Optimizing Patient Flow: New Challenge for Hospitalists

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Medical Director Inpatient Care Coordination, John Muir Health

Patient Flow:
Let’s get the HOSPITALISTS to fix it….

What is Patient Flow? Hospital Throughput?

Efficiency of in-hospital transitions:
- Admissions: ED
- Admissions: Post-surgical
- Inpatient: unit to unit
- Discharge transitions
- Diagnostics
Why is Patient Flow a Big Deal?

**Learning Objectives**
- CMS
- Joint Commission
- Clinical Outcomes & Patient Satisfaction
- Evolving Role of ED
- Challenges to Improve Pt Throughput

Patient Flow meets the Triple Aim

**Improving patient throughput efficiency:**
- Improves outcomes
- Improves patient experience
- Reduces costs

VALUE to Our Customers
CMS Measures: Efficiency of Care

**Hospital Compare:**
- AMI: Time to ECG, ASA, PCI or tPA
- PNA: Time to blood cxs, antibiotic
- ED: Time to eval by physician, time to pain med for fx bone, LWBS
- CVA: Time to tPA, time to head CT result

Note: these are outcome based

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CMS Measures: Efficiency of Care

**Hospital Compare: ED Turnaround Time (TAT)**
- OP-18: TAT-Discharge Patients
  - door to discharge
- ED-1: TAT-Admissions
  - door to departure: admits
- ED-2: TAT-Decision
  - decision to departure: admits

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CMS Measures: Efficiency of Care

**Hospital Compare: Timely and Effective Care**
- ED TAT is a surrogate measure for hospital efficiency
- ED TAT currently NOT a pay for performance measure
- CMS planning to include ED Throughput as a value based purchasing measure
- ED-TAT measures: FY2014
Joint Commission: Patient Flow
LD.04.03.11:
- The hospital manages the flow of patients throughout the hospital
- Leadership use of data to identify, mitigate, and manage issues affecting patient flow throughout the hospital
- Safety for boarded patients
- *The management of ED throughput as a system-wide issue*

Pt Flow and Clinical Outcomes

*Effect of ED Crowding on...Outcomes*
Bernstein et al. Ac Em Med. 2009, 16(1):1-10

ED crowding & Increased ED LOS
- Increased in-hospital mortality
- Longer time till tx: PNA & acute pain
- Increased LWBS

Pt Flow and Clinical Outcomes

*Decreasing waiting time...improving patient satisfaction*
Triage focused process improvements:
- Increased patient satisfaction

*Active Bed Management...*
Hospitalist triage for admissions:
- Reduced ambulance diversion
**Evolving Role of EDs in US**
Maganti et. al. RAND Research Report, 2013

2003-2009:
- Unscheduled admissions from ED increased by 17%
- Medicare accounts for 48% of ED admissions
- Inpatient care accounts for 31% of US healthcare spending
- Outpt PCPs: increased referrals to EDs for timely and complex work-ups

**Evolving Role of EDs**
National Trends in Emergency Department Occupancy, 2001 to 2008: ...

*ED crowding is growing twice as fast as visits, rising to unsustainable proportions*

**Challenges to Improve Pt Throughput**
The Influence of Hospital Census on ED LOS
Lucas et.al. Ac Em Med, 2009; 16:597-562

ED LOS correlated:
- Number of admissions
- Census in ICU and IMCU
Challenges to Improve Pt Throughput

Patient Arrival Times

Acute Care Transitions (ACT) by Date/Element

"Talent wins games, but teamwork and intelligence wins championships."  Michael Jordan
Better, Faster, Cheaper

- **Better** (improved patient experience, safer, better patient satisfaction)
- **Faster** (door to doc, door to admit decision, admit decision to disposition)
- **Less costly** (less costly, reduced cost per visit)
How to Stop Hospitals From Killing Us

Medical errors kill enough people to fill four jumbo jets a week. A surgeon with five simple ways to make health care safer.

MARTY SHALMAY

When there is a plane crash in the U.S., even a minor one, it makes headlines. There is a thorough federal investigation, and the tragedy often yields important lessons for the aviation industry. Pilots and airlines thus learn how to do their jobs more safely.

The world of American medicine is far duller: Medical mistakes kill enough people each week to fill four jumbo jets. But these mistakes go largely unnoticed by the world at large, and the medical community rarely learns from them. The same preventable mistakes are made over and over again, and patients are left in the dark about which hospitals have significantly better (or worse) safety records.

