
Assessing the feasibility, performance of geriatric clinics

BY EDWARD B. DANIELS
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OUTPATIENT CARE

Geriatric outpatient clinics offer a way for healthcare providers to add Medicare patients and better manage their care. Opening a new clinic, however, requires a substantial commitment from hospital executives and a sizable investment, sometimes including an operating subsidy until clinic volume can cover initial expenses and continuing operations. Hospitals considering such a move should weigh the strategic effects on medical staff members; assess competitors; conduct a detailed marketing analysis; and forecast expenses and revenues.

By the year 2030, experts project, people age 65 and older will make up nearly 22 percent of the United States' population.^a Faced with the healthcare demands of an aging society, many hospitals are adding new services targeted to the elderly.

a. Fowles, Donald G., *Profile of Older Americans*, a 1988 study by the Program Resources Department, American Association of Retired Persons, and the Administration on Aging, U.S. Department of Health and Human Services.

Before Medicare began its prospective payment system, hospitals found that by aggressively marketing to seniors, they could boost Medicare patient volumes and margins with relatively low investments.

While Medicare profit margins since have dropped dramatically, almost half of hospital revenues still come from serving older patients. As long as Medicare payments exceed incremental costs, adding Medicare volume remains wise for hospitals with excess capacities. Opening a geriatric outpatient clinic offers a way of doing this—and better managing the care of senior patients.

A geriatric outpatient clinic provides an array of services based around a hub of primary physician care similar to that provided by other family practitioners and general internists. The clinic also may offer specialist physician care, such as cardiology, otolaryngology, dermatology, psychiatry, and ophthalmology.

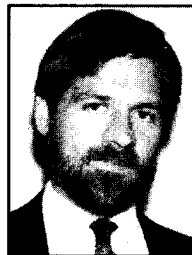
Additional services vary but typically include:

- ▶ Nursing care provided by geriatric nurse practitioners who assist physicians, educate patients, perform physical examinations, and handle other tasks;
- ▶ Case management, often handled through automated means, to coordinate psychological, social, environmental, and medical care for clinic patients at home and while hospitalized in an acute care setting;

- ▶ Patient and community education programs that serve a dual role of improving patient care and providing a marketing forum; and
- ▶ Insurance counseling that assists patients with claims processing and sometimes with selecting supplementary insurance policies.

Geriatric clinics are best located in storefronts or ground floor office suites. Facilities usually have from 1,000 to 5,500 square feet of space, but those with at least 3,500 square

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feet appear to be most efficient.

Because a geriatric outpatient clinic provides services beyond those offered in a physician's office, the clinic's staff is larger, more professional, and trained in aging services. Typically, clinics include these positions: an administrative director (one full-time equivalent or FTE); a medical director also serving as a primary care physician (one FTE); additional primary care physicians as needed; a nurse practitioner (one FTE minimum); a social worker (three-quarter FTE minimum); a clinical aide and radiology technician (three-quarter FTE minimum); and a clerk or receptionist (one FTE minimum).

Other positions, such as insurance counselor, registered nurse, licensed practical nurse, nurse's aide, and patient educator are used by some clinics to support volume and service requirements. Specialist physicians who treat patients in the clinics typically are not paid staff members.

Evaluating feasibility

Developing a geriatric outpatient clinic may help attract additional Medicare patient volume and provide a way to control use of hospital resources. The clinic will require a considerable management commitment and a large initial capital investment, including possible operating subsidies until clinic volume can sustain its ongoing operations.

STRATEGIC EFFECT. The first step in evaluating the feasibility of developing a geriatric outpatient clinic is to consider its strategic effects:

- ▶ Is the senior population a marketing priority for the hospital?
- ▶ Are competitors focusing on seniors and gaining market share?
- ▶ Will the hospital's board and its medical staff support the development of a geriatric clinic? Medical staff support for a geriat-

ric outpatient clinic may be difficult to achieve if physicians believe the clinic will compete with their practices. Including the medical staff in the decision and implementation process helps avoid potential ad-

verse reactions.

