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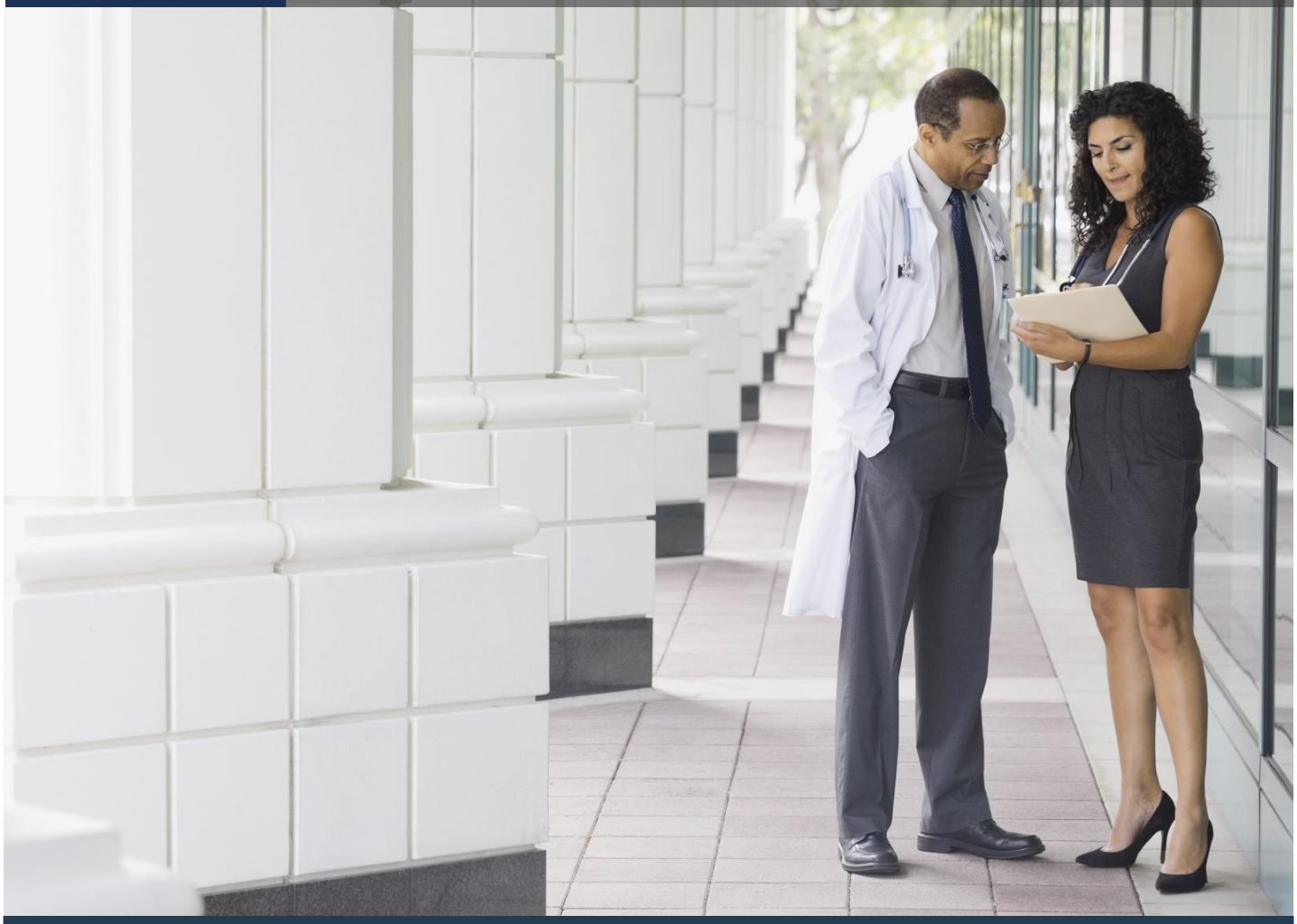

RETURNING TO 'NORMAL' AFTER COVID-19

PART 2: AMBULATORY SERVICES

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This post of our multi-part series will focus on resuming ambulatory services. In our prior post [Link], we overviewed various topics [demand, patient prioritization, and capacity] health systems should explore when resuming inpatient, elective surgeries – many of the questions and discussion points raised in that paper are relevant to Ambulatory Services, and we recommend that everyone read that post prior to this one. This post will focus on steps to help guide operations over the next 30 to 180 days – in future posts, we will explore medium and longer-term decisions for health systems.