Relative Growth by Country

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The Dilemma

- Negative current hospital margins
- 25% projected decrease in future payments
- Unresponsive to real time patient demand
- Suspect quality by public perception
- Poor patient experience
- Faster… better…. cheaper mandate
Q: Please rate the following clinical areas on the difficulty of achieving results in improved efficiency and cost reduction.

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<td>35%</td>
<td>23%</td>
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<tr>
<td>Surgery</td>
<td>15%</td>
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<td>25%</td>
<td>34%</td>
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<td>19%</td>
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<tr>
<td>Outpatient/ambulatory</td>
<td>4%</td>
<td>21%</td>
<td>40%</td>
<td>28%</td>
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Base = 250

Emergency Medicine Explained

Hub of the Enterprise
Transforming the ED's Role in Delivering Agile and Coordinated Care

- Fostering Collaborative Throughput
- Strategizing Observation Patient Management
- Hardwiring Continuity of Care
- Managing High-Utilizer Populations
Emergency Medicine News:
June 2000 - Volume 10 - Issue 8 - 7/14/00
doi: 10.1097/01.EMN.0000049390.44545.7F
Special Report

Special Report: All Roads Begin in the ED

Scheck, Anne

The idea that crowded emergency departments are a financial drain on the hospitals they serve has long been a powerful one. However, recent examination shows what might happen when the volume of ED patients declines. This research suggests that the ED is a gateway of growing importance for hospital admissions.

Emergency rooms gaining power in US healthcare, study finds
By Elea Veeck - 05/29/13 12:30 PM ET

Emergency departments (EDs) play an increasingly important role in U.S. healthcare by serving as a portal for hospital admissions and supplementing the work of primary care doctors, according to a new study.

Survey: The ED is the Nexus of Care

by Jim Augustine, MD on October 3, 2013

New EDX data from nearly 100 EDs shows that the emergency department admits at least 60% of important volume.
The Growing Role of Emergency Departments in Hospital Admissions
Jenessah D. Schaar, M.D., M.H.S., and Arjan K. Verhees, M.D., M.B.A.

E.R.’s Account for Half of Hospital Admissions, Study Says
By ROSE ABELSON
Published May 29, 2013

Emergency rooms account for about half of the nation’s hospital admissions and accounted for virtually all of the rise in admissions between 2003 and 2009, according to a study released on Monday.

Share of Inpatient Admissions

- Emergency Dept
- Referrals
- Other
From: The Hospitalist, November 2013
Hospitalists Have Opportunity to Transform Healthcare

Despite system-wide challenges, hospitalists should strive to redefine the practice of medicine

By Valerie S. MD, FHM

“I’m going to the zoo,” my two-and-a-half-year-old daughter confidently declared. She said it so casually, as if she was letting me know that she was going to the playground.

Thinking I could use this as a great parenting opportunity and push my toddler to think through her decisions, I replied in a concerned tone: “Brianna, the zoo is really, really hot. What are you going to do about that?”
Effect of Emergency Department CROWding on Outcomes of Admitted Patients

Benjamin C. Sava, MD, MPH, Bonnie P. Isa, MD, Robert L. Wynne, PhD, David Engdahl, MD, Lin-Lung Lai, PhD, Ambatkaran M, MD,淮他赫T一林, MD, Steven M. John, MD

**Study objective:** Emergency department (ED) crowding is a prevalent health service problem and risk factor for patient, hospital, and community outcomes. ED crowding affects patient care, ED resource utilization, and hospital financial performance. Numerous studies have explored ED crowding's complex causes and unpredictable adverse outcomes. This study evaluated the relationship between ED crowding and outpatient ED performance using hospital, patient, and financial characteristics. The study employed a cross-sectional, multi-level, and multi-method approach to identify ED crowding's impact on outpatient ED performance, specifically patient outcomes and financial sustainability. The findings enhance our understanding of ED crowding's multifaceted consequences and may guide future research and ED crowding mitigation strategies.

**Results:** Out of 90 hospitals included, 32 hospitals (35.5%) experienced crowding. The annual costs associated with ED crowding were estimated for each hospital using linear regression models. The study found that hospitals with higher ED crowding levels experienced increased financial costs and reduced patient outcomes. The linear regression models showed that outpatient ED performance was negatively impacted by ED crowding, with higher crowding levels associated with lower patient satisfaction and increased financial losses.

