Although hospitals have long outsourced certain support services such as food and laundry services, the outsourcing of patient care services is a relatively recent phenomenon except for certain specialized clinical services such as rehabilitation services and emergency department staffing. As attorneys who advise healthcare providers, Waller Lansden commissioned the 2006 Hospital Outsourcing Trends in Clinical Services Survey (the Survey) not only to gauge the prevalence of hospital outsourcing but to better understand the types of patient care services being outsourced, how decisions are being made to outsource patient care services, and the models that hospitals are using to outsource patient care services. We believe this information can be very helpful to hospital executives who are considering their options with respect to outsourcing patient care services. Further, we believe the Survey offers benchmarks from which we can gauge future developments in the outsourcing of patient care services.
Seventy-eight percent of the respondents to the Survey indicated that they are currently outsourcing some patient care services. Nearly half of Survey respondents (45 percent) currently outsource one or two patient care services. However, a significant percentage (21 percent) of the respondents currently outsource five or more patient care services. Further, the Survey did not indicate much of a difference between the outsourcing of patient care services between for-profit hospitals and health systems (84 percent currently outsource patient care services) and tax-exempt hospitals and health systems (77 percent currently outsource patient care services). Over one-half of the respondents obtain one to nine percent of their revenue from outsourced patient services and another 11 percent get 10 to 19 percent.

Although one might have expected smaller hospitals to outsource more patient care services due to the difficulty of establishing specialized patient care services in a cost-efficient manner in a smaller setting, we were surprised to find that among the respondents to the Survey, larger hospitals (200 beds or more) were more likely to outsource patient care services than small hospitals (less than 50 beds). Specifically, 68 percent of small hospitals indicated that they currently outsource patient care services compared to 86 percent of larger hospitals.

The Prevalence of Hospital Outsourcing of Patient Care Services

According to the Survey, the top ten patient care services currently being outsourced are:

- Dialysis 31%
- Sleep Disorders 24%
- Diagnostic Imaging 23%
- Laboratory Services 20%
- Physical Therapy 18%
- Hospitalists 17%
- Specialty Equipment 17%
- Rehabilitation Services 14%
- Hospice Care 13%
- Wound Care 13%

Further, when asked what patient care services they were looking to outsource in the next 12 months, the most popular responses were: sleep services, wound care, hospitalists and physical therapy.

Several observations can be made with respect to top ten outsourced services identified above. First, the categories of patient care services being outsourced either require specialized knowledge or specialized equipment to deliver the services in a cost-effective manner. For example, a hospital looking to develop a hospitalist program may elect to outsource the service because it lacks the program knowledge and experience necessary to launch the service in a cost-effective manner. Such specialized knowledge includes understanding staffing ratios, billing acumen, and marketing the service to physicians and third-party payors. Similarly, a hospital may outsource to defray the capital costs of developing a new service when it is unclear that demand will be sufficient to covers such costs. For example, a hospital seeking to develop a wound care center may decide to outsource the center because it does not want to make the capital commitment to build out the center, including the purchase of hyperbaric chambers.

Second, the listing suggests that patient care outsourcing decisions continue to be driven by reimbursement considerations. For instance, it is not surprising that dialysis services were the number one outsourced patient care services. Despite the fact that Medicare pays hospital-based ESRD facilities slightly more than freestanding ESRD facilities, hospitals typically lose money on the provision of dialysis services to
inpatients. Therefore, many hospitals have chosen to cease providing dialysis services completely. Instead, such hospitals will contract with a freestanding center to provide both inpatient and outpatient dialysis services to the hospital’s patients.

Third, several of the top ten outsourced patient care services are fairly new patient service lines that hospitals may be initiating for the first time or joint venturing with members of its medical staff. For example, we have observed an increase in sleep laboratory ventures in our practice. Hospitals often evaluate these ventures with full awareness that if they do not partner with medical staff members to develop such services, members of their medical staff may develop competing facilities. On the other hand, wound care services, another comparatively new patient service line for most hospitals, will typically be furnished by a third party management company since few physicians have significant wound care experience.

