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Patient Flow: Improving Care and Throughput

EXECUTIVE SUMMARY

Most of us believe that the best quality care is also the most efficient, but demonstrating a direct, quantifiable relationship between the two is not often easy or possible. One area related to care that *can* demonstrate direct correlation between quality and efficiency is **patient flow**, or the tracking and managing of patients from the moment they enter a care setting until the time they are discharged.

Like workflow, which focuses on establishing rational frameworks for analyzing, streamlining and automating work processes, patient flow offers a disciplined way of looking at all the processes that support a patient as he or she travels through the myriad handoffs in a hospital or clinic. Reengineering patient flow has emerged as a trend in the healthcare industry because of the combination of rising patient demand, limited bed/treatment capacity and emphases on improving customer service and the patient experience. Hospitals especially are trying to get control of this process.

Hospitals tackling patient flow find it similar to reengineering the revenue cycle: great returns in efficiency can come from rationalizing a complex and inefficient process that has grown haphazardly over the years into its own functional silo. As in the revenue cycle, successful patient flow solutions require transcending these silos based on a comprehensive view of processes that span an enterprise. Even more than the revenue cycle, however, patient flow can have a direct impact on

quality of care—getting a patient to the right diagnostic test at the right time can frequently mean the difference between good and bad care—and have a major impact on the costs of care delivery.

This issue of Information Edge explores how three hospitals—Condell Medical Center in Libertyville, Ill., United Hospital in St. Paul, Minn. (Allina Hospitals & Clinics), and Lucile Packard Children's Hospital at Stanford, in Palo Alto, Calif.—have addressed the issue of patient flow and derived measured benefits from the effort.



Diversionsary tactics

Five years ago when David Miller arrived as VP of operations at United Hospital in St. Paul, Minn., he found that the hospital had a serious problem with ambulance diversions: they were often diverted away from United to other hospitals. It was clear, quickly, that the problem was one of optimizing capacity.

“Patients couldn't get up to the proper units,” he recalls. Today, after streamlining the patient flow process, United Hospital claims it has jumped to the best—meaning the lowest—rate of ambulance diversion in the area from previously being the worst. “Now we're matching patient demand with appropriate resources,” Miller says, adding that the hospital uses computers to track patient demand minute to minute.

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WELCOME NEW PROGRAM PARTNER

The Scottsdale Institute is pleased to announce Korn/Ferry International as a Program Partner.

Korn/Ferry's Healthcare Services Practice is comprised of search experts spanning North America, committed to securing the industry's top executives for a diverse range of healthcare organizations including: Integrated Delivery Systems, Academic Health Science Centers, Hospital Systems, Health Insurance Companies, Multi-Specialty Physician Practices, Pharmacy Benefit Management Companies, Long Term Care/Assisted Living Companies, Home Health Companies, Healthcare Associations and other Service Delivery companies.

Korn/Ferry has served many healthcare institutions including: one-half of the top academic medical centers; one-third of the top 100 integrated delivery systems; one-half of the top 25 health insurance companies; and over 500 medium to large sized hospitals and other healthcare organizations for over twenty years.

Welcome Thomas J. Giella, practice leader, Healthcare Services Practice and the entire management team at Korn/Ferry.



David Miller, VP of operations, United Hospital, Allina Hospitals and Clinics, St. Paul, Minn.



Those computers use the NaviCare system, now owned by Hill-Rom but originally developed in United Hospital's OR and then expanded as a total patient flow solution.

In the beginning of its effort, United Hospital wrote a demand schedule for each hour of the day in order to clarify, for example, if 20 ambulances were expected during any such period. The next step was to create a centralized area that worked closely with the units throughout the hospital to manage all the admissions and transfers. That early aspect of the initiative also included elimination of the "secret" telephone numbers that physicians had in order to get patients admitted to the hospital.

On demand

Key patient flow functions of the new system include patient placement, employee staffing and patient scheduling. Employee staffing is critical in planning the appropriate number of nurses in the appropriate areas to accept every patient when the demand hits.

When Miller and his team looked at the situation closely they discovered that when physicians made rounds at the hospital, they were seeing the sickest patients first, which resulted in delayed discharges for the healthier ones. United worked with the physicians so they would see patients to be discharged early allowing for greater capacity.

