JANUARY 1999

THE HENRY J. KAISER FAMILY FOUNDATION

Privatization of Public Hospitals

Prepared for The Henry J. Kaiser Family Foundation by:

The Economic and Social Research Institute

Privatization of Public Hospitals

Prepared for

The Henry J. Kaiser Family Foundation

Prepared by

Economic and Social Research Institute

Mark W. Legnini
Stephanie E. Anthony
Elliot K. Wicks
Jack A. Meyer
Lise S. Rybowski
Larry S. Stepnick

January 1999

Contents

About Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

Acknowledgments

The authors would like to thank Roice Luke, Ph.D., Director and Professor at the Williamson Institute, Virginia Commonwealth University, for assisting in cleaning and organizing the data we used in the quantitative portion of our analysis. In addition, we thank all the individuals who agreed to be interviewed for this project. We are also grateful to the Henry J. Kaiser Family Foundation for their support of this study.

Executive Summary

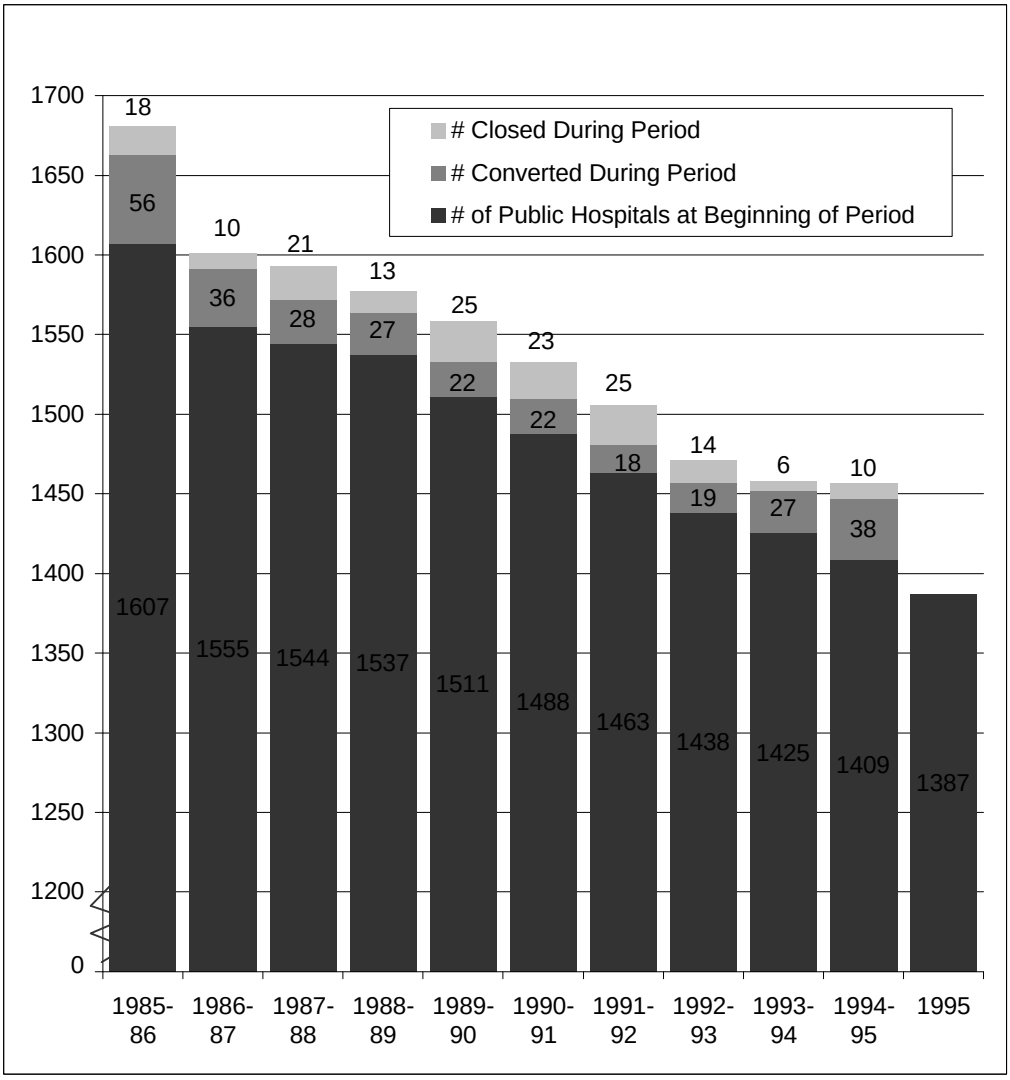
The Henry J. Kaiser Family Foundation commissioned the Economic and Social Research Institute (ESRI) to conduct this study to better understand the causes and effects of the conversions of public hospitals to private ownership or management. We explored conversions that occur via lease, sale, management contract, merger, consolidation, and the establishment of an independent hospital authority.

We were especially interested in determining how the conversions to private status affect the hospitals' public purpose. Conversions of these public hospitals to non-public status naturally raise questions about their continued commitment to the mission of serving needy populations. Do the conversions adversely affect access for vulnerable populations served by the formerly public hospital? A related issue is the prominent role many public hospitals play in graduate medical education. Do these programs, whose residents provide much of public hospitals' free care, shrink under private ownership or management?

In researching these issues, we analyzed national data for trends in public hospital conversions, reviewed 25 to 30 instances of conversion (ten of which are profiled in this document), and chose five cases for intensive study through telephone interviews and site visits. These five were Boston Medical Center in Boston, Massachusetts; Brackenridge Hospital in Austin, Texas; University Hospital at the University of Colorado's Health Sciences Center in Denver, Colorado; Sutter Medical Center of Santa Rosa in Santa Rosa, California; and Oakwood Healthcare System, in suburban Detroit, Michigan.

Public, non-federal hospitals account for almost one-quarter of community hospitals in the United States. As shown in the bar chart on the next page, however, the number of public hospitals has been decreasing at least since the mid-1980s. This trend can be summarized as follows: for every 100 public hospitals, one is closing and two are converting to private ownership or management annually. From 1985 to 1995, the number of public hospitals in the United States declined by 14 percent. The number of conversions of hospitals from public to non-public status is not evenly distributed across the United States; 12 states accounted for approximately two-thirds of the conversions from 1985 to 1995. As the map on page 3 illustrates, a disproportionate number of the states with a high proportion of conversions are located in the South.

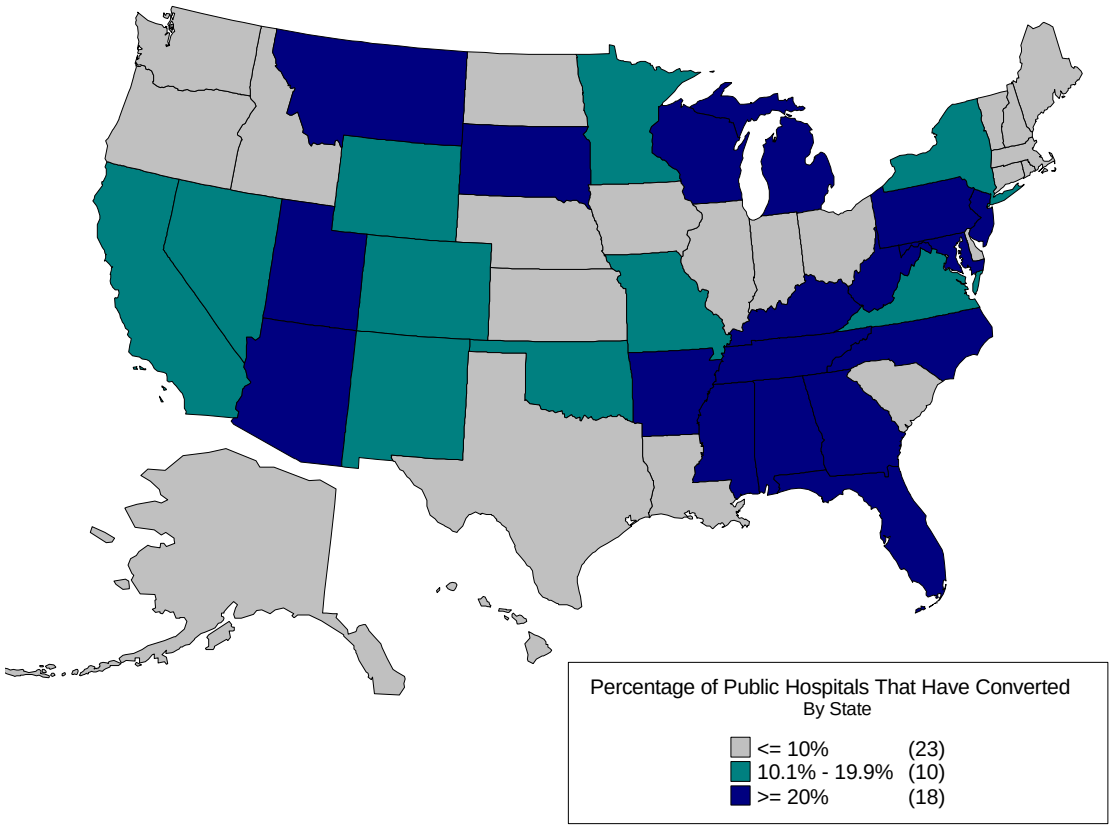
Figure 1: Number of Public Hospitals, Conversions, and Closures, United States, 1985-1995



Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

Note: The Y-axis starts at 1200 rather than zero, which makes the closures and conversions appear to be larger relative to the number of public hospitals than they actually are. The graph does, however, accurately portray the trends.

Figure 2: Proportion of Public Hospitals Converting to Non-public Status, by State, 1985-1995



Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

Case Study Sites

Our analysis is based on a detailed review of five public hospital conversions (including one academic medical center). A brief description of each is outlined below.

Boston Medical Center

In 1996, Boston City Hospital (BCH), a public teaching hospital, Boston Specialty and Rehabilitation Hospital (BSRH), a public long-term care hospital, and Boston University Medical Center Hospital (BUMCH), a private, non-profit teaching hospital, consolidated their operations to form Boston Medical Center (BMC), a private, non-profit entity. As part of the

consolidation agreement between the city of Boston and BUMCH, BSRH closed 90 days after the affiliation and its services were consolidated into the former BCH facility at BMC.

Brackenridge Hospital and Children's Hospital

Brackenridge Hospital and Children's Hospital were owned and operated by the city of Austin, Texas. On October 1, 1995, the city of Austin leased all of the assets of both hospitals to Seton Healthcare Network, a local, non-profit hospital system operated by the Daughters of Charity National Health System. Under the 30-year renewable lease, Seton effectively took over financial and operational responsibility for both institutions.

University Hospital

In 1991, the Colorado legislature passed a law enabling University Hospital, part of the University of Colorado's Health Sciences Center, to become a "quasi-public" organization under an authority structure. Under the University Hospital Authority, the institution retains several of the benefits of a public institution, but may operate free of many of the constraints on personnel management, debt issuance, and purchasing normally imposed by the state.

Sutter Medical Center of Santa Rosa

Sutter Medical Center of Santa Rosa, California is the result of a 1996 agreement between Sonoma County, located north of San Francisco, and Sutter Health, a non-profit organization that operates 26 hospitals in Northern California. Sutter leases the former county hospital and operates it under contract to the county.

Oakwood Healthcare System

Oakwood Healthcare System, in Dearborn, Michigan, is a product of the 1991 merger of Oakwood Hospital, a non-profit community hospital, and the five public hospitals that made up the People's Community Hospital Authority (PCHA), which served more than 20 communities in the suburban Detroit area.

Key Findings from the Case Studies

Motivations for Conversion

- The hospitals converted to private ownership or management to recover from or avert financial difficulties, due largely to increased competition for patients and revenue and changes in reimbursement caused by the growth of managed care. These market forces and the changes they wrought on public hospitals were often no different from what the community's private hospitals had already experienced earlier.
- The public sector placed constraints on these hospitals that handicapped both governance and management vis-à-vis private hospital competitors. These constraints included an

inability to raise capital, complicated or inefficient purchasing and compensation systems, and requirements to develop competitive strategies in public because of open meeting laws.

- The governmental entities typically were not willing to continue to operate a hospital outside of the market; that is, to totally subsidize a hospital exclusively for the poor. Therefore, in most cases, the solution for failing public hospitals was to find a way to make them competitive so they could survive to serve both low-income patients and others. This meant that unique market characteristics played an important role in these conversions, since the desired outcome of the conversion was a hospital that would be successful in its local market.

Process of Conversion

- These conversions were essentially political processes, and those hospitals that approached them as such had greater initial success. Essential political strategies were to "embrace perceived opposition" and "appease affected parties."
- Private organizations that were successful in negotiating agreements to purchase, lease or manage public hospitals were credible partners with a good track record in serving communities, including vulnerable populations, and organizational characteristics that made them acceptable stewards of the hospital's mission in the eyes of the community.

Effect on Hospital Operations

- The manner in which the hospital handled inevitable changes in staffing, compensation, work rules, and job content was key to the success of these conversions. Management that involved labor early in the conversion process and worked with them to ease the effects of change on the formerly public workforce had fewer problems. It was necessary for the new, private-sector managers of these facilities to balance good business practices with: 1) a less aggressive method of reducing labor costs than the approach often encountered in corporate "turn-around" efforts (for example, job redesign and attrition versus large lay-offs); and 2) commitments to maintain levels of charity care on which the community depended from the formerly public institution.

Effect on the Local Community

- Conversions that went relatively smoothly were led by individuals who recognized from the outset the need to assure the community that the hospital's public mission would be preserved, and who developed mechanisms to ensure that the new entity would maintain a commitment to the mission of providing care to the uninsured.
- In most instances, access to care for low-income patients has been preserved after conversion and teaching programs have not been cut. Most community respondents told us, however, that the access issue would require continued monitoring by the community.

The bottom line emerging from our study is that hospitals committed to the public good of effectively serving lower-income people must first survive. Remaining viable in today's highly competitive health care market requires some basic ingredients of good business

management. This translates into flexibility in managing labor and purchasing costs; access to capital; and the ability to conduct business-like strategic planning.

Ironically, these basic business components, if they enable institutions with a public mission to attract a base of paying patients, will enable them also to continue serving vulnerable populations. Instead of a Hobson's choice between public status with no modern business practices and private status with no commitment to the indigent, our study uncovered a wider set of options. By adopting the essentials of modern business practices, public institutions that convert to private status (and even those that do not) hope to balance the goals of financial viability and serving a public mission. Indeed, our findings suggest that the former is a precondition to the latter in today's competitive health care environment.

Our findings suggest that, with health care as well as other public services, communities across the country are struggling to build market-oriented strategies into the delivery of public services without abandoning their commitment to serve those who may be left behind by the market.

Overview

In recent years, public hospitals around the country have affiliated with or been acquired by private hospitals or hospital systems at an unprecedented rate. This trend toward conversion of public hospitals to private ownership or management typically reflects public hospitals' desires to ensure short- and long-term financial stability and enhance negotiating power in an era of decreased public subsidies and increased competition for funding and patients.

Concern about this trend emanates from two vital roles traditionally filled by public hospitals. First, they often are considered the "providers of last resort," ensuring access to medical services for those who cannot go elsewhere. Primarily, this constitutes removing financial barriers to care for the uninsured and under-insured by serving eligible patients without expectation of payment. In addition, however, public hospitals also provide unique services for under-served populations (such as, translators for non-English speaking patients) that address non-financial barriers to care for patients such as newly-arrived immigrants. Second, urban public hospitals have traditionally filled the role of major teaching institutions. Not only are they affiliated with local medical schools for the training of medical students and residents, but they often sponsor their own independent residency programs. These residents provide most of the free care that is available from public hospitals. In this role, urban public hospitals are often providers of highly specialized care, and the only route for non-paying patients to the most sophisticated diagnostic and treatment services and equipment. The policy question this issue raises is: can these "public goods" that public hospitals provide survive the hospitals' conversions to private ownership or management?

The motives for the conversions we examined were mostly related to the hospitals' financial viability. Public hospitals have always required subsidies to support their mission of caring for patients who cannot afford to pay. The cities, counties, and taxing districts that own and operate the hospitals have supported that mission to a varying extent over the years. Some states (Massachusetts, for example) also have established indigent care funding pools for hospitals that see large numbers of uninsured patients. These pools require hospitals to contribute some amount (usually a percentage of their revenues) to an account from which the state then re-distributes funds to hospitals based on their indigent care load. In addition, Medicaid includes a program of supplemental payments to disproportionate-share hospitals (DSH) that combines federal, state and local funds in a state program that distributes money to hospitals that serve large numbers of Medicaid and uninsured patients. However, at the same time that hospitals' costs have increased and sources of subsidy have become the target of public-sector cost-cutting efforts, the increasingly competitive hospital market puts an additional burden on public hospitals' ability to generate patient care revenues.

Hospital use has been declining nationally since the early 1980's, due to the substitution of case-based (diagnosis-related group) reimbursement for cost-based reimbursement and the growth of managed care plans that generate much of their savings from reducing hospital

days used by their enrollees. As all hospitals, both public and private, compete for fewer patient-care revenues, public hospitals are often left with the financial burden of charity care. Private hospitals, having lost their ability (under the former, cost-based reimbursement) to shift the cost of charity care to insurers who reimburse them for other patients, respond by cutting their charity care load, increasing the burden on public hospitals. At the same time, Medicaid (and especially Medicaid managed care plans) has begun to look more attractive to private hospitals searching for revenue. Private hospitals have often successfully attracted Medicaid patients who used to receive services at the public hospital. This one-two punch both deprives the public hospital of one of its major sources of revenue (Medicaid patients) and leaves it with increasing numbers of patients who have no source of payment.

For our analysis, we defined public hospitals to include: hospitals that are owned by a city, county, or state; district hospitals that are owned and operated by a state taxing district; and public-sector academic medical centers, defined as teaching hospitals operated by public universities. Recent studies of hospital conversions have focused primarily on hospitals that have converted to *for*-profit status, examining the impact on a community when a former not-for-profit hospital (whether public or private) becomes part of an investor-owned hospital organization. These studies focus on how the hospitals balance their responsibility of providing health care to members of a community with the desire to make a profit for their shareholders. Very few studies, however, have explored the effect on communities and hospital operations of the privatization of public hospital care, broadly defined to encompass conversions from public to private (often non-profit) status. Our study fills that void in the literature.

Prototypes of Conversions

The term “conversion” is often used to describe a wide range of reorganization activity by public hospitals. For example, leases, asset sales, closures, mergers, consolidations, affiliations, and joint-ventures are all characterized as conversions in the relevant literature. In addition, the entity that assumes either ownership or management of a former public hospital can take many forms. The resulting organization can be purely private, such as a non-profit or for-profit corporation; quasi-public, such as a hospital authority, public benefit corporation, or hospital taxing district; or a public-private partnership, which can result from affiliations and joint-ventures. The following tables describe the diversity of reorganization activity that is occurring around the country and the range of organizations now operating former public hospitals. The degree of continued involvement by the government entity that previously owned or operated the public hospital varies and is determined by state law or the contract between the parties.

Table 1: Mechanisms for Public Hospital Conversions

Mechanism for Conversion	Definition
Lease	A contract granting the use or occupation of property during a specified time period in exchange for rent. In the Brackenridge and Sutter Medical Center conversions, all of the assets of the former public hospital were leased. At Boston Medical Center, only the building was leased.
Merger	A union of two or more corporations. Typically, it implies the absorption of one corporation into the other. In Detroit, the PCHA hospitals merged into the Oakwood system.
Sale	The transfer of some or all of the assets of a corporation (partial or full asset sale) in exchange for a specified amount of money or its equivalent. Typically, the government no longer will be involved in the ownership or management of the former public hospital.
Management Contract	Management by an existing health system or management company. The degree of ongoing involvement by the local government varies, as does the length of the management contract.
Consolidation	The union or combination of two or more entities into one system. Boston Medical Center is the result of the consolidation of Boston City Hospital and Boston University Medical Center Hospital.
Closure	A situation where a public hospital ceases operations temporarily or permanently. Typically, all of the assets of the former public hospital will be sold to another entity and the hospital will no longer be referred to under its previous name.
Joint-Venture	A partnership, often to share risk or expertise.
Public/Private Partnership	The transfer to or combination with an existing private health system. There still may be a high level of ongoing involvement by and accountability to the local government.
Affiliation	A close association between two or more organizations. The entities maintain separate ownership and governance.

Source: National Association of Public Hospitals and Health Systems, *The Safety Net in Transition: Monograph II, Reforming the Legal Structure and Governance of Safety Net Health Systems*, June 1996.

Table 2: Types of Entities that Own and Operate Former Public Hospitals

Type of Entity	Definition
Private:	
Non-Profit	A tax-exempt corporation, created under a state's non-profit corporation law to serve a charitable purpose. Any profits from its operation are reinvested in the corporation. Boston Medical Center, Sutter Medical Center, Seton Healthcare, and Oakwood Healthcare System are all private, non-profit organizations.
For-Profit	A corporation that is not tax-exempt, the profits of which are distributed in a systematic manner to the corporation's owners.
Quasi-Public:	
Hospital Authority	A public body or agency of a governmental unit created by a state statute to administer a portion of the powers of the government delegated to it. University Hospital in Colorado is now owned and operated by a hospital authority.
Public Benefit Corporation	A public corporate entity that provides a specific public benefit to state residents. Often established under a state's public benefit corporation law. The profits from this corporation inure to the state or the people of the state.
Hospital Taxing District	A quasi-municipal but independent corporation covering a defined geographic area that is established under state legislation. A hospital taxing district has taxing authority and operates a district hospital.
Public/Private Partnership:	Include affiliations, consolidations and joint-ventures. Each entity maintains its own board and ownership status.

Source: National Association of Public Hospitals and Health Systems, *The Safety Net in Transition: Monograph II, Reforming the Legal Structure and Governance of Safety Net Health Systems*, June 1996.

Objectives of the Study

The main objective of this study is to understand the causes and effects of the conversion of public hospitals to private ownership or management. We look at conversions that occur via lease, sale, management contract, merger, consolidation, and the establishment of an independent hospital authority.

In undertaking the study, we were particularly interested in understanding how the conversion to private status affects hospitals' public missions. Although many private community hospitals have roots as charitable institutions with a mission to serve people with limited financial means, in recent years many of these hospitals have assumed a more "business-like" approach to providing care. In some cases, the consequence has been that the public hospitals have assumed an even more prominent role in serving populations who have difficulty accessing care. Public hospitals have often been the providers of last resort, serving not only large Medicaid populations, but also indigent and other difficult-to-serve populations without any form of insurance or social supports.

Conversion of public hospitals to non-public status naturally raises questions about the hospitals' continued commitments to the mission of serving needy populations. Do the conversions adversely affect access to care for some populations served by the formerly public hospital? A related issue is the prominent role many public hospitals play in providing graduate medical education. The residents in public hospitals' teaching programs often staff

the hospitals' clinics, which provide care to large numbers of uninsured patients. We also were interested in the effect that conversion to private ownership or management would have on these teaching programs. Thus, a particular focus of our study was to determine whether conversions changed the missions of the hospitals and affected the populations they serve. We sought to determine the role the hospital's public mission played in deliberations leading to conversion and the consequences once the hospital adopted its new management, ownership or governance structure.

We explore five major issues in this study:

- the motivations for seeking these new arrangements, on the part of both the governmental agency and the private organization;
- the process by which the conversion was accepted by government, hospital officials and community members;
- the structure of the conversion (for example, lease, sale, or merger);
- the effect of the reorganization on the public hospital's internal operations (for example, costs, revenues, clinical practices, and labor relations); and
- the effect of the reorganization on the external community in which the hospital is located, including the fulfillment of the hospital's social mission.

We also identify models for reorganization that are common and successful.

Methodology

Our research approach to this issue is primarily qualitative, although the report contains a small quantitative component. First, we analyzed data on all public hospital conversions from 1985 through 1995 to determine if any patterns emerge from the data that can help us understand the reasons for and consequences of these conversions. We then conducted intensive telephone interviews to gather detailed information in five sites, supplemented in two of those locations by site visits. These interviews and site visits served as the basis for our five case studies of public hospital conversions. We also did further research to describe and analyze an additional 10 conversions to illustrate the diversity of conversion activity that is occurring around the country.

National Data

Using 1985 through 1995 data from the American Hospital Association's *Annual Survey of Hospitals*, we sought to describe the scope of public hospital conversions nationally, by year and by state, and to explore some of the characteristics of the hospitals that converted. During the period from 1985 through 1995, approximately 293 public hospitals converted to non-profit or for-profit ownership or management, and 165 public hospitals closed. The effect was to reduce the total number of public hospitals over that period by roughly 14 percent from 1,607 to 1,387. During that same period, a smaller number of formerly-converted public hospitals converted *back* to public status by, for example, terminating management contracts with private firms, thereby creating a small flow of institutions moving from private to public

status. In addition, conversions were not evenly distributed across the country; 12 states accounted for approximately two-thirds of these conversions. A disproportionate number of the states with high numbers of conversions were located in the South.

Because the motivations for conversion typically include the inability to remain financially viable in the local hospital market, and because post-conversion strategies usually focus on making the hospital more competitive in that market, we attempted to look at some characteristics of converting public hospitals *vis-à-vis* their competitors. However, the available data did not allow statistical analyses of these characteristics. Laying out relevant descriptive characteristics, such as market competitiveness and hospital efficiency, did not reveal patterns that might provide useful insights into reasons for conversion. This reflects the inadequacy of available databases for analysis of this particular issue, and also echoes comments we heard from respondents about the unique nature of each instance of public hospital conversion.

Case Studies

In selecting the five case study sites, we first searched various information sources for publicized conversions of public hospitals. These secondary sources included the national and local newspaper files of the LEXIS/NEXIS database; reports and monographs on hospital conversions and mergers prepared for and by foundations and government agencies; and telephone interviews with individuals knowledgeable about hospital conversions. After identifying 25 to 30 public hospital conversions, we contacted hospital officials to invite them to participate in the study and ask for their approval to interview staff members as our primary source of information about the conversion. Through additional research, we identified various members of the community to interview who were knowledgeable about or involved in the conversion process at the site in question.

In choosing sites, we looked for geographic diversity as well as diversity in the type of reorganization, and attempted to include an investor-owned hospital system, an academic medical center, and a mix of urban and suburban/rural hospitals. We avoided choosing sites where the conversion was so recent that the impact on hospital operations and the community might not be evident.

The process of identifying and selecting hospitals to participate as case studies in our project proved more difficult than we had anticipated. Many hospital administrators expressed reservations about participating in the study because of the sensitive nature of the topic and a fear of potentially being portrayed negatively. Hospitals that decided not to participate explained that this concern does not lessen over time after a conversion. Hospital staff and community members who agreed to participate confirmed that the subject was highly sensitive and contentious. One formerly public hospital, after agreeing to participate in the study and after a month of telephone calls, letters and faxes, backed out at the insistence of the national headquarters of its investor-owned purchaser.

The fact that we were turned down by some hospitals may have introduced some bias into our study. Hospitals that declined to participate may have a different conversion history than those that agreed to be subjects of our case studies. For example, a hospital's reluctance to

participate may reflect continuing community hostility regarding the conversion, which could, in turn, reflect a change in the hospital's mission and the clientele it seeks to serve. Those agreeing to participate might, on the other hand, be conversions that were more successful and thus no longer as controversial within their communities.

Ultimately we chose five sites for intensive study. These include Boston Medical Center in Boston, Massachusetts; University Hospital at the University of Colorado's Health Sciences Center in Denver, Colorado; Brackenridge Hospital in Austin, Texas; Sutter Medical Center of Santa Rosa in Santa Rosa, California; and Oakwood Healthcare System, in suburban Detroit, Michigan. We collected background material on each case study hospital from secondary sources, such as local newspapers that publicized the conversion and relevant legal documents (including consolidation or lease agreements, annual reports, mission statements, and enabling legislation). The bulk of our information, however, was obtained through structured telephone interviews of 30 to 75 minutes in length with between 10 and 20 individuals at each site. These individuals were hospital administrators and staff members, state and local government officials and policy makers, representatives of local safety net providers, and other community observers who could give us insightful perspectives on the issues. To the degree possible in each site, our list of interviewees included:

- Hospital CEOs
- Hospital CFOs
- Chiefs of medical staffs
- Members of the pre-conversion governing body of the public institution
- Members of the post-conversion governing body
- Directors of the public hospital residency programs
- Hospital attorneys
- Hospital medical directors
- Hospital employees, particularly those affiliated with hospital unions or employee associations
- Representatives of local safety net providers, including community health centers and public health agencies
- Representatives of patient advocacy groups
- Representatives of labor unions
- State or local hospital association executives

In two cases, University Hospital at the University of Colorado's Health Sciences Center and Sutter Medical Center of Santa Rosa, we visited the site so we could observe the hospital environment first-hand and speak at length with additional individuals who were knowledgeable about the local health care and hospital market. These site visits were supplemented with additional telephone interviews.

Additional Profiles of Public Hospital Conversions

In researching numerous public hospital conversions and contacting hospital officials to recruit hospitals to participate in our study, it became clear that public-to-private hospital conversions (mostly to non-profit status) are occurring all over the country and that there are a variety of reorganization models. To illustrate this variety, we include in the appendix of this report 10 one-page profiles that describe additional public hospital reorganizations around the country. We collected the information for these profiles from newspaper articles, annual financial reports and telephone interviews.

Case Study Sites

Our analysis is based on a detailed review of five public hospital conversions. A brief description of each is outlined below.

Boston Medical Center

A consolidation of a public teaching hospital and a private teaching hospital, resulting in a single private, non-profit entity.

In 1996, Boston City Hospital (BCH), a public teaching hospital, Boston Specialty and Rehabilitation Hospital (BSRH), a public long-term care hospital, and Boston University Medical Center Hospital (BUMCH), a private, non-profit teaching hospital, consolidated their operations to form Boston Medical Center (BMC), a private, non-profit entity. As part of the consolidation agreement between the city of Boston and BUMCH, BSRH closed 90 days after the affiliation and its services were consolidated into the former BCH facility at BMC. The consolidation was initiated by a desire on the part of the hospitals' administrators to assure economic viability in an era of managed care, which engendered cost-cutting initiatives and increased competition for paying patients. The two hospitals were logical partners for affiliation as they were both teaching hospitals of Boston University's School of Medicine and had collaborated for many years on health care and physician-training programs. They also were located physically across the street from one another.

Although there was opposition to the consolidation initially from certain employee and patient advocacy groups, and problems to overcome in effectuating the consolidation, the affiliation is generally considered to be a success by hospital administrators and staff, community physicians, patients, and other community representatives. The hospitals consolidated duplicative services in many areas and cut costs, while continuing to provide essential health care services to community residents, particularly its indigent populations.

Two issues that remain contentious at BMC are the cultural integration of the patient populations and physician staff of the two hospitals and the physical consolidation of the two hospital buildings at BMC. BCH typically served an urban population base with large numbers of indigent patients, while BUMCH served patients from Boston's suburbs who were referred to the medical center for mostly inpatient care. Some critics of the consolidation claim that BMC has yet to develop an effective way to serve both patient populations with one standard of care, in a manner in which both patients and physicians are satisfied. In addition,

there are future plans to consolidate the two hospital buildings into a single facility. This issue has caused some to question which patient population base BMC should and will continue to serve. These issues have served as barriers to the complete consolidation of the two hospitals into a single, private hospital entity.

