Optimizing Patient Throughput and Capacity

Key Strategies for Health Systems to Improve Financial Performance

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With many health systems today operating on razor-thin margins, the question arises: How is it possible to focus on accelerating hospital patient throughput as a means of reducing costs, improving outcomes, and driving new revenue when existing hospital resources are already stretched to their limits?

As C-suite executives at U.S.-based health systems adapt their strategic priorities to the realities of the current healthcare environment and macroeconomic pressures, leaders need to consider how their decisions affect the ways care gets delivered to their patients and communities.

Leaders must act with more urgency in the face of massive financial pressures. They can no longer introduce changes incrementally. And to reverse the downward trend, they must take a more holistic approach to business model reinvention that will drive revenue growth at the same time operating costs are addressed.

ECONOMIC SNAPSHOT

↓5%

Decline in hospital outpatient revenue as of March 2024[1]

↑12.4%

Amount inflation grew from 2021 to 2023 — more than 2x faster than the growth of Medicare reimbursement for hospital inpatient care[3]

↓28.3%

Decline in hospitals' and health systems' number of days of cash on hand since 2022[4]

$130 billion

Underpayment from Medicare and Medicaid in 2022, with Medicare paying $.82 per dollar that hospitals spent caring for patients, which resulted in a shortfall of almost $100 billion[5]

↑20.2%

Increase in claim denials by commercial payers in 2023[4]

↑19.7%

Increase in the time taken by commercial payers in 2023 to process and pay hospital claims from date of submission[3]

Consider the Economic Realities

Demand for higher acuity care is rising while financial instability is growing worse. Meanwhile, ongoing workforce shortages, disruptions in supply chains, and high levels of inflation have collectively driven up costs, creating an environment of financial uncertainty for many hospitals and health systems across the United States.

The post-pandemic rebound is also showing troubling signs. After a historically challenging year in 2022, in which more than half of U.S. hospitals closed out the year operating at a loss, many hospitals spent much of 2023 struggling to break even. That trend has continued into 2024. And even though the first two months of 2024 showed some operating-margin growth, March saw a dip in operating margins with hospital outpatient revenue declining 5%, reflecting the competitive challenges of providing outpatient care amid a shift to less-expensive retail clinics and urgent-care centers.[1]

But there are some bright spots. 2024 shepherded in more merger and acquisition activity, and some hospitals are expanding into high-performing service areas and testing value-based care approaches to offset the losses.[1] At the same time, there are signs of improvement among the top 20 large nonprofit health systems. Most of them reported higher patient volumes, which translated into higher operating and net margins in the first three months of 2024 compared with the same period in 2023.[2]

Financial Impact on Hospital Operations

As financial uncertainty looms, trends such as an aging population, higher patient acuity, staffing constraints, limited post-acute and primary care resources, and an increase in emergency department (ED) utilization for ambulatory sensitive conditions, have all placed a significant strain on hospital operations.

Ongoing financial uncertainty also affects more than hospital and health systems resources, budgets, and their ability to invest in new technologies and services. It also negatively impacts the culture of the organization and the morale of the providers, nurses and team members working to deliver high quality care to their patients. →

Hospital Operational Challenges in Today's Environment

↑19%

Increase in patient length of stay in 2022 compared with 2019[8]

