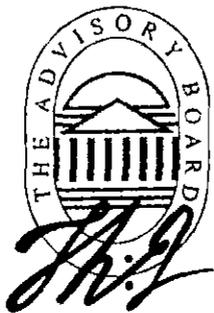


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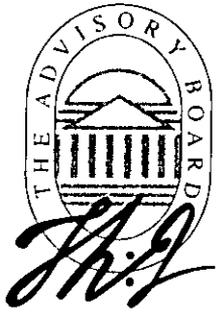
Hospital-Hospital Partnerships

Successful Collaboration in an Era of Reform

- Addressing Community Health Problems
- Reducing Service Duplication
- Preparing for Managed Care and Capitation
- Forming "Quasi-Mergers"



HEALTH CARE ADVISORY BOARD



Hospital-Hospital Partnerships

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Hospital-Hospital Partnerships:

Successful Collaboration in an Era of Reform

Health Care Advisory Board Research Initiative

Hospital Networks

This study is the first in a two-part series on hospital networks that the Health Care Advisory Board will continue throughout 1994. This study examines relatively loose affiliations among hospitals.

In 1994, the Health Care Advisory Board will release a study on hospital mergers and acquisitions.

We look forward to serving you in the coming year. If you have any questions related to this report, the upcoming study or any other issues regarding hospital networks, please remember that the staff of the Health Care Advisory Board is at your call.

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Advisors to the Study

The Health Care Advisory Board wishes to express its appreciation to all of the individuals and organizations who were so generous with their time and expertise during our research on hospital-hospital collaboration. The ideas and insights of the experts interviewed by the research staff have been invaluable in the analysis of ideas covered in this report. These individuals are listed in the back of this study.

In addition to the many member and nonmember hospitals (many of which prefer to remain anonymous) that contributed to the research, the Health Care Advisory Board specifically would like to thank the following organizations for their time and insights.

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Hospital-Hospital Partnerships: Successful Collaboration in an Era of Reform

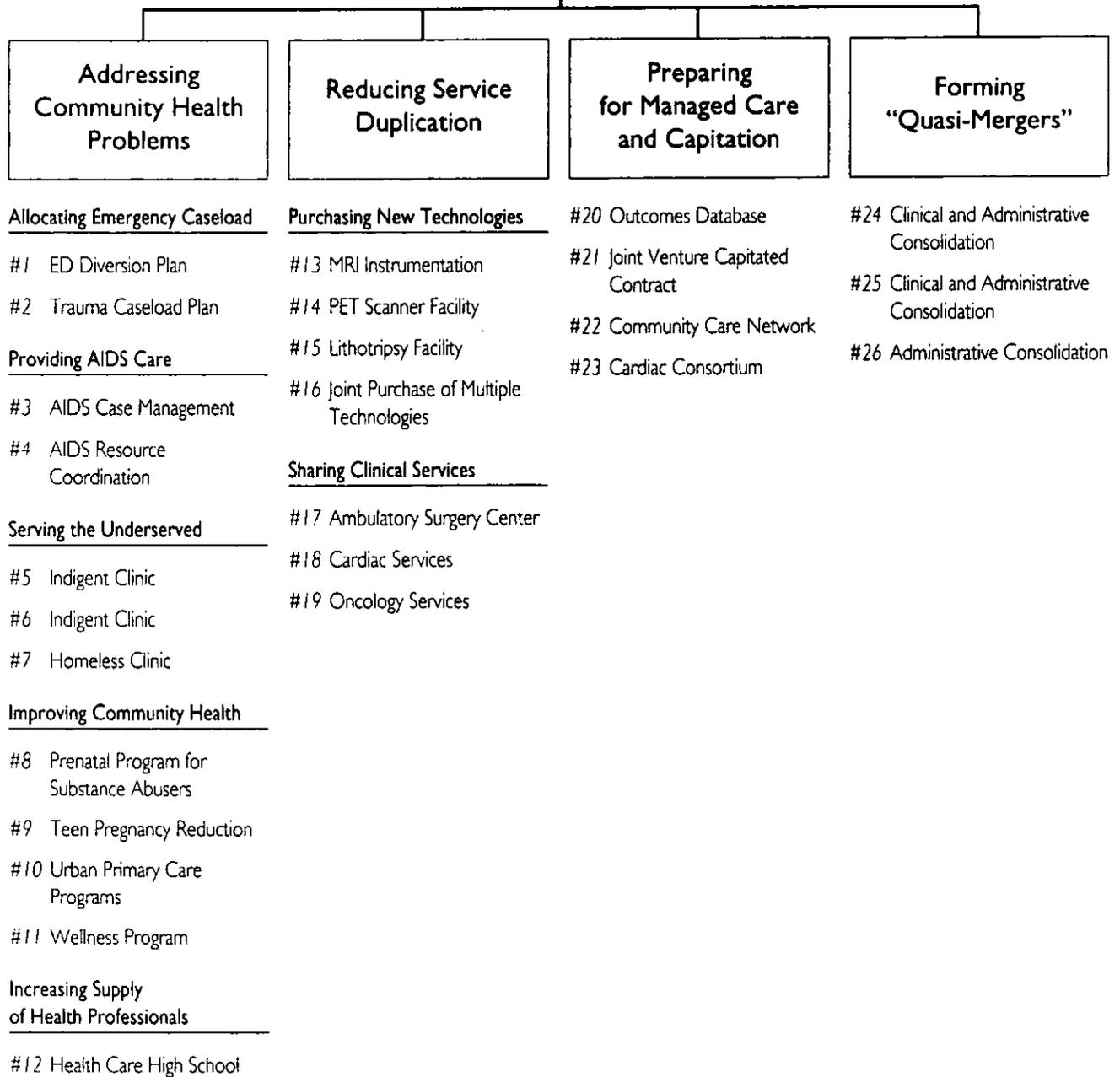


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Note on Research Methodology

In the course of researching this report, The Advisory Board performed over 75 interviews with experts in the field of hospital-hospital collaboration. Sources consulted included over 50 hospitals and health systems as well as a number of consultants, trade associations and government agencies. In addition, the staff reviewed over 750 pages of articles and research reports.

Through the interviews and literature, the staff obtained detailed information on the most successful collaborative efforts being pursued throughout North America. While this report offers what we believe to be comprehensive profiles of these efforts, there is no guarantee that the report covers every detail of each venture, nor that it covers every innovative and successful venture that exists in the marketplace.

Hospitals and health systems that participated in this study have not been identified by name in order to protect the confidentiality of information provided.

Legal Caveat

The path to collaboration is fraught with legal complexity and, at times, legal uncertainty. With the exception of those collaborative efforts that address community health problems, most of the joint ventures profiled in this report raise legal questions regarding antitrust issues and restraint of trade.

Legal prohibitions against antitrust behavior are addressed by the *Sherman Act* of 1890 and the *Clayton Act* of 1914. The *Sherman Act* “prohibits contracts, combinations, and conspiracies that unreasonably restrain trade.” The *Clayton Act* “deals with price discrimination, exclusive dealing and tying arrangements, and with mergers and acquisitions.”

The Health Care Advisory Board cannot provide the legal expertise needed to fully address all legal issues involved. As a result, it would be a disservice to suggest that members rely on any legal commentary in this report as a basis for action. While health care reform may reduce legal constraints in this area, we cannot stress too strongly that anyone seriously considering steps toward collaboration should consult legal counsel.

Essay

Ten Salient Observations on Hospital-Hospital Collaboration

Observation #1

Hospital-hospital collaboration is not a front-burner issue today; cost control, integration with physicians and alliances with payers are much more crucial to long-term survival in a capitated, managed care environment

Numerous Issues More Important to Long-Term Survival than Hospital-Hospital Alliances

Cost Control

- Creating economic incentives for cost control
- Treating patients in the right care modality
- Reducing inpatient utilization
- Consolidating clinical, administrative functions

Integration with Physicians

- "Locking in" primary care physicians (PCPs)
- Achieving proper mix, number of PCPs and specialists

Alliances with Payers

- Accepting (and profitably managing) capitated risk
- Marketing aggressively to payers
- Providing the entire continuum of care (e.g., clinics, home care, rehabilitation)
- Providing broad geographic coverage for all services
- Enhancing negotiating clout with payers

Observation #2

Even in the few instances in which collaboration seems able to address these urgent needs, it may not be the best vehicle for doing so

Observation #3

Rationale: Loosely-aligned collaborative arrangements are ill-equipped to make the difficult decisions required to compete successfully under managed care; venture will (almost inevitably) break down as soon as one (still autonomous) partner begins to feel pain

Strategic Imperative	Problem with Collaboration
Cost cutting through clinical service consolidation	<p>→</p> <ul style="list-style-type: none"> • While collaboration offers potential to rationalize clinical services, it seldom is able to do so • Reason: One partner inevitably loses when services are consolidated; Example: Independent hospital not likely to be willing to "give up" profitable open heart business (even if consolidation lowers costs, boosts overall profits)
Increasing negotiating leverage through joint managed care contracting	<p>→</p> <ul style="list-style-type: none"> • While collaborative contracting efforts offer the potential to enhance negotiating clout with payers, they seldom do so • Reason: Payer can bypass system by signing individual deals with hospitals; most independent entities would rather accept a (somewhat less attractive) contract than no contract at all
Offering geographic coverage for hospital services	<p>→</p> <ul style="list-style-type: none"> • Collaborative efforts can offer a "one-stop" shop to payers for all hospital services in an area • Problem: Most payers require only a few hospitals in their network to provide adequate geographic coverage; it is no great hardship to negotiate separate deals with a handful of hospitals (as it would be with hundreds of individual physicians)

Observation #4

Advisory Board View: A full-equity merger is far better suited to achieving those (relatively few) strategic imperatives that do require hospital-hospital alliances

Strategic Imperative	Benefits of Full Equity Merger
Cost cutting through clinical service rationalization	<p>→</p> <ul style="list-style-type: none"> • Bottom line of merged system (and therefore every part of system) is enhanced through any cost-cutting initiative • Because each hospital is now a cost center (rather than an independent entity with its own bottom line), no individual hospital's financial fortunes are hurt through service consolidations
Increasing negotiating leverage through joint managed care contracting	<p>→</p> <ul style="list-style-type: none"> • With a merger, only the resulting system has the power to sign payer contracts (and system receives revenues, profits from any contract) • Result: Individual hospitals do not have the power (or incentive) to sign contracts on their own

Observation #5

That is not to say that some collaborative efforts are not worthwhile; a number of ventures can yield significant benefit (at very little cost), and the initiative may prove a useful stepping stone to a (more difficult to implement) equity merger

Observation #6

Advisory Board View: Collaborative efforts work best if both partners realize benefits from the program; in fact, collaboration is highly unlikely to succeed unless this "win-win" scenario is clear from the start

Observation #7

Three recommended targets for collaborative efforts; First Target: Ventures that address societal health problems, since these efforts yield significant financial, community and public relations benefits at modest cost

Variety of Community Problems Can Be Addressed through Hospital-to-Hospital Collaboration

Problem	How Collaboration Can Address Problem
Lack of alternative care sites for AIDS patients; Result: Patients use high-cost ED, inpatient services at most, if not all, area hospitals	<ul style="list-style-type: none"> • Hospitals can develop joint case management program that coordinates appropriate care for AIDS patients • Result: Costs of care are lowered, yielding benefit to all area hospitals; one collaborative effort reduced inpatient days by 50%
Lack of primary care facilities for indigent and homeless individuals; Result: Hospitals bear cost for patients who seek non-urgent care at high-cost EDs, and for patients who do not seek timely primary care, and therefore need urgent or emergent care later (after condition deteriorates)	<ul style="list-style-type: none"> • Hospitals jointly build and staff clinics to care for the indigent and/or the homeless • Several collaborative efforts have been successful in reducing inappropriate and/or avoidable ED visits, yielding benefit to all area hospitals; one indigent clinic open 10 hours per week was able to reduce costs by over \$400,000 for area hospitals
High percentage of low-birth-weight babies born to mothers with substance abuse and/or alcohol problems; Result: Area hospitals forced to "pick up tab" for health care needs of both mother and child (since most of these women do not have insurance)	<ul style="list-style-type: none"> • Hospitals develop "outreach" program designed to: <ul style="list-style-type: none"> - Help expectant mothers end their abuse - Provide prenatal care to infants • Collaborative effort is very likely to pay for itself: program costs \$2,000 to \$3,000 for each expectant mother, while cost of caring for low-birth-weight baby would be roughly \$10,000

Observation #8

Second Target: Ventures in which hospitals share the investment, operating costs for expensive, new services that each partner would have difficulty financing profitably on its own

Observation #9

Reason: In these instances, collaboration brings a valued service to a community at lower cost than otherwise would have been possible (since fixed costs are spread over a larger number of patients); in some instances, collaboration is the only way to make the venture financially feasible

Joint Ownership Of New Services Offers Clear Financial Benefits

Technology/Service	Description	Benefits
MRI	Two hospitals shared purchase of \$3 million MRI machine	<ul style="list-style-type: none"> • \$700,000 annual cost savings
PET	Two hospitals shared \$5.7 million investment for equipment and facility construction	<ul style="list-style-type: none"> • Cost per PET exam almost cut in half because patient volumes shared by two facilities
Lithotripsy	Two hospitals split investment cost of \$3 million for equipment purchase	<ul style="list-style-type: none"> • Center is profitable • Would-be competitors have shied away from entering market
Ambulatory Surgery Center	Two hospitals, physician group shared \$5 million investment cost to build new facility	<ul style="list-style-type: none"> • Each partner realizes \$320,000 in annual profit (versus a \$420,000 loss if pursued independently)
Cardiac Services	One hospital provides angioplasty, open heart services, second hospital will provide outpatient cardiac care; total investment costs of \$6 million will be shared	<ul style="list-style-type: none"> • Cardiology discharges increased by 15% • Estimated increase in profits of \$850,000 (over profits generated if each hospital built its own open heart program)
Oncology Services	\$1.2 million investment cost of new oncology facility shared by local and out-of-state hospital	<ul style="list-style-type: none"> • 10% increase in inpatient volume for local hospital • 23% increase in outpatient volume for local hospital • Increase in specialized case referrals for out-of-state hospital

Observation #10

Third Target: Partnerships that provide payers (and enrollees) with lower cost, higher quality and/or more convenient care than would have been possible without the venture; sponsors of these programs seeing large increases in managed care patient volumes

Chapter One:

Addressing Community Health Problems

Chapter One

Six Salient Observations on Addressing Community Health Problems

Observation #1

Advisory Board View: Hospital partnerships geared toward tackling community-wide health problems provide the single best opportunity for successful collaboration; hospitals advised to focus early efforts on these types of ventures

Numerous Collaborative Efforts Address Community Health Problems

Community Health Problem

Collaborative Program

Uneven presentation of patients to area EDs; some EDs will be overburdened while others will have excess capacity

Diversion plan to shift patients away from overcrowded EDs to those with "slack" capacity

AIDS patients unaware of (or otherwise unable to access) non-hospital services; Result: Overuse of high-cost inpatient services, poor quality of care

Jointly-funded case management program for patients that incorporates new and existing services into central referral system

Inappropriate use of (high-cost) ED for primary care by indigent/homeless individuals

Jointly-financed, jointly-operated indigent clinic to provide primary care, address other needs of this population

High numbers of low-birth-weight babies born to substance abusers; Result: High costs of care for treatment in neonatal intensive care unit

Jointly-sponsored prenatal care program for substance-abusing mothers to help them attain and maintain sobriety and increase health of unborn children

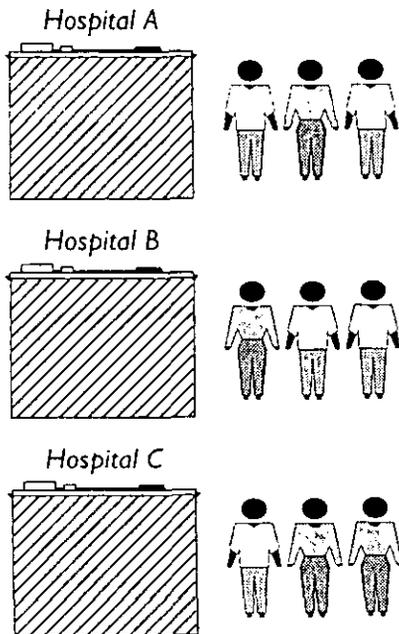
Observation #2

Reason: These collaborative ventures provide a clear financial “win-win” result for all participants, and also enable hospitals to fulfill their charitable, nonprofit mission of serving the community

**Hypothetical Example:
Building Indigent Clinic Provides “Win-Win” Result
for Hospital Partners**

Before Indigent Clinic

Each hospital treats indigent patients in (high-cost) ED



After Indigent Clinic

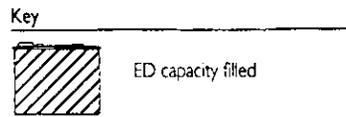
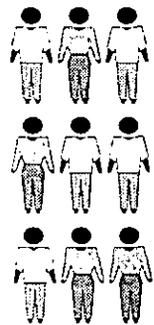
Indigent patients use lower-cost clinic, thus avoiding future ED visits



Advisory Board Estimate

Clinic open 10 hours per week saves area hospitals \$400,000 annually

Full-time clinic could save \$1.6 million each year



Observation #3

Main benefit of these types of efforts: they generate a high payoff at a low cost; example after example illustrates how a minimal investment by hospital partners can generate significant benefits for hospital and community

Collaborative Efforts Generate Significant Benefit at Low Cost

Joint Program	Costs of Program	Benefits of Program
AIDS Case Management Program	• \$132,000 annually	<ul style="list-style-type: none"> • Nearly 60% reduction in inpatient days for those patients treated (from 1,065 to 457 days annually) • 33% reduction in average length of stay (from 18 to 12 days) • 50% reduction in annual number of inpatient admissions (from 90 to 46)
Indigent Clinic	• \$140,000 annually	• \$400,000 annual cost savings
Emergency Department Diversion Plan	<ul style="list-style-type: none"> • \$150 one-time phone hook-up fee • \$30 monthly for each hospital • Minimal staff time 	<ul style="list-style-type: none"> • Reduced stress on all area EDs • Improved patient care

Observation #4

(Unsurprising) Result: Hospitals face few problems when developing partnerships with competitors—there are few political risks involved with community projects, while they provide an opportunity to improve hospitals’ standing with area residents

Observation #5

Additional Benefit: Initial efforts build trust among partners, paving the way for additional (possibly more complicated) ventures in the future

Plan To Allocate Trauma Patients Leads to Plans for Future Collaboration

Collaborative Effort: Design of Trauma System "Call Schedule"

- Community copes with growing number of trauma cases by allocating cases among hospitals according to "call schedule"
- County hospital designated as primary trauma center, with two private institutions acting as secondary trauma centers and five community hospitals serving as a "safety net"

Result: Improvements in Efficiency

- Efficiency improvements have resulted, allowing hospitals to keep pace with the growing trauma load and increase access to emergency care for the community's residents

Future Collaborative Injury Prevention Program Planned

- Future collaborative efforts are planned: first initiative will be an injury prevention program to promote a safe community

Observation #6

Caveat: While benefits of these programs are significant, overall strategic importance for hospital is minimal; collaborative ventures to improve community health will not address hospital's most important financial imperative: surviving under an increasingly managed care, capitated environment

Case Example #1

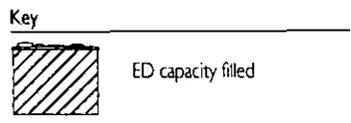
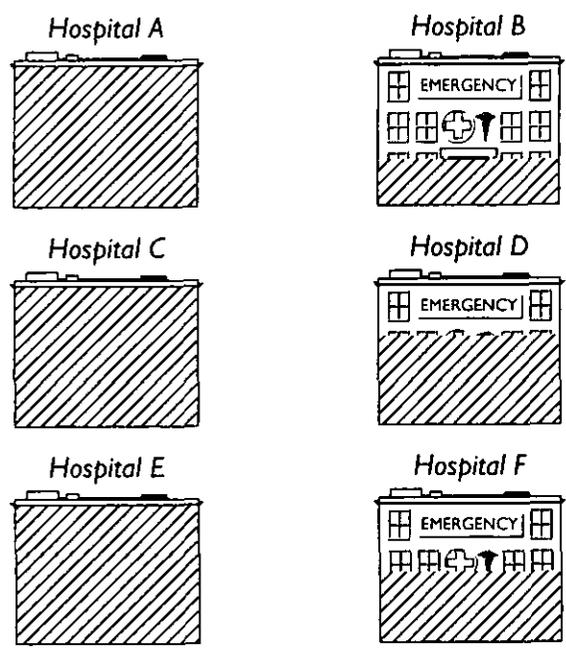
Urban Hospitals Work Together To Distribute ED Patient Loads Equitably

Description

Six urban hospitals participating in ED "diversion plan" intended to allocate city's ED cases more evenly among institutions, thus preventing overcrowding in inner-city EDs

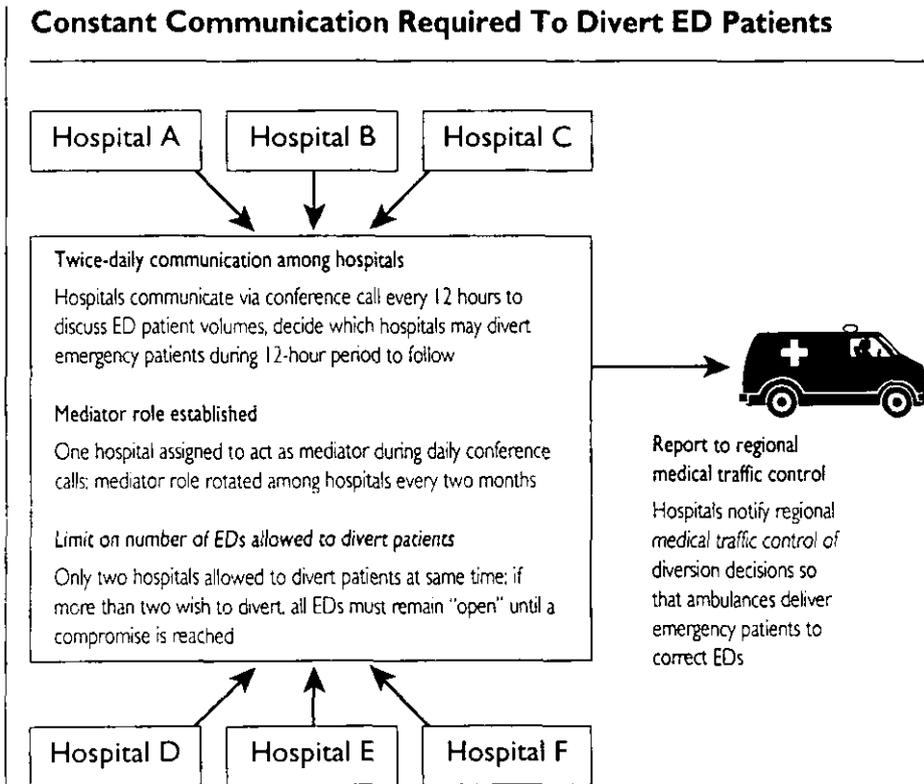
- Prior to creation of diversion plan, distribution of ED patient loads among city hospitals was "left to chance"
- Result: At any given time, some of city's EDs would be "bursting at the seams" while others would be operating well below capacity

Some EDs "Burst at Seams," While Others Have Excess Capacity



Solution: Hospitals experiencing overcrowding problem in the ED allowed to divert emergency patients to other participating institutions; **Exception:** Patients in life-threatening situations, who must be accepted at any hospital

Basic Mechanism: Hospitals communicate twice daily to discuss ED patient volume; mediator determines which hospitals are allowed to divert, notifies medical traffic control of diversion status



No formal oversight structure required; program is supported by state hospital association's Emergency Medical Services committee

Costs

Cost of implementing diversion plan negligible

- Main cost of program planning was staff time; each hospital placed one or two representatives (ED's physician director, nurse manager, and/or administrator) on planning committee, which met several times monthly for six months
- Interconnecting telephone system cost each hospital \$100-\$200 for initial hookup and an average monthly service charge of \$30

Results

Diversion plan is resulting in more even flow of patients through EDs, better overall communication among hospitals

- While no hard data are available, all hospitals report reduced stress on EDs as result of diversion plan; in addition, patient care has improved because patients are brought to hospitals able to provide more timely treatment
- Side Benefit: Daily calls are a trust-building vehicle among participants, enhancing overall communication among hospitals

Source: "Collaboration: Hospitals Find that Working Together is Tough, Rewarding—and Vital," *Hospitals*, December 5, 1991, pages 24-33; Advisory Board interviews.