Brackenridge Hospital and Children's Hospital

A lease of two public hospitals to a private, non-profit hospital system.

Brackenridge Hospital and Children's Hospital are two former public hospitals located in Austin, Texas. On October 1, 1995, the city of Austin leased all of the assets of both hospitals to Seton Healthcare Network, a local, non-profit hospital system operated by the Daughters of Charity National Health System. Under the 30-year renewable lease, Seton effectively took over financial and operational responsibility for both institutions.

A number of factors drove the city's decision to enter into a leasing arrangement with Seton, including mounting operating losses at the hospitals and city rules that made it difficult to attract and retain top-notch hospital management or to operate the hospitals efficiently. More importantly, perhaps, because Brackenridge and Children's were the only independent hospitals operating in a rapidly-consolidating health care environment, city leadership began to doubt the ability of the city to operate the hospitals effectively. These factors combined to raise the distinct possibility that the hospitals would have to shut their doors, as the city no longer believed it could afford to subsidize operations. For its part, Seton was interested in the lease arrangement because of its commitment to continue serving the indigent population in Austin. Seton management realized, moreover, that if Brackenridge and Children's closed their doors, all of the burden for caring for the indigent in the city would likely fall on Seton anyway. Thus, in their view, it was better to fix the problem before the hospitals closed.

Issues remain in the Roman Catholic community about the provision of reproductive health care services at the hospital. Seton, the local Catholic bishop and the city have re-worked the lease agreement to meet the church's objections, and to allow the hospital to provide sterilization and contraceptive services; this new agreement awaits approval by the Vatican. The money paid by Seton under the lease arrangement has helped the city pay off its existing hospital debt, and even provided for a small surplus. The hospitals themselves have received $17 million in capital improvements since the takeover, and are on sounder financial footing as part of a non-profit system that is well-positioned to succeed in the dynamic Austin market. Finally, Seton appears to be more than meeting its obligations to continue to provide a wide array of services to the indigent population.

University Hospital

A transfer of the assets of a state-owned academic medical center to a quasi-public hospital authority.

In 1991, the Colorado legislature passed a law enabling University Hospital, an academic medical center affiliated with the University of Colorado's Health Sciences Center, to become a non-profit organization under an authority structure. As the University Hospital Authority,

the institution is "quasi-public;" it retains several of the benefits of a public institution, but may operate free of many of the constraints on personnel management, debt issuance, and purchasing normally imposed by the state.

The reorganization of University Hospital was driven by years of financial losses, which resulted in a drain on the resources of the University of Colorado, and particularly the Health Sciences Center. Despite significant opposition, administrators at the Health Sciences Center and the hospital—with the support of expert studies and as a result of various crises—convinced the University Regents and state legislators that the long-term survival of the hospital depended on its being freed from the state's requirements and restrictions.

To date, the conversion to the Authority structure is regarded as a success. Free to issue debt, hire and fire, purchase equipment, and invest in the facility, the hospital has seen dramatic improvements in its productivity and its financial performance. Having upgraded its ability to provide tertiary and quaternary care—the traditional role of an academic medical center—it has become a competitive force in the local market, and has been able to enter into several profitable partnerships to win managed care contracts. It is also exceeding the state-imposed requirement to provide care for the medically indigent. Although there is some concern in the community that the hospital's efforts in this area are not sufficient to meet the need, leaders of community health centers concurred that University Hospital would have been significantly less able to serve this population had it not reorganized to compete in a managed care environment.

Sutter Medical Center of Santa Rosa

A lease of the assets of a county hospital to a private, non-profit health care system.

Sutter Medical Center of Santa Rosa, California is the result of a lease (of the physical assets) and a health services contract (enumerating services to be provided) between Sonoma County, located north of San Francisco, and Sutter Health, a non-profit organization that operates 26 hospitals in Northern California. The former county hospital had been losing money and patients for a number of years, and received no operating subsidy and only limited capital from the county. The county supervisors considered proposals from an investor-owned company and from Sutter before choosing the latter, and negotiated agreements with Sutter to maintain certain clinical programs and access to care for low-income patients. Sutter, which manages a half-dozen former county or district hospitals, wanted a foothold in the inpatient care market in Santa Rosa. In return, Sutter agreed to make substantial capital investments in an aging facility that might not meet the state's new seismic safety standards for hospital buildings, which go into effect in the year 2008. There was opposition in the community to the transfer of responsibility for the hospital from the county to a private firm, and attempts to block the transaction. Particularly vociferous opposition (which continues to this day) came from the labor union which represents the majority of the hospital's employees.

Sutter Health has made capital improvements to the facility, developed new clinical programs, and cut operating costs. The lower operating costs are the result of job re-design in several areas, some lay-offs, economies of scale from using Sutter's corporate systems for back-office

functions such as purchasing, and a cut in the hospital's family practice residency program. Although union representatives maintain that these cost-cutting measures compromise quality of care and access for the uninsured, safety net providers in the community have seen no diminution in access for their patients. There is, however, a feeling that the hospital is no longer an active advocate for the poor, as the county hospital had been. Since the hospital continued to lose money until quite recently, there is some feeling that the community needs to continue to monitor quality and access issues.

Oakwood Healthcare System

A merger of a network of five public hospitals into a private, non-profit hospital system.

Oakwood Healthcare System, in Dearborn, Michigan, is a product of the merger of Oakwood Hospital, a non-profit community hospital, and the five public hospitals that made up the People's Community Hospital Authority (PCHA), which served more than 20 communities in the suburban Detroit area. In the 1980s, PCHA officials became concerned about the financial viability of the system's public hospitals, because of the limitations that public status placed on their management, planning, and financing flexibility. The initial solution was to convert the hospitals to non-profit status, but without any change in actual operations. This proved inadequate to restore financial profitability. The next step was to consider merger with another institution. Oakwood Hospital was an attractive partner because of its financial strength, good reputation, and commitment to serving the populations that the PCHA hospitals viewed as their constituents. Oakwood saw the merger as a chance to expand its service area, build market share, and generally strengthen its competitive position.

The merger process went relatively smoothly, partly because labor and other stakeholders were persuaded that the hospitals could not survive without a change in status. Key representatives of the PCHA hospitals were committed to the merger and made efforts to persuade the communities that the plan would be in their interests. The 1991 merger—which went through several intermediate steps—has resulted in consolidation of systems, governance, and management. However, progress toward clinical integration and merging of medical staff has been slower. The public mission seems to have been preserved; hospital officials report no significant change in payer mix. Controversy, however, has arisen even seven years after the merger: one of the communities, Ypsilanti, has sued to bring its former PCHA hospital back under control of the city, fearing that it will otherwise eventually be closed by Oakwood. In July 1998, however, this lawsuit was dismissed and the parties reached a settlement designed to ensure the continued operation of the Ypsilanti hospital, at least in the short-term. For example, Oakwood must ensure that the hospital continues to function as a "primary care-focused community hospital" and that medical services in the community be provided by a "network of community-based primary care physicians." In addition, the hospital is permitted to continue to seek relationships with other local providers to ensure geographic accessibility to community members. However, if Oakwood decides to close the hospital or diminish its investment in the hospital, it must provide notice to the community and give the community the option to buy the hospital.

Overview of National Data

Public, non-federal hospitals account for almost one-quarter of community hospitals in the United States. As shown in Figure 3, the number of public hospitals has been decreasing at least since the mid-1980s. In fact, from 1985 to 1995, the number of public hospitals declined by nearly 14 percent. During this period, 293 public hospitals converted to private ownership or management, and 165 closed; an additional 20 formerly public hospitals closed after converting to non-public status.[1] A small number of public hospitals that converted to non-public status converted back to public status in subsequent years.[2] For example, some counties and hospital districts have terminated management contracts with private firms and re-assumed direct control of their public hospital. This trend in public hospital conversions can be summarized as follows: for every 100 public hospitals, one is closing and two are converting to private ownership or management annually.

The number of conversions of hospitals from public to non-public status is not evenly distributed across the United States. In fact, 12 states accounted for approximately two-thirds of the conversions from 1985-95. In a number of these states, between 25 and 40 percent of all public hospitals converted to non-public status. As Figure 4 illustrates, a disproportionate number of the states with high numbers of conversions are located in the South. (See Table 3 and Figure 4).

It is reasonable to ask whether public hospitals that close or convert to some private status differ in some systematic ways from hospitals that do not undergo such changes. We attempted to explore this question by comparing public hospitals that experienced a change in ownership or management status to other hospitals in their market area, defined as a metropolitan statistical area (MSA) for hospitals within an MSA and as the other non-MSA hospitals in the state for hospitals located outside an MSA. (At first glance, it might seem appropriate to compare only public hospitals that experience a status change to those that do not. But we concluded that market conditions from area to area differ to such a degree that such a comparison would not prove useful or valid.)[3]

---

[1] Calculations here and at subsequent points in this narrative are based on an effort by ESRI to verify, clean, and organize data from the American Hospital Association *Annual Survey of Hospitals*.

[2] This is one reason why in Figure 1 subtracting the number of conversions and closures from the number of public hospitals in one year does not equal the number of public hospitals in the subsequent year. The discrepancy may also reflect the fact that some hospitals listed as closed in one year may be coded as being reopened in a subsequent year. An examination of the data suggests that some hospitals that have had public status at some point are incorrectly coded in other years. Where such errors were obvious, we tried to adjust to correct the problem.

[3] In choosing the characteristics by which to compare the converting and closing hospitals to other hospitals in their market area, we were constrained by the data in the American Hospital Association database, supplemented by several other data elements available to us. Our task was also greatly complicated by the fact that the AHA data appear to include a number of coding errors with respect to public hospitals. Before analyzing the data, we went to considerable effort to try to decipher these problems and correct them by applying rules of reason. But some problems undoubtedly remain.

Our basic approach was to compare every public hospital undergoing a status change to the other hospitals in its market area for the two years prior to the year in which the public hospital changed ownership or management status.

We chose to compare hospitals using variables that we thought might possibly explain why a public hospital would convert or close. For example, it is reasonable to ask whether the level of competition in a market might explain why some public hospitals convert and others do not. To test for this, we examined variables that measure the level of managed care penetration, the degree to which hospitals in a market are aligned (through mergers or strong strategic alliances), the degree to which physicians operate in large groups, and the size of population of the MSA in which the public hospital is located.

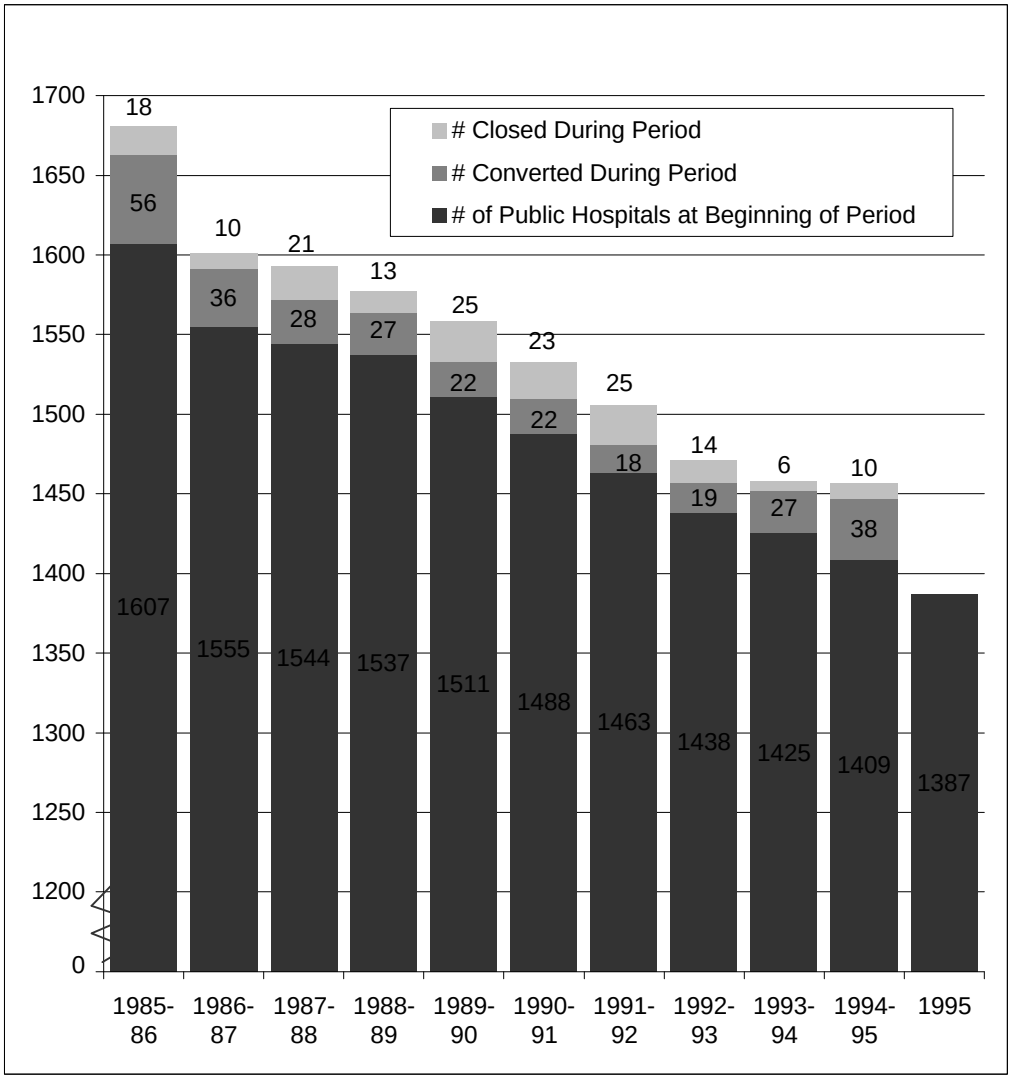
We also thought that public hospitals that undergo a status change might be ones that are relatively inefficient compared to their competitors; for example, they might have high expenses per adjusted admission or a high ratio of FTEs to staffed beds.[4] Our analysis did not indicate that public hospitals that convert or close were significantly less efficient (as measured by these proxies) than other hospitals in their market areas. In some instances, in fact, the findings were counter-intuitive.

In general, we did not find important and significant relationships between the various explanatory variables and hospital conversion or closure. In other words, the effort to identify characteristics that distinguish between closing or converting public hospitals and other hospitals in their market area did not yield significant insights. There is nothing obviously different about these hospitals that seems to explain in a systematic way why they changed from public to non-public status. We did not find this result particularly surprising, however, because our qualitative analysis also led us to the conclusion that converting hospitals are often quite different from one another, as are the markets in which they operate.

For the eleven years in our database we identified all instances of public hospital status modifications. We then compared the change with respect to a specific variable for these public hospitals for each year of the two-year period preceding the conversion to the changes in the same variable for the non-public hospitals in the same service area for that two-year period. We did tests of statistical significance to determine if any of the differences that we observed were large enough to be considered "real."

[4] We also speculated that public hospitals that convert or close might be experiencing financial stress and that such stress might be reflected by a decline in admissions that was greater than other hospitals in their service area. We did find that *non-MSA* (such as rural) public hospitals that experienced a status change were more likely than other hospitals in their service area to have suffered from declining admissions, but this was not the case elsewhere.

Figure 3: Number of Public Hospitals, Conversions, and Closures, United States, 1985-1995



Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

*Note: The Y-axis starts at 1200 rather than zero, which makes the closures and conversions appear to be larger relative to the number of public hospitals than they actually are. The graph does, however, accurately portray the trends.

Table 3: Number of Public Hospitals, Conversions, and Closures, by Region and State, 1985-1995

	Number of Public Hospitals*	Number Converted	Number Closed	Percent Converted	Percent Closed
Region 1 (New England)					
Connecticut	2	0	0	0%	0%
Maine	4	0	0	0%	0%
Massachusetts	13	1	4	8%	31%
Total for Region 1	**19**	**1**	**4**	**5%**	**21%**
Region 2 (Mid Atlantic)					
New Jersey	5	1	1	20%	20%
New York	32	4	4	13%	13%
Pennsylvania	9	4	3	44%	33%
Total for Region 2	**46**	**9**	**8**	**19%**	**17%**
Region 3 (South Atlantic)					
D.C.	1	0	0	0%	0%
Florida	57	20	8	35%	14%
Georgia	105	26	7	25%	7%
Maryland	1	1	0	100%	0%
North Carolina	52	11	1	21%	2%
South Carolina	31	1	1	3%	3%
Virginia	7	1	1	14%	14%
West Virginia	17	6	2	35%	12%
Total for Region 3	**271**	**66**	**20**	**24%**	**7%**
Region 4 (East North Central)					
Illinois	43	4	3	9%	7%
Indiana	52	3	1	6%	2%
Michigan	48	22	4	46%	8%
Ohio	28	2	2	7%	7%
Wisconsin	11	3	1	27%	9%
Total for Region 4	**182**	**34**	**11**	**19%**	**6%**
Region 5 (East South Central)					
Alabama	63	14	3	22%	5%
Kentucky	25	11	1	44%	4%
Mississippi	80	20	7	25%	9%
Tennessee	43	13	1	30%	2%
Total for Region 5	**211**	**58**	**12**	**27%**	**6%**
Region 6 (West North Central)					
Iowa	68	1	4	2%	6%
Kansas	89	6	7	7%	8%
Minnesota	76	9	9	12%	12%
Missouri	46	5	3	11%	7%
Nebraska	49	1	5	2%	10%
South Dakota	11	4	1	36%	9%
Total for Region 6	**339**	**26**	**29**	**8%**	**9%**
Region 7 (West South Central)					
Arkansas	43	16	6	37%	14%
Louisiana	75	5	8	7%	11%
Oklahoma	72	12	3	17%	4%
Texas	195	18	26	9%	13%
Total for Region 7	**385**	**51**	**43**	**13%**	**11%**

Table 3: Continued . . .

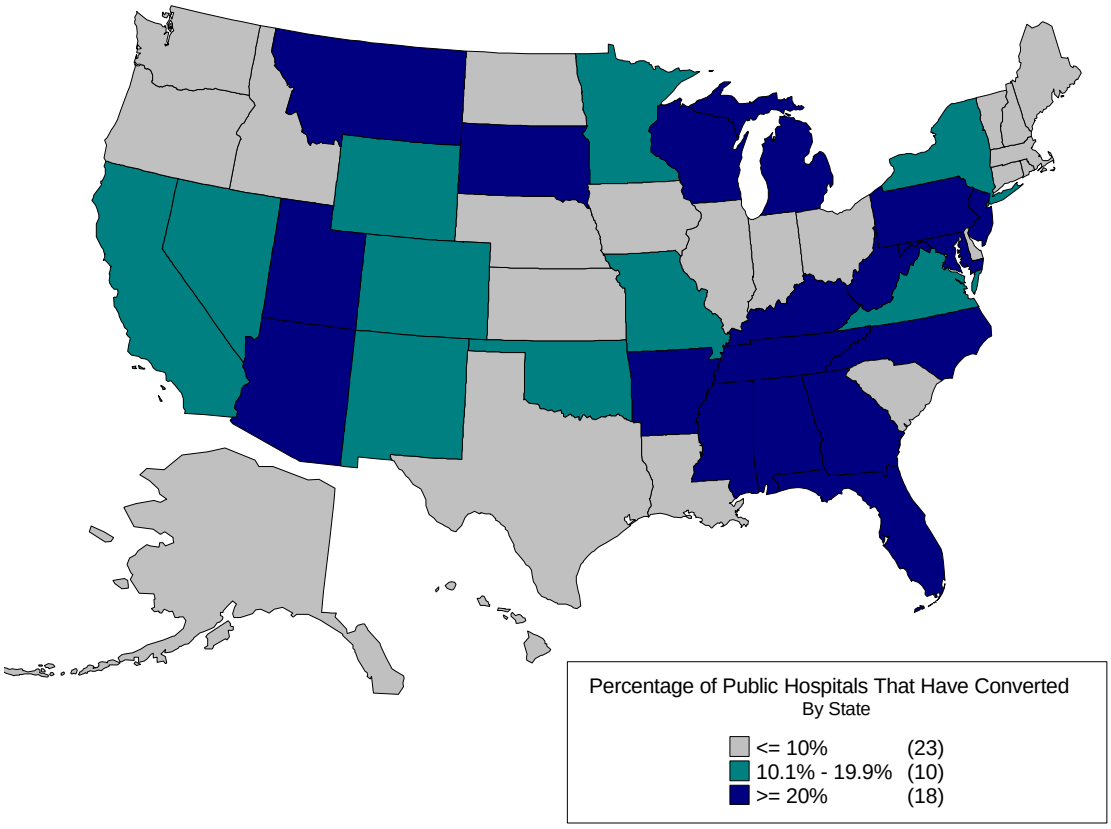
	Number of Public Hospitals*	Number Converted	Number Closed	Percent Converted	Percent Closed
Region 8 (Mountain)					
Arizona	10	4	2	40%	20%
Colorado	35	4	2	11%	6%
Idaho	30	0	2	0%	7%
Montana	20	10	1	50%	5%
Nevada	11	2	0	18%	0%
New Mexico	17	3	2	18%	12%
Utah	11	3	0	27%	0%
Wyoming	20	3	1	15%	5%
Total for Region 8	**154**	**29**	**10**	**19%**	**6%**
Region 9 (Pacific)					
Alaska	9	0	0	0 %	0%
California	111	16	11	14%	10%
Hawaii	8	0	0	0%	0%
Oregon	21	2	3	10%	14%
Washington	45	0	2	0%	4%
Total for Region 9	**194**	**18**	**16**	**9%**	**8%**
Region 0 (Associated Areas)					
American Samoa	1	0	0	0%	0%
Guam	1	0	0	0%	0%
Puerto Rico	24	1	11	4%	46%
Virgin Islands	2	0	0	0%	0%
Total for Region 0	**28**	**1**	**11**	**4%**	**39%**
Total	**1,829**	**293**	**164**	**16%**	**9%**

Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

*Number of hospitals that were coded as public at any time between 1985-1995. States with no public hospitals were excluded from the table.

*Note: The count of public hospitals includes all hospitals that at any time during the period 1985-1995 were designated as a public hospital in the American Hospital Association Annual Survey of Hospitals.

Figure 4: Proportion of Public Hospitals Converting to Non-public Status, by State, 1985-1995



Source: ESRI analysis of data from the American Hospital Association, *Annual Survey of Hospitals, 1985-1995.*

Key Findings and Cross-Cutting Themes

Key Findings from the Case Studies

Our richest source of information was the five case studies, based to a great extent on face-to-face and telephone interviews with informants inside the hospitals and out in the communities. We summarize here the most important points, organized into four categories: the motivations for conversion, the process of conversion, its effect on hospital operations, and also its effect on the local community.

Motivations for Conversion

- The public hospitals converted to private ownership or management primarily because they were trying either to recover from or avert imminent financial difficulties. The emergence of the hospitals' financial problems was largely a consequence of the increasingly competitive nature of the hospital industry and the change in payment resulting from the growth of managed care in both the public and private sectors. The public hospitals were in danger of losing both patients and revenues. To a great extent, the forces motivating these conversions and the changes they ultimately wrought were what most private hospitals had already experienced some time ago.
- The constraints placed on these hospitals as public institutions made it extremely difficult for them to adapt to the new competitive environment. These constraints included: open meeting requirements; limits on the hospitals' capacity to downsize the work force or change the mix of workers because of government work rules or political opposition; inability to hire top quality managers; barriers to entering joint ventures; limits on the ability to raise capital through borrowing; and the inherent deliberative nature and slower pace of making decisions through public processes. These constraints of public governance and management made it difficult for hospital administrators to adopt good business practices, even functions as basic as capital budgeting, which other businesses in competitive industries (which the hospital industry had become) knew were necessary for market survival.
- To preserve the institution for indigent patients, for whom it was the provider of last resort, those responsible for the public hospitals decided it was necessary to operate the institution for *everyone* – that is, to use the market to make the hospital financially viable by attracting not only patients who cannot afford to pay, but also those who can. We did not find government willing to continue to subsidize a hospital that would serve the poor exclusively. This attempt to use market mechanisms to preserve the hospitals' social mission called for the public hospitals to make changes similar to those that private hospitals had made earlier.

Process of Conversion

- Successful conversions were led by individuals who recognized that public hospitals could not achieve their mission of serving indigent and vulnerable populations if they could not survive. These leaders were successful in persuading stakeholders that the hospital had to be able to adopt good business practices to continue operating, and that to do this required being able to operate with the flexibility of a private entity. They were able to convince the community that the choice was not between having the hospital achieve its mission by continuing as a public entity and converting to a private institution. Rather, the choice was between pursuing its mission as a private institution and retaining its public identity and not surviving.
- The private hospital organizations that were successful in negotiating agreements with cities or counties had to be credible partners with a good track record in serving communities, including vulnerable populations such as Medicaid patients and the uninsured. In several cases other organizations, including some investor-owned firms, were not considered acceptable stewards for the hospital's continuing mission because their values, corporate culture or prior experience were at odds with community norms.

Effect on Hospital Operations

- While moving in the direction of dependence upon market discipline to promote efficient operation, the successful conversion leaders recognized the need to accommodate labor by not adopting the "slash and burn" tactics of some corporate "turn-arounds" that have initiated massive layoffs as part of cost-cutting initiatives. Often this was accomplished by deriving significant efficiencies from economies of scale, incorporating administrative functions into those of a parent organization or hospital system. Labor had to give up some of the protections of public sector work rules and generous pay and benefit provisions that sometimes made the public hospital less competitive. At the same time, to ease the transition, most public hospital conversions included some temporary "grandfathering" of wages and job positions and achieved labor force reductions primarily through attrition rather than layoffs. In this way, the "social contract" between employer and employee was not ripped up, but revised. The lesson was that it is difficult to do this *to* labor, but possible to do it *with* them.

Effect on the Local Community

- Conversions that went relatively smoothly were led by individuals who recognized from the outset the need to assure the community that the hospital's public mission would be preserved, and who developed mechanisms to ensure that the new entity would maintain a commitment to the mission of providing care to the uninsured (for example, contractually requiring the new governing body to maintain specific levels of charity care).
- Conversions of public hospitals to non-profit status did not appear to reduce access for populations who traditionally have been served by public hospitals. In general, the new non-profit institutions continued to provide at least the same level of care to low-income and other vulnerable populations as the public hospital had. Conversions also did not appear to adversely affect training programs operated by the public hospitals, as programs

generally operated at their pre-conversion size and level after the change in ownership or management. Their communities will continue to monitor these institutions, however, to ensure that the commitment to access continues as the newly-converted institutions compete to survive.

Cross-Cutting Themes

Motivations for Conversion

The following reasons were cited as the primary public-sector motivations for conversion of the public hospital. Hospital officials at each of the case study sites began to question whether they had the managerial resources and knowledge to operate a hospital efficiently in the current marketplace. Caught between an inability to keep pace with changes in the hospital industry and a need to ensure that the hospital did not become a financial liability for taxpayers, hospital officials sought outside help.

Continued Financial Viability

Maintaining financial viability of the public hospital was the principal public-sector motivation for conversion. Hospital administrators were either trying to curb immediate losses or forestall the likelihood of future losses. The administrators felt it would be easier to cut costs, by streamlining at least administrative or "back-office" operations and taking advantage of economies of scale, as private institutions. Four of the public hospitals had sustained significant financial losses for a number of years prior to conversion. The one exception, BCH, faced an uncertain financial future. Hospital administrators in Boston questioned whether the hospital's public funding sources would remain sufficient to support operation of the public hospital. For example, hospital officials anticipated future cuts in disproportionate share hospital (DSH) payments and a change in reimbursement from the state's generous indigent care pool to capitated payments. In fact, both of these fears were eventually realized subsequent to the conversion. In the case of the two Boston hospitals that merged to form Boston Medical Center, the motivation for both sides was long-term viability. According to some respondents, the merger was more important for Boston University Medical Center Hospital's (BUMCH) immediate survival than Boston City Hospital's (BCH).

Ability to Attract a Broad Range of Patients

Increased competition for patients—in large part because of managed care and selective contracting—was also an influential factor at all of the hospitals. Competition for Medicaid revenues increased with the Medicaid expansions of the late 1980s and early 1990s and Medicaid's shift to managed care in the mid-1990s, which enabled more and more patients to seek care from providers other than the traditional safety net institutions. Management at each of the case study hospitals felt it was essential to become part of a larger health system to attract these patients, as affiliations offered increased bargaining power in negotiating managed care contracts with health plans and other third-party payers and a larger system within which to provide care to a broader range of patients. In Austin, the public hospital was the last remaining stand-alone institution in a rapidly-consolidating market. In Boston, BCH

and BUMCH were two of the last. In states like Massachusetts, which provide significant funding for charity care through a state-wide indigent care reimbursement pool, competition even for uncompensated patients can be fierce.

Freedom from Constraints of Public Governance

Another motivation for conversion at all of the former public hospitals was a need to get out from under the constraints of being a public entity, with all of the restrictions and lack of flexibility that this status entails. In Boston, Denver, and Detroit, it was necessary to make changes in state law to permit a transfer of control of the public hospital. Other restrictive aspects of public governance were open meeting acts, which precluded the hospitals from developing competitive strategies in private, and public payroll, personnel, and purchasing systems which made it difficult for the public hospital to operate efficiently. For example, the City of Austin's salary and compensation regulations made it difficult to hire and retain good managers. In Denver, almost 90 percent of the hospital's nurses resigned or threatened to strike over low wages mandated by an annual state-wide salary survey.

One aspect of public governance that proved particularly troublesome for hospitals that were trying to compete for patients was state open meeting requirements. Administrators from four of the five hospitals in our study complained about the effect that these laws have on the ability of public hospital governing boards to create strategic plans in private that allow them to compete effectively in their markets. Trustees and administrators argued that public hospitals cannot operate like a business because their competitors can send representatives to public hospital board meetings to hear them lay out their strategy.

In retrospect, it is difficult to assess the true importance of this issue. It would seem that, given the other impediments to effective management of public hospitals, this might have been less an issue of keeping strategy secrets from competitors than an issue of the complications that arise from governing and managing a complex institution in an open, political forum. Although public hospitals might suffer in today's market because of their inability to conduct strategic planning in private, discussions about the fate of the public hospital and the options available to solve its problems gain needed credibility when conducted in a public, rather than private forum. Boston officials feel they benefited from holding public hearings, legislative sessions, and city council deliberations in the public domain.

Access to Capital

Access to capital was another important issue at a few of the hospitals. For example, University Hospital in Denver could not issue debt, and as a result the hospital could not invest in the new equipment and facilities it needed to be a true tertiary care referral center. The Sonoma County supervisors in Santa Rosa had not provided their hospital with an annual capital budget for several years. Money was not available to upgrade the hospital's physical plant or to expand programs to attract a broader patient base—both important if the hospital were to attract patients who have a choice of hospitals. In general, the technological imperative inherent in modern medicine, plus the need to attract patients with facilities, staff and services, drive the hospital industry's current need for capital. Among our five case study

hospitals, the only exception to this was Boston Medical Center. Hospital administrators in Boston claimed that access to capital was not a problem for the public hospital, whose inpatient facility had been replaced a decade ago.

