Scheduling Strategies

for Ambulatory Surgery Centers

Dawn Q. McLane-Kinzie RN, MSA, CASC, CNOR

Contents

Successful surgery scheduling in the ASC

Chapter

1

Successful surgery scheduling in the ASC

Surgery scheduling lies at the heart of any ambulatory surgery center (ASC). How well it works determines staff productivity and operating room use: It determines whether the environment is harmonious or is the cause of frutrations in every working aspect of the center. It affects employees, physicians, patients, families, and other facilities. Successful scheduling, therefore, is crucial to an ASC's success.

This chapter flow charts (on p. 6) a sample successful scheduling process for a typical surgery center.

The steps involved in successful scheduling

1. Initiate the scheduling process. The physician office scheduler may use phone, fax, e-mail, or the Internet to communicate with the physician's

office depending on what modalities your center chooses to use and how your policies are written.

2. Confirm the patient demographics, the date and time of the surgery, and the procedure and medical diagnosis.

3. Gather insurance information. A copy of the patient's insurance card (front and back—the insurance company's phone numbers are usually on the back of the card) is especially helpful for the center's patient account representatives as they confirm the patient's insurance coverage.

4. Verify that the insurance is in your center's network (if required) and that the insurance company will approve a specific procedure.

5. Determine whether the patient has unmet deductible or co-pay amounts that should be collected at the time of service, depending upon your financial policies.

6. Collect information about any pre-testing—such as lab, x-ray, or EKG tests—the physician orders, and where center preop nurses can find that information.

7. Record when anyone is using the special equipment (e.g. a laser or C-arm) that all physicians who use the center share. Doing so will help to ensure that physicians have everything they need when patients arrive for surgery.

8. Determine whether there are any conflicts that would affect scheduling of this procedure at the requested date and time. If there are, the procedure may need to be performed on a different day or time.

9. Notify the center's materials manager or clinical director about any requests for items that are not normally kept at the center (e.g., special implant). An experienced surgery scheduler may be able to juggle the schedule to accommodate all cases and their equipment needs.

Each person's role in scheduling

As the flow chart reveals, surgery scheduling touches nearly every function in a surgery center.

Patient registration

This department can and should pre-register a patient using the demographics (including insurance or payer information) provided in the scheduling program. Doing so reduces the time it takes to admit a patient on the day of surgery. The registrar will verify this information when the patient arrives.

Preop nurse

The preop nurse prepares the chart at least 24–48 hours before the date of surgery. This job includes recording information about the patient's pretesting and ensuring that the patient's chart is complete.

Figure 1.1 — Sample scheduling process flowsheet

Receive call from surgeon office *Scheduler*
Receive fax from surgeon office *Scheduler*

Verify information on fax and schedule into block or open time/conflict checking *Scheduler*	**Notify materials manager if resource needed (equipment or implant)** *Scheduler/materials manager*

Complete patient demographics in scheduling program *Scheduler*
Preop worksheet to registration and patient account representative *Scheduler*
Insurance verification/patient call if necessary regarding co-pay/deductible *Accounts receivable specialist*
Preop phone call for patient history and demographic record verified *Pre-op nurse/admitting clerk*
Patient chart completed *Preop nurse*

The preop nurse will then call the patient and gather information known as the "history" to determine whether he or she is medically appropriate for the ASC environment. If the preop nurse discovers that significant medical history or preop tests are abnormal, the chart is usually referred to the medical director or anesthesia director who determines whether the surgery will be performed as scheduled and whether any other action is needed. The scheduler may also learn important information, such as any special consent or the need for an interpreter. Communicating this information in advance of the date of surgery can prevent delays, cancellations, and frustration.

Surgery nurses, anesthesia providers, and surgeons/physicians

These staff members live by the surgery schedule. They rely on the schedule to include the correct procedure at the correct time, to assign the accurate amount of time for the procedure, and to assign the amount of time necessary to turn-over the operating room between procedures. For their purposes, the schedule must account for the availability of equipment and instruments (including implants) and any special requests for the patient's referring physician to attend the surgery. It also must plan to handle credentialing and privileging issues (which absolutely must be done in advance of the date of surgery). The practitioner must observe or participate.

Post-acute care unit and Phase II recovery nurses

This group of personnel is probably the least directly affected by the scheduler's actions. However, if something doesn't go as planned in the patient's care, the recovery nursing staff will feel the impact. They may

experience backups in the recovery schedule or patients who have high acuity levels and who present additional challenges in the recovery process.

Materials management staff

This part of the ASC team must know in advance of the date of surgery what equipment, instrumentation, or supplies/implants the surgery will require. Materials staff may need to make calls to locate equipment, talk to vendor representatives, and, hopefully, avoid overnight shipping, which can be very expensive and eliminate profits for a particular case.

Patient accounts or receivables

This department depends on scheduling to ensure that correct information is provided about the insurance company and payers. If this information is not correct, the claim may be rejected, thus delaying payment. For example, if implants are billable to your payers, having this information available at the time of scheduling will prepare coders to add it to the procedure codes when billing the claim. Also note that many payers have multiple addresses (e.g., Blue Cross Blue Shield) and keeping a copy of the insurance card (front and back) will ensure that you use the correct address when entering the patient's demographics and billing the claim.

