

Think Outside the (Block Scheduling) Box

Get a new perspective on how the block schedule can optimize OR profits.



Imagine a powerful tool that would revolutionize efficiency, quality, and patient flow in the operating room. When used correctly, block scheduling bridges the gap between surgeon demand and available support staffing. As unending technological advancements result in new surgical

techniques, operating room managers and administrators must further adapt the traditional block model to account for ever-increasing utilization. By identifying and eliminating the flaws in the traditional block schedule model, perioperative services can create an even better scheduling approach.

Defining The Problem: The Roots of OR Scheduling Issues

As reported by MedCity News, the Medical Group Management Association estimates that most surgical center operating rooms achieve only **50 to 60 percent utilization** despite the fact that surgeons perform more than 51 million surgeries every year in the United States.

Every minute of wasted OR time costs about \$70 of revenue.

At the same time, every minute of OR staff time costs at least \$50.¹

An overtime rate exceeding 3.5 percent for perioperative staff indicates problems with a facility's scheduling system.

Common Factors Contributing to Problems with OR Scheduling:

1. Delayed case starts, an issue that compounds as the day progresses.

Ideally, 95 percent of the team should be in the room five minutes before the first scheduled case of the day begins.

2. Schedule changes on the day of surgery. Many ORs struggle with cancellation rates higher than 1 percent and time changes in more than 15 percent of cases.

Ideally, 90 percent of cases should start within 15 minutes of the planned start time. This applies to all cases throughout the day.

3. Add-on cases rate exceeding 14 percent or even higher for academic medical centers and trauma hospitals.

While it may be impossible to reduce urgent and emergent add-on cases, effective block scheduling can often eliminate elective add-ons.

4. Poor utilization of resources, generally defined as less than 80 percent when reasonable turnover time is included in room used time. Target utilization should be:

- 90 to 95 percent morning utilization
- 80 to 85 percent afternoon utilization
- 50 percent utilization after 8 p.m.

5. Extended pre-op and post-op stays for patients.

Target post-procedure observation periods of no more than 90 minutes pre-op and 75 minutes post-op.

Ideally, 100% of all scheduled patients should have a complete chart at 4 p.m. the day before surgery. A complete chart includes a nursing assessment, signed and completed informed consent, History and Physical, result of all ordered testing/consultations/clearances.

6. Lack of an effective scheduling pathway. Allowing offices to book electronically instead of calling/faxing will increase satisfaction, accuracy, and compliance with scheduling policies will help to eliminate operational and financial inefficiencies.

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Basics of the Block Schedule

With a traditional block schedule, the OR manager divides each day into “blocks” for each surgical suite. Each surgical team, or “block holder,” is allocated specific blocks depending on their needs. The block schedule details the department, surgeon, type of surgical procedure, and required resources for each block.

Benefits of the Block Schedule



In theory, the block schedule has key advantages that facilitate a profitable, efficient OR.

Direct Surgeon Access

Surgeons struggle with near-constant demands on their time. Allowing them direct access to the block schedule lets them work around their competing priorities without resorting to expensive add-on time. With a block system that allows doctors to manage their own time, they can increase their productivity. In this competitive environment, surgeons prefer facilities that offer streamlined scheduling, creating a direct, measurable impact on revenue and market share.

Improved Staff Planning

Implementing an OR team system streamlines the schedule and reduces

the number of add-on cases. With this structure, each block in the week is associated with a designated “pod” of staff members depending on the needs of the surgeon for that room. This reduces expensive overtime wages for after-hours procedures and improves staff retention by offering the benefit of a more stable work schedule. This typically results in improved morale and productivity across nursing, anesthesia, and other OR teams.

Heightened Financial Returns

A well-run block schedule accommodates more daily cases without overspending on human resources or overbooking the facility. This directly increases the surgical center’s profits by reducing the cost per case.

Common Block Schedule Mistakes

Despite best efforts when implementing a new scheduling system, even a carefully planned block schedule may not have the expected effect on OR efficiency. Thorough due diligence can increase the likelihood of success with awareness of these common mistakes that allow late cases, overtime, and operational issues to persist.

Mismatched Resources and Demand

The block structure does not reflect the demand for staff coverage and resources. Existing surgeons block rooms they don't use, resulting in a low utilization rate and the inability to add new surgeons to make up the lost profit.

