PART I

FOUNDATIONS OF HEALTHCARE MARKETING

Feature Case: Hospital Consolidation

This real-life case invites students to consider the dynamic relationship healthcare providers have with their local and regional market and to appreciate the need to balance organizational and community interests when making important decisions that affect the healthcare marketplace. Participant and facility names and various numerical values have been modified to preserve anonymity and accentuate points of learning.

The case also encourages students to consider the long-term impact certain strategic initiatives have on healthcare organizations and their stakeholders, including patients, physicians, payers, and the public, and to actively consider stakeholder expectations in connection with these decisions. Finally, this case introduces students to important healthcare industry issues and trends, including forces that shape a healthcare organization's mission, vision, and market-based strategies for growth and development, as discussed in Part I of this text.

Introduction

In many ways the 2001 holiday season was no different than any other. Dallin Call—chief executive officer of Kimball Hospital—genuinely enjoyed the traditional music, decorations,

and seemingly endless social gatherings characteristic of the time of year. It was dissimilar in one respect, however: Dallin was full of anxiety and could not shake it. Three months earlier, Dallin's Rocky Mountain–based healthcare system—Great Western Hospital Corporation (GWHC)—initiated merger/consolidation talks with the county-based operators of his hospital's chief rival, Tanner Medical Center, and a December 31 deadline to formally initiate negotiations or walk away was looming. Dallin understood that his personal recommendation to his corporate supervisors and community-based board would greatly influence their eventual decision to press ahead with consolidation talks or continue the more than 40-year practice of offering competitive but duplicative healthcare services to the community. Dallin's recommendation and the ultimate decision to consolidate or not would be the most important local healthcare market decision in a generation or more and would greatly impact the lives of numerous healthcare professionals and the nature and quality of healthcare services for area residents for years to come.

Merger and Consolidation Trends

In general, the local market mirrored the healthcare issues and challenges observed nationally, including a trend toward hospital mergers, acquisitions, and consolidations brought about by myriad organizational and market forces (Cuellar and Gertler 2003; Haleblian et al. 2009). In the decade preceding Kimball Hospital's deliberations, the healthcare industry underwent a wave of consolidations that transformed the hospital marketplace. By the mid-1990s, hospital mergers and acquisitions had increased by nearly tenfold the rate observed only five years earlier (Vogt and Town 2006).

From his readings and observations, Dallin noted that some of the more important advantages to hospital mergers and consolidations included much needed access to capital and elimination of non-value-added duplication of expensive healthcare services. Mindful that consolidation was rarely a panacea, however, Dallin identified a handful of concerns and potential disadvantages, including the potential for higher costs and prices and lower quality following reduced competition (Tenn 2011; Vogt and Town 2006).

The Local Market and Demographics

Prattville's high desert community of 50,000 generally supported two competing hospitals for more than 70 years. About 75 percent of one hospital's clinical programs and services were duplicated by its cross-town rival, and local citizens traveled to out-of-area hospitals to receive roughly $40 million per year in healthcare services either not provided or poorly delivered by local hospitals.

From early 2000 through mid-2001, important changes in the leadership and governance of Prattville's rival hospitals set the stage for the important talks that soon

followed. Among these leadership changes was the appointment of new hospital board chairmen, new hospital administrators/CEOs, new Blade County commissioners, and new regional and systemwide leadership at GWHC. Moreover, each hospital's respective plans to introduce an even greater array of duplicate services or expand on existing duplicate services prompted Dallin to ask himself three important questions: Was his hospital's mission focused on what was right and best for the Prattville community or GWHC? Would a consolidation of hospital operations improve Prattville area residents' access to services and the cost and quality of healthcare? And which organization—Kimball Hospital (GWHC) or county-owned/operated Tanner Medical Center—was best positioned to assume leadership, ownership, and management of the community's hospital/healthcare system?

Mindful of the sea change in local and central office leadership and increasingly troubled by an awareness that each hospital's strategic plan called for more and more non-value-added duplication of hospital services, Dallin contacted his immediate supervisor and suggested the time might be right to revisit the idea of hospital cooperation—even consolidation. The most recent serious attempt at merger/consolidation talks failed in 1983, and authorities revisited the idea in 1990 without success. When merger/consolidation talks resurfaced in 2001, GWHC was ever mindful of its longstanding, publicly stated commitment to the community. Yet GWHC was cognizant of important political and marketplace realities. A profile of key ownership, market, financial, operating, and political dimensions of Prattville's hospital/healthcare community is presented in Exhibit 1.

