

Portion Control Opportunities: Real Time Gains for Hospital Patient Throughput

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Streamlining the discharge process to increase bed availability is an outcome measure of multidisciplinary efficiency and effectiveness; it signals that the hospital's systems, people, and processes are aligned to deliver the best patient care possible. Getting patients in and out of beds smoothly is one of the toughest challenges in running a hospital today. Capitalizing on precious resources, saving on construction of new beds, and maintaining or even reducing costs in a time when access to capital is difficult are clearly among the ultimate goals of hospital leadership (Goldberg and Petasnick 2010). Being fiscally responsible while improving the inpatient discharge process demonstrates to stakeholders (e.g., doctors, employees, patients, community) that the healthcare organization has their best interest at heart.

Effective patient discharge is challenging. A problem in any one element (of the dozens involved) in the discharge process can cause delays in case management coordination and support services, the actual movement of the patient from the bed, follow-up care needs, and other next steps in care delivery. Many hospitals have streamlined the discharge process, assigning autocratic decision-making authority to bed "czars" to properly allocate in-demand resources to get the patient out and turn over beds to new patients coming from the operating room, the emergency department, or direct admission. This bed-czar system has helped, but it has not prevented lengths of stay from increasing, which has led to constructive criticism from stakeholders and reports of decreasing satisfaction from patients. This indicates that the facility's overall patient throughput requires re-examination. This can be best accomplished through an approach known as portion control opportunities (PCOs).

PCOs are the identification of smaller, more manageable issues that stem from a larger, broader, overarching issue. It allows the leadership team to concentrate on one key element to make the process change more targeted. For example, stating the goal "We need to improve hospital patient throughput" encompasses too broad an issue to effectively address. Instead, focusing on and solving for one of the many factors (PCOs) that make up the larger issue (in this example, hospital patient throughput) will present results in a way that is both manageable and attainable. A way to address

the potential PCOs in this case would be to say, “We need to improve our inpatient discharge process” or “We need to improve our bed management process” so that the issue needing improvement is clear and specific.

The challenge in improving the discharge (or any other) process is in making the inefficiencies of the current process quantifiable; that is, enabling the measurement of the money, time, and effort lost in following inefficient processes, which can be vast. This is especially true when staffing hours and supply costs are added. By narrowing the scope into PCOs, inefficiencies can be specifically and effectively identified, measured, and improved.

FIVE CONSIDERATIONS IN USING PCOS TO IMPROVE THE INPATIENT DISCHARGE PROCESS

Once clear-cut PCOs have been selected, leaders should consider five key process improvement elements to ensure success of the PCO. Each can be examined independently, but when used together these five elements can be foundational strategies for hospitals to eliminate obstacles to efficient and cost-effective patient throughput.

1. *Process mapping.* A process map is an essential tool for fully understanding how patients move throughout the system, how staff document and perform their daily tasks, and how physicians provide care. It allows operational processes to be assessed so that flaws in the system and opportunities for improvement can be determined. In process mapping, flowcharts are used to clarify processes and procedures. For example, a chart may identify how tasks are done, by whom, in what order, and how quickly (Whittenburg 2010). The flowchart must tell a story of specific processes, such as room turnaround, and must be neither too broad (which can lead to lack of focus and depth in analysis) nor too narrow (which may lead to missed opportunities by excluding a vital subprocess) (Hammer and Champy 1993). Process mapping consistently reveals the ideal versus the reality—how things should be done compared with how things are done. These revelations are eye-opening for finding inefficiencies.

A long list of items needs to be completed for each patient prior to discharge. The Joint Commission and AMA Discharge Standards require hospitals “to provide an assessment of a patient’s learning needs, abilities, preferences, and readiness that considers culture, religion, emotional barriers, physical and cognitive limitations, language barriers, and financial implications” (Goodman 2007). For a case manager this requirement, added to the task of filling out discharge paperwork, can be daunting; for a case manager with 15 to 20 patients, the amount of work is tremendous. Leaders must know how case managers capture all the necessary information and ensure that the task is done accurately and in a timely manner. Individual process maps for each case manager can help leaders in this regard. Leaders can see how each manager performs the task, how much time is spent on each task, and how the processes differ, and then they can develop strategies to eliminate variation and standardize practices for all case managers. A PCO in this case would be “improved discharge care coordination” and would include standardized indicators used per patient discharge, such as

- estimating discharge within 24 hours of admission,
- notifying the family of potential discharges at least 24 hours beforehand,
- initiating discharge orders by 10 am on the day of discharge,
- making home care and durable medical equipment arrangements,
- scheduling a follow-up appointment at least 12 hours before discharge, and
- providing patient education within 24 hours of admission.

