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
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.

   **Tip:** You can use Emojis and change your skin tone by clicking the button.
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.”
System-wide View of Patient Flow of Helps to Avoid Isolated Perspectives and Flow Projects

Off-Service Patients
Med/Surg “Boarders” / Unnecessary Bed Days
Discharge Delays

No Telemetry Beds

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
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: 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

**Aim**

**Primary Drivers**

S1. Provide end-of-life care in accordance with patients’ wishes (what care, and where)

S2. Decrease demand for medical-surgical beds by preventing avoidable hospital readmissions

S3. Decrease unnecessary bed days after patients meet medical readiness criteria for discharge or transfer to community settings of care

S4. Decrease ED visits and acute care hospital admissions

S5. Decrease demand for hospital beds by reducing preventable harm

S6. Decrease artificial variation in surgical scheduling

**Secondary Drivers**

S7. Utilize a data-driven learning system for hospital-wide patient flow

S8. Utilize real-time demand and capacity management processes

S9. Improve efficiencies, length of stay, and throughput in the emergency department

S10. Improve efficiencies, length of stay, and throughput in the short stay unit

S11. Improve efficiencies, length of stay, and throughput in the intensive care unit

S12. Improve efficiencies, length of stay, and throughput in medical-surgical units

S13. Improve efficiencies and throughput in the operating room

S14. Develop medical readiness criteria for timely progression of patients to appropriate clinical units throughout the hospital stay and at discharge

**Shape or Reduce Demand**

Optimize patient placement to ensure the right care, in the right place, at the right time

**Match Capacity and Demand**

Redesign the System

3 Simple Rules
Primary Driver:
Shaping and Reducing Demand
Changing the Cultural Norm

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

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

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans

Transition from Hospital to Home or other Care Setting

Transition to Community Care Settings

Primary & Specialty Care

- Review Plan & Visit Plan
- Assess, Plan & Self-Management Support
- Coordinate Care

Home Health Care

- Assess, Plan & Self-Management Support
- Comprehensive Care

Skilled Nursing Care Centers

Teachback & Learning

- Assessment of Needs
- Flex post acute F/U Care
- Handover Communications

Alternative or Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure
30 Day Readmissions: Primary & Secondary Heart Failure 65+

30 Day Readmissions
Primary & Secondary Heart Failure
UCSF Medical Center Heart Failure Program

Annual Averages
2009 = 24%
2010 = 19%
2011 = 13%
2012 = 12%
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.johnshopkinsolutions.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*

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).


Primary Driver:
Match Capacity and Demand
Data Analytics Influence Model

- What Happened
- Why did it Happen
- What is likely to Happen
- How to influence what Happens

Value of Information:
- Data
- Information
- Knowledge
- Insight
- Action

- Raw Data
- Standard Reports & Measures
- Trend Measurement
- Ad Hoc / Drill down Reporting
- Descriptive Modeling
- Predictive Modeling
- Planning Models/Tools

Institute for Healthcare Improvement
James M. Anderson Center
For Health Systems Excellence
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?
  
  o 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?)

  o 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)

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**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**

<table>
<thead>
<tr>
<th></th>
<th>Beds</th>
<th>Usable Beds</th>
<th>Average Occupancy Rate</th>
<th>% of Time in Red Zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care</td>
<td>77</td>
<td>77</td>
<td>82.1%</td>
<td>65.3%</td>
</tr>
<tr>
<td>Med/Surg</td>
<td>441</td>
<td>417</td>
<td>92.9%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Observation</td>
<td>32</td>
<td>32</td>
<td>39.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Med/Surg &amp; Obs</td>
<td>473</td>
<td>449</td>
<td>89.6%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

**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**

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<td>77</td>
<td>84.8%</td>
<td>51.2%</td>
</tr>
<tr>
<td>Med/Surg</td>
<td>484</td>
<td>457</td>
<td>87.4%</td>
<td>71.0%</td>
</tr>
<tr>
<td>Observation</td>
<td>18</td>
<td>18</td>
<td>71.7%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Med/Surg &amp; Obs</td>
<td>502</td>
<td>475</td>
<td>86.6%</td>
<td>66.2%</td>
</tr>
</tbody>
</table>
Real-Time Demand and Capacity (RTDC) Management Processes