Fourth, several of the top ten outsourced patient care services are rather well-established patient care services for which the hospital industry has significant experience utilizing third party delivery. For example, many hospitals have relied upon outside vendors to deliver hospice services, rehabilitation services and clinical laboratory services. While some hospitals continue to utilize outside vendors to furnish such services, others have decided that they can move the service in-house without a loss of either efficacy or efficiency.

Fifth, the inclusion of certain patient care services in the Survey’s top ten outsourced patient care services is probably more a factor of overall activity in that segment of the healthcare industry rather than any other characteristic of the service. For example, the number of new diagnostic imaging providers has increased significantly within the past several years. This activity has led more hospitals to evaluate service delivery alternatives for imaging services in both inpatient and outpatient settings. Similarly, as already mentioned, sleep laboratory services have seen similar growth in recent years.

Sixth, and finally, the inclusion of several patient care services on the Survey’s list of top ten outsourced patient care services most likely results from a favorable treatment of the service under the Federal physician self-referral prohibition, commonly referred to as the Stark law. Although the law prohibits many financial relationships between hospitals and physicians in a position to make referrals to the hospital, the law treats favorably patient care services such as imaging center joint ventures with radiologists, dialysis center joint ventures, sleep laboratory joint ventures, cancer center joint ventures with radiation oncologists (11th most frequently outsourced according to our Survey) and outpatient surgery center joint ventures (13th most frequently outsourced according to our Survey).

The Survey asked respondents to indicate their top two reasons for outsourcing a particular patient care service. More than half of the respondents indicated that vendor expertise is their primary reason for choosing to outsource a particular patient care service. However, as we observed above, financial considerations weigh heavily in a hospital’s decision to choose to outsource. Specifically, respondents indicated that the following financial concerns influenced their decision to outsource a patient care service: (1) cost savings (23 percent of Survey respondents); (2) revenue enhancement (18 percent of Survey respondents) and (3) access to capital (8 percent of the Survey respondents). As hospitals continue to reinvent themselves in response to changes in both payment systems and patient demands for services, the outsourcing of a new patient care service is often a chance to develop a new revenue stream while reducing the hospital’s overall financial commitment and exposure to the new service line.

We were somewhat surprised that requests by physicians for outsourcing a patient care service were only indicated by 17 percent of the Survey respondents. Anecdotally, we often hear that a hospital’s decision to move into a particular service
line or to restructure an existing patient care service line is driven by the demands of physicians. This may be either an offensive or defensive move to partner with physicians before the hospital is faced with the possibility of competing with physicians. Or, it may be simply to distinguish the hospital’s existing service lines to attract a given specialist.

Ten percent of the respondents indicated that they had stopped some outsourcing of patient services in the last 24 months. Only five services were mentioned more than once (each was mentioned twice): sleep services, physical therapy, radiology, behavioral health and food services. Of the 26 hospitals that indicated that they had stopped outsourcing some services, the most frequently cited reasons were cost (54 percent) and vendor quality (31 percent). Given that vendor expertise and cost savings were cited as primary reasons for outsourcing, it is not surprising that the outsourcing arrangement would be terminated if these goals were not attained.

### How Are Outsourced Patient Care Services Being Structured?

For the purposes of our Survey, three basic structures were identified for outsourcing patient care services:

(a) Structures whereby the hospital joint ventures the service and the profits are split among the joint venture partners;

(b) Contractual arrangements whereby the vendor of the service retains residual profits associated with the service; and

(c) Agreements with outside vendors where the profits are retained by the hospital or health system.

A joint venture between a hospital and its surgeons to provide outpatient surgery services is an example of a joint venture described in (a) since the revenue would be collected by the joint venture entity and the profits would be split between the owners of the joint venture. A contract between a hospital and a vendor of laboratory services is an example of (b). Finally, a joint venture between a hospital and its neurologists to create a new legal entity to purchase a gamma knife that will be leased to the hospital so that the hospital can provide gamma knife services to its patients would be treated simply as an agreement with an outside vendor is an example of (c) because the gamma knife services would be billed by the hospital and all profits from the service would be retained by the hospital.