Private Sector Motivations

What were the motivations of the private-sector partners involved in conversions? In Detroit and Santa Rosa, it was to enter a new geographic market or expand presence in an existing market. In Austin, it was an extension of the private hospital's existing role as an indigent care provider and anticipation that a large additional indigent care burden would fall on the hospital if the public hospital failed. In Boston, it was the same long-term survival issues that threatened the public hospital.

Process and Structure of Conversion

At four of the five public hospitals we studied, the ownership or management structure that the former public institution eventually adopted was not the first option considered by government officials to solve their problems. The resulting structures were dependent on the motivations for the conversion, political feasibility in the local market, and the extent of organized opposition to the conversion at the specific site.

Although one interviewee in Boston asserted that there were potential alternatives to complete privatization of the public hospital in Boston, such as the creation of a hospital authority to run the hospital, the only option taken seriously by decision-makers for the city, particularly the influential mayor, was consolidation of the public and private hospitals. The creation of Boston Medical Center (BMC), a private, non-profit 501(c)(3) corporation, was authorized by state legislation that gave the city of Boston one year to consolidate the two hospitals under a single governance structure. A mayor's advisory committee, which strongly recommended a complete consolidation of the two hospitals, was responsible for guiding the state legislature and city government officials on implementation of the consolidation plan.

In Austin, the first alternative considered was the establishment of a taxing district, recommended by a city task force created to address the issue of indigent care. A second task force was created to focus on Brackenridge Hospital specifically, and it recommended the creation of an independent authority that would run the hospital free of many of the constraints of city management (for example, personnel and purchasing policies). Doubts arose about the ability of the authority to operate the hospital successfully, however, and the city finally decided to lease the facility to Seton Healthcare Network, a local Catholic hospital system.

The first attempt to separate University Hospital in Denver from state control occurred in 1989 when the state formed a private, non-profit (non-stock) corporation to which it transferred the assets and liabilities of the hospital. The Colorado Association of Public Employees filed a successful lawsuit to prevent the transaction, however, and the transfer was found to be an unconstitutional transfer of a public asset by the state's Supreme Court. Consequently, in 1991, the state legislature created a quasi-governmental hospital authority to take responsibility for the hospital. The authority, a 501(c)(3) corporation owned by the

people of Colorado, owns the assets of the hospital and is a semi-independent agency of state government.

In 1993, the Sonoma County board of supervisors turned responsibility for the day-to-day operation of the county hospital in Santa Rosa over to a five-member board of trustees comprised of community residents and physicians. However, as operating losses mounted, the Trustees eventually recommended to the supervisors that the hospital be leased to a private operator.

Conversion of the People's Community Hospital Authority (PCHA) in Michigan began with passage by the state legislature of enabling legislation that allowed the assets of PCHA's five hospitals to be transferred to a new 501(c)(3) organization with the same board members as PCHA. It became clear almost immediately, however, that the new entity, United Care, would not be the solution to PCHA's financial troubles. Shortly thereafter, United Care leased three of the hospitals to Oakwood Hospital, an area competitor. Eventually, United Care and Oakwood merged into a new entity in a two-stage process (although for legal reasons on paper an organization that represents the former PCHA hospital remains).

In two cities, Austin and Santa Rosa, the governmental entity continues to own all of the hospital's assets, but leases them to the private hospital system which manages the facility. While most of the public assets in the Boston conversion were merged into the new corporation, the BCH facility is still owned by the city's Public Health Commission and is leased to Boston Medical Center. In Colorado, the quasi-public hospital authority holds and manages the assets of the hospital. Concern over a reversion clause in the documents creating United Care led cautious administrators of the former PCHA hospitals in Detroit to maintain the legal name of United Care on paper, now called Oakwood United, and grant a 99-year lease of the hospitals to Oakwood Healthcare System.

Change in Governance Structure

At each of the case study sites, a change in governance structure was one of the primary objectives of the conversion. As noted earlier, it was the constraints of public governance, in part, that drove these conversions. At four of the hospitals, the new governing body has maintained a community-based and local focus by including members of the former public hospital board and community leaders on the new hospital board. The exception is Brackenridge.

Prior to the lease of Brackenridge and Children's Hospitals, Austin's city council served as the governing body and board of directors for the public hospitals. Since the conversion, Seton's board has assumed fiduciary responsibility for and governance of the hospitals. The hospitals do not have their own boards. Although Brackenridge's chief of staff is invited to attend Seton's board meetings, it is on a non-voting basis. In addition, administration and management of the two hospitals have been consolidated. For example, there is one CEO and one CFO for all of the hospitals within the Seton system. However, at each of Seton's hospitals, there is a high-level administrator who handles day-to-day operations of the hospital and a Physician Executive Committee that monitors quality.

Boston Medical Center is governed by a 30-member board: 10 members are appointed by the mayor; 10 are appointed by Boston University's trustees; six members are executives or physicians from the city's health commission, BU's School of Medicine, and BMC's administration and medical staff; and four members represent the city's community health centers. To monitor quality and service provision, BMC's board submits an annual report to the Boston Public Health Commission, the mayor of Boston, and the Boston City Council.

In Denver, governance of the Authority rests with a nine-member board. Three members represent the University and six represent the state at large. The board must report annually to the state legislature.

Sutter Medical Center in Santa Rosa is governed by a board made up of all but one of the former county hospital trustees (one trustee did not express an interest in continuing), and three Sutter executives. All nine members are appointed by Sutter. These trustees submit an annual report to the county supervisors.

In Detroit, both Oakwood Hospital and Oakwood United (holding the assets of the former PCHA hospitals) initially operated under a parent corporation called Oakwood Health Services Corporation. Recently, Oakwood Hospital and this parent company merged into a single entity called Oakwood Healthcare System (or Oakwood Hospital Corporation), but Oakwood United remains a separate entity (because of the United Care reversion clause) that leases its hospitals to Oakwood. Oakwood United no longer has a separate governing board, however, so fiduciary responsibility rests with Oakwood Healthcare System. In addition, Oakwood Healthcare System is now a subsidiary corporation of Oakwood Healthcare, Inc.

Effect on Hospital Operations

There were many similarities across the case study sites in the internal changes that occurred as a result of the public hospital conversions. These can be summarized as follows:

- *Freedom from public administrative constraints, such as personnel and purchasing regulations, that enable hospital officials to cut costs on "back office" functions*. For example, the former public hospitals in Austin and Santa Rosa now purchase through their respective private systems, Daughters of Charity and Sutter, taking advantage of economies of scale and less bureaucratic purchasing procedures.
- *Staff reductions, in both administrative and clinical areas, mostly through job re-design, retirement, or attrition*. Many sites had what were characterized as high staff-to-patient ratios. In Austin and Santa Rosa, where the hospitals now are operated by large private systems, the public hospital's staff-to-patient ratios were above both national norms and their respective systems' averages. Across all sites, outright lay-offs, however, were few.
- *Consolidation of departments and functions across institutions to minimize or eliminate duplication*. In the case of Oakwood, with several hospital locations, re-allocation of functions across sites has been smoother on the administrative side than on the clinical side. In Boston, administrators were able to consolidate some clinical units, in addition to administrative units, particularly when the patient census did not justify operating two units at facilities located across the street from one another. Even single-site cases, such

as Santa Rosa, took the opportunity to consolidate administrative and clinical functions within the institution (for example, the hospital now provides consolidated mother and baby care instead of separate obstetrical and newborn services).

- *Access to capital not available before the conversion to make what were characterized as long-overdue investments that, in part, allowed the hospitals to increase their revenue-generating potential among paying patients*. In Denver, hospital administrators borrowed money to expand and develop new specialty care services. In Santa Rosa, officials upgraded the physical plant to improve the hospital's image among paying patients. All sites are depending on some change in payer mix to improve their bottom line.
- *Flexibility to reduce or redistribute teaching and training responsibilities*. Although teaching programs were unchanged in Denver, Boston, and Austin, the number of residents in Sutter Medical Center's relatively small residency training program has been decreased in line with the decline in inpatient census. Beginning in 1998, the program will accept 10 rather than 13 new residents. In Detroit, almost all of the teaching programs remain at Oakwood Hospital, but Oakwood administrators are considering distributing some of the programs among the former PCHA facilities, where there currently are only two small teaching programs.

Effect on the Local Community

Access to Care Maintained

We observed that public hospitals have used conversions to cut costs and attract capital to modernize. In the process, however, have they been able to maintain their community missions? We did not, in general, find that local safety net providers, patient advocates and other members of the community thought access to care for the uninsured had been adversely affected by the conversions of the public hospitals. In fact, most of the written agreements that defined the conversions included "maintenance of effort" language, requiring the hospital to maintain specific levels of charity care for the length of the agreement.

In Austin, Seton pledged to maintain its commitment to provide charity care and will receive an annual payment from the city equal to the city's average expenditure for uncompensated care for the three years prior to the lease. In Denver, the hospital is required by law to spend a certain level of funding on indigent care, which it has surpassed. Measured in service units (inpatient days and outpatient visits), however, the state has determined that the hospital's recent indigent care load has dropped slightly, although it is still higher than it is required to be, and this has been the source of some controversy. In addition, some observers are uncertain whether the change in the hospital's indigent care load can fairly be attributed to the conversion which took place seven years ago or to subsequent changes in the Denver market, such as the increase in managed care, which usually results in less use of inpatient days.

In Santa Rosa, community observers do not perceive a decrease in access to charity care but sense that, outside the walls of the hospital in the community at large, Sutter is not the strong advocate for indigent and other vulnerable populations that the county hospital once was. In Detroit, the biggest concern in the former PCHA communities is that Oakwood will

change the service mix of one of the least-successful hospitals in the system, which would, in the minds of the town where it is located, jeopardize the existence of the community hospital. In Boston, while no specific levels of charity care are set forth in the consolidation agreement, most observers agree that access to care has been enhanced at BMC since the consolidation by the creation of over 50 outreach worker positions and the improvement of translation and other "enabling" services. In addition, BMC adopted the former public hospital's mission to serve all patients who present themselves for care "regardless of ability to pay."

In most of these communities, however, we were told that "the jury is still out" on this issue. There will be continued scrutiny of the new arrangements for some time to see if current conditions are just a "honeymoon" period with respect to the private organization's commitment to the formerly public hospital's charity care responsibilities.

Continued Oversight

Three of the hospitals we studied have, since the conversion, developed a publicly-accountable oversight body to monitor the institution's commitment to preserve the public mission of the public hospital. For example, the Austin City Council appointed a five-member oversight committee to hold monthly public meetings to monitor Seton's activities in three areas: access to care, level of services provided, and quality of care. In Detroit and Boston, oversight has been consolidated with governance of the private institution. At these sites, community members and health center representatives have significant representation on the post-conversion governing board. In Boston, the Boston Public Health Commission also monitors the maintenance of BMC's public mission through annual reports it receives from BMC. In addition, in July 1998, the mayor of Boston created an advisory board made up of nine community members that is responsible for monitoring health care access in Boston for all city residents, but particularly its indigent population. The creation of such an entity was recommended at the time of the consolidation of BCH and BUMCH. In Denver and Santa Rosa, no formal or informal oversight entity was charged with monitoring access to care and continued maintenance of the former public hospital's mission.

Other Lessons Learned

Our research reveals certain lessons about conversions of public hospitals to private, non-profit or for-profit status. Given the small number of cases we studied, we cannot say with certainty that these lessons are generalizable, but we nevertheless think they are worth consideration.

The Politics of Conversion

Hospital officials contemplating a public hospital conversion should not view the effort principally as an organizational or managerial change, but instead as primarily a *political* process. Communities that have realized this and addressed the conversions in this manner seem to have been the most successful. As one participant in Boston recommended, the first thing one should do when considering transferring the ownership or management of a public facility to private hands is to predict who will be adversely affected and cater to them as much as possible ahead of time. "Embrace perceived opposition" (for example, bring them into the

process, put them on committees and boards, etc.) and "appease affected parties" (for example, creating plans to compensate employees who would be significantly hurt financially) was the advice people offered. To do this, leaders must identify the constituencies involved (in the term's broadest sense, such as taxpayers and the media), the stakeholders in the process, and how they can be won over. It can also help to have an independent, objective analysis of the situation at hand by a respected outside party. In Austin, for example, an independent consultant's analysis of the public hospital's current position and future fate was key to bringing the parties together to take action. This conversion process becomes a campaign for the hearts and minds of the community, and as with any other campaign, it involves the media. For example, those responsible for putting Boston Medical Center together met early in the process with the editorial boards of the *Boston Globe* and the *Boston Herald* to brief them on the proposed merger. In contrast, the union representing the former public employees in Santa Rosa, which was essentially left out of conversion discussions, continues to oppose Sutter Health's management of the county hospital in Santa Rosa and publishes a widely-distributed *Scam Sheet* detailing alleged abuses by the Sutter corporation.

The Role of Organized Labor

Labor relations also played an important role at each of the hospitals we observed. Gaining the management flexibility to influence staffing levels and mix, productivity, and labor costs is often stated as a reason for wanting to get out from under the public sector personnel system and to "escape the grip of the political process" in governing and operating these hospitals. In order to compete with private hospitals in the same market, the converted public hospitals attempted to lower their costs, enhance their revenue-generating potential, and change their image as the "poor-people's hospital." Several observers cited the difficulty that public employees had in accepting these changes and adopting a more consumer-oriented culture in the workplace. As one hospital manager put it, "civil service is not a customer service culture." A board member at one county hospital characterized the changes as going from a public employment "entitlement" mentality ("the gravy train," as he put it) to a customer-focused, service approach where employees are held accountable and rewarded for their performance. In several cities observers said that, in retrospect, it was a mistake not to involve employees and their representatives in the planning process. In the two instances where employees were most heavily involved (Detroit and Boston), the labor issues seemed to be far less contentious.

Making these changes, and most importantly balancing them with the continued commitment to access, teaching, etc., usually means undergoing significant changes from the way the hospital previously did business. These changes are interpreted by some as a repudiation of the hospital's former mission, and by others as a fact of life in today's hospital market. But often the changes were threatening to organized labor, which across the five sites had roles that ranged from a consistent and vociferous opponent of conversion (Santa Rosa) to partners in the conversion process (Boston) and in governing the new entity (Detroit). Although labor opposition was not a deal-breaker in any of our sites, it was always an important issue that needed to be addressed.

Organized labor's public opposition to these hospital conversions centered on how the change in ownership/management and its modifications to staffing would adversely affect quality of

care and access to care, and usually included an appeal to keep public facilities accountable to the public—that is, operating under public management. Labor's concern about the quality of care typically was not echoed by the hospital medical staff or health center observers. In fact, we found little evidence that patient access had changed after a conversion. Instead, we detected a feeling among safety net providers that the community will be watching the new organization for any signs that its commitment to the under-served is diminishing. Union opposition to conversions seems based on concerns about the employment impact for their members associated with job redesign or re-engineering. The conversion often meant downsizing and the loss of union jobs or changes in the classification, mix, and average pay of jobs. The conversion was often a strategic setback for the union, which had been more successful on behalf of its members when dealing with a political body (the county legislature, for instance) than it would be in dealing with a private hospital or system.

Market Forces as Motivators

One positive aspect of the ubiquitous market forces and the common responses hospitals have to them is that public hospitals considering conversion need not "re-invent the wheel." Many institutions have gone through the same process. Those involved in the Denver experience, for example, benefited from visiting other academic medical centers in similar situations prior to approaching the state legislature. In addition, because these changes in ownership or management are not new to the hospital industry, it is possible to recruit administrators who are experienced in leading and managing major transitions of this type. There was universal agreement in Denver that having such a person was crucial to making their reorganization succeed.

Most of the people with whom we spoke who were responsible for governance of public hospitals saw their inability to compete successfully with private hospitals as a principal reason for conversion. As one of the new private administrators put it, running a hospital in today's market calls for skills that are not necessarily within the set of core competencies of government. In addition, operating a public hospital is very different from other services provided by government. To paraphrase one observer, the city fire department does not have to support itself by competing against private fire departments for selective contracts with fire insurance companies. Though cognizant of the problems of running a public hospital in today's market, these policy-makers were unwilling or unable to allocate the public funds necessary to either totally subsidize a hospital for the poor (both capital and operating subsidy) or provide the capital necessary to help a public hospital compete with private hospitals in a way that allows it to generate its own operating margin. An additional market-related criticism of the public hospital governing bodies is that they failed to inform or educate their communities about changes in the health care market and how those changes were affecting their local public hospital. For some in the community, that lack of preparation made the decision to turn over operations or ownership seem precipitate.

Unique Market Characteristics

Although we did find important issues that arose across the five sites we examined, some with whom we spoke argued that these formerly public hospitals had more in common with peers in the same market or in the same category of facility (for example, large urban teaching

hospitals versus small rural facilities) than they did with each other simply on the basis of once having been publicly owned and managed. As one observer put it when referring to public hospitals converting to private ownership or management, "When you've seen one, you've seen one." This may be a function of the goal adopted by every new private owner/operator we observed: to compete for paying patients as well as to maintain a unique responsibility to the under-served. Once this goal is adopted, the competitive characteristics of the hospital (its service complement, cost structure, etc.) become as important as the public nature of its mission. That is, its ability to compete successfully *in its own market* becomes as important as its "public-ness." In that respect, as markets differ so will the competitive responses of the hospitals.

One example is Massachusetts' level of payment for Medicaid and uncompensated care services. To a greater extent than in most other states, Massachusetts' uncompensated care pool and its Medicaid program have become generous payers and very much in demand, so public facilities in Massachusetts are no longer the only ones willing to take Medicaid and charity patients. Therefore, public institutions have to compete aggressively for these patients, with both public and private hospitals. In other states, Medicaid and charity care patients are not as lucrative for private hospitals, and public hospitals have more of that market to themselves. This is especially true in states without an uncompensated care pool or with less managed care and selective contracting, since selective contracting tends to drive down the reimbursement rates of other payers relative to public payers such as Medicaid.

Another set of unique circumstances is the political and regulatory environments that confront hospitals in some states and not others. For example, California's stringent new seismic safety standards that become effective in the year 2008 were singled out as one of the most important public policy issues for that state's hospital industry. The state's hospital association estimates that as many as half the hospital buildings in California currently might not conform to these standards. Since public hospitals have often experienced less capital investment over the last few decades and therefore might be using older facilities than private hospitals, they will be disproportionately affected by this legislation (California Senate Bill 1953). This is obviously an issue unique to California.

The Importance of the Public Mission

Agreement on the mission of the new entity by all stakeholders involved in the conversion process was portrayed as essential to the conversion's success. There are issues in the conversion process that will continue to be addressed for years after the conversion takes place, but something as fundamental as mission must be clear and agreed upon up front. Organizational cultures may differ, but for the conversion to be successful the organizations must agree on mission. One corollary for public hospitals is the importance of working with credible private organizations known for their commitment to the public hospital's mission. For example, we were told that talks between the City of Austin (on behalf of Brackenridge) and proposed private partners "would have gone nowhere" if the proposed partner had been for-profit or had a spotty record in serving the indigent. In Santa Rosa, an investor-owned hospital system's bid for the county hospital was rejected for fear that the company would drastically alter the character of the institution.

The Importance of Leadership

Leadership and perseverance were essential to conversions deemed successful by most observers. These conversions usually required that one or two people "put the process on their backs" and carry it to completion. These individuals had to be politically astute because most of the issues with which they dealt are political rather than technical in nature. They also had to be willing to compromise. Often they were charismatic and able to sway the opinions of others. There also had to be a commitment on the part of leaders on both sides to negotiate honestly, openly, and in good faith.

The leaders, however, often characterized their experience as one they would not want to go through again. Some of them paid a greater price than they anticipated in terms of personal vilification over the more contentious issues in the conversion process. They had to be able to "take the heat" and refuse to walk away from the process because of it.

Nobody Wants Surprises

When combining organizations as complex as hospitals, all parties involved need to "get to know each other" for the new organization or new relationships to work. For example, Boston City Hospital and Boston University Medical Center Hospital had co-existed (literally across the street from one another) and shared programs for decades, so there were few surprises when they merged. Several people mentioned that either this type of long-standing relationship or extensive "due diligence" by both parties during the affiliation process seem necessary to ensure that there are no surprises.

Additional Issues

Cities or counties that acted early (before financial losses mounted up, for example) theoretically had the broadest range of options available to them when considering the future of their public hospitals. Unfortunately, crises are often needed to make people act, and the first sign of a problem does not always generate a response. In addition, respondents told us it is important not to waste too much time evaluating politically infeasible options. In Austin, for example, too little value was derived from spending time on the politically-doomed taxing district or from letting the ultimately unsuccessful negotiations for creating an Authority drag on for months.

There are so many facets to the organizations involved in these conversions that making the process work is a long and complicated task. For example, Oakwood Healthcare System consolidated governance, management, physical plant, and programs with PCHA (five district hospitals), but did not initially consolidate their medical staffs. This issue is now coming back to haunt them, as the physicians are not in agreement on some issues fundamental to the success of the new organization, such as growth, new markets, and credentialing. At Boston Medical Center, as one person put it, the merger happened on paper in 1996, but the "real merger" (for example, the consolidation of the patient population and medical staff and proposed consolidation of the two buildings) is happening now and will continue for some time. This is in part because the controversies and opposition surrounding the conversion of a public hospital die hard. This is illustrated by the lawsuit filed by the town of Ypsilanti, Michigan against Oakwood Healthcare System, several years after the conversion, to return

control of one of the PCHA hospitals to the community. The problems are not fully resolved once the leases and contracts are signed. Even though the process of hammering out an agreement might seem like a monumental task, the toughest times are often after the conversion. In Santa Rosa, some observers are waiting to see whether the recent improvement in the hospital's bottom line will be permanent and if not, how long Sutter will tolerate financial losses at the hospital before taking new actions that will revive controversies over staffing and charity care. In Austin, continuing controversy regarding the provision of reproductive health services in a hospital managed by a Catholic health system awaits resolution by the church hierarchy.

Boston Medical Center — Boston, Massachusetts

A consolidation of a public teaching hospital and a private teaching hospital, resulting in a single private, non-profit entity.

Introduction

On July 1, 1996, Boston City Hospital (BCH), the city of Boston's public acute care hospital, Boston Specialty and Rehabilitation Hospital (BSRH), a public long-term care hospital, and Boston University Medical Center Hospital (BUMCH), a private, non-profit hospital, consolidated their operations to form a new entity, Boston Medical Center (BMC), a private, non-profit 501(c)(3) corporation. Legislation authorizing the consolidation between the formerly public and private hospitals was introduced in the Massachusetts state legislature in July 1995. The legislation included a one-year sunset provision, according to which the city of Boston had to consolidate the operations of BCH and BSRH with BUMCH within one year or would lose its authority to do so. After a year of public debate and approval by the Boston City Council, the hospitals consolidated. According to the consolidation agreement, BSRH closed 90 days after the affiliation, and its services were consolidated with those of BCH. Located in Boston's South End, BMC operates 432 licensed beds on its two contiguous campuses. The former BCH site is referred to as the Harrison Avenue campus and the former BUMCH site is referred to as the East Newton campus.

Motivations for Conversion

The primary motivation for the consolidation of BCH and BUMCH was the long-term survival of both hospitals. National changes in the health care industry resounded in Boston, a city famous for its academic medical centers and its competitive hospital industry. Expansion of managed care in the city and surrounding suburbs (particularly Medicaid and Medicare managed care expansions) forced cost-cutting initiatives at all hospitals and increased competition for managed care patients. There was also competition for the patients referred from Boston's neighborhood health centers. The health centers, which are the primary feeder systems of indigent and Medicaid patients to the area's hospitals, do not have exclusive contracts with hospitals in Boston. Competition for their patients is fierce, as the uncompensated (or free) care pool, which subsidizes charity care in Massachusetts, and Medicaid reimbursement in the state are generous compared to other states. Finally, like many hospitals around the country, Boston hospitals have excess bed capacity and a low patient census, due, in part, to technological advances in health care that increasingly reduced the need for hospitalizations and length of stay. These factors threatened the future economic viability of these institutions.

Strategic alliances among BCH's and BUMCH's competitors also drove the affiliation. To respond to changes in health care, hospitals around the state, and particularly in Boston, were affiliating to gain market share and bargaining power at an unprecedented rate. Massachusetts General Hospital and Brigham and Women's Hospital had already joined to form Partners HealthCare System, Inc., and Beth Israel Hospital had affiliated with Deaconess Hospital to become Beth Israel Deaconess Medical Center, which in turn affiliated with smaller area hospitals to form CareGroup. Administrators of BCH and BUMCH, both stand-alone hospitals, recognized that larger systems with increased access to funding sources and patient bases would be better able to negotiate with both public and private payers.

According to most respondents, it was in the interest of both BCH and BUMCH to affiliate. There was some debate among those interviewed as to which hospital was losing money in the years leading up to the consolidation. The general sense, however, is that in the two years before the affiliation, BCH had operated at a small profit and BUMCH had sustained minor losses. Yet, both hospitals were economically stable, at least in the short-term, at the time of the affiliation. The hospitals typically served different patient populations that sufficiently supported their day-to-day operations.

Thus, a key motivation for this consolidation was a desire to strengthen the position of the two hospitals in a rapidly consolidating local market. The hospitals were driven not by significant current financial losses, but rather by their perception of the need for a strategic alliance to position themselves more strongly *vis-à-vis* major payers. The climate was seen as risky for isolated providers as other major hospitals developed affiliations.

BCH and BUMCH were logical partners for affiliation for several reasons. Physically, the two hospital campuses have been located across the street from each other for over 100 years. The hospitals were also linked clinically, as physicians and residents had worked on both sides of the street irrespective of their employer for over 20 years. The hospitals are both teaching hospitals of Boston University's (BU) School of Medicine, and the chief of surgery, for example, at BCH was also the chief of surgery at BUMCH and the head of the surgery department at the medical school. Five years prior to the affiliation, the two hospitals also began to coordinate their services and eliminate duplicative units. Clinically and programmatically, there already was a significant amount of collaboration between the two hospitals when consolidation discussions commenced.

BCH's Motives to Consolidate

BCH had its own incentives to affiliate apart from the general trends in health and hospital care. City officials were concerned that BCH's future revenue streams were in jeopardy, and that the city would not be able to support hospital operations with public funds indefinitely. For example, the federal government had been threatening throughout the early to mid-1990s to make cuts in Medicaid payments to disproportionate share hospitals (DSH), which provide care to large numbers of Medicaid and charity care patients. These threats eventually materialized under the Balanced Budget Act of 1997. Prior to the affiliation, BCH provided over one-third of the charity care in Massachusetts and, by far, the most charity care in the city of Boston. As a result, the hospital received substantial DSH payments. In addition, there had been talk of future plans to capitate reimbursement from the free care pool, of which BCH

received the largest share in the state. Hospital administrators feared this might have further limited BCH's public funding sources. With Medicaid eligibility expansions, and more individuals carrying insurance cards, officials also feared that new Medicaid enrollees might not continue to choose BCH as their hospital, particularly because it is considered Boston's safety net hospital or hospital of last resort. Some respondents asserted that BCH wanted to disassociate itself from this image and attract a broader range of patients. Medicaid managed care expansions might further erode BCH's patient base, as more and more patients would be able to obtain primary care in an office setting, rather than the hospital's emergency department.

Because BCH was literally a department of the city government, many respondents claimed that BCH was not operated as efficiently as it could have been, particularly in the areas of purchasing, personnel, budget outlays, and long-term planning. According to one respondent, the city employees responsible for purchasing were not clinically trained or medically informed and did not know one piece of medical equipment from another. The individual felt this caused inefficiencies and delays in purchasing. In terms of budget outlays, one critic of the hospital's public governance remarked that the city would never have understood the necessity of spending money for the services of a high-priced, specialty surgeon who would attract a broad range of patients and generate millions of dollars in revenues for the hospital. Respondents felt that BCH could not rapidly respond to changes in the health care industry, which were necessary to compete effectively for dollars and patients with larger hospitals or private hospital systems. City controllers knew that public hospitals around the country that remained under public governance were being forced to drastically reduce costs to survive or face closure.

BUMCH's Motives to Consolidate

BUMCH, on the other hand, faced tough competition for commercial-paying patients, often referred from practitioners and hospitals from Boston's suburbs. Unlike BCH, the only public hospital in the city, BUMCH competed for commercial-paying patients with larger and perhaps better known private hospitals, such as Massachusetts General Hospital, Beth Israel Deaconess Hospital, and New England Medical Center. Again, as Medicaid and managed care expanded, competition for paying patients would continue to increase.

Some respondents suggested that BUMCH had additional motives. For example, by consolidating with BCH, BUMCH would gain access to BCH's urban patient population base, for which other hospitals in the city were beginning to compete because of generous reimbursement rates for these patients. Competition for these patients might be unique to states like Massachusetts that have favorable reimbursement rates for uncompensated care and Medicaid patients. In states with less generous reimbursement, competition for these patients would only engender financial burdens.

Process of Conversion

The consolidation between BCH and BUMCH is generally considered to be a success, due in large part to the formation of the Mayor's Advisory Committee on Health Care (or the

McGovern Commission, which was named after a local attorney and former state senator, Patricia McGovern, who acted as the chairperson of the commission). The McGovern Commission was convened by the mayor of Boston in June 1994 to analyze the implications of a potential consolidation between BCH and BUMCH on the hospitals' operations and the community, and to make recommendations to the state legislature for implementation of such a plan. The McGovern Commission's report was completed in May 1995.

The McGovern Commission was divided into subcommittees, each of which submitted its own report to the mayor. The issues addressed by the subcommittees were: clinical services, governance, labor relations, public health, community relations, finance and debt, operations, and facilities planning. Most of these issues surrounding the consolidation of BCH and BUMCH were settled relatively smoothly, except the governance issue (see below) and the labor issue (see the section on labor opposition).

The McGovern Commission succeeded the Segel Commission, organized by Boston's previous mayor in the early 1990s to study the current and future state of health care in Boston. Based on the changing health care environment in Boston and around the country, the Segel Commission recommended that the city's public hospital needed to protect its role as a safety net provider for the indigent while modifying its governance structure to adapt to the needs of consumers and increased competition among hospitals. The Segel Commission suggested the creation of an integrated, community-based network of health care services and providers throughout the city, including BCH; Boston Specialty and Rehabilitation Hospital (BSRH); Boston's community health centers; and some entity responsible for public health activities. It recommended that the network have continued, strong ties to BUMCH and Boston University's School of Medicine as its private partners. However, the Segel Commission did not specify any governance structure for the new network.

When the McGovern Commission was convened, the mayor gathered representatives from former public hospitals around the country that had recently converted their ownership or management structure to identify diverse and successful models for reorganization. According to several members of the McGovern Commission whom we interviewed, various options were presented, including a few that would have kept the hospital in the public domain. For example, one option was to create a hospital authority, which is an independent public entity that would own and operate the public hospital. However, to the dismay of these respondents, options other than complete privatization of the hospital were never seriously considered by the mayor or the majority of the McGovern Commission. These respondents believed that the mayor wanted the city out of the costly hospital business entirely. Thus, the only option genuinely analyzed by the McGovern Commission was a consolidation of BCH and BUMCH into a single, private institution. Supporters of the consolidation and privatization of BCH claimed that this governance structure was necessary to get out from under the crippling constraints of public governance. The private model was based on the governance structure of Boston's community health centers—private entities driven by a public mission.

