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Rachel LeMahieu presents:

## **OR Utilization Guidelines**



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Thursday, December 7, 2017, 2:00pm ET

**PRESENTER: RACHEL LEMAHIEU**



Rachel LeMahieu, MSN, RNFA, CNOR, is the Director of Surgical Services, Cath Lab, and Specials at Henderson Hospital in Henderson, Nevada. Rachel received her BSN from the University of Wisconsin, Madison and her MSN at Gonzaga University in Spokane, Washington.

Rachel is responsible for the clinical, financial, and administrative functions of the operating room, pre-admit testing center, recovery room, pre-operative area, anesthesia, lithotripsy, sterile processing department, cath/specials lab, and endoscopy.

Rachel has 17 years of experience in the Operating Room ranging from circulator, scrub, RNFA, educator, charge nurse, manager, and director. She has lead Lean processes and Surgical Site Infection Bundle implementations at her facilities. Rachel was the team lead for the SUSP program at Spring Valley Hospital. Her latest project was the opening of Henderson Hospital Outpatient Surgery Department in the innovative medical community of Union Village.

**WEBINAR AGENDA:**

During the 60-minute presentation Rachel will be discussing enhancing OR use with modified block scheduling techniques, policy revision for block scheduling, capturing surgeon buy in for block optimization and using your resources for sustaining change in block allocation and utilization.



Our presenter looks forward to addressing your questions. Attendees will be on a listen only mode throughout today's presentation, but you are able to submit a question during the webinar using the "Questions" or "Chat" feature on your webinar dashboard.

You are welcome to submit your questions prior to today's webinar. Please email [webinar@mdpublishing.com](mailto:webinar@mdpublishing.com) with the subject line **"Attendee Question for OR Today's Webinar."**

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<b>Policy Title:</b>	Operating Room Utilization Guidelines		
<b>Location:</b>		<b>Department:</b>	Surgical Services
<b>Policy Number:</b>		<b>Review Due:</b>	September 2019
<b>Original Effective Date:</b>	September 2016	<b>Reviewed Dates:</b>	

**I. Scope:**

Medical Staff

**II. Purpose:**

To promote optimal use of available OR time and to ensure that surgeons who are consistent users of the facility have regular access to available OR time.

**III. Policy:**

The department of surgical services will use a modified block scheduling format. A modified block provides physicians/physician groups the opportunity to have assigned times for scheduled cases. This guideline provides a mechanism for surgeons who are infrequent users or newcomers the ability to acquire available block time or to use open time on a first-come/ first-served basis. Block time will be assigned to physicians/physician groups showing the highest utilization of available OR time. Block time will be limited so as not to exceed 75% of available OR time during normal operations. Requests that exceed the 75% in total will not be approved.

**DEFINITIONS:**

Modified Block Schedule: This type of block allows for some “open” time and provides a release time prior to the surgery date.

Hours of Operation: This is the time available for elective surgical procedures to be performed.

In and Out Time: This is the total room time and is calculated from the time the patient enters the room until the time the patient leaves the room. This time will be used to calculate utilization.

Turnover Time: This is the time for room clean up and preparation between cases. This time will not be used to calculate utilization.

Start Time: This is the time the patient arrives in the procedural suite.

Block Utilization Committee: This committee consists of the CEO, the Director of Surgical Services and designees.

Late Case Starts: Any case that has not started within 5 minutes of the scheduled start time will be

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considered late and may be moved to the end of the schedule.

Physician Arrival Time: All surgeons should be in the surgical suite ready to scrub fifteen (15) minutes before the scheduled starting time of the operation. If the surgeon fails to arrive in the surgical suite by the scheduled starting time for his case, the case will be placed at the end of the schedule and the next case will be moved up. A surgeon or anesthesiologist who has a 7:30 a.m. case scheduled must be in the Operating Room by 7:15 a.m. on the morning of the surgery. If this rule is not followed, the surgeon or anesthesiologist will not be allowed to schedule 7:30 a.m. cases in the future.

