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AMBULATORY CARE OF THE FUTURE

OPTIMIZING HEALTH, SERVICE AND COST BY TRANSFORMING THE CARE DELIVERY MODEL

THE CHARTIS GROUP
Management Consultants

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Ambulatory Care of the Future: Optimizing Health, Service and Cost by Transforming the Care Delivery Model

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The Increasing Focus on Ambulatory Care

Managing ambulatory care has become critically important from numerous perspectives, including the financing and delivery of comprehensive, coordinated patient care. In markets dominated by fee-for-service reimbursement, outpatient services provide the majority of operating margin for most health systems. In more advanced managed care markets, successful ambulatory operations are essential to effective patient care and population health management. Outpatient care continues to expand as increasing numbers of procedures and treatments transition to the ambulatory setting. For these and other reasons, improving ambulatory performance has become a top strategic priority for health systems nationwide.

Achieving superior ambulatory performance in a manner that improves health, patient experience and cost is vital to future health system success

Health system leaders face a range of managerial challenges as ambulatory care becomes increasingly important and complex. Some health systems are developing new operational processes and systems as they attempt to better coordinate and manage a broad, distributed network of ambulatory locations comprised of diverse providers. These forward-thinking organizations recognize that achieving superior ambulatory performance in a manner that improves health, patient experience and cost is vital to future health system success, even if the challenges of achieving these improvements can be daunting.

Ambulatory Care Becoming Increasingly Complex

Effectively managing ambulatory services has become progressively more difficult for provider organizations. Many providers find their capacity and resources stretched to the limit by continued growth in outpatient volumes. Over the past 20 years, a broad range of care has steadily transitioned from inpatient to outpatient settings. In fact, from 1988 to 2008, the percentage of total hospital gross revenue attributed to outpatient activity increased from 21% to 39%.[1] This trend is expected to continue, with outpatient visits projected to grow by more than 20% by 2019.[2]

Primary care continues to serve as the initial entry point to the health care system for many patients and is the conduit for more specialized downstream services. However, the structural and geographic complexity of many primary care networks has signifi-

cantly increased. As networks have expanded, so have the challenges associated with managing a diverse collection of physicians, with differing loyalties, referral patterns and behaviors. Today, many network structures more closely resemble a loosely-configured set of physician practices, rather than a coordinated, integrated organization. Effectively managing these sprawling networks to achieve superior performance is a difficult task that crosses a wide range of processes and systems, including operations, IT systems, personnel, and governance.

The changes impacting specialty services differ, but are equally challenging. Advances in technology, coupled with an expanding number of prescription medicines, have led to increasingly complex treatment regimens in the outpatient setting, requiring interdisciplinary coordination. For example, a single cancer patient may receive care from many specialists, including medical oncologists, radiologists, radiation oncologists, pathologists, surgeons, and reconstructive surgeons, with each specialist typically responsible for only one aspect of care, and no professional managing the patient's overall care across the continuum of services. These trends are visible in many specialty areas, such as cardiac care and diabetes, and require greater management sophistication and care coordination than ever before.

While providers are determining how to effectively deal with these changes in ambulatory volumes, network scale, and care complexity, they are facing greater performance pressure from payers in many markets. As payers move to limit payment for readmissions and begin to more rigorously evaluate Ambulatory-Care-Sensitive Admissions, in which effective outpatient care can often prevent hospitalization, provider organizations are focusing on follow-up care and patient transitioning from inpatient to post-acute care. The ability to manage chronic conditions with demonstrable positive outcomes is starting to pay off in some markets. For example, in 2009, BCBS of Massachusetts began implementing a new payment system which explicitly connects payments to achievement of health, quality, and budgetary goals. Providers can earn incentive payments up to 10% of the total per member, per month payment based on performance along a range of ambulatory and hospital care measures.[3] As market forces continue to evolve, with incentives and rewards increasingly tied to outcomes across the continuum of care, progressive provider organizations are searching for a comprehensive approach to improving ambulatory patient service and access.

