"Managing up" to improve patient flow

How to convince administration to invest in throughput (and your group)

Keywords: Convincing hospital executives to invest in throughput

by David J. Yu, MD, MBA

Published in the December 2014 issue of Today's Hospitalist

Editor's note: This is the third in a series of articles on how to improve patient flow. The full series covers three themes:

1)Are you fixing patient-flow problems or causing them?
2)Getting rid of what doesn't work
3)"Managing up" to improve patient flow

MANY HOSPITALIST GROUPS find themselves with not enough staff or resources to move patients efficiently through the hospital. That leads to group directors standing in their CFO's office and complaining: "My doctors are overworked, and I feel this is unsafe!"

Of course, your doctors are overworked. But instead of playing the patient safety card, which the C-suite is already immune to, hospitalists need to approach hospital leadership with solutions.

You need not only data, but analytics to convert data into potential innovations

In my previous articles, I discussed how patient flow should be an enterprise-wide strategic initiative if hospitals are going to survive in the new financial environment. I've covered new processes to consider and old ideas to question.

In this article, I want to discuss how our hospitalist group— the Adult Inpatient Medicine Service (AIMS), part of the Presbyterian Medical Group in Albuquerque, N.M.—"managed up" and convinced leadership to invest major resources.

What kind of resources? Since 2010, AIMS has grown from 10 rounding teams to 18, from one swing shift to four and from two overnight shifts to three. We also launched a program of RN triage and cross coverage that now has nearly eight RN FTEs.

With one rounding team an annual commitment of half a million dollars, our administration has made a tremendous investment—not necessarily in a hospitalist group, but in a throughput process. That investment has paid off: We implemented unit-based rounding throughout the hospital, and cut the left-without-being seen rate in the ED from more than 10% down to 2% and made ambulance diversion a rare event. All the additional staffing costs have been more than offset by the cost savings we've realized through improved patient flow.

But first, we had to make some persuasive arguments. We needed not only data, but analytics to convert those data into potential innovations.

New metrics

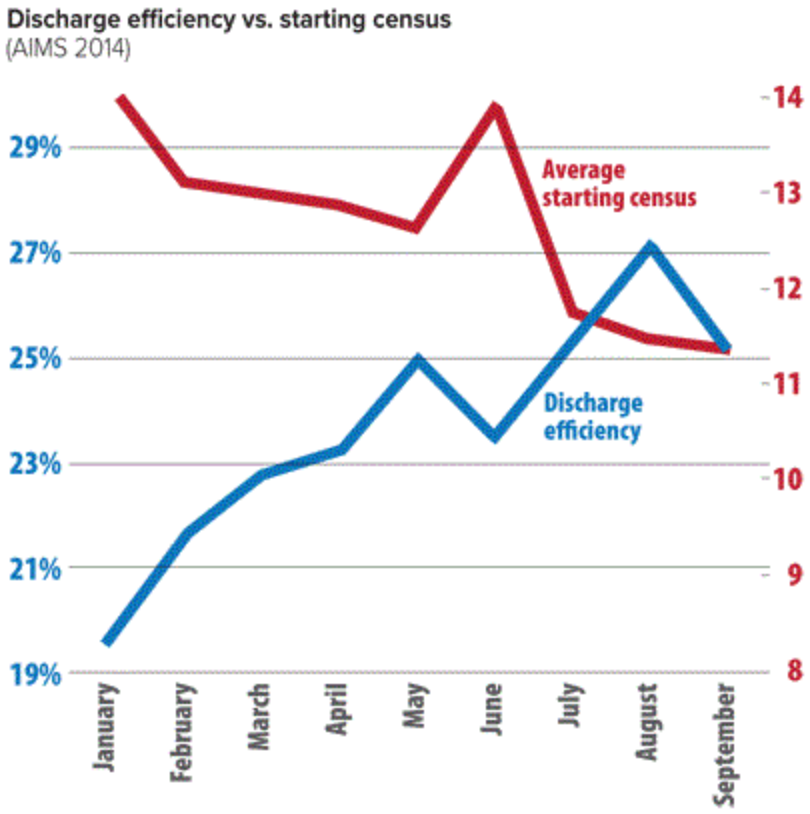
To measure hospitalist productivity from the point of view of throughput and cost reduction, our hospitalist group developed new metrics.