At the same time, concessions may be needed. For example, the clinic may establish a policy that encourages prospective patients whose family physicians are mem-

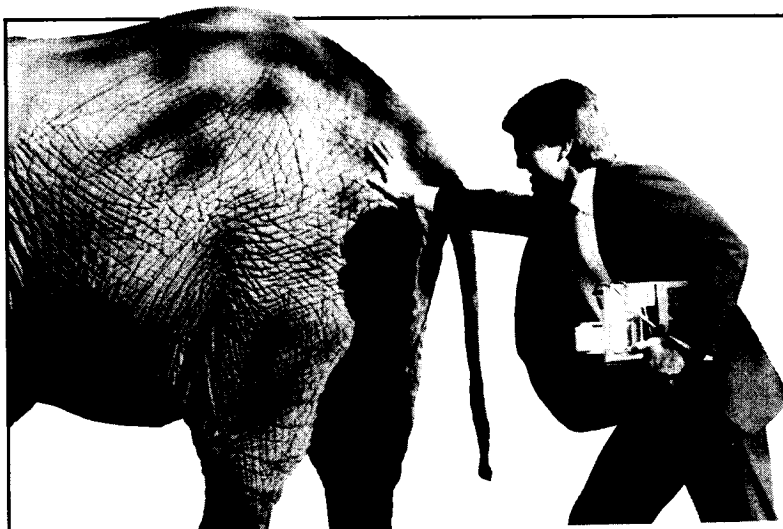


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bers of the medical staff to return to those physicians after being treated at the clinic.

This policy would demonstrate a desire to eliminate competition with staff physicians. Acknowledging that specialty and inpatient care will be referred to members of the hospital's medical staff and that the clinic will enter contracts with staff members for clinic coverage are politically effective strategies that may gain needed allies.

MARKET ANALYSIS. If the political climate is conducive to proceeding, the next step is to perform a market analysis. This consists of:

- ▶ Collecting demographic data on the senior population and its projected growth or decline;
- ▶ Identifying competitors, including other senior services and the number, location, and capacity of primary care physicians in the community. The level of satisfaction with existing services also should be assessed; and

- ▶ Determining the need for services the clinic would provide.

Many healthcare administrators mistakenly believe that people age 65 and older already have doctors and will not want to use a clinic's services. In fact, market analyses frequently show a growing senior population, a sizable number of them (20 percent to 25 percent) without primary care physicians. Many others may be dissatisfied with the time and attention they receive from their current family physicians.

FINANCIAL ANALYSIS. The initial capital investment for a geriatric outpatient clinic typically includes approximately \$25,000 for architect fees; \$150,000 for furniture, fixtures, and equipment; and from \$45 to \$75 per square foot for leasehold improvements. A 4,000-square-foot clinic would require between \$265,000 and \$375,000 in capital costs. Additional start-up costs, such as recruiting and con-

sulting fees and pre-operational salaries, also may be needed.

After start-up costs have been determined, the analyst should prepare a five-year pro forma revenue and expense statement, similar to one shown in Exhibit 1. Start-up costs are amortized and included as clinic expenses.

In Exhibit 1, first year expenses are approximately \$710,189, while gross revenues are only \$48,375, based on 1,125 patient visits. An estimated operating loss of \$661,814 is not necessarily the amount the sponsoring hospital must subsidize. Because the clinic's patient load consists entirely of Medicare outpatients, Medicare payments can cover most operating costs, even during the first year of operation.