Case Example #2

Three Hospitals Use “Call Schedule” To Allocate Trauma Cases, Reduce ED Overcrowding

Description

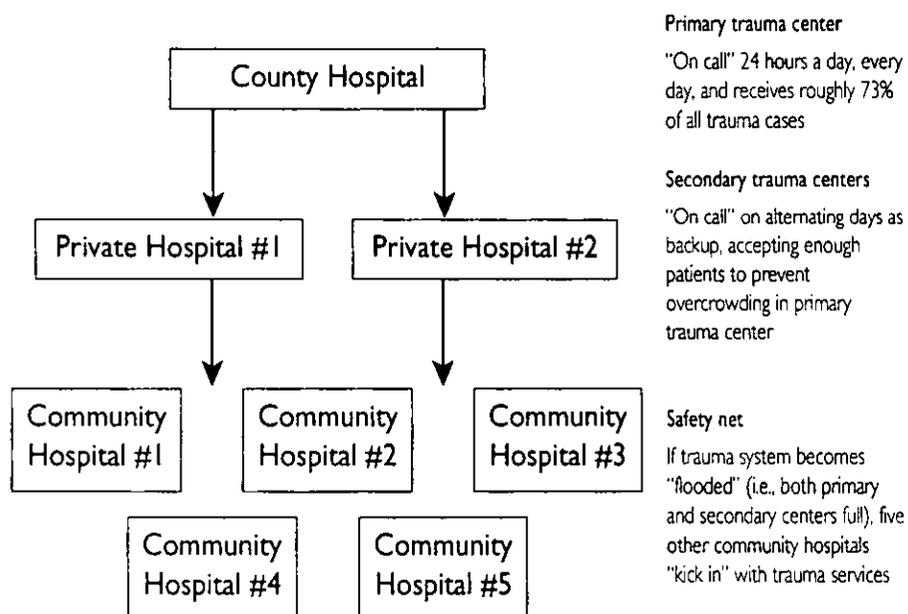
Community attempting to cope with the growing number of trauma cases by allocating cases among one county hospital and two private hospitals according to “call schedule”

Goal of “On Call” System: To allow hospitals to more accurately predict timing and volume of trauma case loads, thus enabling more efficient ED staffing, operations

- Local hospital association, in conjunction with area medical society, developed trauma system “call schedule”
- Schedule designates when each hospital can receive trauma patients (i.e., is “on call”) and when these cases can be sent elsewhere

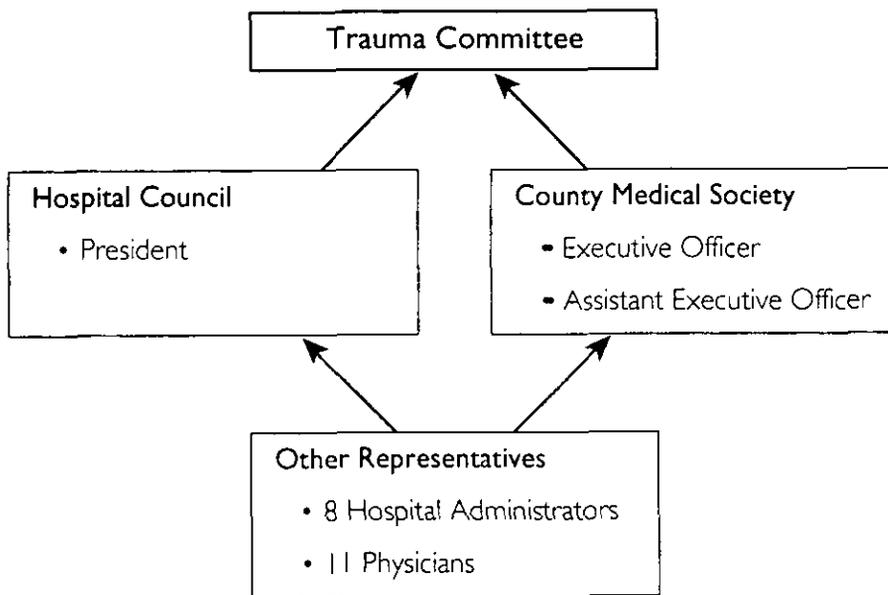
County hospital designated as primary trauma center, with two private institutions acting as secondary trauma centers and five community hospitals serving as a “safety net”

“Call Schedule” Designates Primary and Secondary Centers, Provides Safety Net as Well



Special trauma committee of local hospital association and local medical society members (organizations which include hospital representatives and physicians) oversees project; committee performs scheduling, conflict-resolution functions

Trauma Committee Includes 22 Members



Costs

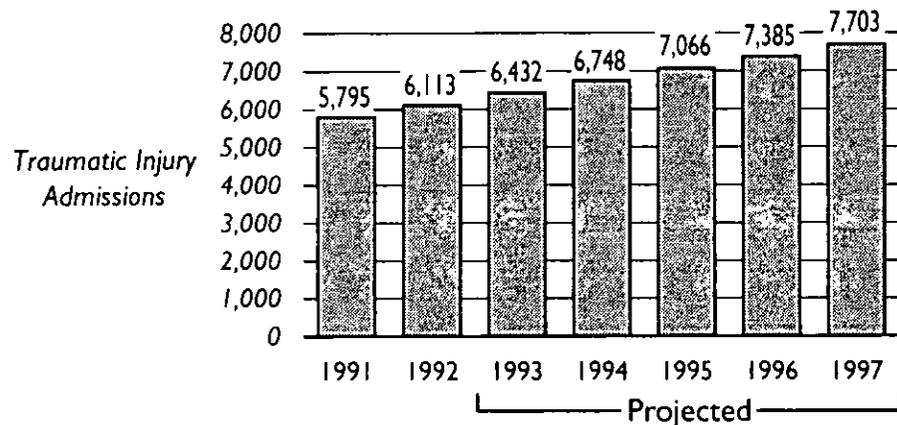
Start-up costs for project a (relatively) modest \$200,000, while operating expenses practically nil

- Local foundation donated \$200,000 for project start-up; funds used to engage two consultants to perform a market overview and handle several accounting functions
- Since plan was put in place, hospitals simply adhering to “their part of the bargain”

Results

Efficiency improvements have resulted, allowing hospitals to keep pace with the growing trauma load and improve availability of care for the community; hospitals further report that the system has been running well for two years

System Allows Hospitals To Keep Pace with Growing Trauma Load



Because of the success of this effort, future collaborative efforts are planned; first initiative will be an injury prevention program to promote a safe community

Source: Advisory Board interviews.

Case Example #3

Collaborative AIDS Case Management Program Cuts Inpatient Days by Over 50%

Description

Three hospitals (at request of county health department) took the lead in expansion of case management program for AIDS patients

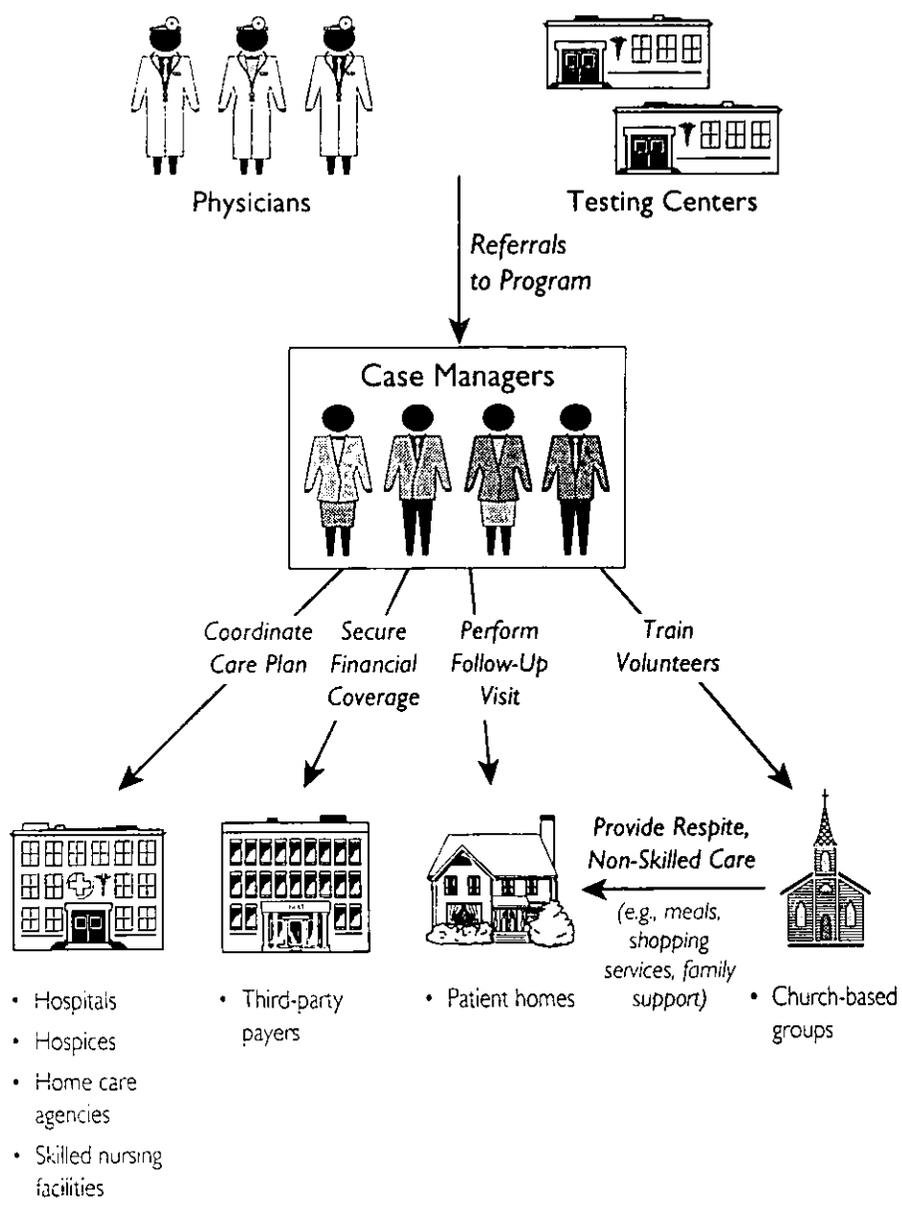
- Three hospitals contribute funds to health department to expand its existing case management function for AIDS patients
- Prior to program expansion, health department employed one program director and one case manager to assist AIDS patients; hospital financing allowed program to hire three additional case managers

Two Goals: First is to create point of entry into health care system for all AIDS patients so that they receive timely, cost-effective care; second goal is to reduce financial losses on AIDS patients by cutting use of inpatient services and increasing reimbursement

Case managers operate out of county health building; they coordinate all aspects of care for between 150 and 175 AIDS patients

- Physicians and testing centers refer AIDS patients to case management program
- Case managers work with area hospitals, home care agencies, other organizations to develop patients' care plans and coordinate delivery of services
- In addition, case managers review patients' financial resources and work with them to secure insurance coverage of some kind

Four Case Managers Are Point of Entry into Health Care System

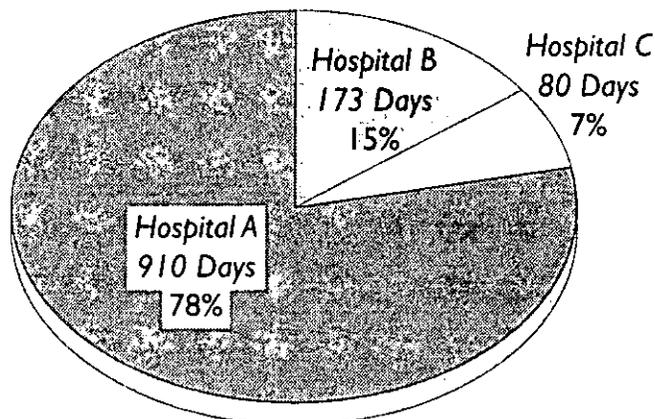


Costs

Program costs roughly \$135,000 annually (bulk is to pay salaries of case managers); hospitals “divvy up” cost of case managers according to number of AIDS patient days

- Hospitals pay the salaries for three of the four case managers at a cost of \$122,000 per year
- Each hospital’s share of total cost is based upon its historical number of AIDS patient days; rationale is that hospital with more AIDS patients is more likely to benefit from program

Hospitals Divide Cost of Case Managers Based Upon Number of AIDS Patient Days



- Health department “picks up tab” for remainder of program’s operating costs (roughly \$12,000 annually)

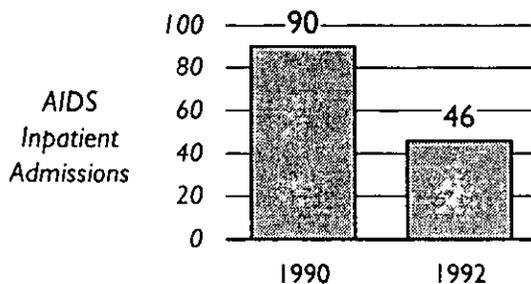
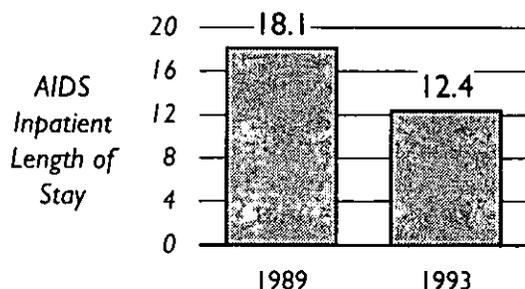
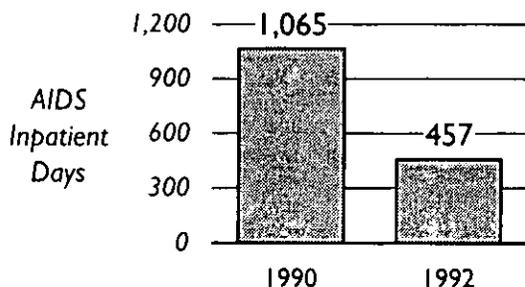
Health Department Finances Other Costs of Program

Item	Annual Cost
Case manager travel	\$8,300
Case manager training/continuing education	\$1,500
Office supplies	\$1,300
Telephone	\$700
Beeper service	\$600
Total Costs	\$12,400

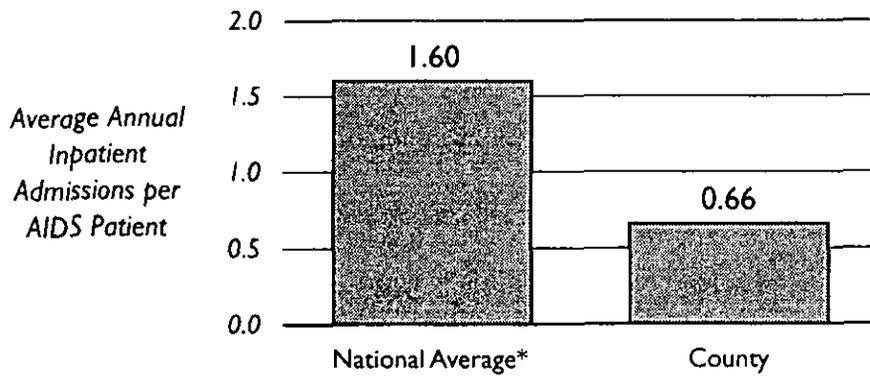
Results

Program has substantially reduced use of inpatient care for AIDS patients: inpatient days are down almost 60%, average length of stay was reduced by almost six days, and overall admissions have been cut by 50% (to less than half the national average)

AIDS Case Management Results in a 57% Reduction in Inpatient Days, a 32% Drop in ALOS and a 48% Cut in Admissions



Annual Admissions Are Only 40% of National Average



* Source: Agency for Health Care Policy and Research, Washington, D.C.

Added Bonus: Due to case manager efforts, every AIDS patient admitted to hospital had some form of insurance coverage

Source: Advisory Board interviews.

Consortium of 15 Hospitals, Other Providers, Payers Coordinates Community's AIDS Resources

Description

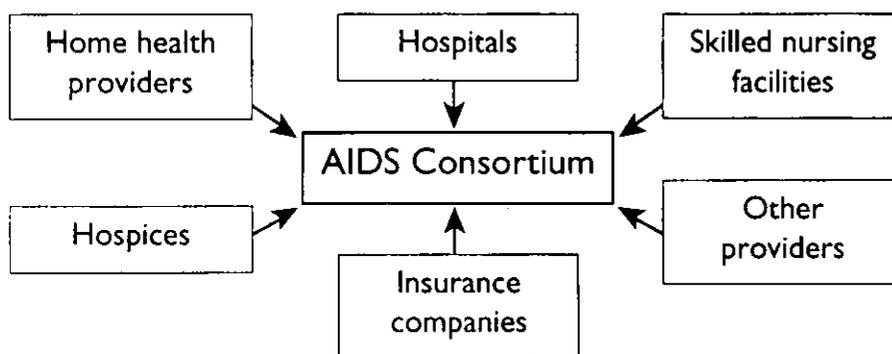
Hospital frustrated by community's lack of comprehensive service program for AIDS patients spearheads creation of consortium to coordinate available resources and fill "gaps" in continuum of care

- In 1985, president of a hospital hard hit with early AIDS cases approached local health council to argue for broad-based effort to manage future care needs of AIDS population
- Health council studied problem for three years, then issued a report identifying the need for the following services:
 - Case management program
 - Coordination of volunteers
 - Personal care program (providing shopping, cleaning and cooking for home-bound patients)
 - Inpatient hospices
 - Outpatient care services
- Instead of "farming out" these projects to different organizations in piecemeal fashion, health council created nonprofit corporation (the consortium) to tackle problem as a whole
- Reason: Belief that best approach would be a coordinated one, with all resources in community behind one program

Consortium comprised of 40+ health care providers and payers, including 15 hospitals

- Participants include hospitals, home health providers, hospices, skilled nursing facilities, insurance companies
- Each member elects a representative to consortium's Board of Directors; board is active in defining consortium's mission, developing policy, budgeting, allocating resources, and providing technical counsel

Various Organizations Participate in Consortium



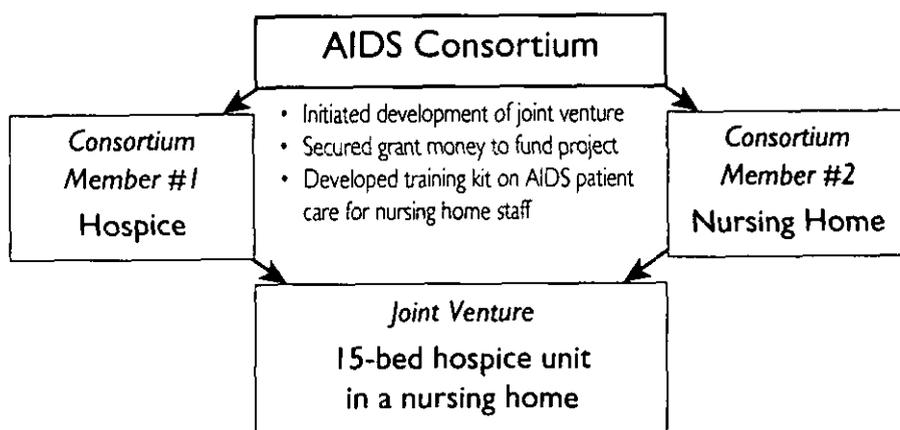
Consortium evaluates potential services, then works with members and outside organizations to ensure that worthwhile projects are brought to fruition

Consortium Provides Wide Array of Services

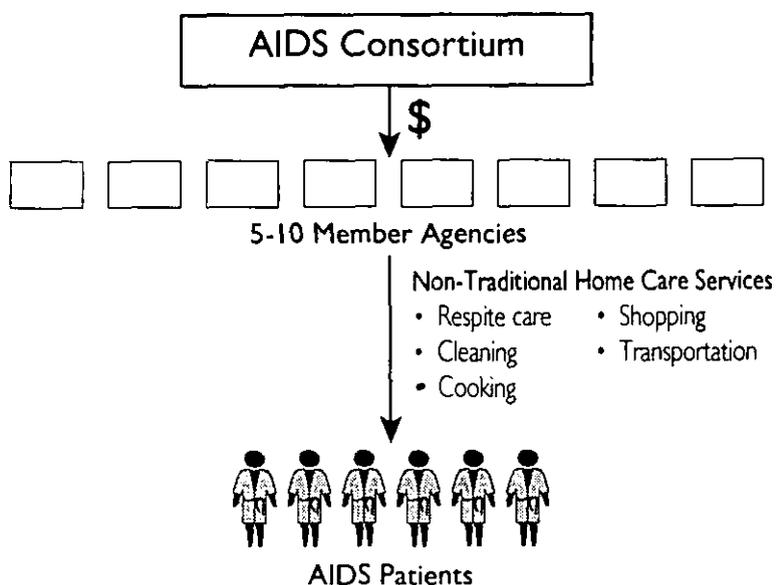
- Case management services with 14 case managers currently serving program's 900 patients
- Financial support for respite care provided by home care agencies
- Data tracking services (including patient demographics, severity of illness, cost of care)
- Educational services for both caregivers and community agencies

Consortium initiates and facilitates development of more complex projects, including securing necessary funding; activities are financed with grant money, donations from community, and consortium membership fees

Example #1: Consortium Initiates Joint Venture Between Hospice and Nursing Home



Example #2: Consortium Funds Services Not Typically Provided by Home Care Agencies



Costs

Consortium operates on annual budget of \$2 million; majority of budget covered by government grants, private foundations, donations

Consortium Funded Largely by Government, Foundation Grants

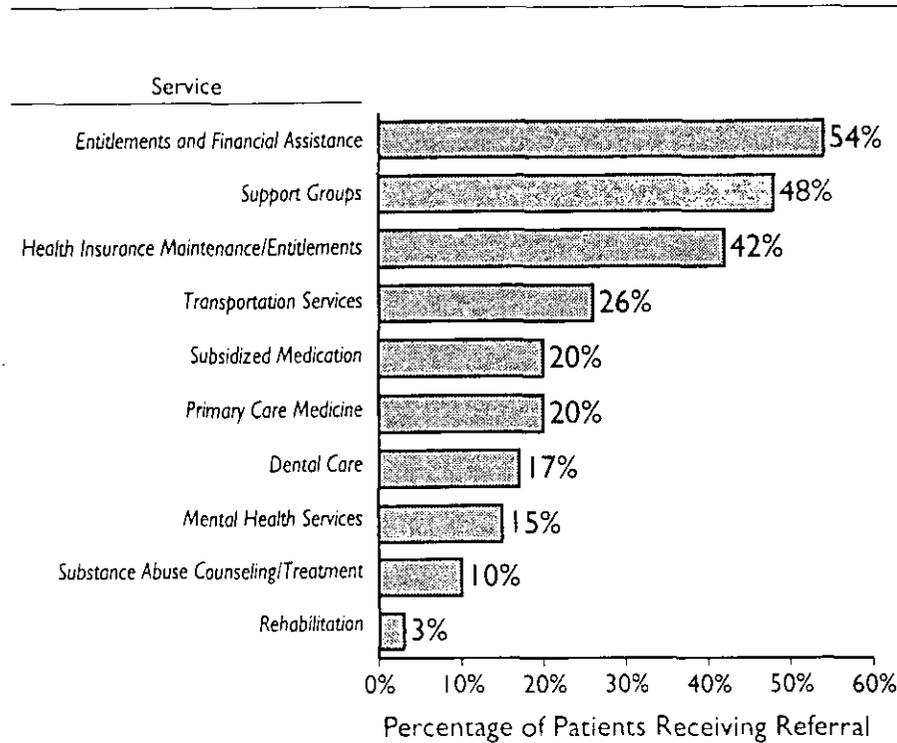
Funding Source	Amount
City, state, and federal government grants	\$1,200,000
Private foundations	\$500,000
Fund-raising through private donations and special events	\$200,000
Consortium membership fees	
– \$5,200 for hospitals	
– \$1,000 for for-profit providers/groups (e.g., infusion therapy companies, nursing homes)	
– \$525 for not-for-profit providers/groups (e.g., hospices, home health agencies)	
Total membership fees	\$100,000
Total	\$2,000,000

Results

Consortium provides needed services, improves quality of care for thousands of area AIDS patients (while often reducing costs, utilization); extensive cost-benefit analysis is currently underway

- Almost 2,000 AIDS patients have been served through case management program; hospital and payer members feel these services have lowered overall cost of care
- Example: 150 patients received home care services at a (modest) cost of \$200,000; this population has had only one emergency department visit and no inpatient readmissions in the past year

Consortium's Extensive Referral Network Has Provided Myriad Services



Source: Advisory Board interviews.

Case Example #5

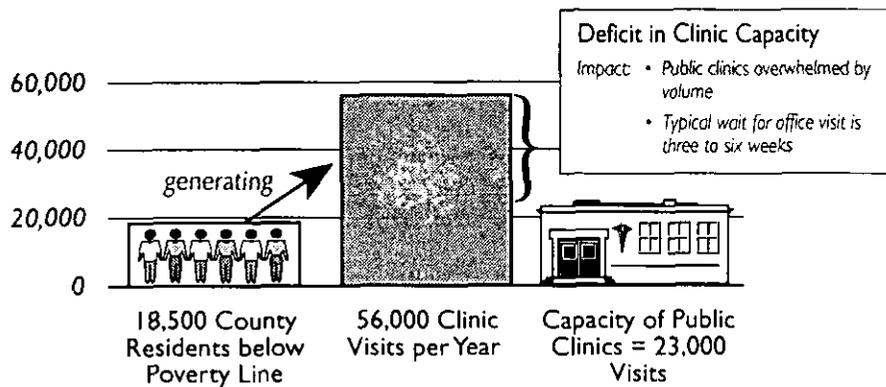
Collaborative Clinic for the Indigent Saves Estimated \$400,000 Annually

Description

Community medical center, working with second hospital, local businesses and nonprofit organizations, built new clinic to increase supply of primary care services for (underserved) indigent population

- Medical center determined that capacity of public clinics (at 23,000 visits annually) was less than half that needed to meet the demand for indigent visits (56,000 per year)
- Negative impact was significant:
 - Public clinics overwhelmed by volume
 - Typical wait for office visit of three to six weeks
 - Hospital emergency departments flooded with indigents seeking primary care

Community Has Less than Half the Capacity Needed To Meet Indigents' Primary Care Needs



Result

- Indigents use hospital ED for primary care needs
- 50% to 60% of ED visitors for chronic and non-urgent problems are uninsured or underinsured
 - 7,250 to 11,400 of these visits are from indigent individuals

Source: Advisory Board interviews.

