Ambulatory & Outpatient Care: A Market-Driven Approach for Success
On-demand. One-stop shopping. What you need, when you need it. These phrases are more than just slogans. They are today’s models for how leading companies are winning customers and revolutionizing the marketplace.

Businesses that provide a wide array of high-quality products easily, quickly—if not instantaneously—and at reasonable price points are rising to the top. These companies will stay at the top if they can nimbly respond to ongoing changes in their respective industries, including technological innovation and customer needs and wants. This can certainly be said for the healthcare industry.

Inpatient stays are dropping while outpatient visits are on the rise thanks to medical advances and new reimbursement rules and payment models. This is good news. Outpatient care is being provided efficiently, economically, and safely.

Urgent care centers are one of the fastest-growing segments in the ambulatory sector. For those who are well-positioned, there is huge potential as millions of Americans newly insured under the Affordable Care Act, many on high-deductible plans, look for less expensive primary care options. These centers are also a critical part of the solution for managing our nation’s healthcare costs. Nineteen percent of healthcare leaders responding to the HealthLeaders Media Ambulatory/Outpatient Care Survey expect to acquire urgent care centers to expand their primary care network, and 18% will partner with urgent care centers. In addition, 93% of providers expect ambulatory/outpatient care net patient revenue for their organization to grow within three years, with 56% estimating that growth at 10% or more.

What does all of this mean? To thrive amidst all this change, providers must move away from the outdated hospital-centric care model and evolve into integrated healthcare networks. And, indeed, the survey indicates that within three years, the ratio of capital budget investment for new program development will be dominated by ambulatory/outpatient care spending (64%) rather than inpatient acute care (36%).

At Jupiter Medical Center, we are offering a wider and wider array of services and operating as a regional system of integrated care. We will open our second urgent care facility in early 2015 and in the coming years will expand to five centers. We have made great strides in strengthening our entire ambulatory care network and creating new opportunities for effective physician alignment.

As we succeed at treating patients in more accessible settings, we have to be strategic in our response to the downward trend in inpatient volume. At Jupiter Medical Center we’ve diversified our inpatient services and increased the intensity of care we provide on an inpatient basis. Our strategic vision is to create a set of world-class clinical services, and develop a network of facilities and access points within our community.

Reforms to payment and changes in delivery models are driven by a common goal: to provide better coordinated care, improved outcomes, and lower costs. Delivering the right care in the right place at the right time—that’s what today’s healthcare is all about.

As healthcare delivery continues to evolve and change, those who both facilitate and respond to this change will rise (and remain) at the top.

John D. Couris  
President and CEO  
Jupiter (Florida) Medical Center  
Lead Advisor for this Intelligence Report
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Methodology

The 2014 Ambulatory & Outpatient Care: A Market-Driven Approach for Success Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In September 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 311 completed surveys are included in the analysis. The bases for the individual questions range from 175 to 311 depending on whether respondents had the knowledge to provide an answer to a given question. The margin of error for a sample size of 311 is +/-5.6% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, and region. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

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UPCOMING INTELLIGENCE REPORT TOPICS

JANUARY  
Annual Industry Survey

FEBRUARY  
Mergers, Acquisitions, and Partnerships

MARCH  
Payer-Provider Strategies

APRIL  
Healthcare IT and Analytics

MAY  
Emergency Department Strategies

JUNE  
Strategic Cost Control

Click here to subscribe.
Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

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**Number of physicians**

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**Region**

- **WEST**: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
- **MIDWEST**: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin
- **SOUTH**: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware
- **NORTHEAST**: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine
It’s not a new concept, but it is one that is getting new attention for new reasons. Nearly two-thirds (61%) of healthcare leaders include expansion of market share among their top three drivers of their outpatient/ambulatory care strategy, according to the HealthLeaders Media Outpatient/Ambulatory Care Survey. At one time, expansion of market share might have meant that a hospital or health system was building a referral base. But expansion of market share in the ambulatory care context isn’t only about acute care admissions.

Most healthcare leaders are striving for better care coordination, and many are placing a priority on population health management, both of which drive the desire to provide patients with a wide set of access alternatives. And healthcare providers recognize the need, eventually, to shift to addressing the overall care needs of patients over a long time span, which ambulatory and outpatient care networks can do. Also, most healthcare providers recognize that new working relationships with payers are coming. Broader ambulatory and outpatient reach and a new wave of consolidation among providers are manifestations of the desire to improve their negotiating positions.

Patrick Dyson, executive vice president of Borgess Health, a not-for-profit health system with three hospitals serving 10 counties in southwest Michigan, acknowledges the classic acute care model and sees the care
continuum—with ambulatory and outpatient care being important elements—as part of a broader view.

“While we have the acute care model and concept,” Dyson says, “we’re thinking about what’s involved pre-hospital—what happens before a person ever enters the acute care setting. And we have to recognize that many patients rarely or never enter an acute care setting. Then there is the whole postacute continuum. What happens when a person leaves the hospital? Will they go home? Will they go to an interim care facility of some sort? So we’re really thinking about a person’s care experience at different points of their life, across that continuum.”

Tactics for delivering higher-quality care more cost-effectively are still emerging. At the same time, the healthcare industry’s financial foundation is threatening to shift, but has yet to do so in a full or expansive way. These are but two factors that focus healthcare leaders on the cost of care, and ambulatory/outpatient care plays a role. Cost control joins market share as a second “classic” motivation driving strategies in ambulatory and outpatient care. More than half (55%) include cost control as a top driver.

About cost, John Couris—president and CEO of the not-for-profit Jupiter (Florida) Medical Center, with 163 acute care beds and 120 long-term care, rehabilitation, and hospice beds—reminds us of how the ambulatory and outpatient care settings meet the longstanding desire to deliver care in a cost-effective way, supported by advances in medicine. He says, “Most healthcare is provided in an outpatient environment. Some of the reasons include technology advances, which have allowed for a greater number of procedures to be completed in the outpatient setting. Primary care continues to do a good job of managing the health and wellness of a community, which translates to fewer resources required to take care of people. So, it tends to cost less in an ambulatory environment versus a hospital setting.”

Some payment models encourage longer-term relationships with patients. Dyson states, “With managed care payers such as Medicare with their Advantage products, you’re building a relationship with a patient over time. That patient is attributed to your system because you provide the lion’s share of their care. Then that leads to accountability for clinical outcomes under some of the evolving value-based purchasing models, incorporating the idea that healthcare providers should be evaluated not just on taking care of an episodic issue, but on helping manage the patient’s care over a longer horizon.”
This broader perspective leads to an examination of what services to provide, and in what location. “Whether they are issues of access, convenience, or geographic markets,” Dyson says, “organizations are decoupling ambulatory services from the main medical center setting and dispersing their array of services in a continuum across the larger geographic region.”

Although organizations are moving away from episodic care and toward long-term care relationships, risk-sharing for accountability (which some see as the ultimate objective) is a top driver now for only 17% of survey respondents. Seeing the need to take on risk on the bottom of the list of drivers does not diminish its importance to Ed Karlovich, chief financial officer for UPMC, a Pittsburgh-based nonprofit health system with 20 hospitals, 400 outpatient sites, and 5,100 licensed beds. He says, “As a provider, if you think in the long term, you’re going to be involved in the insurance side of this business in some fashion, so you’re going to want to have an ambulatory network that will support that.” Indeed, UPMC is very much in the insurance side of the business. The UPMC Health Plan and a set of partners integrated with the UPMC Insurance Services Division count 2.3 million members in Western Pennsylvania.