Projecting the amount of additional Medicare volume generated for the hospital's outpatient and inpatient departments over the five-year period is essential to accu-

EXHIBIT 1: Projected effect of a clinic on hospital operations

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | 5-year total |
|---|------------------|--------------------|--------------------|--------------------|---------------------|---------------------|
| Revenues: | | | | | | |
| Patient service revenue | | | | | | |
| Senior health center | \$ 48,375 | \$ 145,125 | \$ 241,875 | \$ 338,625 | \$ 435,375 | \$ 1,209,375 |
| Outpatient ancillary | 119,126 | 375,248 | 655,194 | 958,966 | 1,286,564 | 3,395,098 |
| Inpatient routine | 73,025 | 219,075 | 365,125 | 511,175 | 657,226 | 1,825,626 |
| Inpatient ancillary | 137,525 | 412,576 | 687,627 | 962,678 | 1,237,729 | 3,438,135 |
| Gross patient service revenue | \$378,051 | \$1,152,024 | \$1,949,821 | \$2,771,444 | \$3,616,894 | \$ 9,868,234 |
| Deductions from patient service revenue (Medicare contractual) | | | | | | |
| Capital | \$ 3,559 | \$ 10,085 | \$ 15,986 | \$ 21,338 | \$ 26,216 | \$ 77,184 |
| Inpatient | (68,296) | (204,888) | (341,481) | (478,073) | (614,665) | (1,707,403) |
| Outpatient | 617,068 | 648,848 | 650,271 | 512,289 | 371,108 | 2,799,584 |
| Total | \$552,331 | \$ 454,045 | \$ 324,776 | \$ 55,554 | \$ (217,341) | \$ 1,169,365 |
| Net patient revenue | \$930,382 | 1,606,069 | 2,274,597 | \$2,826,998 | \$3,399,553 | \$11,037,599 |
| Expenses: | | | | | | |
| Senior health center | \$710,189 | \$ 723,952 | \$ 762,514 | \$ 829,330 | \$ 903,643 | \$ 3,929,628 |
| Outpatient ancillary | 35,381 | 111,450 | 194,595 | 284,816 | 382,111 | 1,008,353 |
| Inpatient routine | 32,064 | 96,191 | 160,319 | 224,447 | 288,574 | 801,595 |
| Inpatient ancillary | 36,757 | 110,270 | 183,783 | 257,296 | 330,809 | 918,915 |
| Total | \$814,391 | \$1,041,863 | \$1,301,211 | \$1,595,889 | \$1,905,137 | \$ 6,658,491 |
| Net revenue | \$115,991 | \$ 564,206 | \$ 973,386 | \$1,231,109 | \$1,494,416 | \$ 4,379,108 |

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rately assess the clinic's performance. The best sources of this data are operating statistics from similar clinics and utilization statistics for the age 65 and older population, both of which can be obtained from various governmental sources.

Typically, a hospital's Medicare payments will increase because of the clinic's 100 percent Medicare volume and because of the increased volume brought by clinic patients to other outpatient areas of the hospital.

Because assessing these factors is complex, a computer model or a computerized cost report package can simplify the task. Assumptions that analysts must make include:

- ▶ How will Medicare volume fluctuate over the next five years without a geriatric clinic? Will cost per stay fluctuate materially?
- ▶ What incremental volume will be generated by clinic patients? This includes visits, inpatient admissions, outpatient activity at the hospital, and incremental volume to a hospital-owned skilled nursing facility, home health agency, durable medical equipment company, or other operating units.
- ▶ How much of the clinic's anticipated volume will be new patients, compared to patients who would use the hospital's services even without adding a geriatric clinic?
- ▶ Will hospital use by clinic patients be different than the average experience of other Medicare patients? Will its case-mix index change? Will cost per stay be improved?
- ▶ How will Medicare payment regulations change over the next five years? Some changes already have been approved, such as changing outpatient radiology services from cost-based payments to a fee-based structure. The Department of Health and Human Services is slated to report to Congress by Jan. 1, 1991, on a model system for Medicare payments for outpatient services,

other than ambulatory surgery. These assumptions could be loaded into a computer model or computerized cost report package to provide Medicare payment estimates with and without a geriatric clinic. For many hospitals, additional net revenue generated from Medicare payments can exceed the costs of geriatric clinic operations.

