

PLANNING

Making the Most of Your Ambulatory Care Assets

By rethinking its suburban strategy and leveraging its existing resources, Beth Israel Deaconess Medical Center avoided nearly \$100 million in new capital spending while enhancing its outpatient market position.

Easy access and convenient, integrated care are the hallmarks of effective ambulatory services, especially in markets that include numerous competitors and niche players vying for patients. But the reality is that outpatient services at many hospital campuses are fragmented, hard to find, and distant from parking.

Developing satellite facilities that are closer to target populations and designed and operated to provide a better patient experience than can be had in a hospital setting is a viable strategy being used by many organizations. But with the downturn in the economy and uncertainty about how healthcare reform will affect future revenue streams, many organizations are looking instead for opportunities to optimize their existing ambulatory care services and facilities without spending millions in scarce capital dollars.

Case Study: Beth Israel Deaconess Medical Center

One such organization is Beth Israel Deaconess Medical Center (BIDMC), a Harvard-affiliated healthcare system in Boston, Massachusetts. By revamping its ambulatory care service development strategy, retooling the scope of services provided at existing sites, and increasing utilization of existing capacity, BIDMC has been able to avoid spending nearly \$100 million in potential new facility development while enhancing its outpatient market position.

BIDMC is located in the Longwood Medical Area in Boston, next to four other major academic medical centers. The faculty clinic practices and many outpatient diagnostic and treatment services are located in two large medical office buildings on the main campus, the Shapiro and Lowry Medical Office Buildings. BIDMC also offers physician services and select diagnostic services at two

off-site ambulatory care centers in Chelsea and Lexington in the northern and northwest suburbs of Boston, as well as at a community health center in Dorchester and a small radiation therapy satellite in Waltham to the west.

The Challenge: Competing with Limited Resources

To accommodate current on-campus volume, the increasing needs of its tertiary and quaternary inpatient programs and services, and its desire to grow select outpatient services, BIDMC initially planned to decompress the congested main campus by relocating or expanding select clinics and outpatient services into a large, new satellite facility some distance west of the main campus in a highly visible location that would be more accessible to patients.

A review of the marketplace showed that many academic medical centers had already developed ambulatory satellites and affiliations with community hospitals in a similar effort to expand geographic reach and volumes, including in the region of the proposed BIDMC satellite. Further review also determined that only a small portion of patients now going to BIDMC's main campus for outpatient services would be likely to shift to a facility as far west as the proposed location. The location also posed a potential issue for BIDMC's nearby community hospital affiliates, which were counting on growing outpatient services to support their own bottom lines.

Even more problematic was the potential cost of developing one or more new satellites at a time when the availability of suitable real estate in the greater Boston region was limited. A more tailored strategy was needed to shift patients from the downtown campus and to grow outpatient services by competing more effectively in the suburbs, while

respecting BIDMC's existing relationships with other providers.

The Response: Targeted Service Development

BIDMC chose a more effective competitive strategy, which would include a network of several smaller satellite ambulatory care centers (ACCs) distributed throughout the suburban region, offering services tailored to the surrounding marketplace. These ACCs would be positioned to increase BIDMC's presence in the region, offer the same high-quality specialty services as provided downtown, and add new patient care volume. This approach would allow BIDMC to leverage its existing sites in Chelsea and Lexington by adding more specialty and complementary services needed in those communities.

A third site is currently being evaluated and is in the planning stages in the southwest in conjunction with BIDMC's community hospital affiliate in Needham. This site will offer specialty services in cancer and other high-end diagnostic and treatment services that will complement, not compete with, services offered by the affiliated hospital.

In addition to leveraging existing assets, the revised plan also called for a much smaller outpatient facility located not far from the main campus, which would provide additional capacity for growth while shifting patients away from the downtown site. The cost of acquiring a site and building the facility was still significant, potentially over \$70 million. Combined with the cost of a new site in Needham and expansion of the Lexington site, BIDMC was looking at a potential capital investment of nearly \$110 million to expand and reposition its ambulatory service delivery system.

