



InPatient Operational Performance Improvement Program (IPOP)

Inter-departmental Patient Service Coordination – Using Workflow Re-engineering Tools to Increase Revenues and Improve Resource Utilization

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Background

What if you called an expensive restaurant for a reservation and the maitre-de said come at seven and we will sit your party when we can, hopefully before nine. Would you bother showing up? Or, how do you feel when you get bumped from a scheduled flight because the previous flight was cancelled, or they simply over booked?

These are terrible situations you always want to avoid, but did you know that in over 99% of the hospitals today that is exactly how they handle services that are requested for inpatients. Conversely, if you are an outpatient or ambulatory patient, the likelihood of getting seen at a specific appointed time is pretty good, while a patient in a bed at that same hospital is considered 'back-fill'. That is, since by their definition inpatients are already in their facility and will most likely be there through tomorrow, your doctor's request for service, say a chest X-ray, is considered time variable. Traditionally hospitals 'schedule' ancillary and other services for inpatients using a fixed block of time usually in the afternoons, then process the inpatient requests for service on a 'catch as catch can' basis. Why do they do this? Here are the usual reasons given:

1. Outpatients take priority since they won't be in the facility long. Hey! They got places to go.
2. Predicting emergency cases is impossible, so you need slack time to cover these. When you do have an emergency case inpatients are the easiest to 'bump'.
3. Since you are here already, waiting should not be a problem; you have nothing else to do!
4. Scheduling inpatients for a specific time is too difficult since the patient may have to go to several different departments for other services, and any department could get a call from the ER at any time. Besides none of our six different scheduling systems can talk to one another.
5. Department staff may not be available to transport the patient from the floor or to another service department.
6. There is no guarantee the patient will be available at a specific time since nursing (or another care giver) is always doing something to/with them.

...and that's just the short list.

The Impending Storm

So if hospitals have operated like this for decades, why change now? There are several reasons, such as:

Medicare's value based purchasing or P4P program. This program will be initiated this October and will hold back 5% of a hospital's total Medicare payments. In a 200 bed facility that can easily equal \$5 million. You earn back the \$5 million through a pay for performance program that will monitor about 35 key quality measures. One of those is patient satisfaction. Even if a patient were to get the best of the best medical care, but still have to sit outside Radiology for an hour or two every other day during their stay, how do you think a patient would answer the 'satisfaction' question?

Continued pressure on payments and demands for cost control. This pressure continues as it has in the past. Recently the Obama administration announced they plan to cut health care expenditures by almost a trillion dollars. Financial survival will quickly become the watch word.

Process Re-engineering. A number of larger facilities have started serious process re-engineering programs. In some cases they have invested millions of dollars in sending their management staffs to attend Six Sigma, and LEAN programs. They now are beginning to implement these techniques, but for the most part the work they are doing is on the periphery of the patient. They are now beginning to see that knowing where the patient is at every moment of the day is absolutely critical to really making a difference in efficiency and care effectiveness. As further testimony to this new awareness many hospitals are investing in Electronic Bed Boards, in fact spending \$200,000 or more on them just so housekeeping knows when to clean a room. Soon they will realize the electronic board is only addressing a symptom and not the root cause.

Drive for greater departmental productivity. Because of reimbursement issues this process continues. But streamlining one department while not coordinating with other departments only results in half of the benefits, or probably less. Interdepartmental coordination of all patient activities must be established to really see significant operational benefits.

Introduction of commercial tools and people. More and more of the ranks of hospital operation executives are coming from commercial industry. Some of this is happening because of the introduction of more quality improvement initiatives. These new execs are expecting to find classic production control systems like they used in their commercial businesses. What they find is a serious lack of inter-department coordination, and nothing that even loosely resembles a production control system.

Increasing demand for inpatient beds. More and more hospitals are beginning to experience occupancy over 80 percent. After decades of operating at occupancy of 50-60% they are now struggling with significant throughput issues. Many ED diversions are caused by a lack of inpatient beds. Lost revenues from only one diversion can easily reach \$20,000, and add up to millions over one year. The brut force way to solve the ED diversion problem is to expand the ER by spending tens of millions on capital expansion, perhaps better spent elsewhere.

