Institute for Healthcare Improvement

# Overview of the Hospital Flow Professional Development Program

Patricia Rutherford, RN, MS, retired IHI Vice President and Lead Faculty for IHI Hospital Flow
Lauren Downing, Senior Event Manager, IHI

Hospital Flow Professional Development Program
June 27, 2022

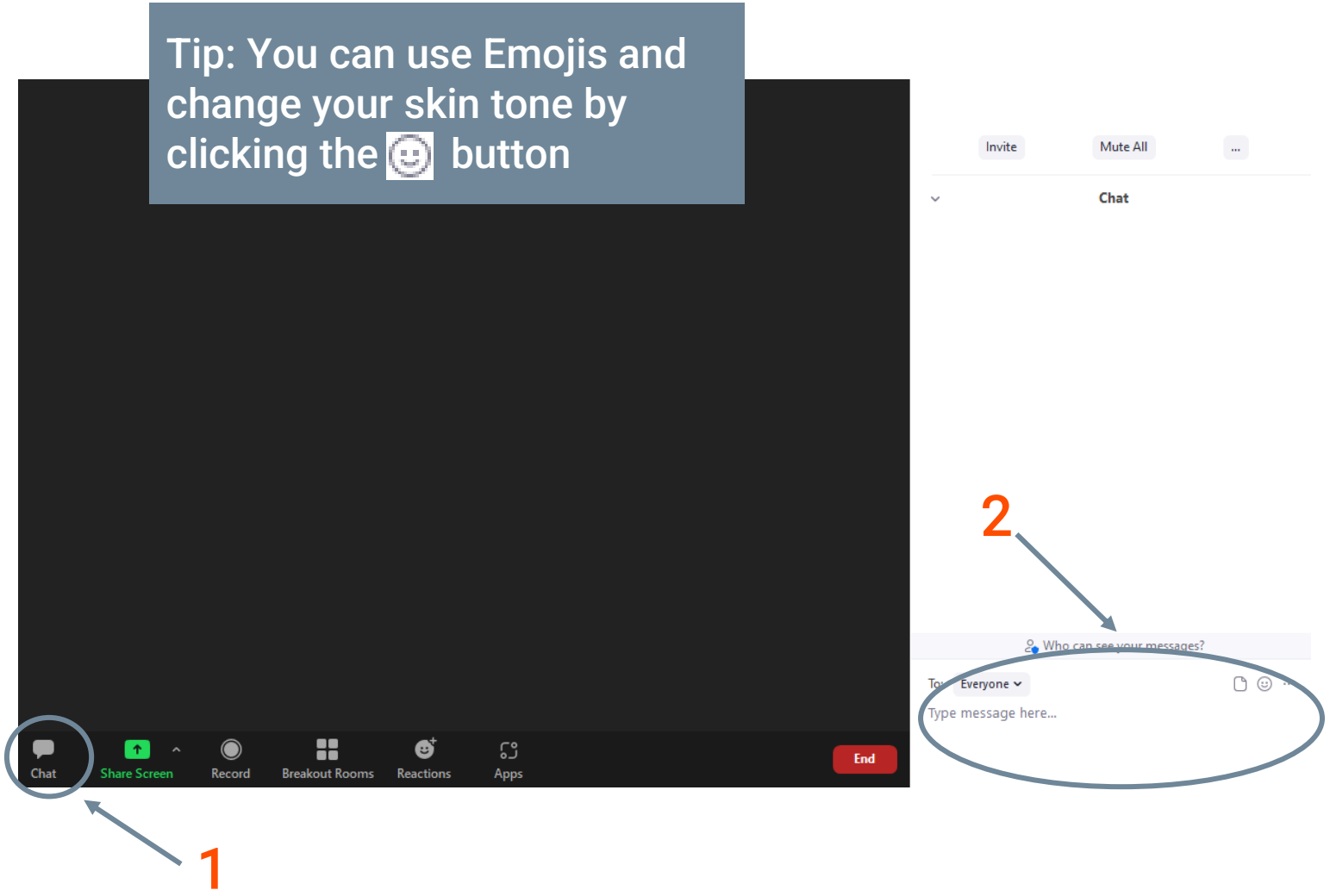
# Joining Us Today

**Lauren Downing**
Senior Event Manager
Institute for Healthcare Improvement

**Pat Rutherford**
Retired Vice President,
Institute for Healthcare Improvement

# Chatting in Questions or Comments

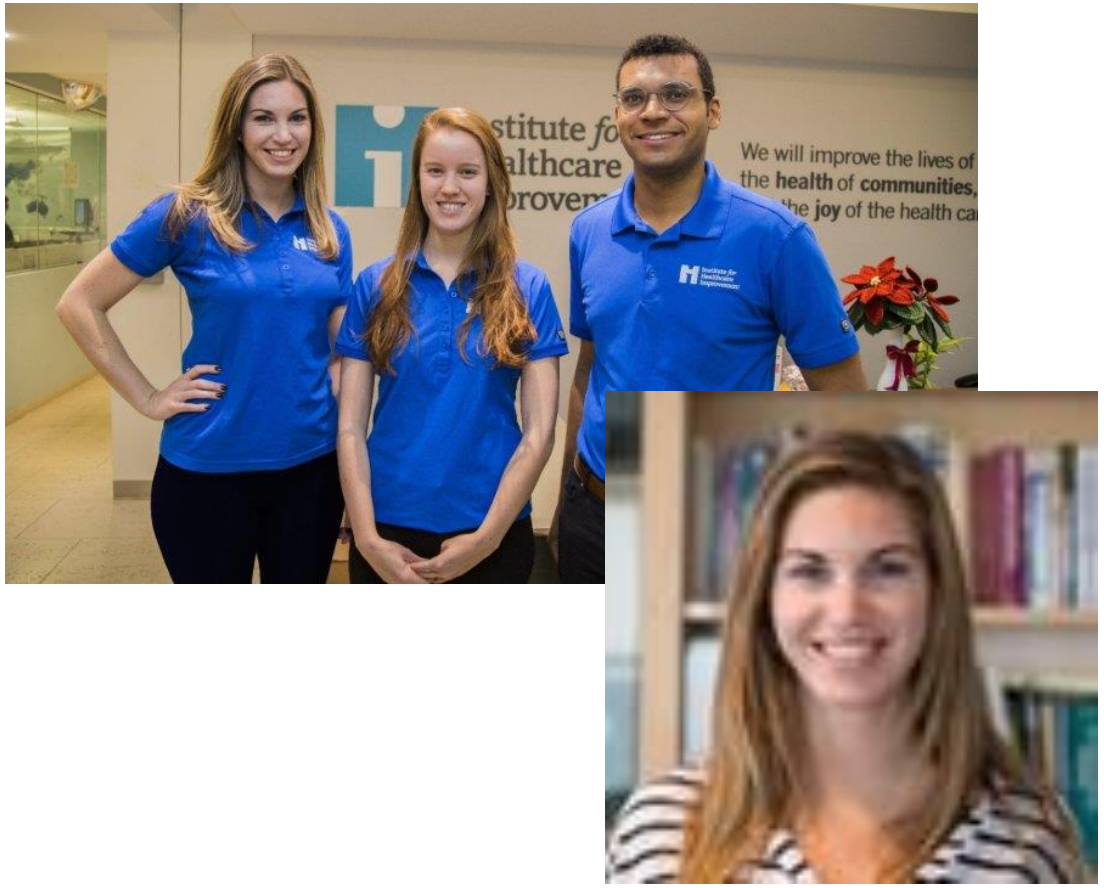
1. **Chat** Click the Chat button at the bottom of the screen to open the chat in the side bar.
2. **Chat Box** Type your message in the field at the bottom of the side bar. Make sure you chat to “Everyone” so all participants can see your message



Institute for Healthcare Improvement

# Strategies to Achieve System-wide Hospital Flow: Right Care, Right Place, Right Time

# Why Hospital Flow Is Key to Patient Safety

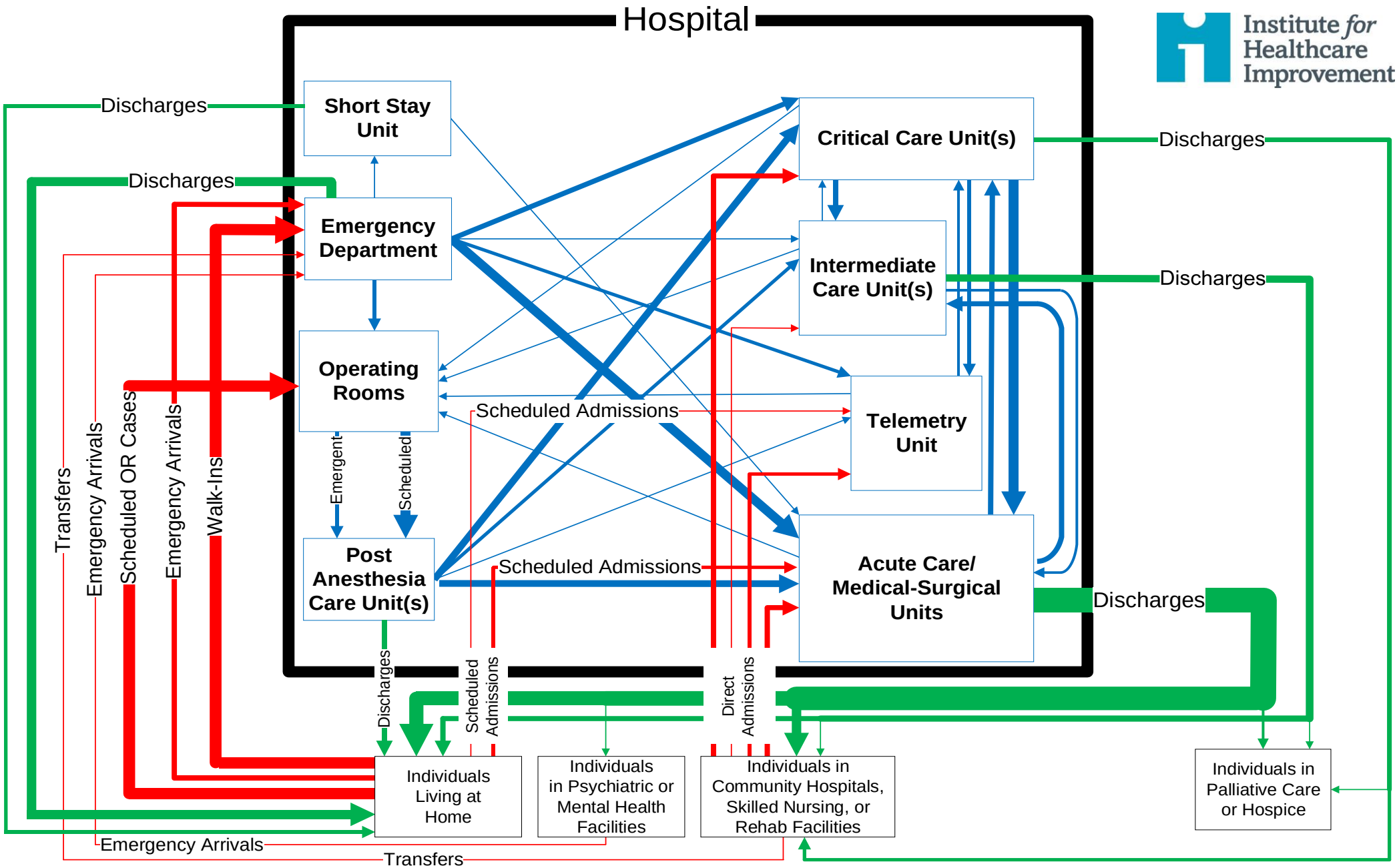




http://www.ihi.org/communities/blogs/why-hospital-flow-is-key-to-patient-safety

# Awaiting Discharge after a Hip Replacement

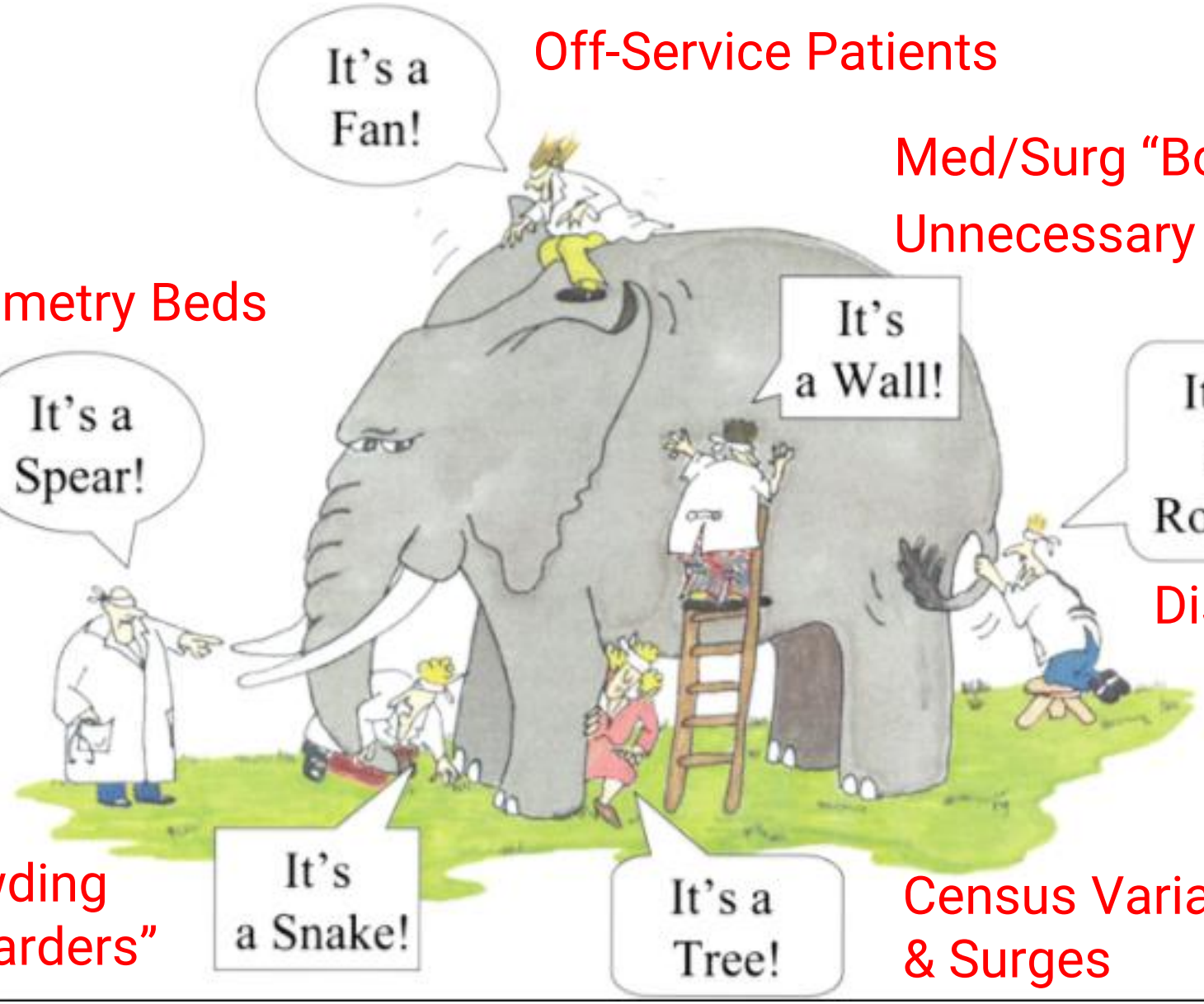
"It turns out that home services are so understaffed and overbooked that the case manager was not able to arrange a visiting nurse and physical therapist to continue my rehab at home -- not even in Boston where there are SO many health care institutions, nor on the Cape where there are SO many older people having surgery after two years of canceling elective procedures. So my discharge was delayed until Thursday afternoon, and I'm getting PT and rehab in the hospital....