**Top contributors: Surgery centers now, primary care soon**

Today, three areas of outpatient care are identified as top financial contributors in nearly equal proportions: surgery centers (22%), specialty care (22%), and imaging (20%). At present, 16% of all respondents say that primary care is the ambulatory/outpatient activity that provides the greatest financial contribution, although that is higher (24%) among physician organizations. Within five years, though, healthcare leaders expect the picture to change, and 33% say that primary care will deliver the greatest financial contribution. The change reflects continued dependence by acute care facilities on patient flow through ambulatory and outpatient settings as well as growing recognition of the care coordination role of primary care practices.

According to Dyson, an advisor to this Intelligence Report, “Most people, if they’re going to get to a specialist or a surgeon, are going to come by way of primary care. If you are trying to drive business to complex surgical and procedural things that you do in the acute care hospital, you need primary
Analysis (continued)

care. We also will be reasserting the role of primary care as a gatekeeper, a
navigator, a coordinator of care. And how do you expand your outpatient
or ambulatory footprint? Primary care is a key way to do that.”

Karlovich reminds us about the shift in financial foundation that must
take place for primary care to become more important as a financial
contributor. “In the traditional fee-for-service model, primary care
practices are not enormously profitable. But if you are taking risk, and
you can manage the population effectively, and you benefit financially
from patients who may not be generating as many downstream
admissions, then you can see how primary care could rise to the top. In
responding to this question, people have to be making the assessment
that they are going to be taking on risk in some fashion.”

Financial decisions are in line with new emphasis

Nearly as many organizations are expanding their ambulatory/
outpatient primary care physician practice network through acquisition
(60%) as through partnerships (62%). Although certainly part of the
ambulatory care landscape, urgent care clinics and convenient care
clinics are used much less frequently as the vehicle for expansion of
primary care and ambulatory services. While both have roughly the same
percentages of proponents (ranging from 13% to 19%), Karlovich tells
us that urgent care clinics might be a better fit for many hospitals and

“We’re investing heavily in improving access points
in ambulatory, while the hospital is investing in
programs and services that increase the intensity of
work that we do.”

—John Couris

health systems than convenient
care clinics. “Providers get into
urgent care for several reasons.
First, they can expand their retail
footprint. Second, they can relieve
pressure on their ED. Finally,
urgent care is similar to what they
actually do today. Convenient care
clinics are really a different care
model.”

Overall, 56% expect net patient
revenue from ambulatory and outpatient services to increase by 10% or
more within three years. Dyson identifies at least three factors influencing
outpatient revenue growth: general population characteristics, a
technology-enabled shift of patient volume from inpatient to outpatient,
and payer practices. He says, “Sociodemographics and the underlying
epidemiology of the community come into play. Technology is allowing
[procedures and other care] to move from an inpatient setting to
outpatient. For example, robotic surgery development has enabled
shorter lengths of stay, which has impacted outpatient growth. And
payers are making determinations that reimbursement or payment is only
going to be in a particular setting.”
More than half (57%) say that their No. 1 priority in new program development investments for expansion of care services over the next three years is ambulatory/outpatient care. Prompted by a larger geographic footprint and what usually is a larger care network, 70% of health systems say their No. 1 new program development investment over the next three years will be outpatient and ambulatory services, compared to 49% of hospitals. Says Karlovich, “It gets back to the way health systems think compared to individual hospitals. Health systems probably compete over a larger geographic area. And health systems may be building their network of care. Small or midsize hospitals, maybe community hospitals, may be thinking about one or two programs, probably at or near their campuses.”

Overall, new program development capital budgets will be split 64% for ambulatory care and 36% for inpatient care within three years. The split will be closer to 50-50 among the industry’s largest organizations. Those with net patient revenues of $1 billion or more expect their new program development capital resources to be split 54% for ambulatory care and 46% for inpatient. Couris, lead advisor to this Intelligence Report, explains that it is a requirement to invest in both. “We’re investing heavily in improving access points in ambulatory, while the hospital is investing in programs and services that increase the intensity of work that we do. If most ... care is going to be provided in the outpatient world, only the sickest and most compromised patients are going to end up in the hospital. If you don’t have services to take care of those sickest patients—if you can’t handle it—you will, over time, become irrelevant.”

Improvements and expansion in the acute care environment demands more funds than in outpatient settings, of course. “The cost to do anything on the inpatient side is enormous compared to ambulatory,” says Karlovich. “Even if you’re doing something small, you just burn through the capital on the inpatient side.”

Patients as consumers: Yes and no
Couris identifies four principal strategic components for Jupiter Medical Center, and he mentions outpatient first. “At the very core of Jupiter Medical Center’s delivery model is the creation of a patient-centered system of care designed to provide predictable, world-class quality care at the lowest cost possible. The strategy has for components: ambulatory, acute care, postacute care, and physician alignment.

“First, in the outpatient world, it’s all about improving access points and

“How do you expand your outpatient or ambulatory footprint? Primary care is a key way to do that.”
—Edward Karlovich
getting into communities that we're currently not in. In the inpatient world, we're increasing the intensity of service and diversifying our portfolio. We don't need to add more beds—we are focusing on medical technology and services differently. In post-acute care, it's all about building out the continuum—services like home health and rehab. The fourth and final piece is physician alignment.” And consumerism is a core concept behind Jupiter’s approach to ambulatory care. “We're in the urgent care space because of consumerism,” Couris says. “We understand the significance of not only being out in the community, but also being more consumer driven.”

Karlovich explains that, despite the need to consider patients as consumers of healthcare services, few patients bring to healthcare transactions the kind of product knowledge that they bring to purchases of conventional consumer products. “It’s not a typical consumer transaction,” he observes. “You may only go to your medical provider once every five years if you’re healthy and just don’t need to see anybody. But as a consumer, you want to have many of the same attributes that exist in routine consumer purchases. You want to be able to get to your product easily, in a location where you want it. You don’t want to be hassled about getting to it. You want to make sure people are friendly and courteous. Those are things that are transferable from the conventional consumer purchase model. What many don’t have, though, is an understanding of the actual service that’s being provided. It’s very hard for many consumers of healthcare services to grasp what’s happening around them.”

Of course, the selection of a healthcare provider should not be a low-involvement decision. In an outpatient environment (which has many characteristics of a retail environment and, in some cases, is in a retail environment), consumer-product priorities will be part of the decision-making. Karlovich describes how a patient may come to a decision as a consumer: “Because I don’t understand it, I view them all as the same and, therefore, I’m going to pick one maybe by price or by location.” Couris adds this insight: “You have to run your ambulatory businesses very differently than you run your hospitals. Free-market principles in the aggregate may not really apply to healthcare. They do, however, apply in the ambulatory setting.”

Healthcare providers find themselves in an environment where consumer preferences become part of patient decision-making, which may be one reason that retail medicine is identified by 29% of survey respondents as the ambulatory or outpatient service presenting the greatest threat over the next three years. Although the current mix of healthcare
services available in chain pharmacies and big-box retailers hardly serves as a substitute for most of the care that occurs in the acute care environment, healthcare leaders should recognize the market power of the organizations involved, their ability to fund their programs, and their merchandising savvy.