Mismatched Strategy and Utilization

In this case, the makeup of the blocks does not reflect the facility's strategic direction. For example, a surgical center with a mission to support women's health must dedicate a large percentage of the blocks to female-focused specialty areas.

Lack of Priority Blocks

High-volume surgeons should receive priority over their lower-volume counterparts. Otherwise, blocks remain reserved for surgeons who rarely bring in business as busier doctors resort to add-on cases. The red flag for this issue is an add-on rate exceeding 15 percent even after block schedule implementation.

Lack of Dedicated Resources for Each Block

When blocks do not differentiate the different types of resources required for different types of cases, a facility may pay for unnecessary staff, or the surgeon may not have enough staff to complete the procedure.

Creating a consistent block schedule protocol tailored to the facility can surmount these obstacles to optimum revenue. OR management must closely guard each block as a valuable source of revenue for the surgical center.

Components of a Successful Block Schedule Plan

Seamless operation is the hallmark of a successful block schedule. Each surgical practice or surgeon has dedicated blocks set aside for use and can independently book patients for these reserved resources. OR Today reports that at the most efficient surgical centers, surgeons feel like they made a reservation at a restaurant. Everything they need, from space to staff, should be ready when they arrive. They have the benefit of setting a routine that works for their needs and having a predictable block of time at your facility every week, which increases satisfaction and thus utilization levels.²

When surgeons cannot easily access the necessary resources through a facility's block schedule, they typically abandon the process and begin booking blocks directly through senior administrators. Cases begin to run late, which impacts staff morale. These best practices can improve the chances of success when implementing a new block schedule system.

1. Establish Utilization Requirements

Overcoming issues with the traditional block schedule starts with addressing utilization requirements, or the amount of time that must be filled before the system allows for add-on time. Many block schedules have the same amount of time available each day, with 50 percent of rooms open. Typically, this type of system halves the available coverage at 3 p.m. and again at 5 p.m. each day, with a single room available on Saturday.

Successful block schedules modernize this approach by using real-time OR data to update available blocks and resources based on actual volume and utilization. Rather than standard block lengths, surgeons have access to variable block lengths depending on the needs of each case. Most facilities should default to full-day blocks, with half-day blocks available only in the morning. Figures 1 and 2 provide examples of the use of utilization reports for resource and block planning.

Rooms Required by Hour of the Day At Target Utilization | Monday - Friday | Jan - Dec 2018

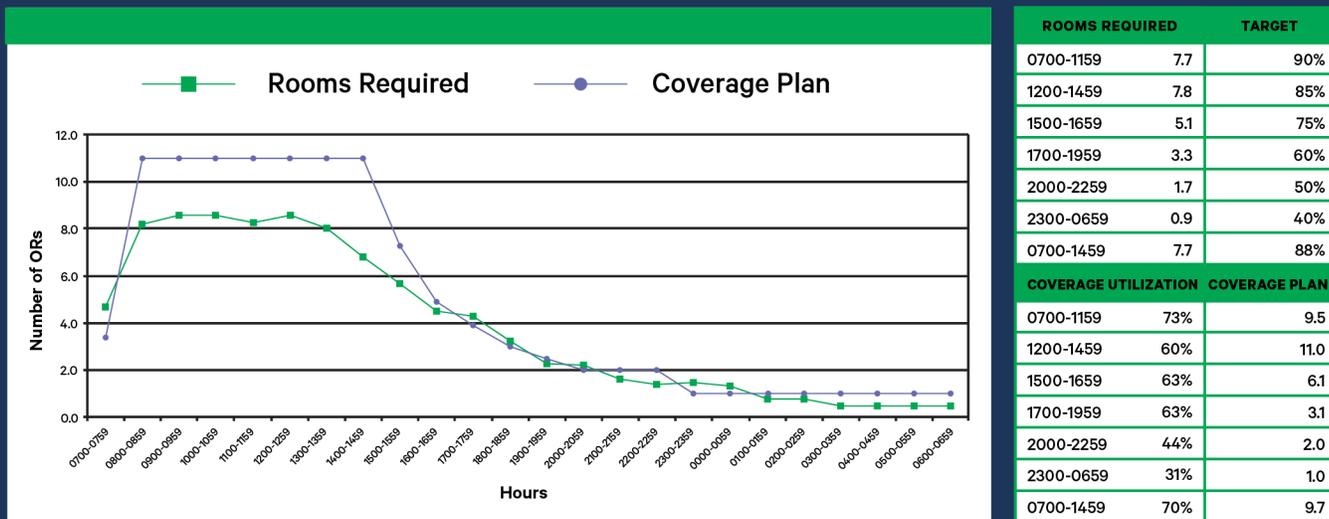


Figure 1

2. Plan Smart Coverage

Instead of treating every surgeon's office equally, OR management should allocate blocks proportionately based on factors that include:

- The overall OR capacity of the facility
- The mission of the hospital or health system, which must be covered regardless of utilization
- Anesthesiology requirements outside the OR
- Attention to the historical utilization of each surgeon alongside designated space for new practices

- Flexibility for daily volume fluctuations based on utilization data
- Available resources, including rooms, equipment, and teams

Based on this information, the facility can determine the maximum number of blocks available per service line per day, limited to the number of rooms available and the number of surgical teams available. OR management should then assign the non-elective blocks before allocating the elective blocks on a first-come, first-serve basis according to the criteria above.

Rooms Required by Hour of the Day At Target Utilization

COVERAGE UTILIZATION		COVERAGE PLAN	ROOMS REQUIRED		TARGET
0700-1159	71%	9.1	0700-1159	7.2	90%
1200-1459	56%	11.0	1200-1459	7.3	85%
1500-1659	59%	6.1	1500-1659	4.8	75%
1700-1959	60%	3.1	1700-1959	3.1	60%
2000-2259	43%	2.0	2000-2259	1.7	50%
2300-0659	28%	1.0	2300-0659	0.7	40%
0700-1459	63%	10.1	0700-1459	7.2	88%

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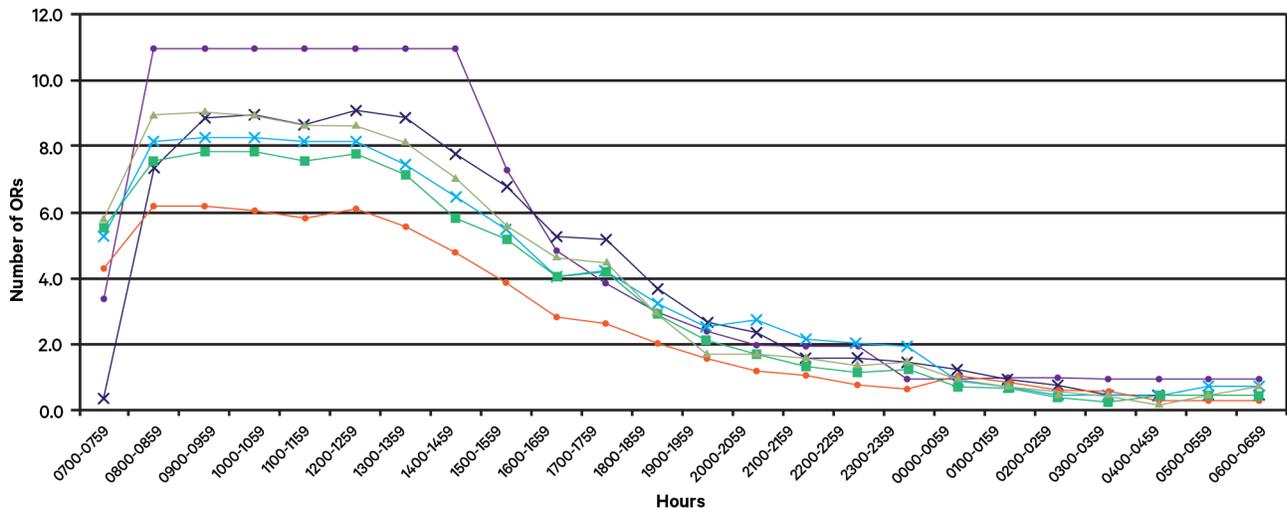


Figure 2

3. Decide How to Prioritize Surgical Practices

Success in block scheduling requires a transparent process that prevents surgeons from dealing directly with senior administrators to book time. A careful balance of priorities caters to growing surgical practices while also welcoming new practices and accommodating those with declining revenue.

Facilities should rank each surgeon based on both accountability and utilization. For small group and individual practices, managers can negotiate specific details of their block access. New practices with low utilization should be subject to a probationary period. First-case blocks should be reserved only for practices with high accountability and utilization rates.

