In-Depth Case Study: Southeast Medical Center

The following case study involving a large organized delivery system exemplifies many of the issues described earlier in this chapter.

History and Evolution

Southeast Medical Center (SMC; a pseudonym) was established as a public hospital in the 1920s, just before the Depression. Located in the Southeast, a $1 million bond financed the 250-bed facility. Major expansion projects in the 1950s increased the hospital's size to 600 beds. Formal affiliation with the local university's College of Medicine residency program in the 1970s further expanded capacity. Thus, SMC became a public academic health center and subsequently assumed multiple missions of patient care, teaching, and research. Capital improvement programs were conducted during the 1970s, and in 1982, a massive renovation and construction project ($160 million) added 550 beds to the facility. In the 1980s, a 59-bed freestanding rehabilitation center was opened adjacent to the hospital, and a physicians' office building was constructed next to the hospital. Medical helicopters were also acquired in 1989, expanding SMC's trauma services. In addition to serving as a regional provider for trauma, SMC also furnishes burn, neonatal, and transplant care for the region.

Responsibility for governance of SMC has shifted over the years. In the early years of operation, a hospital board ran SMC. In the 1940s, the city was given direct control over the hospital. In the 1980s, the state legislature created a public hospital authority (to be appointed by the county commission) to govern the hospital. In the 1990s, the hospital's board of trustees voted to turn operations of the hospital over to a private, not-for-profit corporation (501c-3), the SMC Corporation. However, oversight for charity care remained with the county's hospital authority. The SMC Corporation is directed by a 15-member board of directors and essentially manages the organized delivery system through a lease arrangement with the county hospital authority.

Today, SMC is a private, not-for-profit academic health center that is accredited by JCAHO. It also serves as the primary teaching hospital for the local university. Approximately 1100 private and university-affiliated attending physicians and more than 400 resident physicians in the university's College of Medicine residency program serve the community's medical needs. SMC also serves as the clinical site for associate, baccalaureate, and graduate nursing programs for the university and community colleges.

SMC serves as a regional and international referral service with more than 800 acute care beds. SMC has established community centers in a variety of locations, which has created increased access. In addition to specialized medical services, SMC is committed to providing community resources for education, information, and programs aimed at helping residents stay fit and healthy. Four out of ten patients that passed through the SMC's door came from outside the county.

SMC also operates an HMO health plan for charity care patients. In 1991, the County Commission established the SMC Health Plan to operate as a Medicaid HMO or insurance healthcare plan for the poor. The plan reimburses SMC on a case-by-case basis for medical services, but it also negotiates discounted rates and costs with the hospital. During the early 1990s SMC's payment from the health plan dropped substantially. In 1996, the program was under a freeze by the state and could not enroll participants for more than a year.

Thus, SMC is not just the hospital—it is a comprehensive organized delivery system that also includes facilities distinct from the hospital (i.e., SMC Health Plan). In addition, SMC ambulatory care centers are located throughout the county. SMC was the only public hospital in a metropolitan area with a population of one million or more that received no public subsidy. Most citizens believe that SMC was subsidized by their taxes. In 1971, the County Commission agreed to supplement hospital revenues with property taxes. In 1985, the county commissioners passed a quarter-percent sales tax to fund indigent care. The tax was repealed in 1987. In 1991, the county instituted a one-half percent sales tax to fund indigent care at all hospitals in the county, including SMC.

In sum, while SMC receives no public subsidy, it does receive a portion of the half-cent sales tax which depends on the preferences of the county commissioners each year. Unlike a direct subsidy, no public money is ever guaranteed.

As an academic health center (AHC) SMC has multiple, conjoined missions of teaching, research, and patient care. While providing patient care for approximately 40% of the nation's poor, AHCs are struggling to find a competitive position in today's rapidly changing healthcare environment. Until recently, they have enjoyed a privileged position atop the healthcare pyramid as a niche provider of tertiary services. With the growth of managed care and reductions in government funding, the ability of AHCs to compete is being drastically undercut.

It is widely recognized that multiple missions of teaching, research, and patient care contribute to the production of costly clinical services that are inconsistent with the demand for less expensive services in today's healthcare environment. The majority of the services that AHCs provide are now available elsewhere, such as local community hospitals and specialty private medical practices. Furthermore, it is estimated that roughly 70% of their clinical services can be provided elsewhere at a lower cost. It is believed, for example, that AHCs are approximately 30% more expensive, on a case-mix-adjusted basis, than their nonteach-ing competitors.

