The success of a hospital is often measured by its OR. Surgery programs generate 65 percent of a fiscally sound hospital’s margin. And facilities that are in trouble usually have dysfunctional ORs. Volume might be declining; cases such as GI, endoscopy, or pain management could be clogging the throughput; or the facility may have a “say yes to everything” mentality about its OR. Any of those diagnoses could make a hospital terminal. What’s the key to survival?

“Managing capacity and setting reasonable, rational and explainable constraints on volume so that growth can occur,” is what Sullivan Healthcare Consulting President Randy Heiser says will put a facility on a path to success. Sullivan HC identifies several constraints on increasing volume: Intraoperative constraints involve physical OR space, both the number of rooms available and the size of the rooms; technology and equipment; staff availability; anesthesia availability and coverage; pre- and post-op space for patients; and the availability, storage and adequate areas for processing supplies and instruments. Some external restrictions to increasing surgical volume include budgetary limitations; inpatient bed availability; and the availability of both radiology and rehab services, such as physical therapy, on weekdays and weekends. Fine-tuning these constraints so that they are in synch with volume can lead to increased efficiencies, and—coupled with capacity management—increased surgical volume at just the right level.

**Capacity Management**

Heiser identifies capacity management as “the strategic forecasting of perioperative resources so that suitable investments can be made to achieve your hospital’s measureable OR goals.” Medical leadership and hospital executives enter into a partnership to establish and agree upon the goals. Hospital investments are decided in advance and evolve as part of the budget process. The investments are data-driven and completely transparent. The collaboration between a Surgery Executive Committee (to enforce policies, set budgets and manage capacity) and hospital executives ensures objectives are met and the OR stays on track.
Balancing OR Access & Hospital Capacity

Insights from Sullivan Healthcare Consulting’s President, Randy Heiser

Several factors must be examined as a hospital moves toward managing its OR capacity:

<table>
<thead>
<tr>
<th>Size</th>
<th>• How big should the OR be, and over what footprint?</th>
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<tbody>
<tr>
<td>Time</td>
<td>• What are the hours of operation?</td>
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<tr>
<td>Services</td>
<td>• What services will be offered and how will they be distributed?</td>
</tr>
<tr>
<td>Priority</td>
<td>• Who gets OR time and when?</td>
</tr>
<tr>
<td>Resources</td>
<td>• Which are available and how are they managed?</td>
</tr>
<tr>
<td>Governance</td>
<td>• Who manages capacity?</td>
</tr>
<tr>
<td>Performance</td>
<td>• What are the OR targets and how is the facility going to achieve them?</td>
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After the data is gathered, a capacity management process can be set up. It will need an effective governance structure and solid scheduling policies, as well as resources to determine the budget and capacity process, analyze data and provide recommendations for block changes. This data—once captured, shared and analyzed—serves to justify the changes and sustain them.
Governance, by Committees and Director

The governance structure in the capacity management process is one of the most important components. It involves a Surgery Executive Committee, a revised or improved Surgery Committee and a Surgery Medical Director. The Surgery Executive Committee is like a board of directors, dedicated to the overall program. This group meets frequently to manage capacity, receive data and take any actions necessary. These are the “big picture” people, who provide best practices that focus on patient and surgeon needs, as well as an increase in OR case volume, revenue and margins adequate enough for new technology, medical staff expenses and competitive wages.

A new Surgery Committee would be a bit larger, with department chairs, section chairs, the Director of Perioperative Services, administrators and the Surgery Medical Director among its members. This group approves medical staff policies and communicates policies to relevant staff. It also works with hospital administration and the Surgery Executive Committee on strategic planning.

The Surgery Medical Director is a board-certified surgeon/anesthesiologist. He or she must know the OR inside and out. The Director needs exceptional interpersonal and communication skills with patients, physicians and other clinical and administrative personnel. He or she is respected by those who work in the OR and is committed to improvement of OR processes and systems. This physician would take the lead in making medical and operational policy recommendations to the Surgery and Surgery Executive Committees, and ensure that surgeons and anesthesia providers adhere to those policies.
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**Surgery Scheduling, Block-by-Block**

Surgery scheduling must be done to allow for, of course, scheduled cases, as well as urgent and emergent surgeries, elective surgeries and elective FC/FS access. To be successful, the block scheduling design must be linked to the surgery capacity management plan, and the coverage plan should match demand and be guaranteed by nursing and anesthesiology.

Block scheduling can’t be one-size-fits-all. It should be individual with variable block sizes and release times, and a few half-day blocks. The schedule should be balanced with anticipated inpatient demand and flexibility to increase, decrease and modify blocks. And forget backroom deals. Transparency is essential, with an eye toward a new paradigm: access is a privilege, not a right.

**Review Plans to Ensure Efficiency**

OR coverage plans should be reviewed to compare historic demand versus coverage. Take a look also at usage by day of the week and by week of the month to see what the variability is. This allows facilities to devise a variable OR access plan based on historic urgent, emergent, and elective demand as well as the budgeted plan. It’s the basis for the capacity plan.

But remember, every hospital’s demand is different, from the volume of cases, to the case mix, to the budgeted hours. Having plans that allow for capacity to accommodate all cases, even urgent and emergent ones, will promote increased volume at the capacity your OR can efficiently handle. ♦

**Randy Heiser** has been a hospital consultant since 1983 and has specialized in surgery consulting since 1992. He has experience in hospital and ambulatory center operational redesign and reengineering, quality improvement, and operational analysis in several clinical departments. Throughout his career, Randy has remained focused on comparative data analyses and the use of benchmarking data to improve the operational aspects of clinical programs in hospitals to better manage scarce resources and improve the quality of patient care. This focus has resulted in the development of several innovative programs in use in both the United States and Canada.

For the past 15 years, Randy’s particular emphasis has been on surgery benchmark-management information systems, surgery governance, surgery benchmarking, surgery program analysis, improvement implementation, and reengineering/redesign. He is considered one of North America’s leading experts on surgery scheduling and benchmarking, and he has an impressive track record in implementing operational improvements. He has consulted with surgery programs in the US, Canada, the United Kingdom, Europe, Asia, and South America.

During the past 28 years, Randy has directed more than 500 surgery department operational improvement studies (and participated in an additional 350) in programs ranging from small community hospitals and freestanding surgery centers to some of the largest and most prestigious university hospitals in the US. He was instrumental in the design, development, and implementation of the Surgery Benchmark Program that has been used by more than 280 hospitals. He has also participated in the design of several proprietary surgery scheduling information systems currently available in North America.