“The large retailers have financial capacity to invest in the healthcare industry,” Dyson says. “They know how to drive traffic to their services. And one of our self-criticisms is that we are slow to evolve and adapt; we may not have the speed of response that such large for-profit companies have. Also, there is a disruptive innovation component. They can take what is otherwise a complex service or product and simplify it. Some younger people are not looking for a primary care relationship. They may be saying, ‘Take care of my need when I have the need.’ Retailers can come in, decouple the monolithic healthcare system, and develop more effective ways to deliver some services.”

Dyson reminds us that, although there is a great deal of focus on population health, managing patients across the care continuum applies to a relatively small portion of patients, especially today, while the techniques and funding for such activities are still emerging. As a result, large retailers can offer their easy-access on-demand services to a large population. “Longitudinal management of the patient over time—outcomes, prevention, and managing chronic conditions—is a small part of the healthcare business today. That tends to become more important with aging. That means there is a huge segment that is very episodic,” he says.

**Consumerism and competition**

Ambulatory and outpatient care fills the need to establish long-term relationships with patients. According to Dyson, “Organizations are configuring themselves for relationships with the patient that will extend, hopefully, over a long time horizon. You’re building a relationship with that patient for whatever their needs are at different points in their life. How are you responding to those different needs, and what does that mean in terms of access, convenience, availability, and scope of services? It’s no longer the acute care–centric model, with patients having to drive 60 miles or 20 miles. People no longer have to come to you to get the service they need.”

Just as traditional healthcare providers acknowledge patients as consumers, traditional retailers recognize consumers as patients. While the power and reach of retailers must be acknowledged, traditional providers can take solace in recognizing that retailers are likely to, as
Analysis (continued)

Dyson notes, examine the complex set of services that the healthcare industry provides, “decouple” some, and deliver that smaller set of services effectively. Retailers are sharing the healthcare space, and it’s probably better to welcome their presence than to go toe to toe with them, because just as ambulatory care uses a different business model from acute care, it also uses a different business model from consumer retail.

There are two principal components of cost control that bring it close to the top of the list of drivers of ambulatory and outpatient strategy. First, there is the desire to provide care in the most cost-effective setting, which is prompting increases in ambulatory patient volume and revenue. The second component recognizes that the patient is a consumer, in that patients are responsible for deductibles, copays, and sometimes the whole fee. And while few in ambulatory would want to compete directly with big-box retailers, the fees charged for care services are important elements of the hearty competition among non-retail ambulatory market participants. So the need to compete on price provides additional incentive to control costs.

Healthcare leaders are directing a great deal of resources—and capital investment—toward ambulatory and outpatient care. But with a solid 36% of new program development capital resources expected to be dedicated to inpatient acute care investments in the three-year time frame (48% among large health systems), it is clear that providers are not neglecting acute care as they expand ambulatory care.

“There’s always going to be a place for large central facilities—there will always be things that need to be done on an inpatient basis,” says Karlovich. “And some care can only be justified through economies of scale that a large facility will have. But I will tell you, I think we’re going to be looking at an industry where you’re going to have more locations on an outpatient basis with significantly more competition amongst providers as we begin to overlap in ambulatory environments.”

Michael Zeis is senior research analyst for HealthLeaders Media. He may be contacted at mzeis@healthleadersmedia.com.
CASE STUDY 1

The Building Blocks of an Ambulatory Strategy

When Borgess Health considered what services to include at its new $29.6 million, 65,000-square-foot ambulatory health park in Battle Creek, Michigan, it examined demographics, finances, and regulatory standards.

“It’s like building blocks,” says Patrick Dyson, executive vice president of Borgess Health. “You start with the demographics, community need, and financial impact, and then there are certain services that will be more financially beneficial than others.”

Imaging, physical therapy, and the sleep center, all “significant revenue generators above their cost,” were included, says Dyson. On the other hand, because of its infrastructure costs plus registration and “meet-and-greet” staff, some laboratory services have low margins and do not necessarily help the organization overcome its financial hurdles.

“I think people more and more are looking at the sustainability of a large ambulatory center on its own merit,” says Dyson. “While it is additive to the whole enterprise, you still have to be able to operate the site with some sense of what your financial performance is going to be.”

Although the financial bottom line is important, Dyson says Borgess’ decision whether to include services is not solely financially driven. Regulatory standards, for example, became the deciding factor in evaluating whether to include surgery and endoscopy centers at the health park. To initiate either of those services, Borgess would have been required to prove “minimum volumes” to satisfy Michigan’s certificate of need standards.

“Our judgment was that market potential and the likelihood of getting the certificate of need was low; therefore, we waived that off,” Dyson says. “That was a regulatory assessment, competitive assessment, and fundamental financial assessment.”

Another service that Borgess initially rejected but is now reconsidering at the health park, Dyson says, is an urgent care service, possibly...
Case Study 1 (continued)

even with an intermediate care unit component. “We do have the capability at this site to do extended hours. We’re kind of back to the well of assessing what would be our time frame to consider an IMC urgent care offering at this location,” Dyson says, noting that Burgess has the ability and the infrastructure in place to add facilities to accommodate an IMC unit on the 21-acre site.

The new facility, which opened in June, is one result of Borgess’ evolving ambulatory strategy “identified, articulated, and developed” by the organization a number of years ago, says Dyson. The strategy considers such factors as location, drive distance, competitors, payer mix, and demographics—including gender, age, and household income. The health park is one of three comprehensive ambulatory care off-campus facilities; the other two are Borgess at Woodbridge Hill and Borgess at Westside Family Medical Center, both in Kalamazoo.

The new health park provides a range of outpatient care services, including family and internal medicine, women’s health, cardiology, and physical and occupational therapy. It also houses a pharmacy, a sleep disorders clinic, and a full diagnostic imaging department. The Borgess Medical Group employs more than 200 primary and specialty care physicians and about 90 midlevel providers. Dyson approximates that two-thirds of the physicians were already in a practice and the remaining one-third are new to Borgess’ health park.

New physicians bring the potential for new patients, which in turn brings additional revenue. Borgess, says Dyson, has been fortunate to have “reasonable success” recruiting new physicians.

“When you’re entering a market, you’ve got to build in a relatively short time,” Dyson says. “That’s why acquisition and employment was important to us. It allowed us to acquire, which brings with it an immediate patient base, and then add to that with new recruitment over time so you have organic growth as well as new growth development.”

Dyson says that although it takes three significant ambulatory encounters to make up the same margin as an inpatient discharge, he still expects the health park to produce a positive margin in its first year. Total ambulatory outpatient revenue as a percentage of total patient revenue is about 50% “and growing on a year-to-year basis,” says Dyson.

“Ambulatory is a part of the overall growth of healthcare. But on a one-to-one basis, the margins are still a lot better in the acute care side,” he says. “I think everybody wrestles with the transition of fewer people being admitted to hospitals all across the country, and there’s several reasons that’s occurring. The importance of access and convenience from the patients’ perspective of being able to get their need met with ease of access to locations. I think it will continue to impact how we develop physical locations and what the array of services is. More and more care will be delivered in the home or in ambulatory settings like this.”

—Don Costanzo
CASE STUDY 2

Adopting a Retail Business Model

A former Blockbuster store located in a shopping center is now home to Jupiter Medical Center’s first urgent care center. The site met all of Jupiter’s criteria regarding population density, demographics, access, and physical location.

