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What Would You Do?

can a merger create a vital health system?

The Problem

Community General Hospital and Catholic Community Hospital, after separately serving a small northern city for 100 years, have decided to merge. How should the new entity position itself so that it becomes an increasingly important player in the local and regional market?

The Situation

Community General Hospital (CGH) and Catholic Community Hospital (CCH) are located about a mile from each other in a small, declining northern city. The city was, at one time, a thriving manufacturing center, but it has been gradually losing residents for the past 40 years. Total population is now about 150,000 in the city, with another 175,000 in the suburbs and the remaining service area extending roughly 20 miles in every direction. There are several large hospitals, including a university hospital and medical school, on the periphery of the service area. The service area has an increasingly indigent population, and nearly 20 percent are older than 65 years of age.

CGH and CCH are full-service acute care hospitals that have about \$150 million in annual revenues each. The hospitals provide similar services—largely of a primary and secondary level—to essentially the same service area. With the exception of the hospital-based departments and a handful of primary care physicians, the medical staffs overlap completely. Neither hospital is part of a larger system, and the Catholic hospital is diocesan-sponsored. Both hospitals have a long history of service to the community.

The hospitals have experienced declining financial performance, largely due to duplicative services and a deteriorating payer mix. Age of plant and technology has also been a concern; a major capital infusion is required to bring the

hospitals up to contemporary standards. CCH has less than 10 days of cash on hand, while CGH is in a somewhat less precarious situation (but still subpar) with about 30 days of cash on hand.

The decision to merge, while a slow and painful process, is nonetheless viewed by nearly all as the only way to salvage the healthcare base in the city. And at least a few leaders see the merger as the best way to resize, revitalize, and eventually grow the healthcare base. Instead of viewing local health care as a zero sum game to be fought in the trenches by both hospitals, leaders believe it would be better to focus on increasing the collective draw of the two hospitals from 75 to 85 percent share or more in the primary service area and from 25 to 30 percent or more in the secondary service area. The exhibit on page 105 graphically illustrates the combined entity's current and potential health services role in the region.

The joint board planning committee set forth three goals for the new medical center:

- > To significantly improve quality of care and patient experience/satisfaction
- > To reduce outmigration of area residents for care
- > To create a system that is financially self-supporting and capable of renewal

Because, in the near term, financial improvement and capital conservation will be critical to success, leadership is concerned about how to reduce duplication, generate economies, and create a platform for capital investment. A voluntary collaboration between the hospitals would raise some potential for state grants and significant private philanthropy if a solid plan and case can be made.

Given these considerations, how should the parties proceed?

Alternatives Considered

A management task force from the hospitals identified five main hospital reconfiguration alternatives:

1. Consolidate administrative functions (limited service delivery reconfiguration).
2. Consolidate administrative functions and select clinical support functions, such as lab and pharmacy.
3. Consolidate clinical functions, with two acute care campuses, shifting higher acuity services to one and lower acuity services to the other.^a

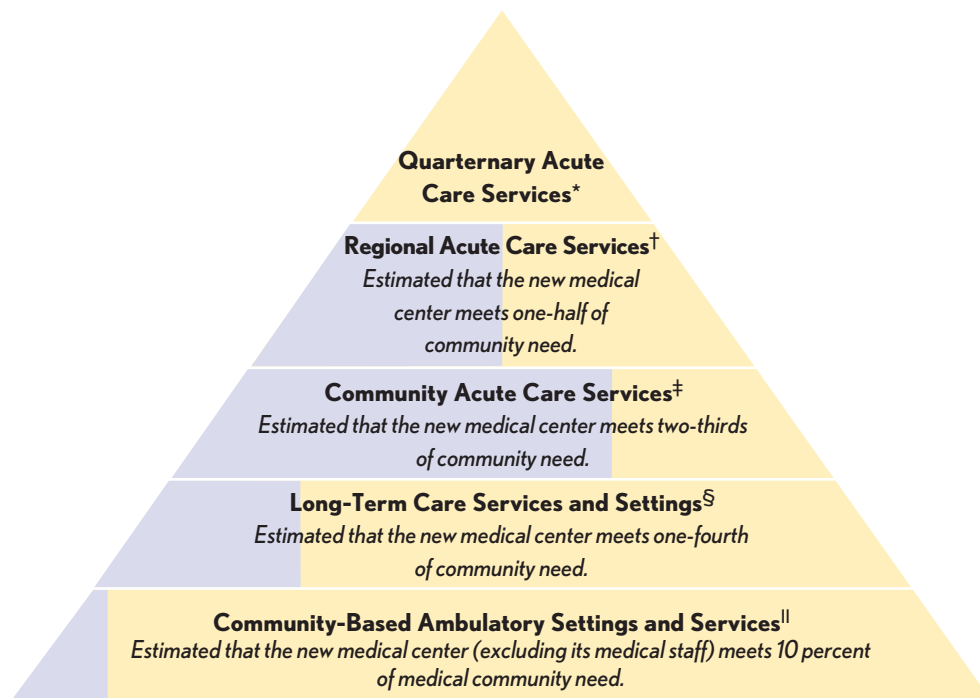
a. Other possible approaches to alternative 3 that were considered included one acute care campus and one nonacute care campus, and two acute care campuses with different service-line emphases.

