

Kurt Salmon 



INDUSTRY INSIGHTS

Building the Continuum:

*A Systematic Approach
to Ambulatory Care*

In response to an increased emphasis on quality and effectiveness of care, hospitals and health systems must refocus their efforts on the broader care continuum, defined as health care outside the traditional hospital walls. No longer can community hospitals consider ambulatory services as separate from their core service and mission. While the ability to “own” the entire ambulatory continuum is not realistic for most community hospitals and systems, hospitals should take a leadership role in organizing the ambulatory continuum to benefit their communities.

Over the past two decades, the community hospital strategy for ambulatory care has generally been bifurcated: either a joint venture with physicians, while trying to build or maintain volumes, or competing with physician-invested ambulatory services, often losing volumes rapidly. Strategy was driven by revenue, profits and efficiency.

Today, hospitals and health system must change their way of thinking about ambulatory services from a profit center and physician economic alignment tool to a targeted care delivery channel that must be organized and coordinated with the other elements of the continuum.

As a result, ambulatory services must be:

- » Highly efficient (focused factories)
- » At locations convenient for the patient (access points within communities rather than on hospital campuses)
- » Integrated into the entire continuum of care rather than a carve-out to capture higher profitability
- » Aligned with physicians in areas beyond economics (integrated systems of health)

To address these needs, we propose that hospitals and health systems develop ambulatory assets using a framework with five levels of care. This framework provides a clear model for organizing future ambulatory services to best serve the patients in their specific communities.

Five levels of ambulatory care

Groupings of ambulatory services and their supporting asset infrastructure must be organized to effectively support the delivery of integrated systems of care across the ambulatory continuum. To this end, successful community hospitals and systems create a logical cadre of ambulatory services and infrastructure in their markets.

Our research suggests that ambulatory services can be organized into five defined groupings. These groupings provide a logical basis for community hospitals and systems to organize the ambulatory continuum in their communities.

Level 1: Virtual health

Virtual health care is defined as education and care provided through the use of email, websites, electronic physician visits, telemedicine and other electronic sources. As patients become more concerned with the value of health care, these avenues of physician-patient communication are likely to become much more relevant in daily operations. The American Medical Association has reported that as many as 70% of all doctor visits are for information only or for matters that can be easily handled over the phone.¹ Virtual health can be further segmented into three areas:

LEVEL I: VIRTUAL HEALTH EXAMPLE
Zipnosis: Online Medical Service
 Zipnosis provides an online, innovative approach to health care for their target market of young adults, ages 18 to 35, who often are not insured, don't get sick often and are looking for ways to save money.

Email: Today, most health plans are piloting programs to pay physicians for online patient consultations. Many physicians are discovering that email is a more efficient manner of scheduling appointments, refilling prescriptions and transmitting standard lab results. By creating a convenient avenue of communication, physicians are noticing a reduced number of phone calls and pages, allowing for better workflow control.

Telemedicine: Telemedicine has also become an integral piece in providing health care to rural communities, patients with chronic conditions and patients who may not be able to easily travel to meet face to face with a physician. However, because telemedicine can cross state lines, some states could require a state license for out-of-state doctors whose use of telemedicine crosses into their jurisdiction, even if the doctor's practice is physically located elsewhere.²

EXHIBIT 1: Five Levels of Ambulatory Care

	AMBULATORY LEVEL	SUMMARY DESCRIPTION
Typically System-wide	LEVEL 1: Virtual Health	> Virtual access and educational strategies focused on providing information and resources to prevent disease and manage chronic illnesses. Lack of face-to-face interaction is the hallmark of assets supporting this ambulatory level.
	LEVEL 2: Mobile Health	> Remote and mobile strategies focused on providing preventive, screening and diagnostic capabilities close to the communities that cannot support or do not have access to specialty care locally. The hallmark of assets supporting this level includes significant use of information systems and mobile infrastructure.
Local (fixed assets)	LEVEL 3: Primary Diagnosis and Treatment	> Mix of primary care services and the supporting diagnostics needed to care for the local populations in a permanent location. The asset base for this level will be primary care offices, imaging, and potentially after-hours care and urgent care, perhaps in conjunction with retail.
	LEVEL 4: Specialty Diagnosis and Treatment	> Multispecialty services for one or more disease states and focused on diagnostic and treatment services that can be done safely outside a hospital environment. The asset base will be focused on specialty diagnostic and treatment services and the supporting medical office space for aligned physicians.
	LEVEL 5: Destination Ambulatory	> A full range of multispecialty services for multiple disease states, focused on providing all types of health care services except those requiring hospital admissions. The asset base will require a sophisticated diagnostic and treatment facility and supporting medical office spaces for aligned multispecialty, single specialty and primary care physicians.

