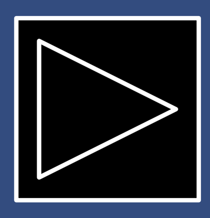
Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Patient Progression Rounds 2.0

TAP TO GO BACK TO KIOSK MENU



Introduction/Problem

BIDMC is continuously striving to improve the quality of care, patient safety and timely access to care without increasing pressure on staff. With high demand and a fixed number of beds the best approach to improving care is to reduce unnecessary hospital days. Excess hospital days are not in our patient's best interest in terms of either safety or quality, nor in the interest of patients who are unable to access our services when our inpatient beds are full.

Aim/Goal

If successful this work will result in:

- Well-coordinated plans leading to higher quality care
- Improved bed availability and reduced length of stay
- Earlier discharge on the day of discharge
- Improved teamwork

A reduction in length of stay as measured by the CMS Length of Stay Index

Specific targets:

- Internal Medicine LOS Index 1.05
- Cardiology LOS Index 1.05
- Hem/Onc LOS Index 1.25

The Team

Project Sponsors: Tony Weiss and Marsha Maurer

Project Leader & Manager: Improvement and Innovation (i2) and Goldratt Consulting

Team Members: Representation from Nursing, Social work, case management, IS, i2, APP leadership, Physician leadership, Hospital Senior leadership

The Interventions

In May 2018, BIDMC partnered with Goldratt Consulting to pilot Patient Progression 2.0 on 12 Reisman, Rosenberg 6, Rosenberg 7 and Farr 7. A key concept in this approach is the Planned Discharge Date (PDD), which is based entirely on the expected clinical needs and recovery of the patient. The PDD is used as a marker to distinguish between appropriate clinical variation and true (non-clinical) disruption and delay. In addition to daily task and progression management, the approach offers insights into the top constraints causing the greatest disruption and delay across the hospital. As a result of the pilot the Case Manager role was identified as critical to patient progression Additional staffing has been approved to address this constraint, including additional RN Case Managers and a Community Resource Specialist to focus on challenging guardianship issues.

In addition to understanding the need for additional resources, some other key learnings and additional areas of opportunity were identified by frontline users. These were further explored at a PPR Summit in early January, attended by 90 BIDMC team members.

The three key areas for additional refinement are:

- Creating a plan of care, both clinically and logistically focused
- Getting a Day Ahead
- Enhanced surveillance and management of complex patients

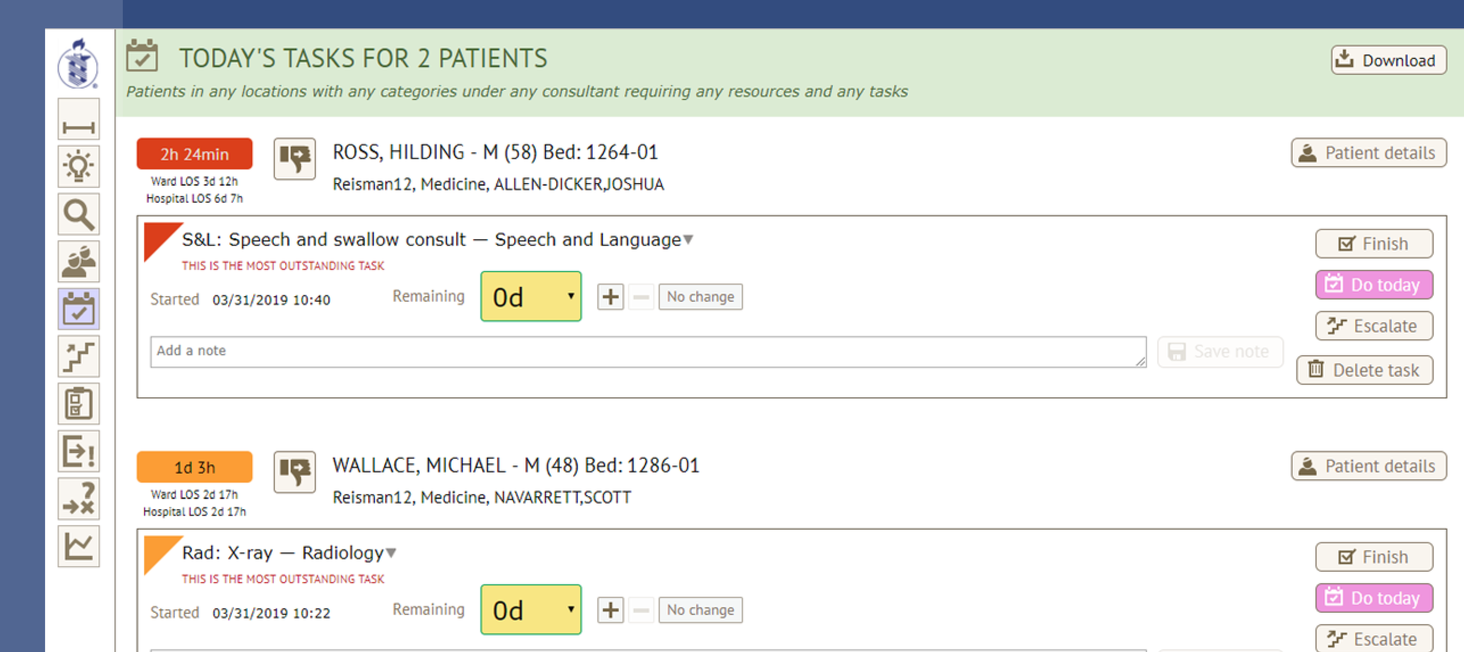
Design teams were then formed to address each topic and create some solutions to implement.

