# CASE STUDY:

# *EAST CHESTNUT REGIONAL HEALTH SYSTEM*

## History

Within the last 10 years, East Chestnut Regional Health System (ECRH) was formed from the merger of three organizations: the East River Medical Center, the Northern Mountain Hospital Consortium, and the Archway Hospital.

### East River Medical Center (ERMC)

ERMC is the anchor hospital for the system. The medical center resides along the east side of the Chestnut River. Historically, ERMC was recognized as the location of choice for medical care. However, this reputation has deteriorated over the last 3 to 5 years. As the city of Chestnut has grown, ERMC has found itself on the edge of an urban blight. Safety has been a concern for patients, visitors, and physicians who use and serve the medical center. The technology offered at the medical center has been maintained at an excellent level of proficiency. At the same time, the medical staff is aging with the average age of the physicians being 57. There are younger primary care physicians who serve the specialists, but the specialists are aging as well. ERMC boasts a Level 1 Trauma Center with an air service. The total number of licensed beds for ERMC is 550. On any given day, the occupancy rate is 300 heads on the beds.

### Northern Mountain Hospital Consortium (NMHC)

NMHC was originally formed in response to the migration of patients to Chestnut. Due to the rather aggressive strategies carried out by the hospitals in Chestnut, these rural hospitals decided to create a consortium of rural hospitals so that they could gain economies of scale in a number of areas, which include group purchasing, benefit administration, and physician and staff recruitment. Additionally, they worked together to stem any further deterioration of their market share. Patients were selecting to go to the larger community for services and leaving the smaller communities that collared the Chestnut metropolitan area. NMHC represented individual hospitals in four counties that circled Chestnut County: Walnut, Butternut, Oak, and Maple. Walnut and Butternut Counties had good employment with Oak and Maple Counties being mostly rural. In each county, the inpatient facilities averaged about 20 years of age. The upkeep of these facilities has been sketchy. No facility needs any major upgrades, but modernization is needed. The state does not have a Certificate of Need (CON) process. The medical staff makeup varies each location. The hospitals in Oak and Maple Counties are critical access hospitals. Further details will be provided regarding these organizations later in the case study.

### Archway Hospital (AH)

AH is located directly in the community of Chestnut. It fully resides in the urban area of the community. The hospital has 200 registered beds, but on any given day there are only 50 to 75 patients in this facility. This hospital was a Doctor of Osteopathy (DO) hospital; therefore, most of the physicians that worked out of this facility were DOs. The payer mix for this hospital was heavily burdened with Medicare and Medicaid. This payer mix composed nearly 85% of the reimbursement. The facility is aging and needs considerable repairs. It is questionable if it will be worth the investment in this facility.

## Leadership and Organizational Culture

The original merger that created the East Chestnut Regional Health System (ECRH) occurred 10 years ago. This merger was between ERMC and AH. AH had a rather dynamic leader who was about 57 years old at the time of the merger. The AH CEO became the new President and Chief Executive Officer of ECRH after the merger. Since this CEO had only worked in a smaller organization, he had not experienced the cultural changes and demands that occur after the merging of a large organization. Additionally, he began to change the culture of the organization such that decisions were made on a decentralized basis. He trusted the management team at AH to do the right things and make the right decisions with low supervision. However, the Chief Operating Officer (COO) who was put in charge was originally from AH but left 2 years after the merger with a new COO being put in place. This COO developed a rather poor reputation and was known to want to build his own empire at AH and to be dishonest at times. This reputation created a culture within the traditional AH that lacked a cohesive team effort to create a system. This positioning of the COO was left unattended by the President and CEO of ECRH since he was actively pursuing the acquisition of NMHC. The hospitals of NMHC were doing okay, but those in the consortium realized that their ability to stand alone was becoming difficult in today’s market. When the leadership of the consortium assessed the market as to a partnership, they decided that ECRH would be the best choice. The other option was to develop a for-profit hospital that also resided in Chestnut. The leadership was attracted to what they saw happen with AH. They liked that the central leadership of the system allowed AH to continue on as their own entity without a lot of centralized control.