This means, ironically, that I am living proof of the very problem we set out to address across our region -- experiencing bed shortages because people who don't need acute care are occupying beds that others need more. Our health care delivery system in the US is so broken (even for a privileged few), that it feels nearly impossible to make the major changes that are needed; but we are still trying."




**Key:** **Blue arrows:** Flow within hospital | **Red arrows:** Flow into hospital | **Green arrows:** Flow out of hospital | **Width of arrows:** Typical flow volumes

# System-wide View of Patient Flow of Helps to Avoid Isolated Perspectives and Flow Projects




Off-Service Patients

Med/Surg "Boarders" / Unnecessary Bed Days

No Telemetry Beds

Discharge Delays

ED Crowding and "Boarders"

Census Variability & Surges

# Wait Times in the ED > It's a Community-wide Problem!

## Gridlock

Community | Emergency Department | Hospital | Discharge | Community

Care Management → Long Wait Times → Over Capacity → Extended Length of Stay → Lack of Services

**Lack of Coordination and Fragmented Information Systems**

SOONER SAFER SMARTER — Emergency Department Waits and Patient Flow Initiative — putting the Patient First

SASKATCHEWAN HEALTH QUALITY COUNCIL

# Addressing the Complexities of Emergency Department Overcrowding

Improving Flow: Addressing the Complexities of Emergency Department Overcrowding

*Patricia Rutherford | IHI Blog Post Monday, April 11, 2022*

## Efficiency Improvements in the ED

- Separate flows in the ED (based on acuity) with dedicated clinical teams for each flow.
- Create a separate protocol-driven unit for short-stay patients with relatively straightforward diagnoses.

## Partnerships with Community Providers

- Provide end-of-life care in accordance with patients' wishes.
- Utilize ED case managers to facilitate discharges to home.
- Support patients with low-acuity needs in community-based care settings.

## Addressing Common Bottlenecks in the Hospital

- Reduce Discharge Delays
- Reduce Unnecessary Bed Days
- "Smooth" Uneven Elective Surgical Scheduling

# Guiding the Flock:
# Simple Rules to Improve Hospital-wide Patient Flow

Guiding the Flock: Three Simple Rules to Improve Hospital-wide Patient Flow. Lloyd Provost and Pat Rutherford, IHI blog post Aug. 7, 2018

# Simple Rules to Improve Hospital-wide Patient Flow

We propose the adoption of these three simple rules for governing complex systems for achieving hospital-wide patient flow.

**Right Care, Right Place:** Patients are placed on the appropriate clinical unit alongside the clinical team with disease- or condition-specific expertise.

**Right Time:** There should be no delay greater than two hours in patient progression from one hospital unit or clinical area to another, based on clinical readiness criteria. For example, patients should be transferred within two hours from the ED to an inpatient unit, within one hour from a PACU to a surgical unit, and discharge to home or community care within two hours.

**Available Capacity:** Teams should ensure each unit or clinical area has operational capacity at the beginning of each day. For example, a unit should have one or two beds available and staffed at 7:00 AM based on patient demand patterns.

The challenge of complexity in health care, British Medical Journal, September 2001

Guiding the Flock: Three Simple Rules to Improve Hospital-wide Patient Flow. Lloyd Provost and Pat Rutherford, IHI blog post Aug. 7, 2018

# Simple Rules to Improve Hospital-wide Patient Flow

These simple rules are not intended for judgement or accountability. Rather, they can **form the basis for a hospital-wide flow philosophy that unites all staff and departments to a common purpose**. They can provide the basis for daily flow huddles to manage safe and timely patient progression throughout the hospital.

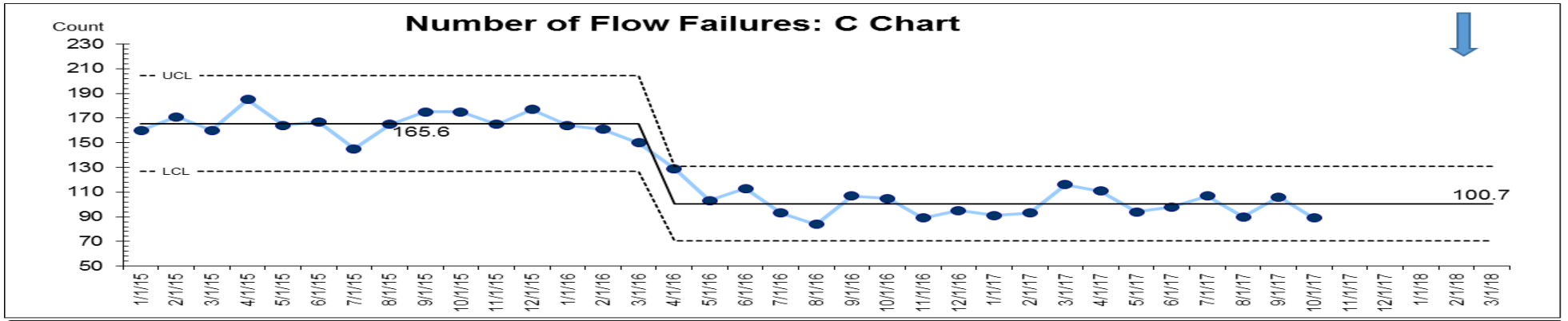
The hospital flow oversight team should create a **hospital-wide learning system to understand failure** to achieve these simple rules and develop approaches to **mitigate flow failures and flow delays.**

The challenge of complexity in health care, British Medical Journal, September 2001

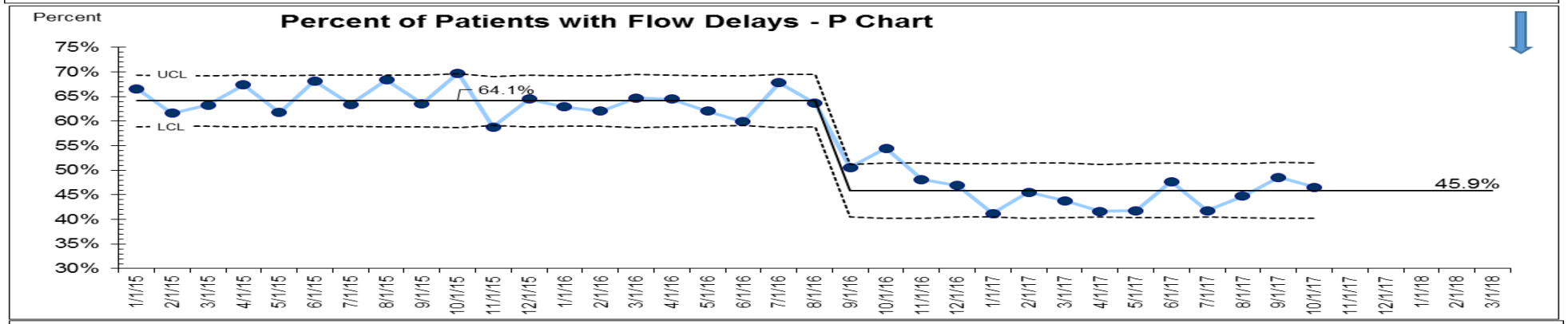
Guiding the Flock: Three Simple Rules to Improve Hospital-wide Patient Flow. Lloyd Provost and Pat Rutherford, IHI blog post Aug. 6, 2018

# Simple Rules to Improve Hospital-wide Patient Flow

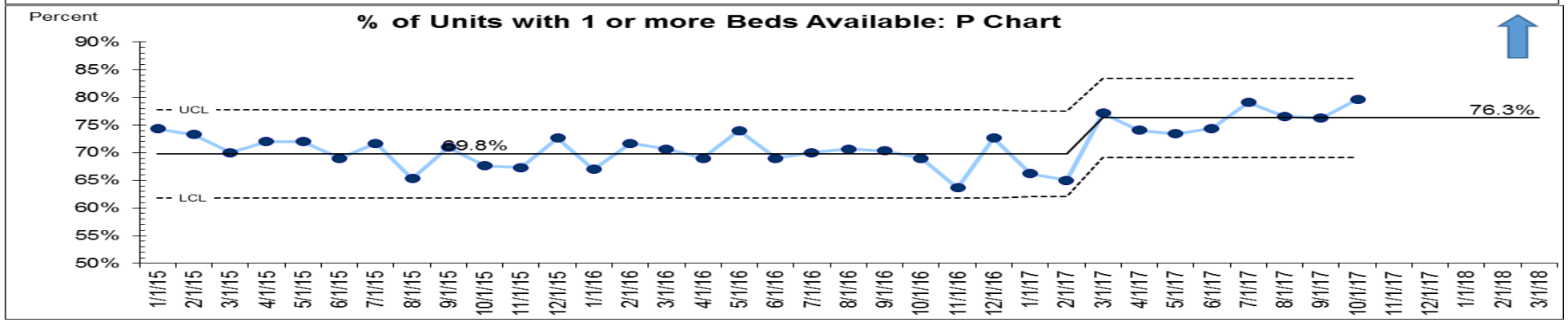
flow failures
wrong place,
wrong care



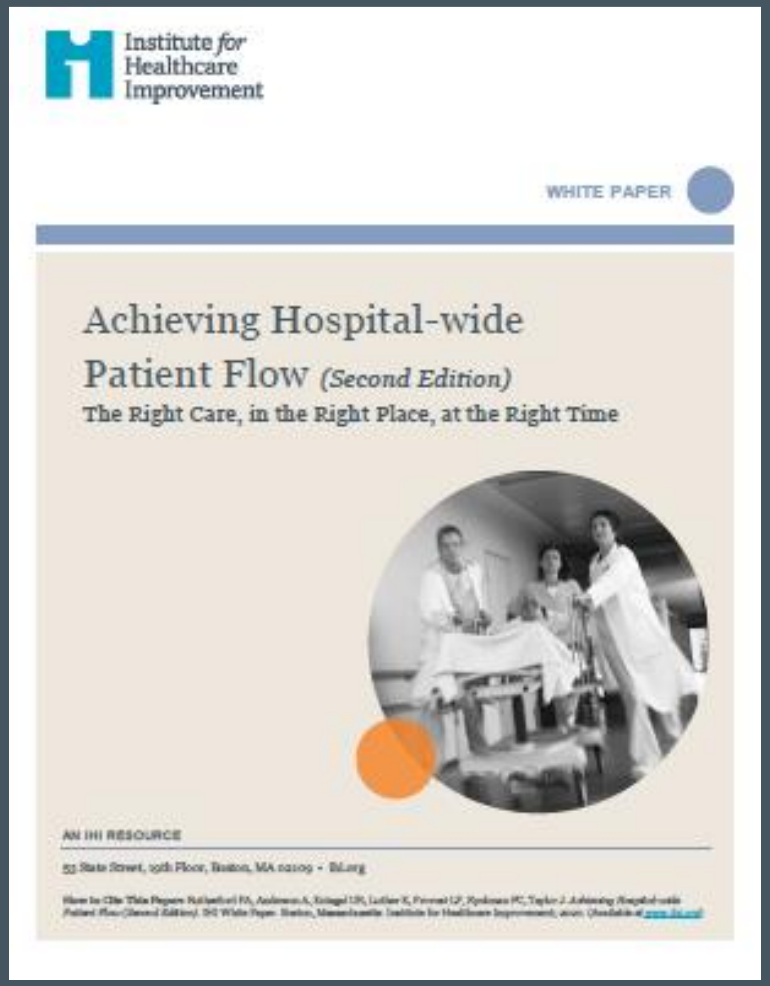

flow delays
wrong time
(delays in patient
progression)




available
capacity

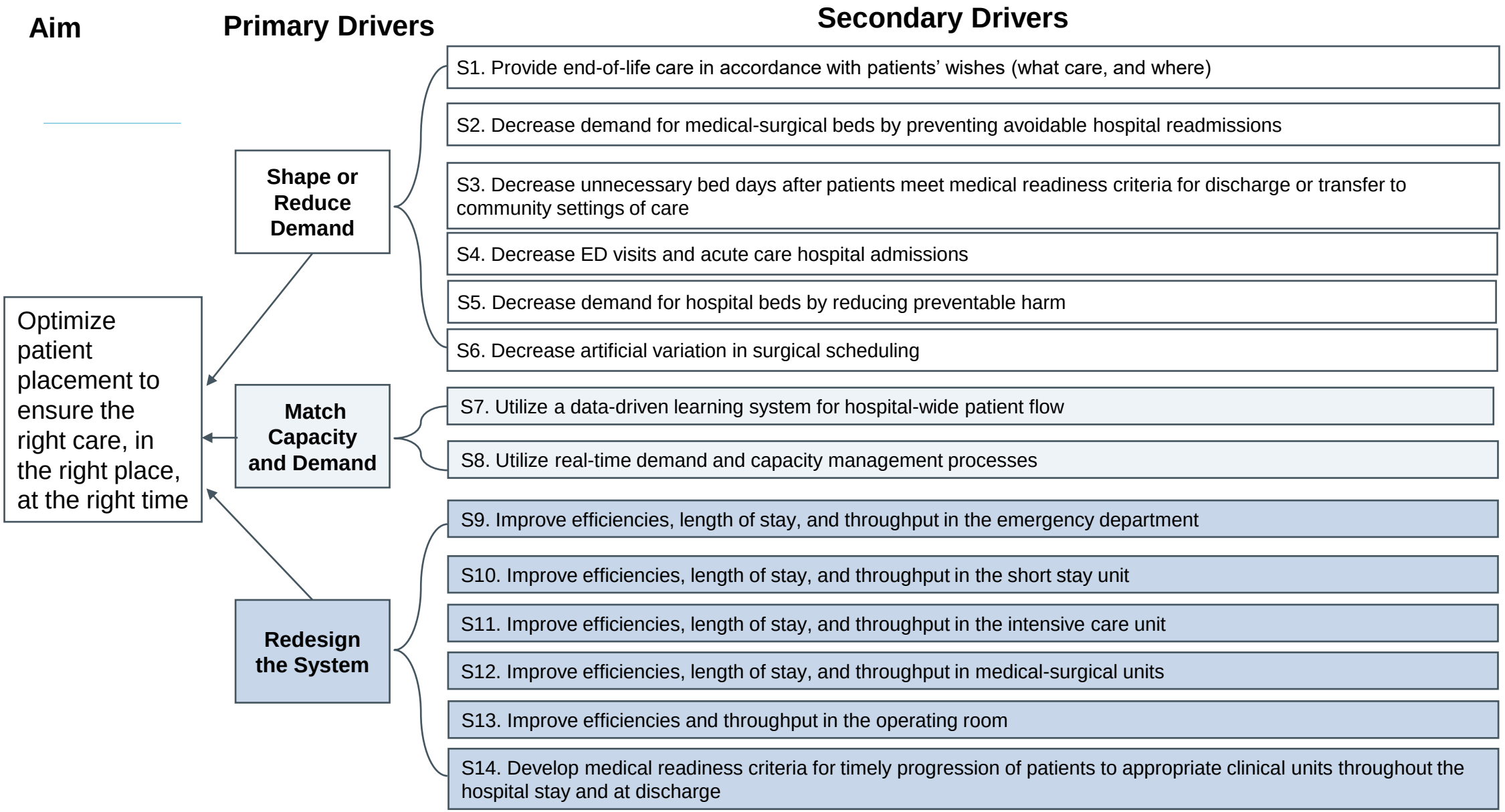


# IHI's Framework and Strategies for Achieving Hospital-wide Patient Flow



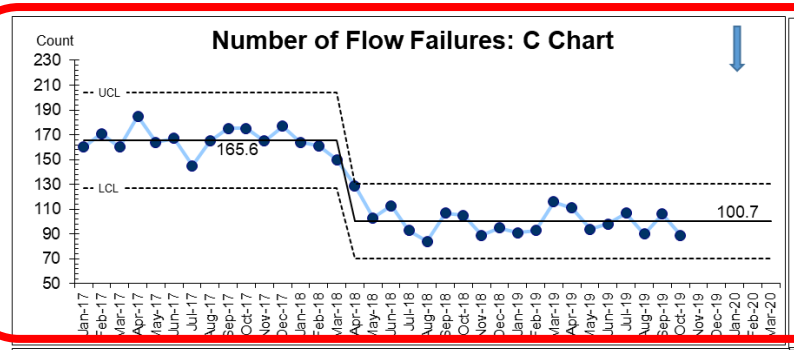

http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Hospital-wide-Patient-Flow.aspx