Results/Progress to Date

1. Implementation of the Task Manager Tool on 4 units:
   - Farr 7
   - 12 Reisman
   - Rosenberg 7
   - Rosenberg 6

2. Buy in and engagement from multidisciplinary teams across the organization

3. Identification of highly motivated, skilled resource nurses to utilize as trainers for the next phases of the rollout



For more information, contact:

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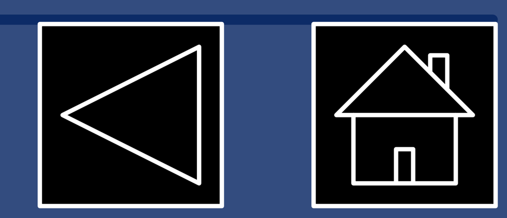


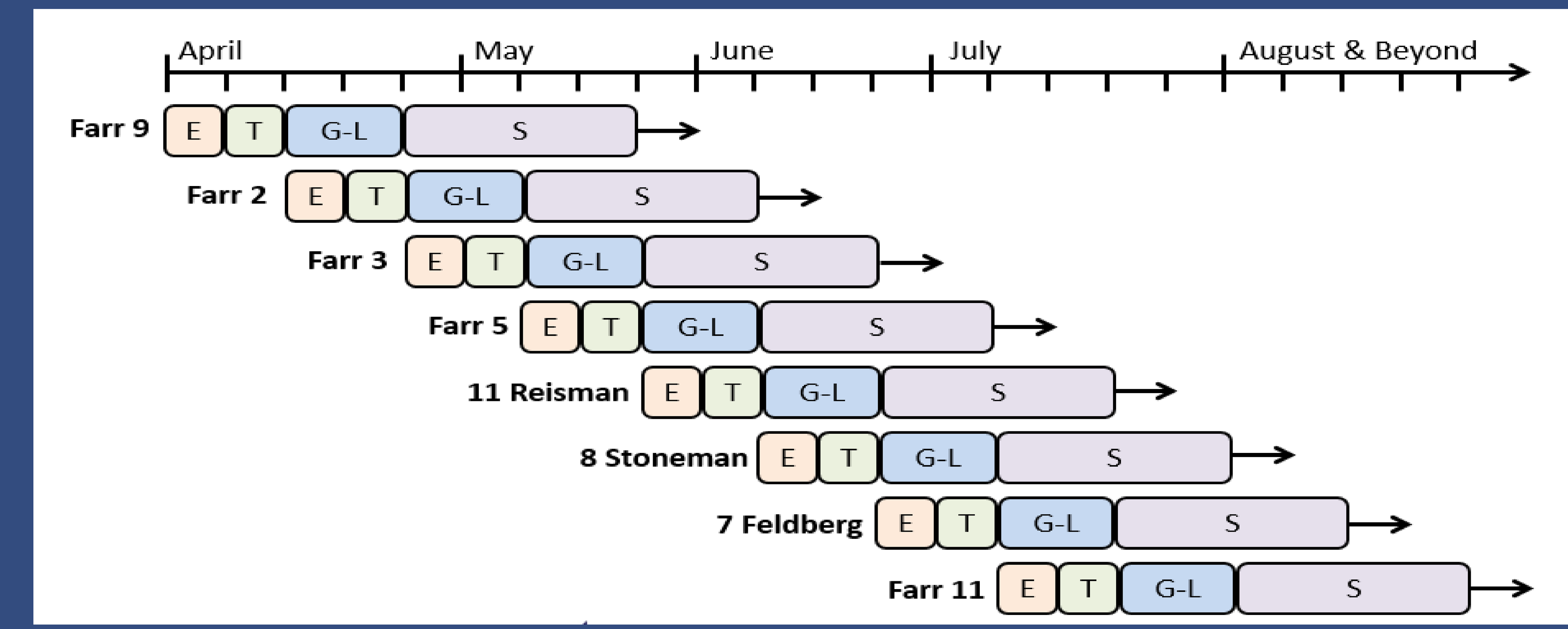
Next Steps

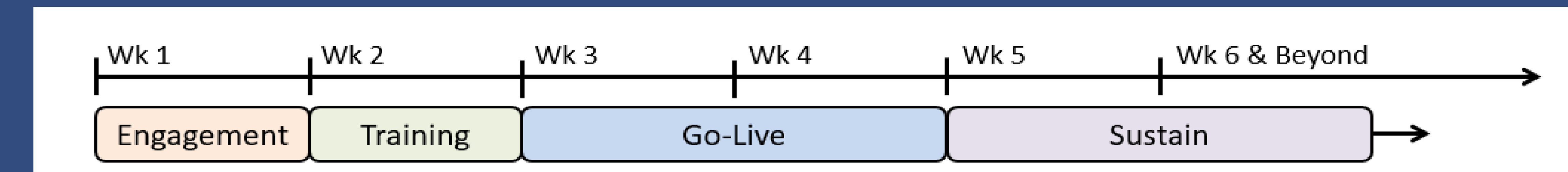
Each floor will use a redesigned structure for Patient Progression Rounds, **that utilizes a meeting "chair" to facilitate cohesive plans of care**

In addition, the complex case management team has undergone some restructuring and now conducts **daily surveillance of potentially high risk of delay patients**. Clinical advisors then support floor case managers to identify and remove potential barriers.

Work with IS to streamline the **Discharge Paperwork process**

Rollout Schedule for Remaining Units:





Lessons Learned

In order to create a cohesive plan of care for patients, both the clinical and logistical needs must be considered. This is only possible when each member of the care team supplies key information from their subject matter expertise to the discussion.

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