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Outpatient outlook

CEO roundtable discussion examines how far the ambulatory market has come and where it's going

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This special report on the state of outpatient care today and what might lie ahead for these services is based on a roundtable held on Nov. 2 at *Modern Healthcare's* Chicago offices with three prominent healthcare executives whose organizations have extensive outpatient operations.



Participants were Marty Bonick, left, Michele Molden and Randy Oostra.

The participants were: Marty Bonick, president and CEO of 462-bed Jewish Hospital, Louisville, Ky.; Michele Molden, president and CEO of the Piedmont Heart Institute, Atlanta; and Randy Oostra, CEO of seven-hospital ProMedica Health System, Toledo, Ohio. David Burda, editor of *Modern Healthcare*, moderated the discussion. This is an edited, abbreviated version of the transcript for the hourlong roundtable.

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David Burda: *Let's talk about the payer mix at your outpatient facilities and how that has changed over the past year, if it has at all.*

Randy Oostra: We have about 45% commercial payers, 35% Medicare, 15% Medicaid,

5% self-pay; and over the last three or four years, that's changed about 5%. So what we've seen is a 5% swing from the commercial payers to Medicaid and Medicare, mostly Medicaid, a little bit of self-pay, but we've seen about a 5% shift. So again, a pretty dramatic effect for us relative to when you look at reimbursement.

Michele Molden: It's very similar (at Piedmont) in terms of the 5% shift over the last few years, a little bit different in that we have more Medicare, less Medicaid, about a 60/40 split between Medicare and commercial insurance and are seeing the same thing, a decline in commercial business, not much change in self-pay or Medicaid, which are small, at least for our big flagship hospitals, but definitely an increase in Medicare.

Marty Bonick: Our payer mix is very similar to my colleagues here, about 45% Medicare, about 40% commercial and about 10% self-pay with Medicaid making up the balance. Our shifts haven't been quite as big, and I would temper that by saying that we have employed a number of revenue-cycle improvements to try to offset and mitigate the changes that are naturally occurring in the payer shift in the downtown campus and then also the placement of new outpatient facilities in other areas of town and offering new services has helped mitigate what we've seen.

Burda: *What factors do you think are making that shift possible? What's happening in the market that would shift commercial to Medicaid or self-pay?*

Molden: From our perspective, one of the things that's happened in Atlanta is, as the economy has worsened and as physician reimbursement has tightened, we're seeing all of the things that have naturally migrated to outpatient care now migrate out into the marketplace and with more physician competition than we've had in the past. That's been one of the reasons.

Oostra: When we look at the area that we cover, seeing kind of what we already talked about, huge unemployment. The 27 counties we cover, we've seen a range from 10% unemployment up to almost 20% unemployment, huge effects on us, huge effects on our institutions, so we've seen quite a major effect.

The revenue cycle

Burda: *Marty, you mentioned revenue-cycle management. Could you tell us some of the things you're doing on that issue and debt collection and billing?*

Bonick: We've really had to ramp up our revenue-cycle efforts, everything from our coding efforts in terms of making sure we're getting the documentation correct going out the door, to what we're doing in the billing office, and making sure our electronic systems are working even to the point of service.

Molden: The same, and we have two large physician practices, one primary care and one cardiology, and we're working not only on our outpatient practices but kind of all the way through the hospital side to make sure that from the very first patient visit in a doctor's office all the way through their surgery or whatever that we are retooling and tightening down all of our revenue-cycle management practices.

Oostra: Probably the biggest change for us was point-of-service collections, quite a cultural change not only for patients but our staff being asked to collect copays on the front. Some of our staff were hesitant to do that; some of our patients were hesitant to do that; but we have been at it now for about two years, and people are much more accepting. Our staff is much more accepting at doing point-of-service collection.

Burda: *We've heard of hospitals asking patients in the emergency room if they are a nonemergent case to pay upfront if they want treatment. Are any of your systems doing something like that?*

Molden: We're doing a better, much better job at screening patients to make sure in fact they are medically emergent, and then we're giving them the option to stay and be seen by a primary-care physician or to receive an immediate referral for the next day, as opposed to staying in the emergency room, recognizing they will have a financial burden if they do.

