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SPECIAL SECTION

TOTAL TRANSFORMATION FOR THE FUTURE

How the ASC Health System Crafted Strategic Partnerships To Better Position Its Facilities

BY GREGORY F. YANK

The ASC Health System, O'Fallon, IL, recently "transitioned" its three hospitals and one nursing home to better position them in a rapidly changing, increasingly competitive healthcare delivery environment. Each facility entered customized strategic partnership arrangements with other Catholic and non-Catholic regionally integrated delivery networks or systems. One hospital was sold; one was placed in a long-term collaborative arrangement; and two facilities will be affiliated with a larger Catholic system. With the facilities receiving services and oversight from their selected partners, the ASC corporate office was downsized and significantly reduced to focus on three areas: the new relationships, the development of new healthcare initiatives for the underserved and underinsured, and the development of funding for new services.

A Vision of Change

The Adorers of the Blood of Christ (ASC), Ruma (IL) Province, sponsored three hospitals and one nursing home in central and southern Illinois: St. Vincent Memorial Hospital (179 beds) in Taylorville, St. Joseph Memorial Hospital (61 beds) in Murphysboro, and St. Clement Hospital (105 beds) and MariaCare Nursing Home (115 beds) in Red Bud.

In 1988, after a thorough assessment, the congregation determined to strengthen its health ministry and not cosponsor or affiliate with another Catholic system, an option they had considered. The system's 1993-95 strategic plan addressed system development: "System size and composition might be altered when consistent with Mission. Corporate services will focus upon strengthening facilities and healthcare delivery in our service areas." It was clear at that time that the ASC Health System in the future had to move in one of two different directions: system growth and expansion or affiliation in some arrangement(s) with larger regional health systems.

System Assessment To address this strategic issue, the system undertook an assessment in early 1993, with the consulting assistance of Accord Limited, Chicago. The system assessment objectives included (1) assessing the effectiveness of meeting the system's founding goals, (2) evaluating the strength of current corporate office services and programs, including identifying the need for new ones, (3) evaluating the system's ability to adapt to national and local healthcare delivery system changes, and (4) developing recommendations for future options.

This assessment process sought input from multiple constituencies—sponsors, board members, medical staff, and senior management. Their participation was critical in decision making and building support for any final decision, given the transformational rather than incremental change the system was considering. Key milestones in the assessment process occurred fairly rapidly:

- Between February and April 1993 the process was completed. It involved face-to-face individual and group interaction with the consultant and key stakeholders (sponsors, boards, physicians).
- In June 1993 the consultant presented the findings and recommendations at a "leadership summit" for facility and system boards, medical

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staff, executive managers, and sponsors.

• From June to September 1993 the system held meetings to consider options with stakeholder groups: system board and corporate members, sisters working in those facilities, local boards, corporate staff and corporate members, facility chief executive officers (CEOs), board chairpersons, physicians at each facility, and the ASC members of the Ruma Province.

Resulting Recommendations This extensive process generated the system board's recommendation, accepted by the corporate members in September 1993, that the ASC health ministry craft strategic partnerships for each facility with other organizations that shared compatible values. The recommendation called for the congregation to be flexible in the nature of their sponsorship and control.

Transition Process

Each facility's arrangement was customized and different to continue meeting the needs of people in its service area while securing the strongest possible future.

St. Joseph Memorial Hospital After several months of analysis and discussion, it was decided that St. Joseph Memorial Hospital should be sold and integrated into Southern Illinois Hospital Services (SIHS), a non-Catholic, not-for-profit, two-hospital system with facilities in Carbondale and Herrin. This transaction, completed in January 1995, included the following key features:

• St. Joseph retained its Catholic identity. There is a separate, signed agreement between SIHS and the local bishop of the Belleville diocese. SISH's president, St. Joseph's CEO, the bishop, and the religious community meet quarterly to review and discuss issues and monitor the ongoing relationship.

• A member of the congregation serves on SIHS's executive management team and leads a systemwide program of mission, values, and ethics. Another ASC sister is corporate director of pastoral care throughout the system.

• Qualified ASC sisters are considered for opportunities within SIHS.

• Two ASC sisters, the president of St. Joseph's medical staff, and the hospital's former board chairperson serve on an 18-person SIHS board.

• St. Joseph contributes a percentage of net income to the ASC ZerrCare Fund for the Underserved for two years after the acquisition date.

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In this relationship, St. Joseph is now financially stronger and contributes to a geographically compatible regional system. The congregation has given up control, but its influence remains strong.

St. Vincent Memorial Hospital St. Vincent Memorial Hospital is in a collaborative affiliation with Memorial Health System (MHS), an emerging non-Catholic integrated delivery system in Springfield, IL. In this shared governance model the ASC sisters and MHS serve as comembers of the St. Vincent Memorial Hospital Corporation. MHS has operational and financial control and responsibility, and the ASC sisters retain key reserved powers. The congregation continues to sponsor the hospital, which remains Catholic. The MHS board replaced the ASC Health System board and St. Vincent receives corporate support from MHS. St. Vincent pays annual stewardship fees to the ASC congregation. MHS

Continued on page 54

KEY LESSONS LEARNED

The ASC Health System's experience revealed the following guidelines for any system attempting a proactive response to change in the health-care delivery system:

• The sponsors' vision and clarity is important, but it will likely evolve during the change process, given the sensitivity of the issues. Moving from a control to an influence mentality is essential, but not an easy transition.

