

OR performance

Managing urgent cases with accountability

A 4-level classification system with built-in accountability measures is used for managing urgent and emergent cases at Munson Medical Center in Traverse City, Michigan, a 390-bed referral center with 14 ORs.

The policy was developed by a steering committee of surgeons, anesthesiologists, OR management, and the administration working with a consultant. The committee started with a 5-level classification designated by the letters A through E but later adopted 4 levels (sidebar).

“As we worked through the ABCDE concept, the committee felt 5 categories made for unnecessary complexity,” says Robert Cline, MD, the medical director of surgical services. “Also, from a medical standpoint, we didn’t need to split hairs between a patient who needed to be in the OR within the hour and one who could wait up to 2 hours. Similarly, we didn’t see a clear clinical difference between 8 and 12 hours.”

The committee also did not want the OR leadership to be faced with the situation in which the OR learns of an add-on case at 7 am that doesn’t need to bump into the schedule in the next 4 hours but can’t wait until the elective schedule is finished at 5 pm. Moreover, the committee thought that if a patient’s medical condition would allow a 24-hour wait for surgery, the patient could also wait for 48 hours.

“This allowed the classifications to be functional for us on the weekends as well,” Dr Cline says.

How the classifications are used

The classifications escalate as time passes. For instance, a Class B case (4 hours) automatically becomes a Class A case (1 hour) and bumps into the schedule if 3 hours have passed. Similarly, a Class C case becomes a Class B case 4 hours from the deadline and becomes a Class A case if it reaches 1 hour.

“The surgeon and anesthesiologists can review this escalation and modify the deadline if the patient is stable, and they agree this is reasonable,” he says. “We rarely need to consider this because we do a good job of meeting the deadlines.”

The Class D category is intended to include any inpatient who must have surgery before being discharged.

“We felt these cases were important to allow, particularly on weekends, to avoid prolonged lengths of stay, even if the surgical urgency did not require a 48-hour deadline,” Dr Cline says.

Accountability measures

Accountability measures built into the policy are intended to encourage compliance by the surgeons, anesthesia providers, and OR management team.



Urgent-emergent case classification

- **Class A Emergency:** Life, limb, and/or sight-threatening condition requiring immediate surgery within 1 hour of declaration and taking precedence over any other case.
- **Class B Emergency:** Life, limb, and/or sight-threatening case requiring surgery within 4 hours.
- **Class C Urgency:** A nonlife-threatening condition that may lead to severe complications if surgery is not performed within 12 hours of classification.
- **Class D Urgency:** Nonlife-threatening condition requiring surgery within 48 hours to prevent severe complications from occurring. Any inpatient case that cannot be discharged until the surgical procedure is performed will be included in this classification.

Source: Munson Medical Center, Traverse City, Michigan.

One measure holds the surgeons accountable for using the agreed-upon classifications. The committee asked each surgical section to define which procedures in its specialty were in Class A, B, C, and D. The steering committee then reviewed and approved the procedures with some changes.

Surgeons are expected to use the agreed-upon classifications when booking cases. They have the latitude to escalate a case to a higher level based on the individual patient's condition. In general, OR leaders do not question the surgeons' assignments of a classification.

"Our staff prompt the surgeons for the classifications and occasionally question a classification if it is not the agreed-upon one," says Dr Cline. For example, the general surgeons classified appendicitis as a Class B procedure (4 hours). One surgeon who insisted on bumping other cases for appendectomies has now agreed that they are Class B.

Being available

In another accountability measure, surgeons are required to be available to come to the OR for Class A and B cases whenever the OR can accommodate them; they must be prepared to leave the office if they need to. For Class C cases, surgeons are expected to come when the OR can accommodate them unless they are involved in patient care activities, such as being in surgery elsewhere or seeing patients in the office (this does not include meetings). If a Class C case has escalated to Class B, the surgeon must come when the OR can accommodate the case even if involved in other patient care.

Staff, anesthesia availability

The third accountability measure is that the OR staff, anesthesia staff, and surgeons must bump into the schedule or call in other personnel to meet the deadlines. For example, if all available staff are assigned on a weekend, and a Class A or B case is booked, the OR management is obligated to make appropriate efforts to call additional staff to take care of the patient within the designated times. Technically, this applies to a surgeon who has booked an appendectomy (4-hour limit) but is involved in another operation that will keep the

surgeon tied up past the deadline; in that case, he or she needs to call in another surgeon.

Together, these aspects of the classification system help keep the surgeons honest in choosing the agreed-to classifications, Dr Cline notes. Escalating levels of penalties are included for surgeons, management, and anesthesia personnel for lack of compliance. Penalties range from counseling to formal letters to fines or loss of OR time. So far, penalties beyond sending letters and providing re-education on the policies haven't been required.

"Our consultant described the process this way—during elective block time, the time belongs to the surgeon to schedule. After elective block time, the time belongs to the patients," Dr Cline says.

"By using the classification system well, we have a system to ensure we meet the patient's needs, at least for timeliness. If that inconveniences the staff, surgeons, or anesthesiologists, that's okay because the system needs to be patient focused." ❖