As a result, AHCs are losing ground to other hospitals and medical practices. They have become providers of a small number of expensive high-tech services involving unique and complex care. However, they continue to be the predominant providers of the nation's charitable care. As an AHC, SMC reflects these trends. For example, SMC's organ transplant center and burn unit are unique high-cost services that account for fewer than 2% of the patients treated at SMC each year.

SMC Leadership

In October 1994, the CEO of SMC abruptly resigned. A former county administrator assumed management of SMC on an interim basis. In 1996, SMC selected a new CEO and president. The new CEO left his current job as director of one of the largest public hospital systems in the United States because he had opposed privatization of that city's hospitals. Nonetheless, shortly after coming to SMC, the new CEO began laying out plans for privatization, and at a forum on the future of public hospitals, he publicly announced that privatization was the best path for many public hospitals, including his own, SMC.

Public hospitals deliver a disproportionate share of charity care compared with their private counterparts. Because the number of public hospitals is decreasing, either by conversion or closure, there is concern about where care to the poor will be provided. From 1985 to 1995, the number of public hospitals in SMC's state dropped from 57 to 29. Eight of these hospitals closed and 20 converted to private institutions.

In 1997, the new CEO explained that SMC could only decide its ownership status after it decided who its partners would be and whether it wanted primarily to be a community hospital, a teaching hospital, or a county charity hospital, and “we don't know that yet.” One month later, he would become an advocate for privatization without identifying partners or articulating what it was SMC primarily wanted to be.

The following potential benefits of privatization were identified prior to conversion:

•  Economic freedom—Private, not-for-profit hospitals can borrow and spend money more easily than public ones, which need government approval. Conversion could make SMC more competitive in the local market.

•  Reduced tax burden—In theory, a more competitive hospital would require less help from state and local taxpayers to stay in the black.

•  Reduced regulatory burden—Freedom from state public record laws would assist in strategic planning.

•  Less political turmoil—Public hospital boards often get bogged down in politics. Private boards, which operate out of the limelight, generally can make decisions without such intense political pressure.

•  Enhanced ability to enter into joint ventures—Essentially, it will become legal for the private institution, SMC, to partner with others, such as a group of doctors, to jointly develop and own ambulatory clinics and other outpatient facilities.

•  Economic benefits—SMC could receive much lower interest rates from the bond market.

•  Enhanced ability to raise private funds—SMC would be more appealing to potential donors as a private, not-for-profit hospital than as an arm of local government.

Potential disadvantages included the following:

•  Change in mission—A private SMC might not meet the community's needs the same way a public one must. The hospital could reduce its commitment to needed services such as its burn center and trauma unit, which lose money.

•  Reduced charity care—SMC provides millions of dollars in free care to poor and uninsured residents. Some indigent patients might find medical care tougher to get if the hospital went private.

•  Less public scrutiny—Private hospitals do not necessarily have to comply with the state's open government laws, making it tougher for the community to keep tabs on their successes and failures.

[Table 2.4](https://content.ashford.edu/books/Wolper.3070.17.1/sections/navpoint10#chap2_tab2_4) contains the results of a public opinion poll regarding the privatization of SMC. Respondents favored keeping the hospital publicly owned by a 3 to 1 ratio. However, the poll did not attempt to learn whether respondents understood the differences between public and private ownership.

The Strategic Plan: Move and Rebuild, 1997-2002

The strategic plan for SMC centered on privatization; that is, converting SMC to a private, not-for-profit corporation, Newco Health Sciences Center, Inc. All other strategic initiatives were based on SMC's conversion to private ownership. The strategic initiatives of the plan were:

•  The 1.5 million square foot facility downtown will be demolished.

•  A new 450-bed hospital and research complex will be built near the university.

Approximately $100 million will be raised from private donations to fund the new construction. This would address problems of SMC's aging physical plant. Also, the location near the university is preferable because downtown is vulnerable to severe weather disasters such as storms and hurricanes.

•  The move near the university will require an estimated $100 million in private funds as well as approval from state healthcare officials to transfer the Certificate of Need (CON) to the new facility. It should be noted that other growing academic health centers (Portland, Oregon; Birmingham, Alabama; and University of Florida) were unable to raise this much money in private funds.

Table 2.4 Results of a Local Newspaper Poll, conducted March 23, 1997

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| --- | --- |
| Opinion on Going Private |   |
| Should remain public | 74% |
| Favor privatization | 13% |
| Don't know | 13% |   |
| Support for Remaining Public |   |  |
| Non-white | 88% |   |
| White | 74% |   |
| African American | 96% |   |
| Concern about Privatization |   |   |
| Somewhat concerned | 34% |   |
| Very concerned | 28% |  |
| A little concerned | 18% |  |
| Not concerned | 17% |  |

•  Profits from the sale of the current SMC site downtown will be used to create and/or expand satellite clinics around the county.