“If I had to grade each one of those criteria, I’d give them an ‘A’ for every one,” says John Couris, president and CEO of Jupiter Medical Center. “It’s sort of like ‘Main and Main.’ It’s got great visibility, great parking, it’s easy to get to, and it’s in the middle of a very densely populated area with lots of houses, condos, and businesses.”

Couris explains that its new urgent care center is part of Jupiter’s overall strategy to improve and increase access points for the community and for its patients. The strategy has for components: ambulatory, acute care, postacute care, and physician alignment.

“In the ambulatory space, we want to increase access points where appropriate and at a cost or at a price point that is affordable by the healthcare consumer. In the inpatient world, we want to diversify our portfolio of services and increase the intensity of service we provide at the institution. Then, in the postacute care model, we’re building that out with assisted-living facilities, nursing homes, home health, etc.,” Couris says.

The ambulatory strategy, he says, also “acts as a hub and spoke strategy with our facility, because we identify services and programs our patients need and can’t get at an urgent care center, but we can provide at our hospital.”

In its first fiscal year, which ended on October 1, 2014, the urgent care center posted approximately 7,000 visits. Jupiter projects a 13% increase in visits in FY 2015. And although initially anticipated by Jupiter, the center did not “cannibalize” any of the business
Case Study 2 (continued)

Salaries and benefits must also reflect both the reduced reimbursements and the work environment of the employees.

“If you’re somebody working in an urgent care center versus maybe in the emergency room of a hospital, you’re not going to get called in as much,” Couris observes. “You don’t have to work all night. You’re not going to have the level of intensity of services that you’d have in an ER versus an urgent care center. So, the work is different.”

The greatest challenge for hospitals that get into the ambulatory business, says Couris, is the tendency to operate them like they would a hospital. “The reality is, this is a retail-oriented ambulatory business.”

In the ambulatory business model, cost structure must reflect the payment and revenue structure, Couris says. “There can be a tendency to layer unnecessary costs with a hospital perspective.”

Jupiter cuts costs, in part, by reducing wait times for patients; turning over exam rooms in a timely manner; ensuring the staffing mix of physician assistants, nurse practitioners, and front desk workers is balanced appropriately; and using supplies judiciously.

“It’s the doctor’s responsibility to manage that,” says Couris. “Those are the things, that when we speak about efficiency, we measure and ultimately translate to the cost of care.”

Jupiter cuts costs, in part, by reducing wait times for patients; turning over exam rooms in a timely manner; ensuring the staffing mix of physician assistants, nurse practitioners, and front desk workers is balanced appropriately; and using supplies judiciously.

“Salaries and benefits must also reflect both the reduced reimbursements and the work environment of the employees.”

“You have to run these like you’re running a retail business,” says Couris. “They have to be lean. They have to be efficient. And you can’t compromise quality. You can’t compromise clinical outcomes and patient safety. But, you have to run them differently.”

The physician at Jupiter’s urgent care center—a new employee—is salaried, but also part of a production-based system. “Our doctors are rewarded on quality, patient outcome, service, and patient safety,” Couris says. “We don’t accept any of our doctors that refer patients to us based on volume. It is based on value.”

There is also a quality bonus attached to physician salaries. Jupiter measures things like appropriate testing and imaging, accurate diagnosis, and follow-up care. One physician will oversee both its current urgent care center and a second one, which Jupiter plans to open in February.

As the organization continues its efforts in the ambulatory market, competition continues to factor more prominently in its business strategy. It plans to open five urgent care walk-in centers in southeastern Florida over the next three years. And though they will be located in
Case Study 2 (continued)

communities that do not overlap each other, they will compete with other established urgent care centers.

“I’m not worried about the competition, not because we’re cavalier about it, but because we have a great product at a great price, and we have a great brand,” says Couris.

In its “market-driven approach” to pricing, Couris says that Jupiter performed an environmental assessment of its competitors. Jupiter’s pricing, he says, is not the least nor the most expensive, but rather it’s based on being “competitive” in the market.

“When it comes to analyzing data and evaluating the competitive landscape, we are dogmatic about our approach,” Couris says. “We’re very, very thorough in analysis of the competition. Quality is going to cost you something, but it shouldn’t break the bank.”

—Don Costanzo
CASE STUDY 3

Ambulatory Care and the Efficiency Imperative

Through a “substantial” investment in outpatient facilities over the past three years, UPMC has developed its own formula for ambulatory success by delivering efficient yet effective care, embracing synergies, and touting its expertise in a progressively competitive marketplace.

“We are operating more and more in consumer marketplaces,” says Edward Karlovich, CFO for UPMC’s academic and community hospitals. “The consumers are asking for services that can be delivered closer to them. We have to deliver those services, and do it more economically. Obviously, if you’re not in an inner-city core, your ability to do things on a more economic basis increases.”

UPMC has a number of ambulatory urgent care and community outpatient facilities in and around the Pittsburgh area. “We’re trying to build a medical system that’s going to meet the future needs of our patients,” Karlovich says. “And to do that, not only do you have to have sophisticated inpatient care, you’ve got to have accessible and high-quality outpatient care.”

Its newest facility—the $21 million, 60,000-square-foot Children’s South in South Fayette Township—opened in September. Outpatient services there include cardiology, orthopedics, neurology, exam space for services such as adolescent and young adult medicine, allergy, gastroenterology, plastic surgery, sleep medicine, and pediatric behavioral health testing. The new facility can accommodate some 100,000 visits per year, with room to expand.

UPMC is also building an orthopedic sports medicine ambulatory facility for adults. The $70 million UPMC Lemieux Sports Complex north of Pittsburgh in Cranberry Township is scheduled for completion in the summer of 2015. “The market is influencing our decision. But, we’re also influencing the market with the decisions we’re making.”

UPMC Pittsburgh-based UPMC is a global nonprofit integrated health system that has more than 60,000 employees, 21 hospitals with more than 5,100 beds, 400 clinical locations including outpatient sites and physician offices, and a 2.3 million-member health insurance division, as well as commercial and international ventures. It reported operating revenue of $11.4 billion in fiscal year 2014.
What Karllovich means by that is as the organization grows its ambulatory capabilities in response to changes to clinical practice and consumer preferences, its success drives changes in consumer perceptions and responses from other providers.

“If consumers begin to have care in a UPMC ambulatory environment and are satisfied with the experience, they may influence others who were less likely to move from a hospital-centric environment to ambulatory environment, thereby modifying the market and requiring further expansion,” he says. “Similarly, other institutions sensing a change will need to react to maintain their market standing.”

Given its strategy for growth in the ambulatory market, how does UPMC go about offsetting its declining high-fee inpatient services with the lower revenues from outpatient care?

“We have to reduce our cost structure,” Karllovich says. “We, as a healthcare community, are being asked to do things more efficiently and more effectively. Whether that’s coming from the federal level, the state level, or from the commercial consumer, we have to do that.”

Karllovich calls the shift toward efficient, cost-effective care a “significant transformation” within the industry. “We’ve got to make our cost structure meet our revenue inflows. And if we don’t, well that’s just a recipe for a long-term problem,” he says. “I don’t know of any business that can cut its way to success. You’ve got to continue to make sure you’ve got revenues coming into the organization.”

UPMC has renegotiated supply chain contracts, reconsidered appropriate staffing levels, and worked closely with its physicians in an effort to spur greater efficiency in its ambulatory environments.