↑24%

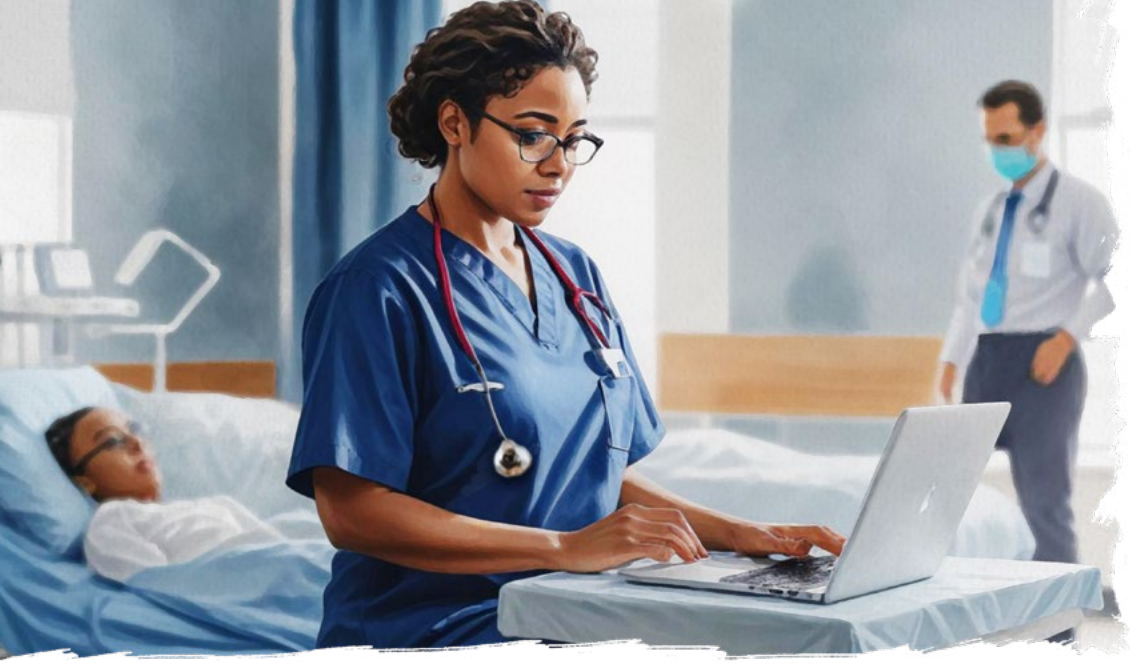
The increase in the typical length of stay among patients that are discharged to a post-acute-care facility.[8]

35%

The amount of estimated lapses in care, miscommunications of information between clinicians, and medication errors, all of which are considered the result of poorly coordinated handoffs[9]

↑12%

Increase in length of stay among patients discharged to skilled-nursing facilities (SNFs) since 2019[10]



Meanwhile, the COVID-19 pandemic fractured an already fragile healthcare system by hindering normal care delivery. Limited access to primary and specialty providers has forced patients into emergency rooms seeking care for ambulatory sensitive conditions such as heart failure, diabetes, and other conditions. This created an influx of more and more admissions of patients with multiple or severe health issues that cannot be treated adequately in outpatient or less-intensive-care settings.

To optimally manage the health of the high-risk populations, while accounting for those in the rising-risk category, organizations must become adept at coordinating care across settings and providers utilizing owned assets, new innovative collaborations, and community partners.

Consider This Care Scenario:

Bernadette is a 75-year-old with multiple serious conditions and has just been admitted to the ED with a heart attack[7]

PATIENT POFILE:

75 years old; has coronary artery disease, chronic obstructive pulmonary disease, and diabetes

Lives with husband, has limited mobility; struggles to secure healthy nutrition

CURRENT STATE JOURNEY: Siloed, Doesn't address barriers to care

Discharged from ED → SNF → Home

FUTURE STATE JOURNEY: Holistic, Integrated

Discharged from ED → Care at Home → Remote Patient Monitoring → Care Management Support → Meals on Wheels → Physician Visits with Transportation → In-Person Care from Nurse

Thought Starter:

As Bernadette's example shows, future patient throughput scenarios should be continuum-based. Strategies should ensure that patients get the care they need, when they need it - before they land in ED - and after they are discharged to home or an alternate care setting. A holistic approach ensures Bernadette isn't struggling with transportation limitations and food insecurity.

Historically, patient throughput has centered on managing the flow of patients through EDs. The primary goals have been to reduce wait times, streamline admissions, and ensure timely treatment to avoid overcrowding. But the opportunity to optimize patient flow is broader — with the potential to significantly improve the bottom line.

The focus on the ED has made sense historically. Overcrowding and long wait times have been shown to lead to patient volumes that may endanger their safety. Factors such as insufficient capacity, inadequate monitoring, and disconnected transfers impact hospital overcrowding and reduce efficiency.[11] Research also shows that high patient volumes can lead to increased patient harm, including healthcare-associated infections, increased length of stay (LOS), and higher rates of readmissions.[12]

The shift toward value-based care and population health underscores the need for broader patient throughput strategies and capacity planning that extends beyond acute-care settings. These strategies promote more effective care coordination, patient engagement, and management throughout the patient journey as patients navigate the different care settings. Patient throughput should be viewed as a systemwide initiative that spans the entire continuum of care—from preadmission to post-discharge.