Other Provider and Community Considerations

Since its inception in 1975, GWHC had established a system of more than 20 hospitals in three neighboring states with highly sophisticated central office support services, including health information technology, central purchasing, laboratory, laundry, marketing/advertising, physician recruitment, quality/risk management, and more. By implementing evidence-based medicine, the system had reduced costs and improved quality and received national acclaim for its remarkable focus on this initiative.

Because of its local ownership and control, employees and supporters of Tanner Medical Center touted the hospital's ability to chart its own course and make its own decisions, independent of out-of-state officers who may or may not have shared the community's healthcare goals and views. Tanner Medical Center enjoyed a measure of "system" support through its affiliation with Voluntary Hospitals of America (VHA), the nation's largest not-for-profit hospital association. Importantly, and for a combination of reasons, local physicians generally favored and supported Tanner over Kimball, reflected by a nearly 2:1 ratio of annual patient admissions to Tanner over Kimball. Many supposed that notwithstanding Kimball's/GWHC's reputation as a high-quality, lower-cost provider, area physicians resisted the corporation's centralized, systematic approach to planning and

Exhibit 1 Select Financial, Operating, and Other Indicators: Kimball Hospital and Tanner Medical Center (Fiscal Year 2000)

	Kimball Hospital	Tanner Medical Center
Hospital ownership and control	GWHC	Blade County
Ownership type	501(c)(3) corporation	Government/county
Licensed beds	110	150
Total patient days—trend (1998/1999/2000)	10,150/10,925/12,775	24,240/25,380/23,725
Average daily census	35	68
Annual gross patient services revenue	$49 million	$97 million
Annual net patient services revenue	$31.5 million	$54.6 million
Market share	26%	52%
Annual marketing/ advertising budget	$141,000	$310,000
Net operating income percentage—trend (1998/1999/2000)	3%/5%/3%	2%/4%/6%
Total debt	N/A (consolidated with GWHC)	$73 million
Financial reserves (savings)	$2.3 billion (GWHC)	$9 million
Employed physicians	8	0
Percentage of local physicians whose first loyalty was to this hospital	35%	65%
Services unique to hospital in local market	Cardiology, acute rehabilitation	Pediatrics, neonatal level II, cancer
Percentage of physicians who favored hospital consolidation	80% (based on fall 2001 survey of Kimball/Tanner medical staffs)	
Public preference for local (versus out of area) ownership and control	68% (based on spring 2001 Kimball Hospital community telephone survey)	

delivering patient care. Indeed, many physicians relocated to Prattville because of the region's laissez-faire approach to medicine, including a lack of managed care and other insurance mechanisms that limited physician reimbursement and autonomy.

A Time for Decision

As CEO, Dallin was also chief market manager and promoter of his hospital/healthcare organization. Positioning his organization for immediate and long-term growth and financial success was an ever-present mandate; orchestrating a well-balanced, integrated, community-wide healthcare system to improve access, cost, and quality of care to the entire Prattville community was no less important. In his heart, Dallin believed the time was right to consolidate or merge the community's two competing hospitals, and the leadership, financial, and other strengths of his company made Kimball Hospital/GWHC the preferred owner/operator of the new entity. Yet, Dallin knew of his community's underlying preference for local ownership and control and of the physician community's long-standing reluctance to embrace his company's philosophy and approach to organizing and delivering care. Although Dallin's organization and community board leaders were independent, critical thinkers, they looked to him for guidance in this matter.

Discussion Questions

1. What key organizational and marketplace issues reopened the door to a potential hospital merger/consolidation?
2. In what ways could Dallin balance the interests of the community with the interests of his employer/corporation?
3. From a patient and community perspective, what might be some of the pros and cons to consolidating the community's hospitals?
4. From this case, can you identify and describe some of the forces that shape a hospital's mission, vision, culture, growth, and development?
5. Who are the key decision makers and other stakeholders (individuals and groups) in this case? What issues and concerns do they have about consolidation, and what are their relative positions of power and influence in Prattville's healthcare community?
6. Would you recommend consolidation of Prattville's two community hospitals? Why or why not?
7. If you would recommend consolidation, which organization should assume ownership/control? Why? What would be the strategic marketing implications of your decision?