The following chart stratifies the structure of these arrangements by the type of patient care service being outsourced (the most common structure is indicated in bold per patient care service):

<table>
<thead>
<tr>
<th>Joint Venture (profits to JV Entity)</th>
<th>Contractual Arrangement (profits retained by vendor)</th>
<th>Outside Vendor Agreement (profits retained by hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis Services 11%</td>
<td>50%</td>
<td>39%</td>
</tr>
<tr>
<td>Sleep Disorders 28%</td>
<td>15%</td>
<td>56%</td>
</tr>
<tr>
<td>Diagnostic Imaging 26%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td>Laboratory Services 19%</td>
<td>42%</td>
<td>40%</td>
</tr>
<tr>
<td>Physical Therapy 21%</td>
<td>23%</td>
<td>56%</td>
</tr>
<tr>
<td>Specialty Equipment 10%</td>
<td>29%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospitalists 6%</td>
<td>67%</td>
<td>27%</td>
</tr>
<tr>
<td>Rehabilitation Services 13%</td>
<td>21%</td>
<td>66%</td>
</tr>
<tr>
<td>Hospice Care 26%</td>
<td>51%</td>
<td>23%</td>
</tr>
<tr>
<td>Wound Care 23%</td>
<td>29%</td>
<td>49%</td>
</tr>
<tr>
<td>Cancer Center 42%</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>Behavioral Health 11%</td>
<td>37%</td>
<td>52%</td>
</tr>
<tr>
<td>Outpatient Surgery 81%</td>
<td>15%</td>
<td>4%</td>
</tr>
<tr>
<td>LTAC 32%</td>
<td>42%</td>
<td>26%</td>
</tr>
<tr>
<td>Bariatric Surgery 58%</td>
<td>25%</td>
<td>17%</td>
</tr>
<tr>
<td>Geriatrics 50%</td>
<td>33%</td>
<td>17%</td>
</tr>
<tr>
<td>Other 6%</td>
<td>31%</td>
<td>63%</td>
</tr>
</tbody>
</table>
This stratified data shows that true joint venture opportunities are limited. In our experience, the primary limitations to such joint ventures are the Stark law and reimbursement. That is, as discussed above, certain services are capable of being joint ventured between a hospital and referring physicians without violating the Stark law. We assume that this explains the prevalence of the joint venture structure in outpatient surgery, bariatric surgery and cancer centers. We were surprised that more sleep lab arrangements were not structured as joint ventures given similar favorable treatment under the Stark law. Likewise, many bariatric surgery joint ventures were originally structured to carve out Medicare and Medicaid patients. Except for diagnostic imaging, those patient care services that are primarily structured as contractual arrangements are fairly well established patient service lines. In many instances, we anticipate that many hospitals providing such patient care services pursuant to contractual arrangements once provided such services directly and found that the service requires specialized knowledge with modest operational margins. Further, in some cases, the service line was heavily targeted by the government in the past (e.g., laboratory services). These factors would explain why hospitals made the decision to continue to make the service available to their patients but let a specialized service vendor "own" the service.

Although the last category, contractual agreements, represents the least integrated of the structural models, it probably represents a larger variation of models than the other structures. Outsource relationships within this structure can range from simple management agreements to purchased service arrangements, from a virtual hospital within a hospital to an under arrangement relationship between the hospital and the service vendor. Given the fact that arrangements adopting this structure clearly remain the hospital's service, many arrangements in this structure are transitional in nature. The hospital may desire to start a new service line and want outside expertise for a limited period of time (e.g., sleep lab, rehabilitation services and behavioral services) until it internally develops such skill set. Or, the contractual agreement may simply be a stepping-stone to a more integrated relationship between the hospital and members of its medical staff (e.g., outpatient imaging and sleep lab services).

What Outsourcing Changes Are Planned?

