

# The Leapfrog Group's Safe Surgical Scheduling Leap

## How will the Leap be Scored?

1. ¼ credit -- The chief of one surgical/procedural department of the hospital has contacted and held discussions with a peer at another hospital that has used admission smoothing to increase patient throughput by at least 15% over a three year period.
2. ½ credit -- The hospital has a written plan for implementing admission smoothing across one surgical/procedural unit within the next 12 months and the hospital board has approved a dedicated budget for its implementation.
3. ¾ credit -- The hospital has implemented admission smoothing in at least one surgical/procedural unit and can document at least a 5% improvement in patient throughput by the end of year one and a 15% improvement by the end of year three in the/those unit(s).
4. Full credit -- The hospital has implemented admission smoothing across all surgical/procedural units and can document at least a 5% improvement in patient throughput by the end of year one and a 15% improvement by the end of year three across all units.

NOTE: Improvement in patient throughput is defined as an increase in patient volume with no increase in staffed beds. Hospitals should use each unit's annual patient-to-bed ratio at the point in time the implementation plan was developed as the benchmark for measuring throughput improvement.

### Exclusion from Hospital Reporting:

#### **Hospitals excluded from reporting on this Leap:**

- Hospitals with no surgical/procedural demand
- Number of beds < 25

#### **Hospitals that may possibly be excluded from reporting on this Leap:**

- Any hospital whose elective admissions are less than 10% of total admissions, should use the Institute for Healthcare Optimization (IHO) ROI calculator to determine if it meets the third basis for exclusion.  
(IHO ROI calculator: <http://www.ihoptimize.org/roi-estimator/>)

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## Implementation Tips

**For hospitals unfamiliar with admission smoothing, below are implementation tips from experts to assist hospitals that seek to implement this Leap:**

### *Phase 0: Preparation for Implementation*

1. The hospital has secured knowledgeable resources to guide it in this initiative.
2. The hospital has identified the measures needed to assess its return on investment from implementing Phase 1. Such measures would commonly include surgical volume, operating room overtime, and wait times for emergent and urgent surgeries, among others.

3. The hospital has identified one or more physician champions to spearhead this initiative. One of those physician champions should be a surgeon.
4. The hospital board has approved a dedicated budget for this initiative

*Phase I: The hospital separates all scheduled and unscheduled cases into distinct patient flows (scheduled cases include both inpatients and outpatients)*

#### **1A. Separate Scheduled and Unscheduled Cases**

1. The hospital has defined the timeframe for what constitutes an 'unscheduled' surgery (e.g., notice of request is less than 24 hours prior to surgery)
2. The hospital's surgeons have classified all cases on the basis of their clinical urgency (suggested, but not limited to, 3-4 classifications), attached a maximum waiting time to each classification, and determined which cases fall into the 'unscheduled' category. These classifications are reviewed and updated periodically by surgical/procedural staff and are also updated as new types of surgery are introduced.
3. The hospital measures and tracks waiting times for unscheduled surgeries on an ongoing basis. (Waiting time = time between booking request and incision)
4. The hospital has reviewed its case types and associated waiting times to determine if clinical diagnosis-based subgroups are warranted (e.g., cardiac, trauma)
5. The hospital has used scientific methods (e.g., queuing theory) to determine the appropriate mix of scheduled and unscheduled operating rooms.

Note: If less than one operating room is needed to guarantee the waiting times determined for each classification, then skip to Phase II.

#### **1B. Separate Work-Ins and Elective Patients**

1. The hospital has identified what constitutes a 'work-in'
2. The hospital has determined how to accommodate 'work-ins' (e.g., add to end of day; dedicated room, incorporate into block time)
3. The hospital has allocated time on the OR schedule for work-ins

#### **1C. Re-allocate Elective Prime Time**

1. The hospital has assessed the scheduled utilization of prime-time for its different surgical services and individual surgeons, in order to raise the scheduled utilization of prime-time to approximately 85%.
2. If the scheduled utilization of prime-time is lower than 85%, the hospital has determined whether elective prime-time needs to be re-allocated.
3. If the scheduled utilization of prime-time is greater than 85%, the hospital has determined whether prime-time should be extended for high-use services and surgeons.

*Phase 2: The hospital separates inpatients and outpatients, then smoothes artificial variability in elective admissions*

#### **2A. Separate Inpatients and Outpatients**

1. The hospital has classified cases as outpatient vs. inpatient
2. The hospital has calculated the number of surgical/procedure rooms (e.g. operating rooms, cath labs) required for each type of group
3. The hospital has decided on the number and type of needed outpatient teams

4. The hospital has allocated prime time to specialty teams across days of the week in an equitable fashion based on case volume.

#### **2B. Smooth Artificial Variability in Elective Admissions**

1. The hospital has adjusted scheduling blocks to optimize the post-operative distribution of patients to specific specialty units (e.g., ICU, telemetry, med/surg) in a fashion that will stabilize specialty unit census to the extent possible.
2. The hospital either utilizes proactive scheduling or caps weekday elective admissions to individual inpatient units
3. The hospital enforces scheduling guidelines for elective cases

*Phase 3: The hospital determines the necessary hospital capacity to provide quality care*

The hospital has used scientific methods to right-size unit and hospital bed capacity.