$240 Billion

The annual projected savings to the healthcare system through effective care coordination and comprehensive management of patient care across the journey.[13]

By focusing on points across the entire patient journey, healthcare organizations have opportunities to achieve better health outcomes, to improve patient satisfaction levels, to lower ED use, and to reduce unnecessary hospital admissions, thereby reducing total cost of care and better positioning them for risk-sharing arrangements.

In today's context, the term patient throughput refers to the efficient movement of patients—from their entry into a hospital system (e.g., through an ED) to their movements through different departments (e.g., diagnostics, treatment, surgery), and, ultimately, to their discharge home or transfer to other care settings such as SNFs or home healthcare.

Thought Starter: Mapping the Bottlenecks

The goal of patient throughput in today's care environment is to optimize the flow of patients through the entire patient journey to ensure timely, effective, and high-quality care while maximizing resource use and minimizing delays. Although achieving that goal may seem daunting due to the complexity of coordinating care within and outside of the hospital, leaders can begin by taking a step back to identify and prioritize the key areas of improvement along the care continuum.

> "We're finding our health system partners are becoming increasingly stressed by patient flow issues such as crowded EDs, avoidable and repeat hospital admissions, and hospital stays that are longer than medically necessary. The more progressive health systems are addressing those challenges more holistically."

Courtney Fortner
President and CEO
Navvis

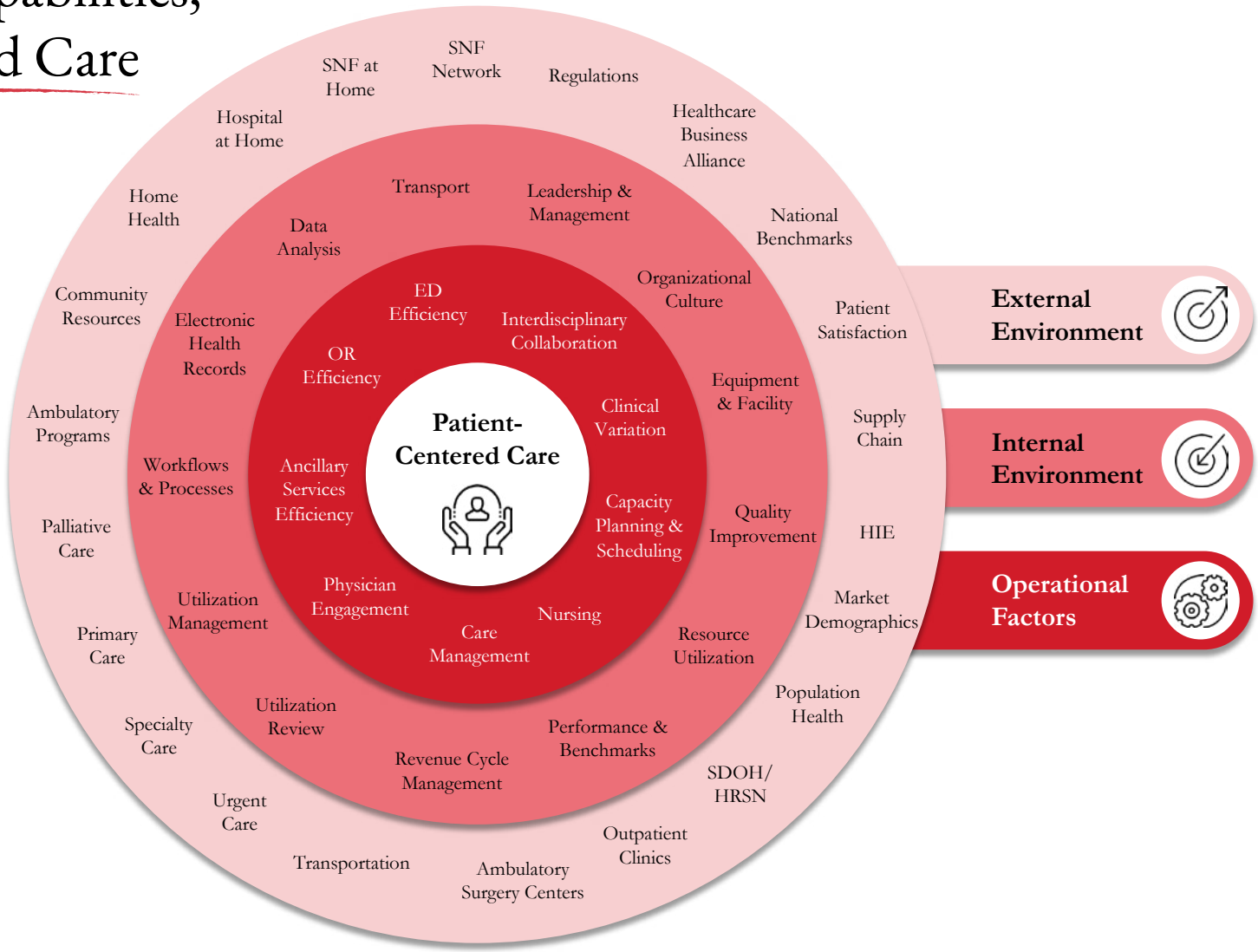
Continuum-Based Model

Collaboration, Capabilities, and Interconnected Care

Managing patient throughput and capacity effectively is essential as patients move along their care journey. From the moment a patient is admitted, data is used to predict surges and optimize resources.

As patients transition from one department to another within an acute-care setting – or even across care settings – efficient care coordination becomes critical.

By involving multidisciplinary teams early in the patient's journey, hospitals can prepare for post-discharge needs well in advance, ensuring that they have a clear plan and resources ready when they leave the hospital.



The Key Tenets of Patient Throughput

Patient throughput requires the ability to deliver the right care, in the right place, at the right time, with the right resources. This approach ensures that patients receive appropriate and timely care, which enhances both efficiency and patient outcomes.

Right Care

Ensure that patients receive care suited specifically to their individual medical needs.

This involves directing patients to the appropriate level of care and creating condition-specific pathways—such as for heart failure or diabetes—that outline precise steps and specific interventions related to treatment and the mitigation of disease progression.

Right Place

