Effective management of the block schedule depends on a strong foundation of clear policies and good governance. Here are some tips from a veteran OR director, Mary Diamond, RN, MBA, CNOR. Diamond is director of surgical services for the Sharp Metropolitan Campus in San Diego, including Sharp Memorial Hospital, a 460-bed trauma center, and Sharp Mary Birch Hospital for Women. She gave a session on block scheduling for new managers at the Managing Today’s OR Suite Conference in October 2005 in San Diego.

Establish governance

Good governance is the basis of a good schedule.

“Don’t try to do it yourself,” Diamond advised OR directors. “You need a committee, a medical staff champion, and administrative support to reinforce decisions.”

The OR’s governing committee should develop scheduling policies, a mechanism for managing the policies, and a protocol for physicians who want to appeal or change the rules. The committee should address issues such as availability and utilization of block time, add-ons to the schedule, and release time. At the Sharp Metropolitan Campus, these decisions are made by an OR committee, which reports to medical staff committees. The OR committee consists of the physician chiefs of service, the medical director of the OR, nurse managers, and administrative representatives. The OR committee makes decisions on block utilization and allocations. It sends its reports to the medical staff committees.

Sharp Memorial also has a medical director of the OR, an anesthesiologist, who collaborates with the nursing and medical staffs on issues affecting the operation of the OR. Diamond has a dotted-line reporting relationship with him.

“Cultivate good communication with your superiors so you will have support when you need it.

“They may be your best line of support in enforcing the policies,” Diamond advises. “No matter how clear and fair you are, someone is not going to like all of the decisions and is going to want to appeal. If your boss is going to hear about it from the physicians, let your boss hear about it from you first.”

Study your practice patterns

Efficient use of OR time strikes a balance between overutilized and underutilized time. Study your practice patterns to see what staffed hours will work best for your organization. Sharp Memorial, for example, keeps 2 rooms open until 11 pm to accommodate surgeons who want to operate after office hours.

Diamond recalls a nurse manager who told her, “No matter what we do, we have a doctor who wants to start at 9 am 3 days a week—that’s 2 hours in the morning wasted.”

The solution: Start staffing that room at 9 am.

“Don’t be locked into thinking every room has to start and stop at the same time. There isn’t any one formula,” Diamond says.

Establish policies for scheduling

After the OR governing structure is in place, set up the scheduling rules. Among issues to address:

- **Who can schedule cases?** At the Sharp Metropolitan facilities, only surgeons and their offices can schedule.
- **How far in advance may procedures be scheduled?** “Do you want to allow 6 weeks, 3 months, or 6 months? Put it in writing,” she advises.
- **What hours is the surgical scheduling office open?** Typically, the hours mirror
surgeons’ office hours because that is when most cases are scheduled. Once the hours are established, communicate that to all involved.

- **How are cases scheduled when the scheduling office is closed?** Under Sharp’s rules, cases must be booked by the scheduling office. The automated scheduling system is sophisticated, and cases need to be scheduled by a person who knows the system. When the office is closed, only cases that will be done in the next 24 hours are scheduled. The charge nurse and clerical staff enter those cases into the system.

- **What are the available hours for elective case scheduling?** Strive to match the hours to practice patterns, as discussed above. Sharp Memorial’s elective schedule starts at 7:20 am, and rooms close in a staggered fashion beginning at 3 pm as volume diminishes.

- **Do you need time for urgent and emergent cases?** If the elective schedule is often bumped, you may want to allocate OR time for urgent and emergent cases. Sharp Memorial sets aside 16 hours a day as “in-house hold time.” To be scheduled into this time, the patient must be in the house or in the ER waiting to be admitted.

- **How do you add to the OR schedule?** Rules need to cover the protocol for add-on cases.

- **What are the rules for bumping the elective schedule?** Bumping the elective schedule to make room for emergencies is sticky. “Communication for bumping the schedule works best physician to physician,” Diamond says. A representative of the medical staff should be designated to manage the bumping policy. Nurses should not be caught in the middle.

**Set policies for managing block time**

Some of the issues to address:

- **What percentage of the schedule is blocked versus open, first-come, first-served time?** This is a decision to be made by each organization. (See related article.)