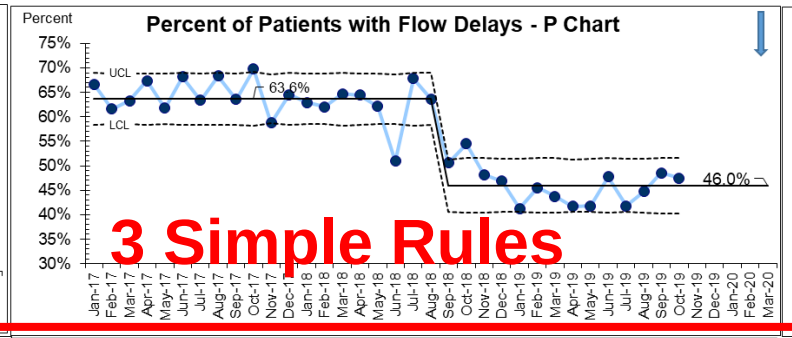
# IHI Driver Diagram for Achieving Hospital-wide Patient Flow

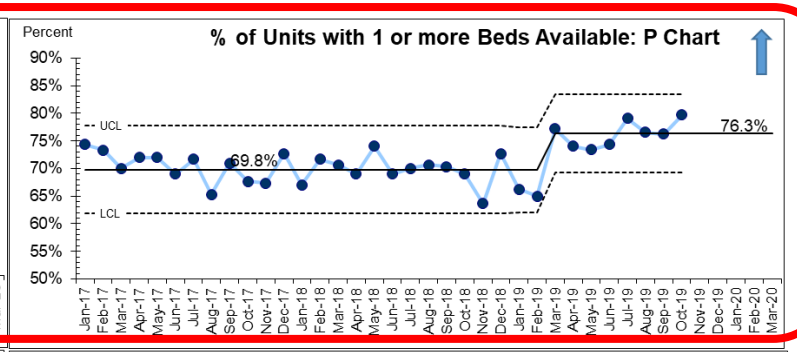



Source: Rutherford PA, Anderson A, Kotagal UR, Luther K, Provost LP, Ryckman FC, Taylor J. *Achieving Hospital-wide Patient Flow (Second Edition)*. IHI White Paper. Boston: Institute for Healthcare Improvement; 2020. (Available at www.ihi.org)

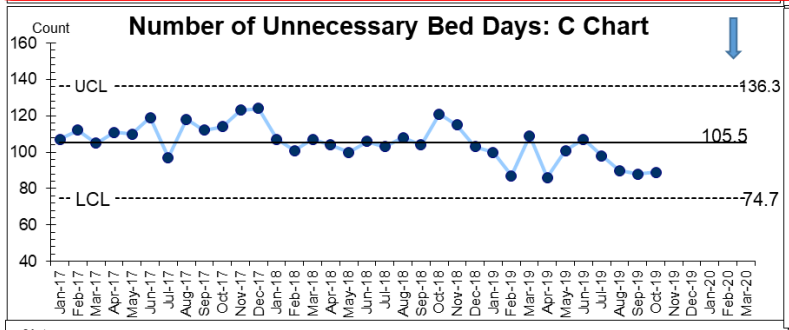
# Recommended Dashboard of Hospital-level Measures

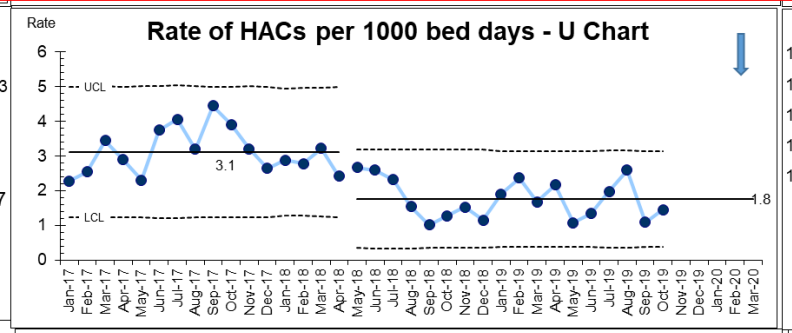


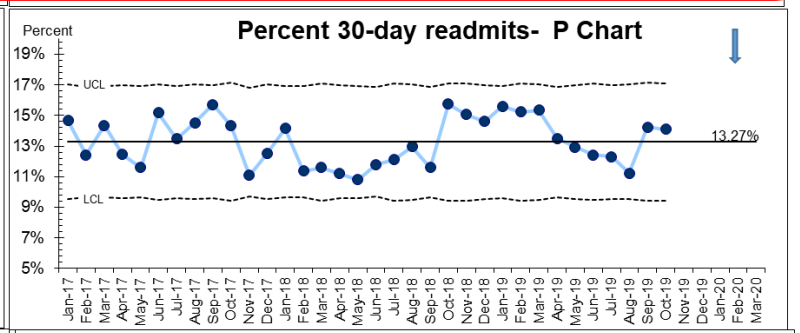



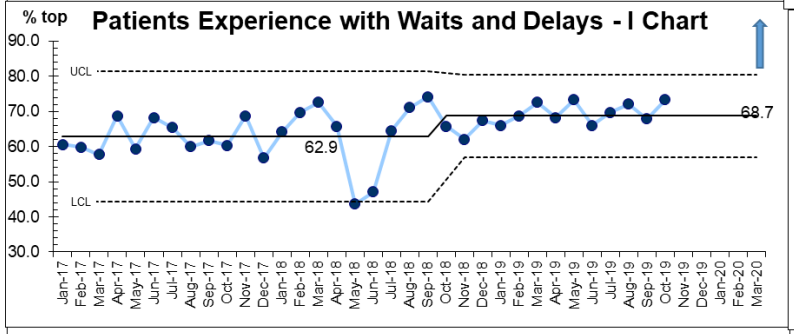



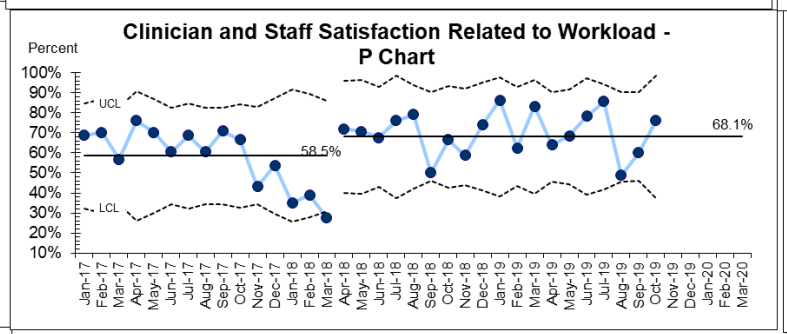

**3 Simple Rules**

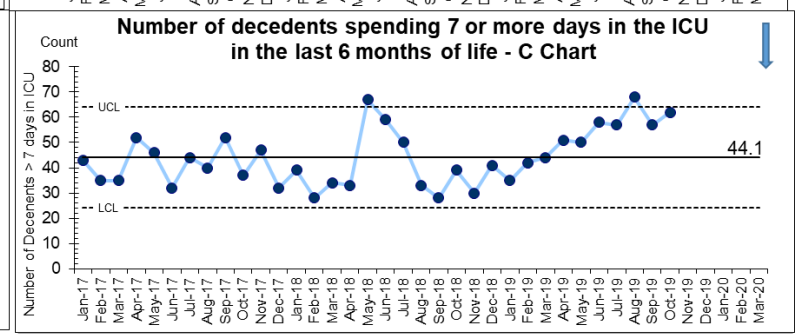


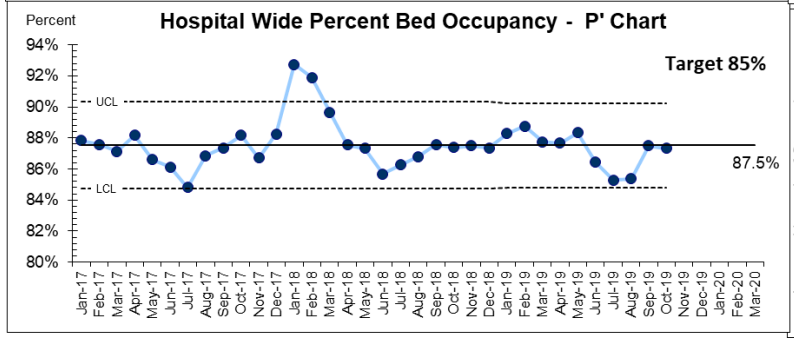



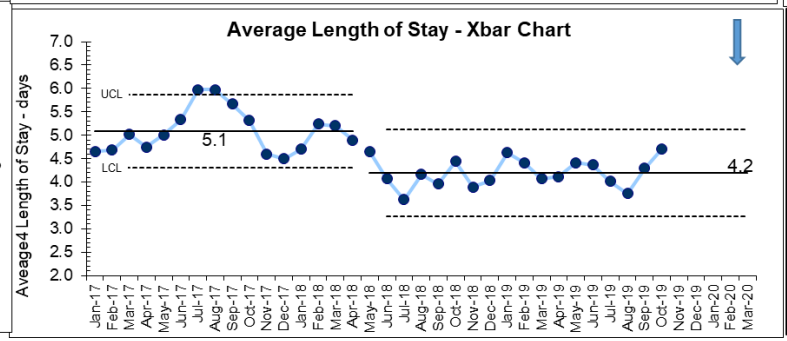



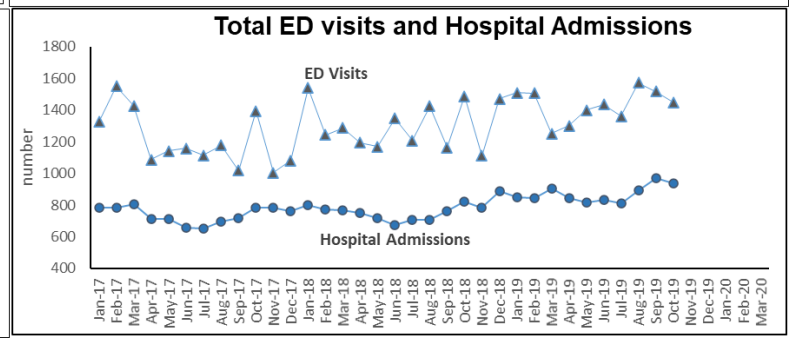



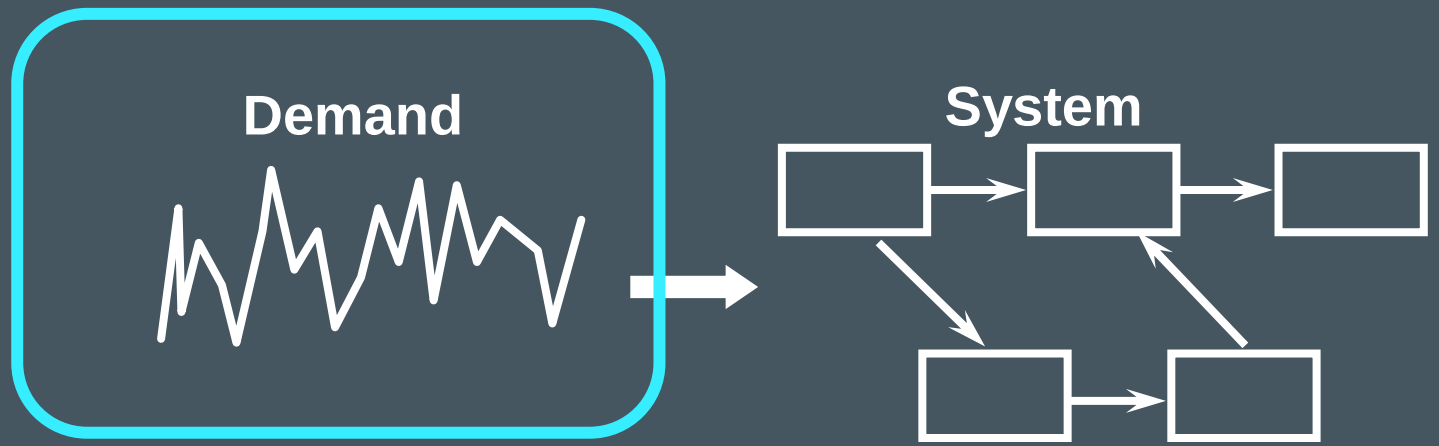



# Primary Driver:
# Shaping and Reducing Demand



# Changing the Cultural Norm

the conversation project

A national campaign encouraging everyone to have a conversation about their wishes for end-of-life care

conversation ready

Collaboration to ensure health care systems are ready to receive and honor wishes for end of life care

Harvard Business Review

The New York Times

abc WORLD NEWS WITH DIANE SAWYER

O THE OPRAH MAGAZINE

STate Action on Avoidable Rehospitalizations

An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement

## Alternative or Supplemental Care for High-Risk Patients

### Transition to Community Care Settings

### Transition from Hospital to Home or other Care Setting

Hospital

Assessment of Needs

Teaching & Learning

Plan post-acute FU Care

Handover Communications

Primary & Specialty Care

Timely Access → Review Plan & Visit Prep → Assess, Plan & Self-Management Support → Coordinate Care

