Maintaining a productive OR as cases shift to ASCs

The migration of surgical procedures from hospital ORs to hospital-owned ambulatory surgery centers (ASCs) is picking up speed. According to a recent survey, three-quarters of larger hospitals now have an ownership stake in more than one ASC. Two-thirds of US health systems are currently planning to increase their ASC investment.

A well-designed ASC development strategy can help a hospital recapture case volume that is exiting the main OR. However, many hospital leaders are unaware of the significant risk that unless an ASC migration is carefully planned, the main OR will likely see productivity declines and cost increases.

The key to avoiding these problems is to create a realistic plan for managing OR volume outmigration. OR leaders can support this effort by thinking strategically about the emerging perioperative business model.

Develop a detailed timeline

Surgical case outmigration is both an inevitable and dynamic process that will evolve over time. The best planning tool is a timeline that anticipates key milestones in case volume movement. To develop a useful timeline, OR leaders should gather information from three sources:

- **Payer policies.** The migration of surgery to ASCs is a long-term trend driven by payers, with the pace being set by the Centers for Medicare & Medicaid Services (CMS). However, OR leaders should pay close attention to short-term moves. Recently, CMS proposed halting the previously planned elimination of the Inpatient Only (IPO) list and reinstating 298 services removed from the list last year. CMS has also proposed removing 256 surgical procedures from its ASC Covered Procedures List. Hospital surgery leaders should continue to monitor CMS communications for upcoming policy changes that could impact the main OR schedule. Differences in coverage by large commercial carriers can drive variation at the state level.
- **Surgeon plans.** OR leaders should have frank discussions with surgeons about their plans for taking cases out of the hospital. For example, payers are directing orthopedic surgeons to perform more knee arthroplasty procedures in ASCs. However, some providers may also be interested in developing same-day outpatient programs for hip or shoulder replacement. Even if surgeons' plans are not set in stone, open communication will provide a basic sense of case volume and timing.
- **The ASC timeline.** The hospital's business plan for a new ASC should include a timeline for building case volume. Depending on the level of detail present, an ASC in-migration timeline can be very useful for planning OR outmigration. Basically, the two plans should mirror each other, eg, a weekly hand surgery block moved to the ASC in March is paralleled by the exit of that block from the main OR. Coordinating timelines is especially important when a hospital outpatient surgery department (HOPD) is being converted to an ASC and a portion of the OR schedule is flipping to the new setting.

Many OR schedules consist of 30% add-on cases.

As information is gathered, a comprehensive case migration timeline can be built. Some volume will migrate by block, so the timeline can project the operational impact in terms of blocks leaving the main OR schedule (sidebar, "OR case migration time").

A detailed case migration timeline is important for planning main OR resources, especially the impact on staffing. OR leaders can use the timeline to guide discussions with two key groups:

- **Anesthesia providers.** Perioperative leaders should meet with anesthesia providers to understand how OR outmigration will impact their volume. A major issue could be the anesthesia group's care model. For example, as OR volumes decline, the remaining case schedule may no longer support medical supervision. This shift will increase costs for anesthesia providers.
- **Nursing and tech staff.** The launch of a new ASC often creates uncertainty among OR staff and concern about job losses. The best strategy is to have a realistic plan for rebalancing volumes and schedules and to be transparent about potential changes to the staffing model.

Transform the schedule

Once the timeline is in place, OR leaders will have a better picture of the operational impact of case migration across multiple quarters. Without this carefully managed approach, hospital outmigration will create large gaps in the OR schedule. The risk is that the OR will become not only less efficient, but also a less desirable place to work.

The first step is to analyze projected volume declines in terms of number of cases and case minutes. As a rule of thumb, every 5 or 6 hours of time subtracted from the schedule equals one room running. An administration-sponsored Surgical Services Executive Committee (SSEC) or other leadership group should redesign the schedule to consolidate remaining volume within the surgeon block system. (For more

information, see our white paper, "The Modern Hospital Operating Room: Overcoming Obstacles to Organizational Transformation.")

OR leaders should pay attention to an important effect—the exit of elective volume to ASCs means that urgent cases will increasingly make up a larger percentage of the OR schedule. Surgical Directions, a Chicago-based healthcare solutions firm, has seen this trend emerge at hospital ORs nationwide. A decade ago, a well-run OR might have an add-on rate of 5% to 10%. Today, many OR schedules consist of 30% add-on cases.

This shift is having a dramatic effect on the daily schedule. Surgeons perform most add-on cases in the afternoon or early evening, after their morning cases and office time. At the same time, lower overall volumes mean that the morning schedule now winds down in the late morning or early afternoon in many ORs. The effect is that many ORs now have two daily starts—one at 7 am and one around 2 or 3 pm—with a significant schedule gap in the early afternoon.

This new volume pattern creates significant problems for staff. First, it leads to loss of income for nursing and tech staff who are increasingly asked to go home early. Second, it increases the need to bring in nurses on call to cover late-day cases. This loss of predictability is at the root of the current nationwide hospital OR staffing crisis (see "Decrease uncertainty to combat burnout, boost retention," OR Manager, July 2021, pp 21-23).

Many anesthesia providers face a combination of both income loss and extended work hours as they cover fewer cases over a longer period each day. Moreover, as OR productivity worsens, there is mounting pressure to increase the hospital anesthesia stipend.