Patient flow triad

Miller cites three elements central to United's patient flow foundation:

1. People—changing the process to one in which the right people are on duty at the right time.
2. Technology—using an automated tool to track patients throughout from registration to discharge.
3. Science—the most elusive part, involves taking an automated predictor tool to 80% confidence level. The tool creates a computer model of patient flow predictions for each hour of each day.

The *people* leg of the triad implies that any solution must bring people together hospital-wide, not just in the emergency department. So, bed meetings are held twice a day, a coordinator's meeting daily, there are super users on all care units and Miller's team does "divert data" reviews for those rare times when a divert occurs. Quite importantly, every patient diversion is considered a sentinel event. Employees have training in Hospital Emergency Incident Command (HEIC), which creates a "command center" and sets processes in motion to address a Yellow Alert and Gridlock congestion event.

The *technology* leg is the system that was developed in the hospital's OR in the late 1990s as an "electronic greaseboard" and expanded in 2001 to the entire hospital. A dedicated patient-placement function was also added that incorporates all patient movement along with divert data and EMSsystem data.

The *science* leg involves use of a proactive data-driven demand forecasting that incorporates variable staffing and contingency plans.

A third-party ROI study found that United Hospital's patient flow initiative achieved \$5 million in annualized benefits with a

payback period of five months. The study also determined that easily another \$10 million in potential savings was possible. Miller adds that the many qualitative benefits include having enough nurses when there's a surge in demand.

Highway to freeway

Jackie Jensen, RN, United Hospital's director of patient flow, said the hospital has just undergone a major redesign of the system. "We've moved from the highway to the freeway where there's no stopping, and controlling on/off ramps with stoplights is key," she says, which means patient admissions, costly patient transfers, and discharges can be better controlled.

The driver for building the new system was a combination of a nursing shortage and an inadequate bed tracking system that could only tell if a bed was empty and cleaned but not if it was a staffed bed. "We also look at the staffing screen to see what staff is available and what staff is needed as well as the acuity of the patient," says Jensen.



Jackie Jensen, RN, director of patient flow, United Hospital, Allina Hospitals and Clinics, St. Paul, Minn.



The NaviCare system acts as the Patient Flow Hub that, in effect, is a communication system that doesn't

really require communication. Staff can look at only their own unit although directors and managers have "whole house views."

"Our philosophy is: never turn a patient away," she says.

No more backdoors

A big challenge in converting to a new system of patient flow was that "physicians had all these backdoor ways of getting their patients admitted," says Jensen. They now have a single number to call for patient placement. "It eliminates loss of patients which means loss of revenue. Diverts from the ED don't happen anymore. We have a dynamic system of flow minute-to minute. We never hold a bed because Patient Placement manages the supply and demand on a minute by minute basis so that whenever a patient needs a bed, they get it," she says.

"If an ED patient comes in and needs a certain bed, they get it first. We track all potential discharges and actual discharges. Nurses are able to say 'I'll have that bed in an hour.' It gives physicians an option, so if a unit is full, we already have a backup unit," Jensen says.

United Hospital's overall patient flow strategy is to:

- Create centralized patient placement;
- Redeploy a staff member in a role as patient flow coordinator;
- Redouble the staff recruiting and retention program efforts;
- Design criteria and procedures around patient diversion; and
- Deploy capacity tools broadly to address intra and interdepartmental capacity and patient flow issues.

The patient placement center is an extremely quiet office with a phone and computer workstations displaying information about the OR, ED, and each unit at the same time. It tracks patients from the time they walk in the door, indicates the treatment they're having and can let housekeeping know, for example, that "in 20 minutes we'll need a bed." The Bed Request Screen categorizes beds not by a



The Scottsdale Institute is pleased to announce Zynx Health Incorporated as Program Partner.

Zynx Health Incorporated, a subsidiary of the Hearst Corporation and based in Beverly Hills, Calif., is a leading supplier of evidence-based clinical knowledge solutions to more than 700 hospitals across the U.S., including university hospitals, academic medical centers, health systems, and community hospitals. Founded in 1996, Zynx Health advances evidence-based medicine through the use of the latest scientific knowledge and best practice guidelines at the "point of care." One of Zynx's strategic product initiatives is the integration of its comprehensive evidence-based content, including order sets, alerts, and reminders, with hospital systems' CPOE and electronic medical record applications. Customers have documented the benefits of using Zynx clinical knowledge to improve the quality, safety and efficiency of patient care in the peer-reviewed medical literature.