Once a pro forma financial statement (such as the one shown in Exhibit 1) is generated, management should be ready to proceed with the decision process. Various members of management and the medical staff should participate. Once a decision to proceed is made, development typically takes from six months to nine months.

Clinic performance

Evaluating the performance of an

existing geriatric clinic is complicated by a clinic's diverse effects on hospital activity. A clinic is not simply a hospital department. It also can be viewed as a physician practice, a marketing program, a way to control inpatient costs, and an innovative clinical service.

The best way to evaluate the clinic's financial performance is to estimate its incremental effect on all aspects of hospital costs and payments. Areas that should be included are the clinic itself, outpatient activity at the hospital, inpatient activity at the hospital, and activity generated at other operating units, such as a home health agency or skilled nursing facility.

One analysis was performed for a geriatric clinic's second year of operation. The resulting incremental income statement is presented in Exhibit 2. By the end of its second

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EXHIBIT 2: Analysis of clinic's financial effect

| Category | Amount | Percentage of total |
|-------------------------------|---------------------------|---------------------|
| Gross charges | | |
| Inpatient routine | \$ 657,951 | 22.40% |
| Inpatient ancillary | 1,043,736 | 35.53 |
| Outpatient ancillary | 404,426 | 13.77 |
| Outpatient laboratory | 530,439 | 18.05 |
| Geriatric outpatient clinic | <u>301,160</u> | <u>10.25</u> |
| Gross revenues | <u>\$2,937,712</u> | 100% |
| Contractuals | | |
| Inpatient | (\$567,005) | |
| Outpatient | 362,157 | |
| Outpatient laboratory | (372,633) | |
| Capital and medical education | <u>161,204</u> | |
| Total contractuals | <u>(\$416,277)</u> | |
| Net revenues | <u>\$2,521,435</u> | |
| Expenses | | |
| Inpatient routine | \$ 320,290 | 21.50% |
| Inpatient ancillary | 170,612 | 11.45 |
| Outpatient ancillary | 131,971 | 8.86 |
| Outpatient laboratory | 153,993 | 10.33 |
| Geriatric outpatient clinic | <u>713,187</u> | <u>47.86</u> |
| Total expenses | <u>\$1,490,053</u> | 100% |
| Net income | <u>\$1,031,382</u> | |

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year, the clinic had developed a base of more than 1,000 Medicare patients.

These patients generated 7,500 visits to the clinic that year. The clinic is located in a hospital belonging to a two-hospital group, so admissions and ancillary procedures were performed at both facilities.

Analysts determined that they would need to review clinic logs of patient visits, referrals, and inpatient admissions. They also collected data from both hospitals on outpatient charges generated by clinic patients; incremental expenses caused by outpatient activity; and inpatient admissions, charges, diagnosis related group (DRG) payments, and expenses.

Neither the clinic nor the hospitals had information systems that made this information easy to ex-

tract. Consequently, analysts used the following methods to extract the needed data.

INPATIENT. Although the clinic kept a log of inpatient admissions, analysts found the data to be incomplete. Many admissions were made through emergency departments or by specialist physicians and were not logged.

The hospitals did not have a tracking system in place to identify utilization for all clinic patients, so this information had to be extracted manually. Medicare inpatient logs were obtained from both hospitals and compared to an alphabetical list of clinic patients.

In all, 211 inpatient admissions with an average length of stay of 9.21 days were attributed to clinic patients. These admissions generated \$1,701,687 in gross charges, of which \$657,951 were routine and \$1,043,736 were ancillary. DRG pay-

ments for these admissions totalled \$1,134,682, yielding a negative inpatient contractual allowance: - \$567,005.

Meanwhile, incremental expenses were estimated at \$490,902. Incremental net income from inpatient activity of clinic patients totalled \$643,780.