#### IV. Procedure:

All requests for block time must be submitted in writing to the Director of Surgical Services.

The hours of block scheduling will be assigned per each physician or physician group and cover either a four, six, eight, or ten hour block. The number of procedures scheduled must fit into that time allotment, and procedures must be scheduled to finish within the allotted block time.

#### Scheduling:

All scheduling within the block time will be done through the surgery scheduler.

There will be one room available each day for urgent, emergent and first-come, first-served cases.

Elective cases for the next day may be scheduled until noon, provided time is available during hours of operation.

All cases scheduled after noon, prior to day of surgery, will be considered add-ons for block schedule purposes.

Blocks will be released based on the following Tier utilization-based program before the scheduled date. This block time utilization percentage must be maintained for a period of three months in order to qualify for a Tier upgrade.

Tier I = 80% block time utilization. Block released in system 24 hours prior to scheduled block start.

Tier II = 70-79% block time utilization. Block released in system 72 hours prior to scheduled block start.

Tier III = below 70% block time utilization. Block released in system 7 days prior to scheduled block start.

Formula used for calculating block time utilization:

$$\% \text{ Utilization} = \frac{\text{Total Room Time Used}}{\text{Block Time Available} - \text{Turnover Time}}$$

A physician may release established blocks or any part of a block to "open scheduling" at any time. If

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an established block is not utilized and has not been released by the physician within the designated Tier release time, utilization will be calculated at 0%. Physicians who release blocks on a routine, patterned basis will be subject to Block Utilization Committee review and revision of block time accordingly. Planned vacations are to be submitted no less than 30 days prior to vacation start to enable other providers to utilize available surgical time.

All utilization data will be presented to the Block Utilization Committee for review. Block time will be reviewed and managed on a monthly basis.

### **Corrective Action:**

To retain block time, an overall 80% utilization of allotted block time must be achieved. If utilization falls below 80% in one month, the physician will be notified in writing and corrective action taken.

1. The first level of corrective action is to move the physician's release time to the appropriate Tier based on their block time utilization rate.
2. The second level of corrective action will be a reduction of the physician's block based on current use rate sufficient to result in 80% block use. For example, if a physician's utilization is at 55%, a 25% reduction of block time will be implemented to result in 80% utilization.
3. The third level of corrective action will be a cancellation of block time if 80% utilization cannot be achieved, once all other measures have been exhausted. Reinstatement of cancelled block time is subject to availability and approval by the Block Utilization Committee. Requests for reinstatement of block time must be submitted to the Director of Surgical Services.

All monthly utilization data will be presented to the Block Utilization Committee for review. The Block Utilization Committee will review compliance with Operating Room Utilization Guidelines policy monthly. The committee will make adjustments as deemed necessary to block time to ensure maximum efficiency in the Surgical Services Department.

During the calculation of times, the following circumstances will be factored into the utilization and surgeon findings:

1. Physician blocks are moved to different rooms, and both will receive credit.
2. The block is bumped by an emergency case. This time will not be counted as non-utilization.
3. Timely release of all or part of a block.
4. Turnover time is not included in utilization calculation.

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<b>Policy Title:</b>	On Time First Case Start Guidelines		
<b>Location:</b>		<b>Department:</b>	Perioperative Services
<b>Policy Number:</b>	S	<b>Review Due:</b>	September 2019
<b>Original Effective Date:</b>	September 2016	<b>Reviewed Dates:</b>	

**I. Scope:**

Medical Staff

**II. Purpose:**

To promote optimal use of available OR time

**III. Policy:** The Department of Surgical Services will use a guideline for First Case Start Times to allow for optimal use of the procedural areas and provide the highest quality of care and service to the customers it serves.

**Definitions:**

First Case: The First Case in each room, each day that is scheduled to start between 6am and 3pm, Monday through Friday, excluding add-ons, emergent or urgent cases.

Start Time: Defined as the time the patient arrives (Wheels In) in the Procedural/OR suite.