Welcome Scott Weingarten, MD, president and CEO, Greg Dorn, MD, executive VP and general manager, Dave Rhew, MD, VP of provider content, Marck Dubois, director of business development, and Charlie Harp, VP of engineering and the entire management team at Zynx.

WELCOME NEW MEMBER

The Scottsdale Institute is proud to welcome new member New York City Health and Hospitals Corporation.

New York City Health and Hospitals Corporation, one of the largest municipal health service systems in the U.S., has facilities in all five city boroughs. HHC's network includes 11 acute-care hospitals, more than a 100 community clinics, 6 diagnostic and treatment centers, 4 long-term care facilities and a certified home health care agency. It also provides medical services to New York City's correctional facilities and operates MetroPlus, an HMO. HHC facilities treat nearly one-fifth of all general hospital discharges and more than one-third of emergency room and clinic visits in New York City.

Welcome Benjamin Chu, MD, president and CEO, and the entire management team at New York City Health and Hospitals Corporation.

traditional floor but by type of bed and patient.

Improvements

The benefits of a reengineered patient flow system at United Hospital include: From period 1 (Oct. 1, 2000 – Sept. 30, 2001) prior to Patient Flow initiative until period 2 (Oct. 1, 2002 – June 30, 2003) when both NaviCare and Patient Placement became fully functional throughout the hospital:

- Inpatients diverted dropped to 12 from a whopping 294;
- ED hours of divert dropped to 18.5 from 100;
- ED Left without Being Seen decreased 49%;
- Number of ED patients with LOS > 12 hours dropped to 31 from 80;
- Number of phone calls needed to get a patients admitted or transferred dropped to 14,000 from 70,000;
- Surgery phone call volume dropped to 2,000 from 10,000.

Jensen claims that improved nursing support is the biggest advantage of the system. “We used to have 10 phone calls per admission for myriad reasons, including calling each floor to make ‘deals’, and many times, ‘Sorry, I’ll need to call back.’ Now, it’s all done without phone calls,” she says. Multiple factors can be programmed into the computer system: preplanned time for patient transfer; level of acuity for each patient; “patient is ready,” “bed is ready” and “floor is ready.”

Jensen says another benefit of the system is that with the Family Vue component volunteers in the surgical area family waiting rooms have exact knowledge of where the patient is at any given time and can communicate that to families.

Losing track in Libertyville

When it came to managing patients through the care process, Condell Medical Center in Libertyville, Ill., found itself mired in out-

dated and unwieldy processes that threatened to spin out of control as demand rose.

“We’re growing, bursting at the seams and we were losing track of patients,” says Pam Richter, director of nursing at the 200-bed hospital, a level-two trauma center and one of the largest hospitals north of Chicago in Lake County. “And we wanted to see how we could improve the flow for them and ourselves.”

Confusion arose, for example, from the time patients arrived at registration, were sent to their first tests and waited at the laboratory, adds Jeanne Swanson, a clinical support expert. “There was no clear-cut way of keeping track of the patient once they left registration. It was up to the patient to go from point A to point B,” she says. Staff often got frustrated when patients were late for appointments.

Richter says a big factor was the lack of a single point of control. “You lose track especially of those patients having multiple procedures and tests. We could tell them they’re scheduled for such-and-such a procedure and they might leapfrog another patient’s appointment, or go to a test scheduled for later. That throws off the whole system,” she says.

Visual control

In March 2003 Condell hired NaviCare to analyze patient flow processes, reengineer them and build an automated system to track patients. “Go live” for the new system occurred during a week in January of this year for all inpatient areas. “It went well. We didn’t even need to put it up in a test environment,” says Richter, adding that a final phase that includes centralized patient transport will go live in August.

Users of the system include the broad base of employees who deal with the patient experience: supervisors who do bed placement in the ER, department directors, transporters, clerical, medical staff and nursing. “Housekeeping uses the NaviCare system

from the very first desk in the lobby through all outpatient areas,” says Swanson, adding that the system has proven quite user friendly. “We literally click and drag. It’s very simple. It’s intuitive—and it has the ever-popular “undo” button.”

Richter says, “It has definitely increased communication with fewer phone calls. On average, there were six to eight telephone calls to get a patient in a bed, asking if the bed is cleaned, calling back to the ER and so on. Now we have a visual tool that handles all that. The screen displays any visit to the hospital. It changes in front of you. I just watch and see where movement is taking place.”