The Response: Operations Improvement

An operations assessment identified opportunities for BIDMC to better utilize capacity in its existing ambulatory and clinic facilities. Time physicians spent in the clinics, scheduling practices and patterns by time of day and day of the week, kept visits versus scheduled visits, no-show rates, hours of operation, and other operating characteristics were evaluated for each specialty at the main campus and in the satellites. Utilization of exam rooms in the faculty practices was

measured, taking into consideration visit volume and duration, turnaround time, physician schedules, OR and procedural block times, number of exam rooms, and room availability.

The operations assessment concluded that although most clinics were busy during the most desirable days, average overall utilization of the exam rooms was less than optimal. Senior leadership worked with faculty to identify the following barriers to efficiency:

- Dedication of clinic space to one specialty.
- Small, fragmented clinic modules.
- Limited time scheduled in the clinic by surgery practices that spend part of the week in the OR.
- Scheduling templates based on time reserved by faculty rather than actual visit volumes.
- Higher than expected no-show rates in certain clinics.
- Room utilization methodology based on scheduled visits rather than kept visits, leading to underestimation of actual capacity available.
- Physician preference for the most popular days, leading to congestion on some days and empty rooms at other times.
- Lack of faculty incentives to use available capacity at off-site locations or to make up cancelled sessions.

These barriers to efficiency impacted BIDMC's ability to optimize the scheduling of the clinics and the use of the clinic space available at all of its ambulatory care sites. Room utilization in FY2008 averaged 46 percent in Shapiro, 41 percent in the Lowry MOB, and 20 percent at the off-site facilities (Table 1). Analysis showed that BIDMC could accommodate many more visits in its existing capacity if room utilization of 60 percent on average could be achieved based on actual kept visits. Not only would operational costs be reduced, but the need to add new capacity through construction could also be delayed for many years.

As a result of the assessment, senior leadership at BIDMC implemented the

Table 1. Analysis of Exam Room Utilization

Practice	Exam Rooms	Exam Room Utilization			Growth Potential
		FY 08	FY 09	FY 10	
Shapiro					
Clinic A	9	39%	43%	64%	Cannot add sessions
Clinic B	22	57%	61%	62%	
Clinic C	64	52%	55%	60%	
Clinic D	14	60%	61%	60%	
Clinic E	10	56%	54%	59%	Limited ability to add sessions
Clinic F	21	43%	43%	55%	
Clinic G	17	49%	51%	54%	
Clinic H	18	56%	56%	54%	
Clinic I	8	53%	53%	53%	
Clinic J	15	40%	41%	51%	Room for growth
Clinic K	4	13%	39%	47%	
Clinic L	13	46%	46%	45%	
Clinic M	10	43%	39%	44%	
Clinic N	6	27%	37%	36%	
Clinic O	3	33%	32%	32%	
Shapiro Subtotal	234	46%	48%	52%	
Lowry					
Clinic A	5	48%	60%	62%	Cannot add sessions
Clinic B	9	49%	52%	55%	Limited ability to add sessions
Clinic C	4	44%	51%	54%	
Clinic D	8	49%	47%	49%	Room for growth
Clinic E	5	47%	49%	49%	
Clinic F	6	43%	44%	48%	
Clinic G	6	40%	40%	37%	
Clinic H	4	35%	35%	37%	
Clinic I	4	35%	33%	32%	
Clinic J	5	25%	34%	31%	
Clinic K	4	24%	20%	22%	
Clinic L	5	21%	19%	20%	
Clinic M	4	8%	11%	10%	
Clinic N	3	10%	8%	7%	
Lowry Subtotal	72	41%	43%	44%	
Main Campus Subtotal	306	43%	45%	48%	
Off-Campus Clinics					
NW Clinic A	16	41%	43%	40%	Room for growth
NW Clinic B	4	38%	34%	34%	
NW Clinic C	8	29%	29%	28%	
North Clinic A	4	31%	37%	37%	
North Clinic B	16	29%	29%	31%	
North Clinic C	6	20%	20%	18%	
North Clinic D	6.5	7%	6%	8%	
Off-Campus Subtotal	61	20%	20%	20%	
Grand Total All locations	366	32%	29%	31%	

Room Utilization Range / Action

>60%: Approaching maximum use - request space and/or implement decompression opportunities
 50% TO 60%: Optimal space utilization - usage that adjusts for peaks and allows for urgent add-on sessions without difficulty

40% TO 50%: Reasonable use but with potential for growth or sharing underused sessions
 < 40%: Underuse - consider consolidation with other services

following strategies to increase clinic exam room utilization:

- Fully schedule any reserved time, share or allocate unscheduled rooms to other providers, target more-level scheduling across the week, or reassign the space if target utilization is not being met.
- Reconfigure facilities to enhance efficiencies (e.g., aggregate smaller clinics).
- Provide more patient reminders to minimize no-shows.
- Increase utilization of satellite facilities

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Ambulatory Care Assets

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by scheduling more physician sessions off site and providing additional radiologist support.