Four Steps of Real-Time Demand Capacity Management

- Predicting Capacity (Step 1)
- Predicting Demand (Step 2)
- Developing a Plan (Step 3)
- Evaluating the Plan (Step 4)

Figure 1. The four steps of real-time demand capacity management are depicted.
## Managing to a Spectrum of Patient Demand

<table>
<thead>
<tr>
<th>Routine / Normal Stress</th>
<th>Outside Routine / Manage Locally</th>
<th>Outside Routine / Requires Outside Help</th>
<th>Threats Requiring Urgent Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day to Day</strong></td>
<td><strong>Enhanced Day to Day</strong></td>
<td><strong>System Escalation</strong></td>
<td><strong>Disaster Plan/Management</strong></td>
</tr>
<tr>
<td>Shift to Shift</td>
<td>Shift to Shift</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Definition
- **Routine / Normal Stress**: Day to day management of patient volumes, admissions, discharges, ORs, ED volume
- **Outside Routine / Manage Locally**: Modification of daily management for patient volume, A/D, ORs, ED.
- **Outside Routine / Requires Outside Help**: “Unexpected” large volume of patients – ED, ICUs, ORs
- **Threats Requiring Urgent Action**: Expansion of services based on predicted urgent events

### Scope
- **Routine / Normal Stress**: Unit Service line Hospital System
- **Outside Routine / Manage Locally**: Unit Service line Hospital System
- **Outside Routine / Requires Outside Help**: Unit Service Line Hospital System Region
- **Threats Requiring Urgent Action**: Units Service Line Hospital System Region
Set up incident command centers, lead by clinical leaders and hospital executives charged with managing surges in patient demand.
Internal Medicine Care Team Models

Routine Care Model

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

- Hospitalist Non-Teaching Team
  - Attending
  - Nurse practitioner

Surge Model

- Supervising Hospitalist
- Attendings
  - Non-hospitalist faculty or medicine fellows
- Frontline Providers
  - Fellows, residents, interns, nurse practitioners, physician assistants

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
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
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

### Foundational Elements for ICU Efficiencies and Patient Flow

<table>
<thead>
<tr>
<th>Stabilization</th>
<th>Weaning</th>
<th>Mobility</th>
<th>Prevent Complications</th>
<th>End of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sepsis protocol</td>
<td>• Decrease Vent hours</td>
<td>• Protocol online</td>
<td>• VAP, CLABSI protocol</td>
<td>• Secure and respect wishes</td>
</tr>
<tr>
<td>• Fluid stability</td>
<td>• Sedation protocol/ w holiday</td>
<td>• Standard workflow</td>
<td>• FMEA – low volume</td>
<td>• Family meeting in 24 hours</td>
</tr>
<tr>
<td>• Ventilator management</td>
<td>• Weaning criteria – “no MD”</td>
<td>• Delirium assessment (CAM-ICU)</td>
<td>• Renal injury</td>
<td>• Clear follow-up plan</td>
</tr>
<tr>
<td></td>
<td>• 24-hour weaning, extubating</td>
<td>• Metrics</td>
<td>• DV ??</td>
<td></td>
</tr>
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**End of Life**
- Secure and respect wishes
- Family meeting in 24 hours
- Clear follow-up plan

**Prevent Complications**
- VAP, CLABSI protocol
- FMEA – low volume
- Renal injury
- DV ??

**Mobility**
- Protocol online
- Standard workflow
- Delirium assessment (CAM-ICU)
- Metrics

**Weaning**
- Decrease Vent hours
- Sedation protocol/ w holiday
- Weaning criteria – “no MD”
- 24-hour weaning, extubating

**Stabilization**
- Sepsis protocol
- Fluid stability
- Ventilator management
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

Discharging Patients when Medically-Ready

Managing Discharge when Medically Ready
% Discharged within 2 Hours of Medically Ready
Includes patients on A6C, A6N, A6S, LA1W, B5CA, A3N, A4N, and A6S

Week Start Date (Patients Discharged)
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
Comments?  Questions?
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
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