The system imports information from the hospital’s scheduling system for the next day’s schedule. While the scheduling system is limited to scheduling ahead of time, the patient flow system allows staff to manage patients while they’re in the hospital, in real-time. Often, says Richter, a patient shows up to get an exam and it’s determined that she needs other services not on the schedule. “Now everybody knows to expect her and know she’s in the building somewhere. And if Mrs. Jones doesn’t show, we know where to look for her.”

Folding cards

Previous efforts to ameliorate the situation included low-tech strategies like tent cards, little folded cards placed on a patient’s bedside table announcing “I’ve gone to GI,” or “I’ve gone to Radiology.” The new system displays onscreen exactly where the patient is at any given time, eliminating the need for tent cards.

Despite the fact that the system was purchased from a vendor, Condell staff sees it as homegrown. “It’s not a commercial product,” says Richter. “This system was developed in a time-consuming process that reflects our own processes. It’s tailored to our specific needs. My system would look very different from the system in a hospital down the street.”

Adds Swanson, “It takes time to build because the system ‘drills down’ into more localized detail than most applications. That helps a lot with ownership. It becomes your system.” For example, the development team had to define patient flow processes for outpatient, radiology, laboratory and other departments.

Still, the effort went fairly quickly, involving vendor staff and an in-house team of six to eight people. Within five months it was up and running, allowing physicians in radiology to take down the traditional white board and markers used for patient scheduling. “That was the biggest change, the hardest part, going from whiteboards to an 18-inch screen,” says Richter. For other users, the software resides on nurses’ laptops or any PC used on the units.

Best investment

For physicians and employees, she says, implementation was painless. Condell spent a week training supervisors from all inpatient and outpatient departments. Ultimately about 100 employees were trained. There were “quite a few” sessions for nursing staff, but none was for more than two hours. For outpatient areas there was a departmental focus, for inpatients, a focus on clinical floors.

Richter says the patient flow system has been one of the best investments Condell has made in recent memory. “You can see a quick, tangible improvement in patient care. Even charting systems don’t have as quick a turnaround. I can’t picture going where we’re going without this.”

Perhaps the best evidence of the new system’s value: when it was down for a brief 15-minute period not long after rollout and employees had to revert back to telephone calls, there was a huge outcry. “To feel such a loss when things aren’t working,” says Richter, was proof of the system’s value.

Maxed out in Northern California

Lucile Packard Children’s Hospital at Stanford, a 264-bed pediatric and obstetric

Upcoming Events

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July 13

A Discussion on Clinical Informatics in Non-Academic Medical Centers

- Dr. Bill McClatchey, CMIO, Piedmont Health System, Atlanta

July 13

The Michiana Health Information Network

- Jay McCutcheon, COO, MHIN
- Robert J. Flanagan, CFO, MHIN
- Dr. Alan Snell, family practice physician and director of clinical and community informatics, St. Joseph Regional Medical Center, South Bend, Ind.

July 15

Patient Station: Memorial Hermann Gives Patients Access to Technology

- David Bradshaw, CIO, Memorial Hermann Health System, Houston

July 19

Improving Patient Flow at Allina and Sutter

- Jackie Jensen, director, patient flow, United Hospital, Allina Hospitals and Clinics, St. Paul, Minn.
- Linda Hancock, Sutter Health, Sacramento, Calif.

more events on next page

*Upcoming Events continued***July 20***Milstein: Leading Large Purchasers to Incentivize Provider Adoption of Clinical IT*

- Arnold Milstein, MD, medical director, Pacific Business Group on Health, senior consultant at Mercer Consulting, chairperson of Leapfrog Group Standards Setting Committee, board member of Integrated Healthcare Association's P4P Program, and purchaser representative to MEDPAC, San Francisco

July 29*Wireless Nursing Communication Improves Efficiency and Patient Satisfaction*

- Bill Greskovich, VP, operations and CIO, St. Agnes HealthCare, Baltimore

August 2*SI Overview Teleconference*

- Shelli Williamson, executive director, Scottsdale Institute

August 4*Clinical Decision Support Implementers Guide*

- Jonathan Teich, MD, PhD, CMO, HEALTHvision and assistant professor of medicine at Harvard University, Boston
- Jerome Osheroff, MD, FACP, Thomson Micromedex, Greenwood Village, Colo.

August 23*Trinity Health: Clinical Repository Helps Win NCQHC Award*

- Paul Conlon, VP for clinical quality and patient safety, Trinity Health, Novi, Mich.

more events on next page

facility that is part of Stanford University Medical Center, discharged 12,460 patients in 2003—and more are expected in 2004, taxing the facility's capacity.