Twelve percent of the respondents intend to outsource additional patient services in the next 12 months. The services mentioned most frequently were sleep services, wound care, hospitalist and physical therapy, which is generally consistent with our current Survey. Most of the respondents (65 percent) said they expect to continue outsourcing at the same level for the next two to three years, while eighteen percent expect their level of outsourcing to increase, twelve percent expect it to decrease and five percent do not know. The reasons cited for doing so were request by physicians (45 percent), expertise of vendor (42 percent), add a new service line (42 percent) and revenue enhancement (35 percent). As noted above, we expected that request by physicians would have been cited more frequently as a reason for current outsourcing than was the case. We observed that it is the most cited reason for planned outsourcing.

Additional Information

If you have additional questions or comments regarding the Survey, please contact any of the following attorneys, who served as the primary authors of this commentary, or any other member of Waller Lansden's Healthcare practice.

- **Reggie Hill**: Reggie.Hill@wallerlaw.com; (615) 850-8473
- **Thomas E. Bartrum**: Thomas.Bartrum@wallerlaw.com; (615) 850-8705
- **Robert A. Guy**: Bobby.Guy@wallerlaw.com; (615) 850-8933

If you would like a full set of the findings from the Survey, please contact Beverly Hedrick, Director of Business Development at Beverly.Hedrick@wallerlaw.com or (615) 850-8898.
A SURVEY SPONSORED BY
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According to Reggie Hill, head of the nationally recognized healthcare practice at Waller Lansden Dortch & Davis LLP: “Waller Lansden sponsored this survey because we understand that many hospitals are making the decision to outsource one or more clinical services, and we believe that such decisions should not be made in a vacuum. Because most outsourced services are not separately licensed, it is difficult to gather any data as to either the prevalence of hospital outsourcing or the types of clinical services being outsourced. In an evolving market, this survey is intended to set benchmarks against which future trends and developments can be measured.”

RESPONDENT PROFILE
The 2006 Hospital Outsourcing Trends in Clinical Services Survey, which is based on responses from 266 executives, was conducted through a combination of online and mail surveying. Sixty-five percent of the respondents were CEOs. More than half (56 percent) of respondents were from a standalone single hospital or facility, while 30 percent were from a single facility of a multihospital system. A large majority of respondents—79 percent—were from nonprofit hospitals.

Selected survey results follow. Read more analysis by attorneys Reggie Hill, Thomas Bartrum and Bobby Guy at www.wallerlaw.com.
OUTSIDE ASSISTANCE

Hiring an outside company to provide housekeeping, food services or supply chain assistance is nothing new for most hospitals. But a recent survey of hospital executives shows the outsourcing trend extends to clinical services as well—and most hospitals don't plan to stop anytime soon.

Seventy-eight percent of hospitals outsource at least one patient service, according to the 2006 Hospital Outsourcing Trends in Clinical Services Survey sponsored by Waller Lansden Dortch & Davis, LLP. The survey of hospital CEOs and COOs found that 83 percent of respondents expect their facilities' outsourcing levels to stay the same or increase over the next two to three years.

Among the survey's other key findings:

• Fifty-five percent of respondents say vendor expertise is the primary reason for outsourcing.
• Dialysis services, sleep disorders and diagnostic imaging are the most outsourced patient services.
• The most common outsourcing arrangement (42 percent) is an agreement with an outside vendor in which the profits are retained by the hospital or system.

Hospital leaders say the outsourcing decision often comes down to two fundamental considerations: talent and cost. “It depends on whether the service they are providing is one they could provide at a greater economy of scale than we could provide in our own facility and still meet the high expectations of patients care,” says Steve Hyde, COO of 320-staffed-bed Rio Grande Regional Hospital in McAllen, Texas.

When evaluating the availability of talent, many hospitals—particularly those in rural areas—find that outside companies can pull from a wider base of professional staff.

“We are in a small area. It is very difficult to recruit to rural America, so it is easier to outsource and let somebody else do it for you,” says Allan Zastrow, CEO of 100-staffed-bed Keokuk (Iowa) Area Hospital.