Senior leadership also created incentives for the faculty to use existing resources more effectively. Policies were reviewed and revised to ensure minimum standards were met for work weeks per year, number of patients seen per session, making up cancelled sessions, and other operating parameters. Room utilization is monitored regularly, and decisions about reallocating exam rooms to other specialties with high utilization are now based on these dashboards (Table 1).

A Cost-Effective Strategy

In the past two years, visits to the clinics in Shapiro have increased by 14 percent, and room utilization has increased to 52 percent overall. Utilization in the Lowry MOB was especially low, since many of the clinics located in the building are surgical practices. Exam rooms were rarely shared, leading to many empty sessions when surgeons were in the OR. After implementing the new operating policies, departments have started to share exam suites and coordinate their clinic schedules with OR schedules to improve room utilization. Renovations are also under way to combine several small clinic modules into larger and more efficient suites, which will further enhance scheduling flexibility and operational efficiencies.

Operational efficiencies and better use of clinical capacity have enabled BIDMC to provide more care out in the suburbs where patients want to be while adding capacity at the main campus to accommodate the growing number of patients

from the downtown Boston area. These changes have increased patient satisfaction and enhanced clinical staff productivity. BIDMC also was able to avoid nearly \$95 million in capital costs, including the construction of the proposed new ACC near the main campus and the expansion of one of the off-site facilities. Existing capacity may accommodate many years of growth, making the immediate construction of new capacity unnecessary.

In addition, the incremental volumes that can be accommodated in existing capacity will generate significant contribution margin for the system. If the off-site clinics increase room utilization by 5 percentage points, it would generate an estimated increase in the contribution margin of \$520,000 to \$670,000, depending on the site (Table 2). Higher utilization of up to 55 percent could generate a contribution margin of \$2 million to \$3 million per site, excluding the potential downstream revenues from patients requiring admission to the hospital or other more intensive procedures at the main campus.

In short, by rethinking its suburban strategy and leveraging its existing

resources, BIDMC avoided major capital spending and is well positioned to strengthen and enhance its ambulatory care services in highly competitive markets. Growing outpatient services at far less cost than originally anticipated has enhanced BIDMC's financial performance and competitive position while ensuring that the organization is better prepared to manage the demands of healthcare reform. ☺

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Lessons Learned: Optimizing Ambulatory Care Resources

BIDMC's journey toward more profitable and patient-centered ambulatory care services illustrates some key lessons all healthcare providers should consider when evaluating their current and future ambulatory care services.

- Accessibility, convenience, and creating an outstanding patient experience must be paramount when making decisions about outpatient services.
- The goals of ambulatory care development must be known and understood within the organization.
- The market potential for growing ambulatory services and its contribution to financial performance must be determined, then outpatient service development must be aligned with market need and potential.
- The efficiency and effectiveness of the existing ambulatory care service delivery system must be evaluated and optimized before any major capital decisions are made.

Table 2. Financial Impact of Increased Utilization of Two Ambulatory Care Centers

Site	Exam Rooms	Avg. Min./Visit	FY 09 Kept Visits	FY 09 Room Util	Improvement Over Current Utilization by 5 Ppt.		Achievement of 55% Utilization		
					Incremental Visits Needed for 5 Ppt. Increase in Utilization	On-Site Incremental Estimated Contribution Margin	Annual Visits Needed for 55% Util	Added Visits Over FY 09	On-Site Estimated Contribution Margin from Added Visits
NW ACC	32	30.8	40,885	33%	6,219	\$672,000	59,897	19,012	\$2,053,000
North ACC	31.5	32.2	28,457	24%	6,165	\$518,000	67,813	39,356	\$3,306,000