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evolve and integrate a new imperative for ambulatory care

Developing a fully integrated ambulatory care system is a critical strategy for ensuring success under healthcare reform.

AT A GLANCE

- > A highly evolved ambulatory care delivery system possesses four key attributes: high-quality care, exceptional levels of access, outstanding patient and staff satisfaction, and cost-effective delivery of care.
- > Such a system seeks to ease management of the patient care continuum by delivering as many services as possible under one umbrella.
- > High-quality, cost-effective care is achieved through improved care coordination and cost management, resulting from a tight connection between physicians and hospitals and between inpatient and outpatient settings.
- > Improved access is an important means to improving patient satisfaction.

National, regional, and state reform initiatives and the imperative to make health care more affordable and accessible are driving significant changes in how hospitals and health systems deliver and manage outpatient services. Market forces largely resulting from healthcare reform are driving the trend toward bundled and global payments, the need to demonstrate higher-quality outcomes for less cost, and the increased focus on improving patient satisfaction. In this environment, providers are compelled to move beyond traditional approaches to ambulatory care services toward more highly evolved and tightly integrated delivery systems.

The most highly evolved outpatient service delivery systems demonstrate four key attributes: high-quality care, exceptional levels of access, outstanding patient and staff satisfaction, and cost-effective delivery of care. Hospitals and health systems have a substantial financial incentive to create an ambulatory care system that displays each of these attributes: increased revenues and margins for outpatient services, and the high potential for downstream revenue for the entire system.

A Broader Outpatient Service Mix

A primary objective for a highly evolved ambulatory care delivery system is to deliver as many services as possible under one umbrella, thereby easing management of the patient care continuum and promoting improved access. To develop such a system, a hospital or health system will need to provide or affiliate with a wider range of ambulatory services. In addition to the traditional array of outpatient services (e.g., surgery, imaging, and physical therapy), the range of services in a more highly evolved system, for example, could include employed physician practices, urgent care centers, wellness and prevention programs, and centers for managing chronic diseases such as diabetes. The aim should be to deliver more outpatient services in convenient, carefully selected locations off site rather than at the main campus,

increasing the likelihood that patients will access them and expanding providers' influence beyond traditional service areas.

Case example: Geographic distribution and integration. Based in Milwaukee, the four-hospital system Columbia St. Mary's (CSM) has an extensive ambulatory care network that includes 200 physicians and 65 community clinics in and around the Milwaukee region. Most sites offer same-day and urgent care appointments and access to specialists. Seven of these sites include larger ambulatory care centers that offer a broader range of services, including a number of specialties and complementary ancillary services. All of the clinics are supported by a state-of-the-art information system that integrates the

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clinical, financial, security, and environmental operations of the system. A \$140 million investment, the IT system allows real-time scheduling across all sites to maximize availability of appointments and ensures that patient records

Pay for Performance and the Ambulatory Care Setting

Medicare, Blue Cross Blue Shield of Massachusetts, Philadelphia Independence Blue Cross, and several other insurance companies across the country are forcing increased collaboration between physicians and hospitals by instituting payment incentives that reward providers that can deliver higher-quality care while reducing costs. The primary metrics being used include readmission rates, chronic disease management measures, and patient satisfaction. Many of the plans involve per-patient global budgets coupled with performance incentives. In some instances, providers can earn the full incentive payments only if their cost reductions occur with quality improvements, thereby discouraging a focus on extreme cost-control measures.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS ALTERNATIVE QUALITY CONTRACT (AQC) METRIC: FIRST-YEAR RESULTS

AQC Metric	First-Year Result
Preventive care measures (e.g., cancer screenings, well-child visits)	The rate of improvement among AQC participants was three times that among non-AQC participants.
Chronic disease management measures	The rate of improvement among AQC participants was more than four times what these providers had accomplished before joining the program.
Hospital readmission rates	AQC participants achieved a decrease equivalent to \$1.8 million in avoided readmission costs.
Nonemergent emergency department (ED) visits	One AQC participant decreased visits by 22 percent, which equals about \$300,000 in avoided ED costs.

Sources: "BCBS of Massachusetts Announces First-Year Results of Alternative Quality Contract," *Healthcare Finance News*, Jan. 21, 2011; Ciavaglia, J., "New Incentive Pays Doctors, Hospitals to Reduce Costs, Improve Care Quality," *phillyburbs.com*, June 8, 2011.

are available to any CSM provider, no matter where the patient is seen. CSM's highly distributed ambulatory care network and integrated systems provide a significant competitive advantage in the marketplace.