Facilitate smooth transitions between different care settings, such as from the ED to inpatient units or from hospitals to post-acute-care facilities.

Smooth transitions ensure that patients receive care in the setting or department most appropriate for their conditions and stages and health statuses.

Implement robust discharge-planning processes beginning on day one, to ensure proactive discussions with the care team, patients, and families, to facilitate smooth, timely transfers to the most appropriate next site of care.

Right Time

Reduce delays in care delivery by optimizing processes like the first surgery starts on time in the operating room and minimizing turnaround times.

Such reductions of delays help prevent unnecessary prolonged hospital stays and reduce waiting times for critical interventions.

Ensure smooth transitions between different care settings (e.g., from hospital to home, HH or SNF) by coordinating care and maintaining effective communication across care teams.

Right Resources

Make sure that the right healthcare professionals are providing appropriate levels of care—for example, the effective use of observation units to monitor patients who do not require full admission, thus conserving inpatient beds for those in greater need.

Involve a range of healthcare providers, including primary care physicians, specialists, nurses, care managers, and social workers across the care continuum.

The involvement of a multidisciplinary team helps manage resources efficiently and serves to provide comprehensive care.

Comprehensive patient throughput strategies are crucial in risk-sharing arrangements as these strategies align incentives, contain costs, improve care management integration/collaboration, and facilitate population health management — all of which tie directly to reimbursement.

Comprehensive patient throughput strategies help hospitals achieve better health outcomes, improve financial performance, and raise levels of patient satisfaction, which are essential in the contexts of value-based care and the evolving healthcare landscape. Aligned throughput-strategy models not only shed light on misaligned provider incentives, but they also serve to facilitate realignment of those incentives to focus on improving clinical outcomes, while controlling costs, and ensuring timely care is delivered in the most appropriate setting with the right resource.

As the healthcare landscape continues to shift, it is imperative that hospitals, providers, and health systems enhance their overall performance through comprehensive patient throughput strategies.

> "With population health, it's important to be able to connect points of care across the entire continuum. Communication can be challenging during those transitions when patients are moved from the hospital to the SNF or back again to the hospital in the event they have a readmission or when they go home.
>
> During those points of transitions, we see communication gaps. By building the relationships between the health system to hospitals to primary care doctors and those SNFs, it opens up those lines of communication."