To assess community needs, medical center surveyed local organizations

Medical Center Assesses Community Needs and Interest

To estimate demand for primary care by the indigent, medical center surveyed local parishes and community groups to identify and confirm:

Demographics of groups lacking adequate primary care

- Age
- Ethnicity
- Neighborhood

Barriers to care in the community

- Convenience to neighborhood
- Convenience to public transportation
- Insurance coverage, reimbursement levels
- Availability of providers

Alternative sources of primary care in the community

- Capacity
- Waiting time for appointment
- Services offered

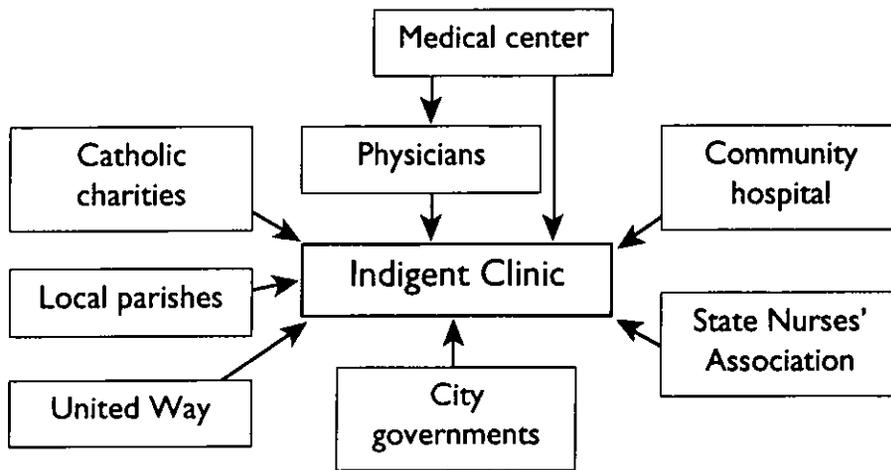
Infant mortality rate and other indicators of inadequate health care

To assess community interest in supporting project, medical center surveyed:

- Local businesses (especially health-related concerns)
- Local charities (United Way, Catholic charities)
- Public health department
- Local branches of medical societies

Main planning body for the clinic project included representatives of most major contributors

Community Groups Involved in Clinic Planning



Clinic operates twelve hours per week and is staffed by volunteers; two physicians are on duty at all times

Clinic Operates with All-Volunteer Staff

- 22 core physicians volunteering on a regular basis
- 49 physicians who accept referred patients in their offices, representing:
 - family practice
 - general practice
 - emergency medicine
 - internal medicine
 - pediatrics
 - psychiatry
 - plastic surgery
 - gastroenterology
- 34 nurses
- 33 screeners, clerical and support staff (including 7 translators)
- 2 dieticians
- 1 attorney
- 1 psychology intern

Costs

Hospital contribution relatively modest (roughly \$40,000), as in-kind donations facilitated clinic start-up, while monetary contributions cover 70% of ongoing clinic expenses

In-Kind Donations Facilitate Clinic Start-Up

- Design work to remodel clinic space
- Used and refurbished equipment and furniture

Donations Cover over 70% of Clinic Expenditures

Clinic Revenues		Clinic Expenditures	
Donations	\$93,000	Employees	\$79,000
Interest Income	\$2,500	Prescriptions	\$18,000
Patients	\$1,500	Rent	\$15,000
		Insurance	\$9,000
		Supplies	\$5,500
		Fund-raising	\$3,000
		Other	\$5,350
Total	\$97,000	Total	\$134,850

Expected Hospital Contribution: \$37,850
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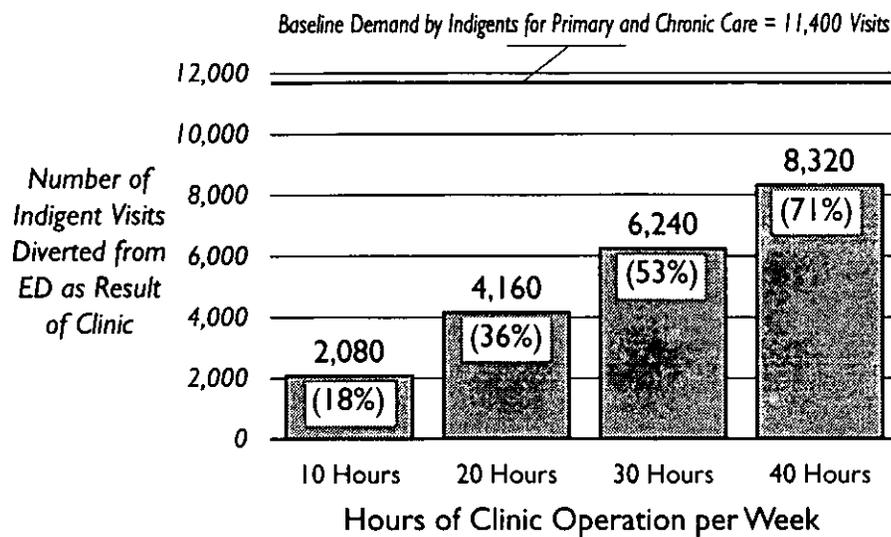
Results

Clinic operated at capacity almost immediately; medical center estimated that full-time clinic could relieve emergency department of over 70% of indigent volume

Collaborative Clinic Can Off-Load Significant Number of ED Indigent Cases

Clinic at full capacity five months after opening

- Clinic is open 12 hours per week
- Hospital estimates clinic would be full even if open 40 hours per week

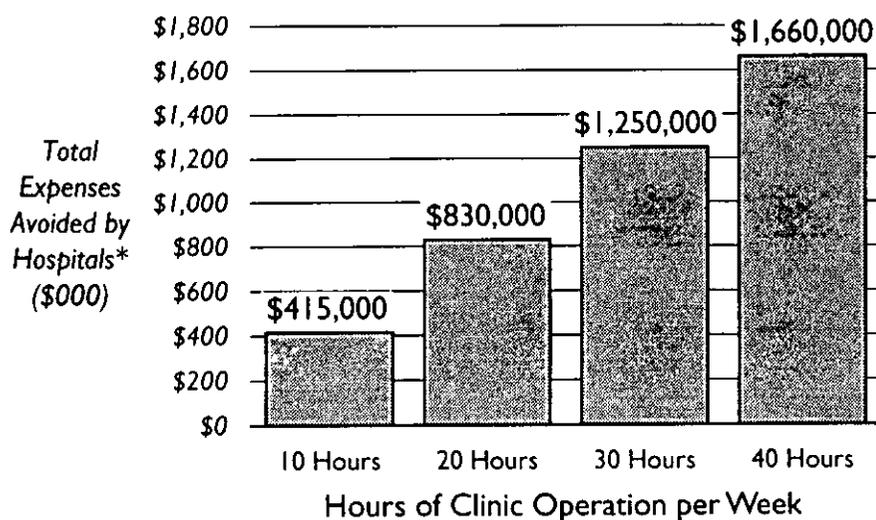


() = Percentage of baseline demand.
 Note: Assumes that 40% of hospital's ED visits are for non-urgent or chronic care, and that 50% of these are for patients who are uninsured or underinsured. Also assumes that approximately 80% of clinic visitors would have presented at the ED; of these, 85% would have been non-urgent and 15% would have been chronic.

Source: Advisory Board analysis and interviews.

Advisory Board Estimate: Hospitals can see a huge financial benefit— clinic could save hospitals in community \$415,000 annually if operated 10 hours per week, over \$1.6 million if open 40 hours

**Advisory Board Hypothetical:
Clinic Could Save Area Hospitals \$1.6 Million Annually**



Note: These savings accrue to the community as a whole; obviously, each sponsoring hospital would see its fair share of the benefit.

* Assumes that approximately 80% of clinic visitors would have presented at the ED; of these visitors, 85% would have been non-urgent and 15% would have been chronic. Of the chronic patients, 40% would require admission, while 60% would be released. The average cost of a clinic visit is \$32. Average direct costs incurred by hospital ED are: \$34 for non-urgent visit; \$74 for visit for chronic condition not requiring admission; \$2,734 for visit and inpatient admission.

Source: Advisory Board analysis and interviews.

Source: Advisory Board analysis and interviews.

Case Example #6

Two Hospitals Support Community Clinic for the Medically Indigent

Description

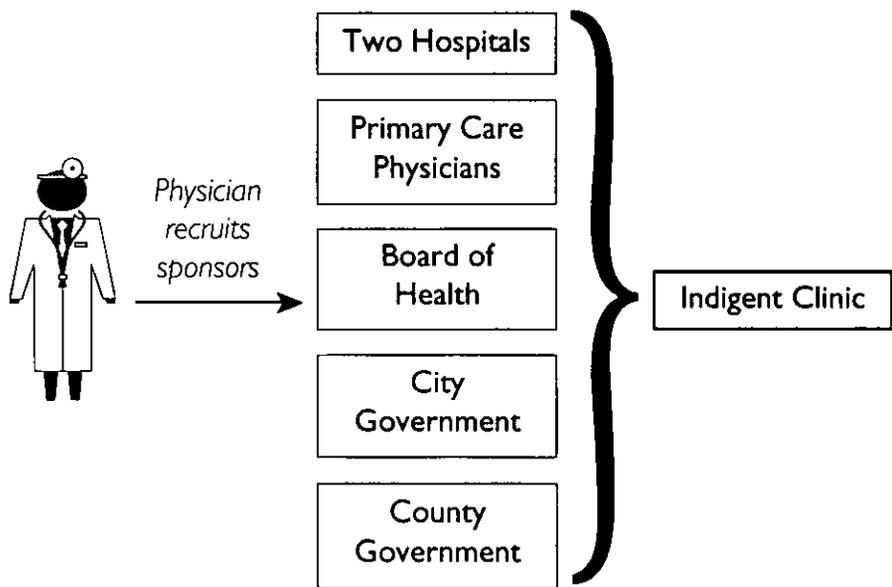
Two hospitals support community outpatient clinic for individuals whose income is below 150% of the federal poverty limit

Goal is to provide community's indigent population with primary care services after city-run clinic closes; corollary objective is to reduce indigents' use of (high-cost) emergency department for primary care by providing a more appropriate (and lower-cost) care site

Retired physician worked with community health care providers, city and county agencies to bring clinic to fruition

- Retired cardiologist dedicated to serving the underprivileged initiated clinic project, recruited sponsors
- Clinic sponsors (in addition to the two area hospitals) include local primary care physicians, Board of Health, city and county governments

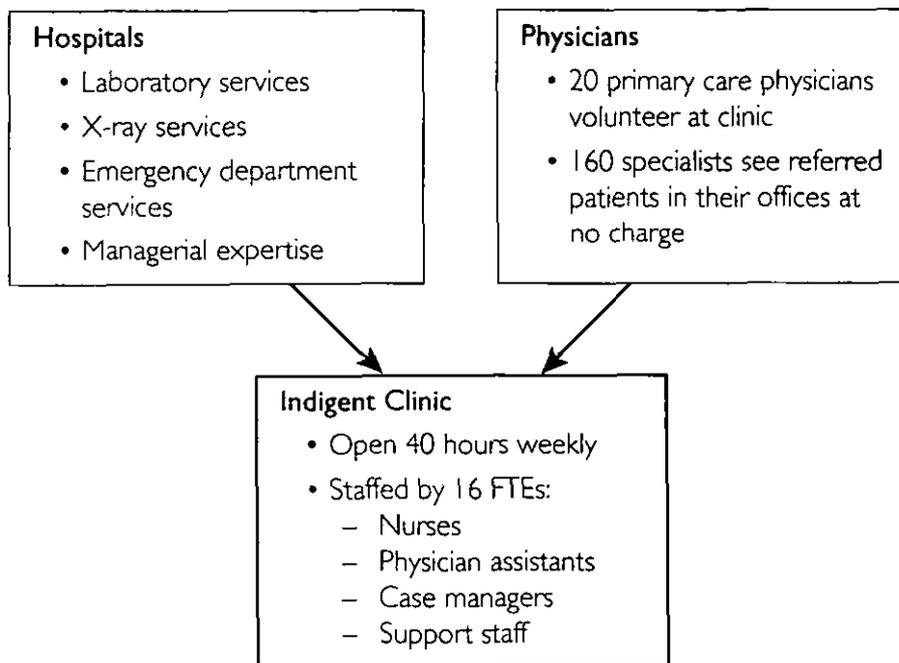
Physician Recruits Numerous Sponsors To Support Indigent Clinic



Outpatient clinic, with support from hospitals and physician volunteers, provides a variety of health care services

- Clinic is located in City-County Health Department building and is open 40 hours per week; clinic provides a full range of primary care services
- Clinic is supported by a salaried staff of 16 full-time equivalents (FTEs), including case managers, nurses, physician assistants, and support staff
- Twenty primary care physicians volunteer their time at clinic; some physicians volunteer one afternoon each week, while others volunteer once per month
- One hundred sixty specialists volunteer by seeing referred patients in their offices at no charge
- Hospitals provide clinic with managerial support as well as laboratory, X-ray and emergency department services

Hospitals, Physicians Provide Variety of Health Care Services



Costs

Volunteer time clearly the biggest investment made by project participants; operating budget equals approximately \$700,000

Time, Service Donations Total Over \$700,000 Annually

Physician Donations

- Physician time valued at \$500,000

Hospital Donations

- Financial donations of \$55,000
- In-kind service donations valued at \$50,000

Public Donations

- Financial donations of \$48,000 from city and county budgets
- In-kind service donation valued at \$84,000 from Board of Health

Results

Participants view indigent clinic as big success; clinic provides needed service to area residents

- Clinic handling 400 patient visits per month and approaching capacity; clinic will be hiring a full-time physician in order to serve expanded patient volume
- Many patients without access to clinic would likely present at hospital EDs; although its impact on ED volume has not been formally tracked, the hospitals believe that clinic has reduced non-urgent ED visits by the indigent
- Clinic director also reports high patient satisfaction; recent surveys indicate that patients are "thrilled" with availability of services and quality of care provided

Source: "Collaboration: Hospitals Find that Working Together Is Tough, Rewarding—and Vital," *Hospitals*, December 5, 1991, pages 18-25; Advisory Board interviews.

Two Hospitals Develop Homeless Clinic, Reduce Non-Emergent Visits to ED

Description

Two hospitals determined need for health care clinic that focused on serving the area's significant homeless population; goal was to provide an appropriate, accessible and comprehensive alternative to the use of emergency departments by the homeless for primary care

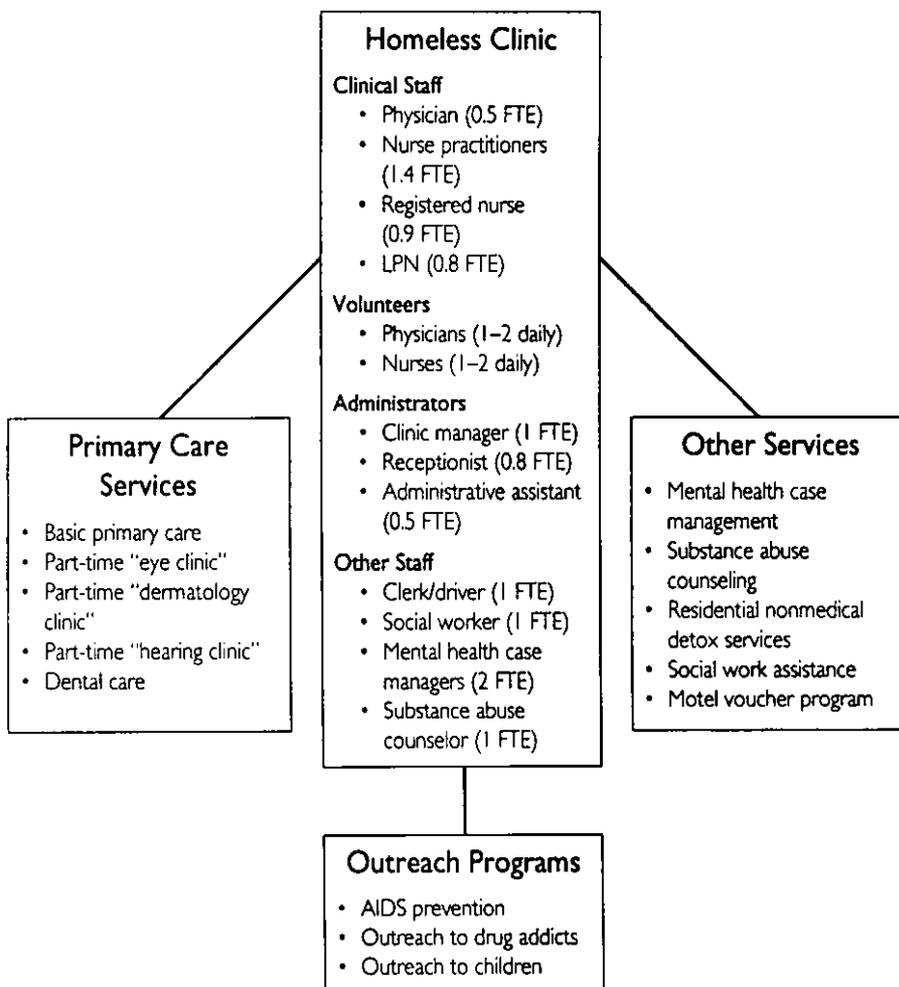
One hospital and network of indigent clinics already existed to serve the homeless; **Problem:** Homeless individuals were not making use of those services (and instead used the ED, often for non-emergent conditions)

Existing Homeless Services Were Inadequate

- Homeless people were unaware of the availability of services because of minimal outreach by network of clinics
- All but one clinic were located outside of the downtown area, thus limiting access by the homeless (who tend to congregate in the city center, close to other services)
- Clinic and hospital services were primarily medical and not geared toward coping with the complex range of problems that homeless individuals face

Clinic provides full spectrum of primary care services five days a week; clinic also addresses other problems linked to homelessness, including substance abuse and mental illness

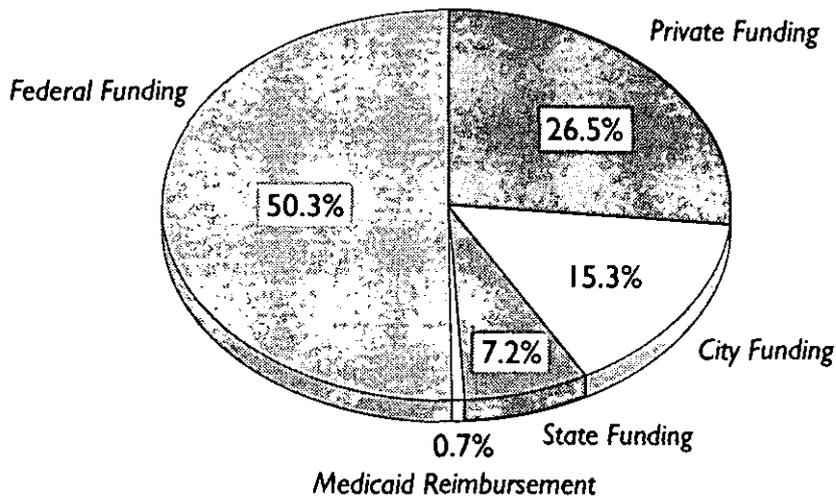
Clinic Provides Primary Care, Other Services



Costs

Costs to hospitals virtually nonexistent: program was initiated with a \$1.4 million grant from the Robert Wood Johnson Foundation, and project receives ongoing funding from governmental and private sources to support the \$1 million annual operating budget

Homeless Clinic Supported by Government, Private Funds



Total Annual Budget = \$1 Million

Results

Homeless clinic serves over 3,000 homeless people annually; without services, these individuals would either present at area EDs or would not seek care at all (which would likely later result in hospital admissions for more serious—and more costly—problems)

While no overall data are available, no question that cost savings are significant; Case in Point: One patient suffering from pneumonia, abscessed tooth and alcoholism was \$700 to \$3,500 less costly to treat in homeless clinic than if patient presented at ED for care

**Case Example:
Homeless Clinic's Treatment of Patient with Pneumonia,
Abscessed Tooth Saves \$700 to \$3,500 Over Hospital Treatment**

Hospital Treatment (estimated)	Cost	Clinic Treatment (actual)	Cost
Initial ED Presentation	\$250-\$800	Two Medical Visits	\$98
Inpatient Admission	\$500	Prescription	\$5
Second ED Presentation	\$250-\$800	Motel Stay (After Clinic Referral)	\$98
Third ED Presentation	\$250-\$800	Three Dental Visits	\$165
(Possible) ICU Admission for DTs	\$1,000	Clinic Counselor	\$74
Emergency Services	\$300-\$400	Detox Visit	\$730
Ambulance	\$350	Social Services	\$46
Social Services	\$38	Total Cost	\$1,216
Total Cost	\$1,938-\$4,688		
Cost Savings		\$722-\$3,472	

Source: Clinic records and analysis.

Source: Advisory Board interviews.

Case Example #8

City-Wide Alliance Forms Network To Provide Prenatal Care to Substance Abusers

Description

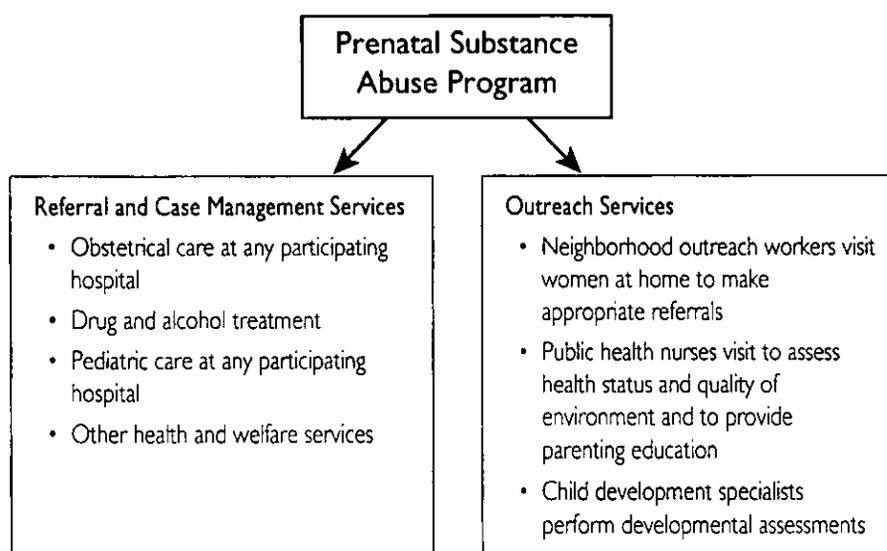
Consortium of (primarily) hospitals creates program to encourage pregnant women with substance abuse problems to seek treatment and prenatal care

Goal is to improve both birth outcomes (and therefore reduce costs of infant care) and to enhance quality of mother-child interaction by helping women achieve and maintain sobriety

Program offers referral/case management and outreach services to eligible women free of charge

- Eight hospitals, county health department, and school of public health form consortium
- Consortium provides coordinated health care services and substance abuse treatment to pregnant women, new mothers
- Referral, outreach services provided at no cost; however, women are financially responsible for their prenatal/pediatric care and substance abuse treatment

Program Provides Case Management, Outreach Services



**Women referred to program by one of participating institutions;
women remain in program until children reach two and a half years
of age**

Woman Participates In Program During Pregnancy and Subsequent 30 Months



- Woman is referred to program during pregnancy or up to one month after delivery
- Program eligibility is determined by a comprehensive assessment of the degree of impairment she is experiencing and the resulting risks to her and her baby's health
- Woman must meet the following program requirements to remain enrolled:
 - Remain compliant with alcohol and drug treatment
 - Attend prenatal visits as scheduled
 - See a pediatrician for scheduled appointments
- Woman remains enrolled in program until child is 30 months old

Costs

Program served 140 women over three-year period at an average cost of \$2,000 to \$3,000 per patient (incurring total program costs of \$350,000); majority of funds provided by sources other than hospitals

Funding Sources Include Government Grants

U.S. Department of Health and Human Services

State Department of Health

Foundation

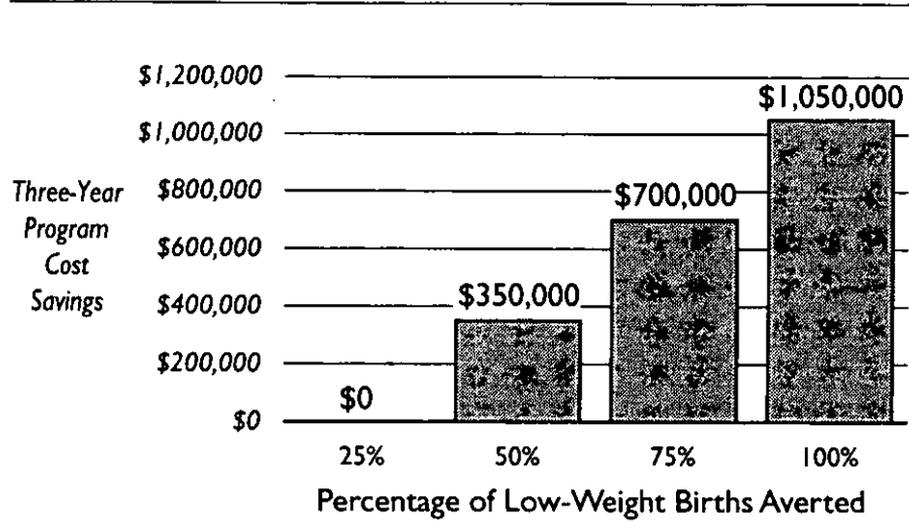
Hospital

Results

While no hard data is available, program reports success in achieving its objectives; Advisory Board estimates that even a marginally successful program would “break even,” while a highly-effective program could save \$700,000 over three years

- Most of the women enrolled in program were able to achieve and maintain sobriety; while no data available, reasonable to assume that majority of these women had healthy, normal-weight babies
- No information on how many program participants were able to avoid having low-birth-weight babies (who can incur an NICU cost of \$10,000 each); Advisory Board estimates that program only had to avert low-weight births for 25% of participants to “break even”

**Averting Only 25% of Low-Weight Births
Would Justify Program Costs**



Source: "A Decade of Competition Ends—A New Era of Cooperation Begins," *Hospitals*, January 20, 1992, pages 44-46; Advisory Board interviews.

