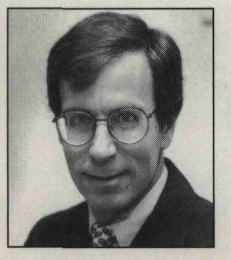
SMALL-CITY HOSPITALS NEED TO COLLABORATE

Key Questions for Healthcare and Community Leaders

BY ALAN M. ZUCKERMAN

The healthcare media and healthcare experts are focusing attention on the ongoing battle in the nation's major metropolitan areas among hospitals, physicians, and insurers for control of a restructured, integrated healthcare delivery system. But lost in the stream of reports are the implications for small cities and rural areas. Occasionally, pundits glibly comment that delivery system changes will come slowly to small towns and rural America, but they never discuss the fundamental differences between urban America, its small cities, and exclusively rural areas.



Mr. Zuckerman is executive vice president, Chi Systems, Inc., Philadelphia.

No Community Immune

No community is likely to be immune to the revolution occurring in healthcare delivery and financing. The unrelenting rise in healthcare costs is forcing employers and the government to seek new cost-control measures for their health insurance plans, based on premises about managed care:

- Managed care offers the most opportunity for near-term cost relief.
- Eventually, with subtle and not-so-subtle encouragement by the federal government, many Medicare beneficiaries will enroll in managed care programs to escape Medicare's ever-increasing copays and deductibles. Beneficiaries will be lured, too, by promises that they will have no claim forms to complete and will be able to continue with their primary care physician.
- Managed care, aided and abetted by technological advances, will fundamentally restructure the way healthcare is delivered. Acute care will be replaced in large part by outpatient, home, and subacute care. Specialty physician services will be provided increasingly by primary care physicians, with resulting reductions in referral rates to specialists of 30 percent or more. The current oversupply of acute and specialty medical care will lead to price wars, mergers, bankruptcies, and the abrupt exit of some providers until the supply has adjusted to the new demand levels early in the twenty-first century.

Small Cities' Problems

How small cities, which typically have two or three hospitals, one of which is Catholic, will cope with these changes is important for several reasons:

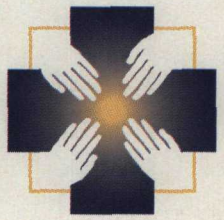
- The United States has hundreds of such communities, in contrast to the 25 to 50 major

The New Covenant process (cosponsored by the National Coalition on Catholic Health Care Ministry, the Catholic Health Association, and Consolidated Catholic Health Care) promotes local, regional, and national collaborative strategies. For more information about the process, call Joanne Elden Beale at 202-296-3993 or the CHA Member Hotline at 800-230-7823.

In addition, CHA offers supportive services and resources: Ethicists Sr. Jean deBlois, CSJ, Dan O'Brien, and Ann Neale address ethical and mission considerations. Philip Karst applies his experience as a CEO to alternative strategies, market negotiations, and sites that have dealt with collaboration issues. He also advises on how various structures affect sponsorship.

metropolitan areas that are the primary battlegrounds today for control of the emerging delivery system.

- Most experts agree that, except in rare instances, these communities are too small to support more than one integrated delivery system and are generally too far from other populated areas to fully and effectively participate in other integrated systems. Until recently, however, federal and state antitrust policies have effectively prohibited meaningful collaboration and have constrained multiple hospitals from developing a single integrated delivery system.
- Small cities' utilization rates for costly services often approximate those in major metropolitan areas. Thus they may need to shrink and restructure the delivery system to a degree similar to their urban counterparts.
- The effect of downsizing and restructuring is likely to be more visible and wrenching in small cities than in larger metropolitan areas because of the comparatively high proportion of healthcare spending in relation to total spending and the relatively self-contained nature of such small communities.



Questions for Community Leaders

In preparing for the coming changes, community leaders in multihospital small cities should ask two key questions:

- **How will downsizing of acute care capacity occur?** Will it result from competition among hospitals? If so, the hospital with the biggest war chest will be the sole surviving hospital. Will downsizing result from collaboration among hospitals? If so, the downsizing can be "managed" in a rational and minimally disruptive fashion.

THE 10 MOST COMMON OBJECTIONS TO THE COLLABORATIVE APPROACH

Objections abound to the revolutionary concept of collaboration among formerly fierce competitors, including these common complaints:

1. Antitrust enforcers will not allow collaboration. Williamsport, PA, Asheville, NC, and other communities have addressed this issue, although it can be a significant hurdle. New antitrust policies appear to allow some previously prohibited arrangements.

2. The physicians will never accept collaboration. Physicians in smaller cities have observed the dramatic changes affecting medical practice in major metropolitan areas with high managed care penetration. In many cases, these physicians are ahead of hospitals in preparing for the new environment. Although some physicians will resist, the medical community will not be a barrier to collaboration.

3. Catholic and non-Catholic (or sectarian-nonsectarian, or public-voluntary) collaborations are difficult to consummate. Some communities such as Asheville have made significant strides in coping with this issue. New, more innovative organizational structures seem to facilitate such collaborations.

4. A hospital monopoly will result in unrestrained price increases except in the most remote areas. Surrounding hospitals will continue to be competitors and offset the potential for price gouging. If prices rise significantly in an unmanaged market, the potential for managed care companies to enter and be successful is high.

5. We can "win." Few, if any, organizations will be winners in competitive battles in smaller cities. And, in the course of those battles, the few winners and the organizations they vanquish will spend down community assets. Trustees should realize that stiff competition will exact a significant toll on the community.

