A **5 point assessment**
for OR efficiency and growth

A Hospital **CEO's Guide** to OR Financial Improvement

SURGICAL DIRECTIONS

Executive summary:

CEOs and other hospital executives play a key role in identifying financial improvement opportunities in perioperative services. To initiate an OR turnaround:

Evaluate key performance indicators for the OR

- OR contribution margin significantly less than 55% indicates overall profitability challenge
- Primetime utilization rate significantly under 75% raises labor costs and other expenses
- Poor access for urgent and emergent cases increases downstream costs
- High average case times undercut potential OR revenue in key procedures
- Excessive schedule gaps increase the need for an anesthesia financial stipend

Understand the drivers of financial improvement in perioperative services

- Establish a Surgical Services Executive Committee (SSEC) to manage the OR schedule
- Reallocate block time to the most productive, high-utilization surgeons
- Create urgent-emergent blocks to improve schedule flow and reduce inpatient costs
- Launch a case time reduction initiative to accommodate additional case volume
- Leverage schedule reforms to eliminate gaps between cases for anesthesia providers

Establish realistic targets for OR financial improvement

- Right-size a 10-room OR — reduce nursing and related costs by more than $3 million
- Increase utilization in an 8-room OR — generate an additional $4 million revenue annually
- Improve urgent-emergent access — cut nursing overtime costs and length of stay
- Reduce average case time for knee arthroplasty — increase volume of high-revenue surgery
- Facilitate a more compact anesthesia schedule — reduce or eliminate financial support

Most hospital ORs today are struggling financially. Unfortunately, CEOs who do not have direct OR experience usually have difficulty assessing perioperative performance. This white paper provides hospital executives with a 5-point framework for identifying opportunities to improve financial performance in perioperative services.

1 | Check OR contribution margin

Background: Most hospitals depend on perioperative services to drive profit margins. In the current environment, however, high nursing and anesthesia coverage costs are reducing OR profitability.

Assessment: Check the OR department contribution margin. In better-performing organizations, perioperative services contributes 55% to the bottom line. If the OR contribution margin is significantly less in your facility, your hospital will struggle to achieve financial sustainability. Conversely, matching the OR contribution margin of top organizations will transform your hospital's financial results.

Opportunity: There are two ways to improve OR margins — increase revenue or decrease expenses. Most hospitals should target both strategies. However, increasing revenue by building case volume is a mid- to long-term opportunity. Hospital leaders can improve perioperative contribution margins in the short term by right-sizing the OR footprint.

Example: *A 10-room OR performs 8,000 cases per year. Despite high volumes, the department is only breaking even. Right-sizing the OR to 7 rooms could reduce costs by more than $3 million on the same volume. These savings would go straight to the bottom line.*

2 | Review primetime utilization

Background: Low OR utilization during primetime (typically 7 a.m. to 3 p.m.) wastes nursing labor, reducing profitability. In addition, inefficiency in daytime utilization forces cases into late afternoon and evening hours. This not only drives up overtime costs but leads to nurse burnout. It also stresses anesthesia staff by requiring more provider hours to cover the same case volume.

Assessment: Review OR utilization during primetime hours. In better-performing ORs, primetime utilization approaches 75%. If the primetime utilization rate in your OR is significantly less, costs will be unsustainably high.

Opportunity: To increase primetime utilization, perioperative leaders must rework the OR schedule so most block time is allocated to surgeons with high utilization rates. The challenge is that organizational dynamics in the OR make any scheduling change complex. The only effective approach is to establish a Surgical Services Executive Committee (SSEC), which is a multidisciplinary governance body for perioperative services. The principal task of an SSEC is to manage block time allocation based on actual utilization.

Example: *Primetime utilization in an 8-room OR is just above 50%. Hospital leaders create an SSEC to govern the OR, and the committee uses predictive analytics to reallocate block time to the most efficient surgeons. Within 6 months primetime utilization is above 70%, allowing the OR to accommodate an additional 10 cases per day. This incremental volume generates an extra $4 million revenue annually.*

3 | Evaluate access for urgent and emergent cases

Background: Following the case cancellations of COVID-19, most ORs prioritized efforts to rebuild elective case volume. But to do this, many allocated nearly all available block time to elective surgery. As a result, most urgent cases are being pushed to late afternoon or evening hours. While emergent cases are accommodated on demand, they typically cause a disruption to the primetime schedule.

Assessment: Ask OR leaders how they accommodate urgent and emergent add-on cases. If they schedule most urgent cases after hours or cancel scheduled surgeries to accommodate emergent cases, your OR is not managing this volume appropriately.