Case Example #9

Joint Hospital/School District Program Reduces Teenage Pregnancies by 15%

Description

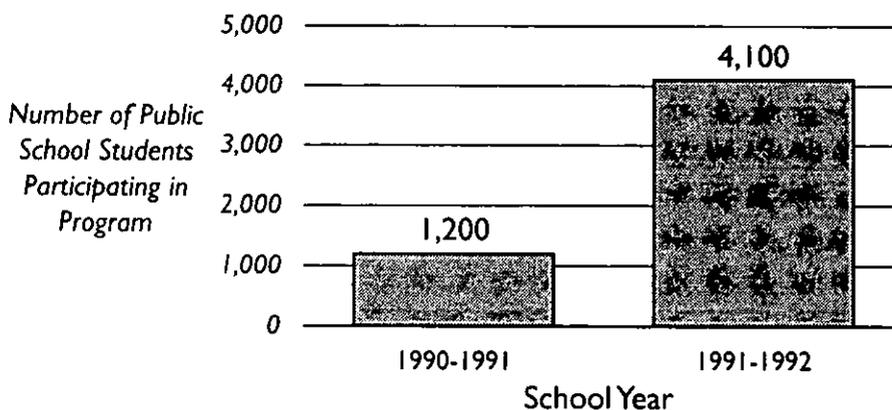
Hospital council with 37 members joins with urban school district to combat teen pregnancy through program that discourages adolescents from becoming sexually active; program spearheaded by physicians from local children's hospital

- Two physicians from adolescent division of local children's hospital worked to get "Postponing Sexual Involvement" (PSI) program installed in city's public schools in late 1990; hospital council has supported program for past year
- Existing (successful) program in Atlanta was used as the model for PSI initiative
- Hope is that, by reducing teen pregnancy rates, PSI can:
 - decrease number of (and considerable cost of health care for) premature and low-birth-weight babies
 - help more students (especially females) to graduate from high school

Cornerstone of PSI program is the use of trained high school students to teach seventh-grade students how to identify, resist peer pressure to have sex

- PSI taught in all of city's public middle schools (reaching 4,100 seventh graders) and 10 parochial schools (reaching 2,000 more students)

Program Now Reaches 4,100 Public School Students Annually



- Program curriculum consists of 10 class sessions

Ten Class Sessions Focus on Sex Education and Postponing Sexual Activity

Sessions 1 through 5

Seventh-grade teachers review basics of sex education

Lessons Include:

- Maturation and Hygiene
- Anatomy and Physiology
- Family Planning
- Becoming a Parent
- Sexually Transmitted Infections

Sessions 6 through 10

Trained high school sophomores, juniors, and seniors cover risks of early sexual involvement and techniques for refusing involvement

Lessons Include:

- Risks of Early Sexual Involvement
- Social Pressures
- Peer Pressures
- Assertiveness Techniques
- Reinforcing Skills (one-month follow-up)

- In addition to targeting seventh graders, school district introduced slightly modified version of PSI to pilot group of fifth graders this year; goal to roll out program to all fifth-grade classes in city schools by 1994

Costs

PSI program relies on community organizations for funding; program has raised almost \$300,000 to fund the program for the 1992-1993 school year

- Over 30 organizations support program with money, in-kind contributions, volunteer time

Over 30 Varied Organizations Support Program

- Children's hospital
- Foundations
- Corporations
- Public agencies
- Health associations

- Funds cover annual operating expenses, including paid staff positions, training materials and brochures

Hospital council provides in-kind support geared toward spreading program to other school districts in council's service area

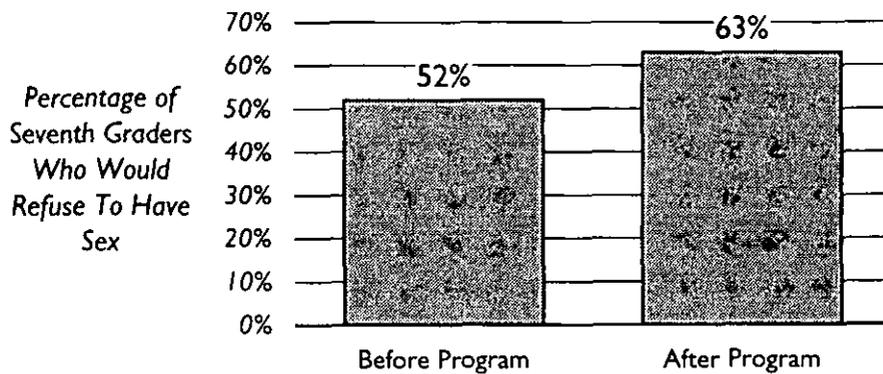
Hospital Council Provides Promotional, Other Support for PSI Program

- Council implemented a "parent satisfaction survey" to gauge reactions to children's participation; goal was to gain support when applying for grants and other funding
- Council surveys other school districts in service area to determine targets for program
- Council hosts breakfasts for school superintendents, principals, PTA members to enlist their support for spread of program
- Council provides space for training of peer leaders

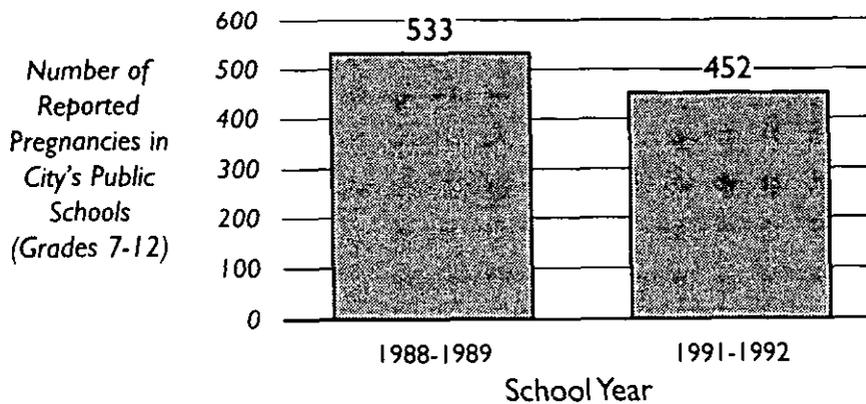
Results

By all (admittedly early) indications, PSI is succeeding in influencing participants to postpone becoming (or to become less) sexually active; in first year of program, teenage pregnancy dropped 15%

Teens Willing To "Just Say No" to Sex Increases 20%



Community Experiences a 15% Decrease in Teen Pregnancy Since Program Inception



Source: Sue McDonald, "Just Say 'No'", *The Cincinnati Enquirer*, "Tempo" Section, April 18, 1993; Advisory Board interviews.

Case Example #10

Eight Hospitals Develop Programs To Combat Social Ills that Adversely Affect Community's Health

Description

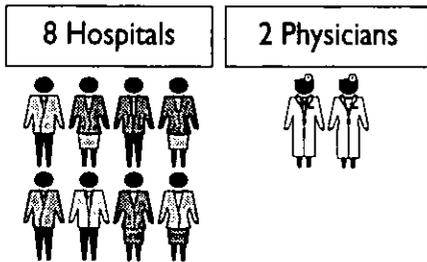
Eight-hospital association and area health coalition form committee charged with improving community's health by addressing widespread social problems

First goal to assess (negative) effect of social and economic problems on health status of population; second goal to identify and support programs that will address these problems in hopes of improving community's health

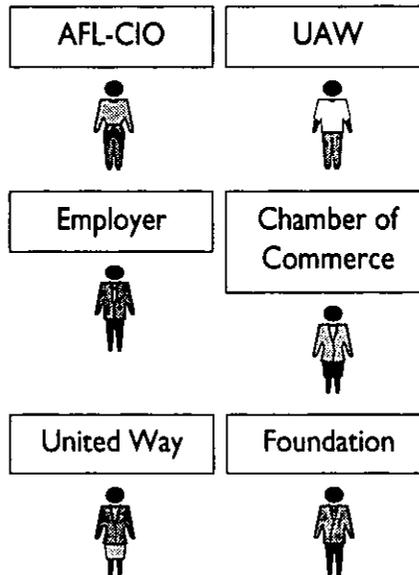
Committee, coined "urban commission," includes a representative from each participating hospital; other individuals represent physicians, unions, businesses, government agencies, other entities

Eighteen Members of Urban Commission Represent Numerous Groups

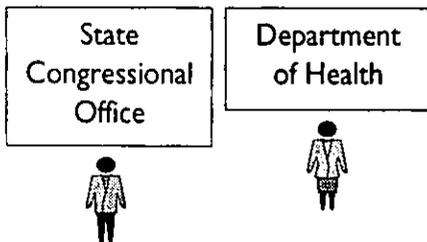
Local Hospital Council Representatives



Health Coalition Representatives



Governmental Agency Representatives

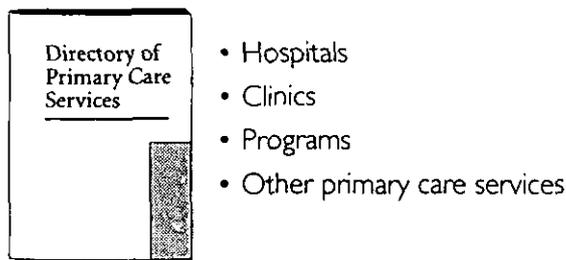


Commission launched demonstration project designed to improve access to primary care as a means of reducing infant mortality

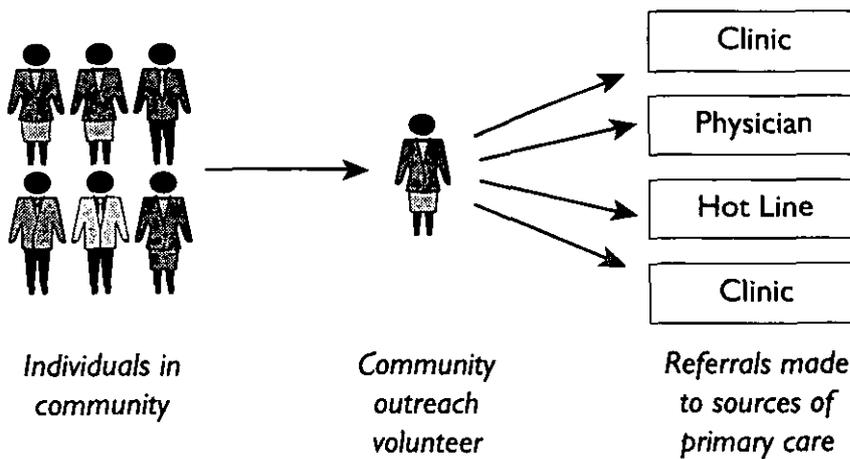
- Diverse inner-city neighborhood chosen as demonstration site
- Project is currently focused on two initiatives:
 - #1 Educating residents about, encouraging use of available primary care services through distribution of health care directory
 - #2 Developing corps of volunteers (drawn from community leaders) to help residents access appropriate care

Commission Develops Two Sources of Referrals

Source #1: Primary Care Directory



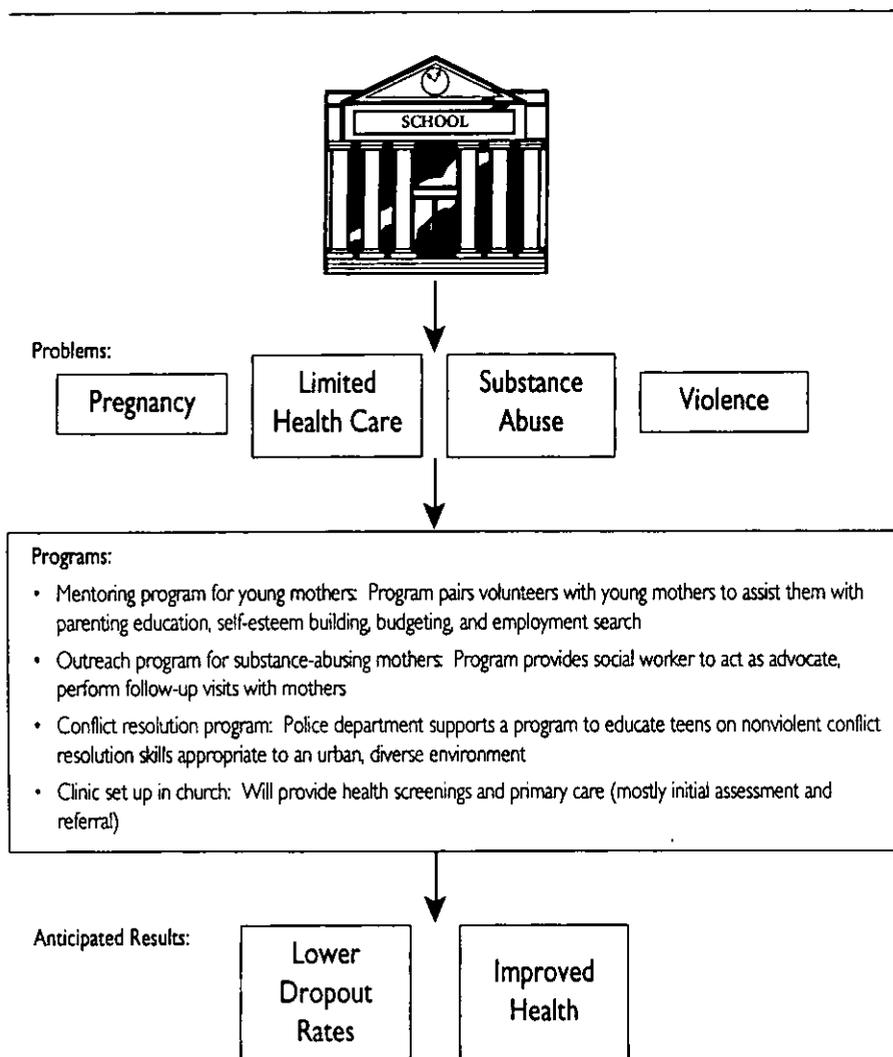
Source #2: Volunteer Referral Service



Commission also sponsoring program to reduce high school dropout rates

- Focus is on addressing social problems which adversely affect health status of teens and lead to higher dropout rates; examples include:
 - Teenage pregnancies, parenthood
 - Limited access to health screenings and primary care
 - Substance abuse
 - Violence as a means of conflict resolution

Commission-Sponsored Programs Address Teen Problems



Costs

Projects sponsored by urban commission supported primarily through members' volunteer time and in-kind support; \$200,000 (over half of which is contributed by hospitals) in total donations required to support programs

Projects Supported by Volunteers, In-Kind Support

Volunteers

- Social workers
- Police
- Mentors
- Focus group leaders
- Fund raisers

In-Kind Support

- Designing brochures and materials
- Printing costs
- Donating facility space
- Providing transportation
- Providing child care
- Providing refreshments

Under \$200,000 in Donations Required To Support Program

Community Focus Groups	\$2,200
Administrative Support	48,000
Health Education	4,000
Directory	17,000
Outreach Training, Other Components	21,500
Program Space	10,000
Staff	90,500
Total	\$193,200

Results

Too early to assess impact of commission's efforts on health status of targeted populations

- Networking for resource directory is almost complete; directory will be issued shortly
- Church-based clinic currently being staffed (and will be operational shortly)
- Five focus groups have been organized to identify health education needs of the community, including two school groups, two parent groups and one youth group
- Volunteers for referral service are currently being trained

Source: Advisory Board interviews.

Case Example #11

Hospitals, Community Groups Create Vision for a Healthy Community

Background

Two hospitals in Midwestern community participate in national initiative to improve health status of communities across the United States

- *Healthy People 2000*, a national strategy for measuring and improving the health of the population in 21 priority areas, was initiated by the U.S. Public Health Service in 1987
- Goal to achieve dramatic improvements in the health status of the nation by the year 2000; specific objectives are detailed in the areas of health promotion and preventive services

Healthy People 2000 Sets Aggressive Targets for Improving Health of Nation

<i>Sample Health Status Objective</i>	<i>1987 National Baseline</i>	<i>Year 2000 Target</i>
Reduce coronary heart disease deaths	135.0 per 100,000 individuals	100.0 per 100,000 individuals
Reduce cancer deaths	133.0 per 100,000 individuals	130.0 per 100,000 individuals
Reduce breast cancer deaths	22.9 per 100,000 individuals	20.6 per 100,000 individuals
Reduce pregnancies among girls 17 years old and younger	71.1 per 1,000 individuals	50.0 per 1,000 individuals
Reduce infant mortality rate	10.1 per 1,000 live births	7.0 per 1,000 live births

Source: *Healthy People 2000*, U.S. Public Health Service, 1990.

- The two hospitals, along with the county health department and citizen committees, established a 200-person volunteer organization with 24 committees to pursue national objectives locally

Twenty-Four Health Categories Studied by Community

Committees on Specific Health Categories

- | | |
|--|---|
| • Physical Activity and Fitness | • Food and Drug Safety |
| • Nutrition | • Oral Health |
| • Tobacco | • Maternal and Infant Health |
| • Alcohol and Other Drugs | • Heart Disease and Stroke |
| • Family Planning | • Cancer |
| • Mental Health/Mental Disorders | • Diabetes and Chronic Disabling Conditions |
| • Violent/Abusive Behaviors | • HIV Infection |
| • Education and Community-Based Programs | • Sexually-Transmitted Diseases |
| • Unintentional Injuries | • Immunization and Infectious Diseases |
| • Occupational Safety and Health | • Clinical Preventive Services |
| • Environmental Health | |

Other Committees

- Children and Adolescents
- Older Adults
- Surveillance and Data Services

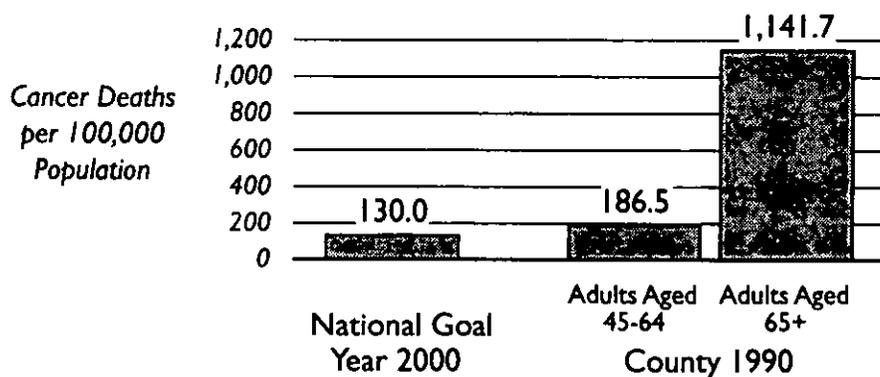
Committees assessed the health status of county against the national baseline data to determine where resources should be allocated

Program Descriptions and Results

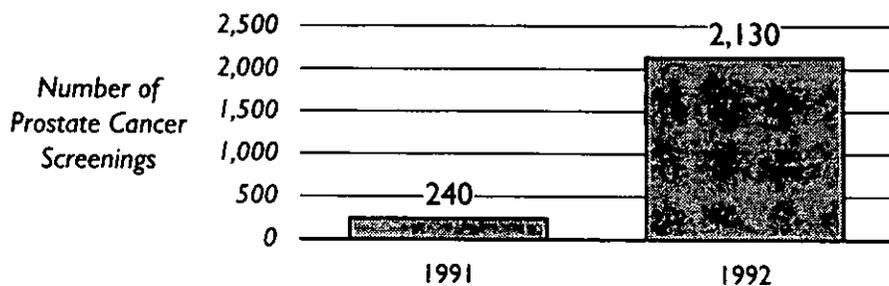
Since inception of community effort, hospitals have implemented or enhanced a number of programs to meet the goals set by committees and improve the health status of the community

Program #1: Hospital-Funded Cancer Education and Screenings

- In county, cancer is the leading cause of death for adults aged 45 to 64, at a rate of 186.5 per 100,000 lives in 1990; for adults aged 65 and over, the 1990 cancer mortality rate was 1,141.7 per 100,000 (the second leading cause of death in this age group)



- Ultimate goal is to reduce cancer deaths to a level equal to or below the national goal; interim objectives include increasing the number of cancer screenings and providing cancer education to a greater number of county residents
- Two hospital initiatives underway to address goals; First Initiative: Prostate cancer education—one participating hospital and community urologists cosponsoring prostate cancer educational programs
- Through community educational efforts and increased physician awareness, the number of prostate cancer screenings provided at hospital increased ninefold in past year—physicians and nurses donated their time, and local laboratory read tests for free (at value of \$12,580)



- Second Initiative: Free breast cancer screenings; fund was established by hospital in conjunction with American Cancer Society to provide free mammograms to 100 uninsured, high-risk women next year (at two hospitals and through use of mobile unit)

Program #2: Hospital-Provided Inoculations

- Committee found that infectious disease still causes many (preventable) illnesses and deaths, despite reduced incidence of these diseases overall
- In response, new influenza immunization program was developed to provide vaccines as part of health screenings conducted by hospitals (in partnership with other community agencies); previously, all immunizations were administered in physician offices
- In 1992, hospitals administered 2,800 influenza vaccines at a cost of \$2.90 per vaccine; while no data are available regarding the increase in vaccinations from previous years, county hospitals are reporting significantly fewer cases of hospitalization for influenza
- This year, each hospital is donating 1,000 doses of pneumococcal vaccine to be administered in conjunction with influenza vaccine at public health centers, elder service centers and 29 Visiting Nurses Association immunization sites; cost to each hospital equals \$5,740

Program #3: Car Seat Safety Program Run by Volunteers

- Although incidence of death by motor vehicle crash was lower in county than both the national baseline and the national objective, committee believed that the county should strive for even fewer such preventable deaths, setting goal of 10 deaths per 100,000 population
- One program to help reach this goal: "Safe Kids Coalition," a volunteer group led by a community pediatrician, which works to ensure child safety
- Last year, volunteers conducted 650 car seat safety checks at local day care centers, educating those parents using below-standard safety seats (or not using them at all)

Source: Advisory Board interviews.

Case Example #12

Hospitals, School District Create “Health Care High School” that Spurs Interest in Health-Related Careers

Description

Inner-city school district and local hospital council work together to establish high school curriculum with focus on health care field

Primary Goal: To expose interested students to an array of health care professions so they may make better-informed career choices;
Secondary Objective: To create a “pipeline” of health care professionals for the community

“Health care high school” part of a broader “magnet school” program which allows students to gain specialized experience in areas of interest

- “Magnet school” program offers six different specialized curricula, encourages students to pursue higher education in these fields

Magnet Schools Encourage Higher Education in Six Areas

- Health Professions
 - Communication Professions
 - Computer Professions
 - Teaching Professions
 - Math and Science Professions
 - Liberal Arts Curriculum
-
- All six “magnet schools” housed in one building
 - Students must complete regular high school curriculum in addition to working in area of specialty

Specialized portion of curriculum comprised of series of structured experiences in health care arena

- In program, students gain general exposure to health care system, tour hospitals and other health care facilities, receive instruction in specific occupations, perform internships in various health care settings

**Health Care High School Curriculum
Maximizes Exposure to the Health Care Field**

Freshman Year	Sophomore Year	Junior Year	Senior Year
Hospital and other facility tours; general exposure to the health care system	Group exposure to the day-to-day activities in various professions: <ul style="list-style-type: none"> • Physicians • Critical Care Nurses • Physical Therapists • Occupational Therapists • Medical Records Personnel 	Two years of internships working one-on-one with on-site "preceptors" to gain very specific experience, develop skills appropriate to various agencies providing health care	

- Program has a clinical coordinator (retired hospital vice president) who oversees clinical portion of curriculum; liaison position will be created to help develop the internship experiences
- Advisory committee comprised of community representatives provides guidance to program; however, school board (along with principal) has ultimate governance responsibility

Costs

Local hospital council and area health care providers donate time and raise money for specialized curriculum; actual cash outlay for hospital is inconsequential

- Sporting event fund raiser (with teams of health care professionals sponsored by hospitals, physicians, and health-related companies) organized by hospital council raised \$110,000 in first year, \$130,000 in second year
- Funds raised are used to support operating costs of program

Hospital Council Raises Funds To Support Health Care High School

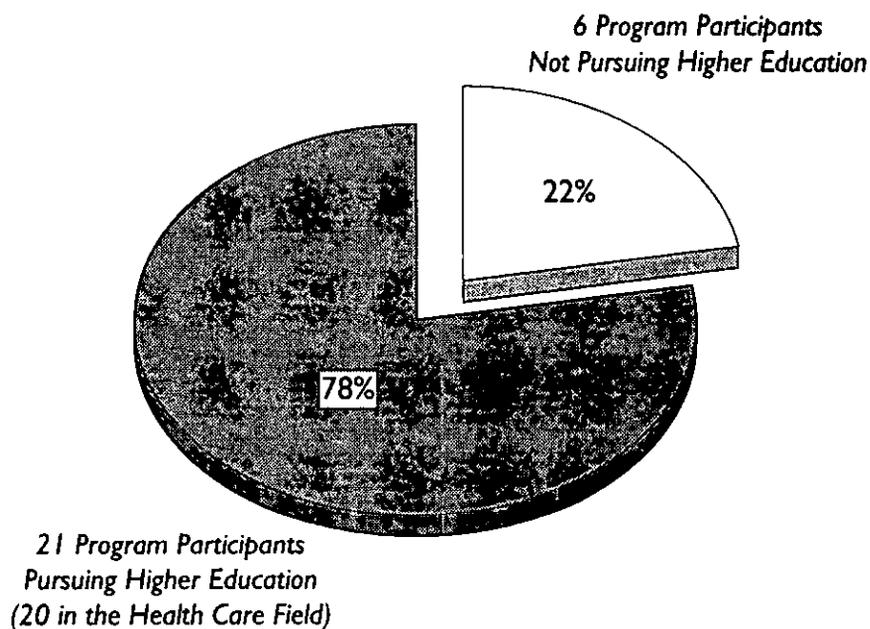
- Salary of clinical coordinator (director of program)
 - Salary of agency liaison (to set up and coordinate internships)
 - Student compensation for a summer enrichment program
 - Scholarship program for higher education
-
- That said, most valuable contribution to program definitely the volunteer time "donated" by health care providers who sponsor student internships; preceptors support 320 internships annually
 - All "regular" school expenses (e.g., general-curriculum teachers, building repair and maintenance costs), as well as transportation to internship locations, lab coats and other related costs are borne by the school district

Results

“Health care high school” boasts high success rate; to date, 27 students have graduated from program—and over 70% are pursuing higher education in the health care field

- 21 out of 27 pursuing higher education (a success in itself for an inner-city school system)
- Of these 21 students, 20 are pursuing a career in the health care field

Nearly Three-Quarters of Graduates Pursue Higher Education in Health Care



Source: Advisory Board interviews.

Chapter Two:

Reducing Service Duplication

Legal Caveat

Reducing service duplication through joint purchase of new technologies or joint provision of clinical services will likely raise complex legal issues regarding antitrust behavior.

The Advisory Board strongly suggests that hospitals considering the pursuit of such ventures consult with legal counsel.