Bonick: We've debated it, and it's very difficult with the current medical tort reform issues to get the physicians engaged. They want some assurances that they are not going to be held liable, and obviously, we can't give them those assurances. So while we've talked about it, we have yet to get anything going in a meaningful fashion at this point.

Burda: *Is outpatient care still profitable?*

Oostra: Oh, it is profitable. The problem is, is when you look at how we get paid from those payers, Medicare typically pays us around, for outpatient services, about 80% of cost. Medicaid, it's a little better than the inpatient side. ... They are in the low 70s for us, about 73%. And then when we look at self-pay, we can get into 35%, 40%. So again, when you look at that reimbursement for our costs and we get more shift toward those payers, a lot more pressure on our institutions, on our hospitals, and so again, it's not that it's not profitable, it's just putting much more pressure on all of us.

Molden: We're similar and different—similar in the cost pressures that continue, a little bit different in the mix. Piedmont was just approaching a 50, or is just approaching a 50-50 inpatient-to-outpatient mix. There's always been a little bit more inpatient-oriented.

Our challenge, of course, is as those procedures shift from inpatient to outpatient and they are paid at a lower rate, at the same time we're having the whole economic downturn. And we're probably about 3% to 4% off budget in terms of anticipated surgeries, but we're finding that the elective-surgery business is very soft even in what you would consider heavy elective spine surgeries and things like that.

Burda: *If there's a Medicare shortfall, Medicaid shortfall, a self-pay shortfall, yet overall the service line is still profitable, where are you making that money up?*

Oostra: Welcome to healthcare right now. I think we're all in the same situation. We talk about performance improvement. We talk about driving for quality. We're talking about getting better as an industry, and it's all the things that you would think that anyone would

do. For us, for a couple years now we froze capital. We froze FTEs. We froze travel. We're reducing marketing expenses and other expenses. We're taking a harder look at nonessential services than ever before. We're actually closing services that we would like to be in but we can no longer afford.

Bonick: We're seeing a lot of the same trends and really squeezing everything that we can out of the revenue cycle and making sure that we're collecting every dollar that's owed to us, and at the same time making sure we're good stewards of the expenses that we have in everything from productivity improvements, benefits, changes.

We have had some lucrative plans that we've had to migrate into something that's a little bit more market-competitive, which will be interesting to see how that pays off in terms of retention and recruitment. In this economy things seem to be going well, but it's always a challenge to maintain that and then focusing aggressively on the supply cost, the nonlabor activities. So it's across the board just trying to look at your processes and see: How can we do things differently?

A public option?

Burda: *Given the payment shortfalls from government insurance programs, Randy, do you support a new government insurance option, non-Medicare, non-Medicaid, and for those who don't have coverage through their private sources or their employers?*

Oostra: I think we'd all agree on certain principles of healthcare reform. That's probably one of those that is probably one of the tougher issues. I have a lot of concerns about it primarily because I think we'd definitely support insurance reform. I think we'd all agree that that's an absolute necessity. Do we need a public option? I have a lot of concerns about just how priorities shift in the future and how priorities get set as a country, and what it does to one of the basic things that we rely on is healthcare. And so, when you look at our organizations and how fundamental they are to communities from a community-benefit standpoint, again, we all can be more effective; we can all be more efficient. I would hope and think there's a better way to do it than going down a public option.

Molden: I couldn't have said it better. I would tell you that that's exactly what I think our systems both believe needs to happen, as well as has huge concerns about how we implement those reforms, absolutely.

Bonick: I'll take a bit of a contrarian viewpoint. I think that there has to be insurance reform, and how you can do it is, there's multiple different options; but if it takes some type of a public option with competing other insurance plans, I wouldn't want to see a uniform system. I think that that could spur things on. And it makes it very difficult for the traditional insurance companies to make a plan that's going to be effective for those small businesses and entrepreneurial startup companies and individuals, and so, if a public option is something that will at least provide some leveling of the playing field out there, I would like to see it, especially if it would help reduce that number of uninsured.