By the time all of this was put together, the President and CEO of ECRH was near retirement. He retired about three years after all of the merger activity was complete. During those three years, he became lax in his leadership role. ECRH deteriorated in market share and profitability during this time. Upon his retirement, the Board of ECRH performed a national search for a replacement. They employed Hunter Brown as the new President and CEO. Mr. Brown was the CEO of a smaller health system and had been in that position for nearly 10 years. Therefore, he had limited experience from other markets in the art of strategic implementation. However, he was also well trained, bright, and articulate in expressing his knowledge. He has now been the President/CEO of ECRH for nine months.

As for the remainder of the leadership team for ECRH, there is a newly hired corporate counsel. She has 15 years of experience and is extremely competent in the work that she does.

The CEO also hired a new Chief Financial Officer. He has taken good strides in managing the accounts receivable throughout the system as well as extracting exceptional dollars from high quality supply chain management.

The Chief Operating Officer (COO) is new and has three years of previous experience from the same organization where the CEO departed.

The Chief Medical Officer (CMO) has been retained from the old leadership team. His reputation is excellent, and he works well with other physicians, including the medical staff and the employed physicians.

The Chief Nursing Officer (CNO) is three years away from retirement. She is known for not getting along with the medical staff and will always defend nursing when at times this is not appropriate.

The Senior Vice President for Human Resources is competent and respected by management and staff throughout the organization.

The remainder of the leadership team was retained from the old regime. This included information technology, employed physician group leadership, marketing, human resources, and other vice presidents or directors responsible for varying service lines. It should be noted that the IT leadership is just completing the implementation of the EPIC system. The future for this team depends on how well the overall implementation of the system goes. Likewise those in the marketing department will need to be stellar in senior leadership advisement regarding the marketing of complex issues that will be encountered ahead. They have been told if marketing misses the target, then replacements will occur within this department.

The new CEO inherited the management team of AH and NMHC. For NMHC the organizational structure was left intact with the COOs for each of the individual hospitals being retained. It was agreed that this traditional structure would be left intact for at least five years. This agreement was near its end and the new CEO had plans to change the existing structure as well as management. This change was being considered for this year’s strategic plan development. Even if the structure of NMHC was going to be changed to a more direct relationship with corporate leadership, all of the existing COO’s would be retained as they have performed well since the merger. As for the COO of AH, he had been recently terminated. An interim COO is now in place pending the board approved closure of this hospital.

## Competitive Assessment

ECRH was not the only provider of care in the community. There was a for-profit hospital, Banford Medical Center (BMC), that had been purchased by a large publicly traded for-profit health system about 10 years ago. The for-profit health system was the largest in the country. The CEO of this hospital was good at optimizing performance as a result of the weaknesses of ECRH and its leadership. He was an effective opportunist.

BMC has 400 registered beds with a current occupancy rate of 85%. They have been effective at taking market share away from ECRH. For each loss of service line market share by ECRH, BMC has shown proportional gains. After the acquisition of BMC, the for-profit immediately moved to build a new facility. This new facility is located on the growing wealthy edge of the community. Additionally, at the time that this new facility was developed, the for-profit syndicated ownership to the physicians. The highest level of syndication occurred with the obstetrics and gynecology physicians in the community. Therefore, women’s services deteriorated at ECRH. It should be noted that this physician syndication occurred before the Affordable Care Act was passed, which precluded hospital ownership by physicians.

It is important that additional information is provided regarding ECRH. ECRH recently purchased 100 acres of land across the interstate from BMC. This land is located northwest of Chester. The intention is to eventually build a new medical center on this location. The initial planning of this land has occurred and it has been approved to build a regional oncology center on this site. The construction of the project is already underway with an anticipated completion in 6 months.