Hospital-Wide Patient Flow Self-Assessment Tool

Pre-work for IHI’s May 2020 Hospital Flow Professional Development Program

Institute for Healthcare Improvement
<table>
<thead>
<tr>
<th>SESSION 1: OCTOBER 4</th>
<th>SESSION 2: OCTOBER 5</th>
<th>SESSION 3: OCTOBER 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome &amp; Overview</td>
<td>Review Plans for the Day</td>
<td>Review Plans for the Day</td>
</tr>
<tr>
<td>Looking at Flow as a System</td>
<td>Memorial Hermann Case Study (VIEW VIDEO IN ADVANCE)</td>
<td>Utilizing Data-driven Learning Systems</td>
</tr>
<tr>
<td>BREAK</td>
<td>Improving Emergency Department Efficiencies and Patient Flow</td>
<td>Managing Elective OR Schedules and Predicting Downstream Demand</td>
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<tr>
<td>Strategies to Achieve System-wide Hospital Flow</td>
<td>BREAK</td>
<td>LUNCH</td>
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<tr>
<td>LUNCH</td>
<td>Improving ICU Efficiencies and Patient Flow (BREAKOUT)</td>
<td>Using Advanced Analytics for Improvement and Forecasting</td>
</tr>
<tr>
<td>Improving ICU Efficiencies and Patient Flow (BREAKOUT)</td>
<td>Reducing Low-Acuity Emergency Department Visits (BREAKOUT)</td>
<td>BREAK</td>
</tr>
<tr>
<td>Improving Med/Surg Efficiencies and Patient Flow (BREAKOUT)</td>
<td>Improving Care of Psychiatric Patients &amp; Short-Stay Units &amp; Observation Status Patients (BREAKOUT)</td>
<td>END OF DAY REFLECTIONS ON LEARNING AND GUIDANCE FOR TEAMS</td>
</tr>
<tr>
<td>BREAK</td>
<td>Using Quality Improvement to Optimize Discharge Efficiency</td>
<td>END OF DAY REFLECTIONS ON LEARNING AND GUIDANCE FOR TEAMS</td>
</tr>
<tr>
<td>Integrating Lean and QI</td>
<td>BREAK</td>
<td>OPEN SPACE?</td>
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<tr>
<td>Storyboard Rounds</td>
<td>LUNCH</td>
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<tr>
<td>BREAK</td>
<td>End of Day Reflections on Learning and Guidance for Teams</td>
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</table>
### SESSION 4: OCTOBER 11
- **Review Plans for the Day**
- **Northwell Health Case Study: A Discussion**
- **Reducing Avoidable Readmission: UCSF** (BREAKOUT)
- **Reducing Avoidable Readmissions: UnityPoint** (BREAKOUT)
  - **BREAK**
- **Value-Added Strategies**
- **LUNCH**
- **Hospital at Home® Model** (BREAKOUT)
- **Complex Care Systems** (BREAKOUT)
  - **BREAK**
- **End of Day Reflections on Learning and Guidance for Teams**

### SESSION 5: OCTOBER 12
- **Review Plans for the Day**
- **Reduce Unnecessary Bed Days**
  - **BREAK**
- **Case Management and Population Health Strategies** (BREAKOUT)
- **Respecting Individual’s Wishes for End-of-Life Care** (BREAKOUT)
  - **LUNCH**
  - **Managing Spectrum of Demand** (BREAKOUT)
- **Strategies to Optimize Staffing to Meet Patient Demand** (BREAKOUT)
  - **BREAK**
- **Creating Value in Health Care**
  - **BREAK**
- **End of Day Reflections on Learning and Guidance for Teams**

### SESSION 6: OCTOBER 13
- **Review Plans for the Day**
- **Cincinnati Children’s Hospital Medical Center Case Study: A Discussion** *(VIEW VIDEO IN ADVANCE)*
- **Utilization of Hospital-wide Metrics to Guide Learning within and across Projects for Achieving Results**
  - **BREAK**
- **Putting it All Together: Strategies to Achieve System-wide Results (Part 1)**
  - **LUNCH**
  - **Putting it All Together: Strategies to Achieve System-wide Results (Part 2)**
  - **BREAK**
- **Final Jeopardy**
- **ADJOURN @ 3:30 PM**
Program Faculty
All Teach!
All Learn!
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

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/feature interventions to improve system-wide patient flow in the hospital health system.

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Insights and New Learning</th>
<th>Ideas for Action Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking at Flow as a System</td>
<td></td>
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<tr>
<td>Strategies to Achieve System-wide Hospital Flow</td>
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<tr>
<td>Improving ICU Efficiencies and Patient Flow (BREAKOUT)</td>
<td></td>
<td></td>
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</tbody>
</table>
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

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

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

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

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