Kasey Montgomery
Vice President, Value-Based Care Operations – Post Acute
Navvis

Tying patient throughput strategies to reimbursement incentives results in:

- **Cost containment:** Lower ED utilization and unnecessary hospital admissions contribute to cost containment efforts within value-based care models. By decreasing avoidable hospitalizations and ED visits, hospitals and health systems can lower overall healthcare costs while maintaining or improving patient care quality.
- **Population health management:** Value-based care emphasizes population health management and preventive care initiatives to keep patients healthy and reduce the need for high cost or inappropriate care. Hospitals/health systems that effectively manage the health of the populations they serve, address social determinants, and engage patients in proactive health behaviors, are better positioned to achieve positive health outcomes and control healthcare spending over the long term.
- **Patient satisfaction:** The Centers for Medicare & Medicaid Services' Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring helps hospitals and governing bodies evaluate patient satisfaction through quantitative measurements. Hospitals with higher HCAHPS scores earn higher reimbursements. The HCAHPS survey evaluates key elements of the patient experience, and by improving patient throughput, hospitals have the opportunity to directly affect the overall patient experience as patients move through the health journey.
- **Care management:** More-effective care management ensures seamless transitions between care settings and reduces fragmented care. Hospitals and health systems that excel in care coordination, discharge planning, and post-discharge follow-up are better equipped to prevent readmissions, improve patient outcomes, and avoid unnecessary healthcare services use, thus reducing overall costs and enhancing patient satisfaction.

Financial Impacts of a Comprehensive Patient Throughput Strategy

Reduced Length of Stay

Potential financial impact: Achieve savings up to tens of millions of dollars by reducing penalties and freeing resources.

Reducing LOS and avoidable days, not only frees up hospital beds for other patients but also lowers the overall cost of care per patient.

Some studies have shown that even a modest reduction in average LOS can lead to up to tens of millions of dollars in annual cost savings for an average hospital.

Decreased Readmissions

Potential financial impact: Improve quality outcomes and reduce costly readmissions.

Effective discharge planning, follow-up care, and community linkages are crucial components of patient throughput strategies.

By ensuring that patients receive appropriate care after discharge, hospitals can reduce the likelihood of readmissions, which are costly and often penalized under value-based care models.

Appropriate, Streamlined, ED Utilization

Potential financial impact: Lower ED usage, reducing operating costs.

Streamlining patient flow from the ED (front door) via timely discharge to home or post-acute care settings (back door) reduces overcrowding and the need for costly emergency interventions.

Additionally, ensuring EDs are caring for the right patients is crucial to a successful patient throughput strategy.

Optimal Resource Allocation

Potential financial impact: Improve quality of care, leading to higher reimbursement rates.

Ensuring clinicians' top-of-license practice at each step along the continuum leads to the deployment of the right resource, at the right time, in the right place.

Technology, process, and equipment optimization aids in achieving operational efficiency as well.

Improved Patient Outcomes And Experience

Potential financial impact: Reduce costs associated with extended LOS, intensive care unit (ICU) admissions, and additional testing.

Effective patient throughput ensures that patients receive timely, appropriate care, which often leads to better health outcomes.

Providing the right care, at the right place, at the right time in a patient journey, with the right resource; also leads to a more positive patient/family experience.

Increase in Early Interventions

Potential financial impact: Prevent care from escalating into more severe conditions that require expensive treatments.

By managing patient care proactively, organizations can prevent the progression of disease.

Hospitals and health systems can also promote support service integration, (such as palliative care), at diagnosis or soon after, and can reduce reliance on unnecessary acute-care utilization and high-cost services such as intensive-care.

Improving care delivery and patient throughput requires a strategic and integrated approach that necessitates leadership and close collaboration at every step. The Navvis approach is rooted in thoughtful care transformation that considers throughput through a broad lens. Navvis's comprehensive solution focuses on improving hospital efficiency, patient experience, continuum care delivery, and financial performance.

5 Strategies for Results-Driven Patient Throughput

1

Map patient care journeys through the health system and document current bottlenecks and areas of greatest opportunity.

The flow of patients through a hospital and out into the extended ecosystem, the services patients use, and the providers that patients access are typically documented through an in-depth assessment of current state practices. Throughout this process, current state findings are verified with hospital leaders and incorporated into a review of relevant hospital reports, procedures, and processes from top to bottom. This process results in a clear understanding of current needs and priorities that translate into agreed-upon priority initiatives.

The overarching goals of a patient throughput initiative vary depending on hospital pain points, market dynamics, and population needs, but the general aim is to identify both clinical and operational barriers that are preventing efficient patient progression across the continuum. Barriers can include delays in discharge processes, disparate communication and hand-off processes, and disconnected post-acute-care options.

The initial phase of the effort should enable hospitals and healthcare organizations to:

Open up hospital capacity for higher-acuity admissions: Reduce excessive LOS to open up hospital capacity for new admissions and specialty services and to ensure care is provided to those who are in need of an acute level of care, leading to increased profitability and improved outcomes.