In addition, ECRH has an orthopedic hospital attached to the current ERMC site and a behavioral health hospital at this same location. ECRH also has two ambulatory surgical centers that are conveniently located on the growing northwest and southwest side in the community. The one surgical center is located on the 100 acre development site. The orthopedic hospital has done well and has been listed in the top 100 orthopedic hospitals. However, the behavioral health hospital is losing significant dollars, so the Board of Directors for ECRH has decided to close down this hospital. ECRH has also developed a joint venture imaging center with the radiologists. This center resides across from a major shopping area in the community. It is conveniently located near heavily populated neighborhoods and shopping. The only downside is the location is not close to physician offices that would refer to this center. However, if a new facility is built on the 100 acres, which would include physician offices, the imaging center will be in an ideal location. Leadership is developing a free standing emergency center on the 100 acre site, which is on the northwest side of Chestnut.

The last competitive issue is the location of a medical school and hospital in the city of Chestnut. The facility resides in a downtown location. This medical school had been established by the state nearly 45 years ago and is associated with Greenbranch University. It mostly serves the indigent community in Chestnut and the surrounding area. This academic center has a rather negative reputation in the surrounding area. There are four other medical academic centers in the state as well as a medical center with a world renowned reputation. There have been ongoing rumors that this world renowned organization was planning on assuming the responsibility of the Chestnut academic center. This change would substantially alter the complexion of the local medical community if it were to occur. Speed in ECRH dealing with some of its market issues is an imperative.

## Additional Market Information: Population Demographics

### Chestnut County

* With 433,689 people, Chestnut County is the 6th most populated county in the state.
* The largest Chestnut County racial/ethnic groups are Caucasian (70.1%), African American (18.5%), and Hispanic (6.5%).
* In 2015, the median household income of Chestnut County residents was $41,777. However, 21.1% of Chestnut County residents live in poverty.
* The median age for Chestnut County residents is 37.7 years old.
* Employment is strong in Chestnut County. Unemployment resides at 4.5%. Employer diversity is strong since the community is not dependent on singular large employers. Employment includes some high-tech jobs, general manufacturing to support the automobile industry, and there is a large university, Greenbranch University, located in the community. The university has 25,000 students and offers most majors, which includes engineering and nursing.

### Walnut County

* With 42,537 people, Walnut County is the 57th most populated county in the state.
* The largest Walnut County racial/ethnic groups are Caucasian (89.8%), followed by Hispanic (7.2%) and African American (3%).
* In 2015, the median household income of Walnut County residents was $55,120. However, 10.8% of Walnut County residents live in poverty.
* The median age for Walnut County residents is 39.8 years old.

### Butternut County

* With 38,352 people, Butternut County is the 65th most populated county in the state.
* The largest Butternut County racial/ethnic groups are White (87.0%), Hispanic (9.5%), and African American (1.7%).
* In 2015, the median household income of Butternut County residents was $50,663. However, 13.4% of Butternut County residents live in poverty.
* The median age for Butternut County residents is 39.7 years old.

### Oak County

* With 37,120 people, Oak County is the 66th most populated county in the state.
* The largest Oak County racial/ethnic groups are Caucasian (93.3%), Hispanic (4.0%), and African American (1.1%).
* In 2015, the median household income of Oak County residents was $42,492. However, 14.9% of Oak County residents live in poverty.
* The median age for Oak County residents is 46.6 years old.

### Maple County

* With 27,816 people, Maple County is the 79th most populated county in the state.
* The largest Maple County racial/ethnic groups are Caucasian (90.8%), Hispanic (7.1%), and African American (1.0%).
* In 2015, the median household income of Maple County residents was $39,353. However, 15.4% of Maple County residents live in poverty.
* The median age for Maple County residents is 48.2 years old.
* Both Oak and Maple Counties are rural with an older population. Many patients have Medicare and Medicaid that come from these two counties. Likewise the hospitals located in each of these counties have been designated as critical access. Like many rural counties, Oak and Maple have been blighted with younger people using drugs, including methamphetamine.

## Employed Physicians

ECRH employs 400 physicians throughout its system. The breakdown for each location is as follows:

### Chestnut County

* 135 primary care
* 100 specialists

### Walnut County

* 40 primary care
* 10 specialists

### Butternut County

* 30 primary care
* 12 specialists

### Oak County

* 27 primary care
* 10 specialists

### Maple County

* 25 primary care
* 11 specialists

There have been ongoing complaints from the newly recruited physicians that their practices have not been marketed well; thus, their patient volumes have been slow to grow.

