Outpatient Care Re-Imagined at New York-Presbyterian

Planning an $896 million ambulatory care center from the ground up has given leaders at New York-Presbyterian Hospital an opportunity to rethink their outpatient surgical services with operational performance in mind.

Leaders at New York-Presbyterian Hospital think outpatient care should be easier, faster, and less institutional than inpatient care. That’s why they are building a new $896 million outpatient center, scheduled to open in 2018.

They aren’t alone. Other health systems in New York and elsewhere are focused on growing their outpatient services, which typically account for 40 percent of a hospital’s revenues. Under health reform, that number is expected to grow.

“As bundled payments become the norm, providers that can deliver efficient outpatient services and coordinated care will have an advantage,” says Tracy Johnson, FACHE, vice president, Health Strategies & Solutions, Philadelphia.

Freeing Up Capacity
New York-Presbyterian Hospital’s proposed outpatient building, called the David H. Koch Center, offers an opportunity for the system to make its outpatient care more patient-centered while improving operational performance. In March, state health regulators offered the preliminary stamp of approval to the plans.

For years, the five-hospital, 2,300-bed institution has been running at capacity in both its inpatient and outpatient surgery services, which currently share the same procedure spaces. Outpatient surgeries at the Weill Cornell campus grew nearly 19 percent from 2009 to 2011, and the hospital has more than 1.5 million outpatient visits each year, says Ellie Dalton, AIA, vice president of capital asset planning.

The proposed 450,000-square-foot outpatient building will expand capacity for both inpatient and outpatient surgery. By shifting outpatient cases to the new facility, operating room (OR) capacity in the main hospital will be freed up to better accommodate complex inpatient procedures. The new building will also consolidate ambulatory services, such as radiation therapy and infusion, that are now sharing space with inpatient services. The goal is to reduce fragmentation and increase ease of access for outpatients, Dalton says.

The ambulatory services center will have 30 procedure rooms for surgery, endoscopy, and interventional radiology. The building will also house preadmission testing, diagnostic imaging, prep/recovery, and gastrointestinal specialty physician practices to enhance integration and coordination of services.

Mapping the Processes
During the early planning stages of the new outpatient building, leaders at New York-Presbyterian Hospital embraced a Lean manufacturing technique called value stream mapping, which is used to identify waste—such as unnecessary movement, delays, and extraneous steps—in patient care processes.

Multidisciplinary task forces documented each step that a patient experiences when visiting the hospital for an outpatient procedure today. Once these steps were charted, they identified opportunities to streamline processes, bring services to patients, or use technology to eliminate tasks or movement (see the exhibit on page 7).

The value stream maps revealed several themes, Dalton says. “There were quite a few extra steps around assembling and consolidating the patient record and registering patients for their procedures.” To help speed check-in at the new building,
the hospital plans to add IT solutions, such as online preregistration.

The value stream maps also revealed inefficient patient movement between services, which increases the number of handoffs and the amount of time required to complete the process. “Ultimately, we wanted the patient to have to navigate as little as possible and bring the services to them,” Dalton says.

To that end, the new building will include private prep/recovery rooms adjacent to each procedure area. The patient will check directly into the prep/recovery room on arrival and receive all services in one place.

This includes identification/procedure validation, vitals, changing, IV starts, and other prep before the procedure, as well as recovery and discharge processing.

“One of the big ‘aha’ moments was when we concluded how important the right number of prep/recovery rooms was to getting patients through the OR,” Dalton says. “Physicians may not always recognize that, sometimes, it is not so much that we need one more OR, but that we need two more prep/recovery rooms.”

In its new ambulatory services building, the hospital plans to have three dedicated prep/recovery rooms for every procedure room. To arrive at that 3:1 ratio, hospital leaders looked at their “best-worst day”—or the 12-hour period that would include the maximum number of their longest procedures.

A simulation model showed that three prep/recovery rooms were needed for every procedure room to avoid bottlenecks and still allow patients to return to the same room without moving their belongings or families. Time and staff resources would also be saved by not having to turn over the rooms as often.

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Establishing Performance Targets
“Having a dedicated outpatient facility gives hospitals the opportunity to reduce variation in scheduling and supplies and, thereby, reduce average case time and processing time,” says Beryl Muniz, RN, MAS, vice president, perioperative services.