“We also benefit if we become more effective managers of our patients by keeping them out of the facilities,” says Karllovich. “In other words, are we doing the right thing so that the patient doesn’t show up in the ED five times a month because they’ve got congestive heart failure and no one’s managing their fluid intake? If we can keep that patient out, then from an insurance perspective, that’s good for us, and we look at ourselves as an integrative delivery system. And, it’s good for the patient.”

Because UPMC is an academic medical center, Karllovich believes that its physicians are always looking to work more efficiently, which bodes well for outpatient care.

“You provide them with the data, and they want to be the best,” he says. “They want to figure out how to do things better and most efficiently. They recognize the pressures that all of us are facing from a cost perspective, and they’re just willing to step up to the plate.”

UPMC also achieves ambulatory efficiencies though its facilities and
its patient care process. “The use of ambulatory facilities, which are generally less expensive to build and maintain, are in many cases limited-use facilities focusing on a small number of services,” Karlovich says. “As with anything that has less variability in services provided, an organization can more easily create standard protocols around the entire patient care process, thereby reducing costs, providing a more consistent customer service and patient care process.”

Achieving synergies by integrating services within a single facility has become increasingly important in UPMC’s approach to provide efficiency. “All the pieces must work together effectively,” Karlovich says. “So, we look at it as a more integrated base of all the services we want to provide together in one location, versus looking at it as a series of subspecialties coming together in a building.”

Karlovich calls UPMC’s Children’s Hospital of Pittsburgh “the premier brand” in the marketplace. So, while the potential for duplication of services exists within the communities where it has opened, and plans to open, ambulatory facilities, Karlovich says “there is no doubt in my mind that our UPMC brand and U.S. News & World Report ranking helps us” in competitive environments.

“This is a business,” Karlovich says. “Across the nation, inpatient utilization is going to fall. There’s going to be a shakeup. The question is, when is the shakeup going to happen? What’s it going to look like? I think we use this just as we’re looking to build a wide-ranging ambulatory environment.

“We recognize we’ve got to be in the entire continuum of this market to be successful,” he adds. “Across the country, hospitals are closing. It doesn’t mean the services aren’t being delivered somewhere. It simply means that that system or that entity economically couldn’t sustain itself to meet the needs of its community and its patients, and they have a different way to deliver the care.”

—Don Costanzo
**FIGURE 1 | Factors Driving Ambulatory/Outpatient Care Strategy**

**Q | What are the top three factors driving your organization’s ambulatory/outpatient care strategy?**

<table>
<thead>
<tr>
<th>Total responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion of market share</td>
<td>61%</td>
</tr>
<tr>
<td>Improved cost control</td>
<td>55%</td>
</tr>
<tr>
<td>Equal or better quality outcomes in such settings</td>
<td>51%</td>
</tr>
<tr>
<td>Areas of healthcare becoming consumer driven</td>
<td>49%</td>
</tr>
<tr>
<td>Improved revenue</td>
<td>44%</td>
</tr>
<tr>
<td>Need to take on risk dictates control of services</td>
<td>17%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Base = 311, Multi-Response*

**TAKEAWAYS**

- Expansion of market share is the item selected most frequently by both hospitals (62%) and health systems (69%).
- Overall, 49% say their strategies reflect how healthcare is becoming consumer-driven. Among health systems, consumer-driven healthcare is selected by 59%, the second most frequently mentioned driver.
- Cost control is the No. 2 item among hospitals (60%) and physician organizations (62%).

**WHAT DOES IT MEAN?**

With all of the alternatives but one selected by 44% or more, we see that there are a variety of factors driving ambulatory and outpatient strategies. Market share tops the list, appropriate for an industry in which revenue is still based on fee-for-service billing. The risk-related desire to control more of the continuum is included as a top factor by only 17%, an indication that healthcare reform may be slow to take hold, even as that reform prompts providers to examine many of their activities from a cost-of-care perspective, including ambulatory/outpatient care. Such scrutiny earns improved cost control the No. 2 spot, cited by 55% overall, but it appears that health systems in particular are looking beyond cost control (cited by 45%), with 59% citing consumer-driven healthcare as one of the top three factors moving their ambulatory/outpatient activity forward.
FIGURE 2 | Tactics to Expand Ambulatory/Outpatient Primary Care Network

What tactics or mechanisms are you using to expand your ambulatory/outpatient primary care network?

**Total responses**

<table>
<thead>
<tr>
<th>Tactics</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner with physician practices, organizations</td>
<td>62%</td>
</tr>
<tr>
<td>Acquire physician practices, organizations</td>
<td>60%</td>
</tr>
<tr>
<td>Partner with community-based organizations</td>
<td>47%</td>
</tr>
<tr>
<td>Develop or join internal or external HIE</td>
<td>33%</td>
</tr>
<tr>
<td>Acquire urgent care clinics</td>
<td>19%</td>
</tr>
<tr>
<td>Partner with urgent care clinics</td>
<td>18%</td>
</tr>
<tr>
<td>Partner with convenient care clinics</td>
<td>16%</td>
</tr>
<tr>
<td>Acquire convenient care clinics</td>
<td>13%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Base = 311, Multi-Response*

**TAKEAWAYS**

- Nearly as many organizations expect to expand their ambulatory/outpatient physician practice network through acquisition (60%) as through partnerships (62%).

- Looking by organization size, though, we see that a higher percentage of those with medium (70%) and high (79%) net patient revenue are expanding their physician practice network through acquisition, compared to those with low net patient revenue (48%).

- Nearly one-fifth (18%) are partnering with urgent care clinics, while 19% are expanding by acquiring urgent care clinics. But again, higher percentages of larger organizations are buying: 28% of those with medium and high levels of net patient revenue are acquiring urgent care clinics, compared to 13% of low-revenue organizations.

**WHAT DOES IT MEAN?**

At this point, most activity in primary care network expansion involves partnering with physician practices or acquiring physician practices. Nearly half (47%) expand their primary care network by partnering with community organizations. Comparatively speaking, urgent care and convenient care are bottom-tier activities when it comes to primary care network expansion.
FIGURE 3  Tactics to Expand Ambulatory/Outpatient Specialty Care Network

Q | What tactics or mechanisms are you using to expand your ambulatory/outpatient specialty care network?

| Total responses |  
|-----------------|-------------------|
| Partner with physician practices, organizations | 64% |
| Acquire physician practices, organizations | 52% |
| Partner with community-based organizations | 41% |
| Develop or join internal or external HIE | 26% |
| Partner with urgent care clinics | 13% |
| Partner with convenient care clinics | 12% |
| Acquire urgent care clinics | 8% |
| Acquire convenient care clinics | 8% |
| Don’t know | 5% |

Base = 311, Multi-Response

TAKEAWAYS

- To expand specialty care networks via physician practices, more health systems than hospitals are involved in partnering (70% vs. 61%, respectively) and acquisition (65% vs. 49%).

- Compared to hospitals (19%), higher percentages of health systems (32%) and physician organizations (34%) are expanding ambulatory/outpatient specialty care networks via an HIE.

- In Figure 2, we see that for primary care expansion, nearly equal percentages of hospitals are expanding ambulatory care via acquisition of physician practices (57%) as are partnering with physician practices (60%). For specialty care, though, hospitals are more inclined to partner (61%) than acquire (49%).

WHAT DOES IT MEAN?

