

A Hospital's Experiment Leads to Better Patient Flow and Care

Larry Beresford

May 07, 2015

Suffering From Poor Patient Flow

A recent article in the *American Journal of Medical Quality* describes the Patient Flow Management Center (PFMC) at the three-hospital, 935-bed Thomas Jefferson University Hospitals system in Philadelphia, Pennsylvania, which resulted in improvements in rates of emergency department (ED) walkouts, ED and post-anesthesia care unit (PACU) boarding, ambulance diversion, and average elapsed time from ED door to hospital bed.^[1]

The comprehensiveness of its approach is noteworthy, as are its implications for hospitalists and for other hospitals. "This is about taking non-value-added steps out of the process and getting rid of the 'silos' of bed management," said lead author Paris B. Lovett, MD, MBA, emergency medicine specialist at Jefferson. "Lots of hospitals suffer from poor patient flow. The problem is the hospital itself being very full—with a mismatch of demand and supply that impacts a lot of areas. We were having all of these problems [at Jefferson]," Dr Lovett said, adding that poor patient flow affects quality, safety, patient experience, cost management, and growth opportunities for the hospital.

In 2010, Jefferson found itself with symptoms of poor patient flow. In 2011, the system's chief operating officer sponsored a balanced-scorecard program to apply formal change processes to improving patient flow, including three half-day "WorkOuts" that used quality improvement processes developed by GE to design a system that could serve as Jefferson's nerve center for patient flow.

Creating a Shared Service Center

The result was Jefferson's PFMC. With an open floor plan and 18 pods, it allows the three-hospital system to integrate services that, in other hospitals, typically do not share management or reporting relationships and are not located in a shared workspace, including:

- Environmental services for cleaning rooms;
- Within-facility patient transport;
- Around-the-clock bed management by a patient flow clinical supervisor who is a critical care nurse;
- Dispatch for local ambulance services and for advanced life support air and ground transport;
- Transfer center for coordinating transfer of patients from other facilities; and
- A single technology platform for all of these functions.

The patient flow team also includes physicians and case managers, with state-of-the-art data and voice communication. Daily bed meetings are held with nurse managers, and notifications of impending hospital admissions are communicated to the relevant staff electronically.

"Coordination and communication are keys to our success," said the center's director, Megan Illg, MHSA. "By bringing all of these services under one umbrella, with centralized authority at all levels, it's more seamless and organized for all transfers of patients into the hospitals, admissions, and discharges out of the hospital."

Centralized placement maximizes bed availability across multiple campuses, while direct admits from community physicians also flow more smoothly. PFMC staff are provided with training, guidelines, and algorithms for maximizing workflow, Illg says. In the hospitals, clinical pathways and checklists help to standardize processes of care for conditions such as congestive heart failure, pneumonia, gastrointestinal bleeds, and strokes. Results after implementing the PFMC include increased monthly admissions, ED visits, and completed patient transports, while ambulance diversion decreased from 87 to 7 hours per month and median times from ED door to provider went from 74 to 41 minutes.

"Whether patients are discharged before 12 or after 2 can make a big difference to patient flow," Dr Lovett says. "And hospitalists have a significant influence on length of stay and time of discharge." Hospitalists are more heavily invested in change and more willing to get on board with new approaches like these, he says.

"We used to have a medicine admitting resident who would review patients presented in the ED for admission. That was a little bit redundant and added time stress," said hospitalist Luis A. Taboada, MD, section leader for hospital medicine teaching services at Jefferson. It made it harder to reach Joint Commission targets for ED admissions within 4 hours. "Sometimes there would be back-and-forth disagreements about whether a patient was appropriate for the hospitalist service. Now, when the patient is admitted through guidelines based on diagnosis, the alerts are sent to us. It means that the patient is taken care of in a more streamlined fashion."

Hospitalists at Jefferson have served on the committees that helped to streamline the processes of patient flow, Dr Taboada added. "We're major stakeholders. We had a meaningful voice, and it increased the value of the hospitalist group to the hospital administration."

Illg said that streamlining the process in this way is also more satisfactory for primary care physicians. "The Philadelphia marketplace has a lot of choices of academic medical centers." This more convenient process of patient flow can be an important asset for referrals from physicians and from community hospitals. One area where further improvement is needed, she said, is the geographic placement of the patients that hospitalists see. Jefferson is now discussing an approach of designated geographical areas for its hospitalists.

References

1. Lovett PB, Illg ML, Sweeney BE. A successful model for a comprehensive patient flow management center at an academy health system. *Am J Med Qual.* 2014 Dec. 30. [Epub ahead of print]

Medscape Internal Medicine © 2015 WebMD, LLC

Cite this article: Larry Beresford. A Hospital's Experiment Leads to Better Patient Flow and Care - *Medscape* - May 07, 2015.

This website uses cookies to deliver its services as described in our [Cookie Policy](#). By using this website, you agree to the use of cookies.

[close](#)