Title: Surgery and Procedural Schedule Management Bend - Policy	**Document #:** 3899
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SUMMARY OF POLICY:

It is the policy of St. Charles Health System (SCHS) to abide by standardized methods for the management of elective, add on, and urgent or emergency case scheduling to support effective resource allocation and safe access to care.

SCOPE:

This is a policy that applies to the St. Charles Health System Surgical and Procedural units within the sites above.

RATIONALE:

This policy exists because The Procedural Scheduling Department will seek input from appropriate surgical and procedural governance Committees and applicable medical staff sections for the material content and implementation of this policy. The Block Oversight Committee is the governing body for this policy.

DEFINITION(S):

Please see the **Caregiver Handbook** for standard system terms

Add-On Case: Case request received the day of procedure or after 5:00pm two business days prior to procedure; scheduled through the department Charge RN according to the instructions in this policy.

Block Time: Room time allocated to specific providers or group of providers to schedule elective cases based on appropriate resource availability as determined by the Procedural Scheduling Office.

Bump: The process of interrupting the planned case schedule for emergency or urgent case access.

Elective Case: Scheduled Intervention planned or booked in advance (see Scheduled Case).

Emergency Case: Immediate life, limb or organ-saving intervention. Access to the Operating Room (OR) or procedure area needed within 60 minutes, except Emergent Trauma cases (defined below).

Emergent Trauma Case: Reference Trauma Team Activation (Bend and Redmond) - Guideline , access required within 15 minutes.

Open (Unassigned) Elective Time: Room time available to schedule elective cases

based on appropriate resource availability as determined by the Procedural Scheduling Office. Cases are prioritized in the order received and not to exceed available Open (Unassigned) Room Time.

Orthopedic Trauma Cases/ Non-urgent Ortho Trauma cases: Also referred to as “cold traumas” which do not require access within 15 minutes, but timely access is required based on patient clinical needs. Non-urgent Ortho Trauma cases can be scheduled in advance through Procedural Scheduling, whereas Orthopedic Trauma Cases are scheduled through the Charge RN.

Schedule Closure: The schedule closes to elective case scheduling at 5:00pm two business days prior to surgery or procedure.

Scheduled Case: Cases that are scheduled according to the instructions in this policy (see Elective Case).

Urgent Case: Intervention for acute onset or potentially life or limb threatening conditions, requiring access within 24 hours to avoid risk of clinical deterioration. ED patients and bedded inpatients requiring surgical intervention will be considered urgent due to length of hospital stay considerations.

POLICY:

1. **Elective Case Scheduling:**

    a. Elective Case Requests must be submitted electronically to the Procedural Scheduling Office prior to Schedule Closure. The surgeon office must provide facility prior authorization and requested resources.

        i. Approved or pending Prior Authorization Number for Hospital Facility Charges is required to schedule a case within 14 days of surgery or procedure. Case must be scheduled to occur within Prior Authorization valid date range.

            1. Authorization requirements apply to all insurance carriers, including Medicare Part A and B.

            2. Procedures that do not require a Prior Authorization Number are specifically labeled as such by physician office, so case can be scheduled.

            3. If resource needs change requiring updated authorization, the case will be removed from schedule until prior authorization is supplied.

        ii. Any case requiring a Supply Chain Fast Track item will not be scheduled until item has been approved.

    b. The name or description of the surgery or procedure must by spelled out on the scheduling request. No abbreviations are to be used.

    c. All cases will be scheduled with the Electronic Health Record (EHR) provider specific average procedure time unless provider requests additional time.

i. If EHR provider specific time not available, case duration will be determined by the EHR average procedure time.

ii. New procedures without EHR duration historical average will defer to the provider.

iii. Turnover times are automatically added between cases by the EHR (defined by procedure card).

d. Elective cases will not be scheduled with an out of room time beyond the end of Unassigned Elective Time or assigned block.

i. If a provider is requesting cases beyond the block time, those cases will be moved to the providers next available block time.

ii. If the patient condition requires access to a room prior to the next block, the scheduling office will offer next available day/time.

e. Elective case sequence (confirmation) is to be received by Schedule Closure time (5pm, 2 business days prior).

i. Case sequence shall consider same day discharge (first), patient type, patient age, anesthesia type, laterality grouping, history of MH (first case), and isolation precautions (last case).

f. Central Sterile Instructions:

i. Some case types require additional lead time to acquire needed supplies and equipment. Such cases are subject to delay pending physician consultation in the event that supplies and equipment are not obtained.

ii. If special instrumentation or supplies are necessary, it is the Physician, or Physician's office, responsibility to contact the vendor representative to arrange for Supply Chain approved items.

iii. Trays and Implants delivery will conform to Vendor Policy.