The new CEO predicted that SMC would go out of business by the year 2005 unless this plan was adopted. Furthermore, he projected a $14.3 million profit by 2005 if the plan were implemented. The former SMC president asked the new CEO to explain what would be a fallback plan in the event things didn't go as planned. The new CEO responded that none existed. Alternatives to privatization had been considered, but none were acceptable.

The unacceptable alternatives to privatization included:

•  selling the hospital to a private for-profit corporation

•  closing the hospital

•  asking for a public bailout in the form of a tax subsidy

In addition, the “Shands Model” was held out as a possible future for SMC as a private hospital. The Shands Model refers to Florida's Shands Hospital, which hit bottom in the late 1970s. As a public academic health center, Shands couldn't afford to make needed safety improvements or hire enough talented workers. Because lawmakers never provided the money executives believed was needed to run a top health center, Shands Hospital converted to a private, not-for-profit corporation in 1980. Shands ran a budget surplus that year and experienced 17 consecutive years of “record-breaking” financial performance. Privatization was credited with turning things around because it freed the hospital from political and financial constraints. SMC officials and board members who supported converting SMC to private status used the Shands Model as a reference. However, Shands, unlike SMC, receives a substantial state subsidy of approximately $10 million annually.

Financial Pressures and Charity Care

Much of the impetus for SMC's conversion was financial. According to the new CEO, SMC was not likely to survive financially as a public institution. He predicted a $31 million loss by 2001 if the hospital's governing board failed to make the hospital private. The auditors, who were retained to verify accuracy of these figures, put the number closer to $44 million. Under a worst-case scenario, the auditors said losses could reach $70 million. Clearly, the new CEO was not exaggerating the precarious financial future facing SMC.

SMC lost market share in the county every year since 1992 (dropping from 23.4% to 15.7%). More than half of SMC's beds were empty each night, and SMC continued to see fewer indigent, Medicare, and Medicaid patients than its competitors. Although SMC's revenues grew by $7 million between 1992 and 1996, expenses increased by $31 million, and annual net income dropped from $14 million to a loss of $46 million. Cash reserves also dropped substantially.

One of the most contentious issues that surfaced in the debate over privatization was the impact on the indigent care mission. Many worried that SMC, as a private entity, would not retain the same commitment to care for the poor and uninsured. Similar fears had sunk previous attempts to privatize SMC in 1990. This time, assurances were made by SMC's president, officials, and others that the hospital's mission would not change because of ownership. SMC's commitment to indigent care would remain a core mission and top priority. Furthermore, the County Hospital Authority would legally retain oversight authority for charitable care. Yet questions were raised about the public hospital authority's ability to carry out the state-mandated mission to serve the poor if SMC went bankrupt. The lease arrangement was also questioned because it did not specify how good, accessible, or extensive the charity care must be.

Despite these unanswered questions, the county officials approved SMC's request to become a private, not-for-profit corporation on the strength of the argument of SMC's CEO that such a move would preserve the hospital's commitment to charity care.

Less than two years after the vote to privatize SMC, the new CEO testified under oath that caring for the poor was no longer SMC's top priority. County officials now admit that they should have done more than rely on his promise—they should have (1) created an effective method for overseeing the hospital's contractual obligation to treat the poor, and (2) determined what sanctions or punishment would be used if SMC violated the lease agreement. A private SMC, without a commitment to serving the indigent, would place an additional burden on the county, which is required by state law to provide health care for poor people.

The Aftermath of Privatization

Ironically, in its final year as a public institution, SMC showed a profit of more than $4 million. As a private hospital, its losses have increased dramatically from 1997 to 2000. Unexpected losses were not part of the strategic plan to “move and rebuild.” The CEO predicted a $7.2 million profit for SMC in its first year as a private hospital, but the hospital lost nearly $6 million in the first two months. SMC and its parent company lost $12.7 million that first year—$11.5 million on the hospital and $1.2 million on the health plan. Confronted with these losses, the CEO continued to argue that SMC was on the right course. In addition, he and his staff attributed the losses to forces outside the hospital's control, including the Federal Balanced Budget Act, which reduced hospital funding, and an increase in the number of patients served by managed care in the region.