As a result, Lucile Packard, which has 862 medical staff and about \$750 million in gross annual revenue, launched a patient flow initiative—what it calls “patient progression”—in early 2003 that resulted in a 7.5% increase in effective capacity and a 7% increase in average occupancy. The move also netted \$3.3 million in increased revenues.



**Susan Flanagan, COO,
Lucile Packard
Children's Hospital
at Stanford,
Palo Alto, Calif.**

Lucile Packard
Children's Hospital
AT STANFORD



Susan Flanagan, Lucile Packard's COO, said the hospital had to get a handle on its growth, which amounted to a 10.4% increase in patient days from 2001 to 2003. “We had increased

demand but were maxed out in capacity,” she says, and at every point as patients progressed through the hospital there were problems: the inability of providers to direct admit patients; inefficient bed placement; inconsistent and reactive care planning; mistimed or delayed ancillary services; lack of communication regarding discharge plans; and bed turnover delays.

The hospital wasn't able to operate at optimal capacity, experienced frequent service failures such as patient diverts and cancellations and experienced “rampant” physician and family dissatisfaction with patient flow processes.

Not an easy sale

“We ultimately had to look at existing capacity. It wasn't an easy sell. Because no one believed that we would be able to make an appreciable improvement in such a complex set of processes. We discussed with our

board the need to make patient flow a priority.” The board supported the initiative as long as it could demonstrate a clear ROI and could show measurable improvements in patient and physician satisfaction. So, Flanagan and her team turned to Stockamp & Associates, Lake Oswego, Ore., who helped reengineer the hospital's revenue cycle—another complex process that spanned the hospital. The hospital had liked the combination of one-on-one work with staff, implementation of new software tools and reengineered processes to achieve measured but self-sustained improvements.

The first step was to understand the environment, which of course involves the treatment of seriously ill children. The patient flow team observed 150 admissions and discharges and conducted interviews with all key stakeholders. After the analysis Lucile Packard set goals:

- Increase effective capacity by 5% to 7%;
- Maximize safe and efficient occupancy and service levels with existing resources;
- Improve coordination and quality of key patient flow and discharge processes to improve patient and physician satisfaction;
- Generate strong financial ROI.

Flanagan says providing comprehensive training to all staff was key to success as well as the electronic tools that really helped staff prioritize their work. And, she adds, perhaps most important was the strategy of addressing patient flow comprehensively.

Leaders from nursing, case management, housekeeping, physicians and admitting were brought together to establish a culture of collaboration and avoid the “blame game.” Action-focused weekly meetings of the change management team were held to monitor patient flow processes through data review and area updates, anticipate and problem-solve issues, and recognize success.

House management

The team conducted diagnostic review and planning activities in the first three months

of 2003 and worked through November of that year to implement extensive changes, which included redesign of processes and workflows, implementation of new IT tools, training and measuring results.

“Under the previous system of ‘house management’ no one could identify the number of patients coming in the door or leaving,” says Flanagan, because of the fragmented and uncoordinated nature of information sharing.

Rectifying that situation involved installation of automated bed-board technology, including patient tracking and reporting, hiring and training of Bed Hub Coordinators and making it possible for information to flow through a centralized point. Also, the quality of that information needed to be improved.

The new house management scheme featured a Bed Control Data and Communication Hub at its core, coordinating communication among physicians, patients, discharge planners, nurses, the ED and outside facilities.

“Case management changed from a slow moving department to a very proactive one with clear professional parameters,” says Flanagan. Integral to that achievement was the establishment of clear performance expectations associated with patient flow. The hospital also combined UR and discharge planning functions to support ownership by staff of the patient flow process at the individual patient level; it also installed patient-tracking and reporting software.

Meeting on beds

Daily bed meetings were streamlined to improve the efficiency of face-to-face information exchange and better predict and manage capacity. “When we started we could accurately predict only 15% of patients who were going home the next day. Now we’re at 60%—and this allowed for up to 20 beds in additional capacity to plan admissions for,” says Flanagan.

In terms of bed management, Lucile Packard was able to match house-keeping staff levels with ongoing demand and still allow enough flexibility in staffing to put resources into areas that suddenly had increased demand for bed turnaround. It also automated the cleaning-request, prioritization and measurement processes, optimizing the functionality of their bed-board tool. Those efforts made it possible to set, meet and sustain specific bed-turnaround goals and manage the resources to meet them.