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HealthPartners Medical Group: An Innovative Model of Ambulatory Care Delivery

History and Background

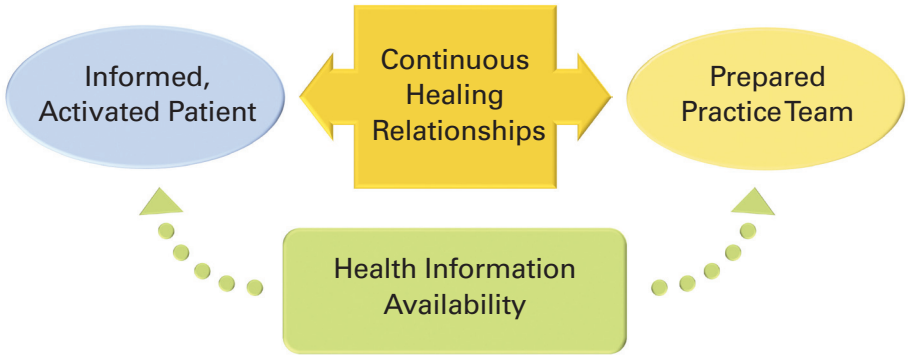
Most leading health systems are assembling the components to enable them to deliver consistent, coordinated care; to date, few have realized that vision. In 2004, HealthPartners Medical Group (HPMG) in Minneapolis introduced an innovative program that successfully integrates care delivery while simultaneously improving health, experience and cost. Over time, HPMG has applied this innovative approach to its entire patient population of 400,000 people, spanning multiple payers and conditions and has achieved significant system-wide improvements in service, outcomes and costs.

With a motto of "Health is what we do. Partnership is how we do it," HPMG's model fosters collaboration with its patients, referring providers, and its internal teams. Starting with Ed Wagner's Chronic Care Model, HPMG's Care Model Process© evolved from an initial concept HPMG called 'The Planned Care Model.' This model is centered on creating continuous healing relationships through the partnership of the prepared practice team, the informed, activated patient, and the availability of health information (see Figure 1). Early initiatives focused on patient access, operations improvement and practice team role definition. In addition, a system-wide EHR was implemented enabling health information availability across providers and sites of care. Ultimately, the overarching framework of the newly developed Care Model Process© brought together all previous initiatives and components to optimize ambulatory care design.

FIG. 1

The Planned Care Model

A condition-neutral, planned care model across primary and specialty care



HPMG's Care Model Process© Design

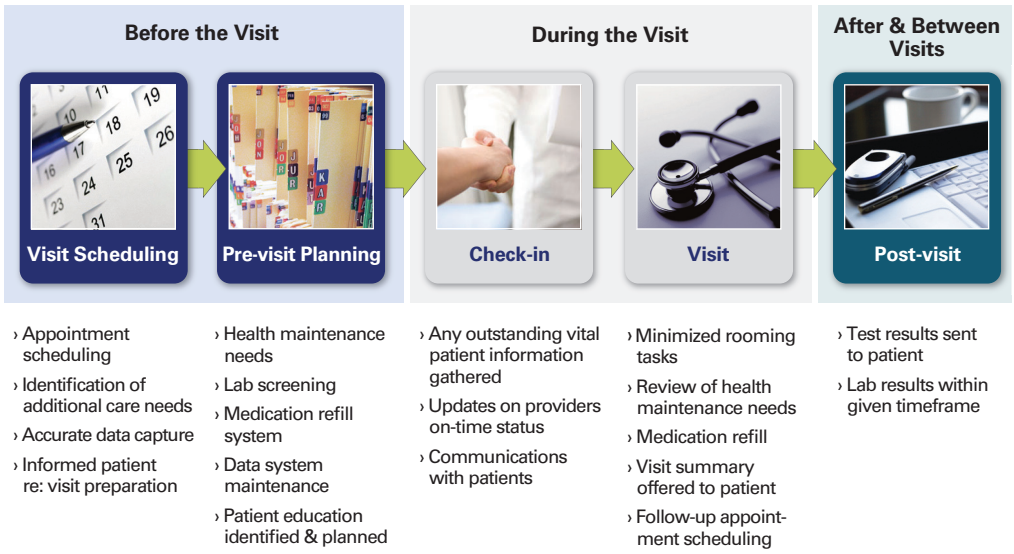
The HPMG model transforms the traditional office visit into a broader relationship with the patient that extends beyond the visit (see Figure 2). From the outset of the design process, HPMG set goals for the overall design including: be transferable across all conditions; increase provider efficiency; have the right person doing the right work; reduce variation in all workflows; support the patient-provider relationship; align accountabilities; and, most significantly, utilize no incremental resources.

