Blazing a trail with patient-centered scheduling

RICK BRIMEYER
Brimeyer LLC
He is president of the Ames, Iowa, consulting firm

Hospital stays are steadily becoming shorter. That's generally a good thing. Patients want to be home. Shorter hospital stays means smaller bills.

But shorter stays also present challenges for hospitals. Sending patients home before they are ready can result in a relapse. Hospitals are penalized by Medicare for re-admissions. Shorter stays also mean that all of the tests, treatments and therapies required for a safe discharge must be completed during a compressed time period.

Late in 2016, I joined a cross-functional team of Mary Greeley Medical Center employees for a three-day rapid improvement event to address this challenge. Frequent schedule conflicts between ancillary services (e.g., lab, therapy, radiology, etc.) were identified as a major barrier to timely patient discharges. The daily schedule conflicts also were a source of employee frustration. Trying to fit all of the required services into a short stay was akin to playing an advanced level of Tetris.

The root cause of the issue was the fact that, while each provider had an independent schedule, these schedules were not coordinated with each other or shared with the most important person — the patient. Each provider basically showed up, hoping to find a ready patient. That rarely was the case. In effect, the game of Tetris was being played blind.

This situation was certainly not unique to MGMC. Prior to the event, we asked the hospital's software provider for advice on who we could benchmark since it includes a scheduling module in its system. Despite counting hundreds of hospitals among their customers, they couldn't point to a single facility that was practicing patient-centered scheduling. We were blazing a new trail.

Because of the monstrosity of the change, we agreed to two strategies while planning the event. First, we set the goal to pilot the concept on a small patient unit rather than facility-wide. The oncology floor was chosen because of its smaller size and highly predictable rounding by tending physicians.

Second, we made it clear that we expected improvement rather than perfection. In fact, the term "betterish" was coined to promote trying something that would move us in the right direction.

A team of 17 employees and leaders from oncology, as well as most of the ancillary departments, gathered for three consecutive days. Unlike most events, the solution was pretty clear. We needed to use the scheduling software tool available to us and begin scheduling all pertinent activities that impacted inpatients on the patients' schedule. The challenge was how to convince already stretched oncology nurses, X-ray techs and therapists to take the extra time to coordinate their daily schedule with the patients' schedules and to resolve conflicts.

Fortunately, most of the participants clearly recognized the waste experienced every day due to schedule conflicts. They saw the added time required to coordinate with the patients' schedule as a worthy investment of their time.

Significant time was required during the event to work through the details:

- What about those activities that are really short (e.g. blood draw)?
- How do we react to unforeseen situations that cause the schedule to change?
- How do we make the schedule visible to everyone who needs to see it and private to those who don't?
- How do we share the schedule with patients and families?

A challenge became obvious early. Even though we were piloting solely on oncology, ancillary departments would have to schedule all departments in order to have schedule integrity for oncology patients. Thus, ancillaries would have the work of scheduling all patients but would realize the benefits of reduced conflicts from oncology patients only initially. Nevertheless, each department "contracted" what they would do to support the pilot.

The pilot was kicked off. Monthly follow-up meetings were required to tweak agreements, address new barriers and, most importantly, provide positive feedback to those implementing change.

And there was plenty of positive news to share. Oncology nursing staff recognized an immediate improvement in patient schedule integrity, allowing them to confidently share the daily plan with patients and their families. Float nurses working shifts on oncology returned to their regular floors with questions of when they would be using patient-centered scheduling.

Even ancillary departments noted improvements in schedule integrity for their services, despite oncology representing a small portion of their workload. As one leader stated, "This is better than betterish!"

Positive feedback resulted in expanding the pilot to larger patient floors faster than originally anticipated. Initial fears that it would be chaotic to expand patient-centered scheduling to more complex patients turned out to be unfounded. Rather, it was chaos trying to deliver services without a schedule.

Today, patient-centered scheduling is the standard across all inpatient units of MGMC. By continually working as a team to address new barriers and using data to identify opportunities, 75 percent of appointments now occur within 30 minutes of schedule. The result is informed patients and families along with higher performing and less frustrated health care workers.

RICK SAYS

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