One metric we follow closely is what we call "discharge efficiency." We define discharge efficiency as the number of discharges we make over 24 hours, divided by the starting census.

If you start with an average census of 100 patients and consistently discharge 20 patients per day, your discharge efficiency is 20%. Start with the same average census and 25 consistent discharges, and discharge efficiency jumps to 25%.

Calculating discharge efficiency also allows you to approximate your average length of stay (aLOS) by dividing 100 by your percentage. A 20% discharge efficiency translates to an aLOS of five days, while 25% delivers an aLOS of four days. That small 5% swing drops aLOS an entire day!

Since 2010, we have maintained our own internal data, which show that discharge efficiency is extremely sensitive to the average starting census. That census, in turn, directly reflects both the number of rounding teams and each rounding physician's workload. We have repeatedly used our analysis of these data to persuade administration to hire more doctors and reduce their daily census.



When we first launched unit-based rounding in 2010, for instance, we started with one 52-bed unit we called Unit Base One. Within four months, our analysis of that unit data showed a significant aLOS improvement. We quickly came up with a business proposal to spread unit-based care to two more medical floors, a proposal administrators immediately adopted.

Controllable costs per discharge

To demonstrate that we are bending the cost curve, AIMS also looks at controllable costs per discharge. That is basically our total cost of the program minus bad debt divided by our number of yearly discharges. On a unit basis, this demonstrates how much the program costs the organization.

Going back to our launch of Unit Base One and Unit Base Two, we demonstrated that after 21 months, Unit Base One had added $2.2 million to the contribution margin by lowering aLOS and increasing admissions.

For Unit Base Two, executives wanted to see how reducing aLOS would also decrease variable expenditures; we showed that after 15 months, we reduced variable expenditures on Unit Base Two by $1.3 million, due to patients' spending less time in the hospital. Adopting unit-based care also allowed hospitalists to increase admissions from 12,503 in 2010 to 14,411 in 2011, a 15% increase.

This year, by comparison, AIMS is on track for more than 18,500 discharges. As for our controllable costs per discharge, we've reduced those from 2010 to 2013 by $162 per discharge as a unit cost.

These are great illustrations of how AIMS has approached our CMO, CFO and COO to discuss budgets, which in turn drive processes. Hospitals are obsessed with financial metrics, year-end margins and bond ratings. The reality is that senior officers can expect very little corrective action if they do not meet goals or budgets.

Hospitalist directors need to understand the C-suite's language and motivations so they can discuss process and resource allocation and determine a mutual solution.

Instead of complaining that our hospitalists were overworked, we documented an inverse relationship between average team census and discharge efficiency. That got administrators' attention. While every department wants more resources, we found a way to successfully compete for an ever-bigger slice of a shrinking pie.

Developing leaders

I've been very fortunate that both my director of practice operations and myself have MBAs and, between us, about 40 years of health care experience. This gave us incredible advantages in interacting with administration.

At the same time, I see a trend for hospitals to outsource their hospitalist programs to corporate management companies. I feel this often reflects administrators' lost patience with what they perceive as poor group leadership and ineffective programs.

It takes time and resources to develop or recruit topnotch medical directors, and they are often set up to fail. I am concerned that our field so frequently promotes young physicians into leadership positions where they (understandably) lack business and management skills or they become the mouthpiece of either administrations or corporate management companies.

I recently tried recruiting an applicant who was just a year and a half out of residency. I was thinking about how we could mentor him as an attending, but another group offered him a director's position and he accepted!

Would a surgery group make a junior attending with less than two years' experience the section chair? Obviously not, so why is this acceptable in our field? Seasoned physicians with decades of clinical and management experience must step up to leadership positions and get the necessary training and business and administrative support.

Otherwise, our field will suffer. It's going to take great leaders to improve patient flow and reduce costs. While we implement innovations to unclog hospitals, let's also develop the skills

that hospitalist leaders need.

David J. Yu, MD, MBA, is the medical director of Adult Inpatient Medicine Services with Presbyterian Medical Group at Presbyterian Hospital in Albuquerque, N.M. You can send him questions or comments to dyu3@phs.org. - See more at: http://www.todayshospitalist.com/index.php?b=articles_read&cnt=1976#sthash.PrX0gYbe.dpuf