Please see page 12 for the findings' comprehensive evaluation.

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**Relationship: ED and HCAHPS “Overall” Percentile Rankings**

- Emergency Department Percentile Rank
- HCAHPS “Overall” Percentile Rank
- Linear (HCAHPS “Overall” Percentile Rank)

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Patient Loyalty Cost

**Why A Restaurant Customer Outs**

1% Die
3% Move Away
16% Unclean Dining Area
14% Bad Food
68% Indifferent Attitude About Service

**Emergency Room Patients**

Please Sign In Remove Sign In Slip and Deposit in Triage Door Mail Slot. Then Press Red Button
Legal Cost

Opportunity Cost

- Net revenue (actual LWBS payer mix)
  - Outpatient facility net revenue @ $300/visit discharge (90% of visits)
  - Inpatient facility net revenue @ $5,000/admission (10% of visits)
  - Professional provider net revenue @ $125/visit (100% of visits)
- 1% LWBS @ 50,000 visits = 500 visits
- Lost opportunity net dollars for every 500 visits LWBS
  - Facility outpatient revenue (450 pts x $300)
  - Facility inpatient revenue (50 pts x $5,000)
  - Professional revenue (500 pts x $125)
- Cost of 1% LWBS at 50,000 volume = $447,500

Capacity Cost

60,000 ED Visits x 1 hour admit (25%) LOS = 15,000 bed hours

- Reduce LOS by 1 Hour
  - If your AVERAGE LOS is 3 Hours/Visit = 5,000 potential new visits
- Financials
  - 5,000 new visits x net $200/visit = $1,000,000 pro fees
  - 5,000 new visits x $500/visit fac = $2,500,000 facility fees
Financial Cost

New York City Taps Doctors’ Income to Quality of Care

The public hospital system is coming out a different patient, along with an
inpatient stay that is more expensive to treat, but many patients will
be happy to pay more in the long run and see improvement in their health.

The Short Life and Lonely Death of Sabrina Seelig

For Mr. Seelig and Ms. Gibson, the letter serves as evidence that their
daughter’s death did matter to someone, and made some difference.

As for what lesson might be taught by Sabrina’s death, Ms. Gibson said there
was one. “No one should go to a hospital without someone with you — no
one,” she said. “Don’t go unless somebody at least knows you’re there.”

The Waits That Matter

John Mas, M.D.

She was 69 years old and,
with the exception of mild
heart disease, was in excellent
health. One day, around mid-
morning, she noticed that her
heart rate was irregular and
she felt slightly short of breath.
Looking at her blood pressure read-
ing, she found that her pulse was 138.
Since her blood pressure was
stable, she decided to forgo a
call to 911 and instead asked her
husband to drive her to the local
hospital — one of the most high-
ly regarded academic medical cen-
ters on the West Coast.

Those of us who have dedi-
cated our careers to health care
must confront the fact that our
mobility is, more likely, severely
impeded to eradicate the stigma and
depriev that bedevils emergency
care is harming and even killing
our patients.

The solution will come too late
to save my mother. But it would
help ease her concerns.
From: The Hospitalist, March 2009
John Nelson: ED Patient Throughput Is New Core Measure

Hospitals are likely to increase their customers’ satisfaction by improving “front-end” throughput from the ED to the inpatient unit. In fact, CMS added two new core measures (known as inpatient quality reporting, or IQR) that hospitals began reporting on Jan. 1.

To understand one reason why your hospital cares so much about patient throughput and discharging patients before noon, think of tables in a restaurant. A restaurant has a limited number of tables, and the more quickly they serve customers, the sooner they’re able to seat a new party. By improving their throughput, they can serve more customers and increase profitability without having to add tables.