To minimize opposition to the consolidation, the mayor included individuals on the commission representing diverse interests. Among others, members of the commission included neighborhood health center directors, a media representative, physicians, a former

state legislator (who served as the chairperson), representatives of the city, and the president of the largest labor union at BCH.

Some people interviewed for this study felt the commission was a "sham." These individuals believed that very few revisions were made to the consolidation plan—that is, from the time of the McGovern Commission's recommendations to the final consolidation agreement—even after extensive public hearings and legislative debates revealed major opposition on specific issues. Although members of the McGovern Commission were volunteers, these critics of the commission labeled members as "paid consultants" to the mayor and claimed they were picked to promote what they felt to be the mayor's agenda—which was to consolidate the two hospitals at all costs. Others complained that all of the major players in the decision-making process were somehow affiliated with BUMCH and did not adequately promote BCH's interests.

Other respondents felt that opponents of the consolidation had ample and genuine opportunity to influence the process. During the two years before the consolidation, there were five major public hearings held in Boston on this issue, at least eight meetings with representatives of Boston's minority communities, and smaller meetings with BCH employee groups. The *Boston Globe* and the *Boston Herald*, the city's largest newspapers, featured numerous articles about the proposed affiliation on almost a daily basis for over a year prior to the consolidation. In addition, the authorizing legislation had to pass the state legislature and the actual consolidation agreement had to be approved by the Boston City Council. One respondent noted that patient advocacy groups and labor representatives lobbied every individual that had influence on the process.

There were also a few informal, grass-roots level opposition groups formed to protest the consolidation or at least serve as oversight entities over the consolidation process. These were "Keep the Public in Health Care" and "Keep Our City Hospital Public." Representatives of the unions, anti-poverty agencies, minority health groups, and state patient advocacy groups organized these groups to make sure the community was heard during the consolidation process. There were no lawsuits filed by these groups to prevent the consolidation from proceeding, but by all accounts, they used political pressure to voice their concerns. One respondent believed, however, that only those individuals that would be directly affected by the consolidation on a daily basis (such as employees) actively opposed the consolidation. This respondent felt that the typical community resident who might use the hospital was not very concerned at the time of the public discussions.

Structure of Conversion

In October 1995, the Massachusetts State Legislature approved legislation (HB 5336–1995 First Annual Session) authorizing the consolidation of BCH, BSRH, and BUMCH and creating the Boston Medical Center (BMC). The legislation also created the Boston Public Health Commission, a seven-member board created to continue the city's public health responsibilities. As noted earlier, BSRH was closed and its services transferred to the BCH site 90 days after the consolidation.

State and city approval for the consolidation was necessary, as BCH was a public entity and controlled public assets. This fact guided the complex structure of the affiliation. On the BCH side, certain assets were transferred directly to BMC. These assets, deemed "a contribution of net assets" in the consolidation agreement, included cash, accounts receivable, inventory, and moveable equipment totaling $58.7 million. Other public assets, however, required judicial approval for transfer. For example, trust fund assets pledged to BCH from private trusts, totaling $24 million, had to be transferred to BMC under *cy pres* proceedings, in which a court determines that the literal and intended use of the trust funds is no longer practical or possible and that the assets will be used for similar charitable purposes by the new private entity. Massachusetts' attorney general supervised this redirection of public funds.

The physical plant of BCH was transferred under a different structure. In 1987, the city decided to rebuild BCH's inpatient facility (the building opened in January 1994). The rebuilding was financed through a Housing and Urban Development-guaranteed/Health and Human Services-approved loan. Pursuant to the consolidation negotiations and agreement, the obligation for this debt remained with the city. Consequently, when Boston's Department of Health and Hospitals (DHH) was dissolved at the time of the consolidation, the lease of the BCH facility was transferred from DHH to the Boston Public Health Commission, and BMC leases the facility from the commission. The lease payments are used to repay the city's HUD loan. BMC now has a 50-year lease of the BCH facilities and premises with four 10-year renewal options. Hence, the lease is considered a 90-year lease.

The transfer of BUMCH assets was simpler because it was a private institution. All of the assets and liabilities of BUMCH and its subsidiaries merged into BMC through a statutory merger, which is a merger defined and guided by state corporate law.

Change in Governance Structure

BCH and BUMCH were separately-owned hospitals prior to the affiliation. BCH was a city-owned and operated acute care hospital since it opened in 1864. As a public hospital mandated to care for all patients regardless of their ability to pay, BCH served mostly indigent and Medicaid patients. BCH was essentially a department of the city government, as it was operated under the Department of Health and Hospitals (DHH) and had no separate legal existence from the city. The board of trustees of DHH, which had nine community-based members appointed by the mayor, had authority over the city's two public hospitals—Boston City Hospital and Boston Specialty and Rehabilitation Hospital. DHH also had responsibility for the city's public health activities.

BUMCH opened its doors in 1855 and had various names throughout the past century. Today, it is alternately referred to as University Hospital or BUMCH. BUMCH was a private, non-profit hospital located on the campus of, but not owned by, Boston University's School of Medicine. BUMCH was a tertiary care medical center, with a patient base primarily comprised of suburban referrals. BUMCH had a board of trustees separate from the University.

Boston Medical Center, the new entity formed by the consolidation of BCH and BUMCH, is a private, non-profit corporation. BMC is governed by a 30-member board of trustees, who are appointed according to their class designation. Class A board members are the 10 members

appointed by the mayor of Boston. Class B board members are the 10 individuals appointed by BUMCH's board of trustees. There are six Class C members, which all serve in an ex officio capacity. Class C members are the executive director of the Public Health Commission, the dean of BU's School of Medicine; the CEO of BMC; the president of the medical staff of BMC; the physician in chief of BMC; and the surgeon in chief of BMC. There are four Class D Board members, who are nominated by the neighborhood health centers in Boston HealthNet (the city's network of community health centers), and must be a senior official or physician of one of the health centers in the network.

Effect on Hospital Operations

Consolidation of Clinical and Non-Clinical Services

In the two years since the affiliation, BMC has consolidated duplicative services in several areas. In addition to security, parking, and maintenance, departments that consolidated first include finance (for example payroll and accounts payable), purchasing, information technology, legal services, and medical records. Many health programs were also consolidated; three women's health programs, for example, were combined into one. In clinical care, BMC consolidated (or plans to consolidate) the following units: coronary care, medical intensive care, oncology, hematology, rehabilitation in the spinal cord unit, emergency testing laboratories, respiratory therapy, inpatient pharmacy, and radiology admissions. Consolidating the neurology department caused one of the few problems, but only because administrators could not agree on a person to chair the department. BMC is currently in the process of consolidating management information systems.

Although the extent of clinical integration at BMC may have been facilitated by the geographic proximity of the two hospitals and by years of close collaboration among programs, departments and staff, BMC consolidated a significant portion of its clinical services. In each of these service areas, leadership was consolidated. The physical units were consolidated only in areas where a low patient census justified consolidation. As one BMC official put it, "we did in two years what most hospitals do in ten." In areas with high, steady patient volumes, such as the operating rooms (OR), the emergency department, and outpatient pharmacy, however, BMC continues to operate two units. In addition, departments that existed at only one of the hospitals prior to the consolidation, such as obstetrics and pediatrics at BCH and cardiology at BUMCH, were unchanged.

Down-Sizing in Capacity and Jobs

BMC reduced its bed capacity in two ways: by consolidating clinical units and closing BSRH. At the time of the affiliation, BCH had 356 beds, BSRH had 80 beds, and BUMCH had 311 beds. Shortly after the consolidation, bed capacity at BMC dropped to 470 licensed beds combined. BMC now operates 432 beds.

There are approximately 600—or 10 percent—fewer FTEs at BMC than there were at BCH and BUMCH combined. There were over 6,000 total employees at the two hospitals before the consolidation. Most of the down-sizing in jobs was accomplished through attrition and

implementation of an early retirement incentive program. This process affected mostly directors, vice presidents and nurses, although one respondent claimed that BMC is currently hiring additional nurses. According to officials, BMC terminated the jobs of substantially fewer people than it had anticipated. BMC was reluctant to reduce the size of the physician staff, however, as long as patient care decisions and patient volume justified current physician staffing ratios.

Impact on the Bottom Line

In total, BMC has cut approximately $31 million in expenses, although officials admit they have a long way to go. BMC is currently operating at a loss and has been since the consolidation. According to one individual we interviewed, who represented the city, BCH had an $8 million surplus in the two years prior to the consolidation. Last year, BMC sustained a $5 million loss on $515 million in revenues. BMC anticipates similar losses for 1998 and 1999 and hopes to break even in 2000.

Revenue Enhancing Activities

Trying to achieve a certain payer mix is a very delicate issue at BMC. Hospital officials stated that while BMC is mandated to serve BCH's traditional patient base, it does not want to lose its "non-poor patients." Access to commercial paying patients and an ability to compete with other hospitals for managed care contracts were not hidden motives of the consolidation. One respondent noted that there have been small shifts in payer mix, particularly an increase in indigent care. BMC's current payer mix is 25 percent uncompensated, 25 percent Medicaid, 25 percent Medicare, 22 percent private, and 3 percent other payments.

Maintenance of the Public Mission

According to BCH and BUMCH officials, maintenance of BCH's public mission was essential to proceeding with the consolidation. This issue pervaded McGovern Commission, legislative, and city council discussions. According to one respondent, the parties worked late into the final nights before the consolidation's sunset date to ensure that the consolidation agreement accurately reflected BCH's mission. BMC's mission statement incorporates BCH's directive to serve all individuals in the community in need of health care services "regardless of ability to

While representatives of BCH believe that the BUMCH and BMC boards fully endorsed BCH's public mission—the mission statement forms the first section of the consolidation agreement—the consolidation agreement does not designate specific levels of uncompensated care that BMC must maintain. Until July 1998, the only methods of ensuring that BMC continued to care for indigent patients were the mandate for BMC to submit an annual report to the public health commission, the mayor, and the city council, and community-based representation on BMC's board. There was no formal oversight entity. However, the mayor of Boston recently announced the creation of a nine-member advisory committee to monitor access to health care for all Boston residents, but particularly its indigent populations. BMC

would fall under the purview of this oversight body. In fact, the call for the creation of such an entity was embodied in the 1996 consolidation agreement between the city and BUMCH.

Whether the public mission has been maintained two years after the affiliation is contested. While acknowledging that BMC advertises to patients in both the city and the suburbs and continues to work with the neighborhood health centers, some respondents feel that BMC has failed to take a proactive role in promoting or reinforcing BCH's traditional urban public mission. They accused BMC of catering to its suburban, commercial-paying patient population. These respondents warned that it is in the best interest of BMC to continue the public mission of BCH, as the free care pool and Medicaid currently are its primary sources of revenue. Other respondents countered that BMC cannot walk away from its referral business, noting that BMC is the only Medicare center of excellence in the city. In addition, as a private hospital system, BMC cannot continue to depend on city subsidies for short- or long-term viability. In the future, it will be increasingly important for BMC to become self-sufficient.

All of the respondents acknowledged this struggle at BMC between preserving the public mission of BCH and maintaining financial viability of the institution. While not prohibitive in terms of making policy or financial decisions, the issue is very real and often in the forefront of BMC's long-term planning discussions. Some respondents expected BMC to be more primary care-oriented than it is—that it would build a strong primary care network and increase its capacity to serve indigent patients. These respondents feel that BMC has been more concerned about the bottom line than about fulfilling this role. BMC officials do not deny a desire to create a medical center that can compete in today's health care environment. But they want to diversify into competitive and lucrative areas, such as biomedical research, while simultaneously maintaining the public mission.

Changes in Clinical Service Provision

The separation of clinical services between the two campuses at BMC has been problematic for patients and physicians from both BMC and the neighborhood health centers, which admit patients at BMC. Again, either through consolidation of services or leaving service units where they were prior to the affiliation, some services are provided only on one side of the street or the other. Because of this, several respondents complained that patients are continuously shuttled back and forth between the two hospitals. An anecdote told by several respondents is of a patient who is admitted to the BCH side for a trauma injury and then is found to also have a heart problem. This patient must then be shuttled by ambulance to the BUMCH side where the cardiac equipment and staff are based. Medical records get lost in this confusion or remain incomplete, and the patient's health is seriously jeopardized.

BMC officials counter that this specific problem would have occurred prior to the consolidation and is not a new phenomenon, because BUMCH has always operated the major cardiology unit. The officials acknowledge, however, that this may be a problem in other service areas and expect to minimize some of the inconvenience in the near future. Officials did not specify how they plan to resolve the issue. Despite the problem, hospital administrators maintain that separation of services in certain areas was necessary to eliminate waste and redundancy in service provision between the two hospitals.

Maintained Commitment to Medical Education and Training

All of the respondents stated that BMC's commitment to medical training has not changed. BMC maintains the same programs that BCH and BUMCH operated prior to the affiliation, as teaching hospitals of BU's School of Medicine. In fact, the two hospitals had already coordinated their residency programs, which are operated by the university's medical school, about five years before the affiliation. BMC offers 21 residency programs with over 500 residents and 150 clinical fellows. The program was recently enhanced by the creation of a new family practice residency training program. Although BCH was not considered an academic health center under the definition used by the Association of Academic Health Centers (AAHC),[5] BCH officials assert that the hospital was operated like an academic health center in that it was a large health care institution that conducted medical research and clinical training. In the early 1970s, BCH was a teaching hospital for Tufts, Harvard and BU, before becoming affiliated solely with BU. Officials at BMC recognize that external factors, such as the reduction in graduate medical education (GME) payments included in the Balanced Budget Act of 1997, will affect the future of medical education at BMC.

Labor Opposition

Although there were no legal challenges to the affiliation between the two hospitals, there was strong opposition to the consolidation on the part of labor unions. The mayor of Boston recognized that maintaining labor relations would be essential to a successful affiliation and included labor representatives in consolidation discussions from the outset. The president of Service Employees International Union (SEIU) Local #285, BCH's largest union, served on the McGovern Commission, and the Commission's Labor Relations Subcommittee analyzed 15 labor issues prior to the consolidation. The consolidation agreement addressed and resolved, in part, the following issues: continued employment, retirement plans, recognition of collective bargaining units, dispute resolution, accrued vacation time and sick leave, and retraining and development.

Prior to the consolidation, there were many unions representing employees at BCH and BUMCH. At BCH, four unions represented 2,515 employees. At BUMCH, at least two unions represented approximately 760 employees. To avoid disparity in work rules and benefits, BMC did not want to continue to negotiate multiple contracts with multiple unions representing the same types of employees. This issue, combined with the fact that BCH employees would no longer be public employees with as much long-term job security, caused concern among the many employees of BCH who were union members.

All employees of both BCH and BUMCH were offered employment with BMC. BUMCH employees carried over all of their earned time in accordance with their BUMCH collective bargaining agreements. BCH employees transferred to BMC under their old contracts, which were then renegotiated in July 1997. As civil servants, BCH employees had generous benefits and had to sacrifice some (for example, vacation days) in transferring to the private sector workforce. The union representatives acknowledged that to achieve a complete integration of

[5] An academic medical or health center includes a school of medicine, various health professions schools, and has affiliated teaching hospitals. (Telephone interview with an official of AAHC, February 1998).

the labor force, there had to be some give-and-take on everyone's part, and BMC officials praised city employees for their sacrifice.

There were several changes in work rules for BCH employees. Some respondents claimed that city employees worked under outdated, generic job descriptions that would make it difficult for an employer to enforce work standards. Consequently, BMC created new, tighter job descriptions, designed new wage rates, and changed its system for former BCH employees from allotted time to earned time (for example, sick time and vacation time are now earned).

Two labor issues that were not resolved easily were the renegotiation of SEIU contracts and recognition of the House Officers' Association, Committee of Interns and Residents (HOA/CIR), the union representing BCH's interns and residents. SEIU, which represented nurses, clerks, and technicians at BCH, and service and maintenance workers at BUMCH, remains the largest union at BMC. SEIU currently represents over 2,000 employees at BMC, now including technicians and clerical workers from the BUMCH side. It was not until July 1997, one year after the affiliation, that BMC and SEIU negotiated a new contract that resolved the issue of parity around salary. The parties expect to resolve disagreements over health insurance, pension, and parking benefits by January 1999, making negotiation discussions a two and a half year process.

The McGovern Commission report concluded that BMC should not be required to recognize HOA/CIR. It argued that BMC was not bound by public labor law and, under private sector labor law, students are not entitled to unionize. After intense public and political pressure by HOA/CIR and its supporters, BMC agreed to recognize HOA in the consolidation agreement. The union now represents 430 interns and residents at BMC, up from roughly 280 at BCH.

Future Consolidation Issues

The two biggest issues facing BMC in the future are the physical consolidation of the two facilities and the cultural consolidation of the patient population and physician staff of the two hospitals. These issues have been the biggest barriers to complete consolidation of BCH and BUMCH and full realization of potential economies of scale.

Physical Consolidation of the Two Buildings

Several respondents suggested that over time, BMC's census might not continue to justify two campuses. Two questions remain in the minds of patients, administrators and staff: which campus will survive, and which patient population should BMC continue to serve? One argument for maintaining the BCH campus is that it has a new inpatient building facility. But some respondents complained that, although it has private and semi-private rooms, it is staffed primarily with attending physicians and residents and has "the feel" of a hospital ward, which might not be attractive to commercial paying patients. However, those in favor of maintaining the BCH site feel that to best serve BMC's public mission, BMC should be more concerned about its urban patient population base.

All of the respondents believed and hoped that physical consolidation of the two buildings will not happen for several years. But all of them agreed that it will occur someday. According to

members of the strategic planning committee, an 80- to 90-member long-term planning body, physical consolidation is one of the major issues being addressed at its meetings.

Cultural Consolidation of the Patient Populations and Medical Staffs

The affiliation between BCH and BUMCH was different from many other public-to-private reorganizations, as it was a complete integration of two hospitals. While business and administrative affairs were integrated easily, integration of patient populations and physician staffs did not fare as well. According to one respondent, "It is inevitable that two very different cultures will exist when you consolidate an urban, safety net hospital with a suburban, referral medical center." This cultural conflict implicates socioeconomic status, rather than ethnic make-up of the patients. This issue was constantly amplified in the media and political arena throughout the consolidation process, and awareness of this issue remains pervasive within the hospital and the community. Many of the respondents agreed that this issue will have to be resolved before physical integration of the two campuses occurs.

The majority of respondents reported that there is still an "our side of the street/their side of the street" mentality that is prevalent at BMC. Urban patients are reluctant to be admitted to the BUMCH side, because they feel that in the past BUMCH would not care for them, so why should they go there now. And suburban patients are often afraid to go to the BCH side, although trauma, pediatrics, and the birthing center are located there, claiming that it is "gang-ridden." One interviewee suggested that these perceptions, whether accurate or not, are generational and will diminish over time. Nonetheless, BMC has begun to address this issue by creating a Diversity Advisory Council in 1997, and hiring a cultural diversity consultant and requiring cultural diversity training for all BMC managers and physicians in 1998.

This tension also pervades the medical staffs, even though physicians have worked on both sides of the street for years. Some respondents felt that BUMCH-related physicians received most of the administrative appointments when departments were consolidated at BMC. Others claimed that the BMC staff, particularly the nursing and high-level administrative staff, is not as ethnically or racially diverse as it was at BCH. BMC officials contest this claim, stating that 40% of BMC's staff classify themselves as minorities.

This cultural clash among patients and physicians has translated into at least the perception that there are two levels of care being provided by BMC at its two campuses. This perceived disparity in care is something that all respondents wanted to see changed. BMC recognizes this tension and has taken some steps to assuage these concerns. A major objective of the Strategic Planning Committee is to develop and implement uniform protocols to achieve consistency in the standards of care between the two sides of the street.

Effect on the Local Community

Access to and Availability of Clinical Services

Access to care for indigent patients has been enhanced, if anything, by the consolidation of BCH and BUMCH, according to both community and hospital respondents. Representatives of the neighborhood health centers complimented BMC on expanding marketing and outreach efforts (through the creation of over 50 outreach worker positions), extending its clinic hours and services, and enhancing translator services. In fact, BMC is serving more uninsured patients than BCH was before the affiliation. BMC is the largest safety net provider in the state of Massachusetts, providing between $130 million and $150 million in free care to vulnerable populations each year. In the year after the merger, the amount of free care provided by BMC jumped 11%, from roughly $131 million in 1996 to $146 million in 1997. Officials believe this trend might flatten out, however, as the free care pool converts to capitation payments, DSH payments are reduced, and Medicaid enrollment continues to expand.

Availability of essential community services, such as trauma care, burn care, and neonatal intensive care, were not adversely affected by the consolidation of BCH and BUMCH. Although service delivery with respect to inpatient care was reorganized, there was no loss or reduction in essential services or change in outpatient services. Many of the respondents felt that these units are staffed at the same level and basically with the same individuals. EMS services that were provided by BCH, and are now provided by BMC, have not been affected.

As stated earlier, the major change in inpatient care is the location of the service, rather than the quality of the service. Although consolidating duplicative services made sense in terms of achieving certain economies of scale, the resultant separation of services has caused confusion for physicians and patients in terms of admissions and coordination of care. In addition, this problem further inflames the urban/suburban patient issue, because some respondents feel that BMC emphasizes its “lucrative” inpatient admissions, such as cardiology, and many of these inpatient service units are located on the East Newton Campus (the former BUMCH).

Although the East Boston Neighborhood Health Center is the major primary care center in Boston, BCH was a large source of primary care in the community, with 50,000 primary care visits per year. As public subsidies shrink, access to the necessary outpatient services for urban populations may be in peril. Conversely, as the trend toward Medicaid managed care continues, and more lower-income patients are connected with an office-based primary care physician, BMC might experience a reduction in costly emergency room visits for primary care. However, some respondents cautioned that it may be too soon to determine the ultimate effects of the consolidation on access to and availability of services for indigent patients.

The Closing of Boston Specialty and Rehabilitation Hospital (BSRH)

BSRH was a long-term care hospital located in the Mattapan section of Boston. The hospital was a large employer in Mattapan, with 207 employees. The consolidation agreement between

BCH and BUMCH provided for the closure of BSRH 90 days after the affiliation. BSRH's services were consolidated with those of BCH and the hospital was shut down in 1996. According to some respondents, the chronic care and rehabilitative services provided by BSRH are not as accessible anymore. Only a small fraction of the hospital's former capacity is now being served: of its 80 or so patients, 30 were transferred to BCH while others were placed in other private institutions. Consequently, only a few of BSRH's employees were hired by BMC. However, another source claims that the hospital was losing $700,000 a month and was not operating efficiently in terms of service provision or labor.

Continued Community Oversight of BMC

According to the consolidation agreement, the public health commission was encouraged to establish an advisory committee to act as an oversight entity to monitor the provision of health care in Boston, particularly to the city's vulnerable populations. In July 1998, the mayor announced the creation of this organization. The committee will include representatives of the city government, the medical community and the Boston community. The advisory committee will not be a watchdog group but an entity to ensure that the public health needs of Boston residents are being met. Some respondents initially contested the need for such an entity, stating that the public health commission serves this purpose, and creating an additional entity would be unnecessary. The two-year delay in setting up this committee has angered other community respondents. These individuals felt that the commission was not doing enough to ensure that BCH's public mission is being carried out, as the commission only collects an annual financial report from BMC and has no enforcement responsibilities. Continued community oversight is also supposed to be achieved by having community representatives (for example, 10 mayoral appointees and four CHC officials) on the BMC board. There was some debate among respondents, however, as to the extent of input into decision-making these representatives actually have.

Relationships with the Community Health Centers Maintained

Like labor unions, Boston's neighborhood/community health centers (CHCs) were included in affiliation discussions from the outset. Two CHC directors served on the McGovern Commission and five CHC officials currently serve on BMC's board of trustees (four are class D board members and one is a mayoral appointee). Provisions for continued relations and partnerships between BMC and the CHCs are specifically included in the consolidation agreement.

Prior to the consolidation, eight CHCs in Boston formed Boston HealthNet, a primary care network of CHCs which negotiates managed care contracts for its patients. There currently are 12 CHCs in HealthNet. Many of these CHCs had long-standing partnerships with BCH, primarily because they historically served the same patient populations. Although many did not have previous affiliations with BUMCH, they now include BU's School of Medicine and BMC as active partners in Boston HealthNet.

CHCs in Boston can operate either on a hospital's license or as a free-standing, non-profit entity. CHCs on a hospital's license can take advantage of the hospital's billing systems and reimbursement arrangements with the state. Independent CHCs negotiate reimbursement

contracts directly with the state. Initially, to obtain access to Medicare, Blue Cross, and free care pool funds, a CHC had to operate on a hospital's license. Currently, CHCs on the BMC license receive larger shares of the free care pool than CHCs that operate independently. Five CHCs operate on BMC's license and seven others operate in the BMC network, but not on its license. East Boston Neighborhood Health Center, the nation's largest primary care clinic, is

CHCs in Boston are very independent entities in terms of governance. CHCs on a hospital's license, like those that are not, have their own board of trustees. They do not have exclusive contracts with any of the hospitals in Boston, because they want their patients to have unrestricted access to the hospital of their choice. The CHCs want to remain independent and do not "want to put all of their eggs in one basket," particularly if the basket has "holes" in it. However, because the CHCs are the primary feeder systems for uninsured and Medicaid patients to Boston's hospitals, every hospital system in Boston, including BMC, wants to maintain relations with the CHCs. BMC officials are aware that each CHC has a different constituency and that BMC will have to "earn" each CHC's patients through individual negotiations.

BMC has continued to collaborate with the CHCs in several areas. CHC practitioners admit patients at both BMC campuses, and BMC physicians and residents work and train at the CHCs. BMC is also developing a managed care health plan for the uninsured with the CHCs, called the BMC HealthNet Plan, that will be marketed at and through the CHC network. However, there continue to be "bumps" in this relationship, based on some respondents' claims that BMC is trying to obtain greater control over the CHCs through a stricter reimbursement contract.

Conclusion

The consolidation of BCH and BUMCH and the creation of BMC is considered a success by most of the people we interviewed. The prevailing viewpoint is that the "old BCH" survived and, while there were problems along the way, they were not insurmountable. Those responsible for the public hospital took necessary measures to assure long-term market survival for Boston's safety net hospital. While the hospital was not losing substantial amounts of money, it did need to strengthen its bargaining power in an environment in which larger, leaner hospital systems attracted the patients and the payers. To facilitate the conversion process and minimize opposition to the privatization of the public hospital, those responsible for the hospital had the foresight to include in the discussions those who would be most affected by the change in ownership, namely employees and patient advocates. While the transition went relatively smoothly, particularly in the areas of administrative and programmatic integration, the optimism surrounding the success of the affiliation between BCH and BUMCH should be tempered by the fact that the consolidation is only two years old. Contentious issues remain involving cultural consolidation of the patient populations and physician staff and physical consolidation of the two campuses of BMC. In addition, many of the respondents warned that it is too soon to determine the ultimate impact of the consolidation on the ability of Boston's indigent population to access health care at BMC.

Brackenridge Hospital — Austin, Texas

A lease of two public hospitals to a private, non-profit hospital system.

Introduction

Brackenridge Hospital, located in Austin, Texas, was founded in the 1880s and operated as a public entity for over 100 years. In the 1980s, Children's Hospital was added to the campus and also run as a public hospital. On October 1, 1995, both hospitals' governance structure changed with the signing of a formal arrangement whereby Seton Healthcare Network, a local, non-profit system operated by the Daughters of Charity National Health System, leased the hospitals' assets under a 30-year renewable agreement, effectively taking over financial and operational responsibility for both institutions.

Brackenridge and Children's Hospitals collectively have 441 licensed beds (Brackenridge has roughly 340 licensed beds, while Children's has 100). Prior to entering into the lease arrangement with Seton, the hospital was owned and operated by the city of Austin, with the city council effectively serving as the board of directors. Seton Healthcare Network is owned by the Daughters of Charity National Health System, a Catholic health care system headquartered in St. Louis, Missouri. A local board of directors has fiduciary responsibility for the entire Seton system. Prior to the leasing arrangement with the city, Seton Healthcare Network owned and operated two hospitals, with 587 licensed beds.

The city of Austin began contemplating a reorganization of the governance structure of Brackenridge and Children's in the late 1980s and early 1990s. After studying the issue and evaluating options for a number of years, the decision to consider an arrangement with Seton was made in 1994, with the actual turnover of operations occurring after roughly a year of negotiations. The lease became effective on October 1, 1995.

Motivations and Process for Conversion

The City of Austin's Motivations for Conversion

A number of factors drove the city's decision to enter into a leasing arrangement with Seton:

- Operating losses were mounting at the hospitals, forcing the city (and its taxpayers) to provide more and more funding.
- City rules on salary/compensation reportedly made it impossible to attract and retain high-quality management.
- The city had a variety of rules and regulations that allegedly constrained hospital management from operating effectively, including rules on personnel (for example, making it difficult to hire and fire individual workers), purchasing (for example, requirements for

competitive bidding and city council approval of all expenditures exceeding $37,000), and public disclosure (for example, open, televised strategic planning sessions).

- The two hospitals were the only independent hospitals in a rapidly-consolidating health care environment. The prospects for survival of any independent hospital—let alone a public one serving primarily the indigent—seemed bleak.

All of these factors combined to raise the distinct possibility that the hospitals would no longer be able to meet their commitment to serve the indigent and might even have to shut their doors, as the city could no longer afford to subsidize operations.

Process of Conversion

In the late 1980s and early 1990s, Austin city management became concerned about the continued operations of Brackenridge Hospital. The institution was increasingly becoming an "indigent hospital" while losing market share. In addition, the hospital lacked talented and creative leadership because city salary constraints made it difficult to attract and retain top-notch talent. The hospital began to rely more and more upon the city for funding, and the city had no means of funding this care other than through general tax revenues collected from city residents.

In 1990, city officials authorized the formation of the Health Care Task Force, a group of 30 to 40 individuals representing a wide variety of community constituents. This group studied the issue of indigent care for two years and ultimately recommended the formation of a "semi-hospital" taxing district under which the hospitals would continue under city ownership and operation but the city would have authority to collect taxes for indigent care.

City officials were not enamored with the idea of the taxing district, since it required voter approval and new legislation. Moreover, in the two years in which the Health Care Task Force worked, city officials became more and more concerned about the hospital's operations, as well as its competitive position within the marketplace. As a result, the city government decided to form a second task force to look more narrowly at what should be done with Brackenridge. To provide for hospital expertise on the committee, the task force included the CEOs of Seton and Columbia/HCA.

This new task force considered a variety of options for Brackenridge, including a taxing district, a hospital authority, and a merger with a for-profit or non-profit entity. Ultimately, the committee recommended the authority option, under which the hospital would continue to be owned by the city but be run under a newly-created independent authority that would be freed from many of the constraints of city management. The authority approach was attractive primarily because it preserved Brackenridge as a public asset committed to serving the indigent and did not require public approval. The merger options were less attractive because the city would be giving away a valuable public asset and would have more difficulty ensuring the new owner's commitment to the indigent.