New Partnerships to Reduce Costs, Improve Quality of Care

Across the nation's changing healthcare landscape, traditional departmental lines—and even more comprehensive service lines in the most advanced hospitals and systems—will be organized into more flexible, integrated services oriented to market-based patient populations. Physicians will play a much greater role in collaborating with acute care providers to manage patient care and avoid unnecessary and duplicative admissions and testing. These new configurations will ensure a tighter connection between physicians and hospitals and between inpatient and outpatient settings to ensure better coordination of care and management of costs. Measuring and demonstrating the quality of care and improved outcomes required under healthcare reform are also easier tasks when services are integrated and organized along service lines.

Integration structures can range from more loosely aligned models, such as joint ventures and medical directorships, to more tightly aligned models, such as employment and shared risk arrangements. The more tightly integrated structures will optimize the collaboration between healthcare organizations and physicians as well as accountability for costs and quality. Finance leaders can promote integration by beginning discussions with commercial payers about structures that can evolve to new models of care delivery and payment (e.g., get paid more for quality, outcomes, and accountability and less for episodic fee-for-service healthcare delivery).

Improved Satisfaction Follows Improved Access

Among the four key attributes of a highly evolved ambulatory care system, achieving outstanding patient and staff satisfaction depends in large part upon whether the system exhibits the other

attributes. Improving patients' access to services regarding not only range of services but also wait times is an important means to raising their satisfaction levels.

Case example: Benefits of operational excellence in access. Beth Israel Deaconess Medical Center (BIDMC) in Boston recently addressed an access problem in its physician practices. Wait times of more than a month to get an appointment in many specialties frustrated patients and limited growth. BIDMC was committed to increasing access and improving patient satisfaction in all of its clinics, starting with medical specialties that had some of the longest lag times. Mark L. Zeidel, MD, the chair of the department of medicine, led an effort to address this problem, working closely with leadership from the organization's ambulatory care services.

Using a mystery caller program, in which callers posing as patients contacted clinics to schedule appointments, data were collected and evaluated to identify problems. Many calls to individual clinics were diverted to voicemail when medical secretaries at individual clinics were unavailable, which increased the likelihood the patient would not call back. When calls were answered in person, schedulers were not always able to help patients navigate the complexities of the referral process and/or find available slots. If clinic schedules were full, schedulers could not book additional patients during the session without physician approvals, delaying the process further.

BIDMC instituted the following solutions to improve access:

- > Centralized and/or podular scheduling for high-volume clinics to avoid diversion of calls to voicemail
- > Latitude afforded to frequently referring departments to directly book appointments for patients for follow-up services (e.g., enabling the emergency department to schedule orthopedic consults or allowing the breast center to schedule mammography tests)
- > Training programs for scheduling staff to enhance their communication skills and

AMBULATORY CARE ASSESSMENT MATRIX			
Parameter	Traditional	Transitional	Highly Evolved
Service Mix and Distribution			
Breadth and depth	> Basic diagnostic and testing services	> Primary care, diagnostics, and select core services	> Full complementary services
Geographic focus	> On campus	> Some decentralization off site	> Comprehensive satellite network
Configuration on main campus	> Fragmented	> Some co-location of services	> Ambulatory care zone with access to convenient parking
Operations focus	> Departmental	> Service line	> Matrix/market-based
Physician Alignment			
Physician integration	> Some aligned physician practices, but little real integration	> Some physician integration through employment or similar models	> Highly integrated physician practices linked with IT/EMR > Shared vision and accountability
Percentage of area physicians that utilize system's outpatient services	> Significant leakage	> Moderate leakage	> Minimal leakage
Efficiency and Effectiveness			
Access	> >2 weeks for primary care > >4 weeks for specialty care	> 1 to 2 weeks for primary care > 2 to 4 weeks for specialty care	> <3 days for urgent/primary care > <1 week for specialty care
Patient satisfaction/customer service orientation	> Beginning to track satisfaction data > No customer service training	> >60th percentile in peer group scoring > One-time customer service training	> >80th percentile in peer group scoring > Ongoing customer service training
Physician satisfaction	> Beginning to track satisfaction data	> 70% of physicians report that they are "highly satisfied"	> 90% of physicians report that they are "highly satisfied"
Quality and outcomes	> Tracking only compliance metrics (e.g., National Patient Safety Goals) > Chronic care management not coordinated	> Tracking compliance and process metrics > Some utilization of chronic care/disease-based protocols	> Dedicated quality team tracking compliance, process, and outcome metrics > Routine utilization of chronic care/disease-based protocols
Room utilization > Procedure/testing rooms > Exam rooms	> <50% > <35%	> 50% to 70% > 35% to 50%	> >70% > >50%
Infrastructure			
Existing ambulatory care strategic plan	> Not highlighted in hospital's strategic plan	> A component of the hospital's strategic plan	> A separate strategic plan from hospital
Ambulatory care management and organizational structure	> Services managed by departmental managers	> Director reports to the C-suite and manages small team	> Director in C-suite with significant P&L responsibility
IT structure	> No existing outpatient electronic health record (EHR) > Outpatient registration and scheduling not linked to hospital	> Outpatient EHR implemented but not linked with inpatient EHR > Outpatient registration and scheduling not linked to hospital	> Outpatient EHR fully integrated with inpatient EHR > Registration and scheduling linked to the hospital
Financial Performance			
Outpatient percentage of total revenue	> <35%	> 35% to 50%	> >50%
Contribution margin for signature ambulatory services	> <20%	> 20% to 35%	> >35%