On time Start: Defined as the “*Patient in Room Time*”, and is within 5 minutes of “Scheduled Case Start Time”.

Physician Arrival Time: Defined as Physician arrival in PreOp/PreOp Holding Area fifteen (15) minutes prior to Scheduled Start time of procedure.

Patient Arrival Time: Patients must be in the PreOP/PreOP Holding areas a minimum of 1 hour prior to Scheduled Start times. If Patient is late arriving and not ready 1 hour prior to Scheduled Start time, Clinical Supervisor and/or Director must be notified and a MIDAS completed.

**IV. Procedure:**

**A.** Physicians will notify Preop RNs upon arrival with arrival time noted and recorded on tracking logs in respective Preop/PreOp Holding Areas. Notification of arrival times and accurate documentation is vital to ensure accuracy of data reporting..

**B.** If a physician is greater than thirty (30) minutes late for a scheduled start time and will cause a

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subsequent physician's case to be late, the case may be moved to the next available time slot.

- C.** The patient will be notified of the delay and notified of the rescheduled start time.
- D.** The RN will enter a Midas regarding the delay for peer review.
- E.** The first scheduled case must have completed the PAT (pre-admit test) process or a complete chart as defined by the Medical Staff Rules and Regulations (Section 5 Surgical Care, Mandatory Pre-Operative Evaluation and Documentation). If incomplete, the case line up may be reordered to allow for a patient that has met the above criteria to be the first case.





January 2, 2014

Dear Dr. X:

Fax: 702-889-XXXX

We are providing you with your monthly block utilization rate. Also, we began monitoring first case on-time starts for the month of December and are reporting this data to you in this letter.

Reminder of the block utilization policy's key components:

Tier Utilization Program

Blocks will be released based on Tier utilization before the scheduled date. Tier utilization rates must be maintained for a period of three months in order to qualify for a Tier upgrade.

- Tier I = 80% block time utilization. Block releases automatically in system 24 hours prior to scheduled block start.
- Tier II = 70-79% block time utilization. Block releases automatically in system 72 hours prior to scheduled block start.
- Tier III = below 70% block time utilization. Block releases automatically in system 7 days prior to scheduled block start.

Formula used for calculating block time utilization:

$$\% \text{ Utilization} = \frac{\text{Total Room Time Used}}{\text{Block Time Available} - \text{Turnover Time}}$$

Effective January 1, 2014, we have initiated Level One corrective action for underutilized blocks, with Tier adjustments based on utilization rates for the month of December. Beginning in February 2014, Level Two corrective action will be initiated based on block usage patterns. This may result in an adjustment to block time available to achieve the 80% utilization rate. For example, if a physician's block utilization rate is 55% for the month, a 25% reduction of block time available will achieve the policy goal of 80% usage of allotted block time. If you continue to have difficulty meeting the 80% utilization rate, please contact our scheduler at 853-3455 to discuss options for increasing your block utilization.

As of December 31, 2013:

**Your block utilization rate for Tuesday is 53%**

**Your block utilization rate for Friday is 91%**

**On time first case start ratio is 90%**



**In accordance with the Block Utilization Policy, on Tuesday and Friday your block will remain on a 7-day release for the month of January 2014.**

We appreciate your support of our hospital's surgery department and look forward to working with you to make your block time as productive and convenient as possible. Please do not hesitate to contact us regarding any concerns you may have.

Sincerely,

Rachel LeMahieu  
Director of Surgical Services  
702-853-3046

Leslie Buchanan  
Operating Room Manager  
702-853-3464

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January 2, 2014

Dear Dr. X:

Fax 702-216-XXXX

We are providing you with your monthly block utilization rate. Also, we began monitoring first case on-time starts for the month of December and are reporting this data to you in this letter.

As of December 31, 2013

**Your block utilization rate for Wednesday is 88%**

**Your block utilization rate for Friday is 98%**

**On time first case start ratio is 90%**

Thank you for being an active member of our surgical team!