BACKGROUND

Systems that are re-opening ambulatory clinics have many things to consider – be it patient and staff safety, developing new workflows, or the whole gamut of opportunities and risks that surround telehealth. There are numerous articles and posts on the restart of onsite Ambulatory clinics; for the most impact, we decided to focus on two of the main considerations: the telehealth paradox and potential workflow modifications.

THE TELEHEALTH PARADOX

Prior to COVID-19, telehealth had limited adoption among patients and physicians. Almost overnight, deregulation and reimbursement parity resulted in an immediate uptake of the technology. Patients embraced telehealth as they became comfortable downloading applications and having medical discussions utilizing their smart phones. Clinicians and clinic staff triaged legacy onsite clinic processes [e.g. registration, rooming, checkout] to create new, albeit sub-optimized, virtual clinic visit processes. Was everyone pleased? Did everything go as desired or planned? Probably not. However, patients did use the technology and health systems learned new information on how to rapidly deploy tools and process and deliver much needed care during a trying time.

Of course, telehealth is not a panacea and health systems will have to determine which services they will continue to provide via telehealth, and in which cases they will attempt to place the telehealth genie back in the bottle. Not only are there physical limitations to telehealth, but our clients have also relayed to us that in some cases, telehealth visits are more time consuming and can affect the efficiency of their clinics. More worrisome is the fact that telehealth deregulation was enabled through temporary emergency waivers and health systems are unsure if or when these waivers will be permanently extended.

With this being said, it does seem unlikely that patients will now forego the convenience of telehealth and rapidly return to their historical onsite ambulatory clinic experience that includes driving long distances to specialty clinics, navigating parking garages, and spending hours in waiting rooms.

Understanding these counteracting forces will be critical in unraveling the telehealth paradox and enabling health systems to successfully navigate ambulatory care delivery in the 'new normal'. To this end, we offer up some topics that we have been discussing with our clients:

- Does telehealth enable our organization to virtually expand our footprint beyond our physical assets into new markets?
- Have we seen notable changes in quality or patient satisfaction for particular segments of telehealth? Why?
- Can we leverage telehealth to provide care not possible in the in-person model, such as coordinating contemporaneous multidisciplinary visits? What service lines or care pathways could this 'seamless' care delivery model thrive?
- One client remarked, "We achieved 80% ambulatory volume during COVID mainly through virtual visits." Could health systems get to 110% [or more] of historic volumes if they strike the right balance between historical onsite visits and more telehealth?
- Which services should we accelerate our telehealth transition and which ones should we revert, as much as possible in the current environment, back to on-site visits?
- Are there competitive advantages to offering telehealth services in your market?

- Do we expect federal and state regulations to continue to allow for flexible telehealth arrangements?
- Will reimbursement parity remain, or do we anticipate a shift back to unequal payments between in-person and telehealth visits?
- Are there demographic or socio-economic considerations that warrant in-person visits [e.g. access to telehealth technology, HIPPA compliance, etc.]?
- Do specific physicians feel more comfortable providing in-person services?
- Are there existing recent investments or other dependencies that shift preferences towards telehealth or on-site?

REVISITING WORKFLOWS

There is no doubt that the new normal will cause health systems to rethink how things are done – both in the ambulatory clinic itself and virtually. Health systems will not only need to develop new workflows to ensure the safety and wellbeing of both their staff and patients, but also now need to consider how they will incorporate virtual visits into their historic ambulatory clinic workflows, if at all. In addition, they will need to consider how they communicate this to all parties [patients, staff, and providers] to ensure they feel safe and confident that the historic clinical delivery is maintained or even improved.

There is clearly no single answer as evidenced by the many approaches being shared. And while we do not have a one-size-fits-all answer, we do have some perspectives on the questions that health systems should begin to ask and offer a few of them for your consideration. For the purposes of clarity, we divided them into two categories: Onsite Pathways and Virtual Pathways.