The bottom line is that traditional staffing models cannot accommodate the new volume pattern that is emerging in many ORs. Here are strategies that department leaders can use to rework blocks to cover volume while protecting the interests of staff:

Block redesign. One strategy is to create designated add-on blocks to accommodate the second start. The key is to use predictive analytics to accurately map utilization (see "Using advanced analytics to maximize OR utilization," OR Manager, December 2020, pp 22-23, 25). Add-on volume may seem chaotic, but analytical tools are increasingly able to identify hidden demand patterns. OR leaders can then create one or more add-on blocks to match the predicted need on a per-day basis.

Staffing redesign. In support of the afternoon block strategy, one option is to replace call coverage with regular paid afternoon shifts. This change is controversial in many hospitals, but OR leaders should perform a careful analysis. Often the cost of staffing a nontraditional late-day shift versus the total cost of overtime and call pay are very close. Paid afternoon shifts could be a huge satisfier for staff while representing little additional cost for the hospital.

Shift redesign. Another strategy is to rework nursing shifts to match new volume patterns. For example, a hospital might reduce the number of open rooms and replace 8-hour nursing shifts with 10- and 12-hour shifts. Transitioning some staff to four 10-hour days or three 12-hour days would enable them to maintain full-time status.

These challenges naturally raise a question: If OR cases are migrating to ambulatory surgery, why not just redeploy OR staff to the ASC? This is an intuitive solution, but OR leaders should be aware of the pros and cons.

The benefit of reassigning OR nurses to a hospital's ASC is that it will reduce the OR's cost structure while solving staffing challenges in the new facility. Under one scenario, an OR could lease experienced nurses to the ASC to provide expert support for more challenging cases.

However, there is a risk that the hospital OR nurse, placed in an ASC, will recreate the complex processes and culture of a large hospital in the new setting. To be successful, an ASC must have very streamlined workflows and offer patients a "retail experience." If OR staff transfer to an ASC, management must make a concerted effort to mentor them in ambulatory processes and expectations. In Surgical Directions' experience, this retraining process may not always be successful (see our white paper, "The Hospitals Executive's Guide to ASC Expansion Strategy").

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OR case migration timeline (simplified example)

2021 Q4
Exiting: Dr. Green Monday 6-hour hand block.

2022 Q1
Exiting: Dr. Brown Wednesday 8-hour knee block.

2022 Q2
Exiting: Dr. Black Tuesday 6-hour hip block.
Entering: Dr. Grey Wednesday 10-hour spine block (new advanced spinal surgery program).

2022 Q3
Exiting: Dr. Gold Monday 4-hour eye block.

2022 Q4
Exiting: Dr. White 6-hour colon block.
Entering: Dr. Blue 8-hour gynecologic block (new women's program).
Entering: Dr. Tan 10-hour neuro block (new advanced neuro program).

Source: Surgical Directions.

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Reinvigorate the business plan

Although schedule redesign is the immediate priority, hospitals also need a long-term strategy for protecting the main OR. Department leaders should work with hospital executives to develop a new surgical services business plan that is suited to the emerging environment.

Start by analyzing the basics. The exit of lower-acuity elective cases means the main OR will increasingly become the site for high-complexity surgery. Successful OR business plans will target surgical specialty programs with a stable or growing volume of more complex procedures.

For example, many complex procedures in neurosurgery and otolaryngology will remain in the inpatient OR for the foreseeable future. These specialties can help form a stable base for strong OR volume. Hospitals may also have existing surgical specialty programs that would benefit from new attention. For instance, a hospital might reinvigorate its women's health program to focus on the advanced surgical needs of an aging population. In all these scenarios, lead with a market analysis to identify potential volume and leverage business development to build referral processes.

The key role of complex surgical specialties strongly suggests the value of a "center of excellence" strategy. Traditionally, this strategy has focused on service lines like cardiovascular surgery and oncology. However, as hospital ORs increasingly concentrate on high-acuity procedures, a center of excellence strategy will help build the processes and volume that are essential to achieving best outcomes.

This approach has implications for facility management. Space constraints in most hospital ORs have traditionally made it difficult to create the infrastructure for the preoperative area and the postoperative anesthesia care unit that is needed to support advanced care programs. As OR volumes decline, many hospitals will be able to repurpose surgical suite space for other clinical needs. This situation creates the opportunity to provide a better clinician and patient experience in the main OR for more complex procedures.

No matter which specialties become the strategic focus, hospitals need to double-down on quality. Patients and providers alike appreciate the fast pace of ASCs. However, although hospital surgery departments should continue to strive for efficiency, the OR "brand" will increasingly center on very careful, very high-quality care for more complex procedures.

Achieving quality is a complex goal, but one key element is investment in staff training and education. OR leaders should focus on building appropriate nursing and technician teams to support complex procedures in alignment with the business strategy. For example, investing in a robotic surgery team will help attract surgeons who want to perform new robotic procedures in GI, colorectal, and gynecologic surgery.

Avoid time wasters

Careful planning is the key to protecting the main OR as cases migrate to an ASC. In addition to the planning priorities described above, the next most important strategy is simply to make sure the ASC launch goes as smoothly as possible. Avanza Healthcare Strategies, a consulting firm based in Austin, Texas, has identified two factors that are key to developing a successful ASC:

Use conservative financial projections. A realistic plan based on historical case volumes and Medicare reimbursement will help a hospital-owned ASC to avoid early problems.

Do not overbuild the ASC facility. A successful ASC is a focused procedural clinic, not a small hospital. Right-sizing the facility will help ensure a manageable ASC cost structure.

These safeguards will help a hospital-owned ASC get off the ground without the problems that absorb executive attention. That in turn will help ensure hospital leaders give the main OR the focus it needs to thrive in the emerging surgical services landscape.

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