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CMS Throughput Core Measures

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<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients</td>
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<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients</td>
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<tr>
<td>Admit Decision Time to ED Departure Time for Admitted Patients</td>
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Tools

- Create analytics for predicting demand
Tools

- Create analytics for predicting demand
- Create staffing models to leverage the MD
• 1/2 hr (30 min door to doctor)
  a @ 06 pts/hr
  b @ 04 pts/hr

• 1/6 hr (15 min door to doctor)
  a @ 10 pts/hr
  b @ 04 pts/hr
**Tools**

- Create analytics for predicting demand
- Create staffing models to leverage the MD
- Create virtual capacity

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**Brazilian doctor killed 7 patients to free up hospital beds, police say**

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**Workflow (Creating Capacity)**
Virtual Capacity

Celebration Hospital Disney - Orlando, Florida

St Charles Hospital - New Orleans, Louisiana

Tools

- Create analytics for predicting demand
- Create staffing models to leverage the MD
- Create virtual capacity/workflow
- Co-management (decrease WIP)
- Form EM/MH and meet as a group regularly
- Create at-risk shared performance metrics
Optimizing Patient Flow: The New Challenge for Hospitalists

David J. Yu, MD, MBA, FACPMFH
Medical Director, Adult Inpatient Medicine Service (AIMS)
Presbyterian Medical Group (PMG), Presbyterian Hospital
Albuquerque, NM

Presbyterian Medical Group, PMG
Adult Inpatient Medicine Service, AIMS
Presbyterian Hospital
- 48 FTE requirements
- 70+ Hospitalist Attending
- 8 RNs, Triage RNs, Cross Cover RNs
- 17 Rounding Teams, 4 Admitting Swing Shifts, 3 Over Night Shifts, 2 Triage Shifts.
- Presbyterian Hospital, Albuquerque, NM, Inner City Tertiary Center, 453 beds
- AIMS performed 16,500 discharges 2013
- Presbyterian Hospital ED 68,888 encounters 2013
- Admits and discharges 80 to 125 patients per day
- Peak volume 85 admissions with H&P in a 24 hour period.

Optimizing Patient Flow
- Reducing waiting time in Emergency Dept for admissions.
- Improvement of flow through the Emergency Dept.
- Hospitalist Program designed for patient flow optimization.
- View Patient Flow as a “Process” and not bits and pieces.
Negative Consequence of Inefficient Patient Flow

- Emergency Dept bypass.
- Emergency Dept wait time, increased Left Without Being Seen.
- Emergency Dept boarding of admitted patients.
- Lack of bed availability for transfers or direct admissions.
- Delay or cancellation of elective surgery.
- ED/ Hospitalist/ Nursing burnout from constant work load burden.

Financial Consequences of Inefficient Patient Flow

- Emergency Dept bypass, wait time, increased Left Without Being Seen.
- Emergency Dept boarding of admitted patients.
- Delay or cancellation of elective surgery.
- ED/ Hospitalist/ Nursing burnout and turnover cost.
- Increased aLOS which has a variable cost component and lost opportunity cost.

Emergency Department Contribution to Patient Flow

- Triage and medical stabilization of patient for disposition. Mission creep of ED.
  - Discharge home
  - Admit to hospital
  - Observation placement
  - Hospice
  - Hospital at Home
  - Patient Navigation to out patient clinic setting (Care Coordinator)
Issues: Hospitalist’s Contribution to ED Patient Flow

- Reduce variation in the acceptance of admission and work up of patient in the ED.
- Standardized process to reduce variation in communication between ED and Hospitalists.
- Standardization of admitting and consulting process with various specialties.
- View ED as a Customer!

Solutions: Hospitalist’s Contribution to ED Patient Flow

- Service Line Agreement with surgical and medical subspecialist regarding admission and consult responsibilities.
- Establish professional team relationship with ED staff, Surgical specialists, and Medical specialist to facilitate communication and a culture of cooperation.
- Hospitalists presence in ED. Triage RN with Triage Physician working closely with ED to aid in the early disposition and management of patients.

Solutions: Hospitalist’s Contribution to ED Patient Flow

- ED physician call AIMS Triage RN to discuss patient for admission, and relevant information is uploaded into EPIC triage note system by Triage RN.
- Triage RN alpha numeric texts AIMS Triage Physician to evaluate admission, who either electronically accepts admission for distribution to rounding team, or has the option to call the ED attending to discuss case. Electronically adds any information and accepts by adding admission attestation order through EPIC.AIMS Triage RN then pages Hospitalist Team next up for admission.
Hospitalist's Contribution to Patient Flow: Reduction of aLOS

Presbyterian Medical Group, Adult Inpatient Medicine Service, annual aLOS

Presbyterian Hospital ED Left Without Being Seen

Presbyterian Medical Group Adult Inpatient Medicine Service Discharges Per Year

PMG AIMS Monthly Discharges 2010 - 2013
aLOS
- Average Length of Stay and Budgeted Bed Capacity determines patient flow.
- Emergency Room is flow directly related to bed availability which is directly associated with Average Length of Stay (assuming fixed resources).
- Hospitalists and Hospitalist Groups play a major role.
- Ancillary Services, Specialists, Nursing, Care Coordination play critical role.

