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Grow hospital market share by integrating ambulatory care across acute service lines

A conversation with Vizient care redesign experts

Introduction

Health systems are facing pressure to grow their footprint and expand services to get ahead of active disruptors in their markets. Many are also working to create better access for patients – all with the goal that building consumer loyalty will bring about financial stability.

A redesigned care model that incorporates strategic ambulatory sites of care also benefits a stretched-thin workforce, improves the patient experience, aligns service lines to improve reimbursements and more.

In this report, you'll find insightful conversation between Vizient experts sharing examples of how health systems can deliver better quality care, increase patient access and satisfaction and overcome challenging payor models by embracing a care redesign strategy.

About our experts

Michael Strilesky

Senior Principal, Physician Strategy Consulting

Mike is a senior principal with more than 18 years of experience leading physician strategy consulting.

He has worked across all aspects of the provider continuum and developed strategies and led engagements for community hospitals, integrated delivery networks, academic medical centers and independent provider organizations.

Tomas Villanueva, DO, MBA, FACPE, SFHM

Senior Principal, Clinical Operations & Quality

Tomas is a board-certified Internist with an extensive background in the acute, subacute and ambulatory arena, and more than 20 years of physician leadership experience.

He serves as a clinical lead for efforts with acute and ambulatory quality, length of stay reduction, mortality index reduction and HEDIS score optimization.

Brian Hardy, RPh, MBA

Associate Vice President, Pharmacy Consulting

Brian is a consulting leader with over 25 years of experience supporting health systems develop ambulatory pharmacy teams.

His work helps health care organizations identify opportunities for implementing or expanding outpatient retail ambulatory, central fill and/or home delivery and specialty pharmacy operations.

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Optimizing service lines outside the hospital

How can hospital leaders determine which services can be moved out of the acute care facilities and delivered more effectively in the ambulatory setting?

Mike Strilesky:

One of the main drivers of an ambulatory strategy is considering how your patients are accessing services and assessing which of those services can be delivered more efficiently in another setting.

Take the operating room for example.

There is a tremendous number of cases being done in hospitals that are better suited to be performed, from a patient convenience and workforce efficiency standpoint, in an ambulatory surgery center (ASC). This disruption can become a strategic revenue driver that both alleviates in-patient capacity issues and captures growth in your market.

To demonstrate how big this opportunity is, double-digit growth is projected for patient volume across ASCs, physician clinics and hospital outpatient departments over the next five years, with patient volume for ASCs expected to grow by 25% over the next 10 years.[1]

Leaders in this space are asking themselves "What's the most convenient opportunity to engage patients?" In some instances that might be a virtual visit instead of a physical site, which shows just how much disruption the healthcare industry is going through right now.

What can health systems do to create a focus around moving pharmacy services to the home setting and what challenges can arise in that space?

Brian Hardy:

Expect to encounter challenges in getting medication delivered to the home, third-party payor coverage and nursing support. We're experiencing nursing shortages nationwide and we've seen a lot of delay in terms of site of care policies because even payors are finding that their own home infusion services are difficult to staff.

Another challenge is around financial reimbursement. During the pandemic, the Centers for Medicare and Medicaid Services (CMS) opened home infusion reimbursement for but limited it to days in which that there is nursing support for the infusion. Meaning there is no reimbursement on non-nurse administration days.

Tomas Villanueva:

Health systems should also continue to develop their own virtual platform. Some physicians have pushed back on that due to concerns around compensation, but the reality is that half the patients whom I treat for chronic conditions can be seen virtually. Follow up visits are often discussions about titration which I could do just as easily on a virtual platform. Not only from a convenience standpoint but it also improves access as well. This is the case not only in primary care but also in specialty.

Getting ahead of disruption in the ambulatory market

What are some of the market trends in prescriptions that are impacting providers?

Brian Hardy:

Over half the prescriptions that were dispensed in 2020 were for specialty medications and there has also been tremendous growth in home infusion leading it to become a $19 billion market today.

There are also threats to health systems participating in the 340B program with manufacturers limiting the amount of products contract pharmacies can receive due to a reaction by many manufacturers about duplicate discounts and concerns about paying rebates and 340B prices. You can see a disproportionate share of hospitals that are at risk of losing eligibility in the program.

New entrants like Amazon are moving into home delivery and specialty pharmacy. You see Humira, the highest spend outpatient drug, losing patent protection. We're going to see some alignment with the payors around which biosimilar they prefer as more biosimilars for Humira come to market. Those are some of the major concerns impacting the financial viability of outpatient pharmacy care.