- **What are the policies for maintaining block time?** Sharp Metropolitan’s rules include:
  - Surgeons are expected to maintain 60% block utilization.
  - Utilization of block time is reviewed quarterly by the OR Committee in January, April, July, and October.
  - Block time released 8 days in advance will not be counted against surgeons in calculating their utilization.
  - Surgeons with higher average block utilization for the previous 6 months have a shorter release time. Surgeons with 75% utilization have a 24-hour release time, and surgeons with 60% to 75% utilization have a 7-day release time.
  - In the quarterly review, the surgeon’s 6-month utilization average is used to determine the release time for the next 3 months.
  - Block time may be released by fax, e-mail, or phone call. Surgeons who call should make a note of whom they talked to.
  - Surgeons who have an average utilization below 60% are encouraged to make changes to be in compliance or risk of having block time adjusted downward.

**Be consistent and fair**

Once the rules are developed, they should be reviewed and approved by the appropriate medical staff committees. Be sure the rules are widely communicated.

“There should be nothing mysterious about how cases get on the schedule,” says Diamond. “Post the rules. Make sure everyone has access to them.

“When a physician complains or doesn’t understand the rules, you can refer him to the chief of surgery. The chief can help him understand that surgical time is a shared resource, and this is a shared decision,” she says.

“Be consistent,” she adds. “Apply the rules equally whether it is for your most prolific scheduler or a surgeon who comes infrequently.” The chief of surgery must abide by the same rules as the most junior surgeon on the staff. “The rules apply to everyone—that is one of the hardest things to do.”

**Think about resource allocation**

If all of the orthopedic surgeons want to operate on Tuesdays, that means multi-
ple demands for equipment like C-arms, fracture tables, and instrument trays. There’s also a demand on downstream resources. If all the orthopedic patients need postop beds on Tuesdays, there may be a bed crunch on other units. “You may need to say to some surgeons, ‘We would like to accommodate you on Tuesdays, but due to our resource allocation, we can’t,’” Diamond says.

**Have clinicians review the schedule**

At Sharp Memorial, service coordinators check the schedule 1 week ahead for conflicts and problems. For example, they may find a case will take longer than scheduled or needs extra setup time.

“The more proactive you can be, the better able you are to run on time on the day of surgery,” Diamond notes.

**Educate, communicate**

“Get to know the surgeons’ office schedulers,” Diamond suggests.

When Sharp Memorial went live with a new surgical scheduling system, the OR held a tea and invited the office staff of every surgeon who had scheduled a case in the past 12 months. Over 100 attended. Every office received a laminated checklist of the information the OR needs to schedule a case.

“We had a great time. Now our staff knows who’s on the other end of the phone. It was great for public relations,” Diamond says.

**Develop reporting tools**

These are some reports Sharp Metropolitan uses to stay on top of scheduling and utilization:

**Individual surgeon monthly report**

This report is sent to every surgeon who has block time every month. The report lists:

- each case the surgeon performed
- the time each case took (patient in to patient out of room)
- total minutes of block time used
- percentage of block time used.

**Letter to individual surgeons**

With the monthly report goes a standard letter to each surgeon from the medical director of the OR. The letter states the surgeon’s block utilization for the past month, 3 months, and 6 months and says, “If you feel this utilization is in error, please contact us for correction.” The letter restates the rules, noting that 60% utilization is required to maintain block time.

“If a surgeon is at risk for losing block time, we have clearly communicated the expectation,” Diamond notes.

**Summary monthly report**

This summary report of block utilization is posted and sent to the OR committee. The report shows the total minutes allocated to each block, minutes used, and minutes released. If a surgeon is routinely releasing block time more than 50% of the time, the surgeon will be asked to give up some of the time.

**Rolling 1-year summary**

This report provides a view of trends in surgeons’ utilization.

“If we see a dip in utilization or a change in practice trends, we can identify it,” Diamond notes. For example, a recent report showed one surgeon had 0 utilization for the past 2 months because he took his cases to a surgery center.

“If we see a downward trend, we work with the physician to adjust the block time before we have to take the time away,” she says.