Opportunity: The immediate solution is to create one or more urgent-emergent blocks during the primetime schedule. Establishing the ability to handle these cases during primetime helps ensure that patients are discharged promptly, reducing length of stay (LOS) significantly.

Example: *As part of its block schedule reform work, an SSEC designates one suite in a 12-room OR for urgent and emergent cases. The flexibility to handle add-on cases during the day helps prevent PACU boarding and reduces unnecessary overnight stays.*

4 | Gauge perioperative efficiency

Background: Efficiency in the OR depends on a carefully orchestrated flow of patients, staff, equipment, supplies and other resources. Friction at any point in this system leads to late case starts, extended turnover times, long case times and other money-wasting inefficiencies.

Assessment: You are probably familiar with the first-case on-time start (FCOTS) rate, which indicates the overall efficiency of perioperative services. For a deeper look at OR efficiency, analyze average case times. This metric indicates the working efficiency of surgeons, anesthesia providers and the nursing organization. There is no set benchmark for case time averages. Begin by asking OR leaders to create a report that shows each surgeon's average case time for a single high-volume procedure. This report will highlight the most efficient surgeons and identify those with room to improve.

Opportunity: In concert with block time reform and other improvements, reducing case times can allow an OR to accommodate more procedures within the same cost structure. This will not only grow perioperative revenue but increase OR profitability.

Example: *An OR reserves four 8-hour blocks for total knee arthroplasty (TKA) every week. On average, each block accommodates 3 TKAs. OR leaders use case time reports to start discussions with orthopedic surgeons about operative efficiency. They also work directly with outlier surgeons, providing them with tools to bring their case times closer to the best performers. Reducing their TKA case times enables many surgeons to perform one additional procedure per block. At an average of $5,449 per procedure (Palmer, 2023.), one additional procedure per block generates an additional $21,796 in revenue every week (4 blocks X $5,449). This adds over $1 million in revenue a year.* Based on their success with knee replacement surgery, OR leaders extend the case time initiative to other high-volume, high-revenue procedures.*

5 | Reassess financial support for anesthesia

Background: The nationwide shortage of anesthesiologists and CRNAs is driving up the cost of anesthesia coverage. In many hospitals, the high cost of anesthesia financial support is a major factor in low OR profitability.

Assessment: Anesthesia stipend benchmarks are available, but they are essentially a measure of the dysfunctional ORs in your region. To assess the true need for anesthesia financial support, evaluate the impact of OR and non-OR anesthesia (NORA) schedules on anesthesia providers. The key question is How "compact" is the anesthesia schedule? Excessive gaps between cases (and excessive travel time between locations) force anesthesia providers to over-staff to cover their contractual obligations, increasing the need for financial support.

Opportunity: Hospital CEOs cannot control the shortage, but they can control how many anesthesia providers are required to cover OR and NORA schedules. Any efforts to increase block utilization and efficiency (described above) will have the side effect of consolidating the anesthesia schedule. This will allow anesthesia to provide full coverage and generate more income with the same staffing, reducing the need for a financial stipend.

Example: *A hospital with a 14-room OR provides its anesthesia partners with annual support of $500,000. A suite of interventions, including block time reform and other scheduling improvements, allows the OR to consolidate case volume to 12 daily rooms. This enables anesthesia providers to generate more revenue per hour, and it also takes recruiting and staffing pressure off the group. During the next round of contract negotiations, the need for financial support is not an issue.*

** Palmer, E., Cardiovascular & Orthopedic Procedures See Highest Reimbursements While Getting the Nod from CMS and Payors, HST Pathways, Dec. 21, 2023: https://www.hstpathways.com/blog/cardiovascular-orthopedic-procedures-see-highest-reimbursements-while-getting-the-nod-from-cms-and-payors/#:~:text=Based%20on%20the%20findings%20from,case%2C%20averaging%20%245%2C449%20per%20procedure.*

Bonus: Watch recruitment and retention

A key issue underlying all the challenges outlined above is the growing provider shortage. The rising cost of both anesthesia coverage (whether employed or contractual) and nursing staff (including OT costs and traveler FTEs) is reducing the profitability of every U.S. surgery department. At the same time, the schedule and process inefficiencies described above inflate coverage needs while fueling burnout.

Forward-thinking CEOs today are carefully monitoring recruitment and retention metrics for both nurses and anesthesia providers. They are also promoting efforts to understand the needs and priorities of nursing and anesthesia professionals as well as surgeons. The key is to use multidisciplinary governance and efficiency improvements to create a working environment that meets the needs of all OR stakeholders.