Your block release will remain at a Tier I which releases automatically in the system **24** hours prior to the scheduled block start. Tier I requires a minimum of 80% block time utilization.

We appreciate your support of our hospital's surgery department and look forward to working with you to make your block time as productive and convenient as possible. Please do not hesitate to contact us regarding any concerns you may have.

Sincerely,

Rachel LeMahieu  
Director of Surgical Services  
702-853-3046

Leslie Buchanan  
Operating Room Manager  
702-853-3464

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September, 2013

Dear Dr. X

Our hospital values its working relationship with you and strives to continue to provide the best possible surgical experience for you and your patients. In an effort to improve efficiencies and to accommodate OR block time as well as ensuring we are able to schedule cases on an urgent or emergent basis, we have revised the block utilization policy. The purpose is to assure that time is set aside for those who prefer block time for the convenience of their practice. We appreciate your support in understanding the need to have more consistent and efficient use of our block time.

Attached is our hospital's revised block utilization policy for your review. A few the most important changes to the policy is a decrease in the utilization rate from 90% to 80% a Tier Utilization Program for block release timeframes, and a 30 day notice for block release due to provider vacation. This change was approved by the hospital's Surgery committee and is required to maintain your block privileges.

#### Tier Utilization Program

The block will be released based upon the following Tier utilization based program before the schedule date. This block time utilization percentage must be maintained for a period of three months in order to qualify for a Tier change.

Tier I = 80% block time utilization - Block released in system 24 hours prior to scheduled block start.

Tier II = 70-79% block time utilization - Block released in system 72 hours prior to scheduled block start.

Tier III = below 70% block time utilization - Block released in system 7 days prior to scheduled block start.

Formula used for calculating block time utilization:

$$\% \text{ Utilization} = \frac{\text{Total Room Time Used}}{\text{Block Time Available} - \text{Turnover Time}}$$

A physician may release established blocks or any part of a block to "open scheduling" at any time. If an established block is not utilized, and has not been released by the physician within their designated Tier release time, utilization will be calculated at 0%. Planned vacations are to be submitted no less than 30 days prior to vacation start to enable other providers to utilize available surgical time.

We will be providing you with updated reports, and block time will be reviewed and managed on a routine monthly basis. To help you make the best use of your allocated block time, may we suggest the following:

- ✓ Verify that patients are scheduled within your block time.

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- ✓ Provide the hospital with appropriate policy driven notice if you are unable to use your block time or you are going on vacation. This allows us adequate time to schedule other cases.
- ✓ Start the first case of your scheduled block on time.

If you continue to have difficulty meeting the 80% utilization rate, please consider taking at least one of the following steps:

- Reduce your block time.
- Reduce the number of days you have blocks.
- Change your start time if your cases consistently begin late.

Please remember that your block time will be reduced if you have not scheduled a case within your designated Tier's block time release. This allows the hospital to accommodate urgent, emergent and first-come, first-served surgeries. In accordance with the policy, your block time requests will be cancelled if we see consistent under-utilization, but we will communicate any problems we observe so you can take appropriate steps to address them.

Your current block utilization rate for DAY is xxx%

Your current block utilization rate for DAY is xxx%

We appreciate your support of our hospital's surgery department and look forward to working with you to make your block time as productive and convenient as possible. Please do not hesitate to contact us regarding any concerns you may have.

Sincerely,

Rachel LeMahieu  
Director of Surgical Services  
702-853-3046

Leslie Buchanan  
Operating Room Manager  
702-853-3464

Attachment-Policy

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<b>Policy Title:</b>	Scheduling of Surgical Procedures		
<b>Location:</b>		<b>Department:</b>	Surgical Services
<b>Policy Number:</b>	L	<b>Review Due:</b>	September 2019
<b>Original Effective Date:</b>	September 2016	<b>Reviewed Dates:</b>	

**I. Scope:**

Surgical Services

**II. Purpose:**

Provide guidelines for efficient utilization of the surgical suites while providing quality patient care and accommodating surgeon's needs.