PART II

THE FIVE Ps OF HEALTHCARE MARKETING

FEATURE CASE: MARKET MANAGEMENT

This real-life case invites students to analyze and prioritize various kinds of information common to a dynamic and competitive healthcare marketplace as part of an organization's strategic marketing process. It presents the unique and important issues and challenges a regional healthcare provider (Community Medical Centers) had to face as it attempted to engage patients, physicians, payers, and the general public in a politically sensitive environment. This case reinforces the material introduced in Part II of this text by asking students to assume the role of assistant director of strategic planning and marketing and to analyze, synthesize, and prioritize findings from Community Medical Centers' recent environmental assessment to position the organization and promote its services to area physicians, patients, payers, and the general public.

Information included in this case was derived from the *California Health Care Almanac*, a publication of the California HealthCare Foundation (2009). Although the information about the Fresno, California, healthcare market is true to fact, modifications have been made to names, roles, settings, and numerical values to preserve anonymity and accentuate points of learning.

Introduction

Twenty-three-year-old Rachel McKee completed her undergraduate degree in healthcare administration with an emphasis in planning and marketing. To her delight, she was offered the position of assistant director of strategic planning and marketing at Community Medical Centers (CMC), a large healthcare organization in central California. Rachel was ambitious and eager to make an early impact. She was pleased that her new boss and mentor, Lindsey Chadwick—a seasoned healthcare veteran—seemed confident in Rachel's ability to process complex information and assume increasingly important responsibilities.

Lindsey understood the intricacies of CMC and the local healthcare market. Her supervisor and members of the board had put her in charge of updating the organization's strategic marketing plan in response to important, ongoing changes in the local and regional markets. Lindsey assigned Rachel the important task of performing an environmental assessment and using the results to complete a strengths, weaknesses, opportunities, and threats (SWOT) analysis and draft a summary of the organization's core strategic initiatives. From these important documents, Lindsey and Rachel would update CMC's strategic marketing plan.

From the outset, Lindsey advised Rachel to gather and assess relevant market information from various sources, including noted health industry publications; organization, statewide, and other publicly available databases; and interviews with executives, physician groups, insurance companies, regulators, and others. Like an investigative reporter, Rachel was directed to probe and dig for important and useful information that would ultimately provide a framework and justification for the organization's marketing plan. From her coursework in college, Rachel remembered that a marketing plan must include timely and accurate information about a market's healthcare providers—notably hospitals and local physicians. She knew that a summary of key market demographics, including patient, employer, and insurance company profiles, was essential. A broad yet detailed understanding of the public at large and the political dynamics among the provider community also was vital. Finally, she needed to gain an overview of key industry trends. After four months of diligent study, networking, and thoughtful analysis, Rachel presented her environmental assessment to Lindsey. Her assessment included the following highlights.

Fresno Market Background

With a total population of 1.6 million people, the greater Fresno area had seen strong growth over the past decade—up 22 percent compared to 14 percent statewide. It was one of the poorest communities in California; the incomes of nearly half of the Fresno area population were below 200 percent of the federal poverty level. Educational attainment was also well below the state average; only 22 percent of adults held a college degree. Approximately 50 percent of the market population were Latino, 37.5 percent were white (non-Latino), and 20 percent were foreign born. The health status of local/regional residents

was generally not good; approximately 20 percent self-reported fair or poor health status, and more than 27 percent were living with asthma, diabetes, or both. The unemployment rate in the area was high and continuing to rise; 15.5 percent of the population was out of work (up 5 percent over the previous year and 5 percent higher than the statewide average). Although agriculture was a vital part of the local and regional economies, the largest employers in the market were public-sector organizations, including Fresno County, the City of Fresno, and the Fresno school district. Two major healthcare systems—CMC and Saint Agnes Medical Center—were among the area's largest private employers (California HealthCare Foundation 2009).