4. Consolidate all clinical services on either the CGH or CCH campus.
5. Build a new hospital and/or campus on a new site.

Given the goals that leadership established for the new medical center, the task force identified the main criteria with which to evaluate each alternative. Although the investments required and associated benefits and costs for each were quantifiable, estimation of the impacts for the other criteria was more subjective.

The exhibit on page III displays the criteria used and the results of the evaluation. The benefits of alternatives 1 and 2 are modest, except for ease and speed of implementation. The more “radical”

NEW MEDICAL CENTER SERVICES—CURRENT AND POTENTIAL ROLE



Shading represents the share of community need for each level of services that the hospitals collectively provide.

* Services include Level I Trauma, Burn Unit or Burn Center, and Transplant.

† Services include Level II Trauma, Radiation Therapy, Specialty-Specific Critical Care, High-Risk Obstetrics, Level III Neonatal, Cardiac Surgery, Inpatient Pediatrics, Invasive Cardiology, Pediatric Intensive Care, Inpatient Neurosurgery, Accredited Stroke Center, Interventional Radiology, Vascular Surgery, Surgical Oncology, Acute Rehabilitation, Specialty-Specific Outpatient Clinics, and Inpatient Psychiatry.

‡ Services include Emergency Care, Inpatient and Outpatient Surgery, Inpatient Medical-Surgical, Critical Care, Imaging, Obstetrics, Noninvasive Cardiology, and Clinical Laboratory.

§ Services include Subacute Care, Rehabilitation, Skilled Nursing Care, Psychiatry, Long-Term Acute Care Hospital (LTAC), Assisted Living, Home Health, and Hospice.

|| Services include Neighborhood Health Centers, Freestanding Cancer Centers, Freestanding Emergency Centers, Family Planning Centers, Freestanding Dialysis Centers, Primary Care Physician Offices, Mental Health Centers, Specialist Physician Offices, Freestanding Therapy Centers, Freestanding Clinical Laboratories, Freestanding Imaging Centers, Freestanding Surgery Centers, and Urgent Care Centers.

STRATEGY CHALLENGE

EVALUATION OF ALTERNATIVES						
Criteria	Description	1 Consolidate Administration	2 Consolidate Administrative and Support Services	3 Consolidate Clinical Services	4 One Hospital, Existing Campus	5 One Hospital, New Campus
Community benefit	Accessibility, patient satisfaction	0	0	3	3	5
Quality improvement	Patient safety and quality of care	0	1	3	3	5
Market responsiveness	Community and physician support					
	Increases in market share	0	0	3	3	5
Operational efficiency	Functionality, efficiency, reduced operating costs	1	2	3	2	5
Revenue gains	Impact on operating revenue	0	0	2	2	3
Magnitude of capital investment	Investments required	0	-1	-2	-4	-5
Ease/speed of implementation	Magnitude of disruption to services, time frame for implementation					
	Politically expedient	5	4	2	-3	-5
Total		6	6	14	6	13

Scale: -5 to 0 to 5

alternatives, 3 to 5, have greater benefits, except for capital cost (although this would be a threshold problem in the absence of major state grants and philanthropy) and, for 4 and 5, ease and speed of implementation. The task force debated the results at length, considered weighing each criterion differently, and discussed at length how to proceed before finally issuing its recommendation. So what is the optimal course to pursue?

The Decision

Despite the appeal of alternative 5 and its high score in the evaluation process, the task force found that the capital investment requirements for this alternative

would render it infeasible in the foreseeable future.

Therefore, the task force recommended to the board that it should proceed expeditiously to implement alternatives 1 through 3, preferably in the following phases:

> Alternative 1 in the next year

> Alternative 2 by years two to three

> Full alternative 3 by years three to five depending on the timing and phasing of required new construction and renovations and availability of funding ●

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