• Not everyone will be happy with all the decisions.

• Keep diocesan bishops fully informed during the process.

• At every stage involve multiple constituencies. Make the process as open as possible, and build in feedback to key groups along the way.

• Decide your future before a crisis and while the facilities are in a solid financial position.

• Do not get locked into one model; stay loose and flexible.

• Recognize that you need others to be partners with you. Neither overestimate nor underestimate your value to others.

• Be clear on who will make final decisions, particularly when various boards are involved.

• It is incumbent on corporate staff to keep the process moving. Stakeholders may tend to move slowly because of the sensitive issues involved. Executive leadership needs to have the vision to move forward while acknowledging the grieving process that change always brings.

• System board and sponsors must recognize and be sensitive to the effects of changes on the corporate staff and address issues of financial incentives or severance arrangements for staff who likely will lose their jobs.

TRANSFORMATION

Continued from page 37

> The congregation continues to sponsor the hospital.

has also agreed to guarantee St. Vincent's debt.

The congregation selected MHS largely because the multispecialty group practice in Taylorville (13 of 16 physicians) had also aligned with MHS. Now both the hospital and this physician group come under the MHS umbrella. The improved planning and strategic integration of the hospital and physician clinic will better serve the community's healthcare needs.

St. Clement Hospital and MariaCare Nursing Home Currently discussions are under way with a Catholic system in St. Louis about some arrangement with these two facilities.

Successful Transition

These arrangements have achieved the following goals:

- Successful transition of the ASC healthcare facilities into stronger, regionally based systems that share compatible values and provide a better long-term future for each facility and for the quality of healthcare in their service areas
- Retention of the ASC congregation's canonical sponsorship of three facilities, while the operational and fiscal responsibility, as well as significant control, is transferred to other regional healthcare systems □

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PHYSICIAN RECRUITMENT

Continued from page 53

- Negotiated at arm's length
- Approved by the hospital governing board or its designees
- Limited so that all incentives provided are described in the agreement (i.e., no "off-agreement" incentives provided)
- Supported by documented community need and community benefit, with a higher degree of community benefit required for crosstown recruitment

To help ensure compliance with IRS standards, tax-exempt hospitals should have clearly established and enforced policies and procedures for board approval (or appropriate delegation) of all recruitment agreements and programs.

The ruling illustrates that documentation of community need/benefit and of the reasonableness of incentives is critical to any recruitment program. Examples of such documentation are[5]:

- Designation as a health professional shortage area
- Community needs assessment by the hospital
- Steps to ensure access and high quality or reduce costs in existing programs

The proposed ruling would also permit reliance on regional or national salary surveys as one means to support the reasonableness of net income guarantee levels. Nevertheless, salary surveys not specifically tailored to the particular physician and community may be insufficient in some circumstances, such as outliers at the high end of a range or with significant fringe benefits. More specific salary surveys involving competitors, however, may raise antitrust issues. For outliers it may be appropriate to retain an independent compensation consultant or at least document the physician's exceptional qualifications.

Protection of Tax-Exempt Status

Assuming a hospital complies with other legal requirements such as the fraud and abuse laws, it must answer two key tax-exempt status questions for its recruitment or retention package:

- Will the incentives result in a disguised distribution of profits from the operation of the organization?
- Is the total incentive package reasonable under all the facts and circumstances, both in absolute total value for the physician(s) recruited and in relation to services required by the hospital and the community?

Although the proposed ruling does not discuss retention incentives, the IRS has solicited comments on them. In the meantime, such incentives should be structured to comply with the recruitment guidelines, perhaps with additional support by a demonstrated community need or benefit. Finally, even if an incentive meets IRS standards, restrictions under the Stark Law and fraud and abuse laws must be considered. Arrangements that may be more of a concern under those laws include retention agreements, crosstown recruitment, and recruitment to urban areas. □

For more information, call Gerald M. Griffith at 313-256-7630.

NOTES

1. Announcement 95-25, 1995-14 Internal Revenue Bulletin 10.
2. Gerald M. Griffith, *A+ Monograph Series*, "Physician Recruitment and Retention: Reconciling Legal Tensions between Tax Law and Fraud and Abuse," National Health Lawyers Association, Washington, DC, 1995.
3. Griffith, *A+ Monograph Series*.
4. See, for example, General Counsel *Memorandum 39862, November 21*, 1991.
5. For discussions of community benefit and community need, see Gerald M. Griffith, "Community Benefits of PHO and MSO Participation," *Journal of Health and Hospital Law*, May-June 1995, p. 129; Griffith, *A+ Monograph Series*, pp. 46-47.