As with primary care expansion (Figure 2), physician practices are selected most often as a mechanism for ambulatory/outpatient specialty care expansion. Unlike what we see in Figure 2, in teaming with physician practices to expand specialty care, considerably higher percentages of organizations are partnering (64%) than acquiring (52%). Otherwise, the approaches used for specialty care generally mirror the approaches used for primary care.
FIGURE 4  Participation in Convenient Care Clinics

Q | Does your organization participate in convenient care clinics through ownership or partnership?

<table>
<thead>
<tr>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we do now</td>
</tr>
<tr>
<td>We plan to within three years</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Base = 311

TAKEAWAYS

- More than one-third (37%) participate in convenient care clinics either through ownership or partnership.
- Nearly half (48%) of health systems are involved in convenient care clinics, compared to 33% of hospitals and 28% of physician organizations.
- By size, we see that 57% from organizations with net patient revenue above $1 billion own or partner with a convenient care clinic. Only 30% of those from organizations with low net patient revenue and 35% of those with medium net patient revenue do so.
- Overall, only 14% of respondents expect to own or partner with convenient care clinics within three years.

WHAT DOES IT MEAN?

Extending access via convenient care clinics is more prevalent in larger organizations than small, with larger organizations probably having both the motivation and the means to incorporate them. In addition, larger organizations can attract executives with the skills to run convenient care clinics, which are different than those needed to run acute care.
FIGURE 5  Participation in Urgent Care Clinics

Q | Does your organization participate in urgent care clinics through ownership or partnership?

<table>
<thead>
<tr>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we do now</td>
</tr>
<tr>
<td>We plan to within three years</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Base = 311

TAKEAWAYS

- With 57% of respondents owning or partnering with an urgent care clinic, the level of participation is higher than with convenient care clinics (37%, Figure 4).

- Nearly three-quarters (70%) of health systems own or partner with an urgent care clinic, more than hospitals (55%) or health systems (40%). There are higher levels of participation in urgent care clinics than convenient care clinics across all settings.

- As we saw with convenient care clinics, larger organizations are more inclined to own or partner with an urgent care clinic. More than two-thirds of medium-revenue organizations (68%) and high-revenue organizations (72%) are involved in urgent care clinics, compared to 47% of low-revenue organizations.

WHAT DOES IT MEAN?

There are three principal reasons that there is more involvement in urgent care clinics than convenient care clinics. First, an urgent care clinic can accept patients with higher acuity levels, thus earning correspondingly higher reimbursement. Second, because patients are cared for in urgent care centers more cost-effectively than in emergency departments, providers can expect some efficiencies by offering an alternative to the ED. Third, urgent care centers offer a set of services that are more familiar to hospitals and health systems than convenient care.
FIGURE 6  Ambulatory/Outpatient Area Offering Greatest Financial Contribution Today

Q | Which area of ambulatory/outpatient care offers the greatest financial contribution today?

<table>
<thead>
<tr>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery centers</td>
</tr>
<tr>
<td>Specialty care</td>
</tr>
<tr>
<td>Imaging</td>
</tr>
<tr>
<td>Primary care</td>
</tr>
<tr>
<td>Office-based surgery</td>
</tr>
<tr>
<td>Physical therapy</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Base = 311

TAKEAWAYS
- Nearly identical percentages identify surgery centers (22%), specialty care (22%), and imaging (20%) as the area of ambulatory or outpatient care that offers the greatest financial contribution today.

- As one would expect, a smaller percentage of physician organizations (6%) than hospitals (23%) or health systems (24%) say that imaging provides the greatest contribution. Also predictably, a greater percentage of physician organizations (24%) than hospitals (16%) or health systems (12%) say that primary care provides the greatest contribution.

- Surgery centers seem especially strong in the Northeast, where 30% say such centers provide the greatest financial contribution; other regions had 19%–22% mention surgery centers.

WHAT DOES IT MEAN?
Office-based surgery, the top contributor for only 3%, does not have the same support as surgery centers (top contributor for 22%), probably because surgery centers have higher numbers of procedures over which to amortize support expenses, and may have sufficient volume to support ancillary but important services such as imaging and lab work. In other words, although advances in medicine allow a wider range of surgery to be performed in outpatient settings, for many it probably makes more sense to do such procedures in outpatient surgery centers instead of private offices.
**FIGURE 7 | Ambulatory/Outpatient Area Expected to Deliver Greatest Financial Contribution in Five Years**

Q: Which area of ambulatory/outpatient care do you expect to be delivering the greatest financial contribution five years from now?

<table>
<thead>
<tr>
<th>Total responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>33%</td>
</tr>
<tr>
<td>Surgery centers</td>
<td>20%</td>
</tr>
<tr>
<td>Specialty care</td>
<td>19%</td>
</tr>
<tr>
<td>Imaging</td>
<td>6%</td>
</tr>
<tr>
<td>Office-based surgery</td>
<td>4%</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>14%</td>
</tr>
</tbody>
</table>

Base = 311

**TAKEAWAYS**

- One-third (33%) of healthcare leaders expect that primary care will deliver the greatest financial contribution five years from now. We saw in Figure 6 that primary care provides the greatest contribution right now for only 16%.

- Today only 12% of health systems say that primary care provides the greatest financial contribution from ambulatory care (Figure 6). But in five years, 39% of healthcare leaders from health systems expect their greatest contribution to come from primary care. Although higher percentages of hospitals and physician organizations also expect primary care to deliver the greatest return in the future, neither matches the 27-point increase we see for health systems.

- In five years, primary care ascends in importance as imaging descends. Only 6% expect imaging to provide the greatest financial contribution from ambulatory services, down from 20% now.

**WHAT DOES IT MEAN?**

With one-third expecting primary care to be the biggest contributor in the five-year time frame, we can see that healthcare reform and the move toward population health are being taken seriously. The decline in those depending on imaging for top revenue no doubt reflects the present attention to imaging reimbursements, overutilization, and unnecessary duplication by both government and commercial payers.
FIGURE 8  Shift in Ambulatory/Outpatient Care Net Patient Revenue in Three Years

Q | Please estimate the expected shift in ambulatory/outpatient care net patient revenue for your organization within three years.

| Total responses |
|-----------------|-----------------|
| 21%             | 35%             |
| 27%             | 10%             |
| 4%              | 3%              |

Base = 277

TAKEAWAYS

- One-fifth (21%) expect net patient revenue from ambulatory/outpatient care to increase by 20% or more within the next three years. The percentage who expect an increase in revenue of 20% or more is fairly consistent across healthcare settings.

- There is a concentration of respondents with high expectations among the largest organizations. Nearly one-third (30%) of organizations with $1 billion or more in net patient revenue expect an increase in net patient revenue from ambulatory/outpatient care of 20% or more, compared to 19% of those from low-revenue organizations and 15% or medium-revenue organizations.

- Nearly half (48%) of physician organizations expect net patient revenue to increase by 10% or more within three years, which is a substantial percentage, but less than hospitals (57%) and health systems (58%).

WHAT DOES IT MEAN?

Projections of revenue growth indicate providers are confident that increased accessibility, greater convenience, and a growing patient sensitivity to the cost of care will, indeed, mean increasing ambulatory and outpatient visits. Advances in medicine also contribute to the overall trend by allowing more procedures to be done in outpatient instead of inpatient settings.
Within three years, what is your estimated ratio of capital budget investment for new program development for inpatient acute care vs. ambulatory/outpatient care?