In a hospital I recently visited they told me based on a survey they did last year there were over 6,000 incidences when a care giver was sent to a patient room to complete a task but the patient was NOT in the room and the task had to be delayed. In some cases this delay (like administering an antibiotic med) in turn delayed a surgery, which in turn delayed a therapy, which then delayed a physician's assessment thereby delaying a discharge order, hence extending the patient stay – no doubt a day of care not paid for by Medicare.

The IPOP Solution

Care coordination across all medical and non-medical services for inpatients is almost non-existent in today's hospitals, yet it is the only way to address this glaring inefficiency. We believe process re-engineering and monitoring the work flow activities among current systems is the most viable solution.

Expanding or replacing your current HIS, even with an EMR, cannot address the problem of lack of care coordination. Here's why:

1. Both HIS and EMR systems are designed to deal with data and transactions. They are very good at moving transactions (orders /results) from one place to another, and storing the results in a repository called an EMR.
2. An EMR is not pro-active and does address work flow issues; in other words, what task needs to be done next, who needs to do it, what is its status, and what happens if it is not done on time?
3. An HIS focuses on ancillary medical activities and in some cases totally ignores support activities such as dietary consults, transportation, social services, financial consults, discharge instructions, and dealing with external services such as home health, rehab, and hospice.

The approach we call InPatient Operational Performance Improvement (IPOP) allows you to keep the existing scheduling and appointment systems you currently run but link them with processes improvement and work flow coordination tools which then allow you to realize the benefits without replacing existing software and thereby avoiding any added software investment. This less 'conflicted' approach continues to support department local control and thereby should rapidly gain the support of ancillary departments. IPOP's secondary goal is to significantly improve resource utilization in departments by improving care coordination through better inter-department communication and work flow management.

IPOP would link all departments and services, internal and external, medical and non-medical, via the following process tools:

1. Work flow documentation tools
2. Work flow analysis tools
3. Data extraction / integration tools
4. Process re-engineering tools
5. Simulation / modeling optimization tools
6. Work Portals

As an example, the Work Portal would present a complete patient itinerary of services and activities for a given inpatient for today, what needs to be done, who needs to do it, when, and the status of where things are as of this moment. In effect it becomes an intelligent, automated checklist that keeps every one (including the patient) aware of where things stand. In addition, it serves as a proactive tool telling us when things are falling behind, and what impact that will have on other services and goals such as discharge.

The Benefits

An IPOP services program offers the capability to coordinate ALL inpatient services across ALL ancillary departments. Some benefits would be:

- 1) Significantly improve patient satisfaction by eliminating or greatly reducing wait times at the ancillary departments (...and stop inpatients from having to sit in hospital attire in public areas!).
- 2) Increase revenue and market share by increasing capacity without increases in capital investment.
- 3) Improve productivity in each ancillary department.
- 4) Eliminate financial losses due to longer than allowed stays under DRG or managed care contracts.
- 5) Eliminate frustration for family members because patients are not in their rooms during visiting hours.
- 6) Avoid or eliminate large capital investments. In 2006 The Advisory Board Company did a study and analysis of Emergency department (ED) diversions entitled: 'IT's Role in Breakthrough Capacity Management' and noted this is a growing issue for many inner city large teaching hospitals. What they found was that in many cases hospitals in their study group could avoid the significant investment in expanded emergency room facilities if they focused on better care coordination for inpatients. They said the backlog of ED patients was a result of a bed shortage, even though most facilities ran at less than 80% utilization. In summary, they stated that quicker inpatient discharges would result in quicker ED admits, thereby eliminating ED diversions.

Health care organizations everywhere are committed to "working smarter, not harder" in order to make the most of their limited resources. That has meant streamlining work flow processes whenever and wherever possible, but the focus has always been departmental. IPOP would be a key tool in streamlining the inter-department care delivery processes.

For more information about IPOP and to discuss how the concept could be introduced to your management team contact Frank Poggio, at FLP@kelzongroup.com or call 312-303-0577.