Once the steps in the overall visit cycle were identified, modules were developed for each segment of the process. The modules were designed by physician-led, cross-functional teams which included nurses, operations and clerical staff, patients and other providers as needed (e.g. dieticians, pharmacists, and patient educators). The tasks within each segment were identified, optimized for efficiency, and assigned to a specific staff or provider role. HPMG began the design process with the "during the visit" stage, as it was easiest to engage patients when they were physically in the clinics, had the fastest time-to-implementation of the design changes, and allowed design team members to witness immediate results, helping to inform the design processes

for the other visit cycle segments. By largely standardizing the care processes, Care Model Process© frees the practice team to focus on care provision, and minimizes the time required for 'workarounds' resulting from broken processes and ill-defined roles.

FIG. 2

Care Model Process©: Key Components



Before the Visit – In HPMG's model, patient care is a continuous focus, even during administrative tasks, such as appointment scheduling. Utilizing a centralized appointment center, clinic schedulers use standard processes and protocols. Regardless of the primary care discipline or physician with whom the patient is seeking an appointment, the scheduler reviews health maintenance care needs with the patient and offers scheduling of any additional services, in addition to scheduling the originally requested appointment. Once the visit is scheduled, the patient is contacted by HPMG in advance of the visit to verify the required patient information and arrange for any pre-visit requirements, such as forms to complete or lab tests to be performed, to ensure an efficient clinic encounter.

During the Visit – Upon arrival at any of HPMG's 23 primary care and numerous specialty clinics, patients are greeted in a welcoming, yet scripted manner. All patients consistently proceed through a standardized check-in process that includes verification of insurance and demographic information and collection of co-payments. The physician's (or other provider's) on-time status is communicated to the patient, and the patient is offered several options if the provider is running behind. Regardless of the reason for the patient's visit, general health maintenance needs are reviewed with the patient to provide ongoing management of periodic health needs (e.g. medication refills), chronic care conditions, and/or required immunizations and the like. At the conclusion of the visit, patients are provided with after-visit summaries, and future appointments are scheduled before the patient leaves the clinic.

After and Between Visits – Perhaps the most significant contributor to HPMG's ambulatory care model success is consistent and standardized management of the

intervals following visits and between visits. Patients receive timely notification of every test result by their preferred method of contact – mail, phone call, or electronic message. Currently, 93% of all lab test results are automatically released via HPMG's On-line Services within 24 hours. This aspect of the model keeps patients informed and engaged in their own care and increases patient compliance and satisfaction. Patients have commented that they really feel "taken care of" or that HPMG "really cares about me," due to the follow up calls and information provided by HPMG during these intervals.[4] HPMG can more effectively manage several primary care health maintenance processes, as well as chronic conditions, due to the successful implementation of between visit protocols. The work to design the between visit protocols began in 2007 in several targeted clinical areas. Today, HPMG has between visit protocols for diabetes, CHF, depression, mammography, colorectal screening and other preventative services, tobacco cessation, pediatric immunizations, child and teen well visits, and pediatric asthma.

Organizational Structure and Cultural Transformation

The existing dyad physician/administrative model was highly leveraged to align the organizational structure with the new patient care model. Similar to the standardization applied across patient care processes, all departments, clinics and administrative areas of the organization are standardized in structure and administrative processes. Medical directors are paired with the appropriate vice presidents; clinic chiefs and department directors are paired with the appropriate administrative supervisors. This structure provides the appropriate balance of clinical and business decision-making and helps the organization transform its culture toward patient-centered care.

