A strong Operating Room Executive Committee (OREC) can support the perioperative leadership team and enable the OR to continue - or regain - its strong contribution to the hospital's bottom line, which for many providers is upward of 70%. This white paper demonstrates the value of a strong OREC for effective block scheduling, an effective way to optimize the surgery schedule, enhance surgeon satisfaction and retention, and increase surgical volumes and revenue.

Consistent complaints heard from surgeons:
- “No one listens to my suggestions”
- “If I were in charge of the OR, things would run smoothly”
- “They do whatever they want regardless of what I tell them”

While such expressions of frustration are often shrouded in emotion, their origin rests in the fact that in many operating rooms, the surgeons really have very little authority or ability to influence processes. The OR is the surgeon's workshop and their patients are the lifeblood of a hospital's financial stability but despite this, operational decisions are often made by administrators and managers outside of the surgeon's sphere of influence. The solution to this problem comes in a well designed, highly effective Operating Room Executive Committee (OREC).

OREC is NOT a traditional OR committee in which surgeons gather primarily to have a meal, vent their frustrations and share stories but have little or no decision-making ability. The essential elements of a high-performance OREC are:
- Authority (granted and supported by senior executive leadership) to make operational decisions in partnership with departmental management
- Members are appointed based on their leadership skills and ability to work cooperatively in the best interest of both surgeons and the hospital
- OREC is an administrative committee, not a medical staff committee
- While OREC may offer advice, their authority does not include personnel discipline, salary or departmental budget
- Similarly, physician quality issues are addressed through the medical staff peer review process, not OREC
OREC Activities & Operating Principles

What OREC Does
- Establishes Rules and Regulations (R&R) governing Perioperative environment functions i.e.:  
  - Hours of operations
  - Number of rooms available
  - Block utilization
  - Requirements for pre-admission testing
  - Establishes key terms and definitions
  - Determines core metrics and benchmarks
  - Reviews performance improvement plans for poor core metric performance, late arrivals, or poor behavior

- Examines and revises policies that may impact quality
- Communicates the R&R of the Perioperative Environment to fellow medical staff members
- Enforces R&R among medical staff members

Case study: How the Operating Room Executive Committee Can Effectively Manage Block Scheduling

This white paper describes the process and successful outcomes resulting from the OREC management of block scheduling at a 302-bed, 11-room OR, non-profit community hospital.

The purpose of the Operating Room Executive Committee in relation to block schedule management is to approve policies, review utilization data on a monthly basis, and adjust allocated blocks as outlined in the policy. This white paper defines the contents of an effective block scheduling system and the necessary elements to manage it effectively. The data illustrates improved block utilization after implementation of the new policies and monthly review by OREC.

The OREC developed and approved a block scheduling policy that clearly defined expectations for surgeons with allocated block time. To ensure transparency, the OREC mailed a letter to each surgeon introducing revisions to the surgery scheduling and block scheduling policies, including the expected benefits to these changes. This same information was presented to the Department of Surgery Steering Committee. The new Block Scheduling policy went into effect 5/1/2012.

Open, clear, concise communication is paramount to the success of block management. Surgeons receive a monthly letter outlining their block utilization, which includes voluntary block release time. The OREC reviews surgeons “at risk” for losing all or a portion of their block time at the monthly meetings. Those surgeons are then notified that they are in jeopardy, and that their blocks will be adjusted in the next quarter if their utilization does not improve. Once the OREC makes the block adjustments, a letter is sent to the affected surgeons outlining their new block schedule. This facilitates the effective management of block time in a standardized, collegial manner.

Results
The number of physician blocks noted “at risk” each month gradually decreased from 20 to 9 by the end of 2013. Adjusted utilization increased from below 70% through 2012 and consistently remained between 70%-80% for 2013. Voluntary release time decreased from over 20% to a monthly average of 10%. It should be noted that Adjusted utilization is the actual patient in-room time plus patient out to patient in time, divided by the total block minutes available, minus case run over minutes, minus voluntary release time. Actual utilization is actual patient in room time plus patient out to patient in time, divided by the total block minutes available.

<table>
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<tr>
<th>Blocks at Risk</th>
<th>Q1 2012 &amp; Q2 2013</th>
<th>Q3 2012</th>
<th>Q4 2012</th>
<th>Adjusted Utilization %</th>
<th>Adjusted Utilization %</th>
<th>Adjusted Utilization %</th>
<th>Adjusted Utilization %</th>
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<td>Surgeon/Group</td>
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<td></td>
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Note: Adjusted utilization is the actual patient in-room time plus patient out to patient in time, divided by the total block minutes available.
Strategies for Implementation

- Goal of standardized, collegial management of block allocation and scheduling
- The OREC developed and approved block scheduling policy outlining clearly defined expectations for surgeons with allocated block time
  - Automatic release times based on specialty
  - Definition of voluntary release
  - Utilization rate of 75% or higher required to retain block time
  - Explanation of block utilization calculation
- Transparency
  - Letter to surgeons introducing revisions to surgery scheduling and block scheduling policies and expected benefits
  - Presentation of information to Department of Surgery Steering Committee
- New block scheduling policy went into effect 5/1/2012
- Clear, concise, open communication is paramount to the success of block management
  - Surgeons receive a monthly letter outlining block utilization, including voluntary block release time
- Monthly review during OREC meeting of surgeons at risk for losing all or a portion of their block time allocation
- Surgeons are notified that they are in jeopardy and that blocks may be adjusted in the next quarter if their utilization does not improve
- When the OREC makes block adjustments, a letter is sent to the affected surgeons providing their new block schedule
Lessons Learned

- The OREC outlined in this essay takes time to create. Spending the first few meetings establishing the purpose, authority and workplan for the committee before beginning to tackle a more difficult policy issue like block scheduling is essential.
- Selection of the right membership is essential. There is no room for personal agendas on the committee.
- The highest level of administrative leadership (we recommend the CEO) should attend and participate in all meetings. The CEO can chair the committee initially, transferring that responsibility to a physician leader once the committee is well established.
- Anesthesia needs to be represented in OREC.
- Surgical Services management should be active participants in all meetings.

Conclusion

Novia consultants have assisted surgical departments across the country in re-engaging surgeons and anesthesiologists in the management of their workplace through the establishment of high-performance Operating Room Executive Committees. This white paper describes how this foundational structure was effectively used to optimize the often challenging management of block scheduling. The result is improved efficiency, enhanced physician satisfaction, bolstered employee morale and most importantly, higher quality patient care.

About Novia

Novia Strategies offers a unique blend of professional expertise that takes a 360° approach to improving your hospital’s efficiency and quality. Novia helps organizations operationalize their strategic plan through expense management, quality improvement, and revenue enhancement. Key focus areas are:

- Non Labor
- Operating Room
- Case Management
- Care Redesign
- Labor Productivity
- Compensation & Benefits
- Pharmacy
- Focused Safety Intervention

Novia’s evidence-based consulting services cover both of the key needs of hospitals: cost reduction without compromising quality, and quality without increasing cost.

About the Authors

Dr. James Ketterhagen is a vascular surgeon with over 20 years experience with expertise in senior healthcare management, quality and patient safety initiatives, and clinical leadership.

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