Home Health Care

Review Home Care Plan → Assess, Plan & Self-Management Support → Coordinate Care

Skilled Nursing Care Centers

Review Plan (Ready & Capable to Care for Resident?) → Reconcile Treatment Plan & Proactive Planning → Plan for Timely Consultation when Status Changes

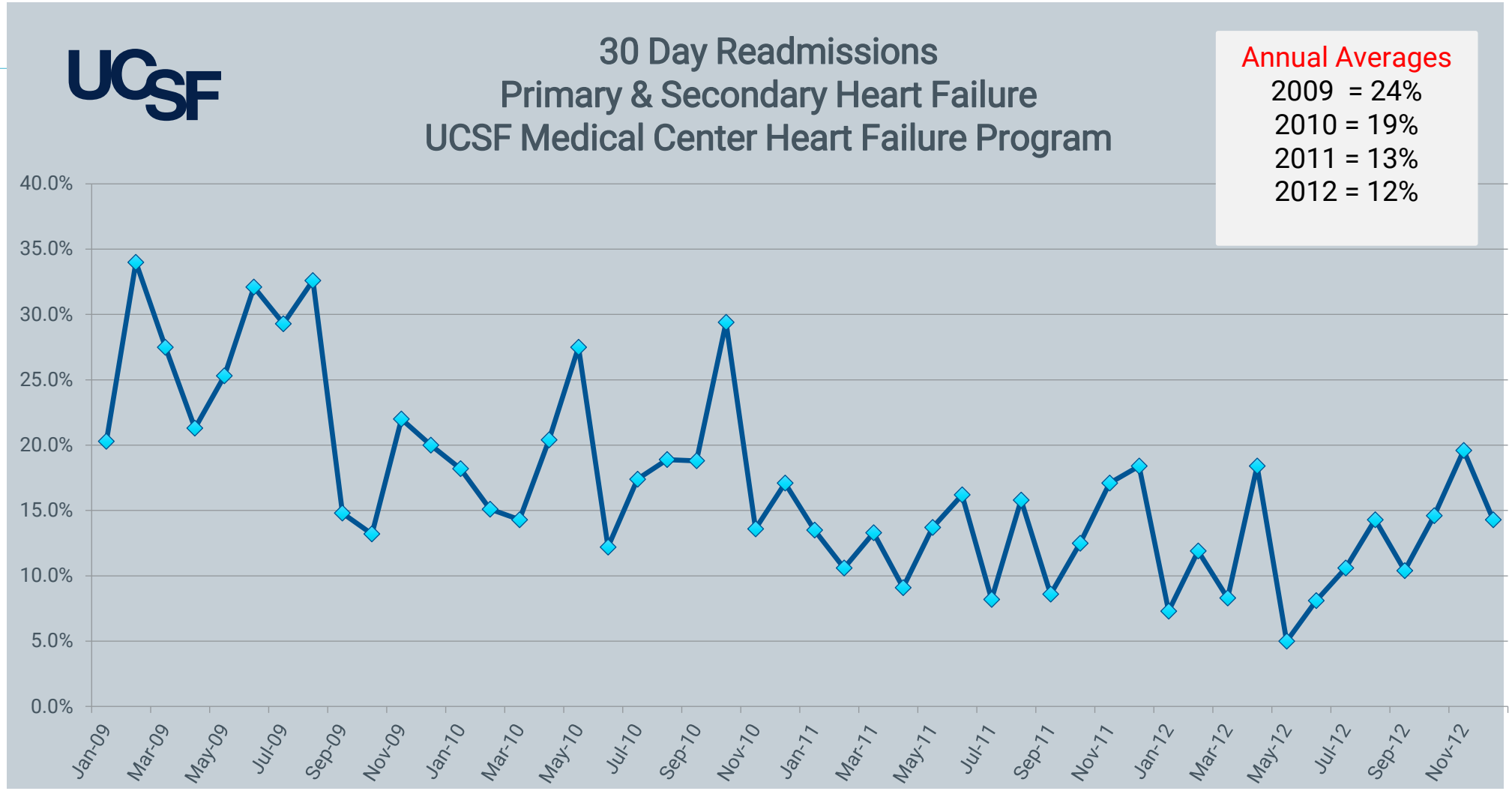
### The Transitional Care Model (TCM)

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

## Design Elements

- Patient and Family Engagement
- Cross-Continuum Team Collaboration
- Health Information Exchange and Shared Care Plans

# 30 Day Readmissions: Primary & Secondary Heart Failure 65+



# Unnecessary Bed Days

**HOSPITAL CARE:** Delays in hospital care and transitions out of the hospital

- Consults, results of tests, imaging and procedures
- Comprehensive assessments for post-acute care needs, interdisciplinary and patient/family planning, decision-making and/or transitions out of hospital to community-based care

**COMMUNITY-BASED CARE AND SERVICES:** Lack of capacity or capability in the community settings of care

- Palliative Care and Hospice (hospital, community or home)
- Community Hospital, LTACs, Skilled Nursing Facilities, Rehabilitation Facilities and Long-Term Care
- Psychiatric and Mental Health services and/or facilities
- Home Health Care services
- Community services (housing, meals, transportation, etc.)

**POLICY AND PAYMENT:** Lack of eligibility and/or payment for needed services

# Is Your Organization Ready for Hospital at Home?

**Organizations seeking to adopt innovative care models often need to develop new systems and roles, while overcoming resistance to change. To successfully implement Hospital at Home you will need to ensure that the conditions are right and that needed resources are readily available.**

Ask yourself the following questions:

1. Is your health system experiencing problems from a lack of hospital capacity?
2. Does your health system have established home health-care delivery capabilities?
3. Do you have physicians with the interest and ability to care for patients in the home environment?
4. Does your health system experience a large volume of Medicare admissions for common problems such as community-acquired pneumonia, heart failure, or chronic obstructive pulmonary disease (COPD)?
5. Does your institution view itself as an innovator in developing and implementing new models or systems of care?

https://www.aha.org/hospitalathome
https://www.johnshopkinssolutions.com/solution/hospital-at-home/

# Reducing Non-Urgent Emergency ED Services

- Extend hours in Primary Care
- Independence at Home (home-based primary care)
- Use of Telemedicine in Primary Care & in Emergency Departments
- Urgent Care Centers (many now part of health care systems)
- Retails Clinics
- Paramedics and Emergency Medical Services managing non-emergency calls*
- Community Health Workers connecting frequent ED users with community-based services*
- Coordinated, Intensive Medical, Social, and Behavioral Health Services*

https://innovations.ahrq.gov/scale-up-and-spread/reports/reducing-non-urgent-emergency-services-learning-community-september-2015

# Clostridium difficile Infection Rates in Hospitals

Many hospitals acknowledge that *C. diff* infections are a widespread problem, especially as the CDC estimates that 94 percent of cases occur in hospitals. *C. diff* infections increase patient length of stay by more than 55 percent and may increase the cost of their care by 40 percent or more.

Two solutions for hospitals to cut down on the infection risk: make sure staff follow hand-hygiene protocols and establish antibiotic stewardship programs.

# “Level-loading” Electively-Scheduled Surgical Cases

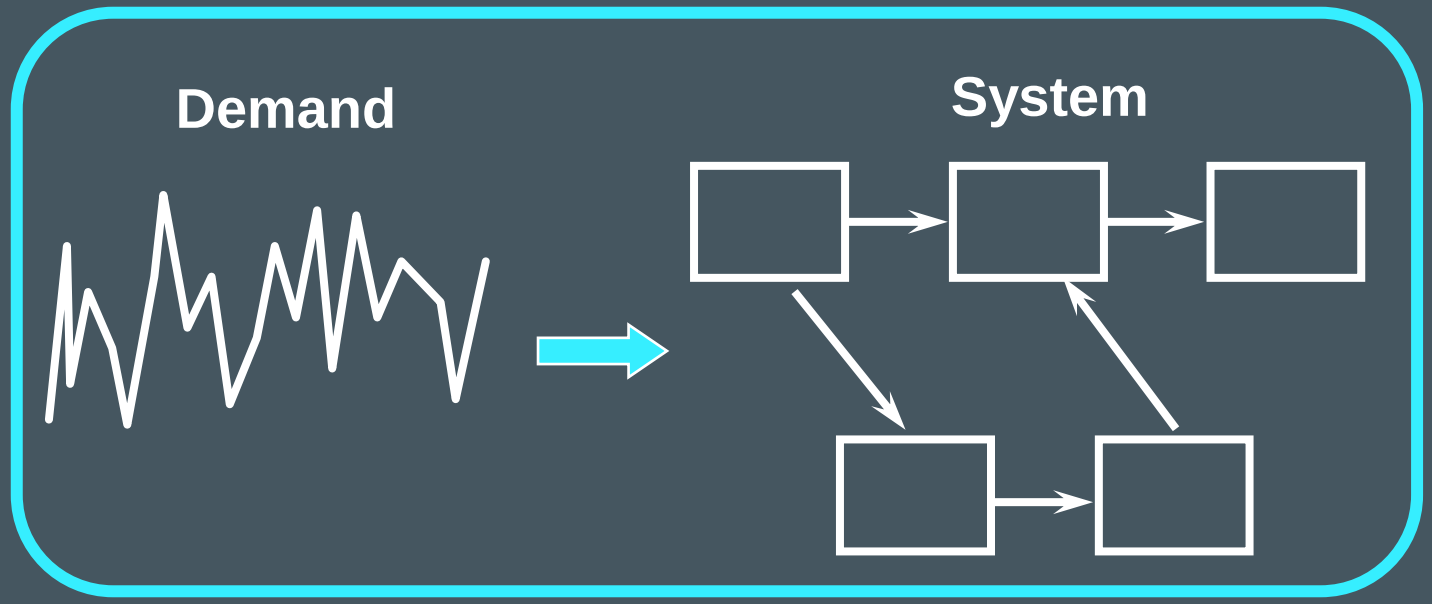
- By smoothing the inherent peaks-and valleys of patient flow, and eliminating the artificial variability, that unnecessarily impair patient flow, hospitals can improve patient safety and quality while simultaneously reducing hospital waste and cost.

- CCHMC: scheduling of “itineraries” for patients having surgical procedures
  - Redesign elective surgical schedules to create a predictable flow of patients to downstream ICUs and inpatient units.
  - Simultaneously schedule OR suite rooms and ICU beds (based on predicted length of stay).

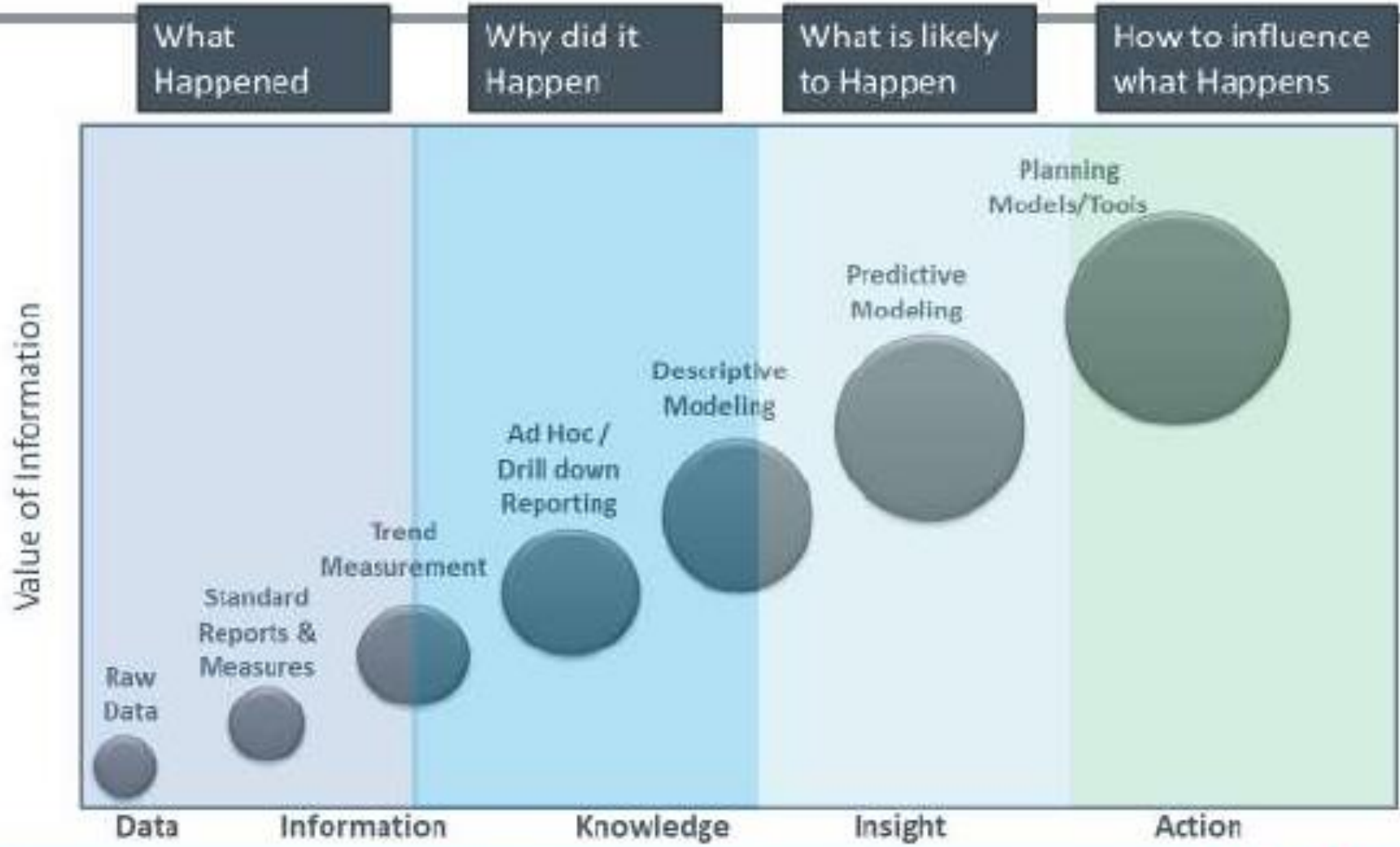
http://www.ihoptimize.org/what-we-do-methodology-flow-variability-management.htm

Litvak E., Bisognano M. More Patients, Less Payment: Increasing Hospital Efficiency In The Aftermath Of Health Reform . *Health Affairs*, 2011, vol. 30, No. 1, pp. 76-80

# Primary Driver:
# Match Capacity and Demand



# Data Analytics Influence Model



# Use Data Analytics to Understand and Manage Seasonal and Day of the Week Variations in Demand

- Looking at historical trends, do you predict a surge in admissions for patients with medical conditions in the winter months?
    - Use seasonal flex units to manage increases in medical patients during the winter months; temporarily decrease elective surgical cases
- Can you anticipate which units need more bed capacity? (Which services consistently have large numbers of “off-service” patients? Which services have planned expansions?)
    - Use data analytics and scenario planning to quantify needs of each service > right-size hospital services and units

# Scenario Planning

## BASELINE SCENARIO

Question: What will our capacity look like at the end of FY2016?