Hospitalist's Contribution to Patient Flow
- Factors which affect patient flow:
  - Perverse incentive not to discharge
  - Census management
  - Cost and work shifting
  - Continuity of care
  - Schedule / Resource Management
  - Bed management / Nursing Perverse incentive not to discharge
  - Communication with consultants
  - Standardized process of patient flow with multidisciplinary approach

Hospitalist Perverse Incentive Not to Discharge: Level Loading Census
- Level loading census due to wRVU structure, sense of “fairness”, and concerned about unequal census
- Result: Leads to Perverse Incentive to hold on to establish patients since discharge would lead to replacement of stable patients with admission of acutely ill patients, and in conjunction with a census cap, best case scenario not to discharge.
Hospitalist Perverse Incentive Not to Discharge: Level Loading Census: Solution

- Hospitalist contract not wRVU related.
- Census to float allow variation. No floor or ceiling on census. PMG, AIMS: First day census of 12 patients, then the census floats depending on discharge and equal distribution.
- Other non wRVU financial and non financial incentives. Extra admissions paid out next pay check or extra shifts paid out or banked.
- Discharge before noon fallacy. Should you praise a hospitalist for discharging someone today at 11 am, that could have been discharged at 4pm yesterday?

Hospitalist Hindrance to Discharge: Census

- Higher the census number, more difficult it is for the hospitalist to discharge the patient on a timely basis.
- Golden 4 Hours: 8am to Noon. Robbing Paul to pay Peter Syndrome: Discharge Before Noon Fallacy.
- Goal PMG/AIMS: 13 to 16 patient encounters per day, including discharges and admissions. Optimization of census: productivity vs patient flow.
- Census management also applies to Care Coordination and Nursing in principle. What are their ratios?

Hospitalist Hindrance to Discharge: Census

AIMS/ PMG monthly aLOS 2011 - 2013
Hospitalist Hindrance to Discharge: Continuity of Care

- Maximize Continuity of Care by increasing the percentage of admissions by the rounding team and minimize service turnover.
- Maximize number of days in a rounding cycle.
- Efficient, standardized, handover and communication process.

Hospitalist Hindrance to Discharge: Cost and Work Shifting

- Silo approach to budget leads to unplanned inefficiencies. Cutting budget in one department leads to cost shifting the same work to higher cost department.
- Example: Reduction of Care Coordination cost leads to Hospitalists spending time coordinating non medical issues at discharge.
- Example: Reduction of Housekeeping might delay multiple admissions and lead to ED by pass.
- “Dropping a dollar to pick up a quarter”. Budget must follow operational alignment of work flow, instead of work flow adjusting to budget. Must break down financial silos and have strategic view of budgeting in multiple departments.

Hospitalist Hindrance to Discharge: Cost and Work Shifting

- Opposite of Cost and Work Shifting is to add resources to take away non medical responsibilities that Hospitalists have to perform. Requires understanding of Return on Investment. Addition of resources to become more efficient.
- Example: AIMS/ PMG uses RN to supplement Triage and Cross Cover Hospitalist to unload work load. AIMS Triage RN, and AIMS Cross Cover RN service.
Hospitalist Hindrance to Discharge: Schedule/ Resource Management

- Reduction of Hospital resources on the weekend.
- Change of work force load in Hospitalists, Specialists, Ancillary Services (PICC line placements), PT, OT, Care Coordinators on weekends.
- Consider hospital operations on weekends as though weekdays. Cost/ benefit of up staffing on the weekends.
- Scheduling to the Work: Matching ED Work Load, and not for ease of scheduling. (10pm to 2am AIMS has 7 Hospitalist performing admissions.)
- “Surface Area” to rapidly admit and evaluate ED admission bolus. (AIMS: 18 Hospitalist available to admit from 8am to 4:30 pm.)
- “Your schedule looks like a Shetland Pony with a birth defect.”