Hospital/Health System Providers

Most of the hospitals in the region were not-for-profit or government/district hospitals. The Fresno community had an acute care bed capacity of 173 per 100,000 (slightly less than the statewide average of 182) and an occupancy rate of 68 percent (greater than the statewide average of 59 percent). The major hospitals ran near capacity at certain times of the year.

The major hospital systems in Fresno County were CMC (800 beds across three hospitals), Saint Agnes Medical Center (more than 400 beds), and Kaiser Permanente Fresno Medical Center (165 beds). These hospital systems represented roughly 50, 30, and 10 percent of the hospital market, respectively. CMC and Saint Agnes served a large geographic area and enjoyed a referral base from several outlying counties. Historically, the relationship between CMC and Saint Agnes had been characterized by little collaboration and intense, long-standing competition bordering on animosity. While Saint Agnes was located in the more affluent part of north Fresno and was often described as the "cash cow" of its 40-hospital parent corporation, CMC's 500-bed flagship facility was located in the heart of Fresno and, with its nine outpatient clinics, served as Fresno County's primary safety net provider.[1] Financial losses at CMC's flagship facility were largely offset by highly profitable operations at its two sister hospitals located in more affluent communities to the north and northeast. In recent years, CMC had reversed its negative financial performance and had become modestly profitable.

Reports from the Office of Statewide Health Planning and Development indicated an increasingly unfavorable payer mix across all Fresno area hospitals—an indication of the community's high levels of poverty, lack of insurance, and Medi-Cal (similar to Medicaid) coverage. The Saint Agnes payer base was approximately 25 percent Medi-Cal. CMC—with its more than 30-year contract with Fresno County to provide indigent care—reported that nearly 40 percent of its patients were covered by Medi-Cal. Major initiatives at CMC included the recent opening of 160 new beds at its flagship hospital, including 56 neonatal intensive care beds. After opening a new patient tower, Saint Agnes added 36 neurosurgery and critical care beds. In some cases, new hospital construction was a response to both capacity issues and compliance with state seismic standards. Both CMC

and Saint Agnes also added new programs to stem the exodus of patients to out-of-area providers of services not previously offered within the community.

Survey respondents' characterizations of the quality of care at Fresno area hospitals ranged from poor to good. Many opted to leave the area when they got "really sick"; a study showed that patients sought nearly $500 million in medical care services outside the greater Fresno area annually for a variety of reasons, notably long wait times, physician shortages, and concerns about the quality of care provided by area hospitals. In recent years, area hospitals aligned themselves with academic teaching programs to support clinical/medical training programs, improve the quality of care, enhance their reputations, and recruit more physicians to the market. Notable associations included CMC's formal affiliation with the University of California, San Francisco, and Saint Agnes's affiliation with Stanford University for cardiology and neurosciences.

Although Saint Agnes was widely regarded as the premier hospital in the market, highly publicized recent outbreaks of methicillin-resistant staphylococcus aureus (MRSA) infections and Legionnaires' disease had raised questions about its patient care and quality.

Physician and Allied Health Community

The greater Fresno area suffered from a notable shortage of primary care and specialist physicians, with 45 primary care physicians per 100,000 residents versus 59 statewide and 118 physicians overall per 100,000 residents versus 174 statewide. An aging physician workforce led market observers to expect shortages to worsen. Nurses and other allied health personnel were also in short supply, causing the federal government to classify most of the market as a health professional shortage area. Primary and specialty physician shortages invariably resulted in long appointment wait times—a key reason many insured patients sought medical care outside the local market. Wait times for dermatologic appointments, for example, were reportedly 9 to 12 months. Other specialists in short supply included neurosurgeons, general surgeons, cardiologists, gastroenterologists, oncologists, otolaryngologists, ophthalmologists, and psychiatrists.

Recruiting new physicians to the Fresno area was challenging because of various factors, including poor payer mix, poor reimbursement, ongoing hospital call coverage obligations, and quality-of-life considerations. Although many physicians already established in the market were overworked, they were apprehensive about losing market share and thus had little interest in recruiting. Many respondents reported that the physician shortage would have been even more acute if it were not for the many foreign-born physicians practicing in the Fresno area, notably natives of India and Pakistan. Many of these physicians were attracted by the area's sizable ethnic communities and focused their practices on patients from their own ethnic background.