Answer:

- Budgeted growth of **883 additional discharges** at **BIDMC** in FY16
- Expect **370 incremental discharges** (in first year of **MetroWest Medical Center** deal)
  - **6.4 day average LOS** expected
- **Closing 14 Obs beds** at **BIDMC**
- Opening **43 new Med/Surg beds at BIDMC** by June 2016 (net addition of 29 beds)

## USING THE SCENARIO PLANNING TOOL

### WHAT DOES THE FUTURE BED CAPACITY LOOK LIKE BY CLINICAL AREA?

### WHAT ARE THE IMPLICATIONS IN TERMS OF CAPACITY PLANNING?

**1 Observe Current State**

| | Beds | Usable Beds | Average Occupancy Rate | % of Time in Red Zone |
|---|---|---|---|---|
| Critical Care | 77 | 77 | 82.1% | 65.3% |
| Med/Surg | 441 | 417 | 92.9% | 96.5% |
| Observation | 32 | 32 | 39.1% | 0.0% |
| Med/Surg & Obs | 473 | 449 | 89.0% | 82.3% |

**2 Describe a Future Scenario**

| | |
|---|---|
| Additional expected discharges per year | 370 |
| Avg LOS (days) of additional discharges [current = 4.1] | 6.4 |
| Critical Care beds added (+) or removed (-) | 0 |
| Med/Surg beds added (+) or removed (-) | 43 |
| Observation beds added (+) or removed (-) | -14 |
| Budgeted increase (+) or decrease (-) in discharges | 626 |
| Organic % growth (+) or decline (-) in discharges | 0.4% |

**3 Understand Future State**

| | Beds | Usable Beds | Average Occupancy Rate | % of Time in Red Zone |
|---|---|---|---|---|
| Critical Care | 77 | 77 | 84.8% | 81.2% |
| Med/Surg | 484 | 457 | 87.4% | 71.0% |
| Observation | 18 | 18 | 71.7% | 12.2% |
| Med/Surg & Obs | 502 | 475 | 86.8% | 66.2% |

Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

# Real-Time Demand and Capacity (RTDC) Management Processes

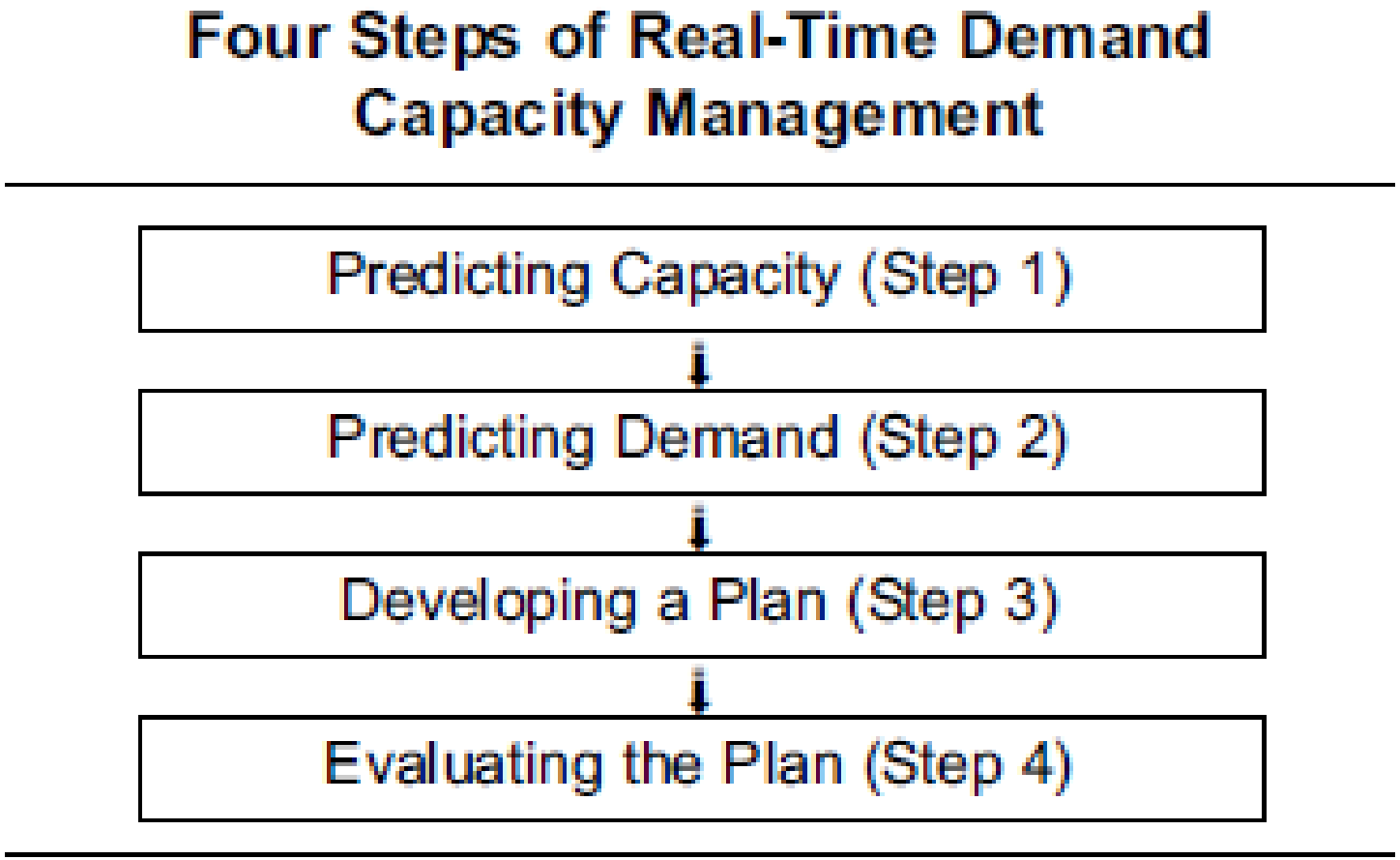


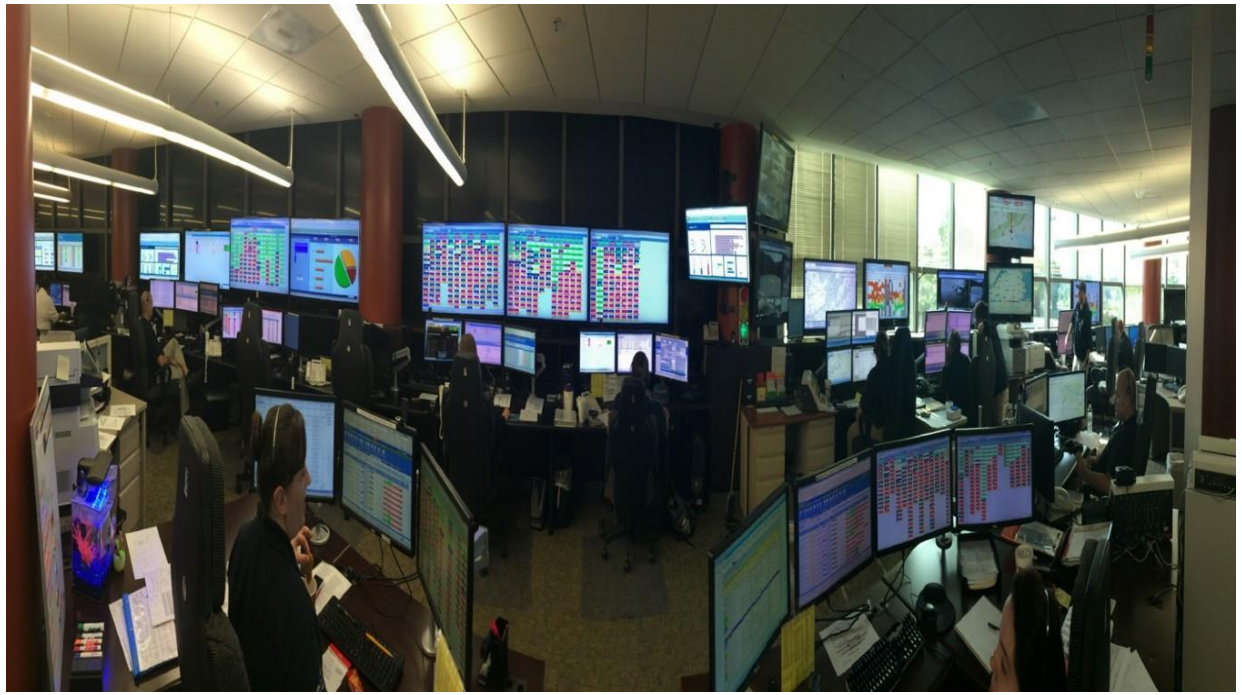

Figure 1. *The four steps of real-time demand capacity management are depicted.*

# Managing to a Spectrum of Patient Demand

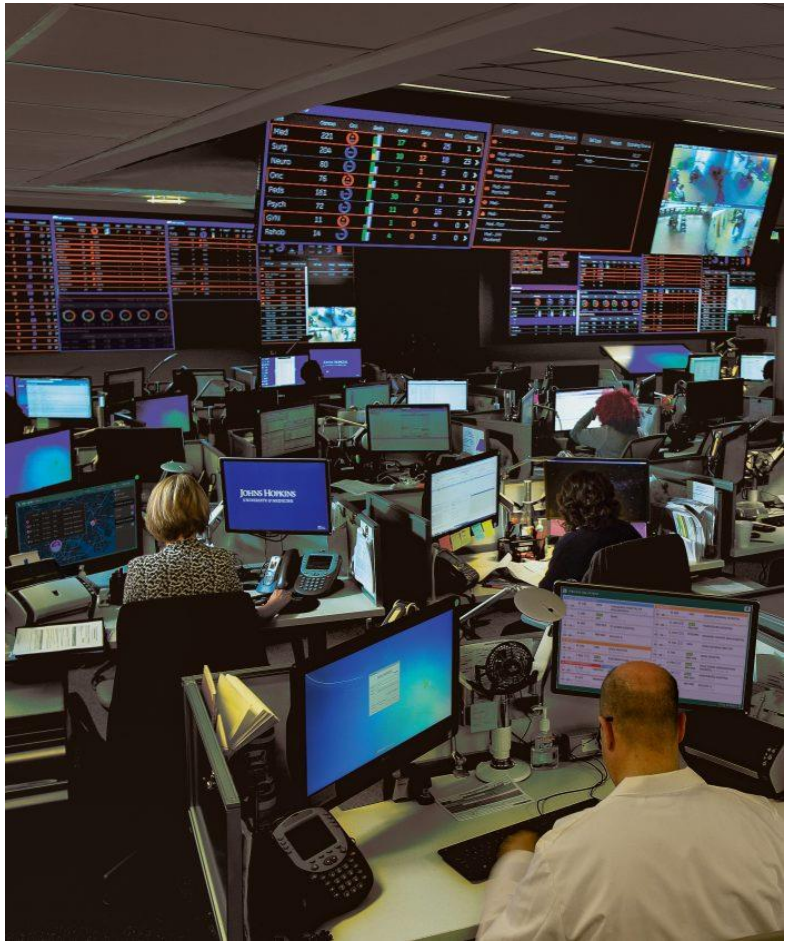
| | Routine / Normal Stress | Outside Routine / Manage Locally | Outside Routine / Requires Outside Help | Threats Requiring Urgent Action |
|---|---|---|---|---|
| | **Day to Day Shift to Shift** | **Enhanced Day to Day Shift to Shift** | System Escalation | **Disaster Plan/ Management** |
| **Definition** | Day to day management of patient volumes, admissions, discharges, ORs, ED volume | Modification of daily management for patient volume, A/D, ORs, ED. | "Unexpected" large volume of patients – ED, ICUs, ORs<br><br>Staffing shortages | Expansion of services based on predicted urgent events |
| **Scope** | **Unit**<br>**Service line**<br>**Hospital**<br>System | **Unit**<br>**Service line**<br>**Hospital**<br>System | Unit<br>**Service Line**<br>**Hospital**<br>**System**<br>Region | Units<br>Service Line<br>**Hospital**<br>**System**<br>**Region** |

# Command Centers > Critical Incident Command Centers

**Carillion Health System – Roanoke,**



**Johns Hopkins – Baltimore, Maryland**

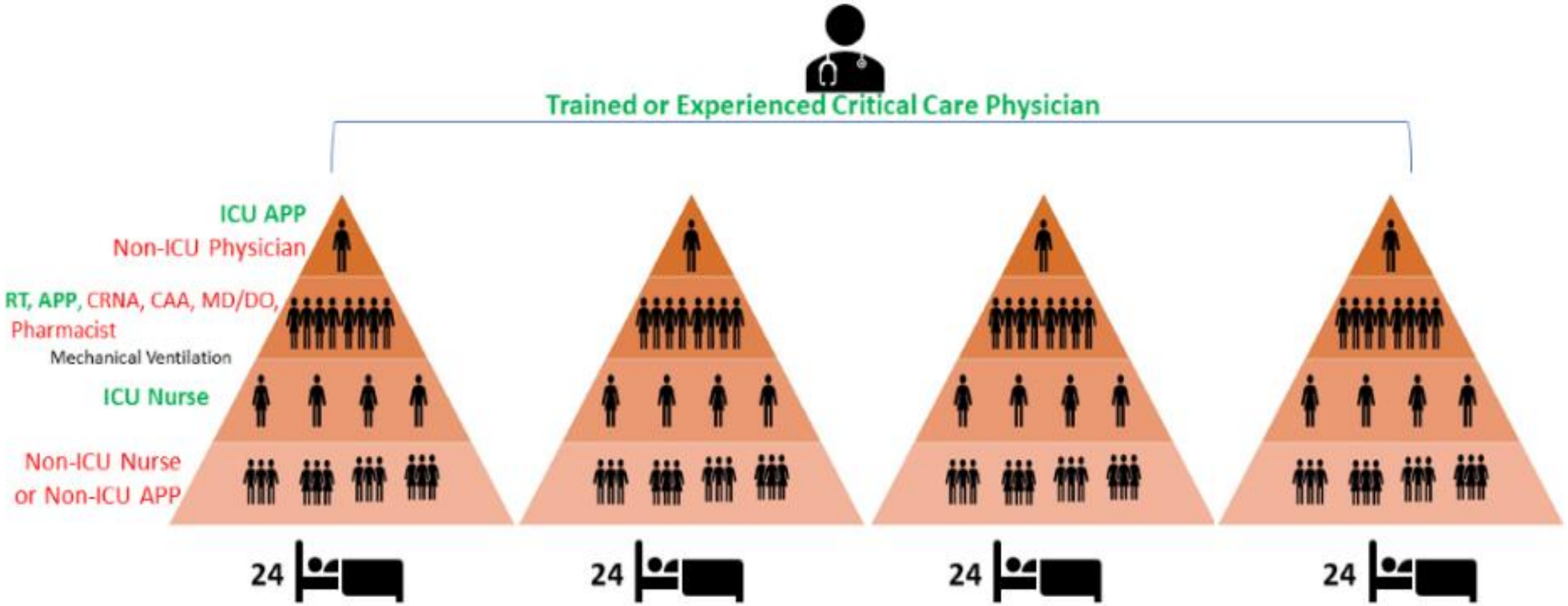


Set up incident command centers, lead by clinical leaders and hospital executives charged with managing surges in patient demand.