**Total responses**

- **Ambulatory/outpatient care expansion**: 64%
- **Inpatient acute care expansion**: 36%

**Base = 175**

**TAKEAWAYS**

- Overall, within three years, healthcare leaders expect that the split between capital investments for new program development will be nearly 2 to 1 in favor of ambulatory care (64%) vs. inpatient acute care (36%).

- The industry’s largest organizations will invest proportionally less than others: Among those with net patient revenue of $1 billion or more, the share of capital going to new program development for ambulatory care services (54%) and inpatient care (46%) is more evenly balanced when compared to the 65%-to-35% split for both low- and medium-revenue organizations.

- While hospitals and health systems have similar balances overall, an examination of unpublished segmented data shows that 54% of hospitals expect an outpatient-to-inpatient investment ratio of at least 70% to 30%, compared to just 44% of health systems.

**WHAT DOES IT MEAN?**

Larger organizations are dedicating proportionally less to ambulatory/outpatient, which may be an indication that they have larger inpatient infrastructures to maintain and enhance. Comparative cost is a factor, too: Improvements in the inpatient environment demand more capital than outpatient improvements. Plus, it is likely that a number of smaller organizations are late to enter the outpatient segment and are investing now to catch up.
FIGURE 10 | Facility Expansion Priorities Over Next Three Years

Q | Please rank the following according to their priority (in overall cumulative dollar level of investments for new program development) when investing in facility expansion over the next three years.

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory/outpatient care</td>
<td>51%</td>
</tr>
<tr>
<td>Acute care surgery or operating room</td>
<td>25%</td>
</tr>
<tr>
<td>General acute care</td>
<td>14%</td>
</tr>
<tr>
<td>Emergency department</td>
<td>10%</td>
</tr>
<tr>
<td>Base = 266</td>
<td></td>
</tr>
</tbody>
</table>

TAKEAWAYS

- Slightly more than half (51%) say that ambulatory/outpatient care is their No. 1 priority in investments for facility expansion to support new program development over the next three years.

- A higher percentage of health systems (58%) than hospitals (43%) say ambulatory care will be their top facility expansion investment over the next three years. Two-thirds (66%) of physician organizations expect ambulatory care to be their greatest facility expansion investment.

- Acute care surgery or operating room investments garnered only 25% of No. 1 responses.

WHAT DOES IT MEAN?

Healthcare leaders are reinforcing the expectation that outpatient and ambulatory care is where growth will be. With more than half ready to commit investment resources, healthcare leaders clearly emphasize expansion into outpatient and ambulatory services, and relatively fewer (25%) say their top new-program investment will be in acute care surgery facilities. The difference is especially noticed among health systems, where 58% say their top investment will be outpatient and, while second on the list, only 20% indicate that acute care surgery facilities will be their No. 1 investment.
**FIGURE 11 | Expansion of Care Service Priorities Over Next Three Years**

Q | Please rank the following according to their priority (in overall cumulative dollar level of investments for new program development) when investing in expansion of care services over the next three years. (Percent ranked first)

<table>
<thead>
<tr>
<th>Total responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory/outpatient care</td>
<td>57%</td>
</tr>
<tr>
<td>Acute care surgery or operating room</td>
<td>24%</td>
</tr>
<tr>
<td>Emergency department</td>
<td>11%</td>
</tr>
<tr>
<td>General acute care</td>
<td>8%</td>
</tr>
</tbody>
</table>

Base = 248

**TAKEAWAYS**

- More than half (57%) say that their No. 1 priority in new program development investment for expansion of care services over the next three years is ambulatory/outpatient care.

- Nearly three-quarters (70%) of healthcare leaders from health systems say their top investment for new development in the expansion of care services will be ambulatory/outpatient care, a percentage that is considerably higher than those recorded for hospitals (49%) or physician organizations (53%).

- That said, ambulatory care is the top investment focus across all settings. Acute care surgery, the care area with the second highest level of No. 1 rankings, was picked by only 24% overall, although that number is higher among physician organizations and hospitals (29% each) than health systems (14%).

**WHAT DOES IT MEAN?**

It is among health systems that the largest difference is observed between ambulatory (70%) and acute care surgery (14%) as leaders’ top care service investment category. It is likely that health systems already have a fairly sophisticated surgery infrastructure and anticipate more or less routine investments, whereas outpatient and ambulatory services, especially community-based services, may require a high degree of new outlays. This is also a sign that health systems expect to be major players in the outpatient/ambulatory arena.
FIGURE 12 | Greatest Competitive Threat to Ambulatory/Outpatient Area

Q | Within the next three years, which ambulatory/outpatient area presents the greatest competitive threat to your organization?

<table>
<thead>
<tr>
<th>Total responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail medicine (e.g., pharmacies, big-box stores)</td>
<td>29%</td>
</tr>
<tr>
<td>On-campus services from hospitals</td>
<td>20%</td>
</tr>
<tr>
<td>Urgent care clinics</td>
<td>13%</td>
</tr>
<tr>
<td>Convenient care clinics</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>None</td>
<td>5%</td>
</tr>
<tr>
<td>Don't know</td>
<td>11%</td>
</tr>
</tbody>
</table>

Base = 311

TAKEAWAYS

- Retail medicine presents the greatest ambulatory/outpatient competitive threat to 29% of respondents. It was identified most frequently as the single greatest threat by health systems (38%) and hospitals (25%).

- The competitive threat mentioned most frequently by physician organizations is on-campus services, selected by 30%, followed by retail medicine (24%).

- More than one-third (36%) of organizations in the Midwest say that retail medicine is the greatest threat to their ambulatory/outpatient services, which is greater than the 20%-29% range in other regions. In the Northeast, 30% say their greatest threat is urgent care clinics, which is notably higher than the 6%-12% range elsewhere.

WHAT DOES IT MEAN?

Some of the reasons that providers are threatened by retail medicine are pervasiveness, ease of entry, customer convenience, low prices, and, for many, an incompatible business model (which serves as an entry barrier for providers). Included in “other” responses are several who see outpatient surgery centers, competition from hospitals/health systems, and competition from physician-owned facilities as their greatest threats.
FIGURE 13 | Dollar Level of Self-Pay

Q | In aggregate, would you say the dollar level of self-pay (vs. third-party pay) is higher for your ambulatory/outpatient services than for your acute care services?

<table>
<thead>
<tr>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-pay is not higher for ambulatory/outpatient</td>
</tr>
<tr>
<td>Self-pay is higher for ambulatory/outpatient</td>
</tr>
<tr>
<td>Don't know</td>
</tr>
</tbody>
</table>

Base = 311

TAKEAWAYS

- Overall, 25% say that self-pay is higher for ambulatory services than acute care services.

- Smaller organizations experience higher self-pay more frequently than larger organizations: 29% of organizations with less than $250 million in net patient revenue say that self-pay is higher for their ambulatory services, compared to 19% of those with net patient revenue above $1 billion.

WHAT DOES IT MEAN?

Offering healthcare services to a broader population—especially walk-in outpatient/ambulatory services, compared to acute care where referrals are more common—probably means that there will be more uninsured patients. In addition, outpatient services often include elective procedures that may not be covered by third parties even if the patient has health insurance.
**FIGURE 14 | Dollar Level of Self-Pay Within Three Years**

Q | Within three years, will the dollar level of self-pay for ambulatory/outpatient services increase, decrease, or remain the same?

