What are three approaches to the allocation of operating room time?

Open access to OR time can be provided on any future workday. At least one scheduled start time option is provided for a case, unless it would be unsafe to perform the procedure. OR time is allocated by service for each weekday, with the service being a department, specialty, group, or surgeon. Services can be pairs of surgeons who follow one another weekly or who alternate every other week. Most facilities also have unblocked, open, first-come first-scheduled, OTHER time on each weekday. Almost all of a service's cases are performed within its allocated time. This model works well for matching anesthesia and OR nurse staffing to workload at surgical suites. The reason is that staffing is usually planned for at least an 8 hour workday and repeats by day of the week. A two week cycle can be used instead (e.g., if surgeons tend to alternate every other week on a given day between clinics and OR). Click here to download a lecture, click here for information on services provided by the Department of Anesthesia, Division of Management Consulting, and click here for a review article **[PDF]**.

Although open access to OR time may be provided on any future workday, when a service has filled its allocated OR time and has another case to be scheduled, too often the one or two offered start times for the extra case may be inconvenient for the surgeon. The Fixed Hours model works nicely for long-term capacity planning at such facilities (click here **[PDF]** for review article). Expanding capacity is always a financial decision, because otherwise there would be unlimited resources every day for every physician. Two approaches can be taken. One option is to expand capacity while reserving the extra capacity as overflow time. The extra capacity is allocated to services once they are consistently using the OR time. This approach can be used to even the workload among the ORs staffed each workday to simplify decision-making on the day of surgery (click here **[PDF]**). Alternatively, time may be reserved for a surgeon in the hope that the surgeon would subsequently bring OR workload to the facility to fill the extra allocated time. The quality of the financial investment of the extra time depends on the contribution margin per OR hour of the surgeon's cases, the likelihood that there are additional cases to be done, and the impact on other parts of the facility (e.g., whether there are sufficient PACU beds for the specific types of patients). Click here to download a lecture, click here and click here for information on services provided by the Department of Anesthesia, Division of Management Consulting, and click here for a paper **[PDF]**.

Finally, open access to OR time can be planned within a reasonable period, usually two weeks or four weeks (Click here **[PDF]**). Allocated time is planned for services using one or two week cycles. Typically, services are individual surgeons or two partners. Once a service (surgeon) has filled or released its allocated OR time for cases during a two or four week cycle, then the service (surgeon) can schedule a case outside of its allocated OR time during the period. The use of one and two week cycles can be combined, for higher and lower workload services, respectively. Allocations are designed to be small enough always to be filled by its surgeons' cases (click here **[PDF]**). Copious overflow time is planned, calculated statistically based on maximizing the efficiency of use of the OR staff (click here **[PDF]**). Click here and click here for application to anesthesia outside of ORs such as at diagnostic and interventional radiology (i.e., so called non-operating room anesthesia [NORA]).

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