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Taking sight of pediatric point of care – Part 2: the outpatient shuffle and the strategic outcomes

Site of care shifts create opportunity to strategically decant hospital volume

As the hospital campus remains core to higher acuity medical and surgical pediatric volume and increased regionalization further strains hospital capacity, children's hospitals and pediatric programs will need to decant hospital-based outpatient departments (HOPD) procedures and other lower acuity outpatient volume to alternative sites of care, most notably ambulatory surgery centers, and care delivered through virtual modalities.

This dynamic is referred to as the "outpatient shuffle."

1. The "shuffle" to pediatric ambulatory surgery centers (ASCs)

Overall, pediatric utilization of ASCs is expected to grow 5% by 2032. Care redesign efforts, fueled by COVID-19, accelerated the shift of lower acuity procedural volume off campus entirely. As such, those surgeries that are predominantly performed as outpatient procedures will continue to be pushed off campus. While few stand-alone pediatric ASCs exist, children's hospitals are increasingly including ASCs within larger ambulatory hub sites that enable the strategic transition of surgical volume off children's hospital campus. For example, Nationwide Children's Hospital is working to transition all pediatric orthopedic surgeries to a newly developed ASC. Likewise, Boston Children's is building an ASC as part of a suburban expansion project. These developments are part of a broader trend to decant lower acuity volume from the hospital campus to improve operational efficiency and reduce costs.

Table 1. Top pediatric ambulatory surgery center procedures by volume forecast, 2022 - 2032

Procedure	Calendar year 2022 volume	10-year growth (%)
Ear tube procedures and myringotomy	208,000	2
Major procedures	170,000	6
Tonsillectomy and/or adenoidectomy	145,000	5
Open treatment of fracture	31,000	8
ACL repair/reconstruction	13,000	10

Notes: Impact of Change®, 2022; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2® All-Payer Claims Data Set, 2019; The following 2019 CMS Limited Data Sets: carrier, denominator, home health agency, hospice, outpatient, skilled nursing facility; Claritas Pop-Facts®, 2022; Sg2 Analysis, 2022.

2. The “shuffle” to virtual

As in-person evaluation and management (E&M) visits and lower acuity urgent care visits that currently occur in the emergency department (ED) are expected to decline (-10% and -5% growth respectively, 2022 - 2027), virtual visits are on the rise. By 2027, 14% of E&M visits are expected to be virtual representing approximately 48 million visits annually across the U.S. This shuffle is primarily driven by consumers. Consumer market data reveals that 56% of moms with children under age 18 prefer virtual visits over in-person visits.[1] Likewise, 60% of these consumers would use virtual for a minor illness, which is up from 51% in 2019 and surpassing urgent care as the top preference. This study suggests that this shift to virtual is here to stay and will continue to grow beyond 2027.[1]

Figure 1. Pediatric evaluation and management visit point of care forecast, 2022 – 2027

14%
of E&M visits forecasted to be virtual by 2027 (48M)

Top virtual-visit service lines	2027 % virtual
Behavioral health	48
Genetics	26
Neurosciences	24
Gastroenterology	20

-10%
In-person E&M visits 2022-2027 (297M)

Note: Analysis includes 0–17 age group only. E&M = evaluation and management, M = million.
Sources: Impact of Change®, 2022; Proprietary Sg2 All-Payer Claims Data Set, 2019; The following 2019 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2022; Sg2 Analysis, 2022.

Impact of outpatient shuffle on spend

While the inpatient to outpatient shift described in the previous section provides various challenges for providers, the outpatient “shuffle” presents providers with an opportunity to create capacity and reduce spend. As pediatric volume, procedural and other shuffles to lower acuity sites of care, acute care capacity is created for higher acuity, complex care that offers more favorable reimbursement. Lower reimbursement for ambulatory activity is offset by a lower cost structure. The wild card in the equation is the variable spend on non-acute supplies, which are often under different contracts that have different and sometimes higher pricing than acute care contracts.

Biggest rate-limiting factors to widespread virtual visit utilization[2]

Of pediatric provider poll respondents:

consumer disinterest	**36%**
provider disinterest	**30%**
lack of reimbursement	**21%**

Considerations for hospitals

What can providers do to optimize ambulatory utilization and manage spend in the ambulatory setting?

1. Determine optimal patient segments that are prime for the shift off-campus. Criteria for patient segmentation might include the following:
   a. Strong physician support and alignment to support the shift off-campus
   b. Financial considerations (i.e., payer mix, differentials between site of care reimbursement and overall ability to reduce costs and manage spend
   c. Current and future volume potential and forecasted supply need
2. Identify priority sites of care and understand the ecosystem in which they operate.
   a. Explore potential to co-locate ASC with other ambulatory and ancillary services (i.e., ambulatory hub)
   b. Strengthen digital infrastructure and overall system connectivity
3. Assess variance in acute versus non-acute spend for various services. Identify opportunities to close the gap between different pricing mechanisms for various services and/or supplies between acute and non-acute settings.

Considerations for suppliers

How can suppliers and manufacturers support provider partners?

1. Determine where provider partners are in the shift from inpatient to outpatient and which patient segments and sites of care present challenges and opportunities.
2. Work with the providers to understand the variance between inpatient and outpatient reimbursement for patient segments and services that matter most to them.
3. Determine how supply needs vary across various sites of care and work with providers to understand current and forecasted volume for specific patient segments and procedures.
4. Work with providers to assess pricing across contracts to understand where there is acute versus non-acute contract variance. Determine if there are opportunities to better align pricing.
5. Be open and transparent when it comes to price increases. Where there is little wiggle room regarding pricing increases, leverage supply assurance as a value proposition.

References

1 Sg2 National Health Care Consumerism and Insurance Coverage Survey, 2019, 2021; Sg2 Analysis, October 2022.

2 Sg2 webinar poll, children's hospitals and pediatric program stakeholders, November 2, 2022. n = 49

Applied analytics

- Data from the Vizient Clinical Data Base and Resource Manager. All rights reserved. Q1 2019–Q1 2022; Sg2 Analysis, 2022.
- Sg2 Impact of Change, 2022; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2019; The following 2019 CMS Limited Data Sets: carrier, denominator, home health agency, hospice, outpatient, skilled nursing facility; Claritas Pop-Facts, 2022; Sg2 Analysis, 2022.
- Sg2 National Health Care Consumerism and Insurance Coverage Survey, 2019, 2021; Sg2 Analysis, 2022

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