Call centers: Historically a triage function or information source, progressive hospitals and systems are increasingly using call centers to deliver care. Types of call centers might include RN triage, ED transfers, physician and facility referrals, appointment scheduling, class scheduling, and patient callbacks for chronic heart failure, post-partum moms, diabetics, ED patients who left without being seen, etc.

These services are considered a unique level of ambulatory access due to the ambiguity around privacy and confidentiality, reimbursement, and standards of care that should apply. As health care reform continues to evolve, many regulatory questions are likely to be further defined and answered.

Level 2: Mobile health

Mobile health care services include remote and mobile strategies aimed at providing preventive, diagnostic and screening capabilities close to communities that do not have access to care locally. The hallmark of these services is the usage of mobile infrastructure, information technology, and, sometimes, rotating physicians and technical staff.

Because populations in many rural markets cannot support dedicated availability of comprehensive health care services, and attracting physicians to live and work in many rural markets proves challenging, these services are critical to providing access to care in rural settings. Moreover, Level 2 services are acutely needed by rural populations—by many measures, rural residents are less healthy than their urban counterparts. Level 2 services are primarily influenced by three factors:

Geographic focus: Historically, hospitals and systems have thought they needed a large, sparsely populated geography to most effectively take advantage of a Level 2 ambulatory model. However, underserved segments of an urban market often have many similarities: lack of resources, poor payor mix, and a need for screening and chronic care management.

Service offerings: Lack of care availability results in patients often forgoing preventive care or specialty diagnostics until disease is advanced. To control costs, early diagnosis is critically important. As such, the logical focus areas for Level 2 services are the leading causes of death: heart disease, cancer and stroke.

LEVEL 2: MOBILE HEALTH EXAMPLES

Cancer services

- > Mobile digital mammography and breast biopsy services
- > Virtual colonoscopy with remote reading and mobile colonoscopy services
- > Education and consultation: Condition education, risk factors, screening types

The high incidence and costs of these diseases make them ideal candidates for remote diagnostic and screening services. Early diagnosis of diseases or risk factors for heart disease, cancer and stroke are key components of hospitals and systems moving “upstream” to manage populations earlier in their disease process.

Lack of physicians: In markets that are candidates for Level 2 models, lack of services goes hand in hand with lack of physicians to provide those services. As such, any mobile health model must consider the way in which provider needs will be addressed. Mobile services provided by non-physician providers are becoming increasingly common in most markets. This is historically true for imaging diagnostics, and is increasingly so for other types of diagnostic and treatment services. The most rural areas continue to test and consider models that allow highly trained and remotely monitored non-physician providers to deliver additional care.

As hospitals and systems develop Level 2 services, it is beneficial to develop a portfolio of remote services for high-incidence, high-cost diseases. Since few, if any, hospital systems in most markets have aggregated such a portfolio of services, there is likely a first mover advantage to solidifying markets.

Level 3: Primary care

The Level 3 ambulatory model is a combination of primary care services and supporting diagnostics needed to care for local populations at a permanent location. For hospitals and systems to be effective in population and patient health management, Level 3 ambulatory models must be aligned and developed throughout the organization's markets. The competitive advantage for this model is the optimization of value for patients and employers, achieved by providing high-quality care and excellent service in a convenient location and at a reduced cost.

The key challenge in this model is to provide the correct range of service options without expanding the menu of services to a level that adds complexity or lacks financial viability. The best mix of services can be determined by separating the Level 3 ambulatory model into its three major components based on who determines the need for care: patients, employers or physicians.

