilization
  - High out-of-block utilization
- Is the block on the right day?
  - Low block utilization but high out-of-block utilization

# Block Utilization Report

## Hospital A

### Block Utilization - Elective Cases Only

1/1/2010 to 12/31/2010

Block	Allocated Block Time Hours						# of Cases	Actual Hours						Block Utilization	
	Scheduled	Facility Release	Facility Release %	Surrender Release	Surrender Release%	Available		Before Block Start	During Block	After Block Stop	No Credit	Out of Block	Total		
Sample Service															
GRETZKY, WAYNE	1,282	56	4%	107	8%	1,120	567	25	973	56	54	123	1,232	87%	
HASEK, DOMINIK	840	16	2%	72	9%	752	236	7	525	70	4	122	728	70%	
HOWE, GORDIE	208	8	4%	16	8%	184	64	2	88	18	1	71	180	48%	
HULL, BOBBY	878	32	4%	22	2%	825	174	9	257	50	0	34	350	31%	
ORR, BOBBY	443	17	4%	76	17%	350	168	10	307	46	12	103	477	88%	
YZERMAN, STEVE	1,002	55	5%	68	7%	879	613	27	751	59	2	246	1,084	85%	
Total	4,653	184	4%	360	8%	4,109	1,822	79	2,900	299	73	699	4,051	71%	

# Does the Block Utilization Report Tell the Whole Story?

- Not usually – one report is insufficient
- Look at OR utilization. Do the stories match?
- What kinds of cases are performed? Elective? Urgent/emergency? Develop a report to show:
  - Elective volume/hours of surgery
  - Urgent/emergency case volume/hours of surgery
- Consider looking by time of day and day of week
  - This might be too much information



# Surgeon Scorecard

Hospital A  
GRETZKY, WAYNE  
12/01/2010 - 12/31/2010

Case Timeline (in minutes)

Patient Type	Case Count	Patient in to Incision	Incision to Closure	Closure to Patient Out	Turnover Time	Total Case Duration
Inpatient	20	29	128	11	29	197
Outpatient	17	11	28	6	27	72
Total	37	21	82	9	28	140

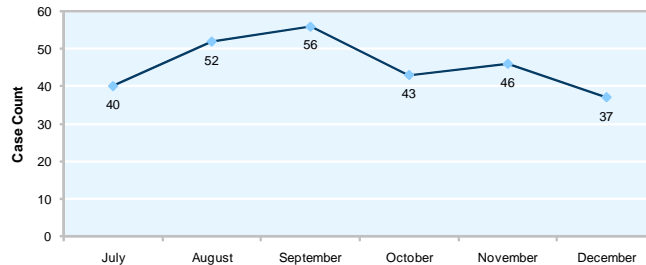
First Case Start Time Accuracy

Case Category	Case Count	Early	On Time	On Time %	Late
First Case of the Day	7	0	5	71%	2

Volumes

Patient Type	Case Count	%	6 Month Total	6 Month %
Inpatient	20	54%	227	53%
Outpatient	17	46%	201	47%
Total	37	100%	428	100%

Surgeon Volume



Payor Mix

Insurance Provider	Contribution %	Insurance Provider	Contribution %
Medicare	N/A	Blue Cross	N/A
Medicaid	N/A	Private	N/A
Self-Pay	N/A	Other	N/A

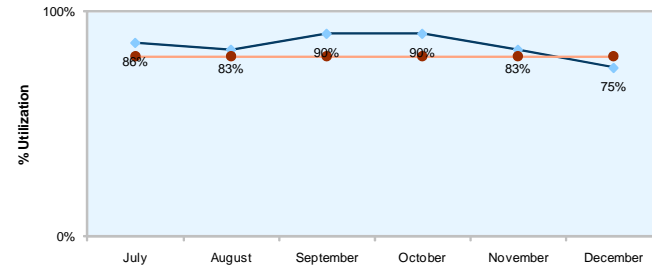
Block Schedule

Block Name	Block Type	Weekday	Rooms	Month Weeks	Start Time	Stop Time
GRETZKY, WAYNE	Surgeon	Monday	1	ALL	0730	1530
GRETZKY, WAYNE	Surgeon	Thursday	1	ALL	0730	1530
GRETZKY, WAYNE	Surgeon	Wednesday	1	ALL	0830	1700

Block Utilization

Block Name	Scheduled Minutes	Released Minutes	Available Minutes	During Block Minutes	Out of Block Minutes	Total Surgical Minutes	Block Utilization
GRETZKY, WAYNE	6870	1470	5400	4028	366	5171	75%
GRETZKY, WAYNE	6870	1470	5400	4028	366	5171	75%

GRETZKY, WAYNE Block Utilization



# Summary

- Mix of block/open/UE access has been shown to be the most effective at improving utilization and growing volume
- Block scheduling requires rules/policies and transparent development and must be performance based – not entitlement
- Physician lead governance structures will allow an OR to implement a new program and sustain it over time, allowing it to adapt to changes in volume

# Reference

All information in this presentation was acquired during Sullivan Healthcare Consulting, Inc's 35 years of experience in perioperative consulting