Fix the "front door": Reduce inappropriate ED visits, and limit unnecessary hospital admissions from the ED (conversion rates).

Create efficiencies at the "back door" for safe and timely discharge: Reduce long LOS among patients ready to be discharged but awaiting placement in SNFs, Home Health or other appropriate options. This group often has the largest opportunity related to avoidable days.

Project the financial impact: Identify the areas, magnitude, and impact of achievable financial improvement on value-based contracts.

2

Let data guide the way.

By gathering and analyzing such data as LOS, readmission rates by service line, mortality rates by service line, and quality outcomes, hospitals can pinpoint where bottlenecks and inefficiencies are occurring and where focused tactics should be deployed. In addition to focused tactics, it is essential to establish a process for continuous improvement, to sustain operational efficiency.

Targeted interventions: A focus on specific patient groups or areas with the highest potential impact can lead to significant improvements. For example, data analysis might reveal that oncology patients or Medicare patients in intensive-care units are major LOS outliers.

Data transparency: Sharing information with unit managers and frontline staff can help break down silos within the organization. Improving communication by sharing information ensures that everyone understands the impact their role has on the big picture and that everyone is working toward the same goals.

Continuous improvement: Data should be used not only to identify initial bottlenecks and challenges but also to track the effectiveness of interventions as a way of making necessary adjustments. The ongoing process helps maintain progress and make adaptations to changing circumstances.

3

Leverage care managers.

Care managers are an integral component to improved patient throughput. Their role in ensuring efficient discharge planning, follow-up care, social determinants of health considerations, and the use of appropriate resources, is the essential ingredient to providing continuous, coordinated, patient-centered care, leading to better outcomes and optimized operations.

CARE MANAGERS

Coordinate care: They play crucial roles in ensuring seamless transitions between care settings, which includes coordinating care as patients move from the ED to inpatient units or from the hospital to their homes or from the hospital to a post-acute care facility.

By managing the transitions effectively, care managers help avoid fragmented care, thereby ensuring that patients receive continuous and coordinated care throughout their healthcare journeys.

Oversee and lead discharge planning: They drive the development and implementation of effective discharge plans. They work with multidisciplinary teams to identify – and mitigate – barriers to discharge, ensuring that patients leave the hospital as soon as they are medically ready. Care managers also provide the resources patients need to avoid a re-hospitalization.

Manage follow-up care: They are responsible for ensuring that patients receive appropriate follow-up care after discharge, which includes scheduling follow-up appointments, arranging home health services, and providing education on the management of medical conditions at home. By coordinating follow-up care, care managers help prevent readmissions.

Help optimize hospital resources: They ensure that patients receive the right care at the right time, in the right setting, and with the right resources, which reduces unnecessary admissions and readmissions and frees up resources for other patients. They also focus on managing high-risk patients who require more-intensive care coordination. By targeting such patients, care managers can have a significant impact on overall throughput and resource use.

4

Align providers and build the operational infrastructure to manage patient throughput across the continuum.

It is crucial to have the support and engagement of hospital and health system leadership, clinical leaders, and operational managers. Alignment of those groups ensures that everyone is working toward common goals and supports initiatives aimed at improving throughput at every point in the chain. Bringing together a multidisciplinary team that includes primary care physicians, specialists, nurses, care managers, and other healthcare practitioners is essential. Members collaborate to address patient flow issues and ensure that care gets coordinated effectively across different departments and care settings.

Take a multidisciplinary approach: Bring together a multidisciplinary team that consists of physicians, nurses, care managers, and other key stakeholders. This approach enables team members to have focused collaboration on how care gets delivered and coordinated effectively across different departments, units and care settings. A multidisciplinary approach informs the operating model and should include best-practice-based roles and responsibilities, standardized tools for mobility, education, and new discharge procedures.

Allocate resources: Ensure that adequate staffing and resources are available to meet patient needs, including right-sized staffing of care managers, nurses, and support staff to manage throughput efficiently. In addition, ensure staff the necessary information to anticipate demand and manage hospital capacity, including bed availability.

Extend investments the hospital has already made: For example, ensure the integration of electronic health records (EHRs) across all care settings so that all providers have access to up-to-date patient information, which facilitates better coordination and continuity of care.