Competitive forces

Burda: *Let's shift gears a little bit and talk about some of the competitive pressures facing hospital outpatient facilities. How have things like retail clinic development, how has that affected your business operations?*

Oostra: It really hasn't. We've seen several retail clinics come and go. Of course we approached every health system about partnering, and actually we've seen most of them go away. What we did in response, we employ around 270 physicians, 100 of which are primary care, and actually when we surveyed our patients, they were preferring to stay at their doctor, and have after-hours and Saturday hours. So actually, most of our practices added Saturday hours and extended their times, and so we did not partner with any of the retail clinics, and at least for our market it's not a trend that really caught on.

Molden: We've seen some small retail clinic penetration in Atlanta, but not significant. More significant for us has actually been concierge medicine. We have had a number of high-volume, primary-care physicians leave their practice, their regular practice, and become concierge physicians. And our primary-care group, which is about 120 primary-care physicians, is actually going to be setting up five physicians in the group to become concierge medicine physicians, because there's a very clear need, and we don't want to lose them from our system.

Burda: *How are you dealing with that physician ownership issue on an outpatient basis? Have you lost physicians to those operations?*

Bonick: We've lost physicians, but we have a number of people who still split their time and stay with the health system. They still need our services for inpatient and maintain that operating-room time, to their advantage typically; but we've tried to maintain those relationships through providing a number of access points into the system. So the geographic dispersion we've done with our outpatient center growth, and having outpatient surgery locations in more areas than just our downtown campus has helped us maintain some of that relationship with our physicians.

Burda: *Randy, how about you? Are physician owners providing stiff competition to ProMedica on the outpatient side?*

Oostra: Sure and, again, I have a number of joint ventures that we're working with physicians. Several large groups and some independent groups trying to come together and trying to do some things together relative to outpatient services, trying to form larger groups and do the types of things, probably pretty logical pressure on the independent physician, their income, so looking for ancillary outpatient services to augment their decrease in reimbursement.

What is interesting, I think, is we're seeing as they have been looking at trying to do new ventures, they've actually approached us as being partners. And I think several years ago they probably would have just gone off and done it on their own, and for whatever reason, I don't know if it is healthcare reform or just concerns about the future, they are looking to see if the health system will partner with them and some of our independent

hospitals as well.

Burda: *How have any of you handled some of the staff privilege issues that can arise? You have a physician on staff, you have the physician as a competitor through another venture, how have you danced around that, dealt with it, not dealt with it?*

Molden: I think we all live in the world some days of competing on one hand and cooperating on the other. We have one situation where we have a joint venture with a group on the Piedmont hospital campus, but they have opened competitive labs, GI labs, at our other community hospital campuses, so on one hand, it was to our advantage to keep that business, as much of it as we could through a joint venture on the main campus, but yet they are our competitor to the other hospital. So, I can't tell you we've figured on any magic to that other than, as you suggested, trying to use the movement in the market and financing, such as it is, to try to build bridges anyway that we can to keep physician loyalty and retention.

Bonick: "Collapetition" is what I call it.

Molden: Exactly, collapetition.

Burda: *Collapetition?*

Oostra: Collaborating and competing at the same time. We have a number of those relationships as well, and our system has made it a little bit more challenging for ourselves in that ... both of our hospitals as well as all of our outpatient centers are under a single provider number, and so we have one medical staff, even though they have different flavors based upon the different campuses, all of them are part of our single provider number. And so, we have one medical staff as well as competing relationships with them at the same time in some cases.

Advances in care

Burda: *Could you tell us some of the procedures that are being done on an outpatient basis now that, maybe five years ago or when you started your career in health administration, you thought no way could that be done on an outpatient basis?*

Oostra: You look at some of the cardiac procedures, the idea that you are going to put in a pacemaker on an outpatient basis or defibrillator or some of the back surgery, I remember back when gallbladders went from an inpatient to a laparoscopic procedure and how devastating at least it appeared to be at the hospitals. And again, we adjust and change and move forward.