For various reasons, Fresno had few large physician practices. Most physicians opted to practice solo or in small groups of fewer than five physicians, and single-specialty

rather than multispecialty groups were the dominant practice type. Although many community physicians maintained admitting and practice privileges at multiple hospitals, they generally concentrated their practice at one hospital. For years, emergency call coverage had been a source of friction between area hospitals and physicians due to the expensive stipends hospitals had to pay to get physicians to provide call coverage.

Unlike in many markets in California and elsewhere, formal integration between physicians and hospitals was limited. Relationships generally were marked by strain and distrust. In recent years, CMC's relationships with its primary physician groups had improved, whereas Saint Agnes's hospital–physician relationships had deteriorated. Hospitals' efforts to attract and align area physicians were focused on joint ventures, many of which failed.

Area physicians' lack of loyalty to area hospitals was evidenced by the extensive movement of various services—including imaging, orthopedics, plastic surgery, and endoscopy—out of hospitals and into physician offices or physician-owned facilities. Many reports suggested that physicians' ongoing dissatisfaction with area hospitals was the basis of this activity.

Payer/Insurance Community

In contrast to other California markets, the greater Fresno area only modestly embraced managed care. Even at their peak in the mid-1990s, health maintenance organizations (HMOs) and their variants never achieved dominance in the Fresno area, and their presence shrank from roughly 30 percent in 2000 to 25 percent today. According to one report, the absence of a strong HMO/managed care presence meant that health system features common to other communities—formation of large multispecialty physician groups, close hospital–physician alignment, provider familiarity with performance measurement and reporting, and aggressive care and utilization management—were not pervasive in the Fresno market.

Only 46 percent of area residents (compared to 59 percent statewide) had private medical insurance, and 16 percent were uninsured. Medi-Cal enrollment was high in the Fresno area, at approximately 30 percent. Fresno's safety net was generally considered weak, fragmented, and inadequate for the needs of the population. Indeed, healthcare was considered a low priority for many of the area's county governments. Blue Shield of California and Anthem Blue Cross were the leading health insurers in the greater Fresno market. As in other regional markets, these health plans were under high pressure to moderate premiums. Many believed that doing so would be extremely challenging in the face of escalating hospital costs. Because some hospitals—notably Saint Agnes and CMC's Clovis Community Medical Center—were considered "must haves" by employer purchasers, these hospitals had strong negotiating leverage with area health plans.

The Future of Healthcare: Key Industry Trends

Rachel recognized that healthcare is a dynamic and ever-changing industry whose future is difficult to predict. Her assessment summarized the key trends that would likely define healthcare's immediate future.

The Economy

Although the economy was slowly improving, it was expected to remain fragile due to continued high unemployment in the United States and Europe. The national economy was expected to impact both demand and supply dimensions of the healthcare industry (Valentine and Masters 2012).

Healthcare Reform

Various elements of the Affordable Care Act were implemented on schedule, including ventures into bundled payment, accountable care organizations (ACOs), and value-based purchasing activities. State health insurance exchanges loomed around the corner; many were in active development. This trend—with its focus on benefits and network development—needed to be monitored (Valentine and Masters 2012).

Hospital–Physician Alignment

Physician employment was expected to remain the preferred approach to hospital–physician alignment. Some physician/medical groups would still favor independence, and most hospitals/health systems would need to balance a dual approach to meeting the needs of both independent and employed physicians. The need to clinically integrate employed and independent physicians would remain critical if hospitals/health systems expected to respond effectively to healthcare reform (Valentine and Masters 2012).

Revenues and Expenses

Per unit revenues (e.g., average net revenue per procedure or per patient day) were expected to increase at a rate slower than cost trends over the next 12 to 24 months. Medicare payments would increase by less than 2 percent, and most states were expected to hold the line on Medicaid payments (or even reduce reimbursement rates). Commercial payers would likely limit rate increases to 4 to 6 percent. Some payers, including Medicare, were expected to tie certain rate increases to documented quality improvements. Value-based purchasing, bundled payments, readmission rate reductions, ACOs, and other risk-based arrangements would present opportunities for greater financial reward for low-cost, high-quality providers. Reducing costs would remain a top priority in the coming fiscal years. Simultaneously, it was

expected that patient throughput and occupancy levels would need to increase in both acute care/hospital-based and outpatient settings to maximize economies of scale (i.e., reduction of per unit cost resulting from high volume) and use of resources (Valentine and Masters 2012).