Involve specialists: Engage and integrate specialists so they are actively involved in throughput efforts. Their involvement is crucial for creating effective care pathways and ensuring that patients receive specialized care promptly. Specialists should collaborate with primary care providers and other members of the care team. Such collaboration ensures that:

- Care is coordinated seamlessly between different levels and sites of care,
- Condition-specific care continuum pathways are developed and implemented, and
- Treatment protocols are standardized for specific conditions, thereby ensuring consistency and quality of care across the healthcare system.

Establish policies and procedures that will support the new care pathways: Developing and implementing standardized care pathways for common conditions helps ensure that patients receive consistent and appropriate care. Standardized care pathways outline the steps and interventions required at each stage of the patient journey. Standardization of discharge planning processes ensures that all patients are prepared for a safe and timely discharge, including the identification of potential barriers to discharge and addressing them proactively.

> “Launching another cost-cutting initiative is not enough to resolve the gap between revenue and expense growth rates. Structural change is needed. Executive teams must directly confront the challenging questions about the value of being a system or network, and how they might restructure to deliver greater value at radically lower cost.
>
> In fact, identifying how to restructure is not the greatest challenge facing health systems. It is acting on the critical strategy decisions and mobilizing people to execute them. Change starts with leaders who acknowledge that they should stop doing what no longer works and build a vision to mobilize people and execute strategies to create new value.”
>
> **Michael Eaton**
> Market President
> Navvis

5

Develop top-down culture change.

Culture change is a crucial component of any successful patient throughput program. To achieve significant operational improvements, healthcare organizations must make a fundamental shift in the way their staffs, processes, and policies are aligned and implemented. Most often, some degree of cultural transformation is required to ensure that all team members understand and are committed to the shared goals of optimizing throughput and improving care delivery.

The senior executive team plays a pivotal role in leading and sustaining change. The team must be an active champion of the change process by setting the tone and expectations for the entire organization. The team's involvement is necessary to:

Set a vision: Clearly communicate the vision and goals of the throughput improvement efforts, ensuring all staff understand the importance and benefits of a new way of delivering care.

Dedicate resources: Allocate necessary resources, including time, funding, and personnel, to support the implementation of new processes and technologies.

Lead by example: Demonstrate commitment through actions and decisions, fostering an environment in which change is embraced and valued.

Encourage accountability: Establish accountability measures to ensure that staff at all levels of the organization are contributing to and are responsible for the success of the throughput strategies.

"The other piece of a patient throughput strategy that is imperative is culture change. We need to think about delivering care differently. At times that requires a reorientation from top to bottom. Whether a hospital is pursuing a value-based care model or not, it will be implementing change one step at a time.

You still need a culture change...or more simply said, a mindset change.

It is really about the continuous internal reflection that says what we did three months ago may not be working now. The population changes. Market circumstances change. Your approach needs to be nimble enough so that you can flex when you need to."

Tina Pike
Senior Vice President, Throughput Client Partner Operations
Navvis

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All Flow, No Friction

About Navvis' Patient Throughput and Capacity Solutions

Navvis is a leading population health company that drives performance in value-based care. As an operating partner to some of the most-innovative U.S. health systems, physician enterprises, and health plans, Navvis provides solutions that accelerate the healthcare journey to value-based care. Our approach is market based. We respect the unique needs of each community's populations need to access care, culture, values, and capabilities. Together with our partners, we set a new national standard in healthcare performance that delivers the affordability, quality, access, and positive experience that all patients deserve.

For health systems and hospitals looking for a strategic and comprehensive approach to throughput and capacity, Navvis delivers a results-driven approach that analyzes the current state and offers a path forward to measurably improve financial performance.

THE SOLUTION INCLUDES:

Avoidable-days tracking: Establishing consistent and accurate avoidable bed-days' tracking processes are critical for achieving a common understanding and setting a strategy for addressing avoidable bed-days.

Multidisciplinary round optimization: Strategies to consistently adopt best practice-based protocols that support efficient and appropriate patient discharge planning.

Observation bed stay optimization: Adoption of best-practice observation processes to create inpatient capacity, increase ED capacity, and reduce hospital cost to treat.

ED process optimization: Alignment with best practice in the ED directly correlating to decreased boarders, appropriate inpatient conversations, and improved ED metrics. Status determination at the portal of entry sets the stage for appropriate inpatient use.

Aligned SNF network and governance: A network of post-acute-care facilities that are aligned to health system goals of patient placement, which is critical to ensuring patients move through the continuum based on their clinical needs.

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