

MANAGED CARE OUTLOOK

Improved OR management alleviates common frustrations

Providers and payers benefit from efficient scheduling, balanced utilization and adequate staffing

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The medical practice environment has changed dramatically. Providers no longer enjoy the luxury of admitting patients three to four days prior to surgery, or observing them for five to six days afterward. So high are the costs of technology and demands for efficiency that providers must move patients in and out of surgery as quickly as possible.

Common frustrations such as lack of block time, inefficient scheduling, delays and cancellations, and poor utilization and staffing come with a big price tag. Providers easily can lose market share because of a dysfunctional operating room (OR). Physicians, in turn, can lose revenue and compromise gains in quality and outcomes.

Unfortunately, the majority of hospital ORs aren't built or managed to serve the interests of anesthesiologists, surgeons or patients. Such was the case of a 750-bed academic medical center in the Midwest. Despite a bottom line of \$49 million, the hospital watched its market share decline from 38% to 34%. Faced with an autocratic OR director, eager young surgeons found it almost impossible to access the OR schedule. OR block time stood at an incredible 98%. If surgeons managed to schedule a procedure, they still faced OR turnover averaging 85 minutes, as well as a nurse turnover rate of 40%.

Hospital executives realized that for every hour lost in the OR, the hospital lost \$1,800. Frustrated hospital executives called in physician consultants to initiate an OR turnaround process. Ideally, providers and payers can work together to replicate this process in any surgical setting:

- Develop a surgical executive committee consisting of executive and medical leaders who

have earned the respect of surgeons. Include key surgical department chairpersons and informal surgical leaders.

- Appoint an anesthesiologist as medical director of perioperative services. This person takes control of the OR schedule, room assignments, and OR process issues such as preoperative testing requirements.

- Allow the committee or task force to collaborate in creating guidelines for block time utilization. For example, setting target OR usage at 85% will ensure that surgeons use their scheduled time.

- Measure OR utilization monthly, and provide surgeons and committee/task force members with monthly utilization reports. Such reports should include OR time blocks, utilization by surgeon, total monthly OR time and cases cancelled.

- Change block time utilization based on surgeon utilization. If a surgeon's OR utilization falls below 85% for three consecutive months, management should reduce the amount of block time. However, if a surgeon's utilization is at 100%, management should increase block time.

- Measure profitability by block time category and payer mix. Unfortunately, not all categories will generate the same levels of profit.

The academic medical center that originally implemented this OR turnaround plan boosted its surgical market share from 25% to 30% within 18 months while growing its surgical volume services to include profitable procedures in otolaryngology, gynecology and sports medicine. On a more qualitative level, the autocratic OR director was toppled in favor of a multidisciplinary, collaborative approach featuring a partnership between medicine and nursing.

Healthcare executives and physician leaders are eager to find lasting OR turnaround solutions. Providers have no choice but to treat surgeons and anesthesiologists as valued clients and re-engineer OR operations. The result will be higher satisfaction and higher quality. MHE

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