Society of Critical Care Medicine
The Intensive Care Professionals

# Tiered Staffing Strategy for Pandemic

## Requiring Significant Mechanical Ventilation



# Internal Medicine Care Team Models

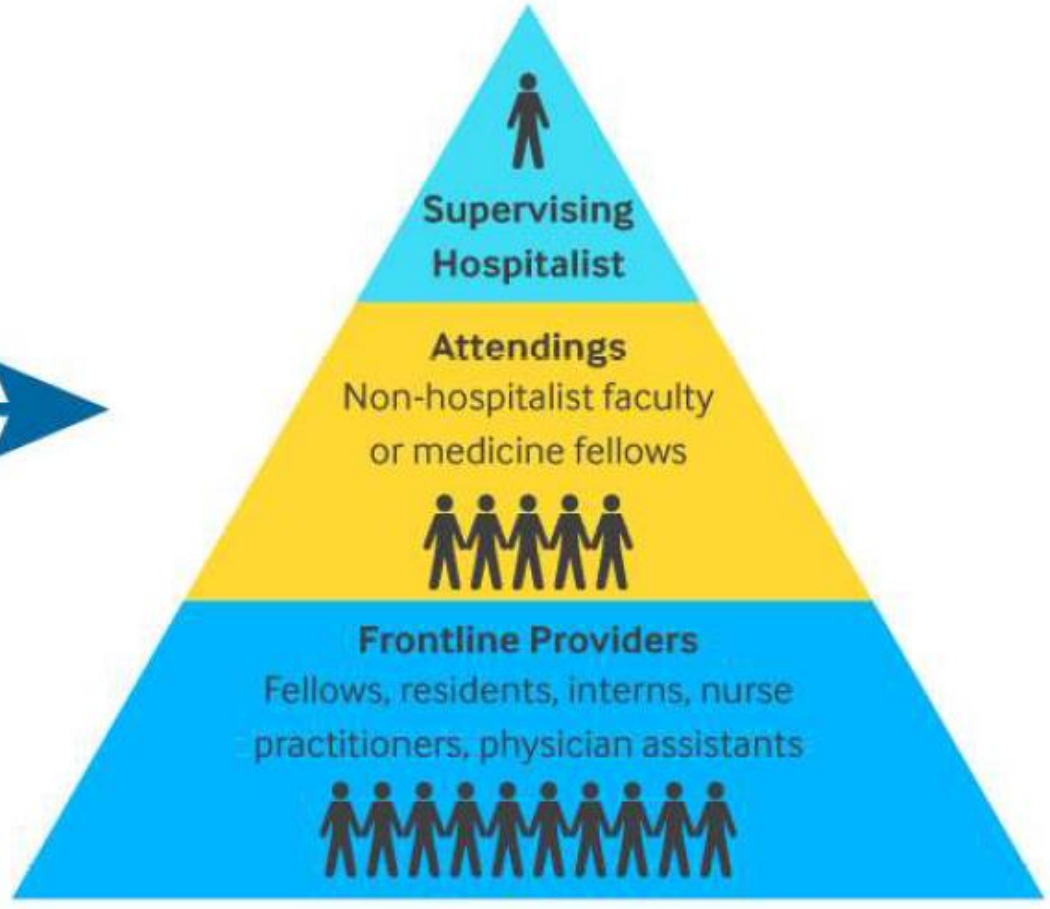
## Routine Care Model

**Hospitalist Teaching Team**
- Attending
  - Two residents
    - Two interns

**Hospitalist Non-Teaching Team**
- Attending
  - Nurse practitioner

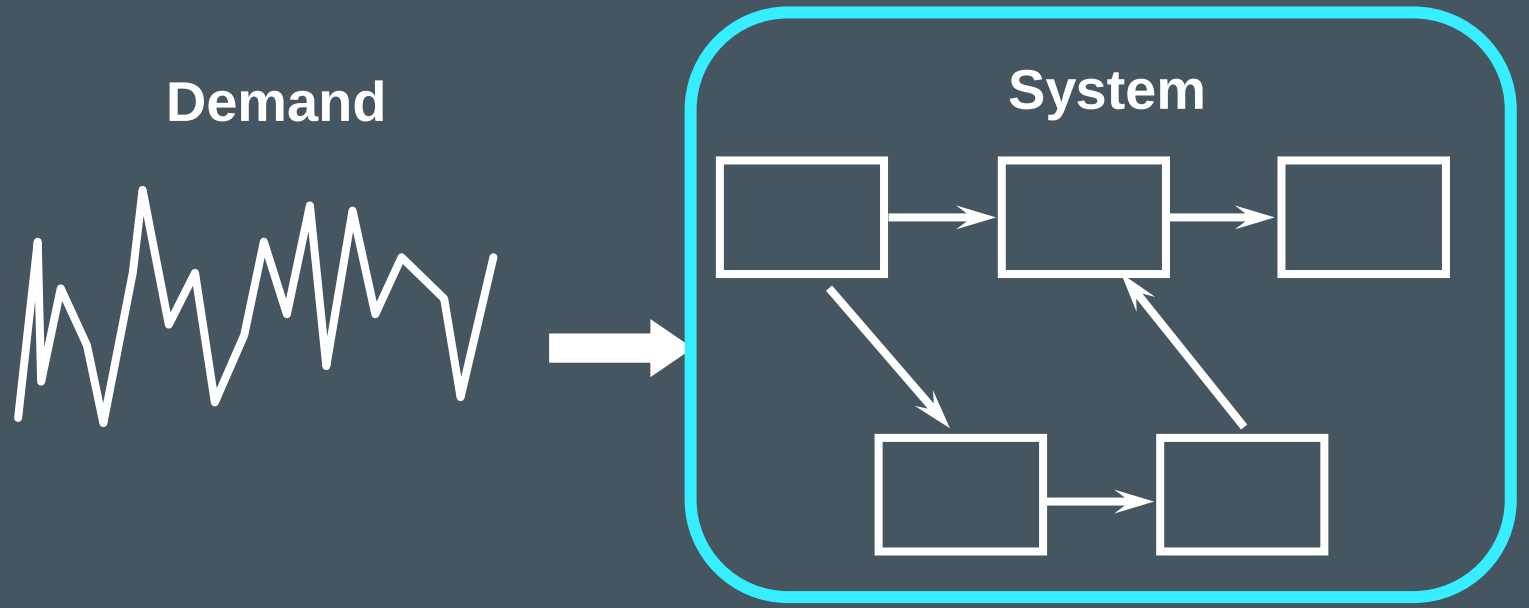
**Indicates recent inpatient internal medicine experience**

## Surge Model

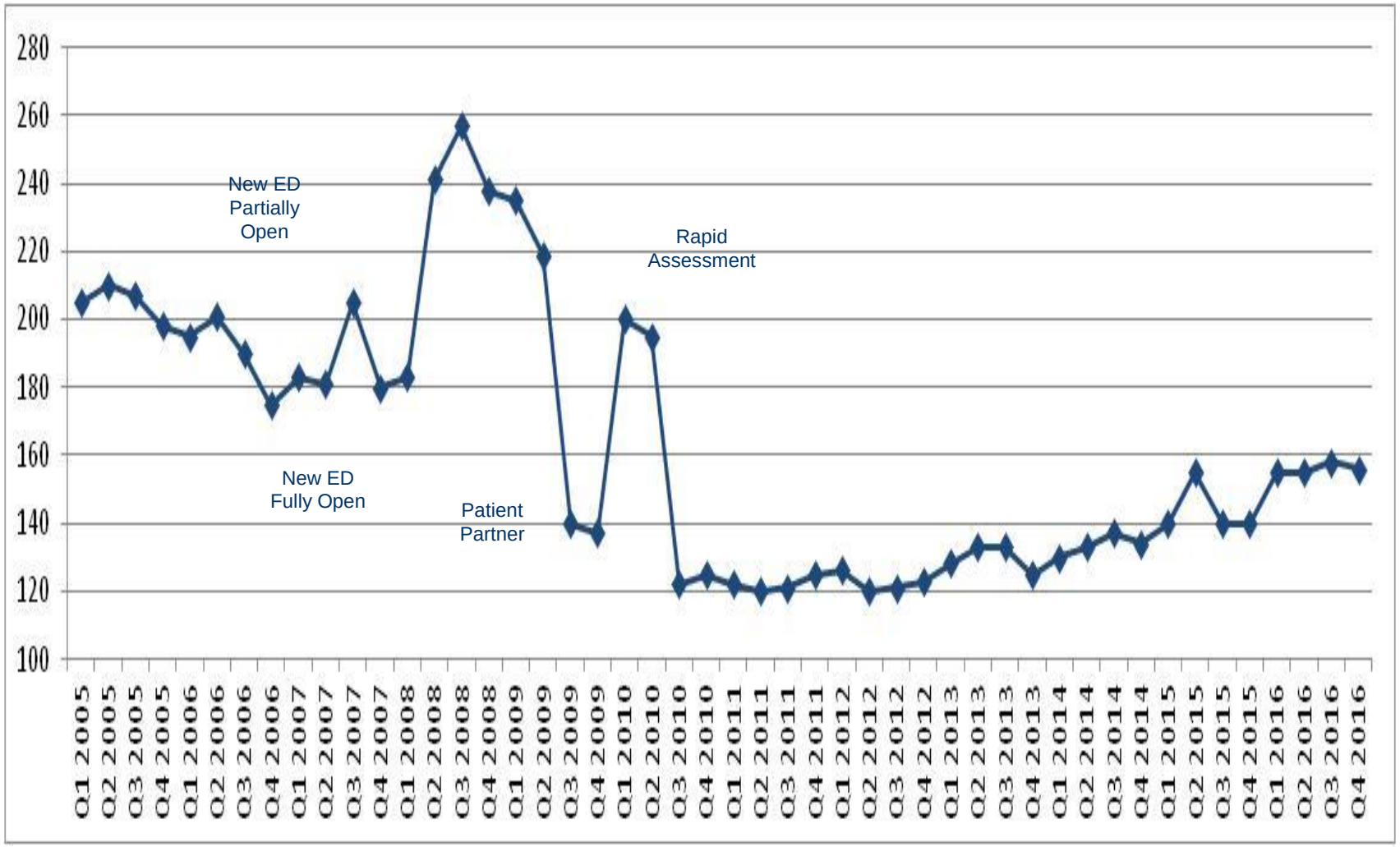



A Primer for Clinician Deployment to the Medicine Floors from an Epicenter of COVID-19, NEJM Catalyst, May 4, 2020

# Primary Driver:
# Redesign the System



# ED Median Total Length of Stay




Cambridge Health Alliance

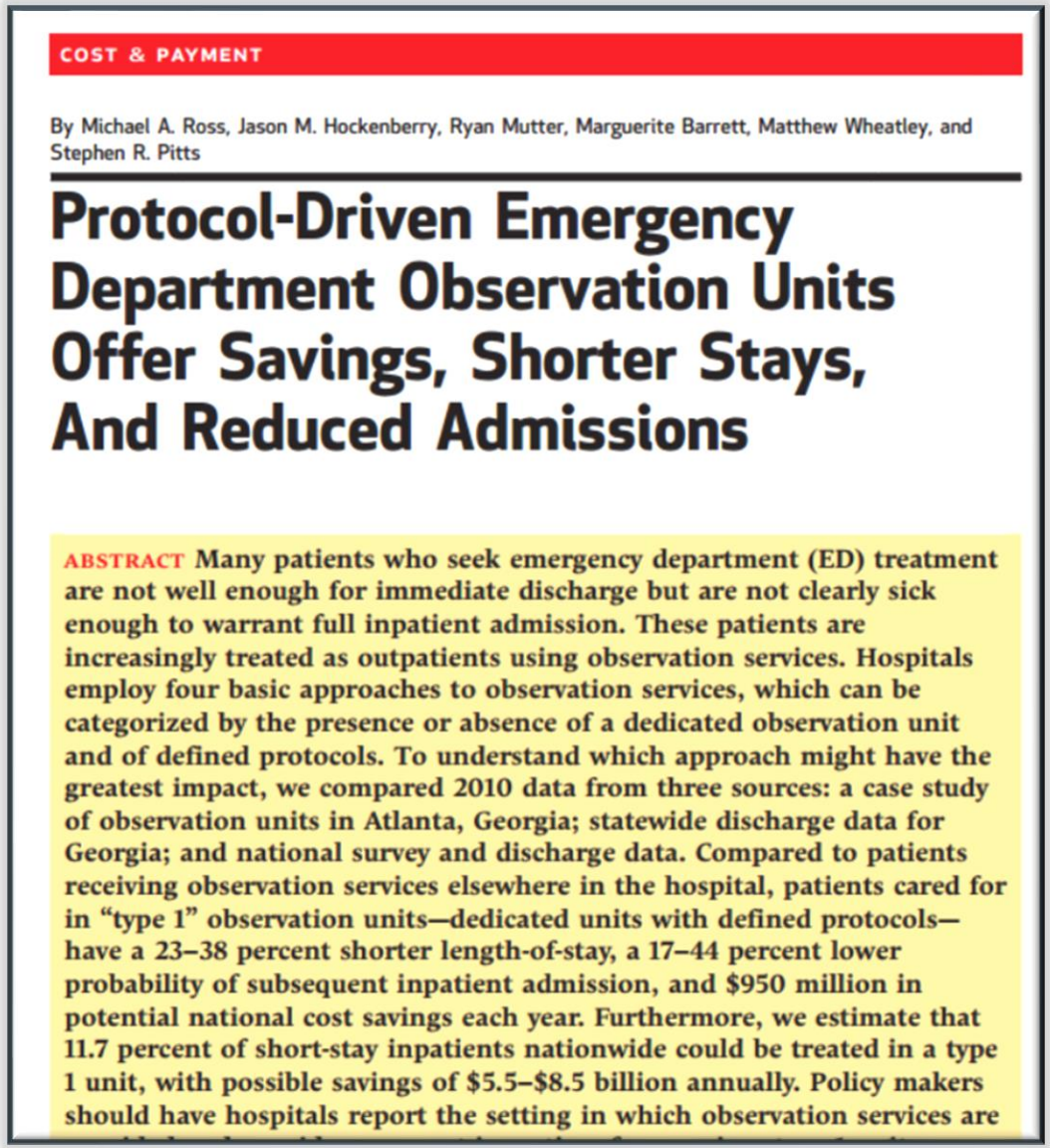
# ED Observation Units

**Management of patients with relatively straightforward admission diagnoses**

- Admissions mainly for diagnostic work-ups
- Disease course is relatively well-defined or knowable