Chapter Two

Nine Salient Observations on Reducing Service Duplication

Observation #1

Reducing service duplication the second best opportunity for hospital-hospital collaboration; hospitals strongly encouraged to explore these efforts, in which partners jointly provide needed clinical services by sharing costs and splitting revenues from pooled patient volume

Observation #2

Two types of collaborative programs to reduce service duplication: first is where partners jointly operate a new service (instead of each investing in competing facilities); second type is when participants consolidate existing multiple services into fewer locations

Two Types of Collaborative Efforts To Reduce Service Duplication

Program	Description
Joint purchase, operation of new service	Participating institutions share in acquisition, operation and management of one new facility or service (rather than each independently offering competing services)
Rationalization of existing, competing services	Participating institutions consolidate multiple facilities or services into fewer locations Often partners may "divvy up" services; for example, two hospitals that both offer open heart and oncology services may decide to consolidate all cardiac services at one hospital and all cancer services at the other institution

Observation #3

Advisory Board View: Duplication reduction efforts are most successful when aimed at new services (rather than the consolidation of existing facilities)

Observation #4

In fact, partnerships for new services often enable hospitals to acquire technologies that otherwise would have been prohibitively expensive; it is not uncommon for ventures to boost profits by hundreds of thousands of dollars

Joint Ownership of New Services Offers Clear Financial Benefits

Technology/Service	Description	Benefits
MRI	Two hospitals shared purchase of \$3 million MRI machine	<ul style="list-style-type: none"> • \$700,000 annual cost savings
PET	Two hospitals shared \$5.7 million investment for equipment and facility construction	<ul style="list-style-type: none"> • Cost per PET exam almost cut in half because patient volumes shared by two facilities
Lithotripsy	Two hospitals split investment cost of \$3 million for equipment purchase	<ul style="list-style-type: none"> • Center is profitable • Would-be competitors have shied away from entering market
Cardiac Services	One hospital provides angioplasty, open heart services, second hospital will provide outpatient cardiac care; total investment costs of \$6 million will be shared	<ul style="list-style-type: none"> • Cardiology discharges increased by 15% • Estimated increase in profits of \$850,000 (over profits generated if each hospital built its own open heart program)
Oncology Services	\$1.2 million investment cost of new oncology facility shared by local and out-of-state hospital	<ul style="list-style-type: none"> • 10% increase in inpatient volume for local hospital • 23% increase in outpatient volume for local hospital • Increase in specialized case referrals for out-of-state hospital

Observation #5

In fact, joint ownership is often the only profitable way to expand service offerings, as collaboration allows high fixed costs to be spread over a larger number of patients

Observation #6

Case in Point: Joint surgery center with three partners the only profitable option—the development of two (or three) competing centers would result in losses for investors

**Advisory Board Estimate:
Single Shared Ambulatory Surgery Facility
the Only Way To Make Venture Profitable**

	One Facility	Two Facilities	Three Facilities
Number of Partner Groups per Facility	3	2	1
Annual Patient Volume per Center ¹	5,635	2,818	1,878
Total Revenue ²	\$4,130,000	\$2,065,594	\$1,376,574
Total Costs	\$3,170,000	\$2,775,620	\$2,644,020
Fixed Costs ³	\$2,381,100	\$2,381,100	\$2,381,100
Variable Costs ⁴	\$788,900	\$394,520	\$262,920
Total Profit (Loss)	\$960,000	(\$710,026)	(\$1,267,446)
Profit (Loss) per Partner Group	\$320,000	(\$355,013)	(\$422,482)

¹ Assumes total area patient volume of 5,635 patients annually. Source: Surgery center analysis.

² Assumes revenue per case equals \$733. Source: Surgery center analysis.

³ Assumes annual fixed costs to operate ambulatory surgery center equal \$2,381,100. Source: Surgery center analysis.

⁴ Assumes variable costs per case equal \$140. Source: Advisory Board estimate.

Source: Gary Montrose, Ashby*Montrose & Co., Denver, Colorado.

Observation #7

Caveat: While such ventures are often successful, they are more difficult to negotiate than those addressing community health problems; partners must work through the (often contentious) issues involving joint management and revenue, profit sharing

Observation #8

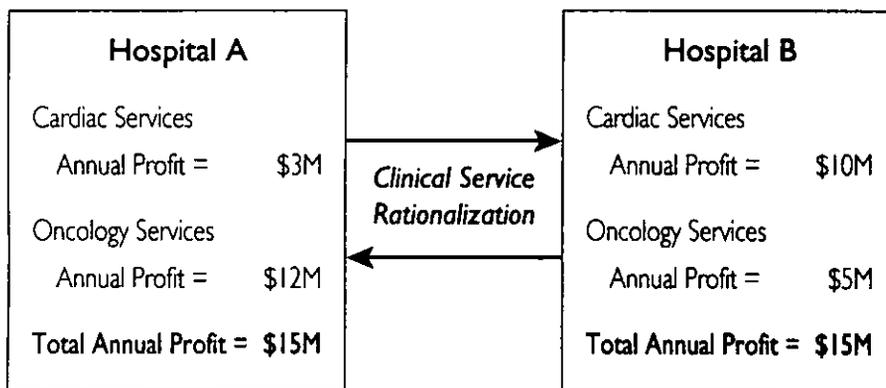
Nevertheless, collaboration on new services is unquestionably much more likely to succeed than are joint ventures to rationalize existing services

Observation #9

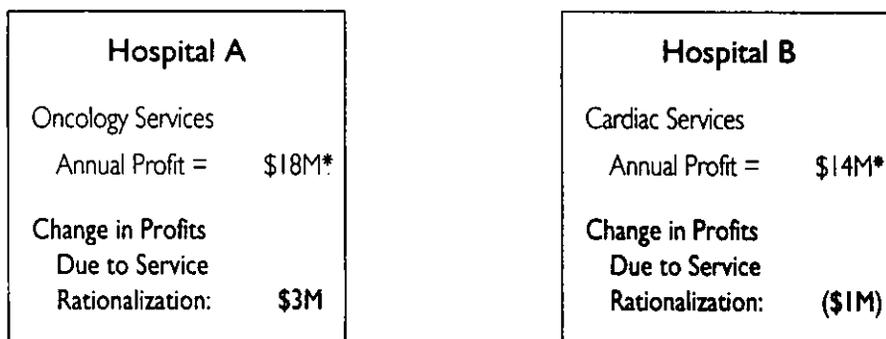
Two reasons for this view: first, the “shuffling” of existing services, even if it yields overall cost savings, is highly likely to leave one partner a financial “loser,” and second, such ventures often force one partner to relinquish management control over an “up-and-running” (and perhaps popular) service

**Advisory Board Hypothetical:
Rationalizing Existing Services
May Generate Financial Loss for One Partner**

Before Clinical Service Rationalization



After Clinical Service Rationalization



* Assumes that collaborative effort boosts overall profits by \$1 million.

Two Hospitals Avoid Service Duplication by Sharing MRI, Saving Nearly \$700,000 Annually

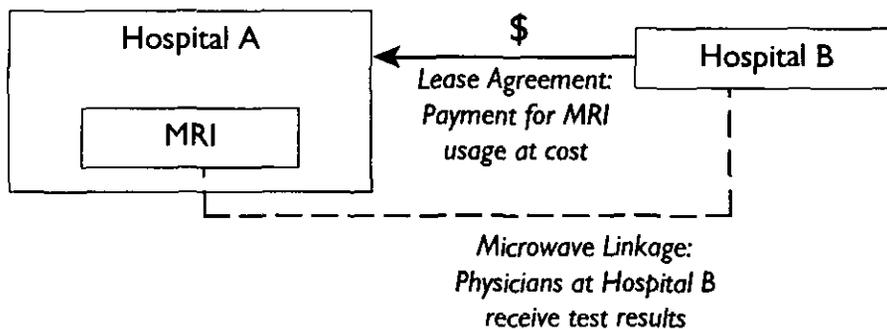
Description

Two hospitals in small town sharing MRI technology; goal is to provide service to community cost-effectively by avoiding expensive duplication of technology, as projected MRI volume in area was not sufficient to warrant two machines

MRI equipment purchased by (and located in) larger hospital; through lease arrangement, smaller hospital's medical staff has full access to equipment

- A microwave link between the two hospitals allows smaller hospital's physicians to receive MRI results, facilitating rapid reporting
- The two hospital CEOs negotiated the leasing arrangement; initial contract signed for a five-year period with an "evergreen clause" so that contract terms can be extended indefinitely

Hospitals Share MRI Cost Via Lease Arrangement



Costs

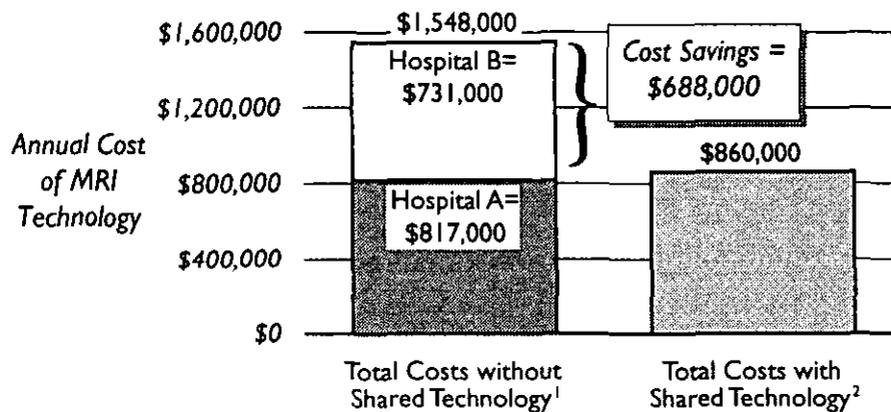
Cost of microwave linkage (approximately \$60,000) borne by smaller hospital; the larger institution shouldered the capital expense of approximately \$3 million for the MRI instrumentation

Results

Sharing technology enabled smaller hospital to avoid large capital investment for own MRI, while larger hospital able to recoup investment earlier due to lease payments; joint venture saves hospitals nearly \$700,000

- Smaller hospital, which accounts for approximately 650 annual MRI procedures (25% of total), was spared unnecessary \$3 million investment for own MRI
- Smaller hospital's lease payments (amounting to approximately \$350,000 annually) will enable larger hospital to recoup investment sooner than if joint venture was not pursued
- Annual cost savings of shared technology equal nearly \$700,000

Sharing Technology Saves Hospitals Approximately \$700,000 Annually



¹ Assumes that each hospital would have invested in MRI technology; fixed costs equal 80% of total costs; variable costs equal \$66 per exam; total patient volume of 2,600 patients annually would have been split 75%/25% between Hospitals A and B. Source: Advisory Board analysis.

² Source: Hospital A.

Source: Advisory Board interviews.

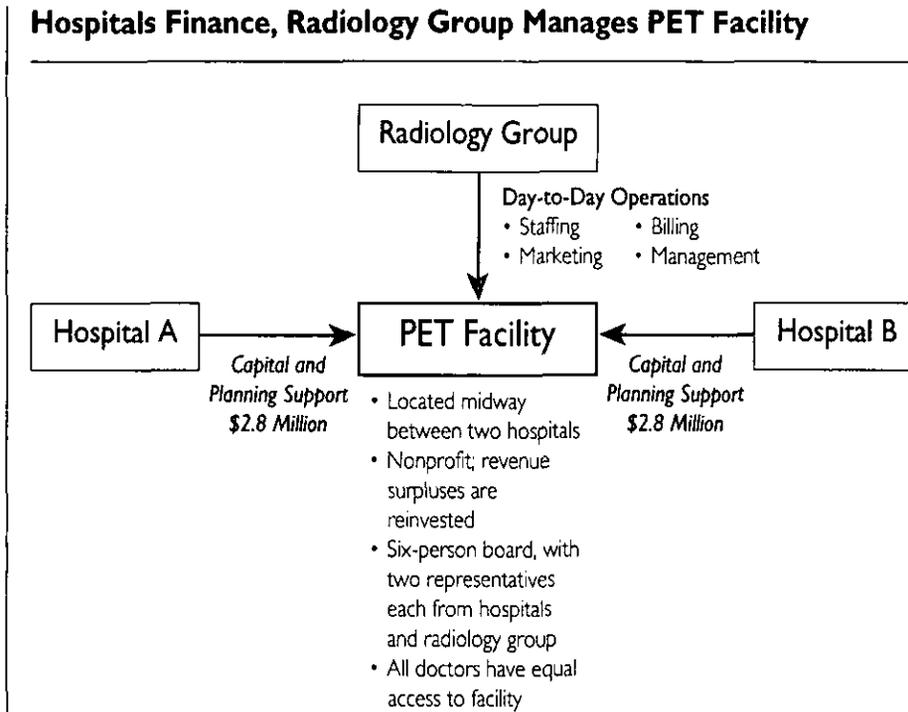
Competing Hospitals Buy Joint PET Facility, Saving an Estimated \$350,000 Annually for Each Hospital

Description

Two competing hospitals and a radiology group entered into joint venture to bring PET technology to market area; goal to provide needed community service while sharing burden of capital investment

- Need for PET scanner in community brought to attention of major area hospital by local radiology group; at that time, nearest PET scanner was located hundreds of miles away
- Market analysis conducted by hospital concluded that patient demand in near term (next 10 to 15 years) justified one PET facility in area
- However, large capital investment required to purchase PET scanner precluded hospital from acquiring technology on its own
- Result: Hospital approached chief rival regarding joint venture for PET facility; two institutions pooled resources to "bankroll" project
- Center, which opened in mid-1992, is located midway between hospitals; both institutions' medical staffs have equal access to its services

Hospital partners provided capital and planning support while radiology group manages day-to-day operations; board composed of two representatives from each hospital and radiology group



Costs

Costs associated with constructing, operating PET center formidable

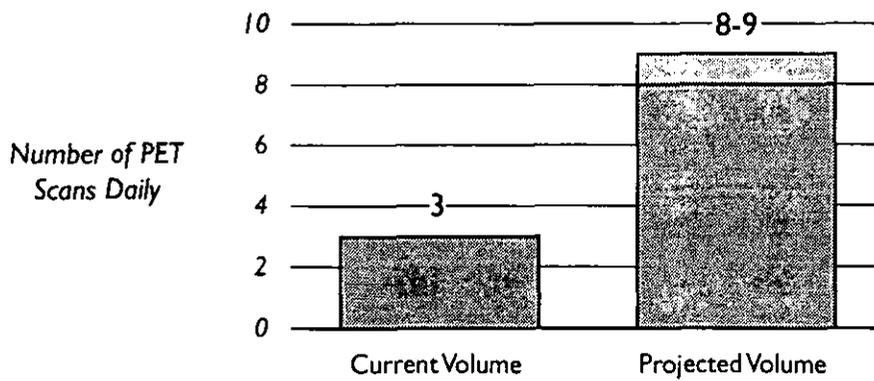
- Facility required initial capital investment of \$5.7 million for construction, equipment; cost was split evenly between the two hospitals
- First-year annual operating costs of \$1.5 million covers staff, supplies, utilities, other ongoing expenses

Results

While facility lost \$900,000 in first year, demand for PET services “living up to expectations” of joint venture partners; if future demand projections are met, facility should become profitable

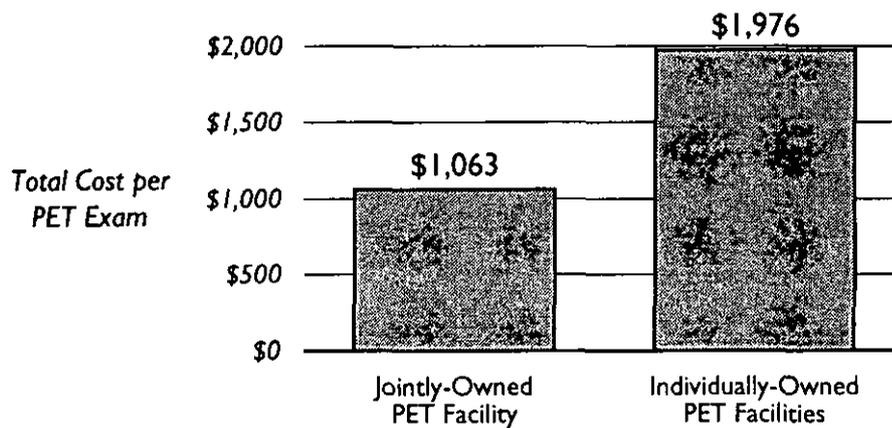
- Actual volume of PET scans in first year of operation is “on track” with volume of three scans per day (necessitating one full-time technologist)
- Facility volume expected to grow to eight or nine scans per day, at which point facility should be profitable

PET Volume Is Three Scans Daily and Growing



Collaboration clearly keeping losses to date to a minimum; Advisory Board estimates that sharing PET technology saving each hospital \$350,000 annually

**Advisory Board Estimate:
Joint Venture Cuts Cost per PET Exam In Half,
Yielding an Annual Savings of \$350,000 for Each Hospital**



Annual Costs without Joint Venture

Number of Exams Performed Annually	780
Cost Per Exam	\$1,976
Total Annual Costs	\$1,541,280

Annual Costs with Joint Venture

Number of Exams Performed Annually	780
Cost Per Exam	\$1,063
Total Annual Costs	\$829,140

Total Cost Savings with Joint Venture **\$712,140**

Cost Savings for Each Hospital **\$356,070**

Assumptions:

- 1 Fixed costs allocated over an eight-year life.
- 2 Annual patient volume would have been split evenly between two hospitals.
- 3 Variable costs per PET exam are \$150.
- 4 Three PET exams per day are performed; clinic hours are five days per week for 52 weeks per year.

Source: Advisory Board analysis.

Source: "Moving Target: Hospitals Take Careful Steps in Acquiring PET," *Hospitals*, April 5, 1992, pages 58-62; Advisory Board interviews and analysis.

Case Example #15

Two Rival Hospitals Establish Successful Joint Venture Kidney Stone Center

Description

Two fierce competitors set aside differences, “join forces” to provide lithotripsy services to half of state; goal was to expand service offerings with minimal investment cost

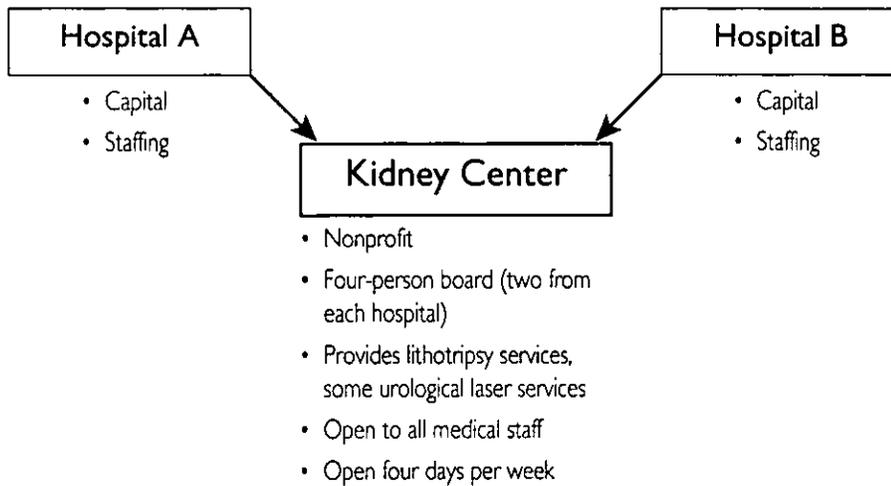
- Located only two miles apart, the two hospitals had historically viewed each other with suspicion, dislike and distrust
- In 1984, institutions began planning joint venture to bring lithotripsy technology to region; at that time, there was only one lithotripter in the entire state
- Result: Joint project received CON for second lithotripter in state in 1986; freestanding kidney stone clinic opened shortly thereafter

Facility is located halfway between the two hospitals, maximizing access for most urologists in service area; facility provides lithotripsy services and some urological laser services four days per week

Kidney center operates as de facto department of both institutions; center’s director reports to board with representatives from each partner hospital

- All staff positions at center were posted at both hospitals; Result: Most of center’s staff was derived from existing hospital employees
- Employees at center are on payroll, benefit plan of one hospital
- Center has director overseeing daily operations; director reports to four-person board, with two representatives from each hospital

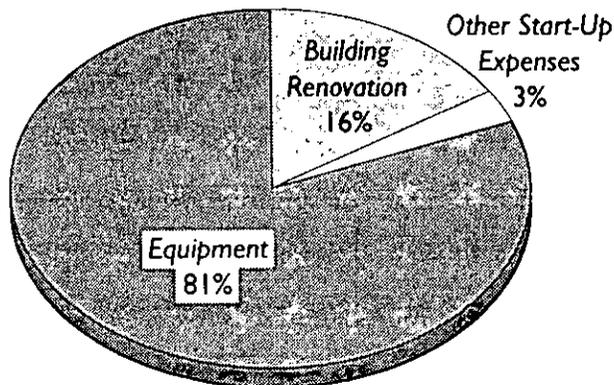
Hospitals Share Staffing, Governance of Kidney Center



Costs

Initial capital investment of nearly \$3 million (mostly for new equipment) shared equally by partner institutions; annual operating costs of roughly \$1 million are covered by revenues

80% of Initial Capital Investment for Equipment Purchase

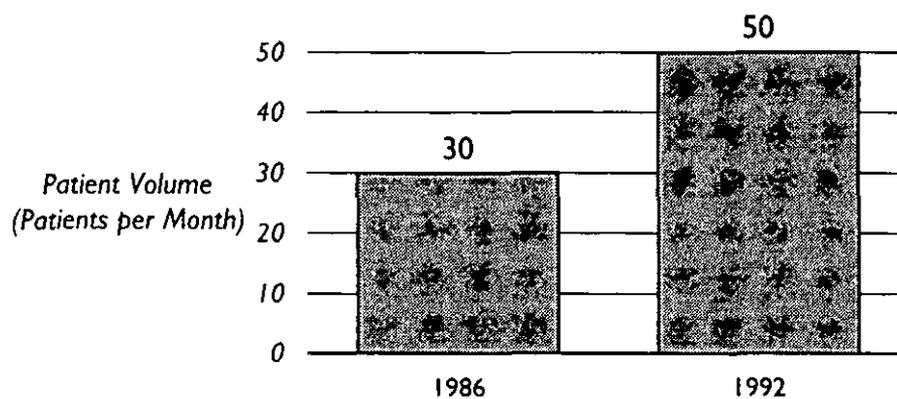


Results

Results to date suggest that center is a success; center generates a profit, would-be competitors have shied away from entering market, and management is considering significant capacity expansion

- While precise data is not available, center is self-supporting; revenues in excess of operating expenses are reinvested in facility
- Both hospitals view project as an unconditional success; a needed service is provided to the community in a structure that is beneficial to both institutions
- Operating four days per week, center serves approximately 50 patients per month (up from 30 when center first opened); consideration being given to opening on a fifth day
- High-quality, cost-effective service provided by center has discouraged competitors in the area from entering market

Patient Volume Jumps 67% Since Center's Opening



Source: "Starting a Joint Venture Kidney Stone Center," *Health Care Strategic Management*, December 1989, pages 12-15; Advisory Board interviews.

Case Example #16

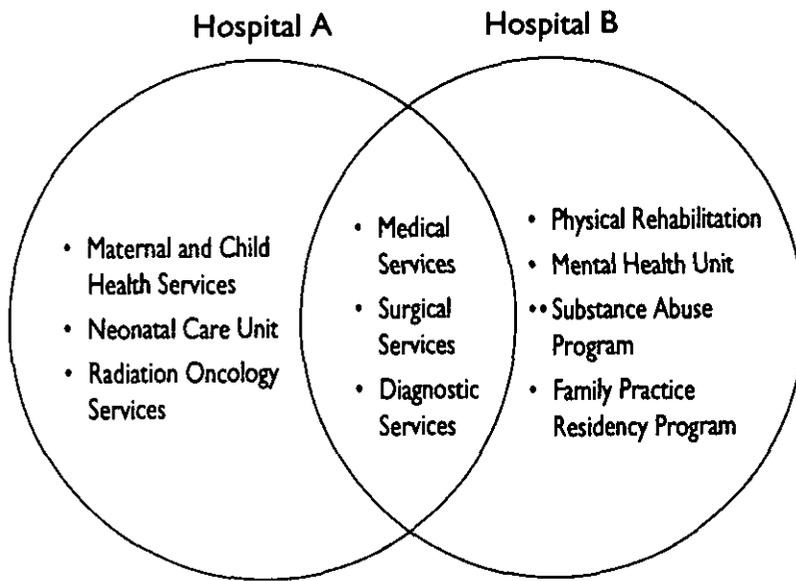
Community Hospitals Jointly Develop Full Array of New Services, Rationalize Current Ones

Description

Two hospitals with view toward avoiding service duplication are collaborating on various technologies through creation of a joint nonprofit organization

- Cooperative mind-set between two hospitals had long history; despite significant duplication of some services, each hospital had previously agreed to “divvy up” a few specialized services

Hospitals “Divide Up” a Few Specialized Services



- To facilitate CON approval for development of technology-intensive services, a joint nonprofit organization was created

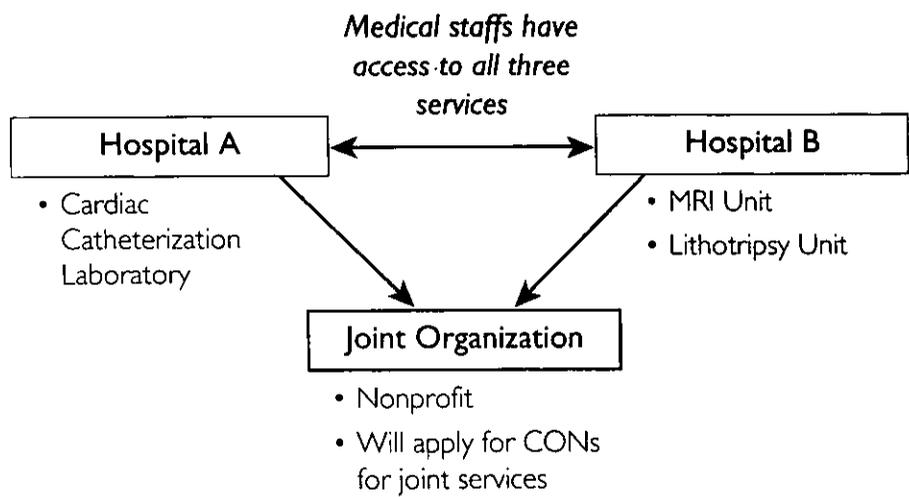
Board of joint organization includes fourteen representatives, responsible for governance of collaborative ventures

- Board representation is shared equally between hospitals
- Board will direct joint planning process for collaborative efforts, including:
 - New service consideration
 - Equipment purchases
 - Capital acquisition
 - CON application

Current plans delineate three new services to be jointly owned and financed; joint MRI and lithotripsy units will be located at smaller hospital, while cardiac catheterization laboratory will be located at larger hospital

- Both medical staffs will have access to all services; physician convenience not affected because hospitals are less than one mile apart
- Future joint services are planned, including upgrade of trauma services and a service for AIDS care