## Service Line Performance Information

The following is a list of bullet points regarding service line performance by ECRH and issues of operational concern.

1. Women’s health services deteriorated significantly since the syndication by Banford Medical Center. Obstetrical deliveries are down 20% across the system. BMC has done an excellent job of creating attractive facility and services for women. This includes nurse navigation, women’s breast center, and a series of other amenities. BMC has also started a neonatal intensive care unit, which rivals the services of ECRH.
2. The cardiologists at ECRH are aging. This has been a traditionally strong service for ECRH, but 50% of the cardiologists will be retiring within the next 3 to 5 years. All cardiologists who serve ERCH are employed by the health system. Cardiology is a service that is gaining strength within the Greenbranch Medical Center, particularly since they brought in a renowned cardiologist to rebuild their program.
3. The orthopedic volumes are down 7%. ECRH does jointly operate an orthopedic hospital with an independent orthopedic group located in the community. There have been some internal problems within the orthopedic group where the old guard of orthopedic surgeons has forced a low retention with younger, and to some degree better trained, surgeons. Retention is becoming a growing concern regarding the status of this group with consideration of ECRH hiring their own surgeons. The joint venture hospital does not exclude other surgeons from working in this hospital.
4. Emergency department (ED) volumes are down 5%. The hospital uses an emergency physician group to supply physicians to cover all of the EDs within ERCH. These physicians are known for poor customer service and making rude comments to patients who are self-pay or Medicaid.
5. The ambulatory visits and services are up 3%. This volume increase is from the younger primary care physicians who have been employed by ECRH. This young group of physicians has become great support for ECRH and refer patients loyally to the organization.
6. General surgery cases are down 4%. The aging surgeons are starting to retire and it is difficult to recruit new surgeons to replace past demand. Some of this work is going to Greenbranch since they have good general surgeons.
7. The oncology services for ECRH have increased in volume and revenue by 4%. ECRH’s development of the new oncology center has created a magnet for referrals to the oncologists. The oncologists are very enthusiastic about the development of this new center and have begun to shift work to ECRH.
8. ECRH has the regional burn center. ECRH works with Greenbranch Medical Center for training residence in the burn setting. This includes the plastic and general surgeons. The downside of this service is that it is losing money. A decision has been made to close down this service with Greenbranch starting their burn center.
9. ECRH is a Level 1 Trauma Center, and this designation has been a historical positive for the system. The helicopter service is well recognized by the community as well as first responder professionals found in the region. They historically have been top of mind for major trauma cases. The usage of this service is down 5% since the for-profit has established a similar service. BMC however only has a Level 2 Trauma Center. They have worked diligently to acquire ambulance services in some of the outlying communities. This has helped feed patients to BMC.
10. The ECRH Board of Directors decided to close down the behavioral health hospital. It is uncertain where patients will be able to receive inpatient care. An active out-patient service will still be provided by ECRH.

## Payer Mix

The payer mix for ECRH has deteriorated. The current inpatient payer mix for the entire system is as follows:

* 55% Medicare
* 15% Medicaid
* 30% Commercial

There has been a long standing joint venture relationship with a national insurance company for commercial insurance. Administratively this venture has not developed as anticipated; however, in some of the regional markets, the Chestnut Care insurance has a strong presence. Of the 30% commercial pay, 20% is Chestnut Care based. The national insurance company in the venture is Aetna. The next strongest product is Anthem. It is the expectation of the CEO that Chestnut Care be leveraged and positioned for growth.

The 15% Medicaid has helped the hospital gain additional disproportionate share dollars, which does help the bottom line of the hospital.

## Historical Strategic Initiatives

### Accountable Care Organization

When the Affordable Care Act was passed in 2010, ECRH decided to get into the one-sided model of an accountable care organization (ACO). This venture has not gone well, and ECRH has decided to leave the ACO business. However, they are concerned about the public image of this decision. The details of the termination are under discussion with a need to determine how to minimize the public perception of termination, particularly since there was so much marketing of their getting in this venture. The regulatory requirements of the government regarding the timing of terminating an ACO venture further complicate this decision.