Some of that's being driven by technology. Some of it I think, what happens with physicians, they become adept at something, they feel comfortable in an outpatient setting. Some of it, as we talked about, is reimbursement-driven, so I think we've all seen that in each one of our markets.

Molden: *In the cardiac world, with the large aligned group, we found that our*

electrophysiologists were all practicing differently, and so once we standardized the practice pattern, everything moved. All of our electrophysiology, for the most part, the majority of it moved from inpatient to outpatient; but all of the orthopedic procedures, that's the other one that just amazes me, is how much orthopedic procedures, with the exception of really implantations, but feet, ankles, hands, arms, other than the real major joint replacements, have all gone the way of outpatient surgery.

Of course, all of the plastics, almost all of it is outpatient today so just a very dramatic shift. And I think certainly physician competence is one piece of that, and much better pain-control medicine, much more aggressive anesthesia support. There have been a lot of changes that I think have facilitated that, but we've seen a very dramatic change in our market.

Burda: *You've mentioned technology as a driver, reimbursement, physician competency, pain-control medication and physician lifestyle/happiness. If you were to rank those, what would you rank as the lead driver in shifting some of these things from inpatient to outpatient?*

Oostra: I'd probably say technology. I think probably on a technology basis. Again, I go back to physician and patient convenience, and I think most physicians are driven by what's the need for the patient.

If you look at a large tertiary hospital, and my dad who's in his 90s, it's a very confusing place, difficult to get to, difficult to park; I need a ride. If I can go to an ambulatory center, park by the door and go in, I think it's for a lot of them, if the technology is right and all the other things, it's just a very convenient location for outpatients.

Molden: I think technology, and I do think the physician piece of that has got to go along with the technology, because we have a lot of patients that come to our campuses from pretty remote areas. Once you get outside of Atlanta, it becomes pretty remote very quickly; and the physicians have to be comfortable that they can see a patient from 2½ hours away and send them home the same day, that there's going to be a good support system in place in that they are going to be OK when they get there.

So to me, it's a mix of both technology and then physician management of that technology to make sure that they are comfortable with the patient care.

Bonick: I would probably put technology followed by reimbursement, but the physician lifestyle and patient convenience is absolutely up there as well. And being on the downtown campus in Louisville, maybe not the metropolis of Chicago or Dallas or some of the other large cities across the country, there's still a challenge with people wanting to come downtown. You have parking issues. You have other things.

And so we've tried to cater to that convenience factor by organizing our service lines around patient activities, and so we have a hand-care emergency center as well as a hand-care operating room to have that quick, efficient, outpatient feel; but we're also then taking a look at our orthopedic services and trying to combine our inpatient and outpatient.

Keeping patients safe

Burda: *We have a lot of procedures historically done on an inpatient basis now in an outpatient basis, free-standing ERs not attached to a full-service hospital. What factors have made this type of operation safe? IT, skill mix?*

Bonick: It's a combination of everything. If nothing else, we place just as much focus on those outpatient facilities as we do on the inpatient. We have a lot higher patient traffic coming through there, and while maybe a lower intensity of services being provided, there's just as much opportunity for something to go wrong; so we've instituted "red rules," which are those most sacred rules within an organization, and particularly, the outpatient surgical environments and procedural areas, making sure that we have active participation and timeouts, making sure that we have positive patient identification for all the patient encounters that we have with each caregiver.

Molden: I would agree with all of that, and it's funny because it has changed our skill mix a little. We've added a number of staff who are really there for the flow and the convenience piece of it—educators, patient representatives, communicators, to make sure that the patients and the families know what to expect when they come because their time with us is so compressed.

And then we do a lot more on the front end, particularly with very specific red rules around patients that have sleep apnea or anybody that's in any kind of anesthesia risk and more kinds of upfront communication from the anesthesiologists. They do a pre-visit now, whether by phone or in person, for the early morning cases to be sure that they've gotten the patient history accurately, and so it has created a very different flow to our outpatient areas, outpatient surgery areas, as a result of just having to make sure everything runs really well.

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