Finding a quality service provider for the right price is the most obvious hurdle for executives considering an outsourcing arrangement. But survey respondents also cite a significant cultural concern for many hospitals: losing control.

“The biggest hurdle is convincing your own organization that someone can bring the talent in and do it within your framework to meet your goals, especially if the organization has never done it before,” says Michael McEachern, COO of 338-licensed-bed Sisters of Charity Providence Hospital in Columbia, S.C.

Dennis Miller, CEO of 185-licensed-bed Williamson Medical Center in Franklin, Tenn., agrees. “You have to look at how it will fit into the culture of the institution,” he says. “You have to be sure you still have control over any area you outsource.”

Most hospital executives agree that clinical services outsourcing will remain a fact of life for the foreseeable future. Rio Grande’s Hyde says organizations must continually re-evaluate outsourced services to determine whether such arrangements still make financial sense and meet patient’s needs.

“Are we still getting good value for our money? Is it still what is best for patient care?” Hyde says. “We will always look at those, but it is not a foregone conclusion that we will do away with them.”

SETTING THE COURSE FOR SUCCESSFUL OUTSOURCING

• Front-end planning, including regulatory and reimbursement planning, is critical.
• Good outsourcing decisions require coordination between multiple departments: administration, financial, risk management and legal.
• Liability risk and profitability risk are important—but often overlooked—considerations in the decision whether to outsource.
• Beware the false sense of security: Medical malpractice and regulatory problems of the outsourcer can impact the hospital, so insurance and indemnity are important.
• Recent price increases in insurance rates, and the prevalence of alternative insurance vehicles, have increased the risk that an outsourcing company’s coverage could be inadequate; demand more than an insurance certificate (at a minimum, investigate the aggregate, know the insurer, become an additional insured, and require notice of material changes).
• Set clear standards, including performance and governance approval standards. A bad relationship can result in delayed and lost collections, lost admissions, ambulance diversions, morale issues, personnel turnover, lack of coordination in insurance plans, and reputational injury.
• Termination and unwind provisions are paramount to provide a clean exit; hospitals should preserve the right to terminate early and often.
Agreements with outside vendors, whereby the profits are retained by the hospital or system.
Contractual arrangements, in which the manager retains the residual profits.
Joint ventures, in which profits are split among the venture partners.

Percentage of all outsourced arrangements:
- 23%
- 35%
- 42%

The most frequently mentioned responses for increasing the number of outsourced services:
- Gaining access to capital; preserve internal capital
- Increase collaboration with physicians through JVs
- Expertise of vendors

The most frequently mentioned responses for decreasing the number of outsourced services:
- Costs of outsourcing too high; in-house more profitable
- Gain more control over the quality of the service
### TYPES OF SERVICES

**What types of services do you currently outsource?**

- Dialysis services: 31%
- Sleep disorders: 24%
- Diagnostic imaging: 23%
- Laboratory services: 20%
- Physical therapy: 18%
- Hospitalist: 17%
- Specialty equipment: 17%
- Rehab services: 14%
- Hospice care: 13%
- Wound care: 13%
- Cancer center: 12%
- Behavioral health: 10%
- Outpatient surgery: 9%
- LTAC: 7%
- Bariatric surgery: 4%
- Geriatrics: 2%
- Others: 6%

**Why did you choose to outsource those services?**

- Expertise of vendor: 55%
- Cost savings: 23%
- Add a new service line: 21%
- Revenue enhancement: 18%
- Request by physicians: 17%
- Access to capital: 8%
- Other: 13%

### LOOKING AHEAD

**Do you intend to outsource any additional patient services in the next 12 months?**

- Yes: 12%
- No: 88%

**If so, why will you outsource this service?**

- Expertise of vendor: 42%
- Cost savings: 15%
- Add a new service line: 42%
- Revenue enhancement: 39%
- Request by physicians: 45%
- Access to capital: 12%
- Other: 9%

**If so, what service?**

- Sleep services: 5
- Wound care: 4
- Hostpialist: 3
- Physical therapy: 3
- All others: 28

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