### Primary Care Medical Home

The employed primary care group has been active in establishing accredited primary care medical homes within all of the primary care offices throughout the ECRH system. This initiative is a positive emerging strategy for ECRH. It has also been an attractive draw for the family practitioners from Greenbranch Medical Center residency program since Greenbranch has established an accredited medical home for their family practice residency program.

### American Nursing Credential Center Status (ANCC)

ECRH has been working on becoming a magnet status for ERMC. This work has stalled out as an initiative. Some of this is due to the nursing leadership within ERMC. The CEO intends to move this priority up in the organization’s goals.

## Information Technology

ECRH has invested heavily in their information technology infrastructure. This investment became a requirement just to be able to gather the data needed for the ACO development. This cost has become significantly greater than anticipated. ECRH fully implemented EPIC as their core information technology system. There have been implementation problems since the ECRH was operating off of multiple systems before the decision to consolidate to one platform. The implementation of EPIC required considerable retraining for the staff and physicians. Data conversions have gone well. The difficulties have been more human-related relative to the effective use of the system. One of the major issues has been the lack of ECRH not meeting meaningful use requirements which has cost ECRH significant lost revenue from not meeting these goals.

## Legal Actions Pending for ECRH

### Federal Trade Commission Investigation

With the merger and acquisition of NMHC, questions of antitrust have been raised. In the service lines of cardiology and oncology it has been found that ECRH controls 60% of the cardiology market and 52% of the oncology market. Chestnut Care in some markets has been strong in steering patient volumes to ERMC. Union leaders for the varying trades were instrumental in precipitating this investigation. At the time that this issue was raised, the President and Executive Branch of the federal government were very pro-labor, thus, their interest in pursuing this matter.

As to the projected disposition of this case, it is anticipated that a negative determination will be made due to the market share control in oncology and cardiology. This could force ECRH to divest their ownership in the Chestnut Care insurance venture. Another option might be that certain hospitals of NMHC be divested. It is not anticipated that both determinations would occur. This case has cost ECRH considerable money to stave off investigation of this allegation.

### Predatory Collections and the Loss of Not-for-profit Tax Status for NMHC

NMHC negotiated that they would continue to act independently. The consortium leadership set policies that included predatory collections for the patients that would be served in the NMHC hospitals. In a recent evening news report, an investigative reporter interviewed an elderly patient that had her home taken from her to pay for her medical bills. This home had been in her family for over 100 years. This story prompted the state’s Attorney General’s Office to investigate the predatory collection policies of ECRH and NMHC.

The state has already taken an aggressive stance to investigate the status of not-for-profits not fulfilling requirements (e.g., charity care, research, and education). The state is in economic trouble and is seeking revenue from wherever they can find it. The outlook is dim regarding the anticipated final decision of the Attorney General’s Office. If NMHC is required to pay taxes, this would wipe out the bottom line for these hospitals and many of the needed services supplied to the indigent population by ECRH would be reduced or eliminated.

## Faith & Main Consultants Report

Within the last year, ECRH contracted with Faith & Main to study the market perception of their women’s services. The following is a summation of the findings of Faith & Main.

### Interest in a Women’s Center Crosses County Lines

* 36% of women in the service area would travel across county lines to receive excellent women’s health services
* 72% of women in Chestnut County would consider using the women’s services of East Chestnut Regional Medical Center
* Women in all counties were most interested in these services:
  + Breast care
  + General gynecology services
  + Female doctors
  + Services in one area
  + Physicals for women

### Interest in a Heart Care and a Health Information Line

* A physician approved source of information
* A nurse help line that could be a resource for women’s care in heart health as well be a source for health navigation.

### Clear Expectations Regarding Getting Appointments with Their Primary Care Physician

* Women expect same-day appointments
  + In the collar counties to Chestnut County, women ranked this in the top 28.7%
  + Chestnut County women ranked this in the top 37.7%
  + Expectation of same-day appointments ranked highest for women of childbearing age
* Percent expecting same-day appointments
  + 42.9 % of Chestnut County women of childbearing age
  + 31.3% of collar county women of childbearing age
* Willingness to be Seen by a Nurse Practitioner Overwhelmingly “Yes”
  + 75.7% of Chestnut County women of childbearing age
  + 76.1% of collar county women of childbearing age

### Respondents Expressed How Health Care Could Be Improved

* 24% of all Chestnut County women, and 26% of all collar county women named adding more primary care doctors and more children’s care with urgent care outranking any other single topic.

