Patient Flow:

A multidisciplinary challenge to control access, patient safety and cost throughout the world

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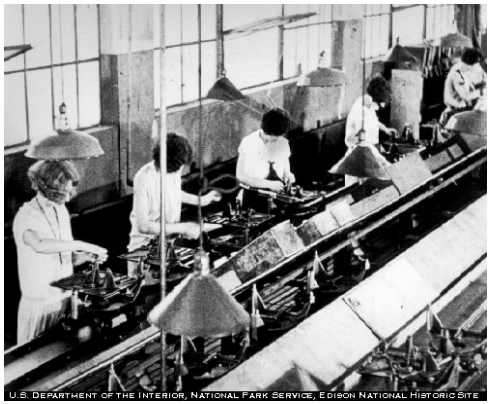
Defining the Challenge

A Hospital Not Only ED Challenge!!

- Patient flow management is a **TOOL** to:
  - Rapidly match the patient to needed services
  - Protect patient safety
  - Maintain safe patient/provider ratios
  - Improve patient and room turnover rates
  - Limit “boarder” status patients in the ED
  - Minimize outpatient area backlogs
  - Reduce the costs of care
  - Improve patient satisfaction, also
  - Meet JCI Standard ACC2.2.1: “The hospital develops a process to manage the flow of patients throughout the hospital



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So Who's Responsible to Assure Success??

- Ultimate responsibility belongs to **LEADERSHIP**
  - Safety, cost, staff time, $$, IT, utilization, satisfaction
- Operational responsibility to **ALL** clinical departments' leadership teams, inpatient, outpatient, OR, procedural areas, imaging, lab and all ancillary services working in harmony.
- Success requires eliminating clinical competition and "blame" and development of a multidisciplinary patient flow taskforce and management team
- Team's decisions must trump existing clinical area, service line decision making as it relates to patient location ,admit/discharge norms, and importantly individual physician placement decision making.

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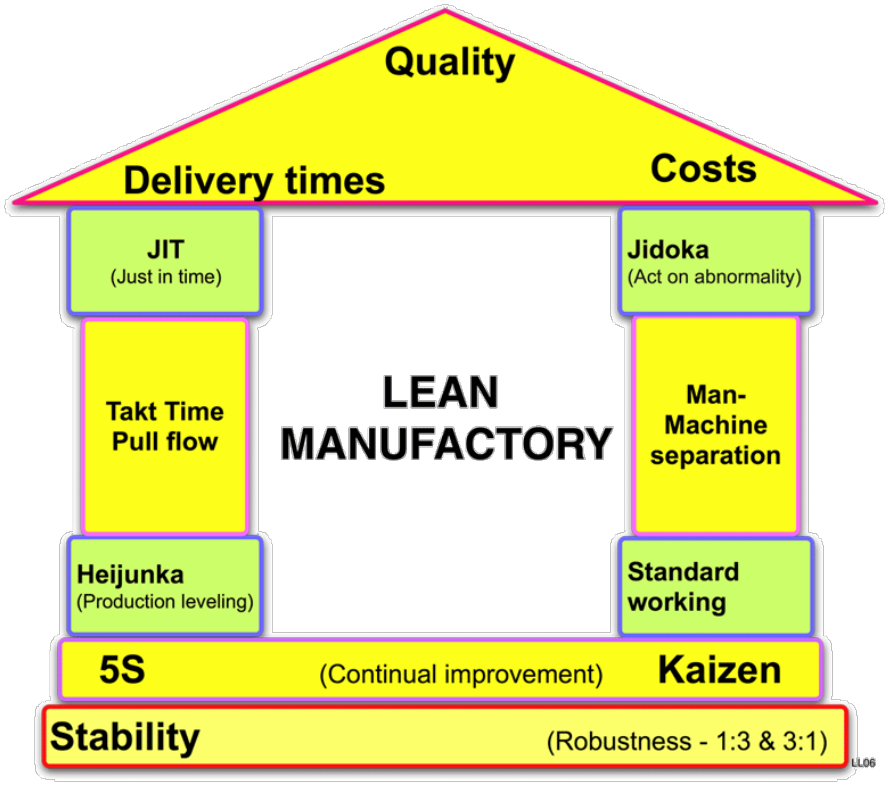
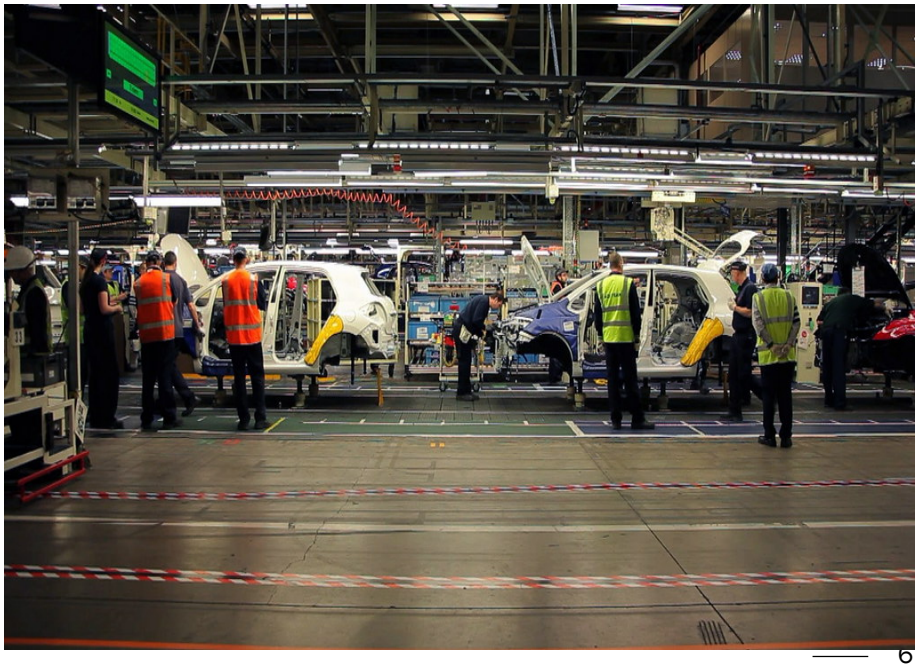
Can We Learn Anything from Other Businesses?