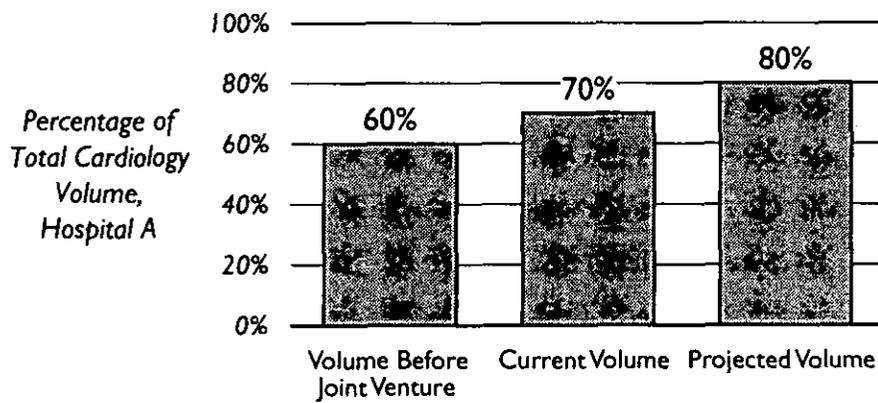
Joint Services Shared by Hospitals



Hospitals also currently rationalizing cardiology and neurosurgery services in an effort to lower costs and improve quality; ultimate goal is for one hospital to handle 80% of all cardiology cases while the other hospital handles neurosurgery

- Cardiology services slowly being moved to one hospital; hospital originally handled approximately 60% of total volume, now handles 70% with an ultimate goal of 80%

**One Hospital Partner
Will Increase Cardiology Volume to 80% of Total**



- Neurosurgery services have not yet been shifted; goal is for second hospital to handle 80% of all cases (up from current 60%)

Costs

All capital costs, operating costs and revenues associated with collaborative technologies will be applied directly to joint organization, which is funded by both hospitals

- \$6.5 million investment required to fund three joint projects to date

Hospitals Equally Share \$6.5 Million Investment

- \$3 million for MRI technology
 - \$2 million for lithotripsy equipment
 - \$1.5 million for cath lab
-
- If acting independently, each hospital would have had difficulty affording the investment and qualifying for CONs for all three services; only one CON would have been awarded per service, so “winning” hospital would have had to “foot the bill” on its own

Results

Too early to evaluate results; up to \$1 million total cost savings is projected, while impact on market share will be tracked

- Hospitals project combined savings of \$500,000 to \$1 million through greater operating efficiencies:
 - Joint purchasing of equipment, supplies and blood
 - Joint pharmacy and formulary inventory procedures
 - Shared nurse staffing in the area of infection control
- Market share growth resulting from joint services will be tracked via a regional hospital database

Joint Ambulatory Surgery Center Boosts Annual Profits by Almost \$1 Million

Description

Two competing hospitals and joint medical staff collaborate on ambulatory surgery center; medical park with four operating rooms, diagnostic services, medical services and overnight recovery bed capability is located halfway between two hospitals

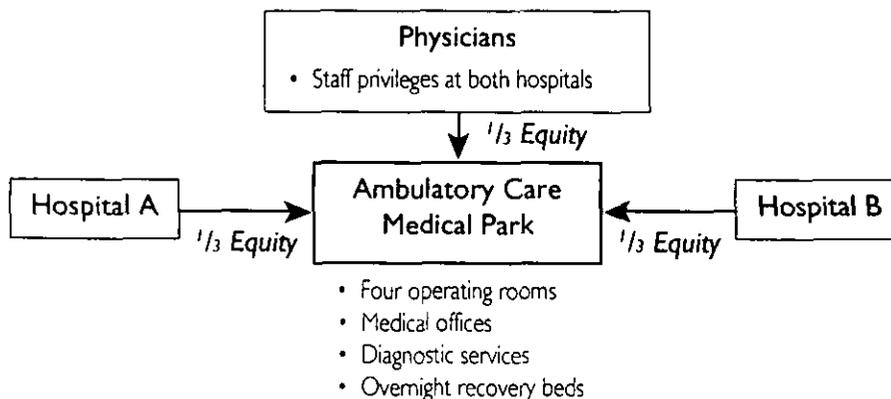
- Each of three groups had been prepared to build a center; groups had not attempted any joint efforts prior to this opportunity (and mistrust prevailed)
- Independent facilitator was employed to assist in communication and analysis; extensive feasibility research and negotiations took nine months, after which joint corporation was formed

Goals of joining forces were twofold; **First Goal:** To increase hospital efficiency and improve convenience for patients and physicians by transferring all outpatient procedures to a lower-cost, non-hospital environment

Second Goal: To attract (and retain) payers and patients by providing a low-cost setting for ambulatory procedures (hospitals shared a combined annual volume of 21,400 surgeries, of which 58% were being performed on an outpatient basis)

Two hospitals and physicians share equity in medical park, with equal financial risks and rewards

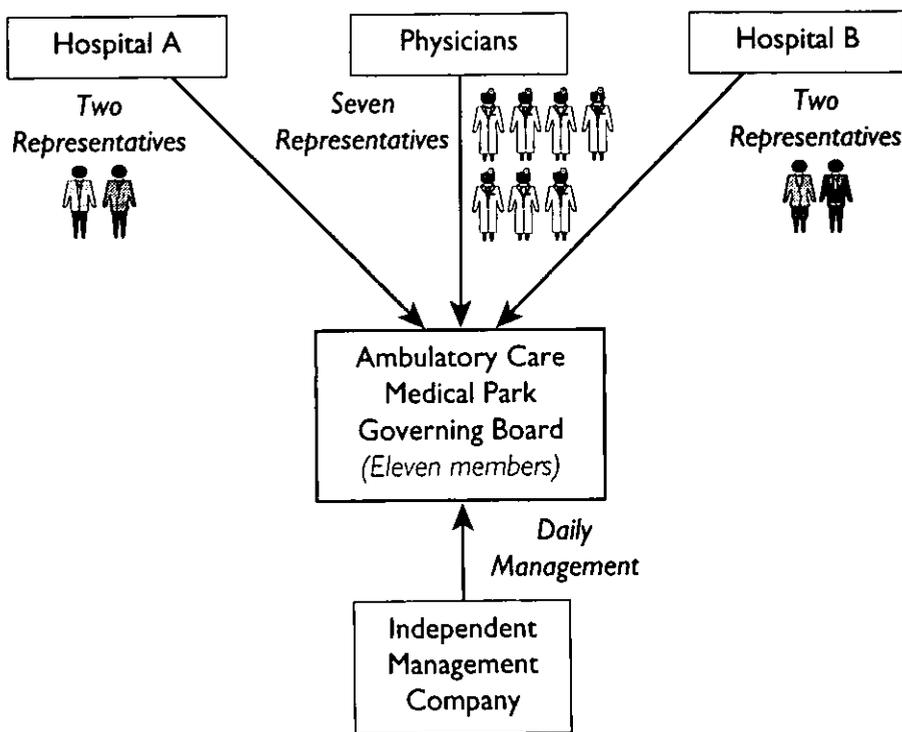
Hospitals, Physicians Share Equity Equally



Board is comprised of seven physicians and two representatives from each hospital; all agreements are made by consensus

- Day-to-day management for the facility is provided by an independent management company

Board Representation Shared by Three Parties



Costs

Total cost of venture estimated to be \$5 million (equally shared by all partners)

- Capital required to build center estimated to be \$4.7 million; equal capital contributions were made by the three parties
- Consulting fees for feasibility study and facilitation were \$150,000; legal and accounting fees amounted to an additional \$150,000

Cost of Joint Project Estimated to be \$5 Million

Building	
Building	\$2,160,000
Design	150,000
Equipment and Furniture	1,500,000
Land	
Land	570,000
Site Development	350,000
Civil Engineering and Landscape Architecture	26,000
Consulting Fees	150,000
Legal and Accounting Fees	150,000
Total Costs	\$5,056,000*

* Total costs were shared equally by two hospitals and physician group.

Results

Advisory Board Estimate: Joint surgery center with three partners the only profitable option; two (or three) centers pursued independently could have resulted in million-dollar loss for investors

Advisory Board Estimate: Collaboration Turns Potential Million-Dollar Loss Into Million-Dollar Profit

	One Facility	Two Facilities	Three Facilities	
Number of Partner Groups per Facility	3	2	1	
Annual Patient Volume per Center ¹	5,635	2,818	1,878	¹ Assumes total area patient volume of 5,635 patients annually. Source: Surgery center analysis.
Total Revenue ²	\$4,130,000	\$2,065,594	\$1,376,574	² Assumes revenue per case equals \$733. Source: Surgery center analysis.
Total Costs	\$3,170,000	\$2,775,620	\$2,644,020	³ Assumes annual fixed costs to operate ambulatory surgery center equal \$2,381,100. Source: Surgery center analysis.
Fixed Costs ³	\$2,381,100	\$2,381,100	\$2,381,100	
Variable Costs ⁴	\$788,900	\$394,520	\$262,920	⁴ Assumes variable costs per case equal \$140. Source: Advisory Board estimate.
Total Profit (Loss)	\$960,000	(\$710,026)	(\$1,267,446)	
Profit (Loss) per Partner Group	\$320,000	(\$355,013)	(\$422,482)	

Source: Gary Montrose, Ashby*Montrose & Co., Denver, Colorado; Advisory Board analysis.

Case Example #18

Two Community Hospitals “Divvy Up” Cardiac Services under Contractual Arrangement

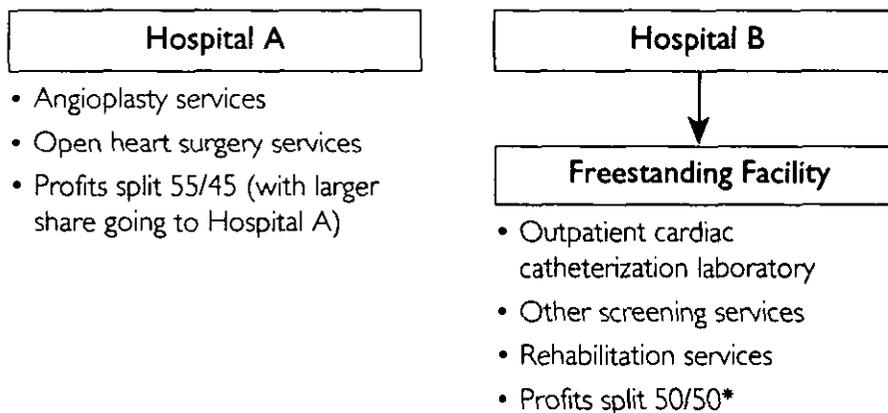
Description

Two area hospitals in race to provide open heart surgery are compelled to collaborate on program; goal was to create a financially competitive, high-quality program with volumes adequate to meet CON requirements

- Both institutions were awarded CONs for open heart surgery which contained minimum-volume requirements
- Problem: Feasibility study concluded that community could readily support one, but not two, open-heart programs (given CON volume stipulations of 200 patients annually)
- Hospitals entered into contractual agreement to jointly operate one open heart program (since creating a separate joint venture entity could have required reapplying for a CON) through use of the “best and brightest” of both hospital staffs

Larger hospital (with more OR space, critical care beds) designated to house joint open heart program; in return, freestanding cardiac care center will be built near smaller hospital

Cardiac Services Shared by Two Hospitals



- Revenues and costs for all outpatient cardiovascular services (e.g., cardiac catheterization, angiography, stress thalium, EKGs and echocardiograms)—including those provided at Hospital A—are pooled; profits are split 50/50.

Costs

Total investment of approximately \$6 million required for open heart program and cardiac center

- Open heart program required initial capital investment of \$2 million for equipment and building renovation (70% contributed by larger hospital)
- Plans for cardiac center require total investment of \$4 million, to be split equally between hospitals

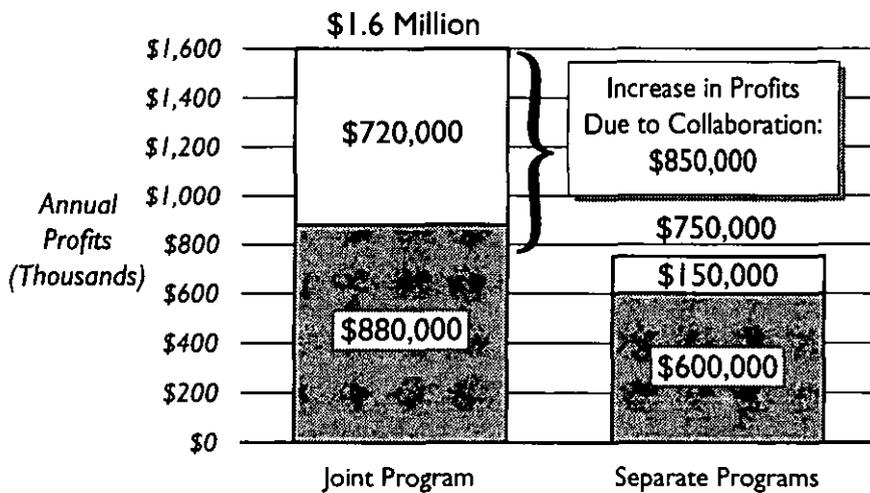
Results

Both institutions view joint operating agreement as success; together, hospitals are providing more services to community (and treating more patients) than either could have done alone

- Program provides needed service to community; before program, patients were travelling over fifty miles to nearest open heart programs for treatment
- Since inception of joint program, cardiology discharges at larger hospital have increased by 15%; smaller hospital has also observed increases in patient volume

Advisory Board Estimate: Collaboration has helped to boost annual profits by \$850,000 (in comparison to profits if each hospital had pursued open heart program on its own)

**Advisory Board Estimate:
Collaboration Boosts Total Profits by \$850,000**



 Hospital A
 Hospital B

Assumptions:

- 1 Fixed investment in open heart program of \$2 million allocated over ten years; Hospital A would have invested \$2 million if developing its own program; Hospital B would have invested \$1.5 million if developing its own program (Source: Hospital A).
- 2 Other fixed costs equal \$700,000 annually (Source: Advisory Board analysis and interviews).
- 3 Joint program patient volume is 250 cases annually; Hospital A would have received 60% of these cases if it developed its own program (Source: Hospital A).
- 4 Variable costs per case equal \$10,000 (Source: Advisory Board analysis and interviews).

Source: Advisory Board interviews.

Joint Oncology Program Generates Increased Patient Volumes for Both Hospital Partners

Description

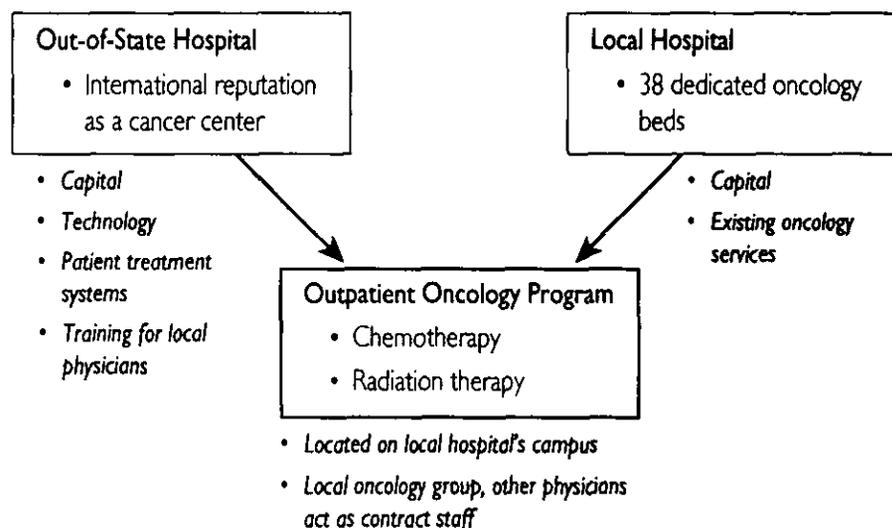
Recognized out-of-state oncology center develops seven-year affiliation with local medical center to establish joint outpatient oncology program located on the local medical center's campus

Goal of local center was to improve access and quality of care for area residents, and to enhance its image and patient volumes; goal of out-of-state center was to expand research case material and to generate referrals of "special" cases that could not be treated locally

New program provides chemotherapy, radiation therapy and supporting services; local medical center incorporated all of its current outpatient services into joint entity

- Program contracted with a local oncology group and independent practitioners to act as contract medical staff for the facility
- A new oncology center will ultimately be constructed to house program; construction should begin in 1994

Joint Facility Located on Local Hospital's Campus



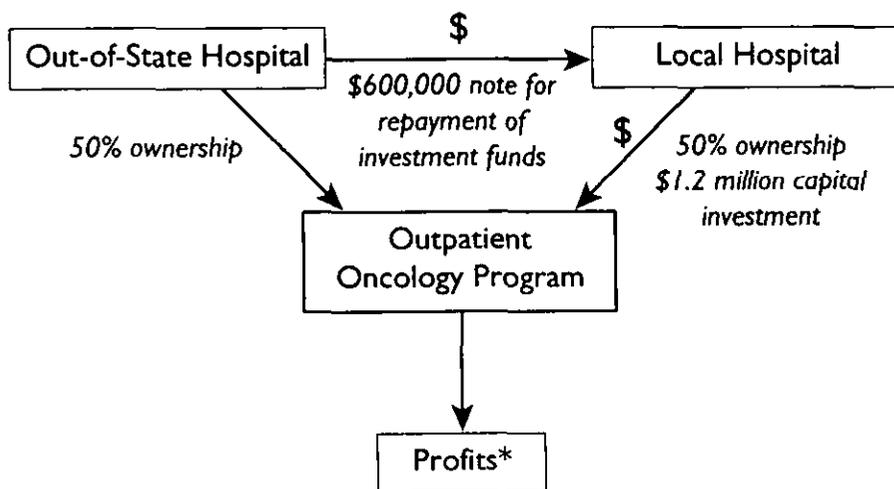
Board is comprised of three members from each institution (although out-of-state center manages the program)

- Board responsibilities include general overview of facility, strategic development, and policy development
- Out-of-state hospital provides daily management (both business and clinical) according to management contract; three top officers of corporation—CEO, CFO and Medical Director—are employed by out-of-state hospital

Costs

Initial capital requirement for start-up was approximately \$1.2 million, provided by local center but subject to 50% repayment by out-of-state hospital; investment was minimized by locating center in a building where radiation therapy was already located

Two Hospitals Share Ownership, Profits of Oncology Program



* Because local center is given credit for patient base it brought to the project, profits are split from additional patients only, subject to a mutually agreed-upon formula.

Results

Project is a success for both institutions; local medical center enjoying a notable increase in both inpatient and outpatient volume since new facility was developed, while out-of-state center reporting an increase in referral volumes

Oncology Program Increases Patient Volumes for Both Hospitals

Local Hospital Increases Patient Volumes, Improves Patient Satisfaction

- Local center reporting patient volume increases of 10% for inpatient services and 23% for outpatient services; market share has increased as well
- Although patient satisfaction was not tracked prior to facility construction, current patient satisfaction is extremely high

Out-of-State Hospital Increases Case Referrals, Enhances Research Effort

- While no data available, local hospital reports that specialized case referrals to the out-of-state center have increased; without joint effort, case referrals would have declined because of significant oncology competition in the area
- In addition, out-of-state facility has enhanced its research through affiliation: local patients have been treated according to facility's care protocols, providing additional data for research and evaluation of patient outcomes

Source: "Joint Oncology Programs Offer Market Opportunities," *Health Care Strategic Management*, October 1990, pages 1, 19-22; "Alliance Strengthens Care," *Health Care Strategic Management*, December 1990, pages 9-12; "Florida Outreach Fits Plan," *Health Care Strategic Management*, February 1991, pages 8-10; Advisory Board interviews.

Chapter Three:

Preparing for Managed Care and Capitation

Legal Caveat

Joint ventures to pursue managed care contracts and capitation will likely raise complex legal issues regarding antitrust behavior.

The Advisory Board strongly suggests that hospitals considering the pursuit of such ventures consult with legal counsel.

Five Salient Observations on Preparing for Managed Care and Capitation

Observation #1

Joint ventures to prepare for managed care and capitation are among the least successful types of collaboration (and should only be pursued opportunistically)

Observation #2

Intended goal of these partnerships is to win (and profitably manage) payer contracts through joint negotiation and/or by cutting costs, providing geographic coverage, or improving quality

Collaborative Efforts To Win Contracts Focus on Payer Appeal

Appeal to Payers	Description	Example
Joint Negotiation	Payers negotiate with one contracting entity representing several hospitals	<ul style="list-style-type: none"> • Two hospitals create a joint organization to assess and negotiate managed care contracts that will bind both organizations
Lower Costs	Payers seek providers who can provide effective patient treatment in lower-cost care modalities	<ul style="list-style-type: none"> • Community hospital, children's hospital jointly manage care under capitated contracts • (Low-cost) community hospital provides routine care, while (specialty) children's hospital provides more complex services • Intended Result: To reduce overall costs of care
Higher Quality	Payers seek providers who can provide high quality of care through low morbidity, low mortality and other patient outcomes measurements	<ul style="list-style-type: none"> • Community hospitals provide clinical, patient satisfaction measures to common database • "Best" hospitals rewarded with higher patient volumes • All hospitals use data to improve quality and to reduce costs
Geographic Coverage	Payers contract with providers who can maximize patient access through broad geographic coverage	<ul style="list-style-type: none"> • Two hospitals in adjoining market areas contract jointly • Result: Hospitals can provide services to patients in a (now expanded) geographic area

Observation #3

Advisory Board View: Even best hospital-hospital collaborative efforts not central to winning (profitable) managed care and capitated contracts; vertical integration with physicians much more central to profiting from managed care

**Hospital-Hospital Partnerships Do Not Offer Payers
What Integration with Physicians Can**

Appropriate Physician Mix

- Payers want to align with systems that have close ties with an appropriate mix of physicians; hospital collaboration in no way rationalizes the mix and number of physicians on their respective medical staffs

Appropriate Modality of Care

- Payers are drawn to systems in which physicians direct patients to the appropriate care modalities within the system, so that care can be delivered in the most cost-effective locations; hospital collaboration does not ensure that physicians will direct patients within full network of care options

High Quality of Care

- Payers want to observe the highest quality care at the lowest cost; hospital ties through collaborative efforts are too loose to ensure that physicians will adhere to joint standards for utilization review or quality assurance

Capitated Risk

- Payers increasingly want to contract with providers who will accept the capitated risk for the entire continuum of care (i.e., providers who accept a fixed price per month per enrollee for all health care services)
- Collaborative ties among hospitals do little to help manage this type of risk; economic integration between hospitals and physicians is much more important

Observation #5

In fact, joint programs which actually achieve lower costs or higher quality than could have been realized by the partners independently are very likely to appeal to payers (and lead to increased patient volumes for all hospitals involved)

Joint Venture To Pursue Capitated Contracts for Pediatric Patients Increases Patient Volume for Both Partners

Two Hospitals Pursue Capitated Contracts

- Community hospital and children's hospital create a joint venture to pursue capitated contracts that allow providers to supply all health care services to a given population of children for a set amount of money per month

Treatment in Appropriate Modality Appeals to Payers

- Appeal to Payers: joint care provision allows highest-quality care in the most cost-effective setting
- Community hospital is most cost-effective for "routine" care; children's hospital most efficiently treats complex cases
- Physicians guide patient to the best-suited, most cost-effective care available in the network; patient may be admitted to community hospital, transferred to children's hospital for specialized care, then sent back to community hospital for less-expensive recovery

Result: Enhanced Patient Volumes, Improved Quality

- Low-cost, high-quality treatment possible through collaboration appeals to payers; one (very large) capitated contract negotiated so far
- Both hospitals report enhanced patient volumes as well as stable or increased market share through collaborative effort
- Surveys of patient families, physicians, nurses and hospital staff members indicate that jointly-developed standards of care, other quality assurance measures have significantly enhanced quality of care

Source: Richard J. Miller, et al., "Joint-Venture, Capitation Model Can Strengthen Market Share," *Healthcare Financial Management*, June 1991, page 92; Advisory Board interviews.