ON-SITE PATHWAYS

Clinic processes and workflows will undoubtedly need to be modified in the post-COVID world. As exposure mitigation strategies are implemented, clinics should also consider secondary effects and how they can most efficiently operate their clinics, given the new workflows. Below are a few discussion points we are having with health system operators:

- Can we reduce the amount of time, the number of contact points, and individuals they interact with in the clinic?
- Can we utilize electronic communication or non-clinical spaces [e.g. parking lots or lobbies] to facilitate any non-clinical aspects of the visits [registration, authorization, revenue cycle, etc.]?
- For patients with multiple chronic issues, can we align multiple visits into a single visit to reduce exposure?
- Can we properly clean and disinfect the space between patient visits? How will turnaround time impact our clinic's capacity? How do we accomplish this efficiently and at the same time provide some visual evidence to the patient [i.e. handwashing]?
- How will we communicate and market to patients that our clinics are safe? What other communications do we need to have with our patients to describe operational changes?
- Does our mix of CMAs, nurses, and physicians need to shift to accommodate new workflows and new volume characteristics?
- Can we cross-train support staff to reduce the number of individuals in the clinic?
- When can we bring back furloughed employees? Can we establish target operational and financial metrics to guide our staffing decisions? And are they the appropriate resources we need given our workflow changes?

VIRTUAL PATHWAYS

In many instances, makeshift workflows were created during the pandemic in order to facilitate a rapid transition to telehealth. Now that telehealth will continue to be a staple of healthcare, health systems will need to invest time and resources to thoroughly analyze and streamline these hastily created workflows. Some considerations we have been talking through that may help drive more optimized telehealth virtual visits are offered below:

- How will patient registration and pre-authorization take place in the telehealth centric model?
- Should we update patient surveys and deliver them via the virtual platform?
- How can we effectively collect necessary vitals and patient history from patients? We do not want it to fall to the provider during the visit.
- Can we rely on smart devices to gather, monitor, and analyze patient metrics?
- Where and how can we reduce the amount of time patients are "on-hold" in virtual waiting rooms?
- How will we coordinate follow-up orders such as specialty consults, diagnostic imaging, or lab work?
- Do we need to convert former clinical space [e.g. patient rooms] into workspaces that support virtual interactions? Can we have providers shift between onsite visits and telehealth visits without disrupting care or productivity?
- Does our mix of CMAs, nurses, and physicians need to shift to accommodate more virtual cases and less in-person cases?
- What limitations exist around authority to prescribe or sign orders in a virtual world?
- Where can we leverage new technology, such as chat bots, to eliminate administrative functions?
- Will we need IT technicians on call to troubleshoot any issues that may arise?
- Can we enable our administrative staff to work remotely?

CONCLUSION

Re-opening ambulatory sites will not simply revolve around returning to normal operations. The 'new normal' dictates that operations must change to reduce exposure risk and we have yet to fully understand the lasting impact of virtual visits. And while all of this could be seen as noise and a disruption to historic delivery of ambulatory care, it could also be seen as an opportunity to improve patient care and value, and potentially create a better and enduring ambulatory experience.

If you have any questions or comments, please reach out to us here.

In the next part of this series, we discuss medium and long-term structural changes to the health care industry – please stay tuned!

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Weller Emmons, Consultant, joined KCG in July 2019. He is passionate about helping health systems design strategies that drive sustainable growth and optimized care delivery.

Prior to joining KCG, Emmons was a Manager in the Strategy & Innovation Group at Hospital Corporation of America (HCA), where he provided analytical insight to HCA's competitive position across the enterprise. In addition, Emmons advised several HCA hospitals on a strategic planning process to accelerate profitability via service line development, facility and access point expansion, potential M&A activity, and other sources of revenue generation. In another role at HCA, Emmons served as project manager on a multi-hospital EHR implementation team.

Emmons earned an MBA from the Owen Graduate School of Management at Vanderbilt University and a BE in Biomedical Engineering from Vanderbilt University.

Note: Prior to re-opening, KCG encourages each health system to ensure they are following precautions that aim to prevent further transmission of COVID-19 outlined by CMS, the American Medical Association [AMA], and other medical professional organizations. Clearly set policies and agreement from stakeholders across the health system will be foundational to pursuing re-opening activities and will ensure that the health system is a safe zone for all.