However, it turns out that the hospital's most significant losses were the result of the hospital's inability as a private corporation to retain “lien authority” and essentially be first in line to collect money from the accident victims it treated. Lien authority did not automatically transfer to the hospital when it converted to a private corporation. The county attorney, who now represents the public hospital authority, warned that the loss of lien authority could significantly cost SMC in incollectable revenue—as much as $20 million annually. The lien authority matter was raised prior to conversion, but had been dismissed by the new CEO, his staff, and consultants as not being a potential problem.

SMC was now mired in financial, political, and legal problems. Employee layoffs were anticipated, but multimillion-dollar losses were not. Many critical issues remain unresolved following SMC's conversion. For example, in order to sell the land on which the current hospital stands, the county would have to pay for demolition as well as removal of asbestos and hazardous waste cleanup. In addition, it has become clear that many important issues had been overlooked in estimating the impact of privatization. The hospital's loss of lien authority as a collection tool has led to unexpected poor financial performance and projections of major future losses (i.e., $20 million annually) for SMC. In addition, because the hospital had used lien money to help cover the cost of emergency care for trauma victims, some worried that SMC would be forced to reduce its trauma services. SMC officials now say the lien authority is crucial to fiscal turnaround.

In addition, when SMC went private it lost the financial protection that government agencies enjoy from lawsuits (litigation damage cap). Although legislative remedies are being pursued in an attempt to restore lien authority for SMC, the resolution of this issue appears elusive for the time being. The County Commission appears unlikely to grant SMC lien authority.

Indigent care clearly slipped as a top priority for SMC and became merely one of many priorities. In addition, the move near the university is on hold. SMC also explored buying other hospitals, the price of which could reach $200 million. How the purchase of these hospitals fit with the strategic plan was never explained.

Finally, SMC was not able to keep its meetings secret despite conversion. There has been intense media scrutiny, and local newspapers are suing SMC in order to open the hospital's records. Furthermore, the State Supreme Court recently ruled that (1) privately leased hospitals cannot meet in secret and cannot keep records from the public, and (2) it is illegal to transfer authority from a public to a private board in an effort to avoid the sunshine laws—essentially what SMC did.

The College of Medicine began to be concerned about how it would train medical students and resident physicians if its main teaching hospital could not survive. The patient census was dropping, employees were being laid off, and morale was deteriorating. The hospital began to look like a dinosaur on the brink of extinction in a hostile healthcare environment. Could a multiprovider teaching hospital and trauma center survive in this region?

The New Plan and New Leadership

In 1999, the physician leadership met to lay out a plan to show the community why the hospital was so essential. Local political leaders and members of the media were invited to view the hospital and its various programs one at a time. These individuals came, listened, wrote, and called their colleagues. The community became aware of the value of a robust and healthy mul-tiprovider system. The Chamber of Commerce, the County Commission, and the County Legislative Delegation worked together to save SMC.

After a consultant's review, these groups spearheaded legislation that ultimately improved reimbursement for indigent care for hospitals across the state, including SMC. During that time, the SMC governing board selected another CEO with a mandate to turn the hospital around. This “turnaround” CEO went to work repairing morale, bringing in a new administration team, and assigning a broad range of tasks to existing and talented administrators. He met with employees on all three shifts, listened, and dealt with issues. Business practices improved dramatically. Managed care contracts were renegotiated. Patient-and physician-friendly operations became the mantra.

As operations improved, more physicians and patients came and the census increased. Admissions, ER visits, and surgeries all increased dramatically. Most of the increased occupancy has been in tertiary care. The improved fiscal viability allowed for the development of new programs (i.e., lung transplants and liver transplants). New state-of-the-art equipment was installed and the physical plant repaired. Finally, the hospital has not diminished its safety net healthcare services for the medically indigent.

Lessons Learned

This organized delivery system has experienced many ups and downs over the years as SMC's priorities have shifted. The leadership team in the mid-1990s tried to totally privatize the system and focused on legal and organizational restructuring rather than the core mission of patient care. This restructuring was in response to pressure from politically oriented board members who brought in a CEO specifically to privatize the hospital. The privatization has been a mixed blessing, with many unanticipated negative consequences. One of the major consequences of privatization, which negatively impacted revenue, was SMC's inability (as a private corporation) to retain lien authority to collect money from accident victims.

When the new leadership team arrived in 1999, it began to focus on meeting the needs of both physicians and patients. The physicians became integral members of the leadership team. The focus shifted to providing high-quality clinical care with high-quality service rather than handling legal and organizational structure issues. The new CEO had been given the authority by the board to focus on the core mission and has done so successfully.

A second major factor in the turnaround was the successful political efforts of the new administration to generate additional state revenue for indigent care, which benefited all hospitals in the state. This was accomplished through a political coalition spearheaded by SMC with support from many political and community groups.

