STATES *of* HEALTH

Community Catalyst *Volume 12, No. 1, Winter 2004*

Triad's New Market Strategy: A Threat to Community Hospitals

Faced with unprecedented financial pressures, many nonprofit hospitals today contemplate hooking up with large corporations and converting to for-profit status. In the deals that result, the talk is largely about stock value and the interests of investors. The larger public-interest question of how the conversion will affect the health of community members often receives short shrift. Most recently, Triad, an HCA spin-off, has emerged as a major player in the market for faltering nonprofits, zeroing in on institutions all the way from Alaska to North Carolina, and this has advocates worried, because the company can be singularly insensitive to community health care needs. But Triad is also remarkably adept at winning public favor. In this States of Health, *we'll look at the broader public policy questions raised by such corporate health ventures, questions that point to the need for stronger oversight and regulatory mechanisms to assure that the public interest is protected in our increasingly market-driven health system.*

According to the local newspaper, groundbreaking for Mountainview Regional Medical Center in Las Cruces, New Mexico, was a gala affair, replete with mariachis, folklorico dancers, and hot Mexican food. The estimated 1,162 invitees were abuzz over the new hospital's cardiac care unit and state-of-the-art sleep center. By all accounts, Mountainview, to be built by the corporate giant Triad of Plano, Texas, would be a world-class operation, and one speaker after another celebrated the economic development that it would purportedly foster. They also affirmed the community's right to "choice" in health care.

Choice, in this case, meant that privately insured Las Cruces residents could go somewhere besides Memorial Medical Center (MMC), which for decades had been the only hospital in town, ministering to everyone, rich and poor, insured and uninsured. The issue of what the advent of "choice" might mean for the rest of the community—for those with scant insurance or no coverage all, and for Memorial itself, was ignored at the ceremony. "The question I get from a lot of people is 'What's going to happen to MMC?' " Mayor Ruben Smith is quoted as saying. "And I say, well, a second facility needs to be supported because it's what is needed, wanted, and the community is really responding to it."

But how would this shiny, new facility replete with boutique health services affect the community's ability to provide care for all its people? Those are the kinds of questions health planners ask, but no such analysis was being done. No one was asking whether Mountainview might destabilize the patient base for Memorial Medical Center and access to services for the community overall.

Memorial's fate became clearer once Mountainview opened its doors. Within months, the older hospital announced that it would have to lay off 134 employees. Roughly a year later, Memorial was placed on the auctioning block. In December, Tennessee-based Province Healthcare Company agreed to lease the 285-bed hospital for $150 million from the city of Las Cruces and Dona Ana County. Las Cruces, a city with a large number of uninsured, now must sustain two for-profit hospitals.

The Truth about Las Cruces

The truth about Las Cruces is that although it is growing rapidly and attracting more wealthy, insured residents, especially retirees, it is still mostly Hispanic and low-income, with an uninsured rate of about 35 percent. Theoretically, these people could "choose" Mountainview over Memorial, but it is unlikely that they would, says MaryAnn Digman, Memorial's former CEO. Mountainview is simply much less accessible. Just two miles apart, the hospitals inhabit different worlds. Mountainview, tucked away in an upscale neighborhood near the golf club, is not on any of the city's bus routes. But every bus in town stops at Memorial, which is clearly visible from the interstate. The poor have been going there for years; they're comfortable there, and wouldn't think of going elsewhere.

Digman further notes that if somehow an uninsured patient or two did show up at Mountainview—even in the emergency room, where the law requires that everyone, regardless of ability to pay, must be "treated and sta-

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bilized"—they would probably not stay long. Mountainview typically transfers uninsured ER patients to Memorial if they need further care. So while a substantial number of the insured health care consumers in Las Cruces have indeed made their way to Mountainview, lured by its tony atmosphere and high-tech accountrements, Memorial has had to provide for the uninsured almost entirely by itself. And their ranks, unfortunately, have been swelling, thanks to the fragile economy in the area.

"And we're seeing that everywhere, because so many employers are dropping coverage," notes Community Catalyst Deputy Director Susan Sherry. "The fact is the health coverage you have today could suddenly be gone tomorrow. Which is exactly why regulators need to be concerned about the viability of our community-based nonprofit hospitals. Their mission is to be there for people, the thoroughly insured and the less insured. They focus on community health needs. But companies like Triad focus on profits and shareholders. And if they suddenly own the only hospital in the area, that's going to have a major impact on health care access for people there."

You can already see the writing on the wall in Las Cruces. With more affluent patients flocking to Moutainview, Memorial's patient mix today is increasingly drawn from the city's lower-income neighborhoods, and these patients are often severely, chronically ill and expensive to treat. For example, diabetes is widespread among them. Then, too, there's the matter of health care costs in general—which are rising—against a backdrop of what hospitals have long claimed are inadequate Medicaid and Medicare reimbursements.[1]

In December 2002, announcing their first round of layoffs, Memorial officials made no bones about what was going on. They noted that the "immediate adjustment in the facility's workforce" was necessary because of an "onset of competition for insured patients" and an "increase in uncompensated care." They also pointed out that these "significant trends . . . have been emerging since the opening of the city's second hospital in August."

Mountainview countered that it had not been in operation long enough to have caused the difficulties, but Memorial had some convincing numbers. For instance, the hospital had provided $38.2 million in uncompensated care in the previous year, but projected that it would spend $45 million on such services by the time the current year was over. With the hit Memorial was taking from the drop-off in insured patients, losses came to a whopping $2 million a month.

Mountainview never denied that it was drawing more of the region's insured patients. Nor did it say much about what it was doing to address charity care needs in Las Cruces, asserting only that it was treating both insured and uninsured patients. It failed to supply any actual statistics and neglected to mention its practice of transferring the uninsured to Memorial and the implicit suggestion that those patients are someone else's responsibility.

Public Relations Maneuvers

One might have expected some kind of public outcry against Mountainview, especially as Memorial's situation continued to deteriorate. After all, thousands of Las Cruceans who had once been served by a decent, solvent, community-oriented hospital increasingly found themselves ghettoized in an understaffed, debt-ridden facility whose future was uncertain. But Digman, who still lives in Las Cruces, reports that to this day, residents by and large see nothing wrong. The prevailing assumption seems to be that Memorial's difficulties are just the result of bad management, and with regard to Mountainview, the buoyant, forward-looking spirit that was so much in evidence at the groundbreaking persists.

Digman credits Triad's well-oiled public relations machine. "Never underestimate Triad's skills," she says. From the minute they roll into town, "they get out and talk to the developers, and convince them that their land will be worth more with one of these hospitals on it," Digman says. "They convince the politicians that there's a lot to be gained in property taxes. They talk up the economic development angle, how there will be more jobs, new jobs."

But what of the public's investment in the nonprofit Memorial, which for years has operated without paying

taxes to the community? Isn't it important to protect the viability of the health institution the community itself has so long nurtured and subsidized?

Such arguments have not been made. Triad and Mountainview have had an absolutely free hand in their approach to the community. And they have won over many local doctors, Digman says.

> *Triad and Mountainview have won over many local doctors…They go to the physicians with high margins and high-volume business and they say, "Once your practice builds over here, you won't need to work elsewhere so much, and you'll be able to limit your exposure to the uninsured."*

"They go to the physicians with high margins and high-volume business and they say, 'Once your practice builds over here, you won't need to work elsewhere so much, and you'll be able to limit your exposure to the uninsured.' " In fact, Digman recalls that when Memorial's chief of staff left for Mountainview, he told her and her board as much.

"He said, 'This is not about the quality of Memorial Medical Center. It's about your payer mix. If I work at Mountainview, even if I'm on call at their ER, I get fewer uninsured, and if I can limit my number of uninsured, then I'm going to make more money.' He was that specific about it," Digman says.

Among the few who have stepped forward to criticize Mountainview is the National Alliance for the Mentally Ill (NAMI), on behalf of the mentally ill of Las Cruces and their families. Their response is instructive because mental illness, perhaps more than any other health issue, points to the community's shared fate on access to care. That's because the disease can strike any family: it knows no income level. Treatment of severe mental illness can be very expensive. If you were insured to start with, you can easily wind up uninsured when coverage is exhausted. The families NAMI represents "sure as the dickens don't want Memorial to go down the tubes," Digman explains, "because it operates a small mental health unit that is just about always full of uninsured patients. The only other place the uninsured mentally ill could go is the for-profit psych hospital here, which would want to transfer them to the state hospital."

Meanwhile, most of Las Cruces low-income residents who increasingly constitute the bulk of Memorial's patient base, are "too consumed with their struggle to survive" to say much about Mountainview at all.

Triad's Game Plan

In the four years since it was spun off from Tennessee-based HCA, Triad has become the nation's third largest health services provider. Its focus, explicitly laid out in its annual report, is small cities in the South, West, and Midwest. According to Attorney Melissa Lopes, who is part of the Community Catalyst team monitoring Triad transactions, it seeks markets that can support lucrative specialty services but that have remained somewhat insulated from non-hospital suppliers and the onslaught of managed care. Las Cruces was made to order.

Granted, Triad usually does not establish a brand-new hospital as it did in Las Cruces. Rather, it buys an existing hospital. Yet Lopes has noticed that after the sale is completed, a scenario curiously like the one in Las Cruces tends to develop. Triad ditches the hospital's aging physical plant, which is often in an older, urban neighborhood, and constructs a lavish "replacement facility" in a more prosperous area, one to which lower-income residents do not have easy access. The Triad hospital, like Mountainview, is then set up to draw most of the well-to-do, insured patients, leaving a competitor to care for the more vulnerable, financially draining population.

"Joint Ventures" or "Conversions": New Name – Same Game

The latest variation on Triad's game

Success and failure

National chain involved in Springfield deal has opposite luck with its two Oregon hospitals

Stories by Diane Dietz
The Register-Guard

FOR-PROFIT HEALTH CARE arrived in Lane County with a bang when the Triad Hospitals chain announced plans to buy into Springfield's McKenzie-Willamette Hospital.

The new … corporate … — will tur…
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work, ending a 49-year legacy and leaving a bitter lawsuit that continues today.

The other is a money-maker in McMinnville that Triad has blessed with an all-new $45 million building and a widely admired CEO.

The experiences couldn't be more different, but views of Triad appear similar in both places.

McMinnville's town leaders sing the corporation's praises. And, although the Roseburg hospital is two years …ow people seem to blame Triad for its demise. …ed in the two cities.

City/Region

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County wants say on hospital sites

A majority of commissioners believes the projects are too important to the area to let cities decide locations on their own

By Matt Cooper and Randi Bjornstad
The Register-Guard

A majority of the Lane County commissioners on Wednesday called for formation of a joint commission to site both the PeaceHealth and McKenzie-Willamette hospital projects, a move that could stall PeaceHealth's efforts to win approval of a new $350 million regional medical center by the end of March.

In a 3-2 vote, Commissioners Pete Sorenson, Bill Dwyer and Tom Lininger agreed to send a letter challenging Springfield's review of PeaceHealth's RiverBend complex on 165 acres in the Gateway area of northwest Springfield.

Opponents of the project have been saying its magnitude warrants review by Eugene and Lane County as well as by Springfield, and the commissioners echoed that argument in a letter sent to officials in both cities.

"The public has relevant economic and social concerns which justify substantially greater public involvement than has occurred," the commissioners' letter reads. "We request the formation of a multi-jurisdictional commission to comprehensively evaluate the impacts of specific locations for both PeaceHealth and McKenzie-Willamette."

Springfield Mayor Sid Leiken responded Wednesday that his city's review of the PeaceHealth project will move ahead with a planned public hearing before the City Council on Feb. 18 and a council decision,

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plan, something it calls the "joint venture," could help it both extend its dominion and reinforce its image as a magnanimous member of whatever community it targets. The corporation approaches capital-starved nonprofits and offers to link up with them, sharing its wealth.

With the sheer numbers of small hospitals across the country that have fallen on hard times, Triad CEO Denny Shelton estimates that his company will be entering into as many as four to six joint ventures annually. In the past year, Triad has broken ground in Denton, Texas, on the first replacement facility to result from such a transaction. It has also closed joint venture deals with McKenzie-Willamette Hospital in Springfield, Oregon; and Valley Hospital in Palmer, Alaska. Additionally, Triad has pursued joint ventures with hospital systems in Alabama and West Virginia. Both attempts have failed. Currently, Triad is in talks to partner with Good Hope Hospital, a nonprofit located in North Carolina.

"When Triad started pushing to buy Good Hope, their people talked to all the surgeons, all the specialists. But they didn't talk to the internists or the pediatricians…..You know, pediatrics just doesn't interest them. It doesn't make money for the hospital."

Triad openly states, however, that it will contribute funds sufficient to make itself the dominant partner in the relationship with these nonprofits. It specifies that it will take over the day-to-day operation of the hospitals as well. So in essence, it is buying them out and converting them to for-profit status, says Attorney Dawn Touzin, who directs Community Catalyst's Triad monitoring team.

"When a nonprofit gives up significant control of its assets, it's a for-profit conversion, no matter whether you call it a joint venture, a partnership, or whatever," she says. "That level of involvement constitutes a conversion—and as such, warrants both regulatory intervention—and a wary response from the targeted community."

Déjà Vu All Over Again

The situation now unfolding in Harnett County, North Carolina, where Triad is ready to enter into the next of its joint ventures, bears watching. The parallel with Las Cruces is inescapable. Here, too, the population is overwhelmingly low-income, yet Triad appears to be ignoring that and catering to a smaller, more well-heeled crowd. It has its eye on Good Hope Hospital in Erwin, a manufacturing town ravaged by the loss of its biggest industry, textiles. The replacement facility it wishes to build would be in Lillington, a pocket of affluence in the county.

Good Hope, with the substantial infusion of resources it would receive from Triad, could endanger nonprofit Betsy Johnson Hospital, its sole competitor. Once more, a Triad hospital could be claiming the lion's share of insured patients and leaving its neighbor with a budget-busting load of charity care. "We could wind up in this county with no nonprofit hospital at all," says T. C. Godwin, a local businessman and director of the community's New Century Bank. "All we'd have would be a huge out-of-state corporation whose driving motivation is to make money for its shareholders."

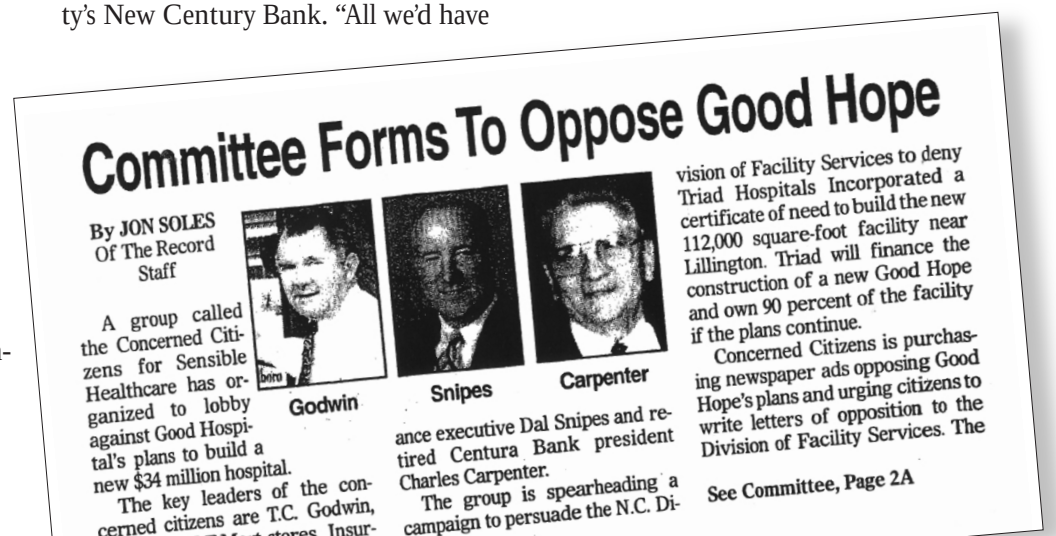
Godwin observes that "when Triad was starting the push to buy Good Hope, their people talked to all the surgeons, all the specialists, but they didn't talk to the internists or the pediatricians, and one of our pediatricians told me, 'You know, pediatrics just doesn't interest them. It doesn't make money for the hospital.' "

He further notes that mental health services would be especially vulnerable under Triad. Currently, Good Hope has Harnett County's only beds for psychiatric care, and such beds are hardly profitable.

Triad's Management Company: A Stunning Conflict of Interest

Triad is making use in Harnett County of a new addition to its arsenal: Quorum Health Resources, a hospital management firm that it purchased in 2001. Quorum, a fellow HCA spin-off, specializes in nonprofit hospitals. Not only does it manage Good Hope, but it also employs the hospital's CEO, Don Annis. It thus has an inside track in negotiating a deal.

The conflict of interest is stunning. The management of the hospital to be sold is a subsidiary of the company that would be buying it. Triad sits on both sides of the table. "Triad won't say how much they're going to pay for Good Hope, and there's a question in my



Committee Forms To Oppose Good Hope

By JON SOLES
Of The Record Staff

A group called the Concerned Citizens for Sensible Healthcare has organized to lobby against Good Hospital's plans to build a new $34 million hospital.

The key leaders of the concerned citizens are T.C. Godwin,

Godwin

Snipes

Carpenter

ance executive Dal Snipes and retired Centura Bank president Charles Carpenter.

The group is spearheading a campaign to persuade the N.C. Di-

vision of Facility Services to deny Triad Hospitals Incorporated a certificate of need to build the new 112,000 square-foot facility near Lillington. Triad will finance the construction of a new Good Hope and own 90 percent of the facility if the plans continue.

Concerned Citizens is purchasing newspaper ads opposing Good Hope's plans and urging citizens to write letters of opposition to the Division of Facility Services. The

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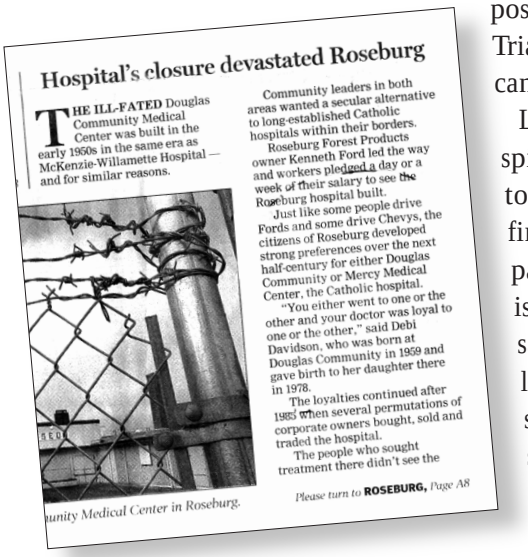
mind about whether the proper oversight is being done," Godwin says. "For example, why wasn't Good Hope put out on the market so other potential buyers could bid on it? Wouldn't that facilitate getting the best price?"

Godwin even wonders whether Quorum has been carrying out its management responsibilities in good faith. "The year before last, Good Hope lost $40,000, and then last year, as Triad was getting ready to buy it, it lost $1.2 million. That sort of depresses the price, wouldn't you think? And if Quorum management is so great, and the hospital is still losing all this money, then why does Triad want to buy it in the first place?"

Quorum management allows Triad to stack the deck in other ways, too. "They've used a lot of scare tactics," says Godwin. "They've been telling their employees that if they're not able to build this new hospital, they'll all be without jobs." On one occasion, Triad also used the Quorum advantage to pack a public forum on the Good Hope transaction. Management simply gave people the day off to attend. In all, nearly 300 citizens showed up for the event, and since so many of them believed they would be unemployed if the deal failed to go through, they spoke up strongly in favor of it.

Despite these less-than-respectable moves, however, Triad does not come across as one to fight dirty. The public relations machine that Digman witnessed in Las Cruces is also working its wonders in Harnett County. In fact, the corporation may have gained even more support in Harnett County than in other parts of the country. The reason is that Quorum has given Triad a way to learn about the ins and outs of an entire community firsthand, since the managers live and work there.



Hospital's closure devastated Roseburg

THE ILL-FATED Douglas Community Medical Center was built in the early 1950s in the same era as McKenzie-Willamette Hospital — and for similar reasons.

Community leaders in both areas wanted a secular alternative to long-established Catholic hospitals within their borders.

Roseburg Forest Products owner Kenneth Ford led the way and workers pledged a day or a week of their salary to see the Roseburg hospital built.

Just like some people drive Fords and some drive Chevys, the citizens of Roseburg developed strong preferences over the next half-century for either Douglas Community or Mercy Medical Center, the Catholic hospital.

"You either went to one or the other and your doctor was loyal to one or the other," said Debi Davidson, who was born at Douglas Community in 1959 and gave birth to her daughter there in 1978.

The loyalties continued after 1985 when several permutations of corporate owners bought, sold and traded the hospital.

The people who sought treatment there didn't see the

unity Medical Center in Roseburg.

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Troubling Maneuvers

According to Adam Searing, project director of the North Carolina Health Access Coalition, one lesson Triad has learned is that in poor, rural Harnett County, the promise of economic development goes a long way. Many people there, like their counterparts in Las Cruces, have been persuaded that letting Triad into their community will not just save jobs but also create new ones, attract businesses to the area, and increase the tax base. Another forceful argument, directed at those who live in and around Lillington, has been that the travel time to a hospital in a neighboring town could mean the difference between life and death.

Galvanized by such hopes and fears, residents have joined with Triad in an ongoing letter-writing blitz to politicians throughout the state, including the governor and the attorney general. For those unable to compose something in their own words, Triad has supplied a form letter they can sign.

Local news coverage has been conspicuously one-sided. "Triad seems to be operating a very well-financed, coordinated media campaign, and the opposing view really isn't getting out there," Searing says. Not only has the media largely skipped over issues like the possible health impacts of the conversion, but it has also completely overlooked the obvious conflict of interest at the heart of the Good Hope deal—which is, according to Searing, "just shocking. It makes absolutely no sense that it is not a major issue."

Searing says Triad's political maneuvers have been expert, too. The sense of vast popular support that the letter-writing blitz has created has been supplemented by "very intense lobbying," he says. Current legislators and senior political figures, including former U.S. senator Robert Morgan, are aligning themselves with the corporation.

Good News on the Legal Front

Advocates face an uphill battle in North Carolina. But Searing is hopeful about Triad in particular and hospital conversions in general. He believes that if other prominent people in the area were better informed about how their community's health care is at stake, they might join Godwin in raising concerns. That, in turn, could lead to more balanced coverage in the local press.

Searing also thinks some coverage in media with a statewide audience might be possible. Triad, after all, is an out-of-state corporation that has already established itself as an integral part of the health care system in North Carolina. Its subsidiary, Quorum, manages at least 10 hospitals there. If the Good Hope conversion comes to pass, and if it's permitted to happen in a way that does not take legitimate community issues into account, a bad precedent could be set for the whole state.

There's been good news on the regulatory front, however. To build the Lillington replacement facility, Triad needs both a Certificate of Need (CON) from the state's Department of Health and Human Services (DHHS) and approval from the state's attorney general. Lopes notes that the company's move to turn Good Hope

into a for-profit facility constitutes a conversion; the state's Certificate of Need process is triggered by Triad's desire to then move the facility from Erwin to Lillington.

This past September, the Certificate of Need application was denied. In its detailed review, DHHS found that Good Hope officials had failed, on nearly every item, to demonstrate that each facility feature or service they proposed for the new medical facility was the most effective and least costly. [2]

Good Hope and Triad are appealing this decision, but even if they win, advocates will have gained a crucial advantage because the denial stalls the whole transaction. One of the biggest problems with for-profit hospital conversions is that AGs typically have just 60 days to examine the case before handing down a decision. With a clock that runs so fast, consumers barely have time to pull together information they want to be considered. As long as the Certificate of Need is still pending, however, the AG faces no pressure to rule on the deal, because it cannot be enacted anyway. There's more time to study the particulars of a situation in depth.

Finally, Searing is confident that if the Triad deal ever does come before the North Carolina AG, he will conduct a thorough, unbiased review of all the relevant information. "He's one of the most respected politicians in the state, and he's seen as very fair," he says.

Valuable Opportunities

Every state needs the kind of legal authority that North Carolina has given its regulators to examine such hospital conversions. Fortunately, more than 30 states have health care conversion laws,[3] and some have Certificate of Need procedures on the books, authorizing them to investigate whether proposed new facilities and/or services are needed, what impact they will have on access to essential services, and how they will affect overall health care costs.

Such regulatory authority provides communities, and consumers with some of their most critical tools for protecting health care access. Anyone who doubts that need only consider the outcome of the joint venture negotiations with Triad in Springfield, Oregon.

Checking Out the Gift Horse

When advocates descended into the turmoil around small, nonprofit McKenzie-Willamette Hospital there, they knew that things weren't going to be easy. McKenzie-Willamette had been financially strapped ever since its powerful rival, Sacred Heart, moved into its backyard several years ago. More recently, with the economic downturn, it faced the threat of insolvency. Hospital officials had sought assistance from one nonprofit health care organization after another—five in all—but none had been willing to invest the resources needed to make McKenzie-Willamette viable. Then, as if on cue, Triad entered with its offer of a joint venture. While some citizens may have harbored reservations about the deal, almost no one wanted to look a gift horse in the mouth.

"People just love that hospital," says Mary Ann Holser, a retired professor of community health who lives in nearby Eugene and works with the Oregon Health Action Campaign (OHAC). "They built it themselves back in the 1950s, with money they got from holding breakfasts and collecting cans. And they felt betrayed when Sacred Heart was allowed to move into its territory and start taking away patients." Indeed, McKenzie-Willamette is suing Sacred Heart. At issue is an allegedly exclusive contract Sacred Heart made with a large insurer.

Residents claim that McKenzie-Willamette has a greater commitment to patient care than Sacred Heart does, and Holser, who has used both hospitals herself, agrees. OHAC executive director Ellen Pinney says, "Sacred Heart is one of the hospitals that is always raised up to us as being lax about charity care, and incredibly hard-core about sending folks to collections if they're uninsured and haven't paid their bills."

But loyalty to McKenzie-Willamette and fury at Sacred Heart, strong as they were, comprised only part of the emotional mix. According to Pinney, people also felt out of touch with the powers and processes that determine what happens with their health care. Like the poor of Las Cruces, they put most of their energy into caring for themselves and their families. "They figured the big decisions were being made elsewhere, and there was nothing the community could do one way or the other," she says.

Equally striking was the element of fear. Springfield is a working-class town, and the loss of a hospital would mean the loss of jobs. Triad's publicity machine not only tapped into this fear but also conjured a vision of prosperity that became especially compelling. Holser recalls that the company "brought in the suits with stories of hospitals they've built elsewhere, and how beautiful these places are and how well they do. Lovely surroundings, great doctors, high quality—they're very good marketers."

Cutting through the Tangle of Circumstances

All in all, it looked like advocates would have to content themselves with serious compromises, especially since they did not begin raising questions until Oregon's attorney general was well into his official review. Instead, they walked away with an impressive portfolio of wins. The AG did approve the transaction, but imposed a series of

conditions, including full charity care for patients with household incomes up to 200 percent of poverty level, and partial charity care for patients with household incomes between 200 and 500 percent.

The ruling "elevates the bar for the whole state," says Pinney. "Now any hospital looking to go for-profit will have to understand that there is a mandate for a commitment on their part. And we can go back to the table with all the other hospitals, whether they're converting or not, and say, 'Why should you guys be providing full charity care at only 150 percent of poverty level when these guys here are providing it at 200 percent?'"

Though unexpected, the Oregon victory was no accident. Part of what made it possible was the community-minded AG, who was poised to listen to consumer concerns. But just as significant were the advocates who cut through the dense tangle of circumstances and directed attention to certain points that are key in every hospital conversion, regardless of local history, politics, or bad blood. Such key points include preserving access for the medically underserved, maintaining community oversight of hospital decisions, and ensuring that essential services are continued, regardless of whether they are profitable.

In addition to the generous charity care provisions, advocates' insistence upon these bottom-line terms yielded the requirement that the hospital continue accepting Medicaid patients. Also, a community-based board of trustees was charged with advising the hospital's governing board on any changes in essential medical services. Further, the AG provided for community involvement in decisions about where Triad might build a replacement facility for McKenzie-Willamette. Needless to say, such involvement could make it much more difficult for Triad to fall back on its familiar strategy of siting its hospital in an area where it would attract mostly insured customers.

A Floor, Not a Ceiling

Oregon represents Triad's first brush with solidly organized community involvement in a joint venture transaction. But advocates elsewhere who wish to shine a light on such deals should view the gains in that state as a floor rather than a ceiling. The truth is that much more can be done.

