HealthManagement.org
Promoting Management and Leadership

Volume 20 - Issue 8, 2020 - Winning Practices

New Care Delivery Paradigms

Dr Gilbert Bejjani, MD
******@***anemasprl.onmicrosoft.com

Anesthesiologist – Head of Department, Chief Medical Officer, Executive Director - Basilique Clinic, CHIREC, Belgium

The added value of shifting traditional inpatient surgeries to outpatient ambulatory care centres

In 2014-2015, under increasing financial pressure, the inpatient hospital beds at 'Clinique de la Basilique' (Basilique Clinic) were converted and adapted for outpatient care. Despite challenges, the clinic succeeded in creating a self-sustained, free-standing, outpatient ambulatory surgical centre. Employment was saved, and a lot of value was brought to patient care. This important and innovative change allowed the clinic to continue its mission in a healthcare environment favouring integrated and networked facilities.

Key Points

- In a value-based healthcare model where value is expressed as quality (i.e. health outcomes) over cost (V=Q/C), it remains difficult to deliver better quality and control costs without rethinking the current prevailing organisational models. Value can be achieved not only by reducing complications but also by impacting cost of care delivery, creating efficiencies in workflow and reducing carbon footprint.
- As such, creating hospital networks with specific goals for individual institutions is an essential step. This is achieved through resizing clinics and hospitals and reallocating resources to meet the goals of each institution within the network.
- Growth is not the sole metric by which success is measured. Financial margins, EBITDA or cash flow can be improved even in the absence of significant increase in caseload. This is achieved through innovation and cost reduction.

Value-based healthcare centres around the delivery of the best possible quality at the lowest possible cost. Reconciling the two sides of this equation remains challenging but is, in our experience, achievable. Processes aimed at reducing complications and medical errors, combined with improved efficiency in workflow and access to care are key.

On close examination, one would be surprised by the number of bottlenecks in our workflow in the inpatient setting. Eliminating redundancy in some processes while promoting it in others can lead to improved process performance, reduced medical errors and enhanced employee and patient satisfaction. The ensuing cost savings, when layered on top of the negotiating power of a hospital network, relating to medical supplies can tilt the equation towards value without any compromise on quality of care.

On a large scale, it is now clear that all institutions are not equal in their ability to deliver the same level of care with the same efficiency. Moreover, the ageing of the population and the increasing complexity of the cases are placing significant financial pressure on hospitals. This is further complicated by the skyrocketing cost of new medical and infrastructural technologies. As a result, resizing facilities within a network and reallocating the work to bring specific cases to the best-suited facility can have a significant positive impact. The ‘good place to do the good work’ easily becomes the ‘best place to do the best work’. Providing some level of institutional specialisation allows implementation of consistent processes and avoidance of redundancy in equipment and other costly infrastructure requirements for care delivery.

Whereas labour and supply cost reductions are typically obvious areas of intervention, rightsizing excess bed capacity and designating speciality centres can be more impactful. We should not fear these changes because at the end of the day they help define the role ‘(there is something) for every site’ in a larger network.

Our experience within our hospital network confirms the above views. On a larger scale, we moved and converted beds between different clinics in our hospital group. On a smaller scale, within each hospital we improved the specific mission it was tasked with.

Background

‘Clinique de la Basilique’ (Basilique Clinic) in the Northwest of Brussels is a smaller facility in the CHIREC hospital group. CHIREC totals more than 300 workers and 1,000 physicians on three hospital sites. One site is in Walloon Brabant (287 beds) and two sites are in Brussels: St-Anne St-Remi in Anderlecht (327 beds) and the brand-new Delta Hospital (438 beds), which opened in December 2017 (Figure 1).

Built in 1976, Basilique Clinic was a pioneering institution. It became the first one-day surgery centre in Belgium in 1986. The Belgian Association of Ambulatory Surgery (BAAS) was born in its walls in 1992, as was the International Association for Ambulatory Surgery (IAAS) in 1995. The clinic then evolved to become a 76-bed hospital. In 2015, a new state-of-the-art hospital was being built to combine two other hospitals in the CHIREC group monopolising most of the available resources. As a result of financial pressure, Basilique Clinic was slated for closure with the intent of moving the hospital beds to a bigger facility.