**Primary goal-to reduce inpatient length of stay by:**

- Streamlining care pathways
- Reducing variation
- Better aligning treatment capacity with patient demand



COST & PAYMENT

By Michael A. Ross, Jason M. Hockenberry, Ryan Mutter, Marguerite Barrett, Matthew Wheatley, and Stephen R. Pitts

## Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, And Reduced Admissions

ABSTRACT Many patients who seek emergency department (ED) treatment are not well enough for immediate discharge but are not clearly sick enough to warrant full inpatient admission. These patients are increasingly treated as outpatients using observation services. Hospitals employ four basic approaches to observation services, which can be categorized by the presence or absence of a dedicated observation unit and of defined protocols. To understand which approach might have the greatest impact, we compared 2010 data from three sources: a case study of observation units in Atlanta, Georgia; statewide discharge data for Georgia; and national survey and discharge data. Compared to patients receiving observation services elsewhere in the hospital, patients cared for in "type 1" observation units—dedicated units with defined protocols—have a 23–38 percent shorter length-of-stay, a 17–44 percent lower probability of subsequent inpatient admission, and $950 million in potential national cost savings each year. Furthermore, we estimate that 11.7 percent of short-stay inpatients nationwide could be treated in a type 1 unit, with possible savings of $5.5–$8.5 billion annually. Policy makers should have hospitals report the setting in which observation services are

# Separate Flows for Elective and Non-Elective Surgical Cases

Mayo Clinic Florida

- Surgical volume and surgical minutes increased by 4% and 5%, respectively;
- Prime time use increased by 5%;
- Overtime staffing decreased by 27%;
- Day-to-day variability decreased by 20%;
- The number of elective schedule same day changes decreased by 70%;
- Staff turnover rate decreased by 41%. Net operating income and margin improved by 38% and 28%, respectively

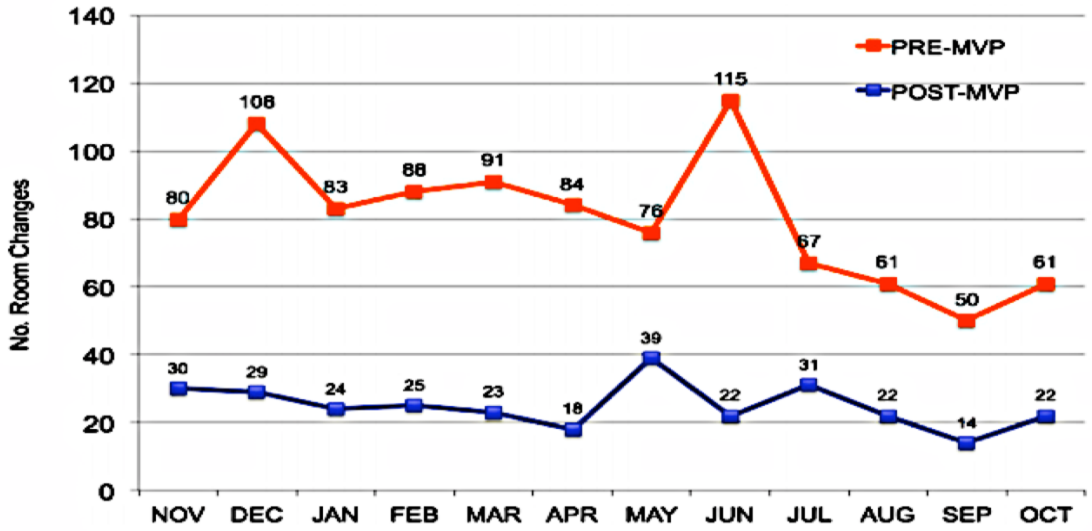
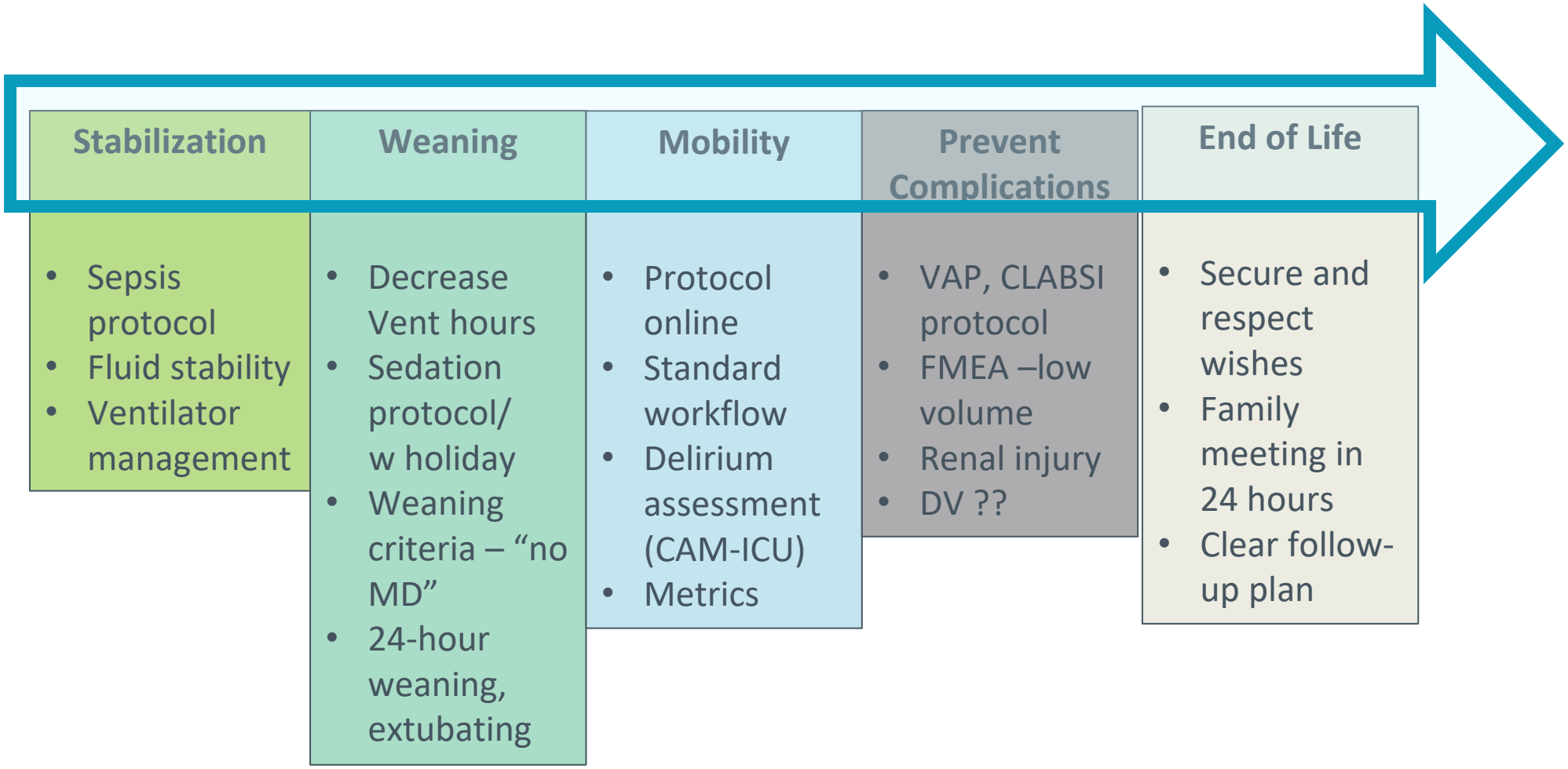



**Figure 4.** Number of changes to elective surgical schedule on the day of surgery before and after implementation of operating room redesign. MVP, managing variability program.

C. Daniel Smith, et al. *Re-Engineering the Operating Room Using Variability Management to Improve Healthcare Value*. Journal of the American College of Surgeons, Volume 216, Issue 4 , Pages 559-568, April 2013

# Foundational Elements for ICU Efficiencies and Patient Flow




MEMORIAL HERMANN

# Standardizing Multidisciplinary Rounds

## Old Model

Resident or other provider presented case and any updates; other input contributed ad hoc:

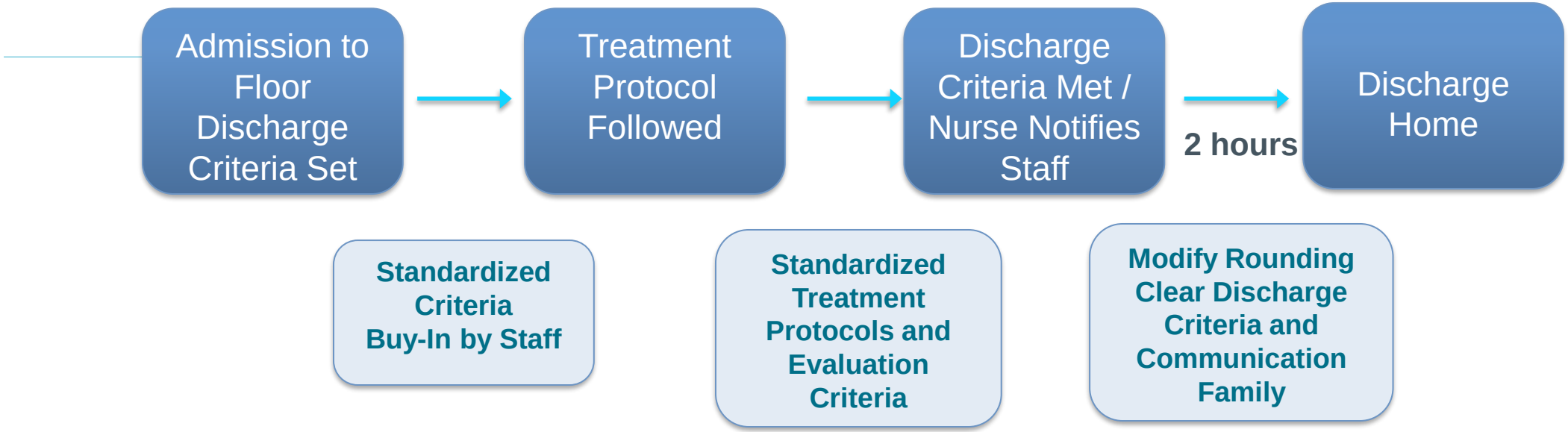
- *Less experienced nurses often felt uncomfortable jumping in unless resident remembered to ask*
- *Residents unclear on contribution*

## Patient Progression Model

Case Manager facilitates discussion prompting each discipline for input on standard, defined elements

- *Created clear expectations for participation and care is planned more collaboratively*

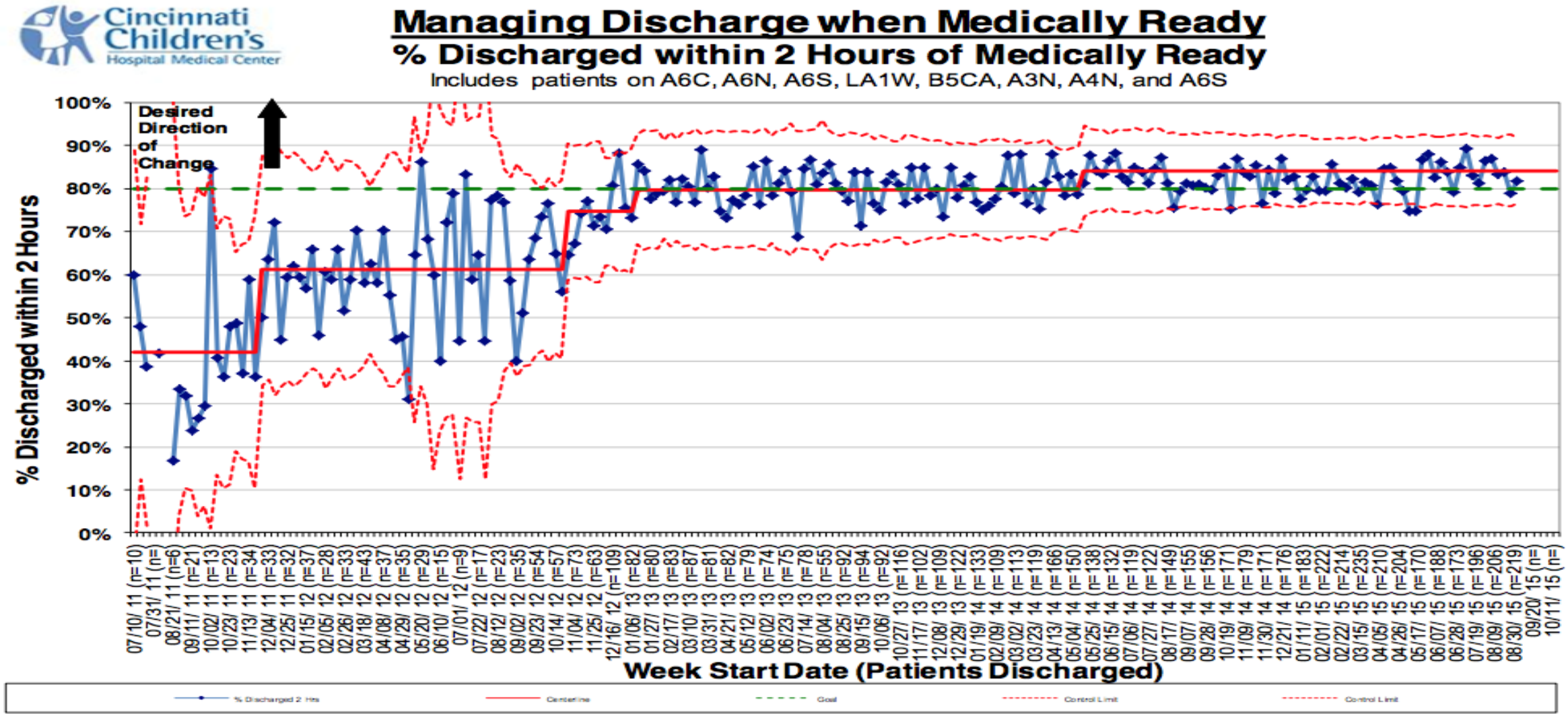
# Discharging Patients when Medically-Ready




- Medical-readiness criteria for discharge established at admission
- Nurse at bedside notifies service when medical discharge criteria are met
- Discharge from hospital with 2 hours (> 2 hours = discharge delay)
- Review length of stay and readmissions as balancing measures

White CM, Statile AM, White DL, et.al.. “Using quality improvement to optimize pediatric discharge efficiency.” *BMJ Qual Saf* 2014 Jan; 23(1): 1-9