The city accepted the recommendation and appointed an authority board, but the negotiations quickly bogged down over money and control issues. The authority board wanted the city to continue to be responsible for capital expenditures and other major funding

sources, while the board would have a relatively free hand in spending the money and would enjoy limited legal liability for their actions.

During the bogged-down negotiations several crises erupted which made members of the city council much more skeptical of the authority model. In early 1994, a $21 million "accounting error" in hospital operations was "discovered." (Revenue from Medicare and Medicaid patients had been counted as the hospital's full charges, rather than the actual payments from these programs.) In addition, allegations of fraud and mismanagement surfaced concerning some individuals within Brackenridge management. The mayor fired the existing city manager; an outside consulting firm, The Hunter Group, was hired to manage the hospital on a temporary basis and to make recommendations about improving the viability of the institution.

The city council also was becoming concerned about the implications of the rapid consolidation among health care providers in Austin. With Columbia/HCA's entry into negotiations to purchase the non-profit St. David health care system, Austin had moved from being a town with six independent hospital systems to one that would likely have just two. Virtually every hospital in the city, with the exception of Brackenridge and Children's, had joined with one of these two systems. City council members and the mayor began to realize that Brackenridge simply could not survive as an independent institution in competition with these two health care giants. (A report by The Hunter Group arrived at the same conclusion.) And while the authority might serve to improve the management and the operation of the hospitals, it also had no assets (other than what the city gave it), making it very difficult for the city to cope with the losses or the accumulated debt.

Some in the city council began to wonder if the authority had the experience and expertise necessary to operate an independent hospital in such a competitive, rapidly-changing environment. City leaders also came to believe that the city really had no business running a competitive enterprise like a hospital. As one observer noted, even the best managed cities should limit themselves to the provision of services that are not subject to intense competition or rapid change, such as police and fire department services. While hospital services may have fit this description twenty years ago, they do not today.

Given the rapid consolidation in the industry, the idea of forming a partnership with one of the two big systems looked more and more attractive. Because of Columbia/HCA's for-profit status, Seton became the natural choice. Yet many community groups still did not like the idea of an outright sale. They wanted to protect Brackenridge as a public asset and to ensure that Seton continued the city's commitment to the indigent and to the provision of women's reproductive health services, which might be a contentious issue for the Catholic Daughters of Charity system. In addition, a sale would have required a public bidding process for the hospital, which brought up the possibility that a for-profit system like Columbia/HCA, which was perceived as having a more limited commitment to providing indigent care, might offer the highest bid and be entitled to buy the facility. Thus, the idea of a leasing arrangement became very attractive, since the city would still own the hospital and could dictate what party it would deal with. Moreover, under a lease, the city could at any time take back operations should Seton be found to have breached the terms of the agreement.

The lease required city council approval, which took roughly a full year and required a series of public hearings and meetings to allow for public comment. In addition, a special advisory

team made up of medical and administrative management at the hospitals, along with community representatives, met on a weekly basis with city leadership to provide their input and comment on key issues. A representative from the American Federation of State, County, and Municipal Employees (AFSCME) sat at the table as a representative of the employees' views (although Brackenridge and Children's are not unionized).

The mayor and city manager were crucial in winning over public support, using the much-publicized $21 million accounting error and charges of fraud and mismanagement as a rallying point for getting something done. The Seton CEO also played a critical role, spending approximately six months attending various public hearings and meetings designed to assuage key constituencies—including employees, advocates for the indigent, and family planning/women's groups. He emphasized Seton's intentions to provide jobs for all employees, to continue the same level of service to the indigent, and to continue providing women's reproductive services at Brackenridge. (This pledge did not include providing abortion services, since such procedures were not offered at Brackenridge). His credibility, as well as that of the entire Seton organization, played a crucial role in appeasing skeptical factions. Allowing representatives of all of these groups to offer their input through a variety of forums was also very important. The strategy was to have all key constituencies participating at the table so that sufficient support could be generated to ensure city council approval.

Benefits to the City from the Seton Alliance

The arrangement with Seton gave the city most of what it wanted:

- The city received enough upfront capital ($10 million plus ownership of existing accounts receivable and other operating accounts) and annual lease payments to retire the hospital's accumulated $61 million debt (from operating losses and bonds issued for the building of Children's Hospital) and even provide for a surplus.
- The city was no longer financially responsible for operating losses at the hospitals.
- The city effectively had a ceiling placed on its ongoing commitment to fund care for the indigent, at a level roughly equal to its former annual commitment of $17 million. This payment consists of $5.6 million for the provision of hospital services for the indigent, $6.4 million a year for the Medical Assistance Program (a program that provides care to low-income residents who do not qualify for Medicaid), and $4.7 million for the provision of resident physician services. While there are some escalator provisions in the contract, Seton now bears most of the risk for increased expenditures.
- Brackenridge and Children's Hospitals' futures were more secure, as they were now part of a larger health care system that is better able to instill operating efficiencies and quality improvement initiatives and to compete for payer contracts. In addition, the hospitals were freed from the constraints of city management.
- The community at large was provided with a vehicle—the Hospital Oversight Council—to hold Seton to specific pledges to continue to offer services to the indigent, including women's reproductive services. The city also extracted an agreement whereby the hospitals would not be identified as Catholic institutions.

Seton's Motivations

As a part of the Daughters of Charity System, Seton Healthcare Network, like Brackenridge, is strongly committed to serving the indigent. According to Seton's CEO, this convergence of mission was perhaps the single most important reason why Seton felt it should enter into an arrangement with Brackenridge and the city.

On a more practical level, however, Seton's management realized that there was little choice but to "step up to the plate." By the time the authority negotiations broke down in 1994, the hospital was in serious trouble. The accounting error had been discovered, independent consultants had been brought in, and it became clear that the hospital might not survive unless something was done. Affiliating with one of the two major systems seemed like the only way any independent hospital would survive, let alone poorly-run public hospitals with an increasing indigent load. More importantly, perhaps, Seton's managers realized that if the hospitals did fail, the burden for indigent care would naturally fall to Seton. (Since Columbia/HCA had purchased St. David's, Seton was the only non-profit system in the area.) Thus, using the philosophy that Seton could "pay now or pay later," senior management decided to pursue some sort of arrangement to take over operational responsibility for the hospitals. By moving early, Seton management hoped to begin looking for ways to reduce costs, increase revenues, and save Brackenridge and Children's before the city was forced to close the doors.

Change in Governance Structure

Prior to the lease arrangement, the city council served as the board of directors, with an advisory board consisting of community members providing advice to the council. After the conversion, the Seton Healthcare Network's board has fiduciary responsibility for Brackenridge. There is no local Brackenridge board, although the chief of staff at each Seton hospital (including Brackenridge) is invited to attend board meetings on a nonvoting basis. Each hospital does maintain a Physician Executive Committee, which is responsible for quality monitoring at the local level.

Along with consolidating governance, Seton has consolidated the administrative and management staff at Brackenridge. One CEO, CFO, nursing executive, and Vice President of Human Resources are now responsible for all hospitals within the Seton system. As a result, total administrative expenses have been reduced significantly. Seton also recently hired a reportedly talented administrator to run Brackenridge on a day-to-day basis. Seton was able to pay a competitive salary to attract the individual, something the city previously was unable to do.

Yet, even with the change in governance and management, the mission of the hospitals remains largely the same. As noted previously, the similarity in the missions of Seton and Brackenridge/Children's was one of the main reasons that the city council and community at large felt reasonably comfortable with the lease arrangement. Without this, a deal likely never have been reached.

Effect on Hospital Operations

Cost Savings from a Variety of Sources

In addition to administrative cost savings, Seton has derived increased efficiencies from a variety of other sources:

Slight Changes in Staffing Patterns Since the Lease

Seton management generally viewed the labor force that they inherited to be a major asset; workers were viewed as both skilled and productive. As a result, Seton has made only minor staffing adjustments since the takeover. These adjustments are not targeted at Brackenridge and Children's, but rather are part of a systemwide effort to cut costs by using lower-skilled staff to take over responsibilities that previously belonged to higher-skilled, more expensive staff. (In fact, in some departments, staffing levels have increased, while in others they have been reduced.) As a result, duties primarily performed by an RN are in some instances being taken over by nurses' aides and other staff. All reductions have been accomplished through attrition; there have been no layoffs since the lease arrangement was signed.

Layoffs Before the Lease

The limited changes in staffing since the commencement of the lease arrangement do not tell the whole story, however. A series of layoffs was made prior to the signing of the lease, a period during which hospital staffing was consistently described as "bloated" and "fat." These layoffs were made based on recommendations of The Hunter Group, whose analyses showed the hospital as significantly overstaffed, with staffing-to-bed ratios well above national and local norms. Another factor driving the city to embark on layoffs was money; Seton made it clear during the negotiations that, although it would agree to hire any number of employees, the lease price Seton would be willing to pay would be higher if the city got rid of the "fat" before the deal went into place.

Thus, two rounds of layoffs were completed before the lease agreement went into effect. These layoffs resulted in the loss of approximately 400 FTEs, as the hospitals went from around 1,900 FTEs to just over 1,500 at the time of the lease agreement. Seton then extended offers to virtually all of the employees who remained at Brackenridge and Children's at the time of the conversion. These offers provided for equal or better pay. (Individuals received raises if their current salary did not match the salaries of the Seton job classifications they were put into.)

Group Purchasing

Brackenridge and Children's have achieved some cost savings by participating in the Daughters of Charity (DOC) national group purchasing program. Previously, all major purchases had to go out to bid to at least three competing firms. By consolidating the purchase of supplies and other items around selected vendors, DOC has been able to extract significant price discounts for Brackenridge and Children's.

Continuous Quality Improvement (CQI) and Practice Redesign

Seton's practice redesign teams have been brought to Brackenridge and Children's hospitals. Nurses and other staff work in cross-hospital teams to improve quality and reduce costs through a variety of initiatives (for example, standardizing supplies and redesigning the process for transporting patients).

Clinical Consolidation in the Future

As noted previously, Seton has consolidated administrative staff. While the initial focus has been on back-office and administrative consolidation, Seton has formalized plans to begin in the Fall of 1998 to evaluate potential clinical service line rationalizations. Before tackling these more controversial issues, Seton's CEO wanted to bring stability to the operation and management at Brackenridge and Children's.

Little Impact on Practice Patterns Thus Far

As of this writing, management had yet to implement initiatives that would affect physician practice. Seton is about to implement processes that will result in the development of clinical pathways and other initiatives to reduce variation in practice patterns among physicians.

Effects on Services and Programs Offered

Capital Improvements and Expansions at Brackenridge and Children's

Seton has invested heavily in Brackenridge, spending $10 million to upgrade outdated intensive care units (ICU) and surgery suites at the main facility (which allowed Brackenridge to be designated a level II trauma center) and $17 million to expand outpatient capacity at Children's Hospital. Seton has also invested several hundred thousand dollars to replace a virtually obsolete telephone switching system at Brackenridge and Children's.

While there had been discussions about making these types of upgrades before the agreement with Seton, it seems unlikely that they would have occurred. For example, the city council had debated the possibility of upgrading the ICU for 12 years. Seton began work on the upgrade a few months after the lease went into effect.

New Ownership for Residency/Teaching Program

Brackenridge and Children's served as a teaching ground for residents in the Central Texas Medical Foundation (CTMF) program. These residents provided care to indigent patients at Brackenridge and Children's, and in the 13 city/county federally-qualified health centers (FQHCs). Under the lease arrangement, Seton is now responsible for provision of this care at Brackenridge and Children's, although they were not initially required to use CTMF. Since the lease arrangement began, however, Seton has acquired CTMF in an effort to instill some managed care discipline into the organization. Seton has committed to provide an additional $2.3 million to CTMF (along with continuing to invest the $4.7 million that comes to Seton from the city). While the jury is still out on whether CTMF will improve, most experts in the community feel that Seton can only serve to improve what was perceived to be a highly

inefficient system by instilling a teaching ethic that emphasizes prevention and coordination/management of care across the continuum.

Effect on Revenues and Bottom Line

The upgraded facilities seem to have helped in stemming the market share loss, as volume is up by five to six percent. At Brackenridge Hospital, the volume increases, however, are primarily limited to an increase in indigent patients coming to Brackenridge for level II trauma and women's health services. At Children's, the increase has been across-the-board, primarily due to positive reaction from physicians and patients to the upgraded facilities.

During the first two years of operation under the lease agreement, the bottom line financial picture has improved slightly, due in part to the fact that disproportionate share payments from the Federal government have actually increased.

Effect on the Local Community

Continued Public Oversight

The Brackenridge Oversight Council

The lease agreement calls for the creation of the Brackenridge Oversight Council, a five-member body that holds monthly meetings to evaluate Seton's performance with respect to three distinct areas: access to care, level of services, and quality.

Access to Care

Access to care is primarily a measure of the level of indigent care. The lease requires Seton to provide charity care at a level equal to four percent of gross revenues (the amount required by state law for organizations to maintain non-profit status), plus the average annual amount of charity care provided by Brackenridge and Children's over the three years prior to the lease. Under the arrangement, the city pays Seton approximately $5.6 million for provision of hospital services to the indigent, roughly the level of annual spending on hospital charity care before the lease.

However, because the city did not have good statistics on how much charity care was provided previously, members of the Oversight Council worked with Seton to develop an historical base upon which to measure future levels of indigent care. The lease allows indigent patients who live within the City of Austin to receive care at any Seton facility and be "counted" toward the lease requirement. Seton provides information to the Council on a quarterly basis on the number of patients who receive charity care according to the City's approved "Brackenridge Financial Assistance Plan" criteria, as well as the costs associated with that care. Members of the Oversight Council, however, indicated that they did not always feel they had the knowledge or resources to deeply or thoroughly analyze these figures.

Level of Services Provided

The lease has detailed requirements that obligate Seton to provide a wide range of services. Some of these services (for example, women's health, children's care, 24-hour emergency/trauma services, radiology, and intensive care) must be provided at Brackenridge or Children's, while other services can be provided anywhere within the Seton system. The Oversight Council has authority to evaluate whether Seton is living up to these requirements. Should changes in the marketplace or new technologies mean that services (for example, cancer treatment) previously provided in the hospital are now more appropriately offered on an outpatient basis, Seton has the right to go to the city council to seek approval for such a change.

Clinical Quality and Patient Satisfaction

Because HMOs and other purchasers are paying attention to clinical quality, Seton has committed to using its internally-developed clinical quality and patient satisfaction measurement system at Brackenridge and Children's. (The city had no system for measuring clinical quality prior to the lease arrangement, but did measure patient satisfaction.) Seton has committed itself to achieving patient satisfaction levels that are as high or higher than a baseline level established after the lease took effect. Seton has also pledged to provide the Oversight Council with reports on key clinical quality indicators (for example, unplanned readmissions or complication rates), and to include national benchmarks.

Membership and Powers

The Oversight Council consists of members who are interested in and knowledgeable about health care; by statute, it must include one local physician who serves indigent patients, one attorney with health care knowledge, and one community-based activist in health care. (The other two members are at-large positions.) In theory, the Oversight Council can recommend that the city council withhold funding for indigent care if Seton fails to meet its obligations. In practice, this option has never been discussed, as it would create a "war" with Seton. (Nor has there been a major breach in responsibility that would warrant the withholding of funds.) Rather, the real power of the Oversight Council is in the media and television coverage that the meetings attract. The meetings provide a public forum for raising any of a variety of problems that might arise, including at times discussing areas that fall outside of the scope of the three areas noted above.

In general, the Oversight Council seems to be doing a good job in surfacing problem areas. This is confirmed primarily through anecdotes. For example, there had been concerns voiced at council meetings that Seton was making it difficult for the indigent to receive sterilization procedures. Seton provided data to the Council to demonstrate otherwise. In another instance, the council suggested that individual complaints and compliments could be better handled by Seton. To improve the situation, Seton implemented a council suggestion to develop a complaint/compliment system in Brackenridge and Children's which makes it much easier for patients and family members to share concerns.

Impact on Level of Indigent Care and Access to Care

Clearly Meeting the Threshold Levels Required in the Lease

While there are anecdotal concerns about the provision of indigent care, the general view is that the level of care provided by Seton remains significantly above the minimum level mandated in the agreement. For its part, Seton management reports a marked increase in the provision of charity care, with self-pay patients (those without some form of insurance) increasing from 12 to 21 percent of volume in the last year, due in part to the rising indigent population. In fact, the level of charity care provided has been approximately double what Seton management expected, in part because of an increase in patient load and in part because Seton has not been able to collect as much money as anticipated from self-pay patients.

Better Access to Trauma Services

Access to trauma services has improved tremendously since the upgrade of the ICU and the designation of Brackenridge as a level II trauma center.

Cost Discipline Leading to Triaging for Routine Services

While Seton apparently is more than meeting its obligation to serve the indigent, there is nevertheless a perception among some members of the community that Seton is making it harder for uninsured persons to receive some services. For example, some concerns relate to the fact that Seton has imposed greater discipline in caring for the indigent. In other words, if an indigent patient comes to the hospital or emergency department for a non-urgent service that can be provided more efficiently in a public clinic, Seton staff may encourage him or her to make an appointment in the lower-cost clinic setting. On the flip side, however, there are also those in the community who believe that Seton is treating indigent patients with more respect than occurred before they took over.

Worsening Capacity Problems in Specialty Clinics

Even before the lease arrangement, there were problems in providing enough care at the specialty clinics at Brackenridge. The problem appears to be getting worse, as evidenced by the fact that the community health clinics in the area report meaningful deterioration in access in a few specialty areas. The problem is in part due to the continued turmoil with CTMF (which will hopefully be addressed by Seton's takeover), and, according to some in the community, due to the fact that private physicians have become less willing to volunteer their services at the clinics since the lease arrangement began, since they no longer view Brackenridge and Children's as "public" hospitals.

Controversy Over Clinic Funding

There is an ongoing controversy over the level of DSH and other city funds that will be made available to the community clinics in Austin. (The lease agreement calls for a formula for sharing of DSH funds between the city, Seton, and the clinics.) There is a concern among the leaders of the community health centers that these DSH funds are simply being used as a

replacement for general tax revenue funds provided to the clinics, with the net result being a decrease in overall city-provided funding for the federally-qualified health center (FQHC) network.

Medical Staff Reaction/Relations

The medical staff generally approved of the lease agreement, as they realized that the city simply did not have the money to invest in the hospital. Virtually all of the doctors are pleased with the new ICU and the expansion at Children's. There is also a general sense that Seton will respond to physician requests for change and/or improvements, whereas under city management such requests often fell on deaf ears, due primarily to a lack of funds and other city priorities. (Doctors had been pushing the city for 20 years to improve the ICU, but it never happened.)

However, some members of the medical staff are not happy about the possibility of services now offered at Brackenridge and/or Children's being consolidated elsewhere in the Seton system. Some doctors also report that they feel like "second-class citizens" within the Seton network, feeling that other doctors get preferential access to referrals.

Reaction from Employees

Understandable Fear and Anxiety

As noted previously, the lease agreement came on the heels of two rounds of layoffs. Not surprisingly, therefore, the labor force was extremely nervous and anxious about the proposed lease arrangement, as they feared continued layoffs and a reduction in salary and benefits. In particular, there were concerns about retirement benefits, particularly for those nearing eligibility for retirement under the city's generous plan. There was also concern about holidays, since the Seton system offered fewer each year.

Variety of Steps to Ease Concerns

Seton management took a variety of steps to ease the concerns of employees:

- Employee concerns were voiced through the local chapter of the American Federation of State, County, and Municipal Employees (AFSCME), which had an "advise and consent" relationship with the employees, and served as a voice for some employees with the city. (Brackenridge and Children's were not unionized.)
- During six months of the negotiations with the city, the Seton CEO participated in meetings and other forums in an attempt to assure all employees that they would be offered employment at Seton, and that their salary would be comparable to what they enjoyed with the city. Over time, the mood changed from one where most employees were against the transition to one where a few were enthusiastic and most were willing to give it a chance, with a small minority remaining openly hostile.

- Seton set up a telephone hotline available to all employees. Seton management responded to all questions and concerns raised through telephone calls, with responses to all questions distributed to the entire staff.

To ease the concerns, Seton and the city agreed to "ease the pain" for employees most affected by the transfer to Seton. To that end, city employees within two to five years of retirement were offered other positions within the city. Individuals within two years of retirement were able to keep their jobs and remain city employees under an arrangement whereby Seton "leased" their services. Seton also agreed to offer these individuals employment once they reached 25 years of service (although many may retire).

Despite the initial hostility to the idea, 1,515 out of 1,530 employees ultimately accepted the offer of Seton employment. A few have become very enthusiastic about the transition, although most appear to have merely accepted the situation. A small pocket of employees remains openly hostile. Employees clearly lament the reduction in benefits, and some fear a new round of layoffs. Finally, what employees appear to miss most is a loss of culture and identity. Workers at Brackenridge and Children's had developed a tight-knit culture that has changed as they have become part of a much larger system.

Conclusion

While not without its opponents, the strategy of leasing Brackenridge and Children's Hospitals to Seton has succeeded in realizing most of what it was sought to achieve. First and foremost, it has helped to preserve and secure the provision of care to the city's indigent population. Without the transfer of operational responsibility, it is quite possible that the city, unable to absorb the continuing flow of red ink, would have been forced to close the hospitals' doors. A related benefit has been an improvement in the city's financial situation. Not only does the arrangement limit the city's ongoing contribution to fund indigent services, it also provides enough capital to pay off the hospitals' accumulated debt. Finally, the hospitals themselves have a much more secure future as a part of the Seton network. In the few years since the arrangement began, both hospitals have enjoyed a significant inflow of capital which has led to meaningful improvements in hospital operations. As part of a multiple hospital system that is not encumbered by the constraints of city rules, moreover, both hospitals have benefited from a variety of actions (for example, consolidating management, group purchasing, and cross-training) that are likely to result in the provision of more cost-effective care. Future actions (for example, clinical consolidation and development of practice guidelines) may help not only to reduce costs further, but also to raise the quality of care provided.

At least one contentious issue remains, however. After a few minor problems with the transition, the arrangement appeared to be running smoothly until objections arose in the Roman Catholic community regarding the provision of reproductive health care services. This forced Seton, the local Catholic bishop and the city to re-work this aspect of the lease agreement. A new agreement has been reached that will allow the hospital to provide sterilization and contraceptive services; this agreement awaits approval by the Vatican.

University Hospital — Denver, Colorado

A transfer of the assets of a state-owned academic medical center to a quasi-public hospital authority.

Introduction

University Hospital is Colorado's only academic medical center and its second largest provider of care for the medically indigent. Based in Denver since 1910, it draws patients from the entire state for specialized services such as organ transplants, but it primarily serves patients in the Denver metropolitan area.

Until 1989, the hospital was owned and managed by the state as part of the University of Colorado's Health Sciences Center. At that time, the state, through legislation, relinquished its control of the hospital, initially by forming a private, non-profit corporation. (This idea of transferring assets and liability to a private, non-profit corporation was based on the experiences of at least four state academic health centers that had done the same: the Universities of Arizona, Florida, Maryland, and West Virginia.) However, a lawsuit brought by the Colorado Association of Public Employees (CAPE) resulted in a 1990 ruling by the Colorado Supreme Court that this approach was unconstitutional; having determined that the supposedly private corporation was not sufficiently separate from the state, the court found that the law establishing the new organization violated the employees' civil rights as state employees as well as the state's prohibition on public institutions issuing debt.

In 1991, the legislature addressed the challenges raised by the previous reorganization by vesting responsibility for the hospital with a new, non-profit legal entity called the Hospital Authority, a quasi-governmental corporate body. Under this new law, the hospital was free to issue debt, and employees were not required to leave the state employee system. Thus, since 1991, the previously public hospital has been operating as a semi-independent agency; it is free of the constraints imposed by many state rules, but is ultimately owned by and accountable to the public. That is, the Authority owns the assets of the hospital, but if the hospital were to dissolve, the assets would return to the regents of the state university.

Motivations for Conversion

The need to pull the hospital out from under the state system was evident to both hospital and community respondents. In the early 1980s, an accounting firm projected that the hospital would continue to generate major losses if it remained under the same structure, but concluded it could be profitable if it were to convert from public status. Since, as a public institution, the hospital could not issue debt, its losses were taking a tremendous toll on the university in general and the Health Sciences Center in particular. Unlike most academic medical centers, which subsidize the health sciences centers with which they are affiliated,

University Hospital was receiving substantial subsidies from the medical school. Moreover, budgetary constraints were hindering the hospital from making the investments—both in the physical plant and in equipment—necessary to sustain its ability to deliver sophisticated, high-quality care. Several people who were involved with the hospital at that time noted that, due to the lack of resources, it was operated more like a community hospital than an academic medical center.

Given the financial situation, and with no reason to believe that the hospital's plight would improve in any way, senior managers at the hospital and the Health Sciences Center determined that the hospital would have to become independent so that it could be more competitive in the market and more cost-effective from an operational perspective. Five specific issues drove this determination:

- The need to be freed from the state purchasing system.

  The hospital was required to use the state's purchasing system, but since it was the only part of the state buying many medical supplies, it did not generate sufficient volume to demand good prices. Also, any item over $500,000 required the approval of the Capital Development Committee of the general assembly—even if the money was coming out of the hospital's operating budget. This rule subjected the hospital's clinical departments to lengthy delays in decisions about major equipment purchases, such as magnetic resonance imaging (MRI) machines.

- The need to be released from the state personnel system.

  Management was convinced that Colorado's personnel system created a pervasive entitlement mentality, in that staff believed that they were entitled to pay and benefits no matter what they did (or did not do). Also, since there was no way to reward good performance, the system stifled any effort to emphasize the importance of job excellence or patient satisfaction.

- The need to be able to develop partnerships and participate in joint ventures.

  University Hospital was prohibited from entering into joint ventures or partnerships because it could not mingle state assets with private assets; this meant that it could not enter into what were, at the time, common relationships among hospitals, such as collaborating to establish a cancer center. Had it not reorganized, this restriction would have kept the hospital from embarking on several relationships over the last several years that have been critical to winning large contracts.

- The need to gain access to capital (through debt or by building capital reserves).

  As noted earlier, the hospital's inability to borrow meant that it had done little to maintain, let alone renovate, its building; as one manager commented, the quality of care was good because the faculty and staff were excellent, but the amenities and environment overall were terrible. People would not come to University Hospital if they had a choice. Moreover, the one time that the hospital was able to build up significant reserves, the state appropriated the savings; this was a huge emotional blow to the staff as well as to the university, which was left with responsibility for the hospital's ongoing deficits.

- The need to be liberated from the state bureaucracy.

  Finally, as part of the state bureaucracy, the hospital was forced to operate under an extremely cumbersome system. Not only did the previous decision-making process require that the general assembly approve major capital expenditures (as indicated above), but it also meant that the university regents had to approve any major operational proposals. This hurt management's ability to make decisions quickly. While this was not a big issue prior to the 1980s, the advent of managed care made it critical for the hospital to be able to respond quickly on both a strategic and tactical level.

Although the growing level of debt created tremendous pressure on the university, and especially its Health Sciences Center, to take some action, a number of political forces created significant constraints. While the president of the university at that time favored the idea of reorganization, the university regents, who served as the publicly elected board of the university as well as the hospital, opposed it vehemently. They did not want to "give away" state assets; specifically, they were concerned about the perception that the state was giving away its assets to a private organization.

In its search for a solution, the Health Sciences Center commissioned a study of its options by an independent entity in 1986. Based on a number of criteria, the study concluded that the hospital should be reorganized as a private non-profit entity, with the authority model ranked as a close second choice. While this still did not convince the Regents, its timing was propitious. As the debt from the hospital continued to mount, a crisis occurred with regard to the hospital's nursing staff. In the context of a national nursing shortage, the state decided, based on its annual statewide salary survey, to reduce nurses' salaries by five percent. But the state's data were out-of-date, and insensitive to geographic location and to the level of competition for nurses in the Denver market. University Hospital was already losing nurses to other institutions and to agencies that could place them back in the hospital at nearly double their previous hourly rate. Out of frustration, 85 to 90 percent of the remaining nurses submitted their resignation and threatened to go on strike.

Consequently, the governor declared an emergency, overrode the state rules, and gave the nurses a 7.5 percent raise. But both the state and the university regents recognized that this approach was not sustainable over the long-term. They agreed that the hospital should leave the state system.

The nursing shortage was a seminal event, the catalyst that launched the reorganization forward. All the elements were already there: the problems were evident, a study of possible solutions was underway, and the regents were reconsidering their position in light of the increasing debt burden, which left them with no borrowing capacity for other activities within the university system. Also, the Regents had been visiting other university hospitals to see how they were dealing with similar issues, so they had gained a broader perspective on the problems.

Process and Structure of Conversion

Following a significant lobbying effort on the part of the then-chancellor of the Health Sciences Center and the former and current directors of the hospital, the proposal to free the hospital from the state by making it a private non-profit corporation sailed through the legislature, notwithstanding some contention regarding care for the medically indigent and the wisdom of "giving away" a state asset. After the court ruled the first model unconstitutional as a result of the state employees' association's lawsuit, the revised proposal establishing the quasi-public authority structure passed even more easily—partly because, after the ruling, the hospital was operating as an undefined entity. According to hospital leaders, University Hospital is now the "darling of the legislature and the pride of the regents," many of whom perceive it as one of the best things they ever did.

The Hospital Authority is a non-profit 501(c)(3) entity, a political subdivision of the state, which is owned by the people of Colorado. Under the Authority model, the hospital can borrow money for long-term capital improvement, bypass the state's cumbersome and costly purchasing procedures, deal more flexibly with employees, respond more swiftly to changing needs in health care, develop partnerships with private organizations, and invest the savings from these benefits into better service to the public. However, although the hospital may now issue bonds, it cannot raise equity.

The legislation required that the chancellor maintain a role in the hospital's strategic management, and that the mission to serve the Health Sciences Center and the health needs of the people of Colorado remain the same. A detailed agreement with the university defines specifically what the hospital has to do under the terms of the law. For example, the hospital must issue annual reports to the legislature saying how it is doing operationally and financially. Also, the hospital must spend a certain level of money for indigent care, a goal that it has consistently exceeded since the reorganization. Specifically, for every $3 the hospital receives from the state's Medically Indigent Fund (created to subsidize charity care in Colorado hospitals), the hospital must contribute an additional $1 of its own money.

However, the hospital continues to have "power struggles" with the Health Sciences Center regarding how assets should be spent. Since the Health Sciences Center is still under the state system, it does not always share the hospital management's views regarding the need to build reserves and issue debt.

Change in Governance Structure

The University Hospital is governed by a nine-member board composed of representatives of both the public and the university. The university has three seats on the board, which are filled by the chancellor of the Health Sciences Center, the president of the university (or a designee), and the president of the medical staff. The chancellor of the Health Sciences Center also serves as chair. The people of Colorado are represented by six members of the public, one from each of the state's six congressional districts. These directors are not elected, but appointed by the regents—based on the recommendations of the current authority board—

and approved by the State Senate. However, the board operates with complete governance authority; it is not accountable to the Regents.

The authority board is focused entirely on the hospital; previously, the hospital was governed by the board of regents, which had fiduciary duties for the entire system of the University of Colorado. The hospital was part of one of four campuses that the regents governed. Unlike the authority directors, the nine regents were elected by the people, not appointed.