The following lessons can be derived from this case study:

•  The organizational structure, legal structure, and size of an organized delivery system may be less important in determining organizational performance than previously thought.

•  The quality of the leadership team and its ability to communicate a common mission and vision to key stakeholders may be far more important than organizational structure in enhancing organizational performance.

•  Political decision making to benefit a small group is antithetical to organizational performance.

•  A focus on internal operations to serve physicians and customers is a fundamental necessity for achieving high levels of organizational performance.

Managerial Implications and Recommendations

The jury is still out on the future of organized delivery systems. It is unclear whether the many problems and issues identified here and elsewhere are due to a flawed strategy, flawed implementation (leadership), or both. Clearly, multiprovider integration has not worked well either in American industry or in health care. The point is not to lay blame when systems struggle or collapse. Rather, we need to identify managerial processes or methods that will enhance the probability that systems will survive and prosper. The overriding goal of systems should be to provide maximum value to the healthcare customer.[145](https://content.ashford.edu/books/Wolper.3070.17.1/sections/navpoint10#chap2_ft145)

The fundamental question is, What types of systems, networks, and alliances are best able to compete effectively and deliver cost-effective care? At this time, however, there is no definitive answer to this question, because there is almost no evidence associating different types of organized arrangements with successful performance or failure.

The future of healthcare systems is highly speculative, given the volatility of markets and future initiatives for healthcare reform. As the government's role in health care expands, these systems become more vulnerable to shifts in government policy.

It seems likely that most multiprovider healthcare systems will emerge successfully from their “growing pains” and continue to solidify their position in the healthcare market as long as they are virtually integrated rather than vertically integrated.

Health care will be purchased primarily on a local or regional basis. Quality and value will be increasingly important to patients who once again have a choice of provider. Fewer resources will be available to deliver care, and the delivery of health care will continue to shift from acute care to ambulatory settings. Barry noted the importance of a system CEO being a “change agent” in this future environment:

Those who can understand and embrace change; those who can transform traditional but key values to tomorrow's environment; those who can educate their boards of trustees, medical communities, and the community at large; and those who can “right size” the production activities of their organizations, and provide both high quality and cost-effective services will be the winners of tomorrow.[146](https://content.ashford.edu/books/Wolper.3070.17.1/sections/navpoint10#chap2_ft146)

Recommendations

•  Healthcare executives in multiprovider healthcare systems need to allow flexibility for member institutions to respond to specific local markets while providing a clearly articulated and well-understood vision for the system.

•  Each system should develop a detailed mission statement and set of behavioral norms (i.e., culture) shared by each facility within the system in order to enhance cohesiveness.

•  Each system should develop a formal strategic plan for the system with input and a high degree of interaction among the corporate office and institutions in all geographic regions.

•  Each system should develop and implement explicit measures for quality of care, patient satisfaction, efficiency, and community benefit, and then provide these data to purchasers and other key stakeholders.

•  Each system should develop an organizational structure that is simple, lean, flat, responsive, customer-driven, risk-taking, and focused.

•  Governance at the corporate level should be strategic in nature, whereas governance at the institutional level should be operational in nature and focused on local community/region needs and concerns.

•  Systems should provide formal and informal education for those responsible for governance at all levels in the system.

•  Systems should provide a clear definition of governance roles, responsibilities, and authority among the system and institutional boards of its component parts.

•  Systems should provide the leadership required for the individual units of a system to think in terms of overall system performance rather than just in terms of the particular unit's performance.

•  Only institutions that fit a particular culture and strategy should be invited to join or remain a member of the system.

•  Systems should align physician incentives and achieve clinical integration.

•  Systems should develop information systems to support the integration of clinical and managerial information.

•  Systems should use their mission and values as a guide in making difficult trade-off decisions.

•  Systems should change their incentive structures to reflect concern for performance of the system as a whole, not just the individual components.

•  Systems should own fewer facilities and contract for most services so that they are virtually integrated rather than vertically integrated.

•  Systems should buy or contract for services only if the additions will add value to the systems' customers and are compatible with the existing mission, values, goals, and culture.

•  Systems should allow the individual operating units within the system to have sufficient autonomy to be responsive to the needs of their local customers.

•  Systems should focus on core competencies rather than trying to be all things to all system components.

•  Systems should not allow success to breed complacency. Each integrative step must be evaluated for systemwide effects.

•  Systems should focus on quality rather than the size of the program or system being integrated.

•  Systems should focus on quality rather than quantity of physician integration.

•  Systems should place high-performing executives in key positions to implement their integration plan.

•  Systems should target selected patient populations and payers.