Access to Capital

Access to capital (funds) would continue to be a key catalyst for mergers, sales, affiliations, and other alliances among hospitals. Capital was expected to be more difficult to obtain in the immediate future due to the weak economy, lower patient volumes, and deteriorating payer mix. Most independent hospital boards would continue to ask whether they could remain independent and, if so, whether they should (Valentine and Masters 2012).

Information Technology

Useful data that could inform clinical and financial decisions in real time would become key to increasing revenues and managing expenses more effectively. Information technology systems and strategies would need to be sufficiently robust to capture large volumes of data that could be readily integrated into decision making (clinical and financial) and marketing efforts (Valentine and Masters 2012).

Consolidations, Closures, Alliances, and Mergers

The healthcare reform agenda was expected to continue, with 5 percent of acute care hospitals closing by 2020. Further consolidation and alignment of hospitals and medical groups was expected as these entities joined together to improve access to capital, form ACOs, and achieve cost reductions through economies of scale (Valentine and Masters 2012).

Clinical Integration and Care Delivery Redesign

Processes associated with clinical integration and care delivery redesign were within the "golden triangle" of cost containment, quality improvement, and financial performance. Future success factors for clinical integration and care delivery redesign included attention to all points of the care continuum: coordination of primary care, acute care, and post–acute care (Valentine and Masters 2012).

Workforce Issues

Pressure to reduce operating costs from 10 to 20 percent over the next three to five years was expected to continue. The enormity of this reduction would mandate further reducing nonclinical staffing, outsourcing functions to less costly vendors, and reducing wages or

holding wages flat and adjusting benefit plans. Backlash from organized labor (i.e., unions) was expected (Valentine and Masters 2012).

Smart Growth

Inpatient and selective outpatient use rates were expected to decline in the immediate/intermediate future because of continued high unemployment, shifting the costs of health-related benefits from employers to employees, increased price shopping among patients seeking to obtain health services at the lowest cost, and postponing nonessential medical care. Accordingly, healthcare leadership teams would need to identify ways to selectively grow their organizations' market share in areas that would improve their profitability (Valentine and Masters 2012).

Next Steps

Lindsey was pleased with the substance and quality of Rachel's environmental assessment. The task of analyzing, synthesizing, and prioritizing these findings—including developing a summary of strategic issues and marketing plans—lay ahead.

Note

1. The term *safety net provider* generally refers to providers (including hospitals and physicians) who offer government-financed programs that enable people to receive healthcare services when they cannot pay for them due to a lack of private resources. For example, Medicaid becomes a safety net for long-term care services after a patient has exhausted his/her private funds.

Discussion Questions

1. According to Rachel's environmental assessment, what were CMC's most important strengths, weaknesses, opportunities, and threats?
2. Identify and describe CMC's most important strategic issues.
3. In what ways should CMC's strategic issues have driven the development of a strategic marketing plan?

4. What are the foremost issues Rachel and Lindsey should have considered as they positioned CMC and promoted its services to area physicians, patients, payers, and the general public?
5. After completing the environmental assessment—including the SWOT analysis and summary of strategic issues—Lindsey and Rachel needed to develop business and marketing plans to advance the organization's strategic initiatives. In your judgment, what are the elements or characteristics of a valid marketing plan?

References

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PART III

INTERPERSONAL SKILLS FOR THE HEALTHCARE MARKETER

Feature Case: Palomar Heart Hospital

This real-life case introduces students to common healthcare marketplace issues and controversies related to specialty hospitals and hospital–physician joint ventures. It also exposes students to examples of interpersonal and interprofessional conflict, inadequate and poorly aligned organizational communication strategies, and inept leadership and teamwork that often lead—as in this case—to poor organizational performance. Participant and facility names and various numerical values have been modified to preserve anonymity and accentuate points of learning.

This case challenges students to consider organizational and marketplace realities when pursuing strategic initiatives, including the need for proactive insurance/managed care contracting, sound financial and business modeling, and credible marketing strategies and plans. The material presented in Part III of this text focuses on helping students effectively manage conflict, improve their leadership skills and teamwork, communicate the right messages to the community, and address other important strategic marketing questions.