2. Add-on Case Scheduling:

a. Add-on case requests are those requested after schedule closure (5:00pm two business days prior) and are intended to facilitate urgent needs that are not supported by designated trauma or cardiac blocks.

i. Add-on case requests should be called to the department Charge RN, and a case request will be submitted electronically by the provider or APP. The Charge RN may assist with Case Entry in urgent/emergent situations.

ii. Authorization and/or documentation demonstrating medical necessity for urgent access is required.

iii. Requests are accepted based on patient acuity and resource availability. Any questions regarding clinical urgency or add-on appropriateness will be

directed to the Anesthesiologist-In-Charge (AIC) or anesthesiologist on call.

iv. The provider will communicate any approved supply and equipment needs, including communication with vendor.

v. Add-on cases will not be accepted greater than 24 hours in advance. Case requests for greater than 24 hours in the future must follow the Elective & Advanced case scheduling process

3. Emergency Case Scheduling:

   a. The first available and appropriate suite will be utilized. If there is not an appropriate suite available, the Charge Nurse may consult with the AIC and providers regarding the necessity to bump the next available room.

   b. It is the responsibility of the provider with the emergency case to communicate with the provider being "bumped." In general, the provider will bump their partner or specialty first, but first available room is the priority.

   c. The final decision on case sequence is owned by the AIC, (or Medical Director for the department). When AIC or on-call anesthesiologist is not available for decision making, the on-call trauma surgeon will be consulted to determine urgency.

4. Management of the Daily Schedule:

   a. Available Resources:

      i. Monday – Friday:

         1. 0730-1730: The number of rooms, for each department (OR, MDU, Cath Lab), running at the Bend Hospital will be determined by the leadership team, and will be based on volume trends, block requests, and desire to level load.
         2. 1730-1900: The Bend Hospital can accommodate 7 total anesthetizing locations, including OR, Cardiac OR, Trauma/Emergent access, and all non-operating room anesthesia (NORA) sites (MDU, Cath Lab, CT, MRI).
         3. 1900-0730: The Bend Hospital can accommodate 5 total anesthetizing locations, including OR, Cardiac OR, Trauma/Emergent access, and all non-operating room anesthesia (NORA) sites (MDU, Cath Lab, CT, MRI).

      ii. Evenings, Weekends and Holidays

         4. The Bend Hospital Procedural Areas will be limited to urgent or emergency case access.
         5. **The Bend Hospital can accommodate 5 total anesthetizing location**s, including OR, Cardiac OR, Trauma/Emergent access, and all non-operating room anesthesia (NORA) sites (MDU, Cath Lab, CT, MRI).

   b. Elective Case Management:

      i. Throughout the day the OR Charge RN and Anesthesiologist in Charge (AIC)

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will monitor the daily schedule for late rooms.

ii. Rooms running late may start an elective scheduled case if 2/3 of the case can be completed prior to the end of block, and the time exceeding end of block is less than 45 minutes.

iii. Elective cases that cannot be 2/3 completed prior to the end of block time will be placed in the add-on queue and performed as soon as resources allow, or will be rescheduled into the next available date/time.

iv. If elective cases must be held, priority will be based on the overall efficiency of the OR schedule and dependent on surgeon-to-surgeon communication.

c. Add-On Case Management:

i. Add-On cases will not be permitted unless they meet add-on criteria (see urgent case definition)

ii. Cases will be scheduled as resources become available, and case start time will depend on acuity and the order in which the cases were requested.

iii. Disagreement regarding add-on order will be resolved with a provider-to-provider conversation. If the dispute is not resolved in a timely manner, the AIC will be consulted if available. Non-business hour or holiday disputes will be escalated through the Perioperative/Cardiovascular manager on call or Administrator on Duty.

iv. If the urgency of a requested add-on case is in question, the on-call trauma surgeon will be consulted to determine urgency.

d. Emergent Case Management:

i. Emergent cases are typically performed in the Emergent Access OR (EOR).

ii. If EOR staff/room are currently occupied, case will be done in next available OR and may result in another case being bumped.

iii. Surgeon involved in emergent case needing to bump another case will communicate the situation directly with the surgeon being bumped.

5. Oversight: Final authority over the schedule rests with the appropriate operational leader and Medical Director, who must consider the following factors when reviewing the overall schedule:

a. Number of cases and hours of surgery or procedure scheduled
b. Number of anesthesia staff available
c. Availability of personnel
d. Equipment and instrument constraints
e. Number of rooms available

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f. Disposition of patient after surgery or procedure

References: *(Documents or Regulatory Requirements to which this document refers, is linked to within Document Library, or from which the document was created.)*

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