Patient-directed care: In patient-directed care, the patient has identified that he or she needs medical care immediately, but the degree of care has not yet reached emergent levels. These criteria set Level 3 care apart from the other levels of care because they suggest that patients will be drawn to their perceived highest-value location for care when their primary care physician is unavailable or they have not cultivated that relationship. The most common patient-directed care models include urgent care facilities, retail clinics, and primary care offices with extended or walk-in hours.

Urgent care: Urgent care is characterized as the delivery of medical care outside of a hospital emergency department on an unscheduled, walk-in basis. Both retail clinics and physician offices with extended hours are types of urgent care locations, providing better access in a lower-cost environment.

Employer-directed care: This relationship is generated through the legal requirement that employers have workers' compensation insurance. As in patient-directed care, value needs to be optimized, which centers on the employer's need to minimize absences due to health or injury and ensure employees are ready to return to work after an injury.

LEVEL 3: PATIENT-DIRECTED CARE EXAMPLE

Southern Urgent Care has 19 locations, 50% in occupational medicine and 50% in urgent care.

These entities are run like urgent care entities, which has its own implications:

- > They operate seven days a week, but hours of operation vary by clinic
- > They are always staffed with a physician in urgent care and a mid-level staff person in occupational medicine
- > They accept select forms of payment

These clinics have performed well over the past 25 years, with an annual EBITDA of 19% and net income of 15%.

Level 4: Single-specialty diagnostic and treatment

Level 4 ambulatory models move beyond basic primary care to focus on a single disease state with specialty physicians, diagnostic and treatment elements. These are "specialty-focused factories" and provide access to the full suite of services traditionally found only on hospital campuses. Sometimes, Level 4 services are co-located with primary care diagnostic and consultative services. Often, these centers also offer access to non-clinical services related to their specific disease state (such as social work and counseling services).

Over the past decade, many Level 4 ambulatory models have sprung up as a result of technology, regulatory and reimbursement trends, allowing physicians to invest in providing highly reimbursed technologies and thereby supplementing their professional fee incomes. As such, Level 4 models have historically been seen as competitive to a hospital's mission. However, the trends toward physician ownership of diagnostic and treatment services in a Level 4 setting are becoming so entrenched that many hospitals have sought to joint-venture Level 4 projects with physicians as a way of aligning the economics of hospitals and physicians.

While economic considerations are critical to the discussion of Level 4 models, the following patient care benefits should also be considered.

Convenience. By providing single-site, off-campus access to a comprehensive array of services, this model eliminates travel and scheduling burdens placed on patients by co-locating multiple outpatient services or eliminates the burdens associated with navigating large, complex inpatient facilities for ambulatory care.

Efficiency. Focus on a single disease state allows operations (such as staffing models, care protocols and service standards) to be tailored to the behaviors of a relatively uniform patient population. As a result, such centers can reduce costs via high resource utilization and eliminate patients' non-value-added time during care (e.g., wait-time).

Expertise. Focus on a single disease state also enables subspecialization of physicians, nurses, mid-level providers and technicians, which can increase the clinical quality of care provided.

The most successful Level 4 models have a combination of higher-reimbursed services and a focused patient population with common needs or services for which care is primarily provided on an ambulatory basis. Population-centered models most often serve women or children. Service-centered models often focus on orthopedics, GI and digestive diseases, eye, dermatology and plastics, and cancer.

Level 5: Destination ambulatory centers

Level 5 ambulatory models combine a broad range of specialties in a typically multidisciplinary or quasi-multidisciplinary fashion. The model benefits from a critical mass of services and physician specialties such that the location of these centers becomes a “destination” for health care, similar to hospitals. As such, the infrastructure to support a Level 5 ambulatory model typically resembles a community hospital without beds. Historically, in a hospital-centric paradigm, the Level 5 ambulatory model typically was used as a starting point for developing a new hospital in a growing suburban market. However, with the shift to outpatient care and the demand for more-efficient methods of delivering ambulatory care, the Level 5 ambulatory model is being viewed as an end point.

LEVEL 4: SINGLE-SPECIALTY DIAGNOSTIC EXAMPLE

The Rocky Mountain Cancer Centers (RMCC) provides an example of Level 4 services. The multispecialty group consists of 70 physicians in the Mountain market that offer services at 20 sites.