### Respondents of Childbearing Age Widely Represented in Study:

* 86% of women respondents of childbearing age in Chestnut County had children under the age of 18
* 76% of women respondents of childbearing age in the collar counties had children under the age of 18

### Willingness to be seen by nurse practitioner was viewed as favorable by those in this study.

### This data from Faith & Main will be used to ramp up improvements in the women’s services for ECRH.

## Strategic Plan Goals for the Upcoming Year

* Women’s service line improvement
  + Increase obstetrical deliveries by 20% over 3 years
  + Establish nurse navigation system for the entire system
  + Facility improvement and development for women’s services
  + Improve access standards for women’s care
    - Assist in the marketing of the implementation of the consultant’s report regarding women’s services
* Oncology Center grand opening
* Mature the retail strategy with the primary care employed physician group
* Assess the market impact of the lawsuits and develop marketing strategy to counteract the negative impact if decisions are made against ECRH
* Aggressively recruit new physicians to reduce the average age of the medical staff and strategically enhance service line development
* Use lean management processes to correct service issues found in the ED. Improve ED visits by 6%.
  + Review physician contracts to enhance physician service performance
  + Investigate the fast track ED concept
  + Implement the free standing ED strategy
* Abandon the Accountable Care Organization (ACO)
* Re-establish relationships with regional emergency medical services to raise the utilization of the medical air service. Growth goal is to get back to the previous level of utilization within 18 months
* Decision to close the regional burn unit and let those cases go to the academic medical center
* Implement the decision to close the behavioral health services of ECRH
* Implement the decision to close AH

## CEO Instruction to Marketing Team

The marketing department for East Chestnut Regional Health System will be asked to step up their game to develop a marketing plan for the regional health system. The CEO has had some concerns regarding the ability of the marketing department to keep up with the rapidly moving strategic environment that he has created. So he established a time line for the department to develop a system wide marketing plan over the next six weeks. The VP of marketing has been in all of the senior leadership cabinet meetings so she is aware of all of the details. Therefore, the learning curve regarding the institutional strategic goals is of no concern.

The following are elements that the CEO wants in the marketing plan.

1. A consultant, Faith & Main, was used to test the impression of the women in the key service markets for East Chestnut Health System. The summary of the consultant’s report can be seen above. The survey covered all aspects of women’s care. The marketing department will need to develop a marketing campaign to match the recommendations of the consultant’s report.
   1. It is recognized that the age span for communicating with women consumers will be quite variable. On one end of the spectrum you have the younger child bearing age women, next are the women that are middle aged followed by women that are pre-elederly then those that are elderly. Therefore, a communication plan using social media to conventional marketing techniques will be required.
2. A communication plan will need to be developed for the closure of the regional burn center as well the exiting the accountable care organization and the closure of the behavioral health hospital.
3. A communication plan will be needed to deal with the closure of AH.
4. A branding strategy will need to be developed to overcome the current weak brand identity that is in place for the combined ECRH entities.
5. Develop marketing strategy for new physicians being recruited to the system. The ideal situation would be to have a common identity for all marketing material. In the past the marketing material has been local hospital based.
6. Develop marketing plan for the Primary Care Medical Home strategy as well the retail strategy for the primary care network.
7. Proactively lay out a framework of communication to manage any negative outcomes of the legal matters that the health system is now confronting.
   1. The Federal Trade Commission investigation of the anti-trust issues for ECRH.
   2. The predatory collections occurred as part of NMHC. It is felt that this case will force these rural hospitals to move to a taxable entity with the loss of their not-for-profit status. The development of this problem came as a result of poor leadership within the consortium.
8. Develop advertising campaign for the opening of the new oncology center.
9. Develop advertising campaign for the ED/Trauma services of ECRH.