- knowledge of physician and clinic scheduling practices or specialty needs
- > Monthly meetings involving division chiefs and administrators—cochaired by Zeidel and Jayne Carvelli Sheehan, senior vice president for ambulatory services—to set standards, verify success in meeting performance targets, and share best practices
- > Faculty incentive plans tied to worked RVUs that would encourage specialty faculty to make better use of capacity available at clinics located off site
- > Provision of adequate physician coverage during heavy vacation periods
- > Scheduling of Friday “clean-up” sessions in many divisions for add-ons or urgent-care needs
- > Recruitment of additional clinical faculty when existing capacity was clearly maximized

By focusing on these solutions, clinical and medical center leadership cultivated significant changes in physician behavior and development of more patient-centered practices. Implemented over a two-year period, the overall effort collectively reduced the number of days to schedule an appointment from 11 to 4.5 days, on average. During the same period, customer service ratings increased from 2.9 to 4.9 on a scale of 1 to 5. Ambulatory visit volume grew significantly over the two-year period, with additional visits generating an estimated \$54 million in incremental contribution margin and \$2.4 million in incremental net margin from downstream revenues.

Organizing and Planning for Ambulatory Care Success

As hospitals and health systems begin to focus less specifically on acute care and more on managing the total care continuum, ambulatory care services development across the organization will become a strategic priority. In a highly evolved, integrated system, management oversight of outpatient services is centralized and located in the C-suite, rather than dispersed among multiple department managers. This concentration of oversight ensures that outpatient issues and opportunities are identified and appropriately addressed and that the focus on enhancing the

ambulatory care delivery system cuts across all departments.

One potential benefit from this approach is the opportunity to significantly lower the cost of providing care and improve the contribution margin of outpatient services. When ambulatory activity is managed separately from inpatient activity, consistent and less expensive standards for staffing, supplies, and support can be provided in the outpatient setting that are difficult to achieve when outpatient services are integrated with inpatient services.

A highly evolved ambulatory care delivery system also includes operating and tracking systems (e.g., electronic medical record, registration and scheduling, billing, and IT) that can meet the highly sensitive demands of ambulatory care patients looking for easy access and convenience. Performance improvement dashboards in these organizations not only focus on the inpatient side, but also include a greater abundance of quality and patient and physician satisfaction metrics built around the outpatient experience and the needs of the ambulatory patient.

A comprehensive strategic plan for the development of outpatient services is another hallmark of highly evolved ambulatory care organizations. A high level of investment ensures organizational consensus on the direction and priorities of outpatient services and their role in the full continuum of patient care. In addition, the focus and dedication of resources engendered by development and execution of a strategic plan promote greater competitive advantage, increased revenues, and higher contribution margin from outpatient services overall.

Getting Started: Assessing Where You Are and Where You Need to Go

The first step for organizations embarking on the journey toward becoming a highly evolved ambulatory care system should be to perform an assessment to gauge where their outpatient services reside on the continuum between traditional and highly evolved ambulatory care. The exhibit

on page 71 displays a tool that physician and administrative leaders can use to complete such an assessment by rating the organization's existing position relative to service mix and distribution, physician alignment, efficiency and effectiveness, infrastructure, and financial performance.

The result will identify both the current state of the ambulatory delivery system and opportunities for improvement. Ratings and aspirations may vary depending on the type of organization performing the assessment. Academic medical centers may place more value on providing the full continuum of services and achieving integration with physicians, and are likely to be more successful than other organization types using this approach. By contrast, community hospital systems may thrive with satellite development off the main campus. The parameters that are assessed as *traditional* or *transitional* should be

designated as top organizational priorities. With priorities identified, strategies and action plans can then be developed that will lead the organization in a new direction toward an integrated ambulatory care delivery system. ●

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