The Journey to Building a Patient Flow Management Center

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Holly Meisner, RN, BSN – Director, Bed Management
Megan Johnston, MHSA – Operations Manager, Patient Flow Management Ctr
Thomas Jefferson University Hospitals, Inc.
Webinar Title and Time

Organizer: Modern Healthcare | Presenter: Modern Healthcare
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Audio PIN: 9

Thank you for attending today's Webinar. The program will start at 1:00pm CT.

Speaker One
CEO
Company A

Speaker Two
President
Company B

Speaker Three
Board Member
Company C
Brian E. Sweeney, RN, MBA, FACHE
Vice President, Clinical and Support Services
Thomas Jefferson University Hospitals of Philadelphia

Responsibilities:
• Managing $125 million in clinical revenue and leading 16 clinical and operational departments at Jefferson, including GI, transplant, environmental services, bed management, and Jefferson's new Patient Flow Management Center

Background:
• Registered nurse, MBA from Temple University
• Fellow of the American College of Healthcare Executives
Megan L. Johnston, MHSA
Operations Manager, Patient Flow Management Center
Thomas Jefferson University Hospitals of Philadelphia

Responsibilities:
• Patient flow data management and analysis, operational support of patient flow software, and coordination and management of strategic projects throughout the Hospital to improve patient flow

Background:
• Master's of Health Services Administration, Xavier University in Cincinnati
• Bachelor of Arts in Psychology from University of Dayton
Holly Meisner, RN, BSN
Director of Bed Management
Thomas Jefferson University Hospitals of Philadelphia

Responsibilities:
• Administrative oversight, coordination and management of patient flow for 957 beds across all three campuses
• Operational support to the software and serves as a patient flow advocate within the strategic initiatives of improving patient flow throughout the organization

Background:
• Registered Nurse with a background in Pediatric Critical Care and has been engaged with Bed Management for over 10 years
• Bachelor of Science in Nursing from University of Pittsburgh
• Currently completing her MBA, member of AONE
Objectives

- Discover how to integrate operational departments to improve patient flow and achieve meaningful results
- Determine how to use patient flow technology to improve operations
- Describe critical success factors associated with implementing rapid change in a complex healthcare organization
Agenda

I. Strategy
II. Design and Development
III. Operating Model
IV. Results
V. Conclusions
Jefferson Hospital Facts

- Philadelphia, PA
- Competitive market – 5 AMCs in 3 miles
- Founding member of Jefferson Health System
- 957 bed academic health system
- 3 campuses
- 46,000 admissions
- 100,000 ED visits
- 8,000 employees
- Level 1 trauma center
I. Strategy
The Case for Change

• ↑ length of stay (inpatient and ED)
• ↑ ED boarding → diversion
• ↑ ED wait time
• ↑ ED left without being seen rate
• ↑ PACU boarding
• ↑ loss of external transfers
Implications of Inefficient Patient Flow

- Quality and safety
- Service
- People
- Finance and operations
- Growth
Strategic Imperatives

• Develop enterprise wide solution
• Create a data driven model
• Eliminate silos & associated waste
• Engage key stakeholders in design
• Do it in 6 months!!!
FY 11 Balanced Scorecard
Strategic Value: Growth

**Measure:** Admissions

**Project Title:** Develop a centralized operational control center for bed management

**Sponsors:** David McQuaid, Geno Merli, MD, Steve Tranquillo

**Process Owners:** Patrice Miller, Mary Ann McGinley and Duane Spencer

**Facilitators:** Jasmine Arfaa, Matt Ahern, Teri Manning, Megan Johnston

**Elevator Speech:**
The purpose of this project is to create a discrete single Control Center for optimizing and coordinating the patient flow process (encompassing admit, diagnose, treat and discharge) resulting in timely 24/7 enterprise-wide (i.e. Center City, JHN, and Methodist Hospital division) patient placement. Furthermore, the development of clearly defined roles and responsibilities of both direct and indirect Control Center staff will be central to the functional ability of this team. The designated core Control Center staff will be empowered to make decisions and will work proactively with TJUH leadership and medical staff to maximize efficiency of patient flow. Success will be measured by: elimination of ED & PACU boarders, increase in the number of external transfers, reduction in ED patients left w/out being seen, and a sustained reduction in ED diversions related to inpatient capacity. Through this initiative patients will receive improved timely, safe, quality patient care.
Methodology

• Used internal facilitators – six sigma, lean, work out
• Series of 3 Work Outs
• 75 participants from key departments
• 83 barriers to timely admission/discharge identified
• Value Stream Mapping
Priority Payoff Matrix
Admission