The challenge and opportunity facing providers today is providing care in alternate settings and being able to:

- Have home infusion services deal with less acute care types of patient populations
- Offer outpatient retail pharmacy services and to have alternate site infusion centers off campus
- Operate consolidated service center pharmacy operations for specialty pharmacy

Health systems should look at using home infusion pharmacies and potentially alternate site infusion pharmacies, as well as using clinical pharmacists to schedule the delivery of medications. This helps create an ambulatory hub for patient populations outside of the hospital.

Within the hospital, we're seeing a lot of retail and specialty pharmacy that is aligned with discharging patients either home or to a skilled nursing facility. There's compliance packaging that can be offered for these patients and these services become more necessary due to the payor environment.

Health systems must already have these services or be able to align with those third-party payor activities to be able to negotiate with payors.

How are new entrants innovating in the ambulatory care landscape?

Mike Strilesky:

We're seeing a lot of disruption right now. Innovators are figuring out how to manage patient care across sites of care that are lower cost and can provide equivalent or higher clinical quality as well as achieve better access for providers and patients.

Health systems cannot simply assume they own the continuum, they must innovate in how they deliver ambulatory and retail care while simultaneously doubling down on making the hospital highly relevant to the community. We're seeing these changes play out:

- Digital channels are derailing conventional referral channels
- Rising acuity is restricting scheduled specialist access
- Disengaged patients are deferring preventative care
- Workforces are centralizing around primary care provider clinics

Brian Hardy:

We're seeing insurers come together as both the insurer and the care provider to create a model where the reimbursement protocols are shifting the care to their own specialty pharmacy infusion operations or aligning with a partner to operate infusion centers. These insurers are driving patients to their preferred sites of care for treatment to better control the costs where patient care occurs.

There are serious threats from these consolidations. The challenge for health systems is that if they don't have alternatives to provide care in sites that are aligned with a payor strategy, they're at-risk for no longer being able to provide care for those patients. We see that both in terms of site of care policies and reimbursement.

Operating your workforce at the top of their license

Can you share some of the challenges you're seeing right now as they relate to the workforce and a few opportunities that can enable teams to work at top-of-license?

Tomas Villanueva:

The reality is that burnout is real among our physician colleagues. A great majority of them are a overwhelmed right now. The electronic medical record is something that is causing a lot of frustration. Practically every time an upgrade occurs the platform changes its workflow. From a physician perspective, changing the flow changes the way I think, and that makes me nervous because in doing that I may have missed something; it's no longer: write an order and it gets done.

Another challenge is patient access. Many of us also have a huge issue because our patients are telling us they're unable to see us. At my practice right now, it takes three months to see me. There have been situations where patients should have been seen sooner but waited and their condition worsened. Systems that base their access on the physician availability are destined to fail, most already are.

Patients are generally getting older and sicker. Our country has not gotten healthier since the pandemic. What we need to do is start embracing operating a top-of-license, based on our compensation model, and many of us have difficulty doing that but the reality is that not everyone needs to see a doctor.

Everyone needs to be seen, just by the right person at the right time, but today's compensation models prevent that mentality. Physicians are taught to be autonomous. Many of us may see other clinicians working at top of license as a threat but we cannot possibly treat the patients that need help at this moment unless we develop a methodology embracing top-of-license treatment.

Brian Hardy:

Health system pharmacies are experiencing their own workforce challenges, especially technician shortages. Technological and regulatory advancements will allow for technicians to practice at the top of their license, with technology and automation reducing the technician workload and labor for prescription dispensing. This will help reduce the impacts of the shortage while improving job satisfaction.

We see a lot more automation in pharmacies today. There are conveyor belts in central fill activities that take a lot of the dispensing functionality out of retail sites and allow pharmacists and technicians to focus more on patient care in the ambulatory setting.

There are also opportunities where pharmacists can support physicians with collaborative practice agreements. For example, in some states there's a lot more opportunity for getting technicians at the top of their license so they can provide immunizations, something that has been a great function of pharmacy during the pandemic. This underlines one of the biggest challenges – there isn't a central body regulating the practice of pharmacy; it's done on a state-by-state basis.

If this is addressed and through the investment of automation, technicians will be able to provide support and immunizations, which gives a lot more job satisfaction.

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> **Tomas Villanueva, DO, MBA, FACPE, SFHM**
> Senior Principal, Clinical Operations & Quality

Establishing clinical quality measures across care settings

What measures are used to gauge performance and clinical quality and what can providers do to maximize reimbursement and patient satisfaction?