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The cultural transformation extends beyond organizational structure toward HPMG's goals of achieving a uniform patient experience across all clinics and providers. HPMG conducted numerous discussions with physicians, starting in 2006, to create a joint vision of how health care should be provided. Together, physicians and administrators established a Physician and Dental Partnership Agreement, which explicitly outlines the "gives" from each side in order to make the joint vision of optimal patient care a reality. For instance, administration agreed to "provide an environment and tools to ensure satisfying and sustainable practices," while the physicians agreed to "reduce unnecessary variation in care to support quality, reliability, and customized care based on patient needs." These tenets are the basis for the cultural change. This partnership agreement and expected behavior is explicitly discussed with prospective physicians during the recruiting process.

HPMG's shared culture is maintained and supported by a high degree of data transparency to promote ongoing improvements, as well as consistency, in care and patient experience. HPMG employs a set of nested data analytics that can be summarized at the system level and can be drilled down to the clinic, physician and individual patient levels, providing progressively more granular information. This information enables HPMG to understand systematic differences across the organization, pinpoint the source of the disparity and develop targeted solutions. The reports also include internal and external benchmarks and are readily available to practice teams on HPMG's intranet. This level of data transparency, coupled with

the feedback mechanism of the data reporting, ensures accountability, adherence to the culture and standards of the HPMG patient care model, and promotes a culture of continuous improvement.

