# After operating room allocations and case scheduling have been changed, what endpoint can be monitored to quantify success?

There are psychological biases in the allocation of OR time. Click here for a review article and click here for application to case scheduling. There are also psychological biases in case scheduling. Click here, click here, click here, click here, and click here for studies. Therefore, monitor completion of a checklist by having it documented with initials of the decision-maker every couple of hours. The checklist confirms that case scheduling days ahead and on the day of surgery have been evaluated to reduce the expected hours of over-utilized OR time. At a hospital with most ORs filled with a single surgeon for at least 8 hours each workday, the checklist can be limited to decisions for the next workday and for the (current) day of surgery.

If OR allocations and OR workload have been unchanged for the past several months, then the end-point to monitor (hopefully) for success is reduction in the mean hours of over-utilized OR time per OR per workday, averaged over four-week periods. Change can be detected within 2 four-week periods. Click here for the article. However, routinely use a moving average over several (e.g., 12) four-week periods. Click here and click here for articles. If workload is changing, but not the procedure mix, then monitor productivity as (hours of OR time during the four-week period) / (allocated hours + 1.50 x hours of over-utilized OR time). A different ratio can be used such as 1.75 or 2.00, whichever has been used for calculating the OR allocations based on minimizing the expected inefficiency of use of OR time. Click here for a review article. Click here for an article explaining other strategies to increase this productivity. If workload and procedures may be changing, then in the numerator use the American Society of Anesthesiologist's Relative Value Guide Units. Click here for a lecture addressing this topic.

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