Collaborative Outcomes Tracking Increases Quality, Reduces Costs

Hospital Collaboration Allows Purchaser Assessment of Providers

- Through collaborative venture, 30 hospitals report uniform measures of outcomes and patient satisfaction, which are compiled in semiannual reports and distributed to local employers
- Area purchasers (representing 350,000 covered lives) then provide strong incentives to their employees to utilize hospitals achieving the best patient outcomes at the lowest cost

(Predicted) Result: Increased Volumes for High-Quality Hospitals, Improved Performance for Others

- Theory: Hospitals that perform best will be rewarded with greater patient volume, while those that are below average will have a powerful incentive to improve quality and/or reduce costs
- Two semiannual data reports have been distributed to date; while no hard data available, hospitals reportedly are using information internally to improve services, and employers are evaluating the data (although no purchasing decisions have yet been made)

Hospitals, Employers, Physicians Build Comprehensive Outcomes Tracking Database

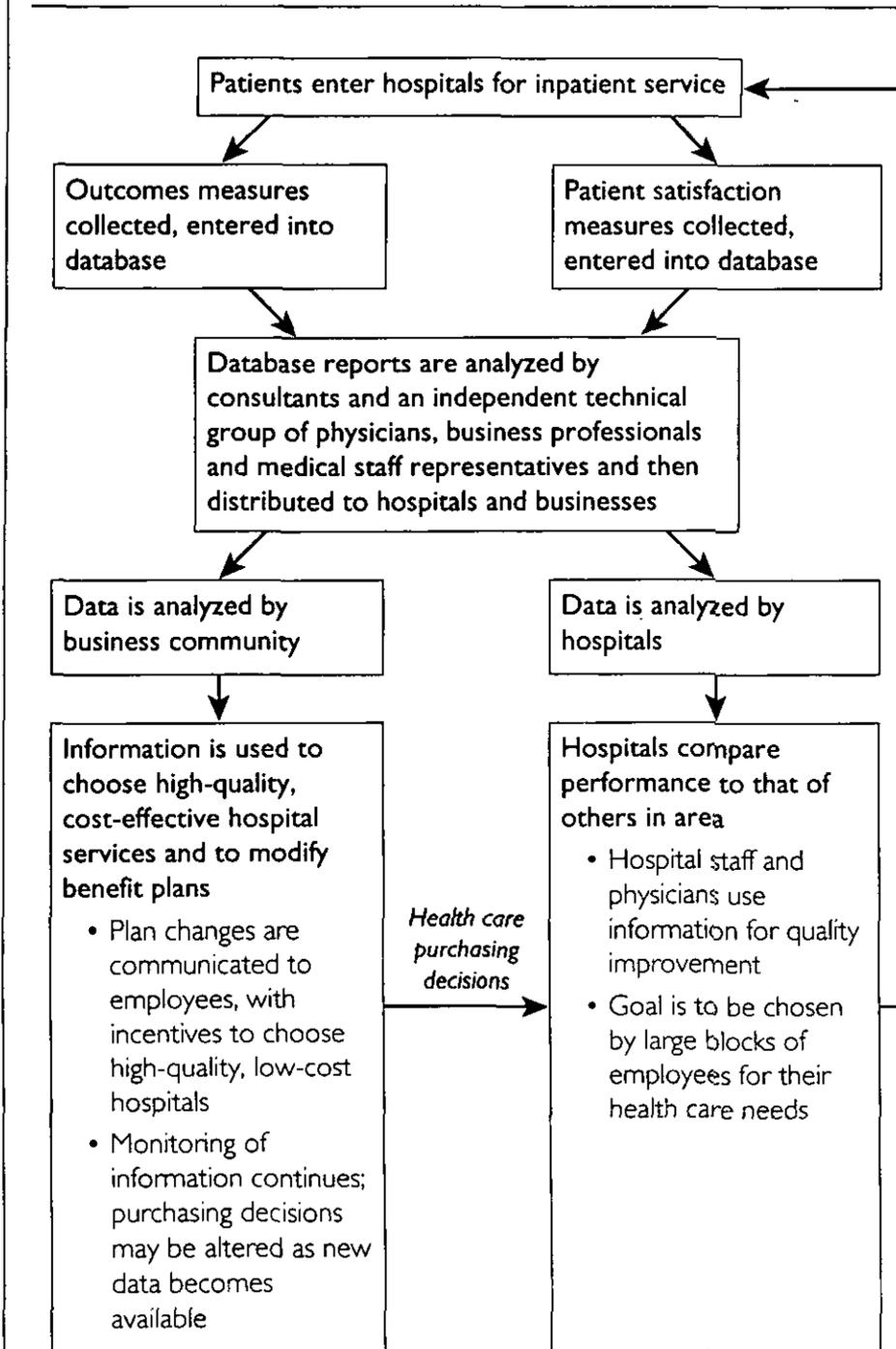
Description

Thirty hospitals, area physicians, and local employers form voluntary coalition to measure and report patient outcomes

Goal is Twofold: To allow area purchasers (representing 350,000 lives) to encourage patients to choose high-quality, cost-effective providers, and to allow providers to see how they “stack up” against competitors (so they can improve performance)

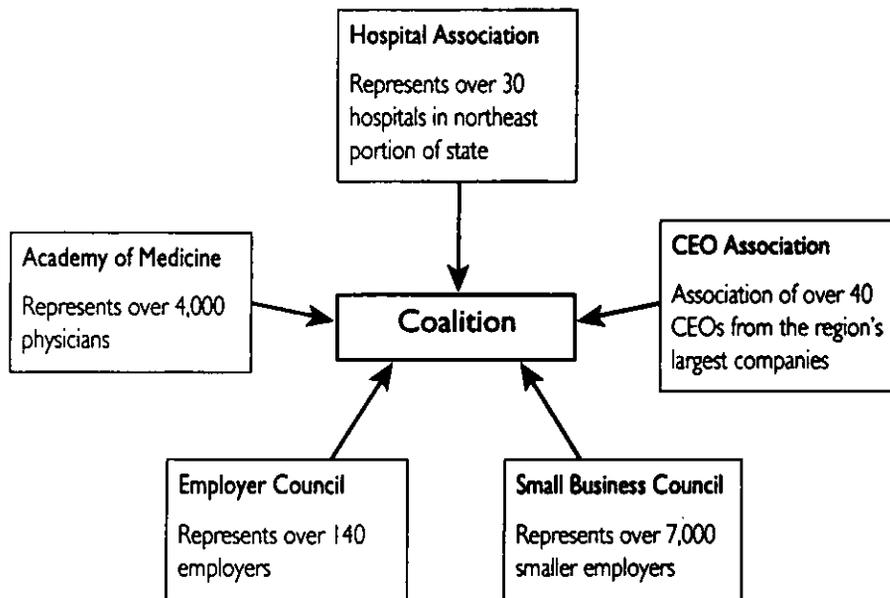
- Hospitals report uniform measures of outcomes and patient satisfaction; local employers then provide strong incentives to their employees to utilize hospitals achieving the best patient outcomes at the lowest cost
- Theory: Hospitals that perform best will be rewarded with greater patient volume, while those that are below average will have a powerful incentive to improve their performance
- Over time, increase in system-wide productivity will help to finance the cost of extending coverage to the uninsured and underinsured

Outcomes Data Drives Purchasing Decisions, Internal Improvement



Coalition participants include both employer and provider organizations, representatives of which administer program

Coalition Comprised of Employer and Provider Organizations



Measures of patient outcomes and patient satisfaction are supplied by hospitals according to uniform standards; two comprehensive data reports are published annually and distributed to coalition members

- Program uses two outcomes tracking models to compare general medical, intensive care, general surgical, and obstetrics/gynecology outcomes across hospitals, as well as a questionnaire to determine patient assessment of care

Variety of Clinical, Patient Satisfaction Measures Are Collected

General Medical Outcomes

- Comparison of (severity-adjusted) observed outcomes with:
 - Predicted mortality
 - Predicted length of stay
- Tracking of outcomes measurements for five medical conditions:
 - Heart attack
 - Congestive heart failure
 - Stroke
 - Pneumonia
 - Chronic obstructive lung disease

Intensive Care Outcomes

- Comparison of (severity-adjusted) observed outcomes with:
 - Predicted mortality
 - Predicted length of stay

General Surgical Outcomes

- Comparison of (severity-adjusted) observed outcomes with:
 - Predicted length of stay
- Tracking of outcomes measurements for eight surgical procedures:
 - Coronary artery bypass
 - Major blood vessel repair or bypass
 - Lung resection
 - Lower bowel resection
 - Spine surgery
 - Repair of fracture and hip replacement
 - Prostatectomy
 - Hysterectomy

Obstetrics and Gynecology Outcomes

- Comparison of (severity-adjusted) observed outcomes with:
 - Predicted mortality
 - Predicted length of stay
 - Predicted Cesarean-section rate
 - Hospital-acquired adverse events
 - Neonatal outcomes
- Tracking of outcomes measurements for:
 - Live births

Patient Satisfaction Questionnaire

General Questions:

- Would patient return to hospital for treatment?
- Would patient brag about hospital to others?
- Would patient recommend hospital to friends and family?

Specific Questions:

- Sixty-nine questions regarding eleven areas of hospital service:
 - Admission procedure
 - Daily care
 - Securing information
 - Nursing care
 - Physician care
 - Ancillary services
 - Housekeeping
 - Living arrangements
 - Discharge
 - Billing
 - Food quality

Costs

During two years of start-up and operation, program incurred \$3 million in annual costs for vendor fees, abstraction and data fees, and system development; three-quarters of cost borne by hospitals, while remainder is financed by corporations and foundation grants

Results

Two semiannual data reports have been distributed to date; while no hard data available, hospitals reportedly are using information internally to improve services, and employers are evaluating the data (although no purchasing decisions have yet been made)

Coalition expects that more disease- and procedure-specific information will be available in the future; Reason: As database expands, sufficient volumes of patients will permit further refinement of data

Source: Coalition documents; Advisory Board interviews.

Two Hospitals Pursue Capitated Contracts for Pediatric Patients, Increase Patient Volume

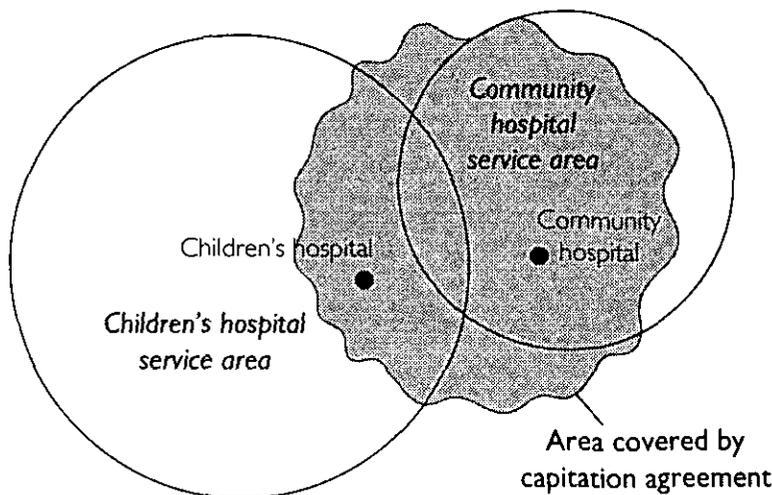
Description

Children's hospital and community hospital create a joint venture to pursue capitated contracts to provide all health care services to a given population of children for a fixed amount of money per month

Goal is to attract managed care contracts by providing the most cost-effective care possible; theory that community hospital is more cost-effective for "routine" care, while children's hospital more efficiently treats complex cases

- Children's hospital receives more than 50% of patient volume from its primary service area; market share is significantly lower in secondary service area
- Community hospital provides a full range of inpatient and outpatient services; hospital includes a 16-bed pediatric unit and can provide newborn nursing for 37 infants
- Hospitals recognized opportunity to lower costs and improve service delivery by jointly providing inpatient care to capitated patients within a designated geographic area

Capitation Agreement Covers Large Portion of Hospitals' Service Areas



Source: Richard J. Miller, et al., "Joint-Venture, Capitation Model Can Strengthen Market Share," *Healthcare Financial Management*, June 1991, page 92.

Five Benefits to Joint Capitation Arrangement

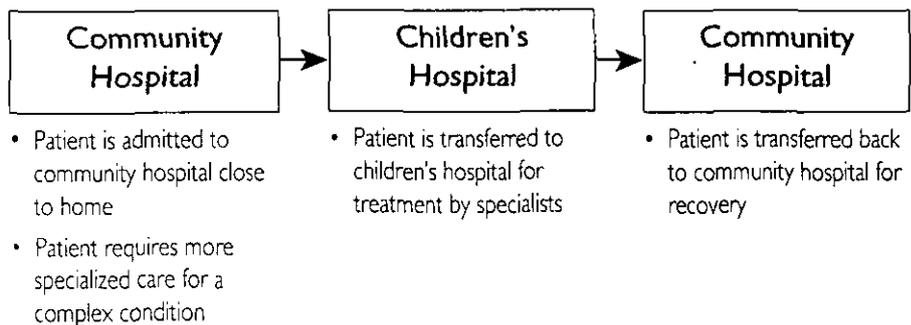
- Benefit #1** Increased market share
- Benefit #2** Positive cash flow (if costs are effectively controlled)
- Benefit #3** Increased referrals to and between hospitals
- Benefit #4** Improved quality and reduced financial risk
- Benefit #5** Lower costs, as treatment will occur in the least costly environment

Source: Richard J. Miller, et al., "Joint-Venture, Capitation Model Can Strengthen Market Share," *Healthcare Financial Management*, June 1991, page 92.

Children’s hospital provides most tertiary services, consulting expertise and case management services; community hospital provides routine patient care as well as administrative functions

- Physicians guide patient to the best-suited, most cost-effective care available in the network; patient may be admitted to community hospital, transferred to children’s hospital for specialized care, then sent back to community hospital for less expensive recovery
- At each stage of treatment, the patient is covered in full by the capitated contract

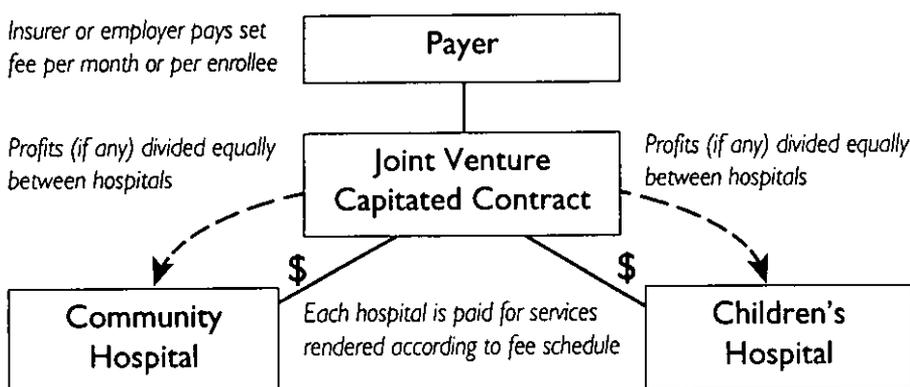
Patient Receives Care in Most Cost-Effective Setting



Hospitals share the financial risk of contract regardless of where care is given; hospitals each maintain separate budget for contract activities and track revenues and expenses independently, but split combined profits (or losses) at end of year

- Community hospital utilizes a special cost-accounting system to track all expenses (direct, indirect, overhead) for contract population
- Direct expenses and revenue associated with pediatric and newborn services are separately cost-accounted—community hospital collects revenue from contracts and each institution's costs are reimbursed through contract fund; any surpluses (or shortages) shared equally
- Indirect expenses are allocated based on generally accepted accounting principles

Hospitals Share Financial Risk Equally



No joint governance structure exists; hospitals have a written agreement which outlines responsibilities of each hospital, with different staff members accountable for various initiatives

- Chief financial officer of children's hospital oversees capitated contract
- Hospital staff members are assigned to oversee joint quality efforts and other initiatives; under the joint venture:
 - Quality assurance policies have been revised
 - New patient care policies have been implemented
 - Staff members at community hospital have been trained in specialized patient care approaches
 - Availability of pediatric supplies and equipment has improved

Costs

Development costs were minimal, comprised solely of hospital staff time

- Children's hospital devoted full-time nursing director and full-time head nurse to the planning process for approximately one year (at a cost of about \$75,000)
- Community hospital's staff nurses participated during the development of quality initiatives

Results

One (large) capitated contract jointly negotiated so far; both hospitals report enhanced patient volumes, improved quality of care due to collaborative effort

- Hospitals report that increases in patient volumes have compensated for minimal stand-alone operating losses (approximately \$50,000 annually)
- Both hospitals have been able to maintain or slightly increase their respective market shares through participation in the joint venture
- Surveys of patient families, physicians, nurses and hospital staff members indicate that revised standards of care, other quality assurance measures have significantly enhanced the quality of care provided at the community hospital

Source: Richard J. Miller, et al., "Joint-Venture, Capitation Model Can Strengthen Market Share," *Healthcare Financial Management*, June 1991, page 92; Advisory Board interviews.

Two Systems Join Forces To Build Comprehensive Provider Network

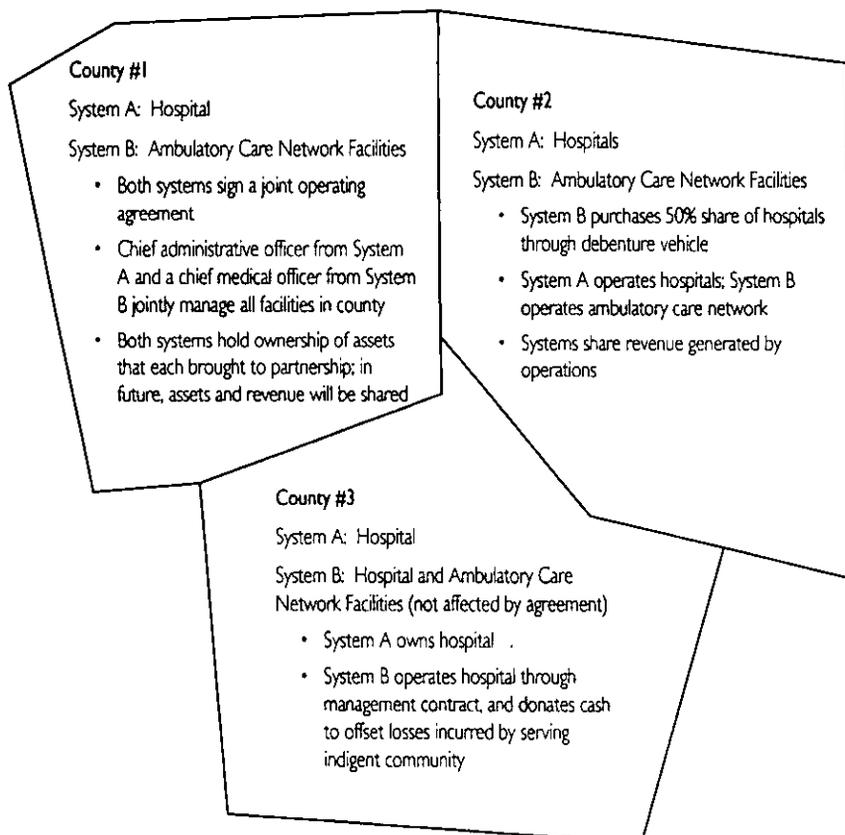
Description

Two health care systems integrate clinical services within overlapping markets; goal is to create a cost-effective system with the geographic coverage to serve both systems' managed care populations

- Each system brings to the partnership a unique area of strength
 - System A has a number of acute care facilities
 - System B has a strong primary care network

Joint projects aimed at consolidating services in three counties (at most, 50% of either system's service area is affected by agreements); full integration is not appropriate as each system must focus independently on non-overlapping markets

Management and Profit-Sharing Arrangements Vary in Each County



Systems are forming joint PHO and collaborating on tertiary service projects; future goals include consolidation of additional services to avoid duplication

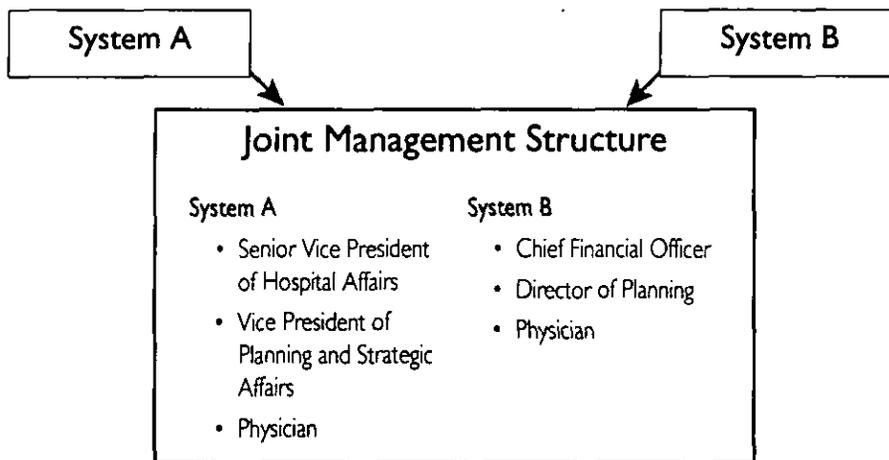
Numerous Collaborative Efforts Are Planned or Under Way

<i>Projects</i>	<i>Description</i>
Joint PHO	A PHO for physicians not already in groups to facilitate managed care contracting
Cardiology Services	A joint heart and vascular institute
Oncology Services	Service duplication will be avoided by: <ul style="list-style-type: none"> • Jointly purchasing and operating radiation therapy equipment • Avoiding creation of new brain tumor program at one system (since one already exists at second system) • Reducing duplication of expensive equipment • Using existing specialists to handle increases in patient volume generated by contracts • Improving referral relationships
Emergency Department Services	Coordination between EDs will be improved by: <ul style="list-style-type: none"> • Sharing patient records through electronic links • Combining (low) nighttime patient volumes at one ED
Future Projects	<ul style="list-style-type: none"> • Managed care • Ambulatory care • Kidney dialysis • Graduate medical education • Home health care

Joint management structure created to oversee all aspects of arrangement; responsibilities include consideration of shared strategic concerns as well as joint management of one hospital

- No dedicated staff of joint structure; staff members of two systems are drawn in to handle certain directives as needed, while projects are assigned by joint management structure

Joint Management Structure Includes Six System Representatives



Responsibilities

- Oversight of shared strategic issues:
 - Capital expenditure
 - Physician recruitment/practice purchase
 - Joint operating budget
 - Strategic planning
 - Assessment of future collaborative ventures
- Management of one hospital

Costs

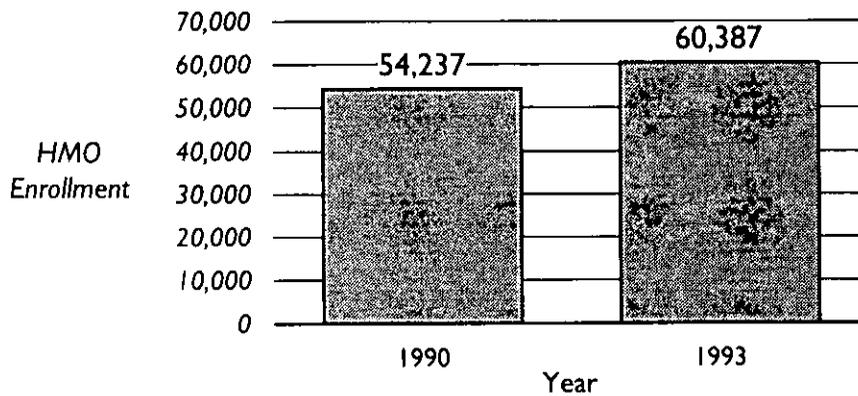
Systems spent three years developing network; while precise data is unavailable, hospital management reports that largest investment was staff time invested in building partnership

Results

Combined systems offer a full continuum of services that each system alone could not provide; network is well-positioned to meet managed care demands

Patient volume has increased markedly since joint efforts began; systems speculate that collaboration has contributed significantly to this growth

**HMO Enrollment at One System
Increases 11% In Years Since Affiliation**



Source: Advisory Board interviews.

Case Example #23

Consortium Develops Collaborative Programs in Cardiac Services

Description

Consortium of hospitals, physicians and community groups created to determine feasibility for statewide planning of cardiac services; goal is to improve the quality and cost-effectiveness of cardiac care services available to the community

- Consortium is a partnership between community representatives, physicians and 15 hospitals with open heart programs
- Group is committed to the design and support of an integrated regional cardiac care system

Collaborative Cardiac Effort Aims To Improve Quality, Reduce Costs

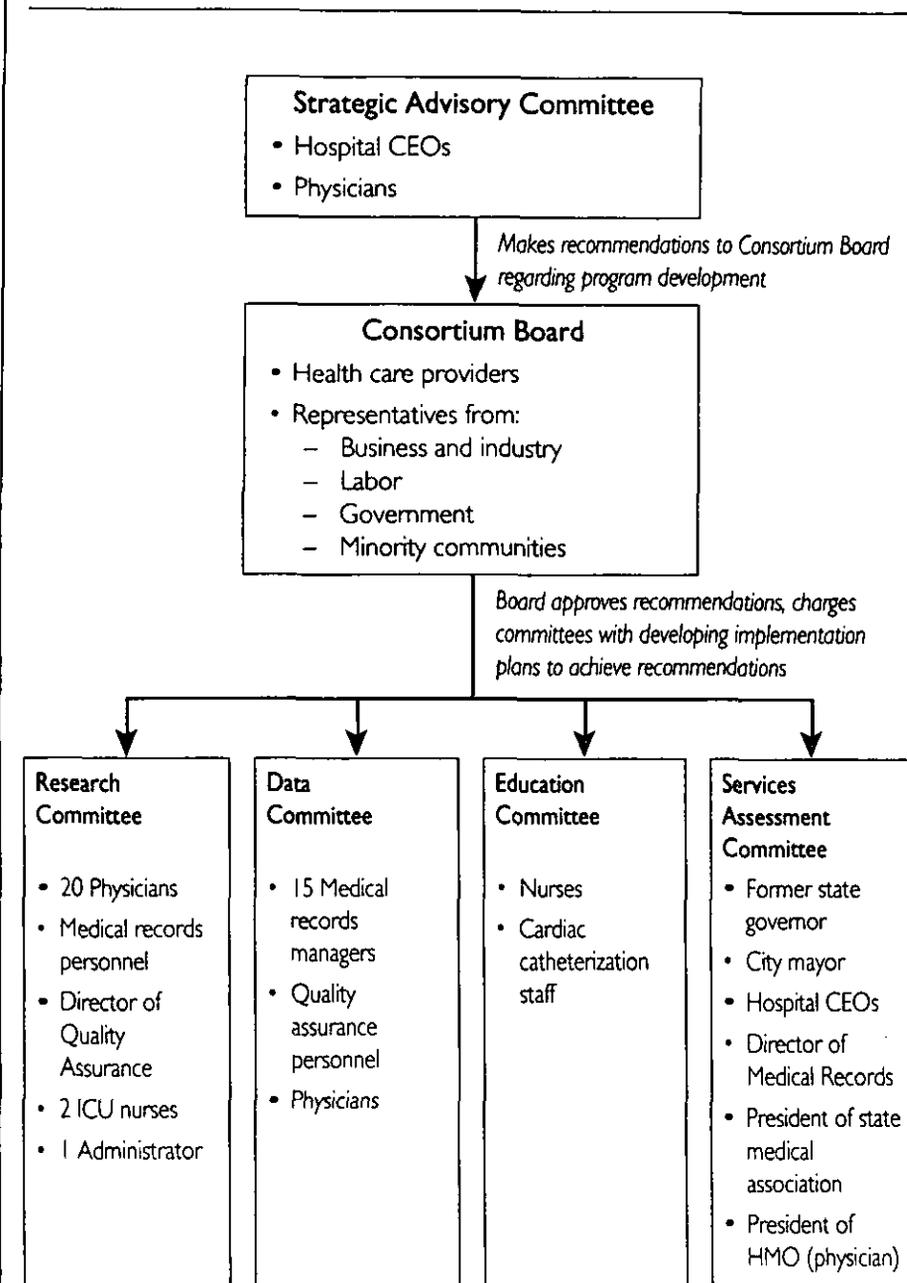
- Improve utilization and cost efficiency of cardiac services
- Institute quality and outcomes tracking systems
- Provide community and professional education
- Support clinical research
- Provide care to the indigent

Initial step of consortium was to assess the supply of (and demand for) cardiac services in the area

- Market assessment study was performed by an independent consultant
- Study found excess market supply; most programs handling volumes under the minimum recommended as necessary for cost-effective, high-quality care

Result: Consortium organized committee system to assess areas for collaboration; Strategic Advisory Committee develops plans and recommendations for consideration by community-based consortium board, while four committees develop work plans to implement recommendations

Four Committees Develop Work Plans To Achieve Consortium Goals



Costs

Initial funding of \$200,000 provided by hospital that spearheaded effort; ongoing funding for planning and operations has been contributed primarily by participating hospitals

Hospitals Contribute Bulk of Funds for Annual Operations

Fiscal Year	Contribution per Hospital
Year 1	\$20,000
Year 2	\$25,000
Year 3	\$15,000

Results

Several collaborative programs are up and running, including an indigent care project, educational symposia, research projects and a cardiology data base

Program #1: Indigent Care Project

- Primary focus is the organization and implementation of patient referral system that will provide care for cardiac patients who do not have sufficient insurance or income to afford such services
- Referral system is designed to insure that all providers share equally in the delivery of care, with services provided on a rotational basis by participating hospitals and physicians
- Access to program occurs through neighborhood clinics; clinic physician serves as primary care provider and refers patients to participating cardiologists
- Organization and support of indigent program is handled by the Education Committee
- Program was initiated in January 1993; data on program costs is currently being collected

Program #2: Educational Symposia

- Consortium offers ongoing educational programs for cardiologists, cardiovascular surgeons, primary care physicians, nurses and other professionals
- Programs are designed to:
 - Improve the caregivers' knowledge base and skill level
 - Provide cardiology professionals with exposure to state-of-the-art technologies and emerging practice modalities
 - Offer cardiac teams opportunities to network with peers throughout the state
- Programs planned for 1993 include an ethics symposium and a meeting that will address new and emerging technologies; a conference on electrophysiology is planned for 1994
- Planning for educational efforts is supported by the Education Committee

Program #3: Research Projects

- High volume of patients represented by participating providers is attracting major studies conducted by external groups; numerous research projects are on the horizon, including:
 - Large clinical trials sponsored by pharmaceutical companies and device manufacturers
 - Research focusing on surgical outcomes
- Income generated by studies will help fund Consortium-initiated research
- Research Committee is responsible for developing the necessary policies, procedures and guidelines pertaining to research activities and for reviewing and approving projects

Program #4: Cardiology Data Base

- Uniform cardiology data base was organized in 1993 to provide reports that will enable Consortium participants to review and examine outcome, quality, appropriateness and cost effectiveness of cardiology services
- Initial data set was created from information available from state hospital association and other organizations
- Study groups will be organized to receive (and respond to) research and results; groups will:
 - Provide Consortium participants with an opportunity to review key data pertaining to the delivery of cardiac services
 - Review practice processes, outcomes, and variations
 - Present recommendations for education and quality improvement
- Three study groups have been appointed for 1993:
 - Cardiology Practice Study Group
 - Surgical Outcomes Research Study Group
 - Male/Female Cardiac Variations Study Group
- The Data Committee provides advisory and technical support for the study groups

Source: Advisory Board interviews.