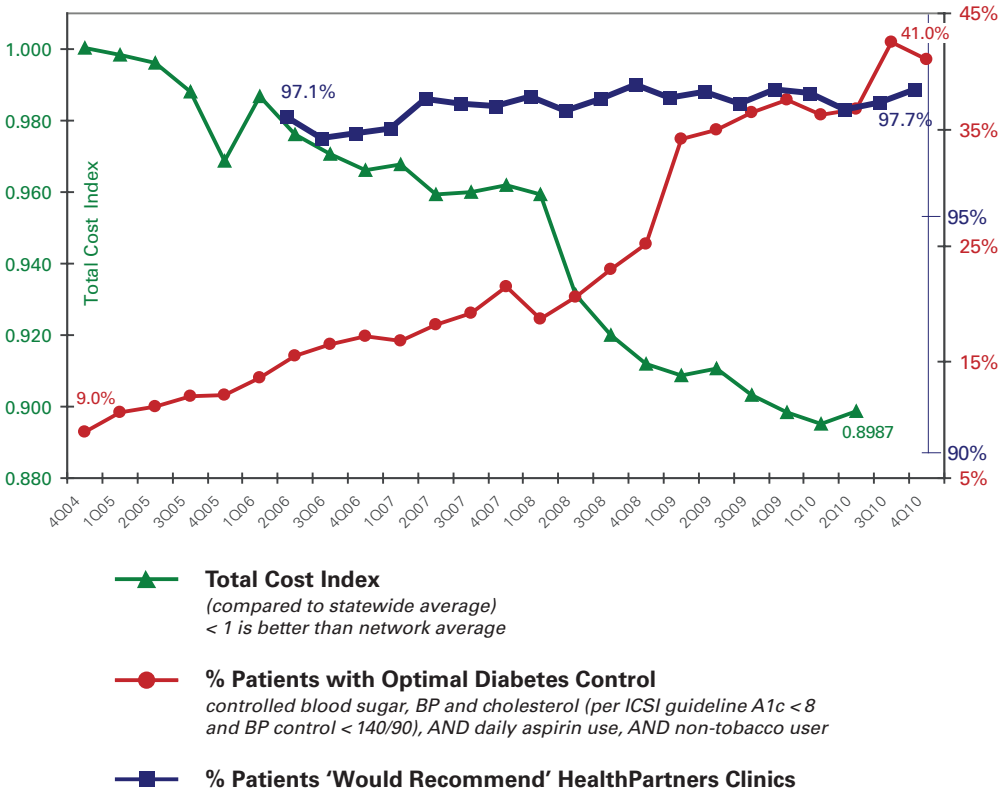
Results

HPMG's work has resulted in significant improvements in the areas of health, patient experience and affordability. As illustrated in Figure 3 below, HPMG has demonstrated dramatic improvement over the past 10 years, across the measures of health (41% of patients with optimized diabetes control[5]), experience (98% of patients would recommend HPMG clinics), and affordability (10% below statewide total cost average). Since the beginning of the Care Model Process© design, HPMG has also reached benchmark levels of employee satisfaction,[6] improved physician satisfaction from the 25th to the 82nd percentile of AMGA member levels, advanced clinical productivity from the 33rd to the 63rd percentile of MGMA standards, and attained a level of 30% same day patient access to providers.[7] In 2009, all HPMG primary care sites were awarded the distinction of being one of the first NCQA-recognized medical homes. Today, HPMG maintains its relentless commitment to performance and continuous "real-time" improvement and modification in the areas of health, experience and total cost.

HPMG's work has resulted in significant improvements in the areas of health, patient experience and affordability.

FIG. 3

HealthPartners Clinics Results: Health-Experience-Affordability



Ambulatory Care Design Principles

Organizations often want to fast-forward to the design phase in order to see rapid improvements and organizational change. Although this approach may result in short-term incremental changes, long-term success is only achieved if alignment among the leadership team and key stakeholders is established around key design principles.

Through our collaboration with HPMG and other clients, we have found that an initial focus on five key design principles provides a foundation for defining the vision and goals of each organization's future ambulatory care model. (See Figure 4 below.) By gaining agreement among the leadership team and key stakeholders on what the future ambulatory care model will encompass, the stage is set for the requisite cultural changes that will ultimately need to occur.

An initial focus on five key design principles provides a foundation for defining the vision and goals of each organization's future ambulatory care model.

A successful ambulatory care operating model must be founded on the following five design principles to ensure success:

1 | Culture & Alignment: Leadership must set a direction for ambulatory operations by aligning around the expectation that the organization achieve excellence across all three aims: health, experience, and total cost. Leadership must explicitly signal their intention to transform care delivery, and their belief that achieving all three aims is desirable and possible.

2 | Reliability: Key processes must systematically and consistently deliver the best care. This often requires some level of standardization to an identified best practice, minimizing variability resulting from individual provider preference.

3 | Customization: Once a process has been standardized to support reliability, care is then tailored to individual patient needs and values. Customization is not at the whim of the practice or individual provider, but rather dictated by what the patient requires.

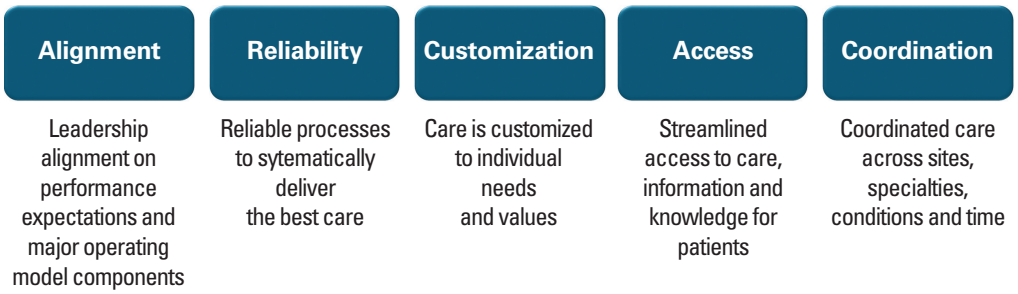
4 | Access: Access to care and information is the foundation of care delivery. Design must ensure streamlined access to care, as well as to the information and knowledge needed by patients and referring providers to understand and participate in decision-making to achieve healthier lifestyles.

5 | Coordination: As ambulatory care becomes more complex and organizations seek to move patients to the most cost efficient care setting possible, effective and efficient mechanisms to coordinate care across sites, specialties, conditions and time are required.

With the design principles in place, organizations can take a fresh look at their existing operating models and candidly assess strengths and weaknesses against these five principles, thereby identifying the biggest gaps to be filled in the new model design. Designing the operating model according to these principles will meet today's needs as well as position the organization for expected future changes in the industry. Organizations will need to shift from an operating model defined by fragmentation, autonomy and a physician-orientation, to one that is patient-centered, and focused on providing seamless and consistent care across all ambulatory settings. Starting with, and continually revisiting, these design principles will

enable an ambulatory care operating model that is flexible, yet drives a consistent and enduring culture and approach to care delivery.