Tomas Villanueva:

I bucket clinical measures into four distinct categories.

Preventative metrics or performance metrics: Many health systems depend on their physicians to handle chronic disease management (CCM) on their own when in fact the greater bulk of the components of CCM can be done by other members of the team. The same holds true for preventative and screening measures contractually agreed upon with the payor. These can be easily handled with the use of standing orders covered by other members of the team for compliance and contractual success.

Coordination of care: Establishing standing orders can drive care consistency. Additionally, resource utilization can identify those patients at the highest risk for using higher levels of care more frequently. Improving access to care is also important, as is risk mitigation and chronic care management.

Medication management: Assessing where there is there an opportunity to combine medications or remove some altogether using a mindful methodology.

Patient experience: Improving patient access and providing a continuous level of professionalism always enhances patient loyalty.

What are you seeing in terms of innovation in the Medicare Advantage space? In the future will organizations create patient segments and personalized care patterns, and what about markets that serve patients outside of Medicare Advantage?

Tomas Villanueva:

Medicare Advantage plans are definitely growing. Many health systems have taken on contracts to be a part of continuing narrow networks that are occurring, whether it be an Accountable Care Organization (ACO) or a Medicare Advantage.

For many markets, the influence of Medicare Advantage is astounding with close to 50% of Medicare beneficiaries being in some type of program. That involves metrics to decrease clinical variation as well as decrease costs.

As the country continues to get older and sicker, payors will not have the resources unless you have a model similar to a Medicare Advantage. CMS has stated that their goal is by the end of the decade to have the great majority of Medicare beneficiaries and some type of Medicare Advantage or an ACO type of methodolog.

Moving forward, I believe that we'll start seeing that more from our commercial payors for younger patients. People want to pay for outcomes in quality and not so much for episodic care and that's where I see it evolving.

This is where using your workforce at the top of their license comes into play. Some of the most successful at-risk practices that I'm aware of use their clinical pharmacists for the greater part of the treatment of diabetes and hypertension.

There are some protocols involved, but they use guidelines to treat these patients and because there is easier access to the pharmacist, they hit their marks and are doing it cheaper.

To be clear, I'm not eliminating the physician, I'm suggesting improving access to the physician for those patients that need a physician for a higher level of more critical thinking, and those patients that need something, say, above what we could use for the guidelines using the 80/20 rule.

What are the differences in measuring performance across acute and ambulatory environments?

Mike Strilesky:

Ambulatory is a little more complicated than the acute care setting. From a prioritization standpoint, we tend to look at things through a service line lens to understand what's growing and ask ourselves if we're capturing our fair share of the market.

Providers can use claims data to look at the share of care and trend share of care over time. This data is never as complete as inpatient market share but provides a useful snapshot to assess the effectiveness of the ambulatory model of care.

Health systems can also strategize by looking at their metrics related to access and quality. Those two areas will determine your market share and financial performance with payors. Access continues to come up as a lagging indicator to drive new patients to the health system, while quality drives value-based payments and supplemental rewards in addition to consumer behaviors that lead to improved financial performance over time.

Tomas Villanueva:

Too add to that, providers are using the same metrics that payors use to measure performance, Healthcare Effectiveness Data and Information Set (HEDIS) scores being a good example on average. To measure patient engagement, hospitals are mostly thinking in terms of efficiency and access.

Another area of measurement is patient adherence to their medication. Do they have plenty of medication and access to refills? Measuring patient experience and patient engagement can be difficult but what most patients are looking for is efficiency and access.

One measure coming down the line that has already been announced by CMS is going to have to do with vulnerable populations, social determinants of health and how you're addressing those. Getting a process to understand that type of data is key because payors are going to look to health systems to use it in the future.

Four action steps to help your health system achieve growth

1. To address capacity issues, provide better patient access and improve reimbursements, examine your service lines with local market research for opportunities to shift procedures to different sites of care.
2. Use technology to create efficiencies where possible. For example, the use of automation can free your workforce from repetitive tasks and so that they can work at top of license, as well as eliminate human error, increase safety and improve patient care.
3. Become patient-centric and view the total patient experience. Determine and regularly review the patient-led metrics that give insights into how your system is addressing patient utilization.
4. Assess your payor mix, especially in light of the public health emergency ending, and the impact on your system.

References

1 "2022 Impact of Change Forecast." Sg2. 2022. pp. 2.

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