Because the hospital remains closely linked with the Health Sciences Center, whose faculty serve as its clinical staff, there was some concern that the varying perspectives of the physicians and other departments within the center (specifically, nursing and pharmacy) would not be adequately represented by the members of the authority board. Accordingly, a decision was made to form a Resource Council, with representatives from selected departments of the Health Sciences Center, that could participate (but not vote) in the board meetings. The dean of the School of Medicine also sits in on meetings as a member of the Resource Council, but without the ability to vote.

Effect on Hospital Operations

The conversion to an authority structure enabled management to make rapid and substantial changes in the hospital's operations, its services, its capabilities, and—fairly quickly—its financial performance. This section reviews several of the more significant changes and their impact on the hospital and its faculty and staff. The next section discusses how those changes affected the community beyond the hospital walls.

Change in Mission

As indicated above, in consideration for the transfer of the hospital to the authority, the hospital agreed to carry out the mission of the Health Sciences Center, that is, to continue to support its training, teaching, and community service programs. This mission is defined by statute: "To facilitate and support the education, research, and public service activities of the health sciences schools operated by the regents of the university of Colorado and to provide patient care, including care for the medically indigent, and specialized services not widely available elsewhere in the state and region."

The reorganization has not changed the mission, which has remained the focal point for the hospital's activities. However, it has been a challenge for the hospital to balance its financial viability with its mission. An academic health center is always at a disadvantage in the local marketplace because of the higher costs associated with research, teaching, and indigent care obligations. Thus, in order to be in a position to work toward the mission (and still compete effectively), the hospital's management pursued major aggressive efforts to manage costs and utilization—some of which were not necessarily consistent with the actual mission.

The CEO of University Hospital, however, noted that it has been much easier for the hospital to meet its mission now that it has "margin." As a result of the reorganization, the hospital has been able to:

- expand existing departments and establish new capabilities and clinical services that were not previously available in the local marketplace;
- serve greater numbers of patients overall and greater numbers of the medically indigent in particular;
- compete regionally and nationally to attract faculty, research grants, students, and house staff; and
- increase its contribution to the school of medicine from $3.2 million in 1988 to $10.8 million in 1998.

Essentially, the leaders of the hospital believe that they could not have continued to fulfill their mission without making certain changes necessary to ensure the financial stability of the institution. Surprisingly, even those community leaders troubled by recent cutbacks in indigent care at the hospital (see section on access issues below) agree with this view. In fact, the ongoing debate about care for the medically indigent illustrates this conundrum. On one hand, the hospital can be regarded as successful in fulfilling its mission as defined by the legislation; that is, it is spending far more on indigent care than the legislation requires. On the other hand, if meeting the mission depends on meeting the need for indigent care in the state, which has been growing rapidly, then the hospital has not been successful. Either way, however, given the freedom to manage itself, there is a broad consensus that the reorganized hospital has been providing far more indigent care than it would have been able to do under the old structure.

Effect on Clinical Services and Programs

Expanding and Improving Specialty Care

Prior to the conversion, the hospital had few special care units, primarily because it lacked the capital to support them. For about 10 years, the hospital was performing only kidney transplants, which was becoming a relatively common procedure. But now, because access to capital enables it to improve its infrastructure and adopt new technologies, the hospital can handle the tertiary and quaternary activities appropriate for an academic medical center. For instance, since the reorganization, the hospital has:

- developed a solid organ transplant program (for example, heart/lung, liver, kidney, pancreas, and bone marrow) that barely existed before;
- added a $100 million intensive care tower with 64 intensive care beds, 12 new operating rooms, and a new heart center; and
- expanded and upgraded its burn unit, which was small and cramped.

During this same period, the hospital has also given up its pediatric unit, but that decision was driven not by the reorganization but by faculty issues, including an interest in consolidating faculty at The Children's Hospital, which is affiliated with the Health Sciences Center.

On the whole, the expanded capabilities and resources of the hospital have been a boon to the Health Sciences Center, creating opportunities for faculty to build practices, conduct

research, and fulfill their teaching responsibilities in ways that did not exist before. However, the perception of some of the faculty at the Health Sciences Center is that the hospital appears to limit its investments to services that are expected to be profitable, which means that it rejects some faculty proposals whose merits are less financial in nature (for example, for service expansions needed for research or teaching purposes, or for new, innovative services that may be very costly or serve a small number of patients). Hospital administrators contest this assertion, claiming that the hospital continues to support many existing and new programs on education and research. Prior to the conversion, such decisions were more political in nature, as is typical in an academic setting; that is, those department chairs and faculty with clout got funding for their projects, while others did without. Thus, by imposing specific criteria, the reorganized hospital has also had an impact on the power structure within the Health Sciences Center.

Promoting the Use of Clinical Pathways

To compete in a managed care environment, the hospital is developing a variety of clinical pathways, 26 of which are completed and currently in use. In an effort to encourage faculty and hospital staff to participate in the creation and application of these pathways, the hospital has put in place incentives for the doctors, usually in the form of stipends for staff and supplies. It also rewards physician "champions" for meeting specific targets associated with their pathways, such as improving patient satisfaction and outcomes, or reducing length of stay (without a resulting degradation in quality). While the need for clinical pathways would have arisen regardless of the conversion, the change has enabled the hospital to reward contributions to quality and efficiency in a way that would not have been possible under state ownership. In the old environment, the hospital had no ability to offer incentives to faculty or staff to do anything creative.

Improving Medical Education

Hospital representatives report that their ability to support the educational mission of the Health Sciences Center has improved tremendously. Training now occurs in a multi-hospital educational system, which includes the VA Hospital across the street from University Hospital, Children's Hospital, and Denver Health (formerly the county hospital, but now also a separate authority). The system is even wider for primary care training.

Most importantly, the institution is now able to provide a much more typical university hospital experience because of its improved tertiary and quaternary care facilities, which means that students can get broader exposure to complex cases. Hospital staff believe that their commitment to education is as strong as it has ever been, but that they now have better tools and venues for clinical teaching.

Effect on Costs and Efficiency

There is little question that the reorganization has allowed the hospital to cut costs, primarily by increasing the efficiency and productivity of both faculty and staff. These changes are evident in the institution's bottom line (see more on this below). But according to the hospital's medical director, they also are apparent from the perspective of the physicians, who

have witnessed significant improvements in the efficiency of the support systems—both human and technological—that affect patient care. For example, because staff now have access to computers, which might never have become available under the old purchasing system, drugs ordered by the doctor get to the patient sooner, resulting in higher quality care and quicker discharge.

Creating a New Personnel Management System

At the time of the reorganization, the hospital operated under policies, procedures, and rules for its staff that were not congruent with each other or with the new goals of the institution. Thus, perhaps the biggest change since the conversion has been the development of an entirely new system for managing personnel, including competitive salaries, the hospital's own retirement program (separate from the state's and from Social Security), and new benefits (such as a cafeteria-style plan). That is, the hospital made significant changes in how it hired and paid personnel, and how it rewarded performance.

Specifically, the administration responded that it made three major changes in the area of human resources management:

- First, the hospital defined performance standards that established expectations and roles for front-line managers. In the past, according to hospital administrators, these managers had not had a "bottom line"—they just applied the state's rules. But without a rulebook, many managers were lost; they did not know how to make decisions. The hospital felt also it had to rein in those who had been flouting the rules. As a result, the human resources staff did a great deal of teaching and training at the management level.
- Second, the hospital took steps to improve the competency of the staff by measuring performance, training staff, holding people accountable, and rewarding competence. Hospital administrators felt that many people were in positions above their level of ability; this often happened because, under the state's rules, it was easier to hire a second person than to fire someone who could not perform adequately in a given role. This problem was thought to be especially acute in administrative areas.
- Finally, the human resources staff provided training and set standards with respect to customer service. As a result, the hospital has seen improvement in both customer satisfaction and employee satisfaction. In fact, one of the most significant changes in employee opinion has been in response to the statement: "My performance matters to this organization." The score on a five-point scale went from 3.5 in 1994 to 4.4 in 1996.

The reorganization resulted in some people being fired, mostly for basic competence issues (such as not showing up for work every day), but only after training and warnings. However, no areas of the hospital were downsized, and some expanded substantially. In general, the medical care staff was least affected by the changes, because individual standards for professional care were already high. It was the support systems—such as billing—that were truly deficient.

Under the law creating the authority structure, the hospital operates under two employment systems: the state's and the authority's. Employees of the hospital at the time of the 1991 reorganization had the right to choose to remain under state rules or to become employees of

the hospital authority. (Under the law that had created a private entity, after a two-year grace period, employees had no choice but to leave the state's system if they wanted to keep their jobs; this was the primary reason for the original lawsuit.) If a position is vacated by a state employee, it can become an authority position; also, new hires are automatically employees of the authority, not the state.

In the beginning, to entice employees to shift into the authority's personnel system, the hospital had dangled a substantial carrot, including a 12 to 15 percent increase in salary, a change in holiday pay to time and a half, and an increase in shift differentiation (that is, additional pay for working the night shift). In the first month, 60 percent of the workforce became authority employees. By the end of the first year, the authority employed a broad majority of the staff; soon, roughly 90 percent elected to become authority employees. As of spring 1998, fewer than 100 of roughly 2,000 positions are filled by state employees.

Although the hospital clearly took advantage of this new system as a means of eliminating poorly performing employees created under what was widely perceived as the state's inefficient personnel system, the staff size has grown somewhat since the reorganization. Just after the hospital became an authority, it had roughly 2,000 positions, 1,500 of which were filled. Under the new system, it was able to fill most vacancies within a few months; it was even able to hire back a few of the nurses who had left during the salary crisis (although many were too angry to return). It also brought on new people to staff purchasing, human resources, and other functions, many of which did not exist before. Now, the hospital has 2,600 employees, or just under 2,100 full-time equivalents (FTEs).

Cutting Back on Care for the Medically Indigent (MI)

The question of the impact of the reorganization on the provision of indigent care is a contentious one. As noted earlier, in dollar terms, the hospital is providing roughly three to four times the amount of indigent care required by the state. No one inside or outside of the hospital said they believed that the institution would have been able to do so much if it had not been freed from the state's constraints.

However, in 1997, the hospital explicitly decided to cut back the amount of indigent care it provides, claiming that the rapidly growing expense for this care was far exceeding the established budget and threatening the profitability of the institution, needed to meet the hospital's other missions. Specifically, it removed 50 percent of the capacity of the outpatient clinic that was exclusively serving the indigent. (This does not actually mean that it saw only half of the usual number of patients, because some of the patients that might have been served by this clinic continued to obtain care from the hospital through its other clinics and the emergency room.)

Although the decision to cut the budget in this way is a function of the hospital's financial independence from the state (and thus its need to remain creditworthy), it would be unfair to say that a similar decision would not have been made if the state had remained the owner of the hospital. As the growth of managed care has lowered reimbursement, increased competition, and made it increasingly hard to shift costs onto other payers, the hospital believes that it has little choice but to limit the amount of indigent care it provides. As far as

the hospital leadership is concerned, the demand for care outstrips its ability to meet it, and it would have had to impose even greater limits had the hospital not been reorganized.

Noting that this is a statewide public policy problem, several people placed the blame with the state, which they accuse of being unwilling to provide adequate support for indigent care. In Colorado, 17 percent of residents are uninsured and eligibility criteria for Medicaid are fairly strict. According to one hospital executive, "Colorado is the third stingiest state in the country in terms of appropriations for the medically indigent." Colorado is also not pursuing as much of the disproportionate share (DSH) funds on behalf of its hospitals as the federal government would allow—a situation that University Hospital is trying to help change, even though DSH payments are scheduled to be cut nationwide under the Balanced Budget Act of 1997. Finally, hospital representatives indicated that the amount of money coming from the state for this purpose has been fairly stable for the past seven to nine years, even though the demand for services has grown substantially. In an interesting side note, one interviewee noted that the fact that the hospital is no longer the state's "problem" is not entirely good because it allows the state to ignore the problem of the medically indigent. According to this view, since the hospital is supposedly dealing with the problem, the medically indigent are no longer on the state's radar screen.

(For a discussion of the community's reaction to this situation, please see the section on Effect on the Local Community below).

Improved Ability to Purchase Efficiently

After the reorganization, the hospital saved $2 million a year right off the block by participating in the purchasing group sponsored by the University Hospital Consortium. In the context of an $85 million budget, $2 million was considered a substantial amount of money. As noted earlier, the reorganization also enabled the hospital to purchase high-ticket items much more quickly and cost-effectively. Changes can also be seen in the bidding process. Since the hospital remains a quasi-public entity, it still bids out most projects competitively, but it benefits from a more streamlined process. For example, the hospital can issue requests for information (RFIs), which are quicker and more manageable than requests for proposals (RFPs). In summary, the hospital now has greater flexibility and less bureaucracy, but remains sensitive to the fact that it is spending public money.

New Ability to Borrow

The reorganization enabled the hospital to make radical changes in its capital budget, which went from $200,000 in the 1980s to roughly $40 million in 1998. Prior to the conversion, the hospital had to rely on current year earnings to fund long-term objectives because it could not raise or build its own capital reserves to buy things or invest appropriately. Now, the hospital can:

- build reserves that it may use to remodel, purchase new equipment like MRIs, and enhance its debt profile (that is, an entity has to have money to borrow money); and
- issue debt to support large capital investments and take advantage of business opportunities.

For example, very soon after the initial reorganization, the hospital borrowed between $16 and $20 million from a major bank in order to have the capital to generate new programs—such as transplants—that would sustain the hospital over the long-term. In 1992, the hospital issued its first bonds for $119 million, most of which was used to build the critical care tower; some went toward paying back previous debts. As a result of its ability to build up reserves and demonstrate solid operations, the hospital has since earned an "A" rating from both Standard & Poors and Moody's. More recently, as a result of its access to capital, the hospital was able to invest in the development of TriWest, a partnership with several Blue Cross plans that won a TriCare (managed care) contract in the western region with CHAMPUS.

Effect on the Bottom Line

The impact of these changes on the hospital's bottom line has been substantial. After years of losses and thin margins, the hospital has been "in the black" since one year after the reorganization, with profits far in excess of the accountants' original projections in the early 1980s.

Changed Payer Mix

Part of the increase in revenues can be attributed to changes in the hospital's payer mix. The amount of money coming in from the state for indigent care has remained roughly stable since the conversion, but has fallen significantly as a proportion of total revenues, from 8.9 percent in 1989 to 4.9 percent in 1997. Revenues from privately insured patients, on the other hand, have grown from 23.4 percent of the total in 1989 to 36.2 percent of the total in 1997. This increase in its share of reimbursement from commercial business is due to the hospital's enhancement of its special care units. Payers are willing to pay more for highly specialized services, so even though costs are high, this is a more profitable area than most other services. This shift in payer mix has been instrumental in providing capital for further investments.

The reorganization has also helped the hospital better meet the demands of managed care payers. The hospital can execute contracts more easily than it could under state rule; it is more nimble, responsive to the market, and flexible. For example, to be part of a managed care initiative that involved the Blue Cross plans, the hospital had to put up capital and move fast enough to win the contract. The hospital also had to act quickly to win Medicaid contracts by forming a managed care company, Colorado Access, with Children's Hospital, Denver Health Medical Center, and the local community health centers (CHCs). On a related note, the hospital's investments did not generally meet with opposition from payers because the changes did not affect the hospital's capacity (that is, it has the roughly the same number of licensed beds).

While the amount of revenues from the privately insured has gone up, Medicaid has fallen slightly as a percent of the total, and Medicare has increased slightly. However, since Medicaid and especially Medicare pay generously in many cases, the hospital would like to see growth in these areas.

Lower Costs, Higher Revenues

Since the reorganization, the hospital has been profitable. Expenses have increased in a manner consistent with similar health care organizations: the budget has grown from $75 million in 1989 to $250 million in 1998. But even factoring in the part-time employees, the hospital still does not have significantly more FTEs now than it had in the early 1990s. (Also, the hospital's length of stay is one of the lowest in the University Health Systems Consortium, and below the median for the city area.) Thus, it has been able to keep its cost structure (as measured by the number of FTEs) constant even as it experienced dramatic growth in clinic and emergency room visits, which grew from 222,277 in 1989 to 309,880 in 1997, as well as growth in inpatient admissions, which grew from 13,532 in 1989 to 14,271 in 1997, during a period when most hospitals have seen a decline in their admissions. According to senior managers, even though labor costs went up, the productivity gains far outweighed the additional expenses; revenues per dollar of salary increased dramatically.

From the hospital's perspective, the real impact of the reorganization has been on revenues. The changes in both product mix and payer mix have increased income tremendously. Because the hospital can now offer tertiary and quaternary care, it is attracting payers who otherwise have no other choices. Their patients used to go to other states, or to local hospitals that offered the services but did not have the volume to do it well. Also, the hospital has been able to increase charges substantially (recognizing that no one pays full charges anymore); prior to the conversion, the regents had kept charges artificially low for political reasons—the hospital was cheaper than its local competitors, with three percent price increases when inflation among other hospitals was high.

The proportion of funds coming from the state is greatly diminished. In the late 1980s, the state contributed $3.4 of the hospital's $80 million budget. Now, the state provides $2.4 of a $240 million budget. This is funding to support the hospital's educational mission, not for indigent care, for which it receives roughly $8 million.

Effect on the Local Community

Legal Fall-out

As noted earlier, the passage of the initial legislation authorizing the creation of an independent non-profit entity resulted in a lawsuit by the Colorado Association of Public Employees (CAPE) on behalf of the employees of University Hospital. (CAPE is an employee association, not a union; Colorado state employees have no collective bargaining rights.) In a suit filed in 1989, CAPE challenged the constitutionality of the law, claiming that it violated the civil rights of the state employees and the state's prohibition against issuing debt. Their argument was that since the regents retained substantial control over the hospital (the law allowed the regents to approve and fire directors of the hospital's new board, and limited the hospital's ability to acquire debt without the approval of the regents), it really was not independent of the state. In an appeal, the state supreme court found in favor of CAPE in December 1990, which was what led the legislature to pass the legislation creating the hospital authority in 1991.

Having succeeded in defeating the original effort to form a private corporation, CAPE filed a second lawsuit against the establishment of an authority, arguing that the employees were still not completely free to stay in the state's personnel system. However, the legal grounds of the case were not as strong the second time, and CAPE had some concerns about what would happen if the hospital had to return to the old model. As a result, CAPE and the hospital settled the case by agreeing to set up a grievance procedure so that anyone electing to remain in the state system who felt discriminated against could seek binding arbitration. So far, the hospital has only had to use this process a few times.

Effect on Access to Care for the Medically Indigent

Because the hospital accounts for indigent care in terms of charges, which have increased sharply since the conversion, it is hard to tell whether it is really serving significantly more people each year. The hospital reports that it provided nearly $55 million in indigent care in 1997 (measured as a total of bad debt and charity writeoffs), far exceeding the state's requirements. However, a study conducted by the state found that the hospital had actually provided significantly less indigent care in the previous year than it had in prior years (as measured in visits and admissions rather than dollars). Reporting on the amount of care provided to participants in the state's Medically Indigent Program in fiscal year 1996, the Colorado Department of Health Care Policy and Financing found that, at University Hospital, admissions fell 43.2 percent (versus a drop statewide of 14.4 percent), inpatient days fell 54 percent (versus a drop statewide of 24.5 percent), and outpatient visits dropped 29.2 percent (versus an increase statewide of 0.4 percent).

The hospital attributed this discrepancy to two factors: the timing of the data reporting (that is, the hospital's timeframe was different from the state's) and the existence of costs for medically indigent care that were not captured by the state's study. Specifically, the hospital was operating an outpatient drug dispensary for the medically indigent that was a huge expense but did not show up in the state's calculation of visits.

In addition, the issue of access to care is complicated by two factors. First, it is almost impossible to say whether the current situation with respect to indigent care has any connection to the hospital's reorganization nine years ago. Nearly everyone active in this area concurred that the problems would have arisen regardless of the hospital's status, and that the hospital's financial success has enabled it to provide more care overall than was available before.

Second, access is affected by the division of responsibilities between the two largest safety net providers in the Denver area. Denver Health, formerly the county hospital, receives significant monies from the city and county to provide care only for those medically indigent living within the county's borders. To that end, in addition to the hospital facility, Denver Health operates a broad network of community health centers (CHCs) that serve the county and city. As a result, all other community health centers in the area focus on the needs of medically indigent residents outside of Denver county, as does University Hospital (even though it physically lies within the county).

Both University Hospital and Denver Health reported that their relationship is strong; while they encounter occasional difficulties in determining who should serve which patients, they are generally able to resolve these problems and respect each other's limits. Also, University Hospital provided useful advice and served as a model for Denver Health's recent reorganization into an authority structure.

However, the hospital's relationship with other local CHCs is mixed. On one hand, the hospital has been an enthusiastic participant in several initiatives with the CHCs. It entered into a venture with the CHCs, Children's Hospital, and Denver Health to form Colorado Access, a Medicaid managed care plan. And in 1996, University Hospital put up money to enable the CHCs to expand their capacity in the metropolitan area. However, in 1997, the hospital decreased its investment in the medically indigent. It withdrew the funding for the clinic expansion, forcing the CHCs to scale back on the new sites that were already operating. As noted earlier, it also cut back the capacity of its on-campus clinic for the medically indigent by half, and restricted access to the pharmacy for only the medically indigent patients served by University Hospital. This put even greater pressure on the CHCs, which regarded the increase in the number of nonpaying patients referred to them as "dumping" on the part of the hospital.

Based on anecdotal evidence, the two major CHCs in the area also believe that the hospital has reduced access to specialty and subspecialty care for the medically indigent. While the problem varies by clinic, they report that fewer of their patients are able to get specialty care from the hospital, and that it takes longer to get them admitted; moreover, some specialties are not accessible at all. Also, based on reports from patients, the hospital appears to be "hassling" them in a way that was not done before. For example, the hospital is said to be turning away undocumented aliens (who are not eligible for state funding) unless they can pay for non-emergent care upfront; in the past, the hospital would treat them regardless of their ability to pay.

Reaction from Competitors

Interestingly, other hospitals in Colorado—even those that were local competitors—did not object to the reorganization of University Hospital. Understanding the constraints under which it was operating, they regarded the change as critical to the survival of the institution that bore the brunt of responsibility for medically indigent care and teaching in the state. Perhaps the only exception to this general acceptance at the time was Denver General Hospital (now Denver Health), which was concerned about having to take on the "overflow" if University Hospital was freed of some of its obligation to the medically indigent; the legislative requirement to continue providing this care resulted in part from Denver General Hospital's lobbying efforts.

It is important to note that this understanding of University Hospital's predicament did not come about independently. Through his position on the board of the Colorado Health and Hospital Association, University Hospital's president invested a great deal of time and effort in educating his colleagues around the state and winning their support.

Continued Public Oversight of the New Entity

In accordance with the legislation establishing the authority, University Hospital submits annual reports to the state that document the extent of care for the medically indigent. However, its compliance is not actually monitored, mostly because the hospital has consistently provided at least two to three times the required amount of care. There are no penalties built into the statute if the hospital does not comply with the requirement.

Other Controversies Reported in the News Media

Recent news reports about University Hospital focus on its plans to relocate the entire facility from the current University of Colorado campus in Denver to a new campus on a former Air Force base in Aurora, Colorado. The University of Colorado also plans to move the entire Health Sciences Center campus to the new Aurora location. Given a need to modernize and augment the facility, but facing strong local opposition to the idea of expanding in its current location, the hospital and the Health Sciences Center now intend to build a new facility, to which they will move in about 10 to 15 years. While this is not a direct result of the reorganization, the hospital would never have had the ability to make such a major move without the financial independence from the state.

Conclusion

Given the amount of time that has passed since the hospital was first reorganized, it is hard to surmise what would have happened (or not) if the hospital had not been released from the state's systems. Particularly in light of the force with which managed care steamrolled into the Denver market, it would not be fair or accurate to attribute all of the changes that have occurred during this period to the hospital's new status. Managed care has had a major impact on how all of the hospitals in the area do business; University Hospital would not have been impervious to the changes in the marketplace. To survive, the hospital—or more likely, the regents as representatives of the state—would have had to do something to enable the institution to compete.

That said, the conversion to an authority can be deemed a success by several measures. Financially, the reorganization is regarded as a great success, especially in light of the recent years of profitability after years of losses under the state. The hospital has become creditworthy and has been able to afford renovations: altogether, the hospital has put almost $400 million into the physical plant since the reorganization. On a less tangible level, University Hospital has been doing well in the "beauty contest" among hospitals. It has been ranked among the top 100 hospitals in the country for the last three to four years. While these rankings are qualitative and subjective, they indicate that the University Hospital is being recognized for its abilities. The hospital has also become a "real" academic medical center. The typical case mix index (which measures severity of patient condition) for a community hospital is 1.0; University's hospital's index was 1.01 before the reorganization, but it is now at 1.5—the highest in the state and comparable to that of its AMC peers. This improvement in capabilities has also made it easier for the institution to recruit and retain highly qualified staff. Finally, both patient and employee satisfaction have been rising since the reorganization—significantly at first, then stabilizing over the last few years.

Sutter Medical Center — Santa Rosa, California

A lease of the assets of a county hospital to a private, non-profit health care system.

Introduction

Sutter Medical Center of Santa Rosa, California, is located in Sonoma County, a rural/suburban area one hour north of San Francisco. The 175-bed hospital, which has been on its present campus for 60 years, was formerly Community Hospital of Sonoma County, the county's public hospital. It is a general acute care facility with a variety of specialized diagnostic and treatment services such as magnetic resonance imaging, skilled nursing beds, cardiovascular surgery, and intensive care units. The land and buildings are owned by the county, but the hospital has been operated since March 1996 under a long-term lease to Sutter Health, a private, non-profit corporation which operates 26 hospitals in Northern California.

Motivations for Conversion

Sonoma County's Motivation

Community Hospital had been incurring large financial losses for three to four years before the lease took effect in 1996; it had also been, for some time, half-empty. The hospital has an older physical plant that probably will not be able to meet California's stringent new seismic standards for the safety of hospital buildings by the year 2008 deadline. No capital budget had been passed for the hospital for years—capital items were approved to be fixed or replaced as they broke. The county supervisors concluded they were not the best people to run a facility in the current hospital marketplace, and hired a consultant to identify potential partners to run the hospital. Columbia/HCA was one—but, according to observers, their proposal "turned people off." The hospital's medical staff was afraid Columbia would "turn the hospital upside down to make a buck." The supervisors were much more comfortable with

The supervisors felt that in today's market, public hospitals (especially small ones) cannot compete for managed care and other third-party payer contracts. Long-term viability for any hospital in the Northern California market is based on the evolution of managed care. To remain a viable entity, they felt the hospital had to become part of a larger, stable, integrated system. Insurers, they reasoned, would not negotiate with small stand-alone hospitals like Community Hospital. Public hospitals have an additional handicap in that they are forced to develop and implement long-term competitive strategies in a public forum (because of California's open meetings act), and their competitors can sit in on their planning meetings.

As one of the supervisors noted, the county's health care obligations do not require that it operate a full-service acute care hospital. California's counties are the providers of last resort for hospital care, but most counties no longer fulfill that requirement by operating their own hospital. In the early 1960s, there were 66 county hospitals in California's 58 counties; today there are 20 county hospitals in only 15 counties. Sonoma County had been unable to provide much-needed capital to the hospital, and its reimbursement for Medicare, Medi-Cal and indigent care were so low relative to costs that the supervisors felt they would eventually have had to contract out their legal obligations to provide health services if they didn't affiliate with an organization that could operate the hospital.

Before Kaiser Permanente built a hospital in Santa Rosa, Kaiser sent its patients to Community Hospital. That in part kept Community Hospital in the black, even generating a surplus to fund charity care. Once Kaiser built its own Santa Rosa facility and stopped sending patients elsewhere, Community Hospital started to lose money every year. Other factors affecting the hospital's deteriorating financial condition were the general decline in hospital use and increasing competition from Memorial Hospital, its principal rival in Santa Rosa. Surplus funds were slowly being exhausted, and the supervisors had not put additional tax revenues into the hospital, which had been running without any operating subsidy from the county's general fund.

The county explored a variety of opportunities to keep the hospital going. For example, it had proposed a consortium with other nearby public hospitals and private health plans to create an employee insurance plan that would utilize Community Hospital. The plan eventually would have been offered as a commercial product to the general public. This proposal died when the largest labor union involved could not deliver its members as plan participants. The county also attempted to negotiate a contract with a local HMO (Health Plan of the Redwoods), but ultimately the health plan was not interested. The supervisors then attempted to downsize the hospital and attract more patient revenue on their own, but they could not go far enough in either cutting costs or raising revenues to make it work. Several observers noted that prior to these attempts, the county never seemed to have a long-term plan for the hospital—everything the supervisors did was reactive. When the hospital was in the black, the county left it alone. When it was in the red, the county would make cuts without regard to the future. Some community and physician respondents thought the supervisors simply did not want to run a hospital anymore. Another group thought it important to allow the facility to escape the grip of the political process. But for all the opposition that developed to letting the hospital go private, there was never any support for allocating tax revenue to keep it a county hospital.

Sutter Health's Motivation

As one respondent observed, Sutter had a reputation for competence in operating hospitals it took over; in contrast, running a medical facility is not a core competency of a city or county government. According to this respondent, "local government does a lot of things well, but running a hospital is not one of them." Sutter had a relationship with a physician group in the area, but no local hospital; the lease of Community Hospital was a way to get into the local inpatient market. Most observers feel that Sutter will eventually build a new inpatient facility (because of the hospital's seismic safety problem), or possibly negotiate to buy Kaiser's

hospital in Santa Rosa. If Sutter decides to build a new hospital, according to the lease agreement, Sutter will own it.

Change in Governance Structure

In 1993, the supervisors turned the day-to-day operations of Community Hospital over to a five-member board of physicians and lay people from the community. Trustees made recommendations to the supervisors, who, in turn, made the ultimate decisions regarding the hospital. The trustees also dealt with day-to-day matters that did not have to go through the supervisors. In 1995, the trustees recommended to the supervisors that the county lease the facility to a private enterprise. The trustees unanimously recommended Sutter over Columbia, but the decision was ultimately made by the supervisors.

The state attorney general was not legally required to be involved in the decision to lease Community Hospital to Sutter. Some county requirements, such as notice, were invoked because the affiliation affected county employees. A lawsuit filed by the largest union at the hospital, Service Employees International Union (SEIU), to prevent the supervisors from leasing the hospital to a private concern, failed.

Sutter created a new private, non-profit corporation to run the hospital, with a community board that carries out the terms of the lease (Sutter maintains certain reserve powers). Community board members are appointed by Sutter, after being recommended locally. Sutter retained four of the five former county hospital trustees (one did not express an interest in continuing) and added three Sutter representatives: Sutter's general counsel, a division president, and the hospital's CEO (who had been installed by Sutter). The county and Sutter agreed that the majority of the hospital's board be local residents (Sutter had done this with other public hospitals it operates). As a result, six of nine community board members are from the community. The chairman of Community Hospital's board of trustees chairs the new Sutter Medical Center board. The physician members are the emergency department director, the hospital's chief of staff, and a former member of the residency program. The old board had less strategic responsibility before Sutter leased the facility; it was described by one observer as having been internally focused, reactive, and heavily influenced by county politics. The new board functions as a more strategic governing body. The board meets monthly, and board committees meet more frequently. Board meetings are now closed, as opposed to the public meeting of the old board (union representatives opposed to the lease of the hospital to Sutter tried to attend the first meeting of the new board and were turned away). Trustees meet with the county supervisors once or twice a month, but it is mostly about public relations issues. Trustees submit an annual report to the supervisors and pay lease fees to the county.