Toyota Production System (TPS)



LEAN science and tools have been adapted by many international hospitals to control flow, quality and costs



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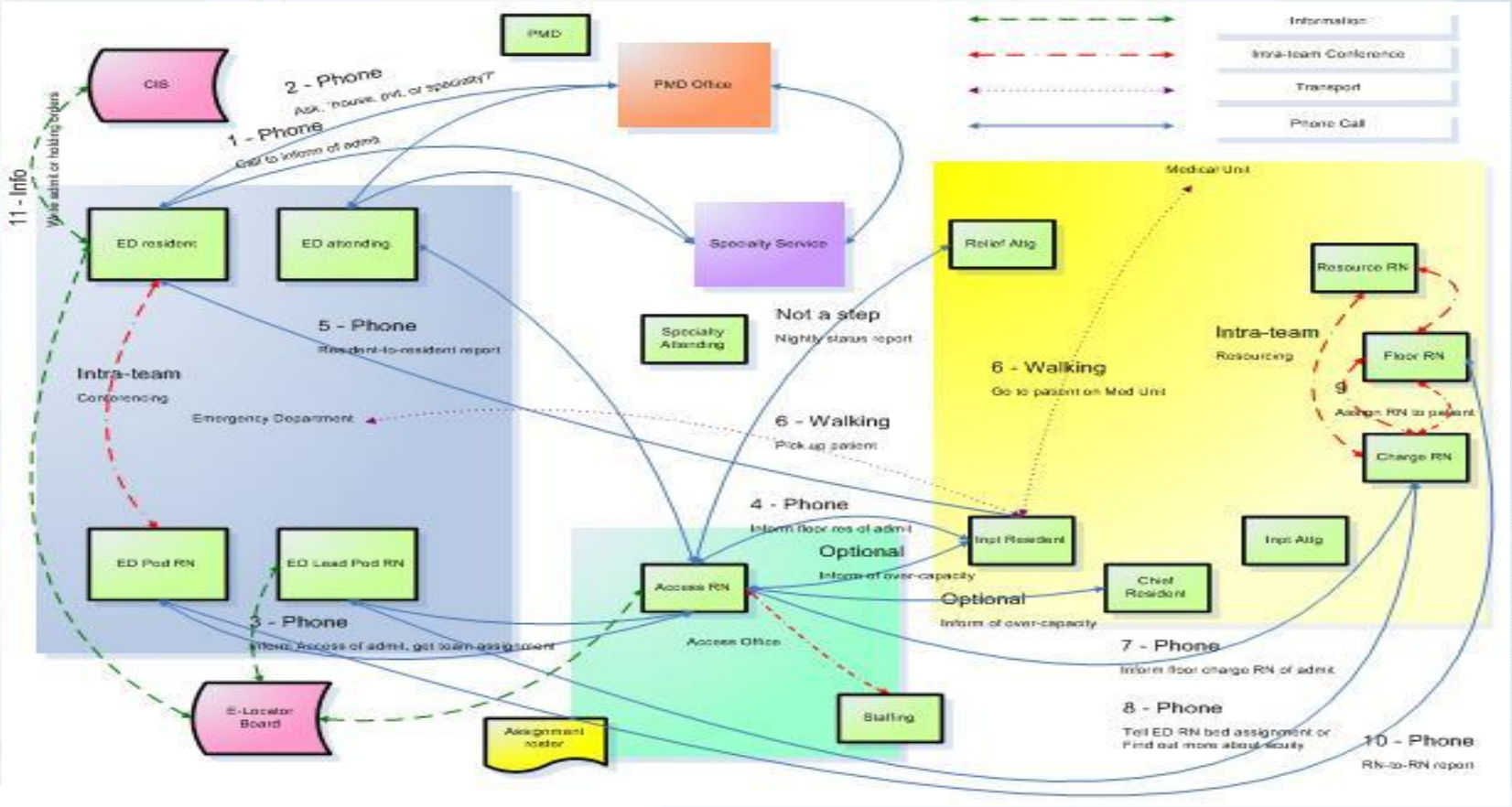
What LEAN principles apply to FLOW