4. Automatically Release Unused Blocks

As discussed above, surgical centers should keep about 50 percent of available blocks open for emergent cases and other last-minute needs. To facilitate this effort, establish an automatic release for unused blocks based on practice utilization. Release blocks into open access if they have not been booked with three to six weeks' notice for surgeons with below 50 percent utilization. Shorten the time frame to two weeks for higher utilization practices. Reserve the lack of automatic release as a privilege for surgeons with above 95 percent utilization of their allotted time.

5. Create Daytime Add-on Blocks

These time slots can accommodate time-sensitive acute care areas, such as orthopedic trauma, without resorting to after-hours add-on blocks. Designate each daytime add-on block for a specific surgeon in the relevant area who will receive that day's emergent and urgent referrals from the emergency department and elsewhere. Define the utilization criteria surgeons must meet to maintain these blocks.

6. Build a Strong Governance Structure

Without clear, definitive governance, an OR cannot realize or sustain the available efficiency gains of a smart block schedule. A leadership team that comprises three to four stakeholders from various departments, including nursing, surgery, and anesthesiology, should meet with OR leadership at least weekly to discuss changes to individual block allocation, iterate the existing block model based on OR data, and enforce policies regarding utilization.

In most facilities, the perioperative medical director should manage this committee. This person should be a hospital employee, not a member of the medical staff. He or she serves as the liaison between the facility's perioperative program and the surgeons on staff, enforcing perioperative policies in real-time to protect the integrity of the block scheduling model.

Pulling it All Together: The Frequent Flyer Model

A “frequent flyer” model assigns surgeons to tiers based on their contributions to the facility and its mission. Examples, which will vary based on the size, type, and vision of each institution, include service, tenure, teaching, historical volume, complexity level of cases, employment status, historical profit, and the amount of time spent doing procedures at other facilities. Considering these attributes allows OR management to fairly allot limited resources such as space, teams, equipment, and imaging services without damaging valuable surgeon relationships.

Create Value for High Performers

As discussed above, the OR must be transparent about the consistent, objective, data-driven formula used to allocate surgeon blocks. Create a clear threshold to meet bronze, silver, gold, and platinum service tiers based on the number of cases and the other factors detailed above.

Attractive offerings for the highest-performing typically include short release times, first choice of available blocks, and access to late rooms. Surgeons who attain the platinum level will have a dedicated team, coordinator, and streamlined process.

Gold, silver, and bronze tiers offer decreasing privileges but still include guaranteed weekly time. Surgeons that are new or have not met the minimum criteria for bronze status can sign up for open blocks only. ORs that serve several low-volume practices can pair them together to share blocks.

Enhance Access to Information

Publishing the practices at each level emphasizes a culture of transparency. Provide a monthly block report that includes a detailed summary of each day’s cases and times, additional urgent and emergent cases, selective cases, and total case time in blocks. According to research published in Becker’s Hospital Review, hospital administrators cite lack of actionable transparency as the biggest OR scheduling challenge.

Many facilities rely solely on weekly or even monthly dashboards that don’t provide the necessary details about real-time utilization. Instead, release daily digests of quick facts that provide insight into the process. This approach gives medical staff and administrators a baseline understanding of the expected OR performance and the root causes of issues such as released and abandoned blocks, late first-case starts, and poor utilization across rooms, block types, and centers.³