<table>
<thead>
<tr>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase</td>
</tr>
<tr>
<td>Decrease</td>
</tr>
<tr>
<td>Remain the same</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

*Base = 311*

**TAKEAWAYS**

- Half (50%) of healthcare leaders from physician organizations expect the dollar level of self-pay care delivered to ambulatory patients to increase within three years, compared to 42% of respondents from hospitals and 43% from health systems.
- More than one-quarter (27%) of respondents from health systems expect that the dollar level of self-pay for ambulatory services will decrease over the next three years, while only 18% of hospitals and physician organizations expect a decrease.
- Higher percentages of respondents from the South (51%) and Northeast (52%) expect the dollar level of ambulatory self-pay to increase, compared to 29% from the West and 37% from the Midwest. The West is the only region where a greater share of providers expects the dollar level of self-pay for ambulatory/outpatient services to decrease (35%) rather than increase (29%).
- Only 26% of healthcare leaders from hospitals with 500 or more beds expect an increase in self-pay revenue, a smaller percentage than from small (47%) or medium (46%) hospitals. This result is balanced out by higher percentages from large hospitals who expect the dollar level of self-pay revenue to stay the same (37%) compared to small (20%) and medium (22%) hospitals.

**WHAT DOES IT MEAN?**

Overall, the levels of self-pay are expected to increase. An advisor notes that many newly insured are covered by insurance packages with high deductibles, which will also increase the levels of bad debt providers will have to cover.
Looking at cost now, but population health is near. An important driver for ambulatory and outpatient care is healthcare reform. Near-term, ambulatory and outpatient care are more cost-efficient ways to deliver certain services, and advances in medicine continue to prompt the migration of care services from acute care to outpatient. In the longer term, ambulatory and outpatient care will be important elements in a care continuum that addresses population health. Because of steps being made toward population health management, there is a great deal of emphasis on improving access to care, especially through primary care practices, and using primary care as a “gatekeeper” or manager of the patient’s overall health. Both factors—cost efficiency and population health management—are compelling reasons to incorporate ambulatory care in strategic planning, and to participate directly or via partnerships.

What about assuming risk? An organization’s strategic planning should take into account the pending shift to value-based purchasing, which implies compensation for outcomes. We are all familiar with readmission penalties, an early manifestation of outcome-based reimbursement that often is dependent on the performance of a care provider outside of the acute care setting. When that principle is extended to broader patient populations and a broader set of care collaborators, the implication is that success will depend on having established close working relationships with care partners. We talk to healthcare leaders who say, “We don’t have to own the care continuum.” Nonetheless, those that are closely aligned to an extensive team providing ambulatory and outpatient services will have advantages.

A higher-acuity acute care patient mix. One advisor reports that his organization sees two dollars of outpatient revenue for every dollar of inpatient revenue. Even without a broad presence in ambulatory care, outpatient visits will greatly outnumber inpatient visits for many organizations. One dynamic at work is the desire to provide access to care in a venue where the patient wants to access care—meet them where they are. To address this need, hospitals and health systems extract appropriate care services from the acute care facility and locate them in the community, or they duplicate those services in the community. In the past, such a hub-and-spoke system would be a source of inpatient admissions. That role will remain, but with more services performed in the outpatient environment, the acuity level of admitted patients will increase, and the mix of care services required in acute care settings will change, too. For this
Recommendations (continued)

reason, we see strong continuing investment in acute-care new-program development, as acute care organizations adjust their mix of care services.

**Even experts need help.** As you examine how to extend your ambulatory and outpatient reach, be sensitive to how the nature of the healthcare business changes as the venue changes. Ambulatory and outpatient care is becoming a consumer-oriented care delivery method. The finances are different, the care team is different, and the definition of provider efficiency is different. Seek executives with the appropriate kind of background and skills to manage in this dynamic environment.

**It’s not about the building.** Especially among those with a hospital and health system perspective, the place where care is provided—the hospital—is considered integral to care. But those making decisions about ambulatory and outpatient investments tend to emphasize the type of service being provided and deemphasize location, at least as a first-order decision. Such a perspective is important to ensure a proper fit and that the patient community needs the services being considered. A second-order decision is: Given that the community needs the service, what are the alternatives for providing that service?
QUESTIONS FOR YOUR TEAM

To address outpatient and ambulatory care issues, consider asking your leadership team these questions:

1. Considering that a factor contributing to growth in ambulatory and outpatient environments is the migration of patients from acute care environments, are we prepared to offer a refined mix of inpatient services, acknowledging a proportionally higher component of high-acuity patients?

2. Are we realistic about revenue for outpatient and ambulatory services, acknowledging pressure on prices due to a higher degree of competition and what is likely to be a higher proportion of services for which patients are responsible for part or all of their fee?

3. As we consider ambulatory and outpatient staffing, do we recognize that we might need managers with a different set of skills to accommodate the consumer-centric slant that is becoming more important in ambulatory and outpatient care today?

4. Do we recognize that many of the variables that determine the mix, level, and location of ambulatory and outpatient services we will offer are highly individualistic to particular market conditions? While it is important to understand industrywide trends, we must tailor our services to match care needs of the communities we serve, considering factors such as population demographics and general health and wellness. In addition, with low barriers to entry, are we considering both the current competitive landscape and likely competitive responses?

5. While we acknowledge the need to make careful and reasoned decisions about where to offer what level of outpatient services, do we at the same time recognize that ease of entry means that we may see a shorter window of viability, and that competitive forces may influence the chances for success, particularly from a revenue perspective? Are we mindful that we could be entering a market that may soon become saturated?

6. Although we can expect some patients to take price into consideration when selecting an outpatient or ambulatory care provider, are we accounting for the strength of our organization’s brand and reputation when making pricing decisions? Brand can be especially important when we consider that a great number of patients who may visit an ambulatory or outpatient facility are selecting a provider without having a great deal of information about their condition or the care services they are going to receive. In such circumstances, are we considering that brand or image stands next to travel time and operating hours among the decision parameters of many patients?

7. Big-box retailers are part of the care continuum. Are we monitoring developments so that we can interact with the consumer retail channel when appropriate? Some retail-based clinics have been operating for close to a decade, so the chances are very good that patients of conventional providers receive at least some of their care at retail clinics. As care provision becomes risk based, do we recognize that it will be important to know what care patients are receiving at clinics rather than to wonder?

8. Are we preparing for a future where the industry becomes defined more by the services performed than the facility where the services are located? This is not to say that the role of acute care will be diminished. Rather, an organization may be defined by how it brings the entire range of care services, including acute care when needed, to bear on the patient community.

9. Do we recognize that accompanying the need to bear risk in the future will be the need to be responsible for care across the continuum, including ambulatory and outpatient care? Reimbursement—that is, patient revenue—will depend on success in managing patient care. In turn, primary care physicians, who are the foundation of ambulatory and outpatient care, will be in a pivotal position to direct ambulatory and outpatient care provision.

10. Do we understand the dynamics of the ambulatory and outpatient environments? The first considerations when making decisions about ambulatory sites and services are market conditions: Do we appreciate the needs of the community and the range of services already available? Especially compared to the factors influencing acute care investment decisions, both factors are fluid in nature, so it’s important to revisit decisions periodically.

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