1. Attending availability
2. Training on Process - Residents are not oriented on the procedures
3. Is the MAR necessary?
4. All areas are understaffed
5. Inappropriate bed type
6. Bed(s)/Room(s) not available
7. Room listed as discharged still occupied
8. Lack of communication between people involved in the process
9. Central Scheduling not Utilized for Direct Admits – Patients sent to ED
10. Nursing, Physicians, Services controlling beds
11. Different processes at different time of the day
12. Underutilization of the Discharge/Admission units
13. Slow response time in getting rooms cleaned/no standard time expectations for room turnaround
14. Discharge not in computer
Recommendations

• Centralize operations to improve communication and coordination – Patient Flow Management Center (PFMC)
• Make patient flow a strategic initiative
• Deploy changes quickly
II. Design and Development
Timeline

- 9/21/10: Workout #1
- 10/29/10: Workout #3
- 11/8/10: Bed Meetings Begin
- 1/18/11: Phase 1 Construction Begins
- 3/15/11: Software Upgrade Go-Live
- 3/16/11: Phase 2 Construction Begins
- 3/21/11: PFMC Opens

[Image: Jefferson University Hospitals logo]
Facilities and Construction

- Relocate departmental personnel to centralized location
- Pod concept to promote teamwork
- Ergonomic workstations
- Adjustable lighting
- Convenient location
- Quiet environment
Patient Flow Software

- Critical part of infrastructure
- Real time data
- Accessibility
- System configuration
- Training
- Reporting
- Support and upgrades
Technology

- Computer
  - Desktop hardware
    - Multiple screens
    - UPS/power back-up
  - Tablet computers
  - LCD screens in hospital
- Telephone
  - Electronic - ACD
  - Headsets/noise cancellation
  - Recording system
  - Activity reports
People

• Roles
  – Clinical staff
  – Non-clinical staff
• Qualities/traits
• Supervisory support
  – Troubleshooting
  – Coaching
  – Accountability
# Patient Placement Matrices

## Geographic Patient Placement of Medicine Patients

<table>
<thead>
<tr>
<th>Resident Team</th>
<th>Service</th>
<th>MDS/SURG Assignment</th>
<th>TELEM ASSIGNMENT</th>
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<tr>
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<td>Med Onc</td>
<td>1) 3 W</td>
<td>1) 3 C</td>
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### CC JHN Bed Assignment Matrix - ICU/Intermediate Beds

***Intensivist/Attending must be notified when a patient will be placed in the ICU***

<table>
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<th>Service/Patient Type</th>
<th>Critical Care Priority</th>
<th>Intermediate Priority</th>
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<td></td>
<td>3) JHN JSouth</td>
<td>3) JHN JSouth</td>
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</table>

### Specific Patient Types/Interventions

- MARS Therapy: ICU or SCCU
- Liver transplant: ICU or JHN
- Heart transplant post-op: SCCU
- Heart transplant (surgical): JCAH or JHN
- ECMO: JCAH or JHN
- Neurosurgery: JCAHICU or JHN
- Neuromuscular: JCAHICU or JHN
- Cardiac: JCAHICU or JHN
- COVID-19: not available at JHN

Effective: 4/13/11
Reviewed: 6/20/11
### Reports

#### Pending Discharge Metric

<table>
<thead>
<tr>
<th>Campus</th>
<th>Unit</th>
<th># of Discharges</th>
<th>Pending Discharge Compliance</th>
<th>Discharge &lt;= 4 Hours from Pending</th>
<th>Discharge &lt;= 24 Hours from Pending</th>
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<td>Center City</td>
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<td>160</td>
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<td>80.62%</td>
<td>90.82%</td>
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<td>92</td>
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<td>135</td>
<td>44.44%</td>
<td>36.67%</td>
<td>71.67%</td>
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</table>

#### Hourly Discharge Compliance

- **Dirty Avg by Hour**
- **Clean Avg by Hour**

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[Jefferson University Hospitals logo]
Patient Flow Dashboard
EVS Dashboard
Stakeholder Engagement

• Communication Plan
• Patient Flow Operations Team
  – Multidisciplinary – case management, nursing, transport, JeffSTAT, EVS, physicians, bed management, transfer center, ED, peri-op
  – Weekly review of scorecard
  – Minutes and action plans
• Nursing vice president meetings
• Ancillary departments
III. Operating Model
Jefferson’s Patient Flow Model