Specialty Hospital Pros and Cons

Advocates argue that specialty hospitals provide higher-quality care at lower per unit costs by concentrating physician skills and other hospital/medical resources on managing complex diseases (Nallamothu et al. 2007). Critics contend that specialty hospitals focus largely on low-risk patients and shift the financial burden of uncompensated care to competing general hospitals. Opponents further argue that physician ownership of specialty hospitals incentivizes physicians to refer patients to their own facilities, cherry-pick low-risk and well-insured patients, and induce demand for certain services (Al-Amin et al. 2010).

Rationale for Hospital–Physician Joint Ventures

The overarching goal of a hospital–physician joint venture is to create a clinical and economic entity that benefits patients and the physicians and hospital(s) participating in it. Patient/community benefits include improved processes of care, services, and outcomes. Potential benefits for participating physicians include opportunities for increased revenues, more efficient use of time, and greater control over operational matters affecting patient care and physician convenience. Benefits for the participating hospital include the maintenance of profitable revenue streams if physician investors sign covenants not to invest in competing facilities (Cohn et al. 2005).

Palomar Heart Hospital

Palomar Heart Hospital (PHH), a provider of cardiology-related services to patients living in and around the Central Valley of California, opened its doors in 2003. The opening of this $50 million state-of-the-art facility was consistent with the nationwide proliferation of physician-owned and hospital–physician joint-ventured specialty hospitals in the early 2000s (Barro, Huckman, and Kessler 2006). PHH was a 51/49 joint venture between Lincoln Healthcare System (LHS) and Central Valley area cardiologists and cardiothoracic surgeons, respectively.

Russell Taylor joined LHS as executive vice president/chief operating officer (EVP/COO) the same month PHH opened its doors. Russell was the third EVP/COO hired in the past 24 months to lead a systemwide financial turnaround of the ailing vertically and horizontally integrated four-hospital healthcare system.

Notwithstanding the PHH facility's physical attractiveness and first-rate technology, PHH lost between $700,000 and $1.1 million per month during its first six months of operation. Expected monthly losses/gains during this period ranged from –$150,000 to $250,000. Losses at PHH not only far exceeded LHS's worst expectations but also contributed significantly to the continued overall underperformance of LHS. After corporate management's repeated but unsuccessful attempts to persuade Phil Surrowitz, PHH's

founding CEO, to adjust and improve PHH's marketing and staffing plans and better manage overall expenses, the decision was made to replace him. Although Russell's span of control stretched across LHS, he knew that stopping the financial hemorrhage at PHH was his first and highest priority. In consultation with other LHS executives, physicians, and trusted staff, Russell identified the central issues leading to PHH's woeful financial and operating performance:

- PHH's leaders were ineffective and neither willing nor able to make the difficult decisions needed to improve the hospital's marketing and operations.
- Conflict existed among area cardiologists and cardiothoracic surgeons. From the outset, jealousies and hard feelings among several of the seven founding physicians/surgeons (each of whom had a substantive ownership interest in PHH) led certain cardiologists to refuse to refer patients to their fellow PHH heart surgeons and vice versa.
- Teamwork among key PHH and LHS personnel was poor. Notwithstanding its 49 percent physician ownership, PHH was an important member of the LHS family of hospitals and related healthcare facilities. Yet PHH's managers resisted assistance and oversight from LHS's corporate personnel, including finance/accounting, marketing/planning, and insurance contracting specialists who were able and willing to assist.
- PHH had insufficient and inappropriate contracts with health insurance plans. Although PHH's managers had been given more than two years' advance notice to negotiate managed care/insurance contracts to ensure adequate patient volumes, roughly 40 percent of the area population was unable to use PHH's services because their HMO or commercial insurance plan had not yet negotiated terms with PHH.
- PHH's cost structure was suffocating. Because of its first-rate construction, technology, costly furnishings, rich staffing mix, and highly paid staff, the hospital needed to perform 45 invasive surgeries/procedures and 280 outpatient procedures per month and maintain an average daily census of 30 patients just to break even financially. In light of competing hospital-based cardiology programs and long-standing strained relations among PHH physicians and surgeons, Russell wondered if other services, including general, bariatric, and colorectal surgery; endoscopy; and other medical/surgical services should be added to PHH's repertoire to increase patient volume and revenues and offset overhead expenses. The idea of adding non-cardiology services to this premier regional heart hospital was not well received by the cardiologist and cardiac surgeon owners. Board members, employees, and

other LHS managers questioned the wisdom of adjusting the facility's mission and core scope of services so soon after opening, while a growing chorus of dissenters argued otherwise.