OUTPATIENT. Collecting data on outpatient activity was more difficult. Comprehensive reports of procedures performed at the geriatric clinic, including laboratory and radiology charges, were provided by the hospital's financial system. Charges for clinic patients seen in other outpatient departments of both hospitals were not tracked.

Consequently, analysts turned to Medicare outpatient logs from both hospitals. As with the inpatient data, an alphabetical listing of clinic patients was used to identify activ-

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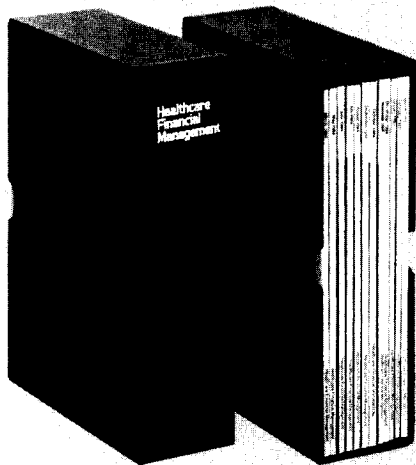
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Geriatric clinics

ity by those patients.

Because of the large volume of data, analysts decided to sample 10 percent of the records for four months of the fiscal year for each hospital.

Based on the study, analysts estimated that clinic patients generated the following outpatient revenues during the year: \$301,160 in clinic facility fees; \$154,099 in radiology charges for procedures performed at the clinic; \$507,971 in laboratory charges; \$250,327 in charges for outpatient activity performed at the hospitals; and \$22,468 in charges for laboratory activity performed at the hospitals. In all, \$1,236,025 in outpatient charges were generated by clinic patients, an average of \$165 per clinic visit, based on 7,500 visits.

Incremental expenses incurred to support the clinic were estimated as \$131,971 for hospital ancillary departments; \$153,993 for laboratory expenses; and \$713,187 for all clinic expenses, bringing a total of \$999,151. Payments for outpatient services were estimated at \$1,225,549, resulting in a net income of \$226,398 for outpatient services. Because of increased Medicare inpatient volume, an additional \$161,205 in payments for capital and medical education costs was obtained.

Combining income from inpatient, outpatient, capital, and medical education yielded a net incremental income of \$1,031,383 for the second year of geriatric clinic operations. This analysis assumed that all clinic activity came from new patients who would not have used the hospital's services if the clinic had not opened. If 10 percent of the patients would have used the hospital anyway, for example, the number of inpatient admissions attributed to the clinic would be reduced by approximately 10 percent, and the incremental volume of outpatient services performed at the hospital also would be reduced.

Outlook for clinics

Any hospital considering a new medical program exclusively serving a Medicare population must be aware of the efforts in Congress and at the Health Care Financing Administration (HCFA) to control spending. Medicare's prospective payment system was created to control spiraling inpatient expenses, and the next area for control may be physician and outpatient care. In fact, payments for laboratory procedures already have been eliminated, and payments for radiology, ambulatory surgery, and other diagnostic procedures currently are blended into a fee-based reimbursement structure.

No one can be certain how payment for providing care in a hospital setting, including a geriatric outpatient clinic, will change. For example, HCFA may implement an ambulatory visit group (AVG) payment mechanism modeled after DRGs.

Whatever regulatory changes are made, geriatric outpatient clinics will remain an effective setting for delivering care to older adults. A clinic acts as a primary care gatekeeper, controlling use of specialty physicians, inpatient care, prescription drugs, and other services. Results from two clinics suggest that geriatric clinics can substantially reduce the per capita rate of inpatient admissions. Inpatient admissions for these clinics average 216 per 1,000, 31 percent below the national average of 313.^b

These features indicate that the clinic model also may become a popular primary care delivery system for health maintenance organizations that serve or want to serve large numbers of Medicare patients. Various facets of geriatric clinic operations may need adjustments as changes occur in Medicare payments, but the clinic setting for delivering care to seniors will survive.

b. "1987 Summary of the National Hospital Discharge Survey," National Center for Health Statistics.