For example, New York–Presbyterian Hospital has a centralized sterile processing department that picks and prepares all of the surgical supplies and instruments. The sterile processing team keeps preference cards for each type of procedure on file, so they know what to send back to the procedural suite in case carts.

This saves the surgeons, nurses, and OR techs valuable time looking for supplies during the case. Since all supplies are kept in sterile processing, rather than in the procedure areas, the hospital reduces unnecessary duplication.

In the new building, hospital leaders plan to expand the use of preference cards to nonsurgical procedures, such as interventional radiology and endoscopy. These areas are not usually standardized with preference cards and pick lists. Muniz says this will create significant efficiencies for the technical staff and allow them to be more patient focused.

According to Muniz, the hospital has set the following performance targets for its new building:
> A 10 percent decrease in case times for outpatient procedures
> A 10 percent reduction in supply costs per case

Source: New York-Presbyterian Hospital and Health Strategies & Solutions, Inc. Used with permission.

As part of its value stream mapping process, New York-Presbyterian Hospital mapped every step a patient currently goes through when coming to the hospital for an endoscopy procedure. The revised process cuts out 10 steps that were determined to be unnecessary. Access a readable version of this map at hfma.org/sfp, Summer 2013.
A 15-minute turnaround time for outpatient cases (compared to a current turnaround time of about 30 minutes, a statistic that blends both inpatient and outpatient procedures)

“What matters most to the physician is minimizing the time spent turning over rooms between cases,” Muniz says. “The easier you can make it for them to get in and do more cases, the happier they are.”

Learning Along the Way
Leaders at New York-Presbyterian Hospital offer this advice for other health systems planning to move their ambulatory services to a dedicated building.

Gain buy-in from clinical leaders early on.
Having department chairs agree to the business case for the new building was a critical step for planners at New York-Presbyterian Hospital.

When physician leaders understood that a dedicated outpatient building offered a chance to improve patient care as well as their own productivity, they helped gain buy-in across the organization, Dalton says. Each clinical area had a task force that included physician leaders who helped set volume targets for the new building.

Don’t jump into design too quickly. If possible, take time to plan ahead. “You need to allow time for your vision to evolve before you get into design,” Dalton advises.

For example, thinking about similarities among interventional radiology, endoscopy, and other outpatient procedures allowed planners at New York-Presbyterian Hospital to standardize room designs that could be easily adapted for emerging new procedures and collaborative approaches.

Collaborate with support services. Staff from laboratory, pharmacy, and environmental services need to understand the new “bar” for performance in an outpatient setting and how they can help achieve that goal.

For instance, in the new outpatient building, onsite lab testing will be located next to the infusion area, and a frozen section lab will be located in the ambulatory surgery suite to ensure quick turnaround times on specimen and lab testing.

In addition, environmental services staff will conduct regular rounds to remove trash and keep patient areas tidy during the day but leave the heavy cleaning for after hours to minimize disruption to patients and staff.

Ensuring More Predictable Scheduling
Fueling many of these changes at New York-Presbyterian Hospital is the idea that efficiency leads to more satisfied patients and families. When inpatient and outpatient surgeries share the same procedure rooms, outpatients often are affected by emergencies and inpatient cases that go longer than expected. This can lead to patient dissatisfaction and operational inefficiencies.

“Having a dedicated outpatient facility gives hospitals the opportunity to reduce variation in scheduling and supplies and, thereby, reduce average case time and processing time.”

New York-Presbyterian Hospital hopes to further enhance its patient satisfaction scores through more predictable scheduling in the outpatient center, as well as redesigned patient flows that reduce patient and family movement. “The real competitive advantage in outpatient care is to put it together better,” Johnson says.

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### Strategies to Reduce Case Times for Outpatient Procedures

- Screen out any high-risk outpatient cases to reduce variation, risk of transfer to the hospital, or unexpected events.
- Schedule cases grouped by specialty for greater efficiency.
- Minimize teaching onsite.
- Establish an adequate ratio of prep/recovery beds to procedure rooms (e.g., 3:1) to ensure flow and minimize delays to and from the OR.
- Establish cleaning processes for faster turnover of procedure rooms.
- Centralize sterile processing and supply picking to minimize stocking requirements in procedure areas.
- Create an efficient workflow with dedicated, circulating staff to facilitate quick turnaround of cases.
- Create a dedicated outpatient environment to eliminate delays caused by inpatient cases and processes.

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