

HEALTH CARE SYSTEMS: THE EMPEROR HAS NO CLOTHES

Allan Fine - CHPS Consulting
John P. Marren, J.D. - Hogan, Marren & McCahill, Ltd.
Special Thanks to David Van Horn - Consultant

Stand-alone hospitals are becoming something of a rarity on the American landscape. While hospital boards have repeatedly voted to form systems in the last 10 to 20 years, they have been just as likely to neglect to identify specific, measurable benefits that a merger would bring to their institution. And even if they did, they frequently discontinued evaluating whether system formation brought the hoped-for benefits, thereby justifying ongoing system participation. It is an incumbent fiduciary obligation to continually ask the question: Does continued participation make sense; that is are we appropriately exercising stewardship over the hospitals' or system's assets by participating in this system? ★ In a sense, boards are in danger of becoming like the emperor in the children's fairy tale, believing they have done the right thing without taking a hard look at today's reality.

Background

Although hospital affiliations have varied in their structure, size, purpose, and types of members, in each instance there have been more or less articulated reasons for their development, and a host of existing business and legal issues. There have been several motivations for the last decade of health system development based on the geographic and demographic marketplace, but generally have included some or all of the following:

- Mandated capitation for Medicaid;
- The fear of widespread Medicare HMO development;
- The fear of widespread commercial HMO/capitation programs;
- The development of aggressive employer health care purchasing coalitions;
- Aggressive, large individual employers;
- The growth of large multi-specialty groups organized to manage “global” capitation;
- The development of private physician management companies;
- The fear of for-profit system competition; and
- A general fear of competition and being excluded from managed care relationships.

These strategic drivers were often expressed in generalized politically correct and legally acceptable goals such as:

- To provide a broad scope and a continuum of health care services with a focus upon community health benefits;
- To improve cost effectiveness and efficiency in the delivery of health care services;

- To maintain and enhance the quality of health care services;
- To integrate physicians and other health care providers in the system;
- To develop the capacity to assume and manage financial risk [capitation];
- To improve the health status of the citizens of the community hospital's service communities; and
- To allow academic medical centers a broader range of access for educational and tertiary treatment programs.

Fundamentally, system formation was driven by the premise that health systems that can deliver services most efficiently and with the highest degree of consolidation were the ones with the best chance of surviving the continuing market pressures. Opportunities for enhanced quality, reduced costs through shared services and capital investments, image branding, and success through enhanced critical mass all contributed to the lure of system participation.

System Formation: Did It Work?

Beyond the rhetoric surrounding system formation, serious doubts exist about participation benefits. Many systems have failed to accomplish stated goals. Some of these systems have disintegrated, others are in the process of collapse, while some languish with little purpose or momentum. Symptoms associated with these failing systems may manifest as:

- Member hospital leaders questioning the ongoing value and purpose of the system even though system formation was initially embraced enthusiastically
- Skepticism because systemwide strategic planning and resource allocation seems to compromise individual hospital strategic initiatives and decisionmaking
- Questioning the appropriateness of redistributing assets to support system initiatives instead of local needs and priorities;
- Fundamental concerns about the value of system participation to member hospitals
- Anxiety as individual hospital culture seems marginalized even though there is no definitive system culture;
- A feeling amongst the medical staff(s) that system formation has "distanced" them from the key decisionmakers;
- Physicians' perception that system participation hasn't enhanced quality of care or services at member hospitals;
- Concerns that these inconsistencies will affect the system and individual hospitals' reputations.

Where any of these symptoms are present, it is the obligation of the system or hospital board and senior executives to begin a careful evaluation to either fix or unwind the system. It is not appropriate to stand still if the hospitals' assets are not being put to their best use.

Failure to Act

When systems fail to demonstrate that their continued existence best utilizes community resources and assets, there is substantial risk of outside intervention. Specifically, communities, special interest groups and regulators may ask, "Does this affiliation serve the best interest of the

community?” and if not, “Is it legal?” One example involves New Hampshire’s attorney general who, in conducting an investigation of the continuing validity of the three-hospital Optima Health System in New Hampshire, concluded, in a March 10, 1998, report on two of the hospitals:

“Both [hospitals] are nonprofit charitable institutions and are bound by a social contract to the local community. Through their trustees and management, [the hospitals] have a fiduciary duty to preserve and to protect their charitable assets and to ensure that those assets are used for purposes consistent with the fundamental charitable missions of the respective institutions.”

The attorney general echoed the sentiments of community members who were concerned that they had lost control of their hospital(s) and their assets. The attorney general ultimately chastised Optima for the relationship between the two Manchester Hospitals, a Catholic and a secular hospital without sufficiently considering the ramifications stating that Optima’s actions “ha[ve] led to the apparent compromise of the charitable identities and missions of both institutions.” The attorney general reached this conclusion because some of the services traditionally provided by the secular hospital directly conflicted with the mandated ethical and religious directives of the Catholic hospital.

Applying our questions from the "Did It Work" section above produces interesting results relative to Optima.

- 1) Optima's formation was enthusiastically embraced, but ultimately the community, physicians, and others began to question the system’s value and purpose.
- 2) Serious questions emerged about systemwide planning and resource allocation, particularly relative to a clinical services transfer from one of the member hospitals;
- 3) This service transfer led to a challenge of the system’s continuation because it allegedly disrupted the hospital's ability to carry out its mission.