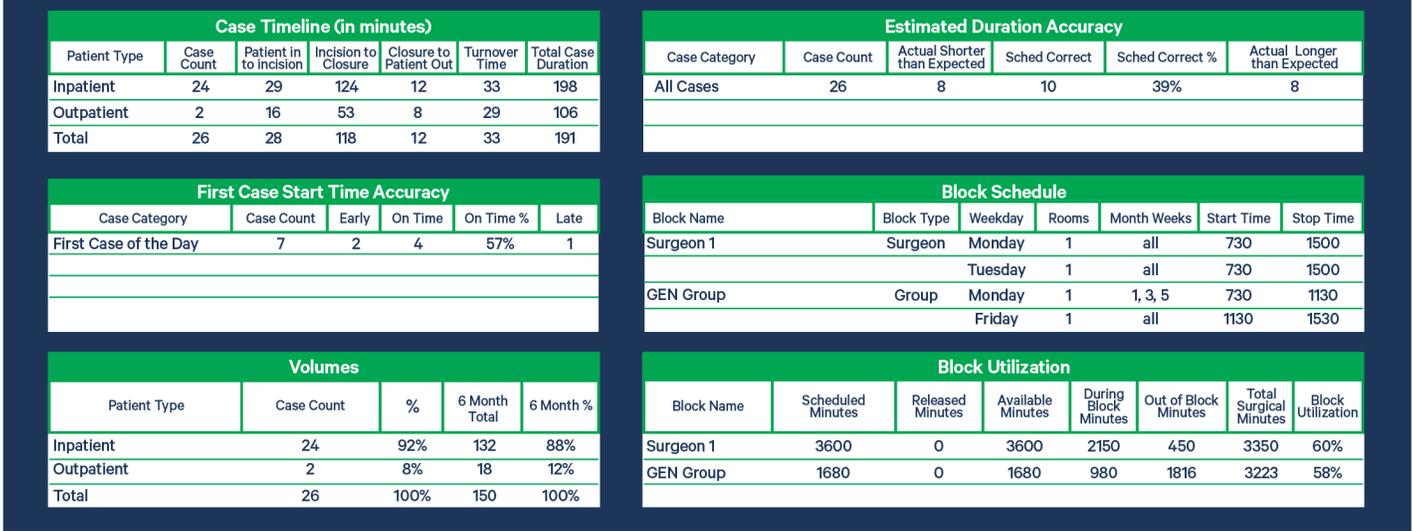


Figure 3

For example, MedCity News envisions a system in which surgeons receive a daily sheet of statistics, such as long-running cases, late cases, cancellations, utilization, and on-time starts. Seeing these numbers, especially in comparison to the other members of the medical staff, often drives physicians to improve performance in lagging areas.

Figure 3 provides a sample of the Surgeon Scorecard developed for a Sullivan Healthcare Consulting client. This approach improves surgeon awareness of utilization and supports an OR culture of accountability for the privilege of block time.⁴

Give New Practices a Trial Period

To attract new practices, consider a six-month trial period for an available slot. The surgeon can use this time to market procedures at your site and increase volume enough to qualify for the desired service tier.

Commit to Changing

The block schedule must have the flexibility to adapt to changing circumstances and correct unforeseen problems. Biweekly review of both the qualitative and quantitative data will inform an iterative process of adjusting the blocks according to actual numbers and staff experience. Schedule management remains essential to facilitate ongoing growth.

Personalize the Approach

OR Today recommends that management directly address surgeons whose usage data shows insufficient utilization, a high rate of late starts, or other issues that threaten productivity. Rather than taking a confrontational approach, OR leaders should collaborate with each group and suggest strategies to help practices meet established utilization goals.

³ <https://www.beckershospitalreview.com/healthcare-information-technology/radically-improving-block-utilization-in-operating-rooms.html>

⁴ <https://www.sullivanhealthcareconsulting.com/single-post/2020/05/14/surgeon-scorecard-case-study-using-a-surgeon-to-monitor-or-utilization>

Why it Matters: The True Impact of a Successful Block Schedule

According to MedNews Today, increasing OR utilization by just one percentage point can translate to hundreds of thousands of dollars in increased revenue for a facility with a single OR. Just a small increase in utilization can result in millions of dollars annually for a 10-OR surgical center or hospital.

Beyond revenue, increasing the surgical capacity of an OR will help fulfill the health care demand for aging Americans. The Census Bureau says that 71 million people in the U.S. will be age 65 or older by 2030. What's more, by 2025, 49 percent of Americans will likely experience the health impact of a chronic disease such as type 2 diabetes. The need for high-tech, efficient, quality hospital-based operating rooms and ambulatory surgical centers will only continue to grow.

As your facility prepares to thrive in the coming months and years, meeting the challenges of scheduling might require more resources than your managers have at their fingertips.

Sullivan Healthcare Consulting offers robust perioperative consulting designed to help OR clients maximize the dramatic potential of this cost center while minimizing its significant risk of financial loss.

Enroll in our Best Practices in Surgery Scheduling program for a comprehensive analysis of your current block schedule to reveal hidden issues that compromise profitability. Our consultants create a customized, consistent block schedule policy for your organization that will enhance schedule accuracy, lower case cost, protect resource utilization, increase the on-time start rate, and increase the daily case rate. Contact Sullivan Healthcare Consulting today to reduce the stress associated with OR scheduling.