Getting physicians involved was an unknown. “We were very unsure if we could engage them,” says Flanagan. In the end, however, the patient flow initiative did engage physicians, largely because of the involvement of two champions: the VP for medical quality and the medical director for care management. Engaging medical staff was required in order to make the discharge-orders process more standardized by setting goals for morning discharge orders by 10:00 am and discharge medication orders the night prior to discharge.

Also, rounding protocols were reorganized so that doctors conduct their discharge rounds early in the day rather than later. Under the old system, specific services might take until 3:00 pm to see healthier patients who could have been discharged that morning.

Measuring flow

Lucile Packard is able to measure patient flow and prioritize staff activity through its new patient flow system, which supports case management, discharge planning and UR, as well as care coordination. The system also provides an executive dashboard for all critical patient flow activities. Managers can monitor changes in demand week to week, the relationship of occupancy and diverts, the impact of LOS on capacity and which patients experienced delays in care or discharge.

The results have been a 7.5% increase in overall capacity and a 4% increase in monthly patient days, which translates to

Upcoming Events continued

August 26

e-ICU Implementation at Memorial Hermann: A Change Management Case Study

- Hugh Gilmore, MD, VP & chief quality officer, Memorial Hermann System, Houston
- Liza Weavind, MD, medical director, Memorial Hermann System, Houston
- Janine Mazabob, clinical operations director, Memorial Hermann Health System, Houston

September 14

The Fourth Leap: Early Returns, Scoring, and Future Direction

- Barbara Rudolph, PhD, director, Leaps and Measures, The Leapfrog Group, Washington, D.C.
- Chuck Denham, MD, The Leapfrog Group, Washington D.C.

September 23

Patients and Clinicians: Joint Owners of a Fully Transparent, Electronic Medical Record

- Tom Delbanco, MD, professor of general medicine and primary care at Harvard Medical School, Boston and founder of the Division of General Medicine and Primary Care at Beth Israel Deaconess Medical Center, Boston

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Conferences
2004-2005**

Fall Conference 2004
Sept. 30-Oct. 1, 2004
Partners HealthCare
Boston

Winter Conference 2005
Feb. 3-4, 2005
Intermountain
Health Care
Salt Lake City and
Park City, Utah

Spring Conference 2005
April 20-22, 2005
Camelback Inn
Scottsdale, Ariz.

1,600 more patient days per year. Also, patient diversions dropped to one or two a week from about eight previously. Profits rose over \$3.3 million annually and average occupancy rose to 90% from a previous 83%.

Besides the improvement to discharge predictability, other care-coordination improvements included a drop in bed turnaround time to 42 minutes from 70 and improved family notification of discharge a day in advance to 87% of the time from only 20% previously. Also, discharge orders written before 10:00 am on the day of discharge rose to 35% from a previous 10%.

Always room for improvement

Flanagan says that among the many lessons learned is the realization that there's almost always an opportunity to improve patient flow and achieve measurable benefits. It's also important to roll out patient flow initiatives unit by unit. "Get gains and secure them," she says, adding that standardized processes are key.

Ann Kirby, RN, a director at Stockamp & Associates, says that hospitals often measure the wrong things when it comes to patient flow. For example, most hospitals measure LOS in days when the more granular LOS in hours might be the right measurement. And sometimes, brand-new kinds of measurement are needed, such as the one developed at Lucile Packard that measures

how well a hospital can predict discharges for the following day.

Dale Stockamp, president of Stockamp, says that his firm began working with hospitals in the area of patient progression because it seemed a natural extension of its traditional revenue-cycle work. "It's a very similar problem to the revenue cycle: complex interfaces, handoffs, funneling hundreds of thousands of patients and accounts through a process. It's a very complex and a very broken process," he says.

"We saw this as lending itself to a comprehensive solution," says Stockamp. That system involves three main parts: 1) process redesign, including how departments interact; 2) IT tools to enable that redesign; and, 3) restructuring people's jobs and retraining. "The need is there because healthcare organizations are strapped for capacity," he says.

Conclusion

Reengineering the patient flow process has emerged as a tremendous industry opportunity because of the need to expand capacity and the renewed emphases on improving safety and the patient experience. All that makes patient flow another example where improving quality means improving the bottom line. For more information on the United Hospital and Lucile Packard case studies, SI members can review presentations given at the spring conference in Scottsdale by visiting www.scottsdaleinstitute.org.



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