FIG. 4
The Chartis Group – HPMG Ambulatory Care Design Principles



Developing the Future Ambulatory Care Model

The HPMG model has been very successful at achieving documented results and has been widely recognized in national industry venues. However, other systems should not seek to create exact replicas of the HPMG ambulatory care model. Each organization must establish both a design process and ambulatory care operating model that aligns with its own strategic plan, clinical goals and priorities, as well as unique, market-specific factors. That said, there are specific operating model components that are shared amongst successful ambulatory care models:

Organization Structure and Clinical Operations Oversight. For many ambulatory networks, the organizational structure and oversight function has not been fully developed. To transform care across multiple, and often disparate entities, new attention must be given to how the entities relate to one another and to how clinical operations are managed across the network. Overarching operational authority must be established to support consistency around determining how and by whom key clinical operating decisions will be made, including policies and procedures, standardization and centralization.

Designation of Centralized Versus Distributed Nature of Core Processes. In the evolution of an ambulatory network, it is essential to determine which aspects of operations could be more effectively managed centrally and which should remain within the purview of each practice. Key processes and roles, such as scheduling and registration, performance measurement and reporting, and shared services staffing, are often evaluated for centralization as organizations seek to benefit from economies of scale and appropriate standardization. This type of targeted centralization can strongly support an organization's cost management strategy of delivering affordable care.

Care Delivery Process. The new operating model rests on a foundational set of core processes and roles that come together to transform care delivery. The principles of standardization, reliability and customization to the patient are essential in creating a new care delivery process that will meet patient and referring physician needs.

Practice Team Development. Design and execution of the new care delivery processes depends on a high functioning practice team. To succeed in the future, practices will need to reassess staffing complements in light of new care requirements and then ensure all members work to the top of their licensure. Defining the right mix of care providers – physicians, associate providers, RNs, LPNs and medical assistants – to provide the right care, is an essential ingredient to ensuring that care is accessible and affordable. As ambulatory networks become large and complex, a strong, well-defined practice team can innovate to continually improve processes and roles, leading to improved performance.

Harnessing Information and Data. Although many organizations have mastered measurement of some core operational processes, such as revenue management and productivity, most have not evolved systems of measurement to include a closer scrutiny of experience and health outcomes, access to care and cost across the continuum or episode of care. Building capabilities and harnessing systems to inform care delivery (for example, to understand what the next care intervention should be), and understanding performance across all three components of health, experience cost, will become increasingly important as health care systems evolve to manage patients across the continuum of care and respond to payers' increasing interest in outcomes and care settings.

Provider Capacity and Utilization Management. More than ever before, it is important to optimize the use of provider and facility resources. After defining the optimal staffing complement, practices will need to translate the clinical commitments of their providers into effective schedules that are coordinated across the practice and sites, and which optimize facility use. Organizations will need to create more sophisticated and proactive methods for managing provider capacity and utilization to ensure optimal performance.

Incentives. As organizations evolve their operating models to meet future ambulatory care requirements and strive towards optimal results, they inevitably will need to revisit how they are incenting their staff, particularly physicians. As described before, many aspects of the operating model will need to change, requiring individual behavior to change as well. For employed physicians, the compensation model must be realigned with the new organizational objectives, must be affordable, and must instill greater individual discipline and accountability. For non-employed physicians, organizations will need to push aggressively towards clinical integration, to support alignment and achievement of common interests.

As organizations embark on their own ambulatory care design initiatives, these comprehensive operating model components can serve as building blocks for each organization to establish sustainable ambulatory performance improvement. As the ambulatory care landscape continues to transform, providers will need to successfully position themselves by putting into place new operating models designed to support increasingly higher levels of performance. Achieving simultaneous results in health, patient experience and cost in the ambulatory setting is not only doable, it is imperative, as overall health system success will be increasingly linked to ambulatory care success.

The principles of standardization, reliability and customization to the patient are essential in creating a new care delivery process that will meet patient and referring physician needs.

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