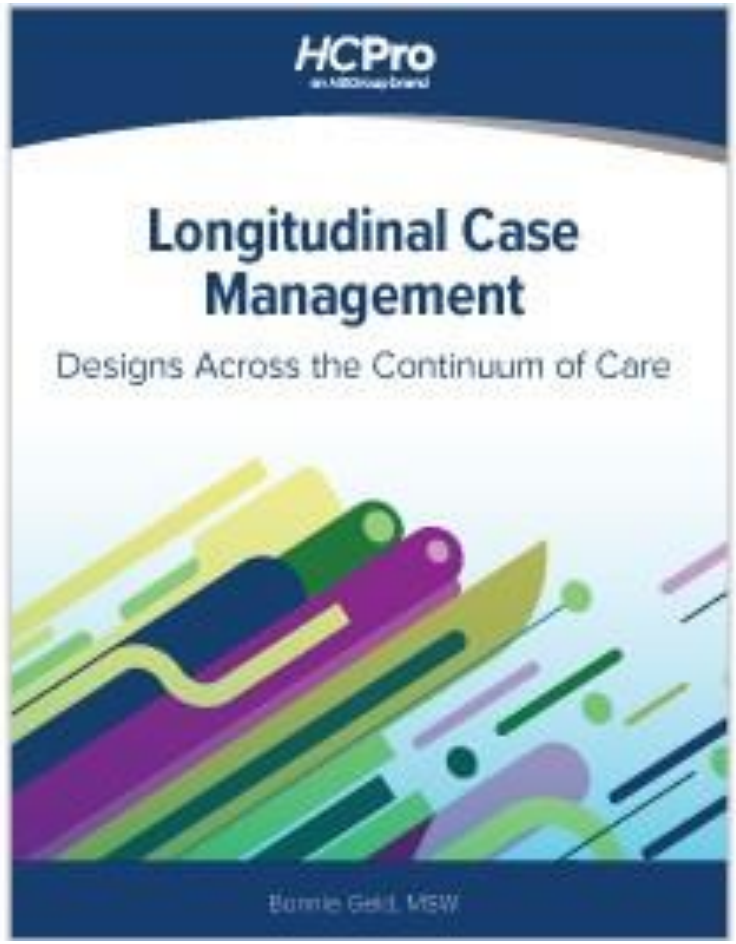
# Discharging Patients when Medically-Ready



# Moving Beyond Traditional Case Management Approaches

## Inpatient Practices

- Discharge Planning
- Interdisciplinary Rounds
- LOS Rounds (weekly)
- Escalation
- Emergency Department Case Management/Social Work
- Payment deals with post acute providers
- Consolidation of Inpatient Case Management and Social Work that resulted in parallel play




CCM
THE CENTER FOR CASE MANAGEMENT

# Comments? Questions?

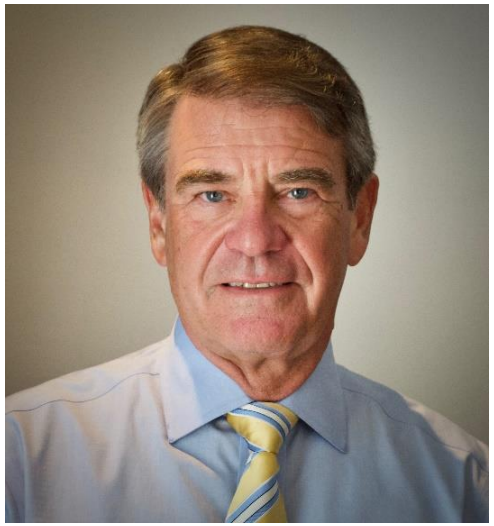
Institute for Healthcare Improvement

# Overview of the Hospital Flow Professional Development Program

Patricia Rutherford, RN, MS, retired IHI Vice President and Lead Faculty for IHI Hospital Flow
Lauren Downing, Senior Event Manager, IHI

Hospital Flow Professional Development Program
June 27, 2022

# IHI Flow Program Core Team



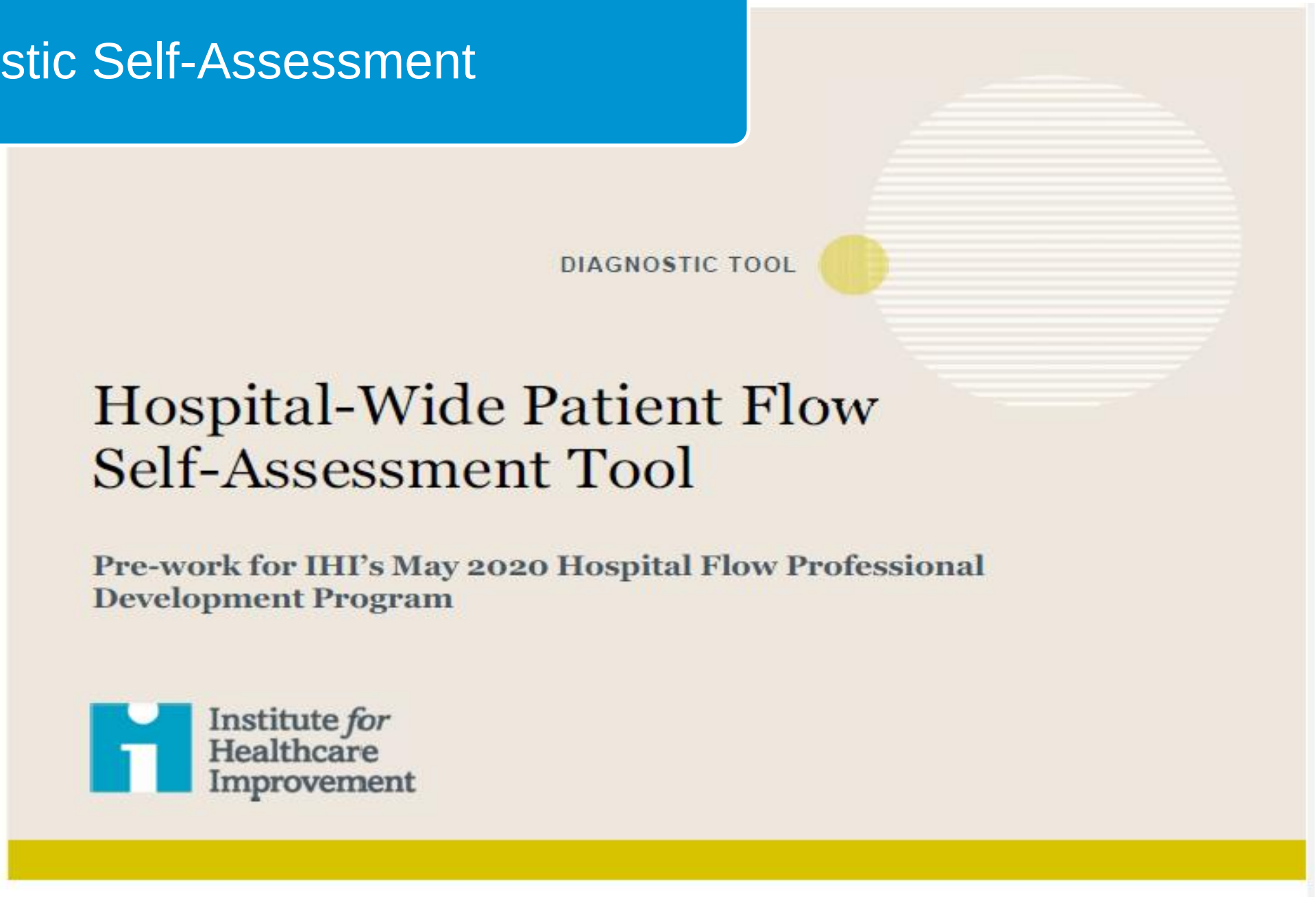
Diagnostic Self-Assessment

Flow Course Sessions and Q&A with Faculty

End-of-Day Reflections on Learning

Prioritization for Action Planning and Selection of a Portfolio of Projects

# Diagnostic Self-Assessment



| SESSION 1: OCTOBER 4 | SESSION 2 :OCTOBER 5 | SESSION 3: OCTOBER 6 |
|---|---|---|
| Welcome & Overview | Review Plans for the Day | Review Plans for the Day |
| Looking at Flow as a System | Memorial Hermann Case Study (VIEW VIDEO IN ADVANCE) | Utilizing Data-driven Learning Systems |
| BREAK | Improving Emergency Department Efficiencies and Patient Flow | Managing Elective OR Schedules and Predicting Downstream Demand |
| Strategies to Achieve System-wide Hospital Flow | BREAK | LUNCH |
| LUNCH | Reducing Low-Acuity Emergency Department Visits (BREAKOUT) | Using Advanced Analytics for Improvement and Forecasting |
| Improving ICU Efficiencies and Patient Flow (BREAKOUT) | Improving Care of Psychiatric Patients & Short-Stay Units & Observation Status Patients (BREAKOUT) | BREAK |
| Improving Med/Surg Efficiencies and Patient Flow (BREAKOUT) | LUNCH | Storyboard Rounds |
| BREAK | Using Quality Improvement to Optimize Discharge Efficiency | BREAK |
| Integrating Lean and QI | BREAK | End of Day Reflections on Learning and Guidance for Teams |
| Storyboard Rounds | Open Space? | |
| BREAK | End of Day Reflections on Learning and Guidance for Teams | |
| End of Day Reflections on Learning and Guidance for Teams | | |

| SESSION 4: OCTOBER 11 | SESSION 5: OCTOBER 12 | SESSION 6: OCTOBER 13 |
|---|---|---|
| Review Plans for the Day | Review Plans for the Day | Review Plans for the Day |
| Northwell Health Case Study: A Discussion | Reduce Unnecessary Bed Days | Cincinnati Children's Hospital Medical Center Case Study: A Discussion (VIEW VIDEO IN ADVANCE) |
| Reducing Avoidable Readmission: UCSF (BREAKOUT) | BREAK | Utilization of Hospital-wide Metrics to Guide Learning within and across Projects for Achieving Results |
| Reducing Avoidable Readmissions: UnityPoint (BREAKOUT) | Case Management and Population Health Strategies (BREAKOUT) | BREAK |
| BREAK | Respecting Individual's Wishes for End-of-Life Care (BREAKOUT) | Putting it All Together: Strategies to Achieve System-wide Results (Part 1) |
| Value-Added Strategies | LUNCH | LUNCH |
| LUNCH | Managing Spectrum of Demand (BREAKOUT) | Putting it All Together: Strategies to Achieve System-wide Results (Part 2) |
| Hospital at Home® Model (BREAKOUT) | Strategies to Optimize Staffing to Meet Patient Demand (BREAKOUT) | BREAK |
| Complex Care Systems (BREAKOUT) | BREAK | Final Jeopardy |
| BREAK | Creating Value in Health Care | ADJOURN @ 3:30 PM |
| End of Day Reflections on Learning and Guidance for Teams | BREAK | |
| | End of Day Reflections on Learning and Guidance for Teams | |

# Program Faculty














# All Teach!
# All Learn!

# End-of-Day Reflections on Learning

At the end of each day your team attending the workshop should spend time discussing important reflections on learning.

End-of-Day Reflections will help your team:

1) to share learning and insights from faculty-led hospital flow program sessions and in participant-led storyboard sessions; and
2) to note promising change ideas and how you might adapt or adopt featured interventions to improve system-wide patient flow in your hospital/health system.

# End-of-Day Reflections on Learning

Institute for Healthcare Improvement

Hospital Flow Professional Development Program
Daily Reflections on Learning

**Session 1: Tuesday, October 4, 2022**

At the end of each day your team attending the workshop should spend time discussing important reflections on learning.
End of Day Reflections will help your team: 1) to share learning and insights from faculty-led hospital flow program sessions and in participant-led storyboard sessions; and 2) to note promising change ideas and how you might adopt featured interventions to improve system-wide patient flow in the hospital/health system.

| Sessions | Insights and New Learning | Ideas for Action Planning |
|---|---|---|
| Looking at Flow as a System | | |
| Strategies to Achieve System-wide Hospital FLow | | |
| Improving ICU Efficiencies and Patient Flow (BREAKOUT) | | |



Institute for Healthcare Improvement

Hospital Flow Professional Development Program
Daily Reflections on Learning

| | | |
|---|---|---|
| Improving Med/Surg Efficiencies and Patient Flow (BREAKOUT) | | |
| Integrating Lean Thinking with Flow Improvement | | |
| Storyboard Rounds | | |

# Prioritization for Action Planning and Selection of a Portfolio of Projects

## On the last day of the Flow Program….

With knowledge of your biggest opportunities for improvement, create an action plan to focus your improvement efforts with selections from the high-level strategies to improve hospital-wide flow.

1. What ideas do you think will help to **build or strengthen the will** for achieving hospital-wide flow?
2. Where is **investment needed for successful execution of hospital-wide change initiatives** to improve hospital-wide performance?
3. Which three or four **high-leverage change ideas and portfolio of improvement projects** do you think will best accelerate your progress toward your desired goals for hospital-wide flow?

# Prioritization for Action Planning and Selection of a Portfolio of Projects

## ACTION PLAN for Building the Will for Achieving Hospital-wide Patient Flow

| Building Will | Priority Area | Action Plans |
|---|---|---|
| Make Delivering the Right Care, at the Right Time and in the Right Place a Strategic Priority | | |
| Leverage Hospital-wide Patient Flow Initiatives to Improve Patient Safety, Patient Experience and Clinician/Staff Satisfaction | | |
| Align Medical Staff and Hospital Executives to Achieve Improved Flow | | |
| Adopt Value-based Care Models to Improve Patient Flow | | |
| Demonstrate that Improved Flow has a Positive Return on Investment | | |
| Connect the Work of Departments and Units to Hospital-Wide Flow Strategies | | |

## ACTION PLAN for High-Leverage Change Ideas for Achieving Hospital-wide Patient Flow

| Shape or Reduce Demand | Priority Area | Action Plans |
|---|---|---|
| Provide end-of-life care (what care, and where) in accordance with patients' wishes | | |
| Decrease demand for medical-surgical beds by preventing avoidable readmissions | | |
| Reduce unnecessary bed days after or transfer to community settings of care patients meet clinical-readiness criteria for discharge | | |
| Decrease ED visits and acute care hospital admissions | | |
| Decrease demand for hospital beds by reducing preventable harm | | |
| Decrease artificial variation in surgical scheduling | | |

# General Guidance for Participants

- Expect to spend 18 hours per week participating in the virtual sessions, plus recommended time (1-2 hours) with your team reflecting on learning and preparing for next sessions by watching 2 videos
- Engage in interactive sessions utilizing the chat function, exercises, storyboard sessions and Q&A throughout the program
- Give us feedback at the end of each session, so that we can continually improve your learning experience
- At the end of each day and in the final session, there will be time to consult with faculty: 1) to discuss how to translate learning from faculty to your local contexts; and 2) to prioritize change ideas for developing your action plans on the final day of the flow program.

# Recommendations for Maximizing Your Organization's Participation in IHI's Flow Program

- Co-locate hospital flow leadership team participants during the IHI Flow Program
  - Project virtual program on a large screen
  - Participants to individually log in on a personal laptop
- Distribute your team members to concurrent breakout sessions.
- Provide a designee to lead an overview of your storyboard and distribute team members to each of the storyboard presentations.
- Convene as a team at the end of each day to reflect on learning throughout the sessions
- During "Putting It All Together" session, convene all participants from your organization's leadership team (either in-person or virtually) for action planning

# Comments? Questions?

# For More Information Contact:

Lauren Downing

ldowning@ihi.org