Chapter Four: Forming “Quasi-Mergers”

Legal Caveat

Joint ventures to form quasi-mergers will likely raise complex legal issues regarding antitrust behavior.

The Advisory Board strongly suggests that hospitals considering the pursuit of such ventures consult with legal counsel.

Six Salient Observations on Forming “Quasi-Mergers”

Observation #1

Most elaborate form of hospital partnerships: efforts to create a “quasi-merger”; these ventures attempt to achieve the benefits of an equity merger while retaining autonomy for the partners via separate boards, management structures and operating budgets

Observation #2

Advisory Board View: While quasi-mergers can result in some significant benefits for partners, such efforts fall far short of what a full equity merger could achieve in terms of maximizing bottom-line profitability

Observation #3

Reason: Key strategic decisions that could move hospital partners forward are almost impossible to implement without a clear authority that puts the good of the partnership above the needs of one (otherwise autonomous) partner

Observation #4

Typical Example: Rationalizing clinical services; decisions to move clinical service to one hospital or another will be hampered by each partners' desire to retain the most lucrative services

**Advisory Board Hypothetical:
Rationalizing Cardiac, OB Services
Can Leave One Hospital a Financial "Loser"**

	Hospital A	Hospital B
Annual Profits from Cardiac Services		
Before Service Rationalization	20%	80%
	Annual Profits = \$2.0 Million	Annual Profits = \$8.0 Million
After Service Rationalization	0%	100%
	Annual Profits = \$0	Annual Profits = \$10.5 Million*
Annual Profits from OB Services		
Before Service Rationalization	70%	30%
	Annual Profits = \$1.4 Million	Annual Profits = \$0.6 Million
After Service Rationalization	100%	0%
	Annual Profits = \$2.5 Million*	Annual Profits = \$0
Total Annual Profit (Loss) from Two Services		
Before Service Rationalization	\$3.4 Million	\$8.6 Million
After Service Rationalization	\$2.5 Million	\$10.5 Million
Change in Profit	(\$0.9 Million)	\$1.9 Million

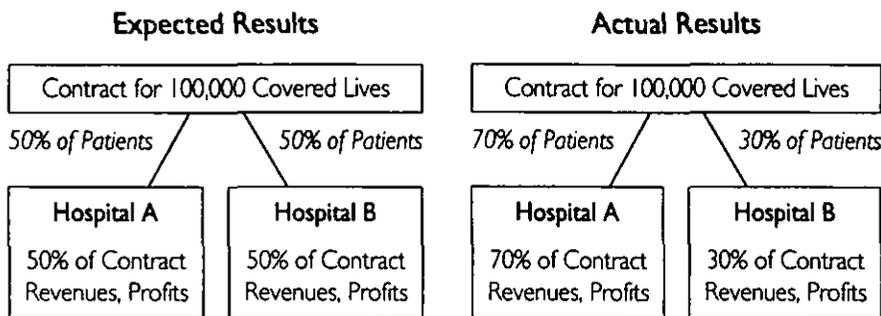
* Assumes that service rationalization boosts overall profits by \$500,000.

Observation #5

Other (all-important) cost-cutting and revenue-generating initiatives are similarly difficult to execute in the absence of a full merger

Profit Allocation May Undermine Collaborative Managed Care Contract

- In a full equity merger, hospital system negotiates managed care contracts, the profits from which accrue to the system as a whole regardless of treatment location
- In a collaborative venture, one partner is likely to "lose out" if enrollees do not use the services of each hospital as anticipated; Result: Contract may "break down" after one year, as "losing" hospital seeks to negotiate new deal on its own
- Hypothetical Example: Two hospitals sign capitated contract covering 100,000 covered lives; revenues from contract allocated according to actual patient usage of the two hospitals
- Initial forecasts indicate that an equal number of patients are projected to use each hospital, so that revenues are expected to be divided "50/50"; instead, 70% of enrollees use one hospital, leaving management of the other institution (rightly or wrongly) feeling "cheated," and unwilling to renew the deal:



Reducing Corporate Staff Difficult To Achieve without Merger

- In a full equity merger, the resulting entity can reduce corporate overhead by mandating that administrative positions be cut, and that FTEs in clinical departments be combined
- In most collaborative efforts, corporate staff reductions are difficult (if not impossible) to achieve, since each (autonomous) partner has an interest in retaining a full complement of corporate and clinical administrative staff

Observation #6

That said, quasi-mergers can be a useful step on the road to a full merger (and they may produce some moderate financial benefits along the way); only problem is if hospitals view these arrangements as a substitute for the "real thing"

Quasi-Merger Helps Two Hospitals Boost Profits \$1.3 Million

Two Hospitals Form Quasi-Merger

- Two hospitals affiliate to create a health system which shares governing body only; each hospital retains independent license, CEOs, medical staffs and foundations

Hospitals Merge Support Areas

- Hospitals merged administrative departments (including marketing, finance and strategic planning) and pursued cost savings opportunities through synergies in support functions

Result: \$1.3 Million in Cost Savings, Revenue Enhancement

- Initiatives projected to generate an estimated \$1.3 million in profit improvement annually; three-fourths of this improvement was due to cost savings from consolidation of administrative areas and joint administrative projects. Examples include:
 - Reduction in collection fees due to enhanced negotiating clout with collection agency
 - Savings on insurance premiums by combining policies
 - Operational cost savings through centralization of discharge planning
 - Savings on TPA fees and employee benefit program expenses through Human Resources Plan consolidations
 - Reduction in audit fees by consolidating contracts with one audit firm
 - Sharing of legal, accounting, and architecture services
 - Sharing of laundry services
 - Increase in interest income through better management, coordination of investments

Two Hospitals Use Quasi-Merger as First Step Toward Full Equity Merger

Quasi-Merger Is First Step in Creating Merger

- In first step toward full merger, two hospitals seek to attain efficiencies while maintaining independence by creating one holding company with two "brand names"
- Joint holding company created to merge both governance structure and balance sheets; company oversees all major support areas for both institutions:
 - Strategic Planning
 - Information Systems
 - Human Resources
 - Finance
 - Facilities Management
 - Materials Management
- Hospitals plan to finalize full equity merger within several years

Initial Efforts Generate Cost Savings

- To date, significant cost savings have been achieved by combining several support areas, including corporate administrative staff, information systems, purchasing and laundry services

Future Goal: Full Equity Merger, Clinical Service Rationalization

- Once full merger is in place, hospitals plan to rationalize as many as 15 clinical services:

– Pulmonary-Thoracic Services	– Orthopedics
– Cardiology	– Urology
– Obstetrics/Gynecology	– General Medicine
– Psychiatry	– Renal Services
– Ophthalmology	– Gastroenterology
– ENT	– Dental Services
– General Surgery	– Geriatric Services
– Plastic Surgery	
- Clinical services will be evaluated individually to determine if services would best be located in one hospital or in a joint ambulatory facility
- One clinical area—psychiatry—is currently planned for rationalization; plan will consolidate all psychiatry services at one hospital (which previously accounted for 80% of two-hospital psychiatry volume) at a projected cost savings of \$600,000

Two Hospitals Merge Support, Clinical Areas, Report Substantial Profit Increase

Description

Two hospitals seek to attain efficiencies possible while maintaining independence through creation of one holding company with two "brand names;" new organization is first step in actual merger with third health system partner

Goal is to gain operating efficiencies of a merger while retaining the market identities of both institutions for marketing and fund-raising purposes

Joint Holding Company Oversees Support Areas for Two Hospitals

- Strategic Planning
- Information Systems
- Human Resources
- Finance
- Facilities Management
- Materials Management

Clinical efficiencies will be realized by determining where to locate each of 15 clinical services

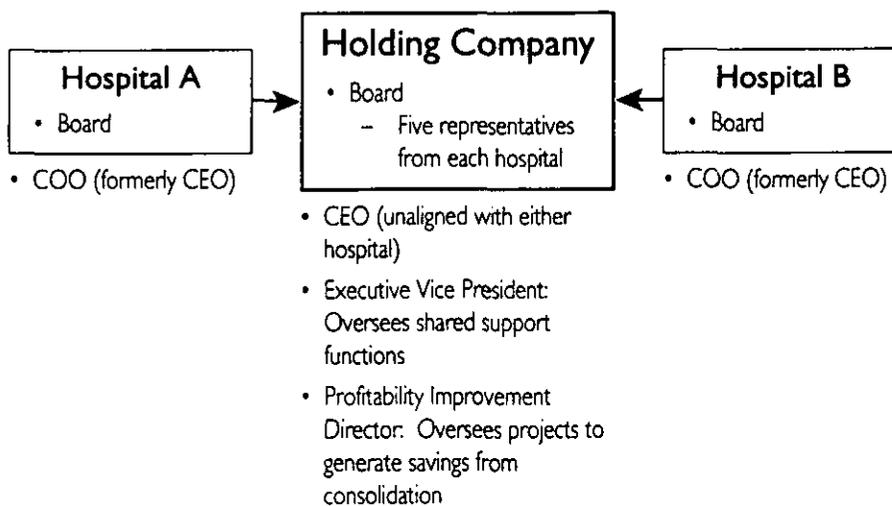
- Clinical services are evaluated individually to determine if services would best be located in one hospital or in a joint ambulatory facility
- Hospital medical staffs were already under one leadership through their joint affiliation with a medical school

Fifteen Clinical Services Being Evaluated for Merger

- | | | |
|-------------------------------|-------------------|----------------------|
| • Pulmonary-Thoracic Services | • ENT | • General Medicine |
| • Cardiology | • General Surgery | • Renal Services |
| • Obstetrics/Gynecology | • Plastic Surgery | • Gastroenterology |
| • Psychiatry | • Orthopedics | • Dental Services |
| • Ophthalmology | • Urology | • Geriatric Services |

Holding company has a board consisting of five members from each hospital's board; hospitals retain their separate boards to support institution-specific efforts (e.g., fund raising)

Hospitals Are Equally Represented on Holding Company Board



Costs

Costs of developing venture undoubtedly large, including significant legal and consulting fees as well as staff time; hospitals unable to provide exact cost figures

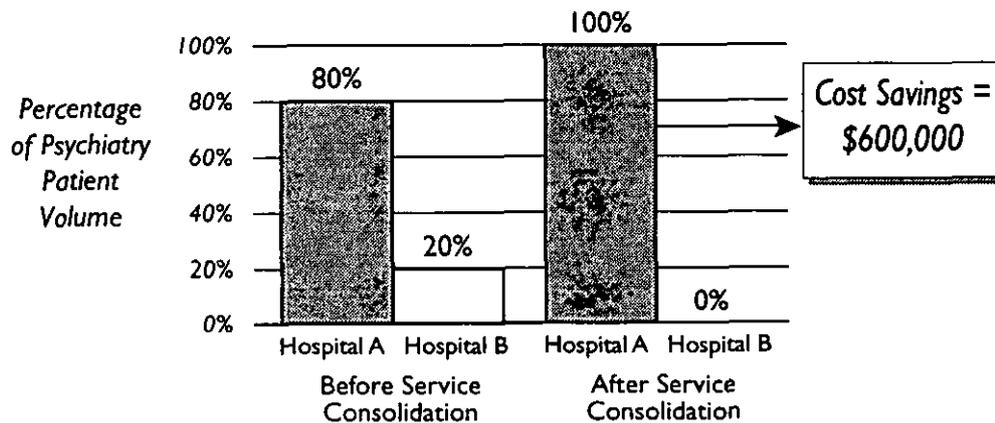
Results

Hospitals reporting first-year profitability improvement of \$11 million; senior management of both institutions feel that the collaborative effort has been a major contributor to the increase

According to hospitals, significant cost savings have occurred as a result of combining support areas such as corporate staff functions, information systems, purchasing and laundry services

Some (moderate) cost savings can be attributed to rationalizing clinical services; consolidating psychiatry services expected to save \$600,000

Consolidating Psychiatry Services Will Yield \$600,000 Cost Savings



Source: Advisory Board interviews.

Four Hospitals Use “Quasi-Merger” To Generate \$1.25 Million in Additional Managed Care Contract Revenues

Description

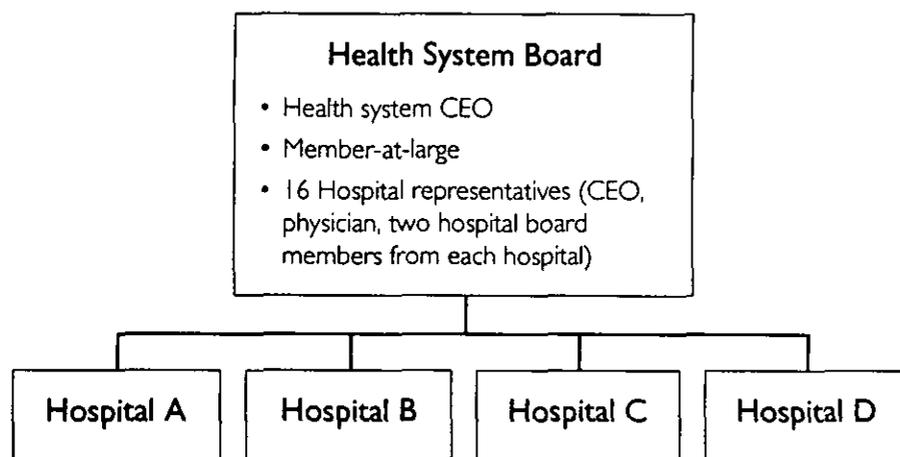
Four hospitals form a fully-affiliated health care network; goal is to provide a competitive advantage by attracting (and profitably managing) managed care contracts, and by cutting costs through service rationalization

- Network includes four hospitals and a merged home health agency
- Network is closely aligned with a variety of physician groups, each of which has assumed and managed capitated risk both independently and collectively with hospitals:
 - Three large multi-specialty clinics
 - A faculty practice plan
 - Independent physicians
- Managed care penetration in area is 35%-40%; hospitals are interested in maintaining and growing their managed care patient volume as market evolves

The hospitals formed a holding company structure with common governance; they merged budgeting and strategic planning, yet each institution remains operationally independent

- Holding company has a CEO and five other staff members; CEO explores network expansion opportunities (with other hospitals and physicians), while other staff supports finance, clinical and managed care initiatives
- Board has 18 representatives, with each hospital represented by two of its own board members, its own CEO and a member of its medical staff; one at-large member and the system CEO are also on the board

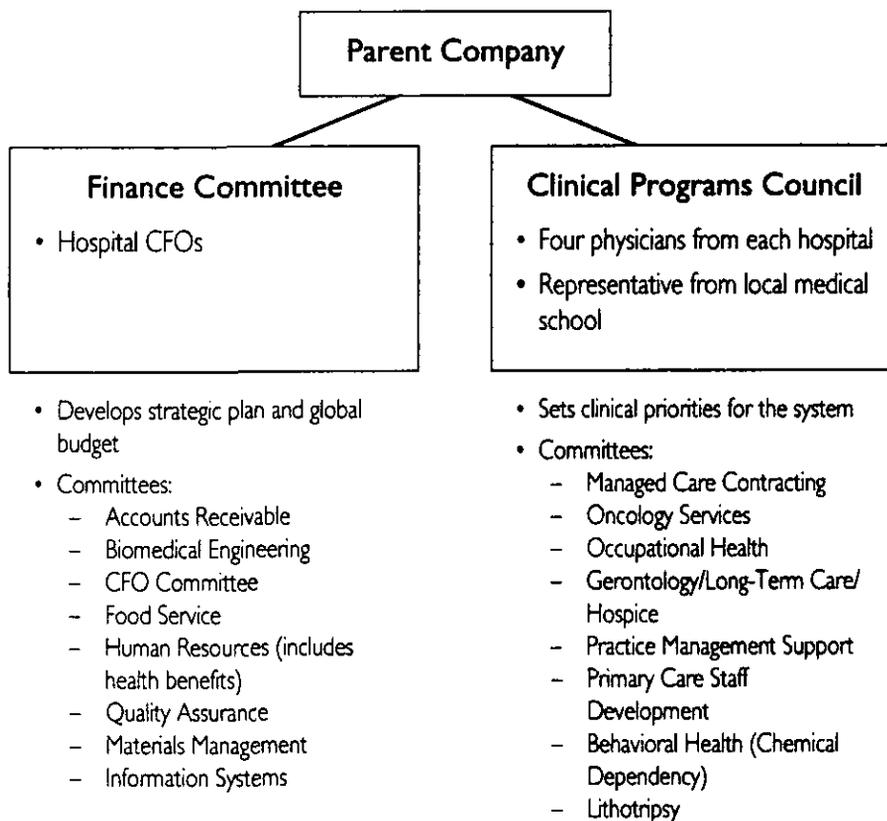
Governance of Holding Company Is Shared by Four Hospitals



Parent company is supported by two committees; each committee forms and oversees subcommittees comprised of member hospital medical staff and other personnel who direct joint activities

- Finance Committee develops the affiliation’s strategic plan and global budget; intent is to assure that joint activities complement the system’s strategic plan by allocating resources so as to reduce administrative costs
- Clinical Programs Council sets clinical priorities for the system; goal is to focus on specific clinical integration opportunities
 - First step was to identify core services at each hospital and build on strong existing programs; hospitals will not add services that would be competitive within the system (thereby avoiding any newly-created duplication of services)
 - Second step will be to consider currently duplicated services and develop a plan for consolidating them

Parent Company Supported by Two Committees



Costs

Start-up costs were minimal (\$450,000), and ongoing operating expenses equal \$300,000 for each hospital

- Start-up costs for joint venture amounted to \$450,000 in legal and consulting fees
- Annual operating costs are \$1.2 million, split equally among four hospitals

Results

Participants feel well-prepared to meet demands of future managed care environment and health care reform

Evidence: Affiliation has already signed or renegotiated 20 managed care contracts since its formation in 1989; contracts contribute \$25 million in net revenues to the system, \$1.25 million of which is directly attributable to collaborative effort

Annual operating expense of \$300,000 per hospital more than justified by collaboration's significant contribution to each hospital's bottom line; early efforts of task forces yielding positive results

- Shared mobile lithotripsy unit project underway in only 90 days, improving physician convenience and patient access and resulting in increased referrals to the system
- Materials management task force cut costs by \$1 million:
 - 40% from jointly-negotiated capital acquisitions
 - 60% from purchase of supplies and materials (e.g., contrast media for diagnostic imaging, laundry services, paper products and consulting services)
- Occupational health task force developed network for referrals among the three hospitals, which includes standardized protocols for care and a shared information network
- Human resources task force created a merged health plan for hospital employees, thereby increasing provider choice and encouraging internal referrals

Source: "Hospitals Seek New Ways To Integrate Health Care," *Hospitals*, April 5, 1992, pages 26-36; Advisory Board interviews.

Two Hospitals Negotiate “Quasi-Merger,” Boost Profits by \$1.3 Million, Enhance Relations with Payers

Description

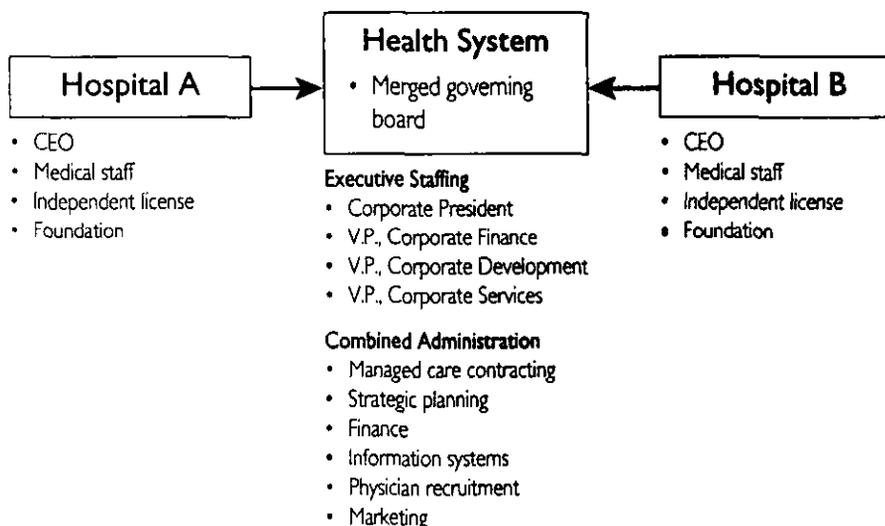
Two hospitals affiliate to create a health system which shares governance, but not balance sheets

Goal of hospitals was twofold: main goal was to become more attractive to managed care payers, while secondary goal was to achieve major operating cost savings and revenue enhancement through collaborative efforts

Hospitals merged governing boards into a 19-member board of directors, with 13 members coming from the larger hospital (division of representation based upon relative asset holdings); each hospital retains independent license, CEOs, medical staffs and foundations

Hospitals moved all top administrative posts to the system level, and fully integrated their information systems; merged administrative departments include marketing, finance and strategic planning

Hospitals Merge All Administrative Departments



To improve hospital finances, system formed 12 operational improvement forums with staff from both hospitals; forums are responsible for generating cost-cutting and revenue enhancement ideas

**Twelve Operational Improvement Forums
Develop Numerous Collaborative Projects**

Operational Improvement Forums

- Human Resources
- Information Systems
- Facilities Management
- Materials Management
- Financial Management
- Accounts Receivable Management
- Patient Care Delivery
- Continuum of Care
- Quality Management
- Resource Management
- Systems Management
- Skilled Nursing/Home Care

Collaborative Projects

- Developing shared information system
- Sharing legal, accounting, and architecture services
- Selecting one collection agency
- Sharing laundry services
- Combining laboratory services
- Combining employee benefits plans
- Combining insurance policies
- Coordinating cash management
- Improving coordination across the continuum of care to increase efficiency and increase referrals

Costs

Costs of joint efforts have been substantial: \$25 million was required to create an integrated information network, while \$3 million was used to develop a primary care support system at one of the hospitals

Results

Main goal of winning managed care contracts achieved well beyond initial hopes: every major HMO in area has contacted system for participation, while largest employer in area has signed capitated contract with the system

Secondary goal of cost reduction and revenue enhancement also being met: operating initiatives projected to generate \$1.3 million in cost savings, revenue increases annually

Operating Initiatives Result in Estimated \$1.3 Million in Annual Profit Improvement

Operating Initiative	Estimated Annual Profit Improvement	
	Year 1	Subsequent Years
Cost Savings		
Increase in interest income on cash reserves	\$170,000	\$170,000
Reduction in collection fees due to negotiating rate with one collection agency	\$140,000	\$140,000
Reduction in insurance premium due to combined insurance policies	\$135,000	\$120,000
Reduction in operating cost for centralized discharge planning	\$0	\$200,000
Savings on TPA fees and employee benefit program expenses through human resources plan consolidations	\$3,000	\$89,000
Reduction in MRI operating costs	N/A	\$150,000
Reduction in audit fees through contracting with one audit firm	N/A	\$50,000
Total Cost Savings	\$448,000	\$919,000
Revenue Enhancement		
Increase in home health admissions	\$100,000	\$200,000
Increase in acute rehab referrals	\$65,000	\$130,000
Payer contracting rate improvements	N/A	N/A
Home office cost report increase in Medicare reimbursement	\$30,000	\$30,000
Total Revenue Enhancement	\$195,000	\$360,000
Total Profit Improvement	\$643,000	\$1,279,000

Source: Advisory Board interviews.

Expert Sources

The Health Care Advisory Board would like to thank those individuals who contributed to this report. The experts listed below were especially giving of their time and expertise.

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