6. Managed care will go away (or never really take hold), and the pressure to collaborate will diminish. Hospitals should not bet on this approach. The only other viable alternative to managing healthcare cost inflation is a single-payer system, and the collaborative approach responds effectively to this model, too.

7. We don't feel any pain, yet. Unless institutions can make a rational case for a different healthcare delivery scenario, hospitals will feel pain. The sooner providers realize this, the sooner the community benefits.

8. We're already part of a statewide/regional network. Few networks that span large geographic areas offer the benefits that local collaborations can provide. Many wide-ranging network relationships will be maintained as a complement to local collaborations.

9. We have mission and culture differences. Refocusing on the community, and away from competition, should allow organizations to resolve their differences.

10. We don't like those people at the other hospital. Like mission and culture differences, real and perceived incompatibilities are at least partly a product of the competitive system. People who are unable to adapt to the collaborative model may be casualties of this new approach.

Community resources will not be wasted in a price war and subsequent subsidization of unprofitable hospital operations, which is inevitable under the competitive model.

• **How will reallocation of community spending be accomplished?** Will reallocation occur under the competitive model? If so, millions of dollars in reduced hospital costs will leave the community in the form of premiums and profits (and overhead) that will accrue to outside managed care firms and entrepreneurs who capitalize on service-development opportunities that are being ignored by local hospitals. Will reallocation result from collaboration among hospitals? If so, it can be managed and will lead to direct contracting, local managed care, and growth in new and underdeveloped services that directly contribute to the community's economic well-being.

The Case for Collaboration

The case for collaboration in the multihospital small city can be summarized in the following points:

• Appropriate stewardship of the community's assets and resources demands that hospitals pursue a collaborative rather than a competitive approach to rightsizing the system.

• From a mission perspective, the competitive approach should be abandoned because collaboration is the most feasible means to refocus the hospitals on meeting true community needs rather than competing to ensure each institution's individual survival.

• Cities such as Williamsport and Harrisburg, PA, and Asheville, NC, offer models of how collaboration can be achieved.

• Community leaders in small cities usually have a rich history of community responsibility and

APPROACHES TO COLLABORATION

Phase I

Activity	Issues	Outputs/Outcomes
Project Initiation, Committee Meeting	Project objectives and logistics.	Expectations of process. Project schedule. Finalized approach/work plan.
External Analysis	What services and volumes will the market demand in the future?	Market profile, including utilization projections.
Internal Analysis	Selected utilization, financial productivity characteristics.	Organizational profiles, including characteristics relevant to evaluation of collaboration.
Interviews	Perceptions and opinions of key decision makers.	Summary of interview results.
Initial Legal Review	Potential antitrust considerations. Compliance with canon law.	Summary of potential legal considerations and options.
Committee Meeting	Review and discussion of findings to date.	Comments on work to date; issues requiring follow-up.
Develop Collaboration Scenarios	What will the hospitals look like under the status quo? If they affiliate?	Scenarios to model and evaluate.
Evaluate Scenarios; Synthesize Findings	All things considered, could and should the hospitals collaborate? How should the collaboration be structured?	Recommendation(s) on form and appropriateness of collaboration.
Committee Meeting	Review and discuss findings and recommendation regarding collaboration.	Decision on whether to proceed with Phase II.

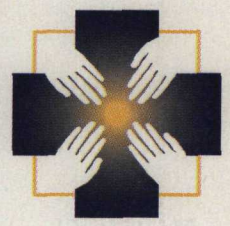
judicious use of community resources, and have the potential to embrace the collaborative approach to delivery reform.

Starting the Collaborative Planning Process

Several basic steps will get the collaborative planning process off the ground. First, leaders of the hospitals need to engage in informal dialogue (usually CEO to CEO and/or board chairperson to board chairperson) about the potential benefits and risks of a collaborative relationship, and each organization needs to determine on its own that collaboration is desirable. If that is accomplished, a second step is agreeing on a structure and process for collaborative discussions. Often each hospital appoints a small task force to study the issue. Representatives usually include the board chairperson; medical staff president; CEO; and, at most, one or two other board members.

A multiphase approach to collaborative planning is likely to be necessary. The **Box** below illustrates examples of early phases of collaboration. These initial phases help leaders conclude whether collaboration is preferable to competition, determine collaboration's logical substance and form, and identify possible problems and various ways to address them.

In three to six months, leaders can test the concept of collaboration and determine whether to pursue it further. In many instances, community leaders will embrace the collaborative approach and it will be a common model as healthcare delivery enters the twenty-first century. □



For more information contact Alan Zuckerman at 313-761-3912.

Phase II

Activity	Issues	Outputs/Outcomes
Committee Meeting	How, specifically, will collaboration be implemented?	Implementation plan.
Resolution of Outstanding Issues	Some issues may be identified, but not resolved, in Phase I.	Elimination of barriers to proceeding.
Committee Meeting	Review of basic elements of collaboration.	
Draft Memorandum of Understanding	Elements of the agreement to collaborate.	Memorandum of understanding.
Due Diligence	Systematic review of legal and financial issues affecting collaboration.	Completed due diligence checklist. Resolution of issues, as appropriate.
Execute Memorandum of Understanding	Final agreement by owners/sponsors.	Executed memorandum of understanding.
Antitrust Compliance	What are the compliance requirements?	Hart, Scott, Rodino filing (if required).
Committee Meeting	Review of collaboration agreement.	
Communication Plan	What is told to whom, when, and by whom?	Communication plan.
Implementation		