- PHH had ineffective marketing plans. Phil Surrowitz enjoyed "good old boy" standing among many of the area's cardiologists, so he did not consider using traditional marketing methods to attract the attention and ultimate business of insurers, primary care physicians, and patients.
- PHH's key managers, physicians, and surgeons had poor financial literacy. Although the CEO and senior financial officer understood the hospital's financial picture, few other managers and employees—including the physician owners—fully appreciated the financial dynamics and nuances.

A summary of select projected and actual financial and operating indicators from PHH's first six months of operation is provided in Exhibit 1.

Next Steps

Russell knew he needed to provide an overview of PHH's performance to date and a compelling plan for improvement at the upcoming meeting of the LHS board. Because various board members still questioned LHS's specialty hospital strategy and the purpose of the PHH joint venture, an overview of the pros and cons of specialty hospitals and hospital–physician joint ventures in general was also in order.

Discussion Questions

1. What are some of the apparent advantages and disadvantages of specialty hospitals from a patient/family perspective? From a physician/hospital perspective? From a community perspective?
2. What are some advantages of participating in hospital–physician joint ventures in terms of a hospital's or health system's overall strategy?
3. What planning and marketing techniques could Russell and his team use to improve the financial and operating performance of PHH?
4. In your judgment, is it too soon to amend the mission, vision, and/or scope of services offered by PHH? Why or why not?
5. What sources of conflict contributed to PHH's poor performance? What leadership and teamwork strategies would you employ to address these conflicts and improve performance?
6. What steps could Russell take to address the interpersonal conflicts with PHH?

EXHIBIT 1
Palomar Heart Hospital: Select Operating and Financial* Data

	Jan		Feb		Mar		Apr		May		Jun		YTD	
	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected	Actual	Projected
Average daily census[1]	12	24	14	28	15	28	16	30	17	30	17	32	15.2	28.6
Invasive surgeries/ procedures[2]	18	30	19	35	19	40	22	45	32	50	31	55	141	255
Outpatient procedures[3]	130	225	139	240	119	265	137	280	167	305	169	330	861	1,645
Medicare percentage (discharges)	66	65	67	65	63	65	65	65	69	65	67	65	66	65
Net revenues[4]	$750	$1,810	$960	$1,991	$1,066	$2,091	$1,242	$2,195	$1,592	$2,327	$1,798	$2,475	$7,408	$12,889
Total expenses[5]	$1,850	$1,960	$2,010	$2,091	$2,016	$2,141	$2,117	$2,195	$2,442	$2,202	$2,523	$2,225	$12,958	$12,814
Net operating income[6]	($1,100)	($150)	($1,050)	($100)	($950)	($50)	($875)	$0	($850)	$125	($725)	$250	($5,550)	$75
Days cash on hand (LHS)[7]	93	95	90	96	86	97	82	98	78	99	75	100	75	100

*In thousands of dollars.

1. Average daily census (ADC) is a measure of inpatient volume. It is a function of both discharges and length of stay. In today's fixed payment systems, increases in ADC ideally should come from increases in discharges rather than from increases in length of stay.
2. Invasive surgeries/procedures include coronary artery bypass surgery, angioplasty, atherectomy, cardiomyoplasty, radiofrequency ablation, stent procedures, and more.
3. Outpatient procedures include treadmill testing, electrocardiography, 24-hour holter monitoring, nuclear cardiology, pacemaker and defibrillator checkups, and more.
4. Net revenues are approximately 37 percent of gross revenues.
5. Total expenses are the sum of all labor and nonlabor expenses, including corporate overhead.
6. Net operating income includes total net revenues less total expenses.
7. Days cash on hand (LHS) measures the number of days LHS could pay for its average daily expenses with the cash and marketable securities it has. It is an important measure of total liquidity.