**III. Policy:**

The surgical services department is responsible for the scheduling of all elective cases for the Operating Room/G.I. Endoscopy suites/Cath Lab/Specials. The surgical services personnel are responsible to schedule cases as accurately as they can, taking in to consideration time, personnel, and equipment requirements. Every effort shall be made to accommodate physician requests, if possible.

**IV. Definitions:**

- A. Start time: The time the patient arrives in the procedural suite
- B. Emergency case: A case that would result in the potential for increased morbidity/mortality. The physician declares the need for an emergency.
- C. Bumping: An elective case may be bumped for an emergency case. The physician declaring the emergency must notify the physician of the case being bumped.
- D. Late case: Any case that is delayed more than 5 minutes past scheduled start time.
- E. Physician arrival time: All surgeons should be in the surgical suite ready to scrub fifteen (15) minutes before the scheduled starting time of the operation. If the surgeon fails to arrive in the surgical suite by the scheduled starting time for his case, the case will be placed at the end of the schedule and the next case will be moved up. A surgeon or anesthesiologist who has a 7:30 a.m. case scheduled must be in the Operating Room by 7:15 a.m. on the morning of the surgery. If this rule is not followed, the surgeon or anesthesiologist will not be allowed to schedule 7:30 a.m. cases in the future.

**V. Procedure:**

A. Scheduling (Elective)

1. Scheduling will usually be performed by the scheduler in the operating room. However, same day (add-ons) or next day cases may be scheduled by the charge nurse.
2. Hours for scheduling elective procedures are 0800-1700, Monday-Friday
3. The elective scheduling time closes at 1700 for finalizing the schedule and distribution to departments.
4. A surgeon on the suspension list may not schedule a surgical procedure.
5. Surgical procedures are scheduled on a first come basis or if the surgeon's office has been granted scheduled block time, they may schedule within their block.
6. Block time is requested in writing by the physician and granted by the Director of Surgery and the Chief Executive Officer of Henderson Hospital.
7. The physician's office initiates the request. The physician and his/her office staff are responsible for arranging any required assistant.
8. The physician's office is responsible to arrange vendor representation in the operating room as needed. If a physician has two rooms concurrently that are orthopedic implant procedures, they must have a vendor representative for each room.
9. The admitting office must be notified of all scheduled procedures so that preadmission can be completed and the patient's pre-operative assessment completed.
10. Elective cases should be scheduled as far in advance as possible. If there are questions about the surgical procedure time, the surgery scheduler will verify the time with the surgeon. In case of cancellations or changes to the schedule, the surgeon or his/her office must notify the surgical services department or house supervisor as soon as possible.
11. Information required includes:
  - Patient name, phone number, date of birth and sex
  - Surgeon and any assistant
  - Operative procedure (must include site, e.g., left or right) and pre-operative diagnosis.
  - Date/Time Requested
  - Patient type (a.m. admit, outpatient)
  - Anesthesia group and anesthesia type (general, block, etc.)

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Special implants, equipment or supplies must be requested at the time of surgery scheduling.

If frozen section is needed, it should be requested at the time of scheduling.

## B. Scheduling (After Hours)

1. The house supervisor will schedule cases after the routine scheduling hours.
2. If the procedure is an elective case (add-on) for the following day, the supervisor will list the case and pertinent information. The supervisor may give an approximate time but no case will be guaranteed a start time until the following morning.
3. All urgent/emergency cases after 1900 will be handled by the OR evening charge nurse, after 2300 the house supervisor and the call personnel will be notified.
4. All emergency procedures will take precedence over all elective procedures. The surgeon with emergency situations will notify the director of surgical services/designee and the emergency will be accommodated in the first available room. Any questions regarding the urgency of the procedure will be referred to the physician involved. In the case of a disagreement, the Chief of Surgery will be notified to assist with the decision.

## C. Distribution of Schedule

1. The department of surgical services prepares and distributes the schedule daily (Monday-Friday).
2. The schedule is posted in Surginet.