Ultimately, because of the charitable nature of the hospitals, the state’s attorney general took jurisdiction and control of the system by establishing advisory boards for each of the two hospital to determine whether continued system participation was in their best interest. The system has since been dismantled.

These problems are avoidable if system and hospital boards evaluate continued system participation before the community, the courts or an attorney general's office become involved. For instance, in contrast to the Optima situation, the board of Northwestern Healthcare Network in Chicago, together with its member hospitals’ board, concluded that their parent company intruded too much on member hospital decisions. To reach that conclusion, the board and senior management commissioned an objective external review of their situation. In so doing, they prepared a strategic and legal options report. Ultimately, they decided that the marketplace had not evolved as anticipated so it was no longer appropriate for the institutions and their community assets to be controlled by a strong central system. As a result, The Northwestern Healthcare Network was dissolved.

Again, applying our questions to the Northwestern Healthcare situation we find:

1. System formation was perceived initially as a way to respond to Chicago's growing managed care environment, and as a means of reducing cost through efficiencies of scale and integrated clinical programming;
2. Over time, skepticism emerged as successful member hospitals began to question the need for centralized system strategic planning, particularly in light of the fact that managed care did not evolve as anticipated, and that existing managed care plans were unwilling to engage in systemwide contracting;
- 3) Ultimately the reality of the marketplace gave rise to fundamental concerns from physicians, trustees, administrators and others about the value of system participation.

The dissolution of the Northwestern Healthcare Network - perhaps because of the timing of actions taken by the trustees and senior managers, or perhaps because there hadn't been significant redistribution of assets and a dominance of central strategy over local initiative - was accomplished with significantly less disruption to the hospitals than in the Optima situation.

The Analysis

The assumptions underlying formation of an integrated delivery system are extremely important in the evaluation process; they form, at least in part, the basis for measuring system success. When a hospital is considering system participation, the failure to adequately articulate projections or to quantify results after affiliation may result in legal exposure for board members, embarrassment to the organization, or a forced unwinding of the affiliation.

A periodic review of system benefits is critical to ensuring ongoing fiduciary compliance. Boards and senior managers must do a comprehensive analysis and literally create an "effectiveness scorecard" in order to review overall system effectiveness.

At a minimum, the analysis and evaluation, or scorecard, should focus on:

- The purpose of forming the system;
- The specific objectives of system formation;
- The assumptions about the marketplace or any other material considerations;
- The anticipated strategic initiatives; and
- Whether the hospitals' resources are managed for the benefit of the community or other beneficiaries.

The scorecard logically starts with the key constituencies of the hospital/system-including the board, management, medical staff, and community/patients. This is not to say that problems reside in one of these areas, but the perspective of each of these constituencies is important for identifying potential problems as well as keys to success.

The board. Governing boards bear the ultimate responsibility for preserving corporate assets and ensuring community service. To fulfill these responsibilities, it's essential that boards assess their composition, governing philosophy and structure.

Management. Senior managers have the greatest impact on a system's effectiveness. Shared vision, philosophy, management style, and commitment are essential ingredients to developing the positive relationships needed to conduct system pursuits. A profile of management's operating philosophy and structure will enable the board to review compatibility of vision, strategy, and style within system and member hospital teams.

Physicians. Frequently, the *medical staff* is unaware of the integrated delivery system's legal and business climate. It is imperative that the medical staff(s) be on the same page as the system. This may be difficult because physicians may remember the rhetoric surrounding system formation but have yet to see the advantages articulated in that rhetoric. A scorecard can help the board and management focus on a program to integrate physicians into system's vision and resolve potential compliance issues related to tax, Medicare fraud and anti-kickback laws.

Employees. Frequently, hospitals fail to modify *employee* specific goals and objectives to reflect system-wide perspectives. Therefore, employees may be working to maximize hospital objectives, which could conflict with system goals. As a result, productivity declines and dissension is inevitable. The goal of an employee review is to determine whether this important constituent, the work force, supports the system, enabling management and the board to accomplish system goals.

Once this analysis is conducted and the scorecard completed, the board and senior management have the information they need to withstand challenges or answer questions about the system's; fix problems inhibiting system effectiveness; and restructure or dissolve the system in accordance with current market realities.

The board cannot assume that a decision made years ago to join or form a system remains viable. Failure to carefully evaluate system integration decisions in the context of current reality can expose the board and management to legal challenges and community action. While it is always difficult to step back and review system participation decisions, it is nonetheless imperative that board and senior management members exercise their stewardship in a vigilant manner.

SIDEBAR QUESTIONS

General questions to consider:

- 1) *Is there sufficient value generated by the system?*
- 2) *Is the loss of local autonomy justified?*
- 3) *Is the reason for system formation and continued participation still justified?*

In order to address these questions appropriately, a comprehensive community benefit analysis is essential. It is incumbent upon the hospital/system to deliberate over the following strategic, operational, organizational, financial and legal considerations.

- 1) *Has our position been enhanced strategically, operationally or financially by remaining in the system?*
- 2) *What are the opportunity costs associated with system participation?*
- 3) *Has participation precluded us from other deals? If so, what has been the impact?*
- 4) *What impact has our participation had on our physician integration?*
- 5) *Have we been able to achieve cost reductions and efficiencies?*
- 6) *Have we established performance measurement systems?*
- 7) *Are we applying "best practices" and benchmarking to our processes (both financial and operational)?*
- 8) *Are we gaining any efficiencies through system integration?*
- 9) *Can we objectively demonstrate hospital and community assets enhancements?*