The management team

Members of the management team deal with any problems that result from any breakdown in the scheduling process. Therefore, managers must hire the right person to perform the scheduling functions. This position requires an intelligent and responsible person who cares about the quality

of his or her work. For more about how to select the right person for the role of surgery scheduler, see Chapter 2.

The medical staff

The board of managers, medical executive committee, and medical and executive directors are responsible for credentialing and privileging the medical staff and others. Credentialing verifies—using specific policies—that the practitioner has the education, training, and experience required by the bylaws of the organization (and that the physicians claim to possess) in order to be on the medical staff. Privileging verifies that the practitioner has the education, training, and experience to perform the procedure(s) he or she requests. The scheduler must verify that any practitioner/physician who schedules a procedure has been granted the privilege to perform the procedures they schedule. The scheduler must notify the management team if any question arises about these privileges.

Patients and family members

Consumers depend upon the physician office staff to give them the date and time of their surgeries. The scheduler will determine, depending on the procedure and based on a policy, the anesthesia type and what time the patient should arrive at the center to prepare for surgery. Usually preparation takes one hour, but the time may vary. For example, pediatric patients who do not require an IV or whose IV will be started in the operating room may only need to arrive 45 minutes ahead of the surgery's scheduled start time. For procedures in which a regional block is administered prior to the patient going to the operating room, the patient may be asked to arrive 90 minutes in advance of the scheduled surgery time.

Block scheduling

There are many ways to set up your schedule in a new center. A strict block schedule will block all or most available time, which usually creates a lot of unused and, therefore, non-productive operating room time. When using this method, the blocks may not be released at all or are not released until the day before the surgery date.

In another method, the open schedule, cases are scheduled on a first come–first served basis. Such schedules can frustrate surgeons, as they may not be able to schedule their cases back-to-back if another surgeon schedules a case behind them. Therefore, surgeons who can anticipate their schedules far in advance, such as ophthalmologists or plastic surgeons, can live with this method far better than OB/GYN or general surgeons, who often schedule within one to three days of surgery and cannot get a time that works for them. I do not recommend this method for an ambulatory surgery schedule.

Modified block scheduling is the most widely used method and affords most centers maximum flexibility. In this system, a physician, practice, or specialty may be granted a block of time, which can range from two hours to an entire day, in which to use the operating room. The center board of managers—usually delegated to the medical executive committee—reviews block use and manages the blocks to maximize use of operating room time. A center should strive to achieve 70% utilization of all operating room time. Eighty-five percent is probably the maximum anyone can hope to achieve in any surgery setting.

In a modified block scheduling format, the center reserves some of the available surgery time for surgeons who can fill the block as required by your center's policies. For example, you may require that a physician fill 60%–70% or more per quarter to keep the block, depending on the maturity of the center.

A new center will probably set the requirements a little lower, but it must diligently review block time use and eventually push to achieve a higher percentage. Unblocked times are called open blocks, which physicians use when they cannot fill a block alone. OB/GYN surgeons or general surgeons, depending upon their practice, may fit into this category.

Blocktime should be released by the office as early as possible, if the surgeon will not be using a block due to vacation, seminar, or another reason. The ASC releases the blocks according to its policies, usually 72 hours to one week in advance if the surgeon has not filled the block. Whatever part of the assigned block is released becomes open time. The surgery scheduler can fill this new open time with any cases that were added to the schedule close to the date of surgery, as cases from OB/GYNs and general surgeons often are. This method allows the surgery scheduler to accommodate the needs of more surgeons, maximize operating room use, and make the staff more productive.

Most centers include a statement in their scheduling policies that prohibits "ghost scheduling" or "phantom scheduling," which is when the office schedules nonexistent cases to hold block time to prevent another physician from taking it. The office then cancels the case the day before the

scheduled surgery if they are not going to use it, which causes the center to lose operating room time.

Figure 1.2 is a sample schedule using a modified block scheduling format.

| Figure 1.2 | SAMPLE MODIFIED BLOCK SCHEDULE |

		Room 1	Room 2	Room 3	Room 4
Monday	AM				
Monday	PM				
Tuesday	AM				
Tuesday	PM				
Wednesday	AM				
Wednesday	PM				
Thursday	AM				
Thursday	PM				
Friday	AM				
Friday	PM				

HCPro

Order your copy today!

Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit *www.hcmarketplace.com*. **If you received a special offer or discount source code, please enter it below.**

Title	Price	Order Code	Quantity	Total
				$

Your order is fully covered by a 30-day, money-back guarantee.	**Shipping*** (see information below)	$
	Sales Tax** (see information below)	$
	Grand Total	$

⮐ **Enter your special Source Code here:** _____

Name

Title

Organization

Street Address

City   State   ZIP

Telephone   Fax

E-mail Address

***Shipping Information**
Please include applicable shipping.
For books under $100, add $10. For books over $100, add $18. For shipping to AK, HI, or PR, add $21.95.

****Tax Information**
Please include applicable sales tax.
States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

BILLING OPTIONS:

☐ Bill me ☐ Check enclosed (payable to HCPro, Inc.) ☐ Bill my facility with PO # _____

☐ Bill my (✓ one):   ☐ VISA   ☐ MasterCard   ☐ AmEx   ☐ Discover

Signature   Account No.   Exp. Date

(Required for authorization)   (Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at *www.hcmarketplace.com*

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945

CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787

FAX THE COMPLETED ORDER FORM TO: 800/639-8511

E-MAIL: *customerservice@hcpro.com*