While some of the sites are essentially physician offices, offering consultative services only, the group has several centers that offer single-site access to a wide array of co-located outpatient cancer services. The more comprehensive centers not only offer clinical care, but also participate in clinical research and offer on-site access to social workers.

Essentially, RMCC's distributed network of Level 4 centers allows many Colorado residents to access comprehensive cancer care, close to home, without navigating cumbersome inpatient facilities. Moreover, co-location of physicians and a common practice infrastructure enables a multidisciplinary approach to diagnosis, planning and treatment.

The benefits of specialty services being grouped into a Level 5 model are fivefold:

- » **Accessibility:** The lack of inpatient beds and the supporting infrastructure required by a hospital allows even very large Level 5 settings to be more accessible to patients than a hospital. This accessibility comes from locating the centers in new growth areas where hospitals have not been developed and from the simplicity of navigation through the campus and the building.
- » **Full range of services:** Physicians and patients benefit from a single “one stop” location with a full range of services. Convenience is often enhanced by open scheduling practices for diagnostics on the campus, allowing patients seeing on-site physicians to schedule and complete needed diagnostic testing in one location.

- » **Multispecialty:** The multispecialty nature of the location is a requirement for effective, rapid cross-referrals in a multispecialty group. Even in the private practice environment, the ability to cross-refer patients increases through the proximity of independent groups. Moreover, most Level 5 settings have developed the reception, registration and information system infrastructure to replicate multispecialty group information flows.
- » **Predictability:** With the exception of freestanding ERs, all of the patients receiving services in a Level 5 ambulatory model are elective and highly predictable in their treatment patterns. Those that are not predictable (ER patients) are generally self-contained within the ER or of such low volumes that they do not disrupt the high-efficiency, fast-turnaround nature of the campus. This predictable nature allows the Level 5 ambulatory model to operate more like a focused factory than even small community hospital settings can.

- » **Efficiency and costs:** With predictability comes greater efficiency. Efficiency coupled with reduced supporting infrastructure (few 24-hour services) and lower-cost facilities results in the ability to contain costs better than alternative delivery mechanisms.

Conclusion

Using this systematic approach, hospitals and health systems can quickly plan, identify and execute on a successful ambulatory strategy to better organize and coordinate care for their patient populations. This framework provides a clear model for organizing future ambulatory services to best serve the patients in their specific communities.

Sources

1 http://www.hcplive.com/print.php?url=pc_online_physician_consultations; January 21, 2009

2 *Emerg Med J* 2010;27:186e188. doi:10.1136/emj.2009.073056

EXHIBIT 2: Destination Ambulatory Center Examples

Midwestern System has several ambulatory destination centers.

SERVICES	SITE 1	SITE 2
Physician Model	> Employed physician group	> Independent physicians
Primary Care Physicians	> 20 FTE > Several physicians in off-site Level 3 models supporting	> 12 FTE > Several physicians in two off-site Level 3 models supporting
Specialty Care Physicians	> 40 FTE	> 10 FTE
Emergency Room	> 65,000 visits > 5.5% admission rate > 26 treatment bays > 6 short-stay beds	> 20,000 visits > 3% admission rate > 15 treatment bays > 6 short-stay beds
Diagnostics	> Full range of non-invasive imaging and specialty diagnostics > Mobile PET, MRI	> Full range of non-invasive imaging > Echo, EKG
Procedural	> 6 operating rooms (2 eye rooms) > 2 procedural rooms	> 6 operating/procedural rooms

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AUTHORS

Kate Lovrien is a senior manager and Luke Peterson is the national director of Kurt Salmon's strategy practice. They have focused their careers on advising community and regional referral hospitals and health care systems on their strategic, physician alignment and organizational challenges. They can be reached at kate.lovrien@kurtsalmon.com and luke.peterson@kurtsalmon.com. Brandon Robertson and Mackenzie Santana of Centura Health also contributed to this article.

CONTACT

120 South Sixth Street, Suite 1600
Minneapolis, MN 55402
612.378.1700
www.kurtsalmon.com