In addition to the lease there is a health care services contract that delineates the responsibilities for on-going operations. The negotiations of both the lease and the health care services contract were described as complicated. The county knew it wanted to get out of the business of running a hospital, but still felt obligated to ensure that certain responsibilities would be met. Some of the tension was over how intrusive the county could be about day-to-day operations. Sutter wanted a fairly free-hand to operate the facility as it saw fit. That is why Sutter created a new non-profit entity over which the county has no jurisdiction. It was

Sutter's goal to be able to run the hospital without dealing with county politics. To address issues of efficiency and productivity after the facility had been losing money for some time, Sutter felt it had to be able to cut costs and did not want those decisions to be caught up in county politics. When the supervisors had tried in the past to make tough operating decisions, they were embroiled in politics; the media would pick up the most controversial issues, and it was very difficult to take action. As it was, there were many public hearings about the conversion, and groups expressed strong opposition to leasing the hospital to Sutter or anyone else.

Effect on Hospital Operations

Capital Investment

Under Sutter's governance, the hospital had its first capital budget in years. In the lease, Sutter agreed to invest $4 million in capital during the first two years. They used $1.5 million to purchase medical equipment in several areas (including new ultrasound equipment, new ICU beds, a new coronary care monitoring system, etc.), replace the roof, improve the electrical system, upgrade the fire alarm system and power plant, and install a new computer system. The hospital's new computer system is now tied into Sutter's system-wide network. Lots of retraining was involved; for example, every employee had to learn how to use the computer network.

Administrative Systems

Sutter claims it can usually realize significant efficiencies without large lay-offs because, over the long run, economies of scale make a bigger difference than changing staffing levels. For example, according to Sutter, using their system-wide purchasing or materials management system and consolidating "back-office" functions, such as billing, into Sutter's larger operation usually result in significant savings. Under Community Hospital's old system, the hospital had purchasing responsibilities but could not cut checks. The hospital had to copy its entire accounts payable system and send it to the county so the county could make payments. The county had myriad purchasing restrictions (for example, they could not import items from outside the U.S.). Also, they had what one person characterized as "environmentally correct" restrictions, like a ban on purchasing disposable diapers. Now, purchasing is done entirely at the hospital, through Sutter or its affiliation with the Voluntary Hospitals of America (VHA). Lab services and telephone system savings from using Sutter centralized systems were also cited.

Salary and Benefits

Retirement benefits for hospital employees were reduced because the county's were more generous than Sutter's. Sutter did add one benefit: a compensation incentive system based on performance. Otherwise, wages were not changed. Sutter has increased some full-time staffing in order to save money by doing less overtime staffing.

Clinical Programs

A new women's and children's health program and an off-campus senior citizens' program are examples of Sutter's attempt to expand services and attract more patients. Some of Sutter's capital improvements were intended to make the facility more attractive and change its image to attract patients who would not have considered going to the old county hospital. Also, Sutter has spent money to develop a level II trauma center (recruiting a new surgeon and other staff, in order to qualify for the designation). These are things most observers said the county never would have done on its own.

Although the hospital is still incurring losses, it hopes to realize several more efficiencies and new sources of revenue in the future. Sutter is opening a new 16-bed sub-acute unit that will run without RNs (it will use licensed vocational nurses [LVNs] and nurses aides). This is for patients who need low-tech chronic care and more personal attention rather than sophisticated intervention. Access to more capital makes the development of new services like these possible, and also makes possible things like recruitment of a new orthopedic surgeon who specializes in pelvic surgery, and a new neurosurgeon.

Third-Party Payers

The hospital's payer mix has changed. Community Hospital had lost its Blue Cross contract but got it back under Sutter. The proportion of insured patients is up slightly, due in part to having trauma surgeons on site 24 hours per day who also bring their elective patients to the hospital. The hospital has more managed care contracts now, since the Sutter system is a big player in managed care and can forge relationships for its hospitals with many plans, even some that would not work with the old Community Hospital. (Members of the hospital's medical staff mentioned that even with more managed care patients, Sutter has placed no clinical practice restrictions on the physicians, even for expensive procedures such as hip replacements.)

Total patient volume was relatively unchanged until the first six months of 1998, when it was up 15 percent. The proportion of Medi-Cal (California's Medicaid program) patients is down slightly (approximately two percent). The hospital's commercial insurers are mostly local managed care plans, but workers compensation is also a significant payer. Overall, however, Medicare and Medi-Cal pay for most of the patients. The hospital is still the provider of choice for charity care in Sonoma County, but funding for charity care patients is up because of use of on-site financial counselors. "We struggle a little more with the no-pay patient—we still provide services for this population, but we look for more ways to solve the problem less expensively."

Indigent care is funded by Sutter, and constitutes 5-6% of revenues. There were written commitments between the county and Sutter regarding the continued provision of certain services at the same site—and some restrictions on where Sutter could build if they replace the facility. Concerns focused on the continued provision of women's and children's services (including abortion—one of the other two hospitals in town, Memorial, is a Catholic hospital and does not perform them), AIDS care, charity care, and Medi-Cal services; these are all stipulated in the agreements between the county and Sutter. Other issues include the

provision of services to county government (such as, police physicals, pre-employment physicals, treatment for the jail population, etc.) that involve inter-county transfers of funds. The county still owns the psychiatric unit: Sutter manages it, but the employees are still county employees. This is a separate agreement, in case the county might want to get out of the inpatient psychiatric business.

Fiscal Prognosis

Average daily census has only recently (first half of 1998) improved, but the hospital's operating margin still reflects a loss (although only 1.7%) for the same reasons as before the affiliation with Sutter (competition with Memorial Hospital across town, and the loss of Kaiser's patients). The hospital could do better financially in 1999 if any of the following occur: prenatal business improves (although the hospital already gets the majority of the county's births); Sutter is awarded the county's level II trauma center contract; or Kaiser gets out of the hospital business in Santa Rosa (as it is thinking of doing). One community observer asked "Is the hospital still in its 'honeymoon' phase with the Sutter system? How long will Sutter's corporate headquarters tolerate losses?" This observer felt that the new hospital board's hardest decisions are yet to come.

Sutter has not cut back services. The same levels of services are provided, but there are points of contention between opponents of leasing the hospital (such as SEIU) and Sutter about *how* they are provided (staffing levels, etc.). There have been anonymous complaints about services, but the supervisors still feel satisfied with what Sutter is doing. In areas such as women's services and indigent care, most observers feel services have not changed; they credit the provisions in the affiliation agreement to maintain a certain level of services in focus areas such as these.

The hospital competes with Memorial Hospital (and to some extent with Kaiser) for patients now more than ever. Although Memorial is acknowledged to have an edge in coronary care, Sutter feels it is its equal in most other services. But the community's image of the facility, because it was the county hospital, is that obtaining health care services at Sutter Medical Center was risky because of traditional perceptions that the quality of care at the former county hospital was not equal to that at a private institution. The hospital is trying now to change that perception and compete for insured patients.

While service cutbacks are not the issue, the challenge for Sutter is to expand or maintain the services that it feels the hospital must have to compete with Memorial Hospital for paying patients, rather than cutting back on services. For example, the local emergency medical services director decided that Sonoma County needs a level II trauma center. Both Sutter and Memorial hospitals will respond to the RFP. They have been engaged in a battle over trauma care for the past two years; as the hospital of last resort, Sutter has been the *de facto* trauma center for some time, but never mustered the resources under the county's management to develop a level II program. This is a very important initiative for Sutter because it will determine where helicopters and ambulances deliver trauma patients in Sonoma County.

Sutter has the only state-licensed neonatal intensive care unit (NICU) in the county. Kaiser, Memorial, and Sutter each deliver approximately 1,500 babies per year (Community Hospital

used to deliver about 2,000 per year). Sutter gets most of the high-risk babies, in part because of the mothers' payer mix. But Memorial wants a NICU also, while Sutter wants to continue to be the only facility in town.

Workforce Issues

Only two of approximately 790 county employees at the hospital chose not to come over to Sutter under the lease. Sutter has said it wanted to change the work culture within the hospital in an attempt to increase attendance and improve performance. Enforcement of these higher expectations has resulted in hundreds of employee grievances, most of which the hospital's administrator says are dismissed as unsubstantial or without merit after investigation. Staffing levels and bed ratios in the Santa Rosa facility were higher than the industry's or Sutter's system-wide average, so Sutter chose to re-engineer positions and further reduce staffing through early retirement, attrition, and some direct lay-offs. As an example of re-engineering positions, the admissions, financial counseling, and ward clerks, formerly distinct positions each with their own job descriptions, all became one job classification.

Redesign of patient care jobs in medical/surgical units resulted in some reductions in staff size. Also, there has been a shift from RNs to LVNs. Some nursing staff did not get new positions, but had the option of re-training; some chose not to stay. There has been a net loss of nursing positions. Hospital physicians we spoke with were not critical of staffing changes; they saw them as necessary, and said getting out of the county civil service system allowed more management flexibility.

Some lay-offs did take place in the context of re-defining jobs. Nursing, for example, was affected. There are no longer separate obstetrical and pediatric nurses for labor, recovery, and the nursery; there is now consolidated mother and baby care. As a result, some nurses have left, some RNs have moved to other Sutter facilities, and some have taken re-designed jobs that can be filled by either an LVN or RN (but at a lower salary). Also, the medical records staffing complement is down from 28 people to 14, mostly through attrition. Hospital-wide reductions in staff total 75 FTEs, or about 10%. Sutter says this is necessary because civil service typically is not a cost-effective nor a customer-service culture. Sutter felt it had to change that to compete, by both cutting its staff and organizing services to be more customer-oriented. There were only a few straight lay-offs (reductions in staff not involving job re-design or attrition).

Graduate Medical Education

The hospital has a family practice residency program affiliated with the University of California at San Francisco with 39 residents; this number will be reduced to 36 with the incoming first-year residents in July 1998. The chief of staff says the reduction makes sense given the volume of patients, which is not adequate to train 13 new people each year. The residency budget had been growing, but under Sutter it has been cut by 10 percent. As of July 1998, the program will begin accepting 10 rather than 13 new residents per year. The head of the program said that the residency program probably would have been eliminated in a cost-cutting move if the county had continued to run the hospital.

Organized Labor

Almost everybody at Sutter Medical Center is unionized—even the residents. SEIU represents the most employees by far. Opposition to the affiliation came mostly from SEIU, but some also came from the union representing the hospital's residents. SEIU filed a lawsuit in 1995 to prevent the county from leasing the hospital to anyone. They lost when the court held that the decision to affiliate was a discretionary act of the board of supervisors. The union then sponsored a ballot initiative (Proposition E) to prevent the county from leasing the hospital to a private entity; it was defeated by approximately 70 percent to 30 percent. The initiative to oppose the affiliation appeared on the ballot in November 1996, several months after the county had leased the hospital to Sutter. If it had passed, it could have reversed the agreement. We were told that the board of supervisors was upset at the level of public uproar about the affiliation (much of it supported by SEIU), and maneuvered, along with Sutter, to keep the anti-affiliation measure off the ballot until after Sutter had already signed the lease agreement with the county.

According to union sources, Sutter agreed to recognize SEIU because the union forced the ballot initiative, and because the other suitor for the hospital, Columbia/HCA, had said it would recognize SEIU if selected. Sutter disagrees with this explanation, saying that it was legally obligated to recognize the union since it represented over 50% of the existing employees at the time Sutter contracted with the County. Others in county government claimed that SEIU extracted a promise from the supervisors before the affiliation that SEIU would be designated to represent the relevant hospital employees. Either way, county supervisors believed that SEIU would be satisfied with this outcome and were angered that the union continues an active campaign in opposition to the affiliation to this day.

Sutter negotiated an interim contract with the union: a two-year contract with no increase in wages the first year and a two percent increase the second. Between the time of the lease (March 1996) and the ballot initiative (November 1996), both SEIU and Sutter waged major public relations campaigns over the ballot initiative. The union's stated position was in opposition to the affiliation because the old Community Hospital was the largest charity care provider in the area, and they assumed Sutter would cut back on charity care. Their continued opposition to Sutter is based on their view that the changes in staffing that Sutter has instituted hurt the quality of care or access to care provided at the hospital. In particular, they feel that reductions in the number of staff, even if achieved through attrition, will jeopardize the quality of care (for example, if fewer nurses caring for the same number of patients are overworked and tired). Moreover, they are concerned about "down-jobbing" in which employees with less skill or training are substituted for those with more skill or training (for example, substituting LVNs or nurses aides for RNs). According to other sources, however, the real issue for SEIU, often articulated in private, is a Northern California-wide fight with the Sutter parent corporation, which union leaders claim is the most difficult hospital employer with which they deal. Sutter says the point of contention is that SEIU wants a master contract with all Sutter facilities, and Sutter insists on negotiating at the individual facility level. SEIU, on the other hand, says that is a bogus issue and the real issue is that Sutter sub-contracts work out, and this costs its members jobs (for example, currently at the Santa Rosa facility photocopying is done at the county print shop by SEIU members, but Sutter retains the right to contract out in the future).

Shortly after the unsuccessful referendum, there were job re-classifications in the admissions department, and people were asked to re-apply for their jobs. Sutter did redesign jobs in admissions and some of the clinical units. There was a small number of lay-offs. There were issues over defining nursing jobs so that they could be filled by LVNs as well as RNs, but the jobs paid the lower LVN wage.

SEIU was probably more effective dealing with the county supervisors than with Sutter. SEIU's opposition is usually expressed in terms of saving Community Hospital from a large company that will change the character of the county's hospital. There have been continuing confrontations over staffing issues, especially in the face of the changes Sutter has instituted in job classifications and definitions and staffing levels. But according to a member of the county government, there was no logic to the staffing at the hospital before the affiliation—it was like a "gravy train." This person felt Sutter offered a good early retirement program to the employees, and there were minimal lay-offs.

Effect on the Local Community

Ability to Compete

One of Sutter's goals is to increase the hospital's potential to serve patients other than Medi-Cal and charity patients. To accomplish this, Sutter is attempting to bolster the facility's image among paying patients. Sutter's strategy is to make the former Community Hospital into a facility that can compete with Memorial Hospital (their biggest competitor and the number one hospital in the local market, run by the Sisters of St. Joseph of Orange), which has a newer facility, more paying patients, and a better image in the community. Obviously, the capital improvements Sutter has made are a part of this. Also, the hospital now has access to all of Sutter's contracts with payers. Because of Sutter, Memorial Hospital and the physician groups in town no longer consider the hospital to be "neutral territory," as they did when it was the county facility. It is now considered a competitor, and might not get some of the patients it used to from referring physicians around town.

Safety Net Issues

Some community observers feel that the hospital does not participate as much as it used to in community-wide discussions about the indigent population. They feel the hospital is not "out in front" anymore as an advocate for the poor, although this is not reflected in any cutback in services. The hospital's service to the poor, they say, is more a contractual obligation now than a matter of public service, as it was when the old Community Hospital was more pro-active on the issue. This is also reflected in some observers' perceptions (but with few concrete examples) of less frequent integration of the hospital's services with community safety net services. "They are responsive to the community, but not an active partner

All of the community safety net providers with whom we spoke said access to care at the hospital is still good. The hospital's family practice clinic is still the county's largest low-income clinic. But there is a lingering fear among a few people with whom we spoke that there

is still some risk of a changing mission at the hospital, and interested parties in the community will continue to monitor the situation. One observer said that once the supervisors put down on paper that the public mission of Community Hospital would be preserved, the county felt its responsibilities were safe and leaped at the chance to have a private system take over the hospital. Critics contend that they did not have the political will to save Community as a public hospital.

One current hospital board member characterized the old Community Hospital mission statement as "long-winded." He said the new one was more focused, but essentially covers the same ground. Even though Sutter has committed to carry on the hospital's charity care responsibilities, the issue of "open access to health care for all" (which appeared in Community Hospital's mission statement) is not in the new Sutter mission statement. As a formal monitoring mechanism, quarterly reports regarding compliance with the commitments in the health services agreement are submitted to the county administrator's office, which serves as the business arm for the supervisors.

One community access issue that arose involves AIDS/HIV care. The hospital is considered the number one AIDS/HIV referral center in Sonoma County and an excellent source of care. But according to one community health care provider, a clinic in the area that is affiliated with both the county health department and the hospital had been told that its physicians could not join the hospital's PPO, because the patients they treat are too high risk. Sutter's explanation was that the physicians could join on a fee-for-service basis, but were not approached about a capitation contract. Stories like this will continue to generate conflicts.

Even though Medi-Cal prenatal services for undocumented women are being terminated by law in California, Sutter has planned to continue these services. The hospital usually takes about 140 high-risk (based on their clinical history) women per year from among the undocumented population. They have committed to take as many as there might be now—and some estimates are that it could be four times that many per year. Overall, as the hospital of choice for indigent care, Sutter is said to still provide the best outreach efforts (for example, translator services) in the community.

We heard only one significant anecdote regarding the hospital's relationship with local community health centers (CHCs). This involved a program with one of the CHCs wherein Community Hospital had performed, for a discounted fee, lab work and certain other minor services for sliding-fee scale patients who qualify for a state-funded reimbursement program. Once Sutter leased the hospital, the fees were no longer discounted, but this might have been because the hospital's new chief financial officer was not aware of the program. The CHC and Sutter are discussing the matter, and the person who brought this example up thinks Sutter will probably reinstate the discount.

Many people are carefully watching to see whether changes at Sutter will result in less access to care for Medi-Cal and charity patients, but so far physicians at community health centers and others involved with safety net providers in the community who would be aware of such changes have not detected any. It is still an issue in the community, however, and the hospital will remain under scrutiny for some time.

Conclusion

The consensus in the community is that while the hospital is "no longer the same" as when it was the county facility (for example, less an advocate for the poor, more efficiently run, different programs, and upgraded facilities), it is still fulfilling its role as the provider of last resort. The new management and continuing market pressures have produced changes in staffing and operations, and their effect on what was formerly public employment has been an issue. The family practice residency program is being scaled back, but access to the hospital's family practice clinic, an important source of care for low-income patients, has not been affected. Now that it is a privately-managed facility, the hospital is an active competitor in the three-hospital market in Santa Rosa, and will sink or swim based on its ability to attract paying patients as well as the uninsured. There will be continued scrutiny of new management's commitment to the uninsured, in part encouraged by the ongoing campaign being waged by organized labor against Sutter Health throughout Northern California.

Oakwood Healthcare System — Dearborn, Michigan

A merger of a network of five public hospitals into a private, non-profit hospital system.

Introduction

The Oakwood Healthcare System in the Detroit, Michigan area currently includes five hospitals, 16 primary care centers, and a number of facilities providing physical therapy services, specialty care services, and services for older adults. This system includes two institutions that are the focus of this public hospital conversion case study: Oakwood Hospital, a non-profit community hospital facility, and the organization that was known before the merger as the People's Community Hospital Authority (PCHA). PCHA was created in the late 1940s by Michigan law as the authority to operate five public hospitals that served more than 20 communities in Wayne and Washtenaw counties in Southeast Michigan. The five hospitals operated 1,200 beds in total; they ranged in size from 148 to 270 beds. Operations were financed in part by a property tax levy in the participating communities, and they were governed by a 47-member board that included two representatives from each community. Some observers noted that the board tended to be highly politicized, because people from the communities frequently used the board as a forum for furthering their political agendas.

Motivations for Conversion

Motivation for PCHA

In the early 1980s, the PCHA hospitals were quite profitable. However, as the competitive environment began to change in the hospital industry in general and in their service area in particular, hospital officials came to realize that they might have trouble surviving in the long run. They were at a particular disadvantage because they were required to conform to all Michigan laws regarding public institutions—for example, prohibitions on joints ventures, requirements that contracts be awarded only after competitive bidding, and open meeting and full disclosure requirements. The open meeting and disclosure provisions were particularly troublesome because they allowed their competitors, as well as media representatives, to hear all of the business deliberations and have access to all future plans. Gaining access to adequate capital for modernization was also a problem for these public institutions, which needed many capital improvements.

A study undertaken by the PCHA board concluded that the hospitals could not continue to labor under these restrictions and still compete effectively. The board decided to petition the state legislature to pass a statute that would allow conversion of the PCHA hospitals from public to private status by transferring all the assets to a new non-profit corporation. The

transfer would involve no financial consideration, but would include the requirement that the new entity assume the labor contracts and debt of the predecessor institutions and continue to fulfill the mission of the PCHA institutions, which was defined as having the newly organized facilities continue to be used for community health purposes. A reversionary clause stipulated that the assets would go back to PCHA if the new institution failed to fulfill this mission.

The board's lobbying efforts were successful in getting enabling legislation, and in January 1989 all of the assets of PCHA were transferred to United Care, a new 501(c)(3) organization with the same board members as the PCHA board. Functionally, there were no changes; the hospitals continued to operate as before. It became apparent almost immediately, however, that this modest change was insufficient to maintain profitability, and the hospitals began to explore opportunities for merger with other institutions. In late 1989, less than a year after the conversion, United Care leased three of the hospitals to Oakwood Hospital, in effect, turning over operation of the hospitals to Oakwood. However, the two hospitals that United Care kept continued to lose money, and it became clear that a merger was the best way to get the United Care hospitals, which were now losing at least $30 million a year, back on sound financial footing. Oakwood and United discussed the possibility of selling two of the hospitals rather than including them in the merger, but United wanted to keep Beyer Hospital as part of the merged system, so only one hospital was sold to an outside party. The merger idea was appealing to United Care not only because it promised to solve a financial crisis, but also because Oakwood's good reputation was seen as enhancing the reputation of the former public hospitals, which were generally perceived as not offering as high quality care as some other institutions in the area.

Motivation for Oakwood

The merger was attractive to Oakwood because Oakwood leaders saw it as an opportunity to strengthen their market position. They gained market share (doubling admissions), access to additional physicians and their patients, broader geographic coverage, and control of bed licenses and $100 million in assets. (Although these acquisitions and the lower debt ratio may have improved Oakwood's borrowing power in the long run, initially the institution's credit rating went down.) The United Care hospitals were either in the same county as Oakwood or in a contiguous county; so this was a natural expansion of Oakwood's service area. The United Care hospitals provided primary and secondary care, whereas Oakwood also included an emphasis on tertiary care. Oakwood was also convinced that economies could be introduced at the newly acquired hospitals which would make them profitable parts of the new, expanded system.

Process of Conversion

The conversion process was not as contentious as might be expected. Several of the community leaders that had a strong involvement with the PCHA hospitals took great pains to educate all of the 20 or so communities that were part of the hospital authority, and ultimately all agreed to the proposed change. However, the discussions between Oakwood and PCHA about potentially closing Beyer—an event that did not happen—created distrust, which

ultimately led to the filing of a lawsuit by the City of Ypsilanti (to be explained in more detail later).

Because it was clear that the hospitals were in financial distress and thus likely to lose large sums of money without some significant change, labor opposition was muted because labor leaders recognized there was no viable alternative. Some of the hospital leaders had explored the possibility of sale to Columbia/HCA, and this prospect seemed less appealing to labor representatives than the merger with Oakwood. Labor's acquiescence was also probably related to the fact that the president of one of the major labor unions, which represented the largest number of PCHA and Oakwood employees, was on the board of PCHA (and remained on the board of the newly merged organization). Labor, therefore, was well informed about PCHA's financial difficulties and the limited alternatives for relief. When the merger took place, wage rates and benefits at the public hospitals were somewhat better than at Oakwood, and staffing ratios were higher. The labor agreements (union contracts) followed the workers to the merged institutions, but over time the wages and benefits were equalized. Most staff reductions did not come at the point of transition but were achieved later through attrition.

The medical staffs of the PCHA institutions were more resistant to the change than the unions, according to some reports. Others said the medical staff were not much involved in the planning process, and many were indifferent to the change, believing that staff operations at the merged institutions would stay essentially the same.

Structure of Conversion

Initially, the new organizational structure formed by the merger consisted of two levels of entities. At the top was the Oakwood parent organization known as Oakwood Health Services Corporation. Oakwood Health Service's subsidiaries included Oakwood Hospital and Oakwood United, which had been United Care. Oakwood Hospital and Oakwood United had separate boards, although there was some overlap in board membership, as well as separate corporate structures. This was done for political and legal reasons. Politically, PCHA did not want it to appear that the PCHA hospitals had simply been absorbed by Oakwood Hospital. Legally, there was some concern that if United Care were absorbed into Oakwood, someone might invoke the reversion clause in the document which had permitted the PCHA hospitals to convert to non-profit status as United Care. The primary condition in that clause was that if United Care sold all or substantially all the assets, the sale had to be at fair market value and the facilities had to continue to be used for community health purposes. If sale was not at fair market value, the reversion clause stipulated that the 23 communities had the right to approve the sale by a vote of the community members. (This clause does not prohibit closure of a hospital, however.) Making United Care (which did business under the name Oakwood United) a subsidiary under Oakwood Health Services, rather than merging with Oakwood Hospital, avoided the question of sale. It was also agreed that for three or four years the board of the new entity had to have the same membership as that of the old entity, which consisted of nine members from Oakwood and nine from the communities in the former PCHA. Even so, extensive efforts were made to integrate the *actual operation* of the old PCHA hospitals with Oakwood.

A 1995 study examined all aspects of the Oakwood system, and the recommendation was that all three corporations in the Oakwood Health Services system be collapsed into one. But only two formally merged: Oakwood Hospital and the parent corporation. This entity is now called Oakwood Healthcare System (or Oakwood Hospital Corporation) and operates the health care delivery systems for the larger parent corporation, Oakwood Healthcare, Inc. Oakwood United remained in name only (because of the reversion clause concern), but the hospitals were leased to Oakwood Healthcare System for 99 years, and all workers were transferred to the new entity. The old entity has no staff, and there is no separate governing board for Oakwood United. This preservation on paper of Oakwood United was probably not necessary, but was a legal safeguard. For all practical purposes, the hospitals are fully merged.

Effect on Hospital Operations

Governance, Administration, and Staffing

Much progress has been made toward integrating the institutions that were separate before the conversion. Systems, governance, and management are well integrated. Consideration is now being given to consolidation of dietary and housekeeping functions. Since the conversion, all of the administrators at the former PCHA hospitals have been replaced and the authority of their replacements has been reduced. The new administrators, who now have the position of vice presidents, are more like site administrators than CEOs. (One observer noted that this merger experience teaches the lesson that in merging the cultures of public and private institutions, the administrators of public hospitals will typically not survive.)

Total staffing has been reduced by several hundred. This was accomplished through a combination of minor layoffs and attrition. This downsizing was one consequence of management's efforts to eliminate a large number of "public hospital inefficiencies." As a private institution, the new organization did not face the same difficulties with the politics of reducing the labor force. In addition to labor inefficiencies, the new management has taken steps to improve the efficiency of financing and purchasing, which has been helped by the increased purchasing volume. According to some sources, the former managers of the public hospitals had not given priority to ensuring profitability and had tended to "let sleeping dogs lie," so there was room for improvement.

Clinical and Physician Staff Integration

The progress toward clinical integration has been slower. In fact, there has been little clinical integration, although discussions have continued to determine which services should be centralized and which left decentralized. The objective, as one participant noted, is to create "systemness," but this has not been easy to achieve. The different cultures of the former PCHA hospitals and Oakwood have been a barrier to integration.

The cultural differences are, in part, a reflection of differences in the medical staffs. Many of the physicians at the former PCHA hospitals are foreign-trained, and the perception has been—though it is changing—that the quality of staff did not match that at Oakwood, which is seen as the "elitist" hospital. Physicians at Oakwood are more entrepreneurial and organized

in a more structured, hierarchical way than at the other hospitals, where physician relationships are characterized by more collegiality and less structure. The former PCHA hospital staffs tend to view themselves as the underdogs and as separate from the Oakwood physicians. They are inclined to see Oakwood as a competitor, taking patients away from "their" hospitals, and they seem less attuned to the reality of the new market dynamics in which hospital systems compete and in which the Oakwood system faces a threat from other hospital systems seeking to encroach on their market. The physician staffs do not trust each other, and they do not trust the administration. At least some of the physicians think they are not respected.

The nature of physician practice in this metropolitan area is different from that of many others. Most physicians are still in solo or two-person practices, and managed care has been slow to make inroads in the area. Even so, physicians have what one observer called a "scarcity mentality" and are fearful about their future and distrustful of change.

These fears do not come, however, from actions by Oakwood to "take over" various specialized services. In fact, some of the services formerly at Oakwood have been moved to the former PCHA hospitals, where there was underused capacity. The medical director has persuaded some of the younger surgeons at Oakwood, who are lower down in the hierarchy, to move their practices to the other hospitals, where they face less competition for operating room time. It has not always been an easy sell, but the physicians who have made the change have generally been pleased with the results.

The combination of these factors has made integration of medical staffs—and, presumably, clinical integration as well—an uphill battle and clearly more difficult than expected. In fact, the system no longer uses the term "integration" and instead talks of moving toward "physician partnerships" across the system. Attempts are being made to develop common clinical pathways and common credentialing, although physicians at one hospital do not automatically have privileges at other hospitals.

One observer, in confirming the difficulties of the integration process, noted that physicians have to be shown the value of the conversion. They need to be persuaded of the "business case" for change; to be convinced that the steps being taken are necessary to survive and prosper. And they have to see that the changes represent a "win-win" situation.

Effect on the Local Community

Preservation of the Public Mission and Maintenance of Services

The new institution has attempted to carry on the public nature of the mission of the former PCHA hospitals, continuing to serve the same patient base. According to hospital authorities, there has been no significant change in payer mix or in the level of uncompensated care and no closure of emergency departments, primary care programs, or behavioral health programs. Even though the formal merger agreement does not contain any provision to maintain a specific level of indigent care, the mission of the new institution is said to be very consistent with that of the PCHA hospitals and is reflected in the formal mission statement of the new

institution. According to one person prominently involved in both the old and new institutions, this is not a coincidence: the people who worked to find a way out of the PCHA hospitals' financial difficulties looked for a partner with a compatible mission; one whose behavior showed that it would keep commitments.

The former PCHA hospitals have not lost services; on the contrary, some services have been added at these hospitals, including neonatology, an MRI mobile unit, and a cardiac catheterization laboratory. The hospitals have also benefited from some expansions and modernization. Rehabilitation beds have been added to one hospital and an obstetrics floor to another, and several psychiatric units have been upgraded.

The medical education programs of the hospital system have not been much affected by the merger. About 95 percent of the residency positions are at Oakwood Hospital. Approximately 120 residents participate in the nine or so different programs. But only an obstetrics program and podiatry program are at sites other than Oakwood Hospital. Administrators are exploring the possibility of adding other rotations at the former PCHA hospitals to accommodate, in addition to the residency rotations, the 500 undergraduate medical students who do inpatient rotations each year.