What Does Your Schedule Look Like?

Form Follows Function
Hospitalist Hindrance to Discharge: Bed Management/ Perverse Nursing Incentive Not to Discharge

- Nursing Perverse Incentive Not to Discharge: Nurses incentivized to delay discharge until end of their shifts to avoid another admission.
- Nursing incentive for decentralized bed management, blocking of beds to avoid admissions.
- Solution: Centralized control of bed management: Bed Management Center. Change of nursing scheduling and resources to remove perverse incentive to avoid nursing admissions and discharges.

Perverse Nursing Incentive

Hospitalist Hindrance to Discharge: Communication with Consultants

- Standardized process to communicate early with consultants.
  - Voicemail service for consults. PMG/AIMS has Voicemail service for consultants with Infectious Disease, Gastroenterology, and Neurology, as well as various service line agreement specific for certain surgical subspecialist regarding late night admissions that require non emergent consults.
Standardized Process of Patient Flow:

- Quality does not stand alone as a tool to be randomly applied as needed. Quality is imbedded in a process.
- Standardization and elimination of waste.
- Before Assembly Line, Model T Ford took 12.5 hours to assemble and priced at $825. Post Assembly Line, 1.5 hours and $240.
- “I am rounding like I did before I was a hospitalists”. David J. Yu, 2010.
- Do you have a “PROCESS”?

Standardized Process of Patient Flow with Multi Disciplinary Approach:

- PMG/AGIS: If we were a factory, we are in the business of producing a “discharge”.
- Evidence Based Management Principles: Lean Six Sigma
  - When people and organizations focus primarily on quality, quality tends to increase and costs fall over time.
  - However, when people and organizations focus primarily on costs, costs tend to rise and quality declines over time.
  - “Every activity and every job is a part of the process”. W. Edwards Deming
  - Physician leaders are re-inventing the wheel.
- Unit Base Rounding with Multidisciplinary Rounding: Lean Six Sigma Project

Unit Base Model with Multidisciplinary Rounding

- Hospitalists are geographically isolated on designated medicine floors, and teamed with care coordination. The Hospitalists, Care Coordinators, Nurses, Physical Therapy, Pharmacy, and ancillary services meet at the Whiteboard to perform multidisciplinary rounds on a daily basis to discuss each patient. This ensures standardization of communication for optimal patient flow and care.
Unit Base Model with Multidisciplinary Rounding

Whiteboard Multidisciplinary Rounds

Why Most Hospital Patient Flow Improvement Projects Fail:
- Must answer question, “What’s in it for me?”
- Was additional resources considered to improve process? Quality is not free. “Return on Investment”.
- Does it add another burdensome layer for the clinical staff?
- There are no bad workers, just bad processes and bad management.
Why Most Hospital Patient Flow Improvement Projects Fail:

MONEYBALL

MONEYBALL: Billy Beane

- Baseball Mentality of 100 years:
  - Buy players to win games
  - Batting averages/ number of hits are the most valued statistics to produce runs
  - Player centric
- Money Ball:
  - Buy wins, not players
  - Wins achieved by getting “runs”, you need to buy “runs” not players
  - You need base runners to produce “runs”
  - On Base Percentage are more critical then batting averages, it doesn’t matter how you get on base
  - Process centric: Card counting at Black Jack
  - “It’s a process, it’s a process”, Billy Beane (Brad Pitt).
Current Hospital Flow Concepts

- ED is a place of diagnosis and treatment.
- ED is the Hospitalist Group’s nemesis!
- Hospitalist main goal is productivity to generate revenue and wRVU is the key statistic.
- Hospitalist is the lone wolf determining hospitalized patients course.
- Weekends are special and minimal work takes place.
- Silo budgets and departmental policies determine patient flow.
- Cut costs to improve margin.
- Clinical provider specific.

Medicine Ball Flow Concepts

- ED is a place of triage and disposition, with multiple disposition options.
- ED is the Hospitalist Group’s customer.
- Hospitalist main goal is throughput/patient flow, and aLOS and variable cost per case are the key statistics of cost reduction.
- Hospitalist must be part of a multidisciplinary team to standardize communication within a quality process designed for patient flow.
- No distinction between weekends and weekdays.
- All departmental policies and budget aligned for patient flow.
- Invest in quality process to reduce waste and improve efficiency to improve margin.
- Process specific.