As value-based care was making inroads into Belgium, Basilique Clinic became an attractive site for a new business model, one that would take it back to its roots as an ambulatory surgical centre. The greatest challenges were saving employment, delivering quality care and achieving long-term financial stability. The clinic was left with a few physicians, less than 50 nurses and limited ancillary and administrative staff.

Innovation is Key

With an uncertain future, we engaged the team members by bringing flexibility and innovation to every step in their workflow. The dual goal was to motivate and support the team in delivering good care to patients, and to promote well-being at work.

Overall, the key innovation was the redesigned physician and patient flow. Physicians could access the operating room availabilities on a web-based platform, allowing real-time, streamlined scheduling. We improved patients' experience without conceding on safety by assigning one 'email' Single Point of Contact (SPOC) for physicians and another 'phone or email' SPOC for operated patients. A double-check was organised for every step to reduce errors. Every admission was planned only one or two hours before the operation to diminish the 7 a.m. rush and bottleneck for front office employees. Administrative verifications were made on admission, while medical record entries were completed and checked by nurses according to the anaesthesiologists' preop exam. Checklists were made available at levels to avoid omissions. A follow-up phone call was made to patients post-discharge. Importantly, we encouraged all stakeholders to challenge processes by providing better alternatives.

Critical decisions were made in consultation between the surgeon, a nurse (chief if needed) and an anaesthesiologist (chief if needed) in order to avoid miscommunication and errors. Task leaders were provided with a dedicated phone number available over the '12-hour' shift. Connection via WhatsApp services, as well as the creation of new documentation and smarter signage were implemented.

The other innovation was our approach to human resources management. We encouraged leadership that inspires positive actions, promotes an exchange of ideas and champions lean processes and innovative workflows. Good communication skills within and outside the clinic were also prized.

As the clinic is open only 12 hours per day, the typical 8-hour shifts were ill-suited for the job. Smaller teams working shorter shifts merged into 8-10-people groups. This allowed better management of the workload while providing adequate coverage including on holidays. Personal workload preferences were met through allocation to different tasks around the facility.

At Basilique Clinic, we have 75 FTE. These include less than 100 staff and over 120 physicians. Half of the medical workforce joined after 2015. We have 5,000 sq. m in two separate buildings, which house 8 interventional rooms, 50 beds and a CT scanner. The total income is around €18 million.

Micro-Hospital Development

Retrofitting the existing facility was challenging and required capital expenditure. Communicating the need clearly was key. From 76 inpatient beds we moved to 50 outpatient beds. It is what we called 'hospital without beds', when in effect we ended up with more beds then we needed to perform our ambulatory procedures. Along the way, some adaptations were made that resulted in better patient comfort. Shared rooms became individual rooms. Lighting was improved, as was the availability of air conditioning. Larger shared space was created for the staff.

In an effort to rebrand the clinic, the local press was regularly solicited. Collaboration with surrounding general physicians, as well as regular communication through scientific or professional meetings was pursued. In just a few years, the community was referring to the clinic in a more positive way.

Value and Sustainability

The rethinking of the clinic was meant to bring excellence in ambulatory surgery and the motto was ‘do better with less’. Less money, less people, less time, less waste, less harm, and so on.

The clinic experienced large growth performing almost 8,000 interventions and more than 6,500 surgeries in 2019 (5,500 interventions and 4,000 surgeries in 2015). Readmission rates and cancellations for unexpected reasons were below 0.1%.

After double-digit growth in activity and financial results, we observed a slowdown in 2018 and even a regression in 2019. But EBITDA and cash flow continued to improve, even this last year! We had no doubt that our efforts would make the clinic’s financial results sustainable, and the stress test results of 2019 confirmed the validity and sustainability of the business model. Although there are many reasons that account for the decrease in growth, this indicator was not our main focus. Our focus on cost reduction including through staff attrition, as well as some well-placed investments allowed for a healthy balance sheet. In fact, we understood from the onset that value-based care was not driven primarily by volume growth.

As we continue to improve our workflow, we remain laser-focussed on improving care, patient satisfaction and staff well-being. Overall, we have achieved our goal of elevating our small clinic into a well-deserved position in our hospital group.

Conflict of Interest

None.

Published on : Thu, 22 Oct 2020