- **Standardize** all processes- remove all variability
  - Managing flow decisions are centralized
  - Unit and department practices adapted
- Remove all **waste** (“muda”) or low value processes
  - Reevaluate value of each step in admit/visit process
  - Pre-visit evaluation, paperwork completion online
  - Match patient need with resources required – not more
- Decisions meet **customer** (patient) – not staff expectations
  - Staff “tradition” and convenience gives way to efficiency/safety
- **Errors** are identified and corrected before progressing
  - “Stop the Line”- No “inspections” ; “Poke-yoke”- fail safe
- **CONTINUAL** process improvement everyone’s\ role

Hospital Challenges are Real!!

Communication to Admit One ED Patient



"Spaghetti Diagram"

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Quality Challenge: Reduce the Error Rate

10 -6 to-7

10 -2 to-3

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Where are the Primary Obstacles to Smooth Patient Flow??

Patient Flow Critical Clinical Sites

- **Outpatient**
  - Emergency dept.
  - Clinics
  - CT/MRI/Ultrasound
  - Laboratory
  - Cardiac cath
  - Interventional rad
  - Endoscopy
  - CT/MRI
  - Day surgery
  - Pharmacy

- **Inpatient**
  - Emergency dept.
  - Medical wards
  - Surgical wards
  - Cardiac monitoring
  - Critical Care Units
  - Surgery suite
  - Pharmacy
  - Medical Imaging

Emergency Dept Plays Central Role

Exacerbate flow

- ↑ ER Visits
- Unnecessary visits
- No after hour clinic care
- No sick/urgent care space
- Limited to 5-day clinic care
- No clinic urgent walk in care
- Specialty clinic backlogs
- Left without treatment pts
- Long imaging waits
- No ED behavioral health
- No care coordination
- Poor medication education

Improve flow

- Urgent care triage area in ED
- Walk in sick clinic care
- Specialty ↓ clinic same day care
- Nursing protocols
- Inpatient/ED observation beds
- Full time ED behavioral health
- Satellite imaging (CT & U/S)
- Satellite lab
- ICU & Med Surg “Held” Beds
- ED Clinical pharmacist
- Follow-up phone calls

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Impatient Med Surg Floors

- Establish “bed control center”
- Manage observation care bed area
- Disease specific clinical guidelines and care maps used
- Begin evening and morning discharge rounds
- All lab & studies completed evening before discharge
- Formal discharge order written the evening before
- Discharge waiting area created
- Pre-discharge contact with PCP
- Pre-discharge pharmacist patient/family med education
- Discharge planner/Social Worker sees all new admits
- Clinic chronic care coordinator (e.g. COPD, CHF, DM) involved
- Clinic visit scheduled within 72 hours
- Follow-up phone calls (floor or clinic)

Outpatient Clinics

- Establish same day appointments (work down backlog)
- Staff urgent/sick care clinic (in clinic or ED)
- Initiate evening clinic hours
- Clinic based behavioral health provider
- Pharmacy consultative clinic- polypharmacy patients
- Chronic disease management nurse (e.g. COPD, CHF, DM)
- Post discharge visits within 72 hours
- Home health visitation program

Specialty Clinics

- Clinic specialty consultant for ED/Med Surg with open schedule blocks
- Evening/weekend appointments until backlog worked down
- Same day appointments

Intensive Care Units

- City/region/system wide on-line live bed logs- coordinate with EMS
- **STRICT** admission and discharge criteria
- Pre-admit ICU consults in the ED
- Pre-discharge step down area (patient/family education)
- MD/RN consultative service to Med Surg floors
- Specialized areas: surgery, neuro-stroke, cardiac
- Unit based clinical pharmacist
- Large units: satellite pharmacy and laboratory
- Uniform ventilator weaning protocols introduced
- Central line placement teams
- Patient/family nursing educator
- Ethics rounds and consultations
- Afternoon review of elective surgery cases scheduled for next day

Operating Theatre- Procedural Areas

- Pre-operative nursing/nurse practitioner clinic- history/education
- Preoperative anesthesia clinic- testing completed
- Telephone, email reminders
- “Flatten” elective scheduling to create even flow 5 days a week
- Separate day surgery rooms/suite for rapid turnover cases
- Open weekend cases to work down backlogs (e.g. endoscopy)
- Satellite pharmacy – prophylactic antibiotic protocols
- Frozen section lab on site
- Uniform case packs
- Pre-printed consents for all common procedures- all elements
- Pre-printed discharge instructions for all common procedures
- Anesthesia, nursing, housekeeping participate in room turnover
- Post-surgery phone calls, Wound clinics

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Questions: