Kurt Salmon

INSIGHTS FOR 200-BED COMMUNITY HOSPITALS

# The New Community Hospital Imperative

*Creating Competitive Advantage to Survive a Changing Market*

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# Executive Summary

Created based on Kurt Salmon's expertise in strategic planning, "The New Community Hospital Imperative: Creating Competitive Advantage to Survive a Changing Market" explores the competitive landscape of today's 200-bed community hospitals. We have distilled our observations of hospital strategy and present a framework to identify the critical factors for hospital success in a changing healthcare market.

Numerous environmental factors constrained the performance of hospitals across the U.S. healthcare system in recent years, and executives of smaller community hospitals now question the long-term viability of standalone community acute-care providers.

This paper explores the question of whether or not the 200-bed independent community hospital is viable over the long term. In response to the question, we provide the following insights:

- Competitive levers. Independent community hospitals can leverage the six key competitive factors that drive market position: effective geographic barriers, favorable payor mix, strong physician alignment, significant high-quality asset base, low-cost structure and high-quality care.
- Strategic framework. Our strategic framework helps hospital leaders evaluate and drive opportunities to improve their competitiveness in the market by focusing on those factors that they can control and that will create a barrier to competitive entry.
- Physician alignment. We believe strong physician alignment is the most impactful competitive advantage available to most hospitals, potentially mitigating geographic and payor mix disadvantages, while helping to support quality and cost-structure initiatives.
- Competitive strategy in action. Competitive strategy in action. We present three case studies to highlight the competitive factors that community hospital leaders have leveraged to the benefit of each organization's market position.

Additionally, the appendices include a high-level comparison of 200-bed hospitals along the dimensions of scope of services, volume and capacity, identifying potential opportunities for competitive differentiation.

# Creating Competitive Advantage

To remain financially viable, a freestanding 200-bed hospital must secure and maintain a sustainable competitive advantage within its service area. Based on Kurt Salmon's consulting experience, the following six competitive factors are strongly correlated with the ability of small, independent hospitals to achieve long-term financial success:

> Effective geographic barriers

> Favorable payor mix

> Strong physician alignment

> Significant high-quality asset base

> Low-cost structure

> High-quality care

The most successful hospitals achieve competitive advantage by exploiting at least one, if not more, of these six factors. The most desirable positioning is to compete on factors that are both within the organization's ability to control and that create effective barriers to entry against competitors.

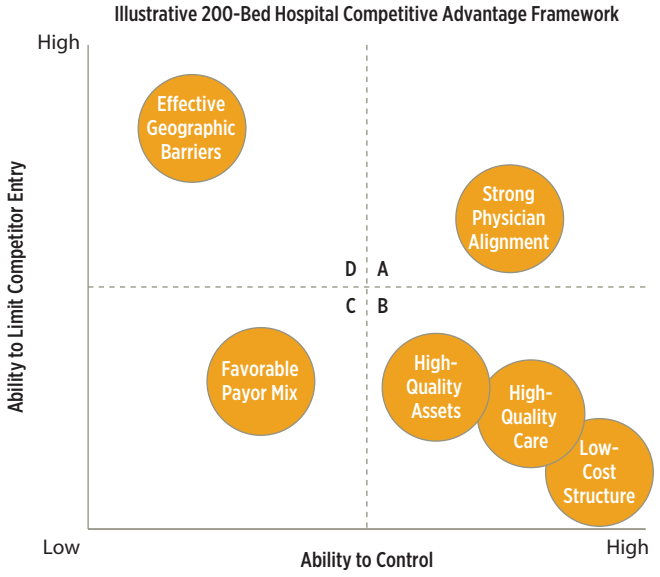
## Strategic Framework

This following framework illustrates the areas where hospital executives can exercise control and influence over a variety of strategic and operational factors. To obtain a superior market position, hospitals must achieve a competitive advantage on one or more competitive factors. The ability to exert control over the factors or use the factors as a barrier to competitor entry, however, varies widely.

Not all competitive factors are created equal. While some factors are difficult to control and don't deter competitors (e.g., payor mix), others can be leveraged to significantly enhance or transform a hospital's strategic position for the better (e.g., physician alignment).

Kurt Salmon has organized the six competitive factors into quadrants (as shown in Exhibit 1). The following sections describe each quadrant by order of its strategic influence on a hospital's competitive position.

**Exhibit 1:** Successful Positioning Focuses on Factors That a Hospital Can Control and That Deter Competitors




## Quadrant A: High Competitive Barrier With High Ability To Control

Competitive factors associated with high barriers to entry that are within a hospital's control describe Quadrant A. Strong alignment with physicians is the primary competitive advantage in this quadrant and can allow a hospital to overcome strategic deficits in geography and/or payor mix (Quadrants C and D).

By ensuring a future stream of patient admissions, a well-aligned medical staff creates a significant competitive advantage for standalone hospitals. Strong alignment between a hospital and its medical staff can serve as an effective barrier against a competitor, who may be seeking to poach financially attractive patients. Recently passed healthcare reform legislation increases the potential value of close physician-hospital alignment, as it will better position hospitals to demonstrate quality and value, with a direct impact on reimbursement. Two hundred–bed hospitals must make securing the primary care base a priority. Hospitals in Quadrant A are well-positioned to pursue competitive factors in Quadrants B, C and D.

*A favorable payor mix does not provide a barrier to competitive entry, and may, in fact, provide an incentive for entry for hospitals seeking better-insured patients.*

## Quadrant B:

### Low Competitive Barrier With High Ability To Control

Competitive factors that do not create a barrier to entry yet are fully within the control of the hospital describe Quadrant B. The factors associated with this quadrant relate to the hospital cost structure, clinical quality and the capital asset base—internal, operationally focused initiatives that are central to the viability of the hospital enterprise. These are factors that all hospitals must continuously work to improve.

Quadrants A, C and D describe strategic factors that are focused on improving a hospital's position in the external environment. However, operational and management performance factors in Quadrant B can hurt, or enhance, a hospital's strategic position. An example of strong performance in Quadrant B is the ability to be profitable on Medicare. Many hospitals do not make money on Medicare because they shift costs to better-insured patients. However, when cost shifting is not an option due to unfavorable payor mix, a hospital must then make money on its Medicare patients to survive. Two hundred–bed hospitals will be challenged to compete on factors in Quadrant B with larger competitors that can achieve greater economies of scale. Hospitals in Quadrant B will be well-served to focus on creating strategic competitive advantages in Quadrants A, C and D.

## Quadrant C:

### Low Competitive Barrier With Low Ability To Control

Competitive factors that do not create a barrier to entry and are difficult for a hospital to control describe Quadrant C.

A favorable payor mix is the primary competitive advantage for this quadrant. A favorable payor mix drives increased profitability and excess cash flow. This, in turn, provides the possibility of reinvestment in clinical programs and facilities, enhancing a hospital's competitive position.

A favorable payor mix does not provide a barrier to competitive entry, and may, in fact, provide an incentive for entry for hospitals seeking better-insured patients. While hospital leaders can design strategies to attract commercially insured patients, the underlying socioeconomic status of the hospital's geographic area largely determines its payor mix. Some large hospitals and systems are able to redirect patients by payor class; however, 200-bed hospitals lack sufficient scale and will be challenged to use contracting as a vehicle to change their payor mix. Hospitals in Quadrant C must implement strategies to defend their well-insured-patient base.

## Quadrant D:

### High Competitive Barrier With Low Ability To Control

Competitive factors that exhibit high barriers to entry with limited ability to control describe Quadrant D. Geography is the most relevant competitive advantage in this quadrant. Barriers limiting patient migration can include natural bodies of water and dispersed populations with limited road access. Geographic barriers make it difficult for patients to migrate and switch organizations and lead to dominant market positions for those hospitals that reap these geographic benefits. In extreme cases, geography prohibits competitor entry, making that hospital the area's sole provider, which enables increased reimbursement rates. Hospitals have minimal ability to change their geography, and those without advantageous geography must create alternative competitive advantages.

**Exhibit 2:** Overview of Case Study Hospitals

| Hospital | Region | Beds | Annual Discharges | Service Area | Market Share | Primary Competitive Factor |
|---|---|---|---|---|---|---|
| Hospital A | Southeast | 200 | 12,000 | Rural/ Suburban | 65% | Geography, Low-Cost Structure |
| Hospital B | Midwest | 150 | 10,000 | Rural | 35% | Physicians |
| Hospital C | West | 235 | 10,000 | Suburban | 50% | Geography, Payor Mix |

**HOSPITAL A**
**Geography Has Provided A Barrier To Entry Against Competitors**

Key Hospital Performance Statistics

- Among strongest financial performers in the state
- Unaligned medical staff has become strategic concern
- Challenging payor mix: 25% commercial, 55% Medicare, 15% Medicaid, 5% other
- Continual focus on creating low-cost structure

**HOSPITAL B**
**Strong Physician Alignment Through An Employment Model Has Created A Competitive Advantage**

Key Hospital Performance Statistics

- Employed medical staff of 150 physicians
- Current focus on reducing cost structure and improving care quality
- Challenging payor mix: 25% commercial, 50% Medicare, 20% Medicaid, 5% other
- Recent $100 million facility investment including beds, ORs and ED

## Hospital Case Examples

Kurt Salmon assessed three independent (non-system) community hospitals ranging between 150 and 235 beds. Each is financially successful but derives its competitive advantage from at least one competitive factor. These cases illustrate how these factors can be translated into above-average financial performance.

Hospital A is located across a river from the major competing hospitals. The river provides a natural barrier between Hospital A and its nearest competitors; due to limited bridge access, patients on Hospital A's side of the river must drive a great distance to receive care at competing hospitals. Primarily as a result of its challenging payor mix, Hospital A is always working to reduce its cost structure.

The medical staff is an independent model comprised of more than 100 physicians, generally in solo and small, independent practices, and one large multispecialty group practice comprised of more than 40 primary care and specialty physicians. Hospital A and the large multispecialty practice are not affiliated.

Though geography has traditionally helped insulate Hospital A from hospital competition, these competitors are attempting to leverage physician alignment to overcome geographic disparities. Hospital A's nearest competitor across the river is attempting to align with the multispecialty practice to attract high-acuity and well-insured patients from Hospital A.

While it is unlikely that substantial patient volume will migrate across the river, the erosion of this small but very profitable patient population may negatively impact Hospital A's financial position. Hospital A must develop a robust physician alignment strategy to reduce the impact of the diminishing effectiveness of its geographical advantage.

Hospital B is located next to a river that also serves as the state border. Across the river is a competing hospital with twice as many beds. Hospital B began employing physicians nearly a decade ago as a strategic move against its competitor to secure future patient volumes. Today Hospital B employs more than 150 physicians in both primary and specialty care. Its competitor does not employ physicians.

Hospital B has taken steps to solidify linkages between the medical staff and the facility. The hospital implemented an electronic health record. This has fostered an integrated medical culture.

With a physician alignment strategy in place, Hospital B can focus on positioning itself for the anticipated requirements of healthcare reform and development of a more favorable payor mix strategy.

*Creating alignment among the medical staff is the most impactful competitive advantage available to most hospitals. Alignment of the medical staff can potentially mitigate geographic and payor mix disadvantages, while helping to support quality and cost-structure initiatives.*

**HOSPITAL C**
**Geographic Barriers And A Favorable Payor Mix Provide A Competitive Advantage**

Key Hospital Performance Statistics

- Historically profitable
- Unaligned medical staff with current focus on creating alignment
- 40% commercial, 45% Medicare, 10% Medicaid, 5% other
- Limited focus on Quadrant B competitive factors

Located outside of a large city, Hospital C is a public district hospital that serves a predominantly suburban county. The hospital benefits from advantageous geography due to its location on a peninsula with limited highway access. Major access points require traversing a bridge, which limits patient migration. The hospital's geographic and payor mix advantages have enabled it to minimize its focus on the operational advantages of cost structure and new capital assets.

Though Hospital C has a traditional medical staff model comprised of small, independent-practice physicians, competing hospitals have aligned with physicians, compelling the hospital to develop a comprehensive alignment strategy. There is concern that independent physicians admitting to Hospital C may eventually join the established networks as they face increasing pressure on maintaining a viable independent practice. In nearby communities, physicians have become increasingly aligned with a handful of networks, including a staff-model HMO, a large IPA and several large-group practices directly affiliated with hospitals. Instituting a physician alignment strategy will define the hospital's future position, particularly in light of future healthcare reform requirements.

## Conclusion

Yes, it is possible for an independent 200-bed community hospital to remain viable over the long term. However, to do so requires the development of at least one sustainable competitive advantage. Hospital executives must clearly understand the competitive advantages that are currently and potentially available to them and their associated strategic trade-offs.

Hospitals that fail to develop a single sustainable competitive advantage cannot remain financially viable. Eventually these organizations will be forced to seek out affiliation opportunities with stronger hospitals or systems, or worse yet, consider closing their doors.

Creating alignment among the medical staff is the most impactful competitive advantage available to most hospitals. Alignment of the medical staff can potentially mitigate geographic and payor mix disadvantages, while helping to support quality and cost-structure initiatives. Kurt Salmon believes that over the next several years, creating strong physician alignment must be a strategic priority for independent 200-bed hospitals.

# Appendices

## Appendices Overview

The following appendices provide snapshots of programs and volumes common to community hospitals. Leveraging national statistics from the American Hospital Association's (AHA) 2009 hospital survey, Kurt Salmon identified a sample of 211 hospitals ranging in size from 150 to 250 beds. Hospitals selected for inclusion in the study sample indicated that they serve as general acute care hospitals and are not part of a healthcare system in the AHA data. In addition, hospitals in which long-term care, skilled nursing, rehabilitation and psychiatry beds comprised more than 50% of total inpatient beds were excluded from the study sample. Information on clinical services offered by hospitals studied in the sample was obtained from hospital-reported AHA survey data.

## Appendix A: Scope of Services

Generally, 200-bed hospital facilities offer a major array of inpatient clinical services. These hospitals have achieved a critical mass of patients to support "bread and butter" inpatient services such as cardiovascular, neurosciences, oncology, orthopedics and women's services. Similarly, comprehensive diagnostic imaging, including CT and MRI, is provided by the hospitals, along with emergency and surgical care.

However, on closer observation it is clear that differences exist, raising questions about the appropriate scope and depth of clinical services smaller community hospitals provide. The following section assesses the service offerings of a select group of 200-bed community hospitals.

### Exhibit 1: Scope of Major Clinical Services Offered in 200-Bed Hospitals

| | Expected | Possible | Unlikely |
|---|---|---|---|
| **Clinical Area/Criteria** | **More than 50% of sample hospitals offer service** | **Between 25% and 50% of sample hospitals offer service** | **Fewer than 25% of sample hospitals offer service** |
| **Emergency Services** | Basic ED services | Trauma Level II or III | Trauma Level I |
| **Cardiology/Cardiovascular** | Medical, interventional cardiology (cath lab) | EP, cardiac surgery | Pediatric EP, pediatric cardiac surgery, heart transplant |
| **Neurosciences** | Stroke care, spine surgery | Primary stroke center | Brain surgery, advanced primary stroke center accreditation |
| **Oncology** | Chemotherapy | Surgical oncology, radiation therapy | Integrated cancer services, clinical trials, bone marrow transplant |
| **Orthopedics** | Joint replacement, extremity surgery (shoulder, foot/ankle, etc.) | | |
| **Surgical Services** | | Bariatric surgery | Transplants (all organs) |
| **Women's Health** | Labor and delivery, special needs nursery | Intermediate NICU (Level II) | Tertiary NICU (Level III) |

## Comparator Reviews

Exhibit 1 illustrates the variation of services available among hospitals sampled in the major program areas of emergency services, cardiovascular, neurosciences, oncology, orthopedics and women's health.

While these hospitals provide an extensive breadth of clinical services, the degree of subspecialty care provided varies widely. A discussion of the factors that may limit the breadth, depth and complexity of care provided at 200-bed hospitals follows.

### Emergency Services. Very Few 200-Bed Hospitals Achieve Level II Trauma Center Designation

The majority of 200-bed hospitals lack comprehensive, high-acuity (Level I and II) trauma services. All hospitals sampled offer emergency medical services, but only 39% were designated trauma centers, with nearly half being Level III and half being Level II. Only nine of the 211 of the hospitals sampled had a Level I designation (4%).

In comparison, fewer than 10% of hospitals in the United States have some type of trauma center[1]. This can be attributed to the wide variety of ancillary, medical and surgical specialists required in-house to provide the highest level of trauma care[2]. A 200-bed hospital is likely to have some degree of subspecialty capability but is likely unable to fulfill the requirements necessary to achieve the designation.

Level I– and Level II–designated trauma centers require 24-hour availability for 16 subspecialists. (Exhibit 2.) Level I centers must have these subspecialists in-house, while Level II subspecialists can be on call. Level I centers act as a referral resource for other hospitals in the region and must adhere to an annual volume requirement of 1,200 admissions or 240 major trauma patients. Level II centers do not have minimum volume requirements.

Level I and II requirements often cannot be met by hospitals in the 200-bed cohort, as these hospitals have difficulty recruiting physicians in high-demand specialties, have difficulty in obtaining call coverage for physicians who have hospital privileges or lack the inpatient volume to support subspecialty clinical programs. Two hundred–bed hospitals that achieve Level II status are often sole community providers, as these hospitals do not have to compete with neighboring hospitals for community physicians.

### Cardiovascular. Cardiac Catheterization Is Bread And Butter for 200-Bed Hospitals, Not Open-Heart Surgery

About 40% of the 200-bed hospitals studied perform cardiac surgery. Catheterization labs are present in almost 60% of the hospitals sampled, and EP services are offered at 33% of hospitals sampled.

### Exhibit 2: Level I and Level II Trauma Center Physician Specialists

| | |
|---|---|
| Anesthesiology | Ophthalmology |
| Cardiac Surgery | Oral Surgery |
| Critical Care Medicine | Orthopedic Surgery |
| Emergency Medicine | Pediatric Surgery |
| Hand Surgery | Plastic Surgery |
| Micro Surgery | Radiology |
| Neurosurgery | Thoracic Surgery |
| Ob/Gyn Surgery | Trauma Surgery |

The publication of the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) validated that patients who underwent percutaneous coronary interventions (PCIs) after a heart attack had better outcomes compared to medical therapy. In the wake of the C-PORT study, the American College of Cardiology (ACC) issued a clinical safety and efficacy endorsement for PCIs performed without on-site surgical backup in 2009. Many states have begun to allow providers to perform PCIs without on-site surgical backup, freeing them from the constraints of providing cardiac surgical care. Variation continues to exist among states about whether diagnostic and/or therapeutic catheterizations are permitted without surgical backup.

The ACC recommends providers perform a minimum of 400 open-heart cases to maintain sufficient skill and competency. The number of open-heart surgeries performed at a hospital is strongly related to the number of interventional catheterizations provided. On average, every three interventions will drive one open-heart case, suggesting that 1,200 interventions are needed to drive 400 open-heart cases. Achieving that volume threshold will likely pose a challenge to many 200-bed hospitals.

### Neurosciences. Primary Stroke Center Designation Is A Distinguisher Among 200-Bed Hospitals

Hospitals in the 200-bed cohort appear to provide an assortment of neurology and neurosurgery services. Procedures to treat neurological and spinal disorders — procedures that treat degenerative disorders, herniated discs and spinal stenosis — have become commonplace due in part to their profitability. Neurological and neurosurgical procedures of higher complexity, however, do not appear to be widely practiced at 200-bed hospitals.

The Joint Commission requires coordination of resources and protocols with EMS, nurses and physicians across a region to provide patient-focused care. Geographic and physician alignment factors may limit the ability of 200-bed hospitals to provide the extensive multidisciplinary subspecialty care necessary to achieve the Joint Commission Advanced Stroke Care designation.

### Oncology. Two Hundred–Bed Hospitals Challenged To Create Integrated Programs

The scope of oncology services provided by 200-bed hospitals is generally focused on chemotherapy and radiation oncology services.

Extensive technical and physician requirements may limit a hospital's ability to support integrated cancer services (e.g., surgical oncologists, medical oncologists, dosimetrists, radiation oncologists and specialty-trained nurses). Geographic factors — including the size of the patient population to be served and competitive dynamics — and physician alignment issues appear to limit the scope of services 200-bed hospitals can provide.

Nearly 87% of hospitals offer at least medical oncology services. It should be noted that hospitals that lack distinct surgical oncology programs may have other non-oncology specialty surgeons (e.g., GI, urology) who perform oncologic surgical resections.

### Orthopedics. Coordinated Program Delivery Is A Distinguisher, Not Clinical Capability

Two hundred–bed hospitals have embraced orthopedic care, with nearly all hospitals offering orthopedic medical and surgical services to serve growing community needs and enhance overall hospital profitability. Defined programs that utilize subspecialty physicians — spine, joint replacement, shoulder, foot/ankle, hand and sports medicine — are well-developed in the 200-bed hospital study sample.

Hospitals, however, face numerous competitive threats, both from other acute care facilities and from physician-owned outpatient surgery centers. Two hundred–bed hospitals must distinguish themselves from other hospitals, as well as physician practices, based on the service and patient experience they provide. For most hospitals, the ability to effectively compete in the orthopedic market by offering a unique resource or asset is no longer a reality. Under this model, many hospitals are being out-competed by aggressive physician groups today.

Hospitals must develop competitive advantages by deploying strategies that strengthen and grow primary care physician relationships. In addition, 200-bed hospitals must effectively coordinate subspecialty care, managing and streamlining the care delivery process from injury to recovery.

### Obstetrics and Neonatology. Potential for Level II NICU Services; Level III Unlikely

Though nearly all of the hospitals offer obstetric (OB) services, fewer than 25% of the hospitals in the study sample had neonatal intensive care units (NICUs), with these hospitals having intermediate (Level II) capabilities.

The disconnect between NICU and OB service offerings at 200-bed hospitals may be reflective of long-term trends in regionalization and, over the last 20 years, deregionalization of NICU services. In the 1970s, high-acuity NICU services were established at tertiary medical centers, most of which had affiliations with academic medical centers. In the 1980s, a number of factors propelled community hospitals to establish NICUs, including community access, physicians' desire to enter private practice and profitability of services. Today, NICUs that service low-birth-weight infants are still primarily located in tertiary medical centers due, in part, to better mortality rates.

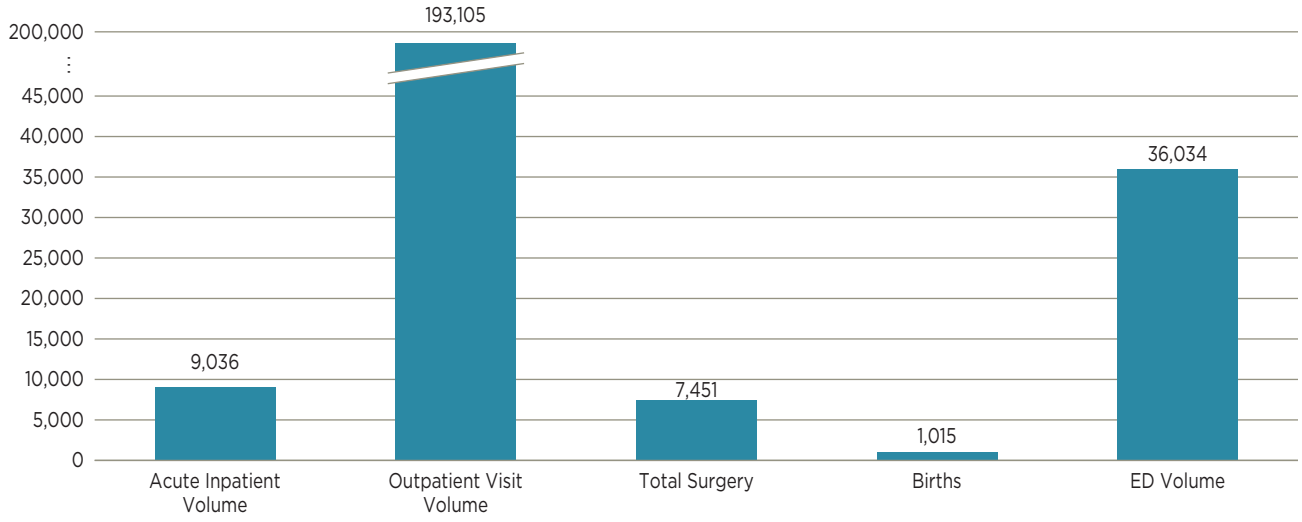
In our experience, at a minimum, a hospital must deliver 2,000 babies annually to provide enough volume to support an NICU. Given the size of communities that 200-bed hospitals often serve, that threshold is not always obtainable.

## Appendix B: Volume and Capacity Profile

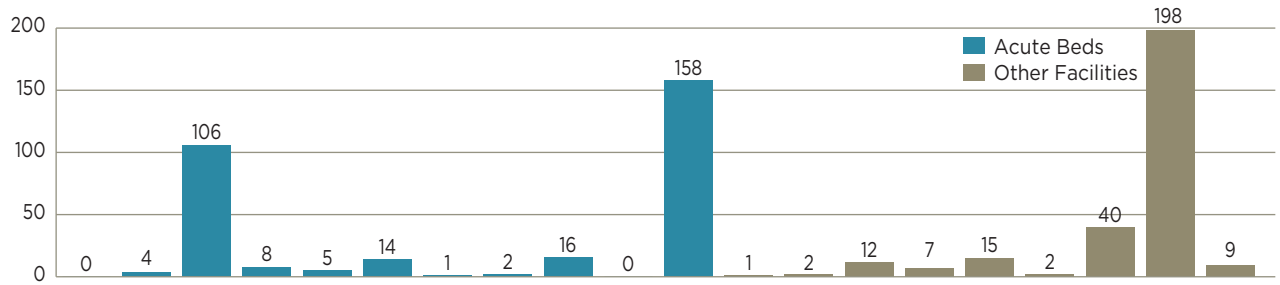
Using AHA data compiled from the scope of services assessment, Kurt Salmon reviewed available data to create a utilization and capacity profile for the typical 200-bed hospital. The analysis presented in this study represents clinical services, average annual hospital utilization and capacity data collected in 2009. On average, the 200-bed hospitals sampled had an average of 198 beds and 9,000 acute inpatient discharges

Hospitals had an average of 7,500 surgical cases. (Exhibits 3 and 4.)

**EXHIBIT 3:** Hospital Volume Profile



## EXHIBIT 4: Hospital Capacity Profile




| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Percent of Total** | **0%** | **2%** | **54%** | **4%** | **3%** | **7%** | **1%** | **1%** | **8%** | **0%** | **80%** | **1%** | **1%** | **6%** | **4%** | **8%** | **1%** | **20%** | **100%** | — |

[1] National Foundation for Trauma Care

[2] "Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage," Centers for Disease Control and Prevention, 2009

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