A Source of Dissension

The prevailing view seems to be that the conversion of the public hospitals has not diminished the level of services for the PCHA communities, which are generally less affluent than Dearborn, where Oakwood Hospital is located. But one community has been skeptical of the hospital system's commitment to serve their population. Beyer Hospital is located in Ypsilanti, a community that has been what one observer labeled as "fiercely protective" of its hospital. Ypsilanti activists seem to believe that the long-run intention of the Oakwood system is to close Beyer, a fear that probably reflects the initial recommendation of Oakwood Hospital to have Beyer sold before the merger. Oakwood leaders say the fear is unwarranted. They agree that the hospital provides needed services to a lower-income population in the area and should remain open, a point confirmed by a 1997 study that Oakwood sponsored to determine what services the Ypsilanti community needed. The system also has exhibited its financial commitment to Beyer by building a medical office building attached to the hospital and a catheterization lab. But hospital system leaders acknowledge that they would like to see some changes at the facility, which has an average census of only between 30 and 40. Administrators would like to make it a short-stay, acute and primary care facility of 50 beds with a range of "boutique" services. This would involve closing the obstetrics service, the critical care unit, and about 100 beds. Administrators believe that such changes are necessary to make the hospital viable in a service area that includes two large, high-reputation hospitals, St. Joseph Mercy and the University of Michigan Medical Center.

The fear of such changes is apparently what has led the City of Ypsilanti, with the support of its mayor, who is a physician, to sue the Oakwood system with the intent of having Beyer Hospital returned to PCHA. The city argues that the 1991 merger constituted a sale, but not at fair market value, and thus asks that the sale be undone.

The Mayor of Ypsilanti initiated the action that led to the suit after rumors circulated in the summer of 1996 that Oakwood planned to close Beyer Hospital. The mayor was concerned because the hospital employs 400 people, is in the heart of the community, is clearly part of the community's identity, and commands great loyalty from community residents, many of whom were born in the hospital and have a strong emotional attachment to it. On the other hand, the mayor said she considered the possibility that such small hospitals may no longer be viable in the new competitive climate, especially because Ypsilanti is easily served by St. Joseph Hospital, which has a real commitment to the area and is no more than 10 minutes away, and somewhat less readily served by the University of Michigan Medical Center, which is 20 to 30 minutes away. (Community residents, however, tend to fear getting treatment at the university hospital, perceiving it as the institution where people are studied.) To test her hypothesis, the mayor queried physicians who practice at both Beyer and St. Joseph. They reported that for more routine kinds of care, Ypsilanti residents are better served at Beyer. They may get lost in the magnitude and complexity of St. Joseph, whereas at Beyer the staff often know the patients personally and provide a kind of personal hands-on nursing care and emotional support that improves patients' prospects of recovery. Moreover, the costs of treatment are generally less at Beyer than at St. Joseph.

The mayor felt action was necessary to preserve the hospital because of her observation that Oakwood was undermining the future of Beyer—by not doing necessary maintenance, by not replacing staff that left, and by overworking the staff that remain. She also says that administrators at Oakwood asked the former CEO of Beyer to persuade the community that Beyer should be closed, which she refused to do. As further evidence of Oakwood's real intent, the mayor points to the fact that Oakwood chose not to have Beyer participate in a contract with an HMO that is planning to be a Medicaid managed care contractor with the state. She notes, also, that the previously mentioned Oakwood study about the future of Beyer Hospital was not begun until after the city filed its suit, and that initially, no community representatives were included in the study group. The mayor suspects that the original intent was that the study group would find that the hospital was unnecessary, and this would be used as justification for closure.

To test the viability of taking Beyer Hospital back into the community's hands for operation, the city hired a hospital management firm that, after studying the situation, reported that they could take over the hospital and operate it profitably within a year. In the spring of 1997, the city decided to file the suit against Oakwood on behalf of PCHA, with the proposed remedy of bringing the hospital back under the control of the community. The suit alleges that there has been an illegal de facto sale of Beyer to Oakwood without a vote of the community. Oakwood had entered a motion to dismiss the suit, but the judge has asked the two sides to work out their differences if possible. In July 1998, however, this lawsuit was dismissed and the parties reached a settlement designed to ensure the continued operation of the Ypsilanti hospital, at least in the short-term. For example, Oakwood must ensure that the hospital continues to function as a "primary care-focused community hospital" and that medical services in the community be provided by a "network of community-based primary care physicians." In addition, the hospital is permitted to continue to seek relationships with other local providers to ensure geographic accessibility to community members. However, if Oakwood decides to close the hospital or diminish its investment in the hospital, it must provide notice to the community and give the community the option to buy the hospital.

Conclusion

Conversion of the PCHA hospitals to non-profit status occurred because the hospitals were losing money, and key leaders were convinced that the situation could not be turned around if the institutions had to continue to operate under the handicaps imposed by being public institutions. But the privatization of the PCHA hospitals represented a unique challenge since it required the approval of over 20 communities. Nevertheless, the process went rather smoothly because, through tireless efforts, people who had a reputation as supporters of the PCHA institutions and their mission were able to persuade both the communities and the labor unions associated with the hospitals that a merger with Oakwood Hospital was the only viable alternative if the institutions were to survive.

In this instance, the conversion went smoothly without much overt opposition. And it appears that the basic mission of the public institutions has been preserved under private ownership. Yet nearly seven years after the conversion took place, at least one of the affected communities is still fighting a battle to return one of the PCHA hospitals to public status. This shows just how contentious these changes can be even in the best of circumstances.

APPENDIX: Additional Profiles of Public Hospital Conversions

In researching numerous public hospital conversions and contacting hospital officials to recruit hospitals to participate in our study, it became clear that public-to-private hospital conversions (mostly to non-profit status) are occurring all over the country and that there are a variety of reorganization models. To illustrate this variety, we include in this report 10 one-page profiles that describe additional public hospital reorganizations around the country. We collected the information for these profiles from newspaper articles, annual financial reports and telephone interviews.

Denver Health Medical Center -- Denver, Colorado

Public Hospital:	*Denver General Hospital*
Governing Body:	*Denver's Department of Health and Hospitals*
New Governing Body:	*Denver Health and Hospital Authority*
New Name:	*Denver Health Medical Center*
Year:	*1997*
Transaction:	*Change in governance structure of a public hospital from a department of the city government to an independent public hospital authority.*

- The Denver Health and Hospital Authority (DHHA) was created by statute to operate Denver Health, an integrated system of hospitals, and medical and social services. DHHA took over operation of Denver Health from Denver's Department of Health and Hospitals on January 1, 1997, and the department was dissolved.
- Denver Health's components include the county public health department, school-based and neighborhood health clinics, all of the ambulatory care centers in Denver, a regional trauma center, a city employee health plan, and the former Denver General Hospital.
- Denver General Hospital was established in 1860 as the city's public hospital and was renamed Denver Health Medical Center (DHMC) when it came under DHHA's control. DHMC is governed by DHHA's board of directors, whose nine members are appointed by the mayor and confirmed by Denver's city councilors.
- DHMC is a 308-bed acute care hospital that provides a range of inpatient and behavioral health services to Denver County residents. DHMC has a large emergency residency training program and operates Denver's medical emergency system and paramedic services. It is also a teaching hospital of the University of Colorado's medical school.
- The governance structure of the public hospital was reorganized because:
    - the hospital was constrained by public governance in areas such as personnel, payroll and salary structures, purchasing, long-term planning, and partnering with private organizations;
    - the hospital faced substantial reductions in public subsidies from Denver taxpayers and public programs, such as Medicaid; and
    - as with the University of Colorado Hospital, which had previously switched to authority governance, the hospital wanted to become a "model that can help public safety net systems survive and thrive into the 21st century.
- DHMC provides roughly 30 percent of the charity care in Colorado. In addition, 65 percent of its revenues come from Medicaid.
- Over 1,000 of Denver Health's 2,500 employees transferred to the new personnel system created under DHHA, while others remained employees of Denver's civil service system. Denver Health learned from the University of Colorado Hospital's experience, and involved its employees in the transition in ways that made employee relations less contentious than they had been during the University Hospital transition.
- The city of Denver will renegotiate with DHHA each year over its subsidy for the provision of indigent care.

Desert Regional Medical Center -- Palm Springs, California

Public Hospital:	*Desert Hospital*
Private Partner:	*Tenet HealthSystem*
New Name:	*Desert Regional Medical Center*
Year:	*1997*
Transaction:	*Lease of a district hospital to a private, for-profit hospital system.*

- Desert Hospital had been operating as an acute care district hospital since 1951. A district hospital is a quasi-public hospital that is owned and operated by a hospital district, which is a taxing district created under California law.
- Prior to its affiliation with Tenet HealthSystem, Desert Hospital was owned by the Desert Hospital District Board and governed by the board of trustees of the Desert Hospital Corporation, an entity set up to operate the hospital.
- In 1997, operation of Desert Hospital—since renamed Desert Regional Medical Center (DRMC)—was transferred through a long-term lease to Tenet HealthSystem, the second largest for-profit hospital chain in the country. Tenet formed a subsidiary, Tenet HealthSystem Desert, Inc., to manage health care delivery at the hospital.
- Pursuant to the lease agreement, Tenet paid $15 million for the 30-year lease of the hospital and agreed to retire over $100 million of the hospital's long-term debts.
- DRMC is governed by a 13-member board of trustees that has maintained a community focus: seven board members are DRMC physicians, four are community leaders, and two were appointed by Desert Hospital's former board.
- DRMC has 388 staffed beds and roughly 1,200 employees. Its core services include a large wellness center, a senior health program, outpatient rehabilitation services, a comprehensive cancer center, women's and infant's health services, a heart center, and the only designated level II trauma center in Riverside County.
- The motivation for leasing DRMC to Tenet was to:
    - gain access to capital;
    - be better able to compete for managed care contracts;
    - obtain purchasing discounts; and
    - minimize losses resulting from the provision of uncompensated care.
- Tenet competed with both Columbia/HCA and Eisenhower Medical Center (Desert Hospital's local competitor) to partner with Desert Hospital.
- Prior to the affiliation with Tenet, Desert Hospital had done substantial cost-cutting. The hospital sold off a $36.5 million medical plaza (which was not fully occupied), which housed various clinical services and offices, and abandoned the operation of a health plan it had been operating for 10 years.

Detroit Receiving Hospital -- Detroit, Michigan

Public Hospital: *Detroit Receiving Hospital (formerly Detroit General Hospital)*
Private Partner*:* *Detroit Medical Center*
Year*:* *1981*
Transaction: *Sale of a city-owned hospital to a private, non-profit health and hospital system.*

- Detroit Receiving Hospital, a 310-bed trauma and emergency care facility, is the successor to the former Detroit General Hospital, which was Detroit's public hospital until 1981. As the city hospital, Detroit Receiving was the safety net hospital and provided mostly trauma and emergency care to the city's indigent population.
- In 1981, the city of Detroit decided to rebuild its public hospital on the Detroit Medical Center (DMC) campus—which included several independent privately-owned hospitals and Wayne State University School of Medicine. The former Detroit General Hospital facility was decrepit and, as a teaching hospital of the medical school—most of its attending physicians were faculty of the medical school—it made sense to rebuild on the DMC campus.
- When the city realized it could not fully subsidize the hospital's rebuilding and continued operations with public funds, city officials decided to transfer ownership of Detroit Receiving to DMC, a private, non-profit medical center. State legislation was passed authorizing the transfer of operations of the public hospital. The building facility, however, remains a public asset.
- Over time, DMC and officials at each of the independent hospitals on DMC's campus—which already shared maintenance, administrative and other services—decided to consolidate duplicative clinical services throughout the campus. Simultaneously, each of the hospitals became wholly-owned subsidiaries of DMC.
- Because Detroit Receiving provided almost 80 to 90 percent trauma and emergency services, it continued to provide these services for the Detroit Medical Center. Detroit Receiving also operates numerous specialty clinics.
- DMC operates eight hospitals, five of which are on the main campus where Detroit Receiving is located. DMC has 19,000 employees, 1,600 of which are at Detroit Receiving, roughly 2,500 physicians, and 45 outpatient clinics. DMC supports roughly 112 residency/fellowship programs and 1,100 residents, 80 of which are at Detroit Receiving. The emergency room residency is based at Detroit Receiving.
- The public mission of the former public hospital is maintained in the city's contract with DMC.
- In 1995, DMC reorganized its governance structure. There is now a 41-member DMC board, and a few subsidiary boards to oversee various clinical service lines. Detroit Receiving has a 10-member quasi-independent clinical board that oversees the trauma service line, which was left intact because a city statute requires the hospital to have its own board. There are community representatives on both the DMC and Detroit Receiving Boards. The DMC board has final authority over operation and budget decisions for the hospital.
- There was labor opposition to the transfer of the public hospital from the 13 unions at Detroit Receiving. The unions sued the city to prevent the transfer of the public hospital, but were ultimately unsuccessful.
- DMC offered employment to all of the former public hospital employees, about 75 percent of which transferred to the private sector workforce. However, these employees were "red-lined," meaning their wage rates were frozen until the salaries of the other DMC employees caught up to those of the former city employees.

Fairview University Medical Center -- Minneapolis, Minnesota

Public Hospital:	*University of Minnesota Hospital and Clinic*
Private Partner:	*Fairview Hospital and Healthcare Services*
New Name:	*Fairview University Medical Center*
Year:	*1997*
Transaction:	*Sale of a state-owned hospital to a private, non-profit health and hospital system.*

- On January 1, 1997, the University of Minnesota Hospital and Clinic (University Hospital), a 545-bed, 4,000 employee hospital facility that was part of the University of Minnesota's academic health center, was acquired by Fairview Hospital and Healthcare Services (Fairview), a private, non-profit network of hospitals, primary care clinics, specialty clinics, physician practice groups, and community-based public health programs.
- Fairview paid $87.5 million for the University Hospital facility.
- As part of the merger, University Hospital's campus was combined with that of Fairview Riverside Medical Center, a 985-bed, 3,000 employee facility, to become Fairview University Medical Center (FUMC). University Hospital's clinical focus includes high-tech surgical procedures and emergency services, while Fairview Riverside provides outpatient services, behavioral health services, obstetrics, and neo-natal intensive care services.
- Fairview simultaneously affiliated with the University of Minnesota's academic health center, physician faculty practice, and associated medical centers. Fairview will provide financial contributions to research and education at the University and expand physician training opportunities for University students and residents throughout the Fairview system.
- The rationale for the sale of University Hospital was to:
    - financially stabilize the hospital in an era of decreased admissions for acute care;
    - become part of a larger system that trains residents and students;
    - expand research opportunities throughout the system;
    - gain access to additional financial resources for research and education; and
    - reach new populations with a broader range of health care services.
- There was labor opposition to the sale of University Hospital from AFSCME Council 6, the state's largest public employee union. The union asked the Attorney General to review the sale for antitrust violations and other problems. The union feared it would not be recognized by Fairview and wanted to preserve its accumulated severance benefits and health benefits. Fairview contended it would recognize any union that was formed by the employees.
- Fairview maintains a 42-member parent board of directors. There is also a Fairview Corporate Board and smaller boards of trustees for each Fairview subsidiary. FUMC has an 18-member board of trustees.
- The University of Minnesota maintains some control over the former University Hospital by having input into decisions regarding research and education. In addition, University representatives have majority representation on the board of FUMC and veto power if Fairview wants to sell the hospital or make major changes.

John L. Doyne Hospital -- Milwaukee, Wisconsin

Public Hospital:	*John L. Doyne Hospital*
Private Partner:	*Froedtert Memorial Lutheran Hospital*
Year:	*1995*
Transaction:	*Closure of a county-owned hospital and sale of its assets to a private, non-profit hospital.*

- In 1995, John L. Doyne Hospital, Milwaukee County's public teaching hospital, closed its doors, and its assets and clinical services were acquired by Froedtert Memorial Lutheran Hospital, a private, non-profit teaching hospital. Both hospitals were located on the campus of the Milwaukee Regional Medical Center.
- In the 1960s, Milwaukee County began to develop a regional academic medical center on a 250 acre lot where John L. Doyne Hospital (JLD) was located. The Milwaukee Regional Medical Center, as it was called, evolved as a public/private partnership between the county and various private health care organizations. For example, the county leased a portion of the land to the Medical College of Wisconsin. JLD was a teaching hospital of the medical college and the school's faculty served as the county hospital's medical staff.
- In 1980, Froedtert Memorial Lutheran Hospital (Froedtert) opened as a private teaching hospital of the medical college on the medical center campus. Froedtert provided specialized clinical services, which JLD discontinued to avoid duplication of services. In addition, the County contracted with Froedtert to provide services to the county's indigent population.
- For 15 years, the partnership between the two teaching hospitals worked well through a commitment to quality medical care, medical education and research, and community service. Over the years, however, Froedtert received acclaim for its success in the areas of transplants and neuroscience, and JLD began to lag behind in terms of efficiency. Several studies revealed that JLD was bogged down by bureaucratic constraints and needed to reorganize its governance and operational structures to survive. However, nothing was done.
- Eventually, high executive turnover, bureaucratic entrenchment, decreased tax support from the community, inability to control operating costs, and lack of flexibility to respond to market changes and increased competition crippled operations at JLD.
- In 1994, at the urging of officials from the medical college and Froedtert, institutions that were interdependent with JLD, the county board of supervisors and the board of trustees of Froedtert decided to consolidate into one, private acute care hospital on the medical center campus.
- On December 31, 1995, the county closed the doors of JLD, thus removing itself from the hospital business after 135 years. The county concluded that remaining a provider of health care in the community would continue to put a strain on taxpayers and public funds.
- As JLD closed, Froedtert expanded its programs and services by acquiring all of JLD's assets.
- The agreement between the county and Froedtert is a direct sale of JLD's assets (including its building facility) to Froedtert for $4.1 million and a lease of the underlying land for 25 years. In addition, the county contracted with Froedtert as its preferred provider for the General Medical Assistance Program, an insurance program for low-income individuals that do not qualify for Medicaid. Froedtert agreed to continue to operate the state's only level I trauma center for at least 2 years. Froedtert will also assume a leadership role in developing a community-based primary care network for underserved county residents.

John Randolph Medical Center -- Hopewell, Virginia

Public Hospital:	*John Randolph Medical Center*
Private Partner:	*Columbia/HCA*
New Name:	*Columbia John Randolph Medical Center*
Year:	*1995*
Transaction:	*Sale of a public hospital, operated by a hospital authority, to a private, for-profit hospital system.*

- In 1995, the John Randolph Medical Center (JRMC), owned and operated by the Hopewell Hospital Authority, was acquired by Columbia/HCA, the nation's largest for-profit hospital chain. The hospital was renamed Columbia John Randolph Medical Center. A hospital authority is a quasi-public taxing agency which is considered a political subdivision of the state.
- JRMC has served a tri-city area (Hopewell, Petersburg, and Colonial Heights) outside of Richmond, Virginia since 1915. The medical center includes the 147-bed John Randolph Hospital, John Randolph Nursing Home, and two MedCare Family Practice Centers.
- In the Fall of 1994, Columbia/HCA owned four hospitals in the Richmond area and 12 hospitals in Virginia, and began discussions with officials at John Randolph Medical Center about its purchase.
- Initially, there was labor and community opposition to the acquisition of the hospital by the for-profit health organization. However, once the deal was endorsed by the influential President of the Southern Christian Leadership Conference, support of the mostly minority community members and their religious institutions was forthcoming.
- Motivation for the sale of JRMC included:
  - increased access to capital;
  - leverage for negotiating better purchasing discounts; and
  - an ability to compete for managed care contracts.
- To achieve economies of scale, Columbia/HCA implemented product-line consolidation and significant lay-offs. The medical center also built a $5 million Family Life Center, which houses the hospital's obstetrics, gynecological, nursery, labor, and pediatric units.
- In 1997, Columbia implemented a new management structure for its Richmond area hospitals. One CEO was named for the five area hospitals and each of the five hospitals is managed by an on-site senior executive that reports to the CEO.
- In addition, all five of Columbia's Richmond area hospitals were given the option to and chose to drop "Columbia" from their name. Consequently, Columbia John Randolph Medical Center is again called JRMC.

PennState Geisinger Health System -- Pennsylvania

Public Academic Health Center:	*Hershey Medical Center (Pennsylvania State University)*
Private Partner:	*Geisinger Health System*
New Name:	*PennState Geisinger Health System*
Year:	*1997*
Transaction:	*Merger of a state-owned medical center with a private, non-profit integrated health system.*

- The Milton S. Hershey Medical Center (HMC) was founded in 1963 by a gift to the state of Pennsylvania from a private trust. HMC included Penn State's College of Medicine, a 504-bed university hospital, a children's hospital and a large physician practice group. HMC was governed by the university's 20-member board of trustees.
- Geisinger Health System (Geisinger) was founded in 1914 and includes Geisinger Medical Center (a 548-bed hospital), a children's hospital, the Geisinger Health Plan, and several clinics. Geisinger had a single board of trustees.
- PennState Geisinger Health System (PSG) was formed by the merger of the clinical operations and patient care services of the two medical centers. As a public asset, HMC's building facility is still owned by the university. Ownership and operation of Penn State's College of Medicine, which was not a part of the merger, also remain with the university, although its education and research enterprises are now closely affiliated with PSG. PSG is governed by a 14-member board of trustees.
- The new physician-led entity operates the PSG Health Plan, one of the state's largest HMOs, oversees 77 clinics, spans 40 contiguous counties in Pennsylvania, and is affiliated with dozens of other hospitals. PSG has net clinical annual revenues of $871 million; over 13,000 employees; 549 residents; roughly 1,400 physicians; and over 1,300 licensed beds.
- Core services offered at PSG include transplants, women's health services, children's health services, a cancer center, rehabilitation services, primary care, EMS, and sports medicine.
- The rationale for the merger was to:
    - make it easier for consumers to utilize a broader range of services without leaving Pennsylvania;
    - facilitate consumer and employee choice;
    - broaden each medical center's patient base;
    - assure an adequate supply of physicians in rural areas of the state;
    - achieve economies of scale while enhancing services;
    - gain access to additional funding sources for research and education; and
    - increase bargaining power when negotiating for patients.
- Although PSG promised that there would be no lay-offs, nurses at HMC protested over cutbacks in benefits from joining the private sector workforce and the fear of an adverse impact on patient care.
- Because HMC was state-owned, the merger required attorney general approval. Pennsylvania's attorney general would not approve the merger until PSG ensured that access to health for consumers would not be adversely affected. An agreement between representatives of the attorney general and the two medical centers spelled out the actions PSG must take to ensure access. For example, PSG had to negotiate with health plans in the area to provide tertiary care (for example organ transplants and high-risk obstetrics) to consumers. If PSG negotiated in good faith in this respect, the attorney general would not challenge the merger.

Regions Hospital -- St. Paul, Minnesota

Public Hospital:	*St. Paul-Ramsey Medical Center*
Private Partner:	*Ramsey Healthcare, Inc.*
Year:	*1986*
Transaction:	*Transfer of control of a county hospital to a newly-created private, non-profit corporation. In 1993, the former public hospital then merged with a private, non-profit health corporation.*

- Regions Hospital, formerly St. Paul-Ramsey Medical Center, was Ramsey County's public hospital until 1986. In that year, the county board of supervisors transferred control of the public hospital to a new private, non-profit corporation, Ramsey Healthcare, Inc. In 1993, Ramsey Healthcare and its subsidiaries (St. Paul-Ramsey Medical Center, Ramsey Clinic, and Ramsey Foundation) merged with HealthPartners, a private, non-profit entity that operates Minnesota's largest health plan. In 1997, the hospital was renamed Regions Hospital to reflect its broad service area.
- St. Paul-Ramsey Medical Center was established as a public hospital for the medically needy in 1872. Its present facility was built in 1965.
- In 1986, the state legislature created Ramsey Healthcare, Inc., a private, non-profit parent corporation, to control operations of St. Paul-Ramsey Medical Center.
- Although the county no longer owned the hospital, several county commissioners served on the board of St. Paul-Ramsey Medical Center.
- Regions Hospital has 427 licensed beds, and employs 889 physicians and 4,200 workers, 2,282 of which are FTEs. There is one governance structure for both the hospital and the health plan.
- As the county hospital, Regions Hospital was renowned for its trauma services and burn care, costly services that did not generate substantial revenues. Hospital administrators wanted to branch out into surgery, cardiology, and critical care, but needed additional funding streams to support these services. Supervisors feared that the hospital would eventually close like others in the local market if they did not seek affiliation with another institution.
- Because Ramsey Healthcare, Inc., was created by state statute, the merger of St. Paul-Ramsey and HealthPartners had to be approved by the state legislature. However, because both parties were private institutions, they simply merged their assets rather than exchanging cash for assets.
- There were two main reasons for the merger between Regions Hospital and HealthPartners:
    - the stand-alone former public hospital could not support the charity care it continued to provide to the county's indigent patients; and
    - the hospital was increasingly burdened by the high costs of operating as a research and teaching hospital of the University of Minnesota's medical school.
- In 1996, 150 physicians completed residencies at Regions Hospital. The hospital operates residency programs in emergency medicine, family practice, obstetrics/gynecology, pathology, psychiatry, and occupational medicine.
- Regions Hospital is still perceived by many community members as the county hospital—or "the county welfare ward"—although it has not been a county-owned hospital for over a decade. Hospital administrators continue to appeal to as broad an array of paying patients as possible to dissociate itself from this image and to generate revenues.

UCSF-Stanford Health Care -- California

Public Academic Health Center:	*University of California San Francisco Medical Center*
Private Partner:	*Stanford University Health Services*
New Name:	*UCSF-Stanford Health Care*
Year:	*1997*
Transaction:	*Merger of a state-owned academic health center and a private, non-profit academic health center.*

- The merger of the University of California San Francisco Medical Center (UCSF), governed by UC's board of regents, and Stanford Health Services (Stanford), governed by Stanford University's board of trustees, took place on November 1, 1997. The new entity, UCSF-Stanford Health Care (UCSF-Stanford) is a private, non-profit corporation.
- UCSF has 15,000 employees and 1,955 licensed beds; Stanford University Medical Center has 13,000 employees and 1,910 licensed beds. Combined, the two health centers have an operating budget of $1 billion. The two medical center campuses are 40 miles apart.
- The board of directors of UCSF-Stanford has 17 members, including representatives from the business community, UC's board of regents, Stanford Health Services, UCSF and Stanford University, and UCSF-Stanford's CEO and chief medical officer.
- The merger consolidated the facilities and clinical activities of four hospitals. The four hospitals are UCSF Medical Center; Mt. Zion Medical Center, which had previously affiliated with UCSF Medical Center; Stanford Health Services; and Lucille Packard Children's Hospital, an affiliate of Stanford Health Services.
- Assets of both medical centers, including equipment, cash, accounts receivable, contract rights, and books and records, were transferred to UCSF-Stanford. UCSF contributed $386 million in assets and Stanford contributed $483 million in assets.
- USCF-Stanford will contract with both UCSF Medical School and Stanford Medical School for the professional services of their faculty members. The medical schools remain independent from the new entity.
- The patient care facilities of the two medical centers were leased by the universities to UCSF-Stanford through a long-term lease. Because USCF Medical Center is a public asset owned by the state of California, rent for the UCSF facility is nominal, set at $1 per year. USCF-Stanford will pay for utilities, services, maintenance, and repairs for both facilities.
- At least 95 percent of UCSF's workforce was offered employment at UCSF-Stanford. Accrued benefits transferred to the new personnel system, seniority was recognized, and salary was unchanged.
- The medical centers merged to:
  - achieve economies of scale in operating costly medical schools and teaching hospitals;
  - mitigate the impact of government cutbacks in the Medicaid and Medicare programs, particularly in GME;
  - compete more effectively for managed care contracts; and
  - eliminate competition against each other.
- There was significant labor opposition to the merger. For example, the California Public Employment Relations Board filed suit against UC's board of regents on behalf of the four unions at UCSF to prevent the merger, claiming that UCSF and Stanford officials did not disclose to the unions the merger discussions in advance of the final decision, in violation of the Higher Education Employer Relations Act. At the time of the merger, this suit was unsettled.

University Medical Center -- Fresno, California

Public Hospital:	*Valley Medical Center*
Private Partner:	*Community Hospitals of Central California*
New Name:	*University Medical Center*
Year:	*1996*
Transaction:	*Lease of a county hospital to a private, non-profit hospital system.*

- In October 1996, operation of Valley Medical Center (VMC), a 417-bed, county hospital, was transferred through a 30-year lease by Fresno County to Community Hospitals of Central California (Community), a private, non-profit hospital system. The hospital was renamed University Medical Center (UMC) and Community was renamed Community Health System.
- Contract terms required Fresno County to pay Community $17.5 million a year, plus its DSH funding from the state, to provide care to the county's indigent residents. In return, Community gained operational control of VMC by paying the county $36 million to lease the facility and its inventory. Community plans to move all of UMC's operations to a new building structure in downtown Fresno by 2001. The former VMC facility will remain the property of the county.
- Pursuant to the lease agreement, Community agreed to maintain various services that VMC provided, such as burn care, AIDS care, neo-natal intensive care and trauma care, and the county's obligation to provide health care to prison inmates and the poor. If Community evolves into a for-profit organization, which many community members fear it might, the county can reduce its payments for the provision of indigent care.
- Four members of Community's board are nominated by Fresno County's board of supervisors—one is a UMC physician—and at least one of these nominees sits on each subcommittee of Community's board.
- The county relinquished control of the hospital:
  - to enhance access to capital and other resources for short-term and continued financial stability;
  - to be better able to adapt to and compete in a managed care environment; and
  - to be free from restrictions in government reimbursements that supported hospital operations.
- VMC's workforce was terminated from employment with the county civil service system and most were hired, "as determined" by Community, with certain negotiated benefits. All but 249 of VMC's 1,473 employees were rehired; 73 turned down offers of employment.
- Union leaders and community members were strongly opposed to the reorganization at VMC. VMC nurses and community representatives organized the "Save Valley Medical Center" coalition and sued the county supervisors to prevent the affiliation on technical grounds. The union wants an injunction to revoke the deal because:
  - Valley Medical Center was financially stronger than Community and, therefore, did not need to affiliate for survival;
  - the deal went forward without any competitive bidding or public vote; and
  - there was an alleged illegal conflict of interest in the decision-making process.
- In addition, the California Nurses' Association, which represented 375 VMC nurses, filed a complaint with the National Labor Relations Board claiming that Community refused to acknowledge the union as the collective bargaining unit for nurses being rehired by Community. The coalition lost and is awaiting a decision from an appellate court. Community's other hospitals are nonunion, and Community officials wanted every employee unionized or no one unionized, as there is significant staff interchange among its hospitals.

The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable. Address: 1015 18th Street, NW Suite 210 Washington, DC 20036-5203 Telephone: 202-833-8877 Facsimile: 202-833-8932 http://www.esresearch.org

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025

650-854-9400 Facsimile: 650-854-4800

Washington Office
1450 G Street, NW, Suite 250
Washington, D.C. 20005

202-347-5270 Facsimile: 202-347-5274

http://www.kff.org

97-1653C-01

Additional free copies of this publication (#1450) are available by calling The Henry J. Kaiser Family Foundation's publication request line at 1-800-656-4533 or download this publication from our website at www.kff.org.