2. *Quantitative and qualitative analysis.* Quantitative analysis is the standard in fact finding. A tracer analysis, for example, maps out point-to-point flow in minutes so that any breakdown in process can be defined incrementally. Knowing that the overall discharge time (order written to room ready for new patient) took six hours is not enough information to indicate which section of the six-hour increment caused the breakdown. Was it the discharge order written to room vacated? Was it the room vacated to room released by environmental services? By understanding exactly where the process failed, leaders can focus their efforts on a specific section of the overall process and get results quicker. These focused efforts are PCOs in action.

Qualitative analysis is harder to interpret, as the data can be subjective. Take patient and staff satisfaction scores. We can surely measure ourselves in peer comparisons and in the consistently low or high scores given, such as for the question, "How well did the nurse keep you informed during your stay?" (Press Ganey 2009). Furthermore, providers soon will receive federal payments on the basis of the satisfaction scores they attained as compared with those of their competitors (Clark 2011). In this case, the PCO would be, "How can we improve nurse/provider-patient communication?" One concept that has been successful is the concept of teachback (Clark 2011). Providers are being retrained to take their time in explaining medical procedures and to make sure patients and their family/caregivers understand the condition, treatments, implications, and necessary steps to recovery. Patients are asked to repeat verbal or written instructions to the provider to demonstrate their comprehension. Repeating the information helps patients retain it, and explaining what they understand the instructions to be can curtail any misinformation and make sure the right message is received.

3. *Software solutions.* Once process maps have been completed, how can the identified manual steps be removed to streamline and enhance the current discharge-order process (a PCO in itself)? Looking at the work flow of physicians and staff to see if the online documentation process matches their current work flow is one of the simplest and most rewarding improvement steps. Often, the way information systems are set up is counterintuitive to the way the work is completed, creating frustration among users and the loss or inaccuracy of data capture. Furthermore, the word "stat" is built into our healthcare vernacular, indicating that labs, diagnostic imaging, and other ancillary services are needed *now*. Should this stat framework, then, be

used to electronically alert the relevant departments that a patient is pending discharge? The hospital is viewed as one entity that works together to deliver efficient and effective patient care. Therefore, a simple software enhancement would ensure that the departments recognize the urgency of a pending discharge and are coordinating their efforts for prompt patient discharge.

4. *Staffing and skill mix.* A software enhancement that provides pending-discharge alerts could also run a variety of reports, such as the number of pending discharge orders. This status report allows leaders to see which discharges are delayed and why—a PCO, especially when the reason is related to staffing. For example, was the delay caused by a patient waiting four hours for a physical therapy consult? If so, leaders could adjust the schedule or staffing to better meet the patient needs—another PCO. If not, leaders can identify other reasons, such as gaps in staffing or coverage.

When examining discharges by hour of day compared with admissions by hour of day, the clear trends are that discharges peak before change of shift and admissions halt at change of shift. If environmental services staff have the same schedule as the nursing staff, what results is a perpetual delay in turning over beds—a PCO, because both sets of staff are coming and going at the same time. If environmental services staff have a different shift change, then they could be turning over the beds vacated by discharged patients; by the time nursing staff get settled in after change of shift, the beds could be filled with new patients who have been waiting in the emergency departments, for example. This removes an admission roadblock for the ED border—another PCO solved.

5. *Project ownership.* If the discharge-process improvement is going to be successful, a designee from senior leadership must sponsor the engagement. Even though the project may involve relatively mundane PCO tasks, such as collecting data and information, preparing the process maps, and brainstorming software solutions, the senior leader is essential to the initiative. If the directive is not coming from the top and those leaders or their representatives are not at the meetings to monitor the progress and the direction of the project, the project will fail. Both the project sponsor or owner and the project manager have to be involved. The owner should be able to quickly make decisions regarding the project's delivery, scope, and budget, while the manager should guide the implementation to success (Kotter 1995; 2002).

CONCLUSION

Identifying process breakdowns through an incremental PCO approach can improve inpatient discharge. This strategic method can have a significant impact on care delivery and can ultimately save the organization thousands of dollars in rework and other inefficiencies. There is no need for the big bang theory approach or for “creative destruction”—the oxymoronic phrase for the concept of blowing up the existing order to create a better system (Kocher and Sahni 2010). Taking a different look at routine processes to determine failures and introduce improvements can lead to considerable organization-wide improvements.

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