Nurse Manager

Teaching Mission

Patient Flow

Case Manager

Physician Leader

Patient Flow Management Center

Support Services
Services in PFMC

- Bed Management
- Transfer Center
- JeffSTAT – Air and Ground Transport
- Environmental Services
- Patient Transportation
- Case Management
- Nursing
- JET - Telemedicine Program
PFMC Operating Elements

• 24/7
• Clinical support
• Multiple campuses
• Unified IS platform
• Multidisciplinary
Medical Directors

• Experience
• Training
• Responsibilities
  – Rounding
  – Arbitration
  – PI projects
  – Physician alignment
  – Respond to physician concerns
Bed Meeting

- Participants
- Times
- Information reviewed
  - Census
  - Blocked beds
  - RTDC
- Action plans
RTDC Daily Processes and Timeline

**Physician Huddle**
- Attending
- House Staff Team
- Case Management
- Social Work
- Nurse Manager

**Nursing Huddle Rounds**
- Nurse Manager
- Charge Nurse
- Bedside Staff Nurse
- Case Manager
- Social Worker

**Hospital Wide Bed Meeting (All Units)**
- Director, Bed Management
- Nurse Manager from every unit
- Case Management/Social Work
- Diagnostic/Ancillary Areas
- EVS
- Transport
- JeffSTAT

**Green Status Units**
- D ≤ C (Demand less than Capacity)
- Care for patients
- Discharge and admit
- Help other units as per action plans

**Red Status Units**
- D > C (Demand exceeds capacity)
- Implement action plan to make D ≤ C

**Essential Activities**
- Initiate discharge list day before
- See patients first (early) on day of discharge
- Identify barriers
- Write “Prepare for Discharge” Orders

**Essential Activities**
- Each nurse manager reports on the unit status
- Review scheduled cases, patients in ED, historical/predictive data, share data on actual admissions

**Getting to Green (short-term action items):**
- Coordinate with “green units” to identify opportunities for assistance
- Identify needed resources (i.e. to facilitate patient discharge or transfer)

**Long Term Action Items**
- Exam accuracy of predicting data
- Trend data over time
- Identify recurring problems / long-term resource needs
- Right-size units

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D = Demand (expected admissions)
C = Capacity (available beds + discharges + transfers out)
Rounds

• Patient Flow
  – Managers
  – PFMC clinical supervisors

• Multidisciplinary
  – Goals
  – Participants
  – Action plan
Hospital Wide Initiatives

- ED Intake Model
- Discharge hotline
- Relocation of unassigned patients
- MRI nurse navigator
- Nursing operations coordinator
- Geographic patient placement
IV. Results
Measurement and Accountability

- Senior leadership support
- Patient flow scorecard
- Patient Flow Operations Team
- SMART goals
- Departmental reporting
Patient Flow Scorecard

- Key metrics
- All departments measured
- Data updated weekly
- Targets based on best practice
Growth: Admissions

Center City Campus

PFMC
Opened
Growth: ED Volume

Center City Campus

PFMC Opened
Growth: ED Admissions

Center City Campus

PFMC Opened
Efficiency: EVS Turn Time

Center City Campus

PFMC Opened

Minutes


Target
Efficiency: EVS Response Time

Center City Campus

PFMC Opened

Targe
Efficiency: Pull Time

Center City - Bed Clean to Bed Occupied (Minutes)

PFMC Opened

Target
Efficiency: Median ED Door to Doc

Center City Campus

PFMC Opened

Resident Caps
Operations: ED Diversion Hours

Center City Campus

PFMC Opened

Resident Caps
Operations: ED LWBS Rate

ED LWBS Rate

PFMC Opened

Resident Caps
Operations: ED Boarding Hours

Center City Campus

PFMC Opened
Resident Caps
Operations: Daily Blocked Beds

Average Blocked Beds per Day

V. Conclusions
Challenges

- Academic model
- RRC work hour requirements
- Silos
- Changing a culture quickly
- IT support
Return on Investment

• Investment
  – Construction expenses - $1.2 million
  – Additional staff - $700,000 annually

• Revenue capture
  – CM loss of LWBS rate @ 7% = $3.7 million
  – Reduction of LWBS rate to 3% = + $2.1 million CM

• ROI
  – 12 month recovery
  – Increase of $1.4 million in CM if 3% LWBS is sustained
The Next Evolution of Our PFMC

• Health Care Reform
  – Transitions in care?
  – Follow up appointments?
  – Readmissions?
  – Home care coordination?

• PFMC Strategic Plan
  – Clinical Pathways
  – LOS Management
  – Cost Containment
Q&A

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