For example, the Oregon AG did not require that the assets from the Triad deal go into a separate and independent charitable foundation. He ruled that the existing foundation associated with the hospital would be adequate. The problem, of course, is that when Triad takes control of the hospital, it will also take control of the foun-

"The intention is to continue to operate out of the location that is there now."
— **SID LEIKEN,** mayor of Springfield

Springfield hospital links with big chain

Triad HOSPITALS, INC.

TRIAD HOSPITALS

■ **Business:** One of the largest for-profit hospital chains in the country, with operations in 18 states

■ **Hospitals:** 48

■ **McKenzie-Willamette:** An announcement is to be made today about a deal with Triad Hospitals.

By JOE HARWOOD and MATT COOPER
The Register-Guard

SPRINGFIELD — If you're going to marry for money, you might as well choose a billionaire.

So it will be for McKenzie-Willamette Hospital, which apparently has found a wealthy spouse in [illegible] Hospitals Inc., the third-largest for-profit hospital chain in the United States.

Faced with declining revenue and patient counts, along with pressure from a larger competitor, cash-strapped McKenzie-Willamette during the past several months has been quietly searching for a financial partner with deep pockets to keep the independent, nonprofit hospital afloat.

McKenzie-Willamette is expected to announce this morning that the search is over and it has signed a deal with Texas-based Triad.

Details of the arrangement — for example, whether Triad would buy McKenzie-Willamette or

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Sid Leiken

The Register-Guard

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SUNDAY, SEPTEMBER 21, 2003

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Reason should govern hospital site search

The city shouldn't ignore sound planning guidelines as it strives to attract operators for a new facility

By PAUL CONTE
For The Register-Guard

Ever since PeaceHealth decided to move Eugene's only hospital to Springfield, Eugene has sought a cure for its worsening case of the "departed hospital blues." The most widely recommended treatment seems to be a strong dose of "Triad" administered by having this corporation and its recent partner, McKenzie-Willamette Hospital, build a new hospital in Eugene.

But this remedy is strong medicine and, unless used properly, may cause the patient more harm than good. An accurate diagnosis is the first step. PeaceHealth's decision bruised city pride, but that will heal on its own. A full scan of the new situation provides reassurance that Eugene is not in mortal danger. Most importantly, residents will still be able to access a full range of hospital services at PeaceHealth's RiverBend campus. For about half of Eugene's population, a trip to the RiverBend site will be quicker than to the current Hilyard Street location.

The only acute condition Eugene suffers is the impending need for hospital services on the southwest (i.e., downtown) side of the Willamette River. (Although PeaceHealth plans to maintain its Hilyard Street facility, this site's services will be limited in scope and of uncertain tenure.)

With this diagnosis in mind, the appropriate therapeutic course is clear: identify suitable hospital sites and help a hospital provider locate at one of them. For Eugene's specific malady, the site should be on the southwest side of the river — not only to be a shorter ambulance, bus, or car ride for residents in this area, but also because it's prudent to have one hospital on each side of the river in case an earthquake damages bridges.

Because PeaceHealth's RiverBend campus will be reasonably convenient for much of the north Eugene population, it's not essential for a second hospital be close to Eugene's overall population center (which is approximately at Second Avenue and Chambers Street). What's necessary is that the hospital be well served by arterial streets and bus service providing efficient access for residents in south and west Eugene.

Please turn to **HOSPITAL,** *Page F4*

Paul Conte is co-chair of the Jefferson Westside Neighbors.

dation, and its decisions about how to handle the foundation's money may be tainted by for-profit interests.

Further, a more thorough look at what the proposed transaction would actually mean for the community might have been commissioned. The letter of the law stipulates only that the AG must make sure both business partners are getting a fair shake, but when a city's hospital system is at risk, that's clearly not enough.

Attorney Carl Patten, also on Community Catalyst's Triad team, says, "One of the main things you need to do is get at the question of how the conversion would impact access to health care for residents, especially the medically underserved." Such an investigation, known as a "health impact study," would ideally be performed by an independent expert, he says, and it takes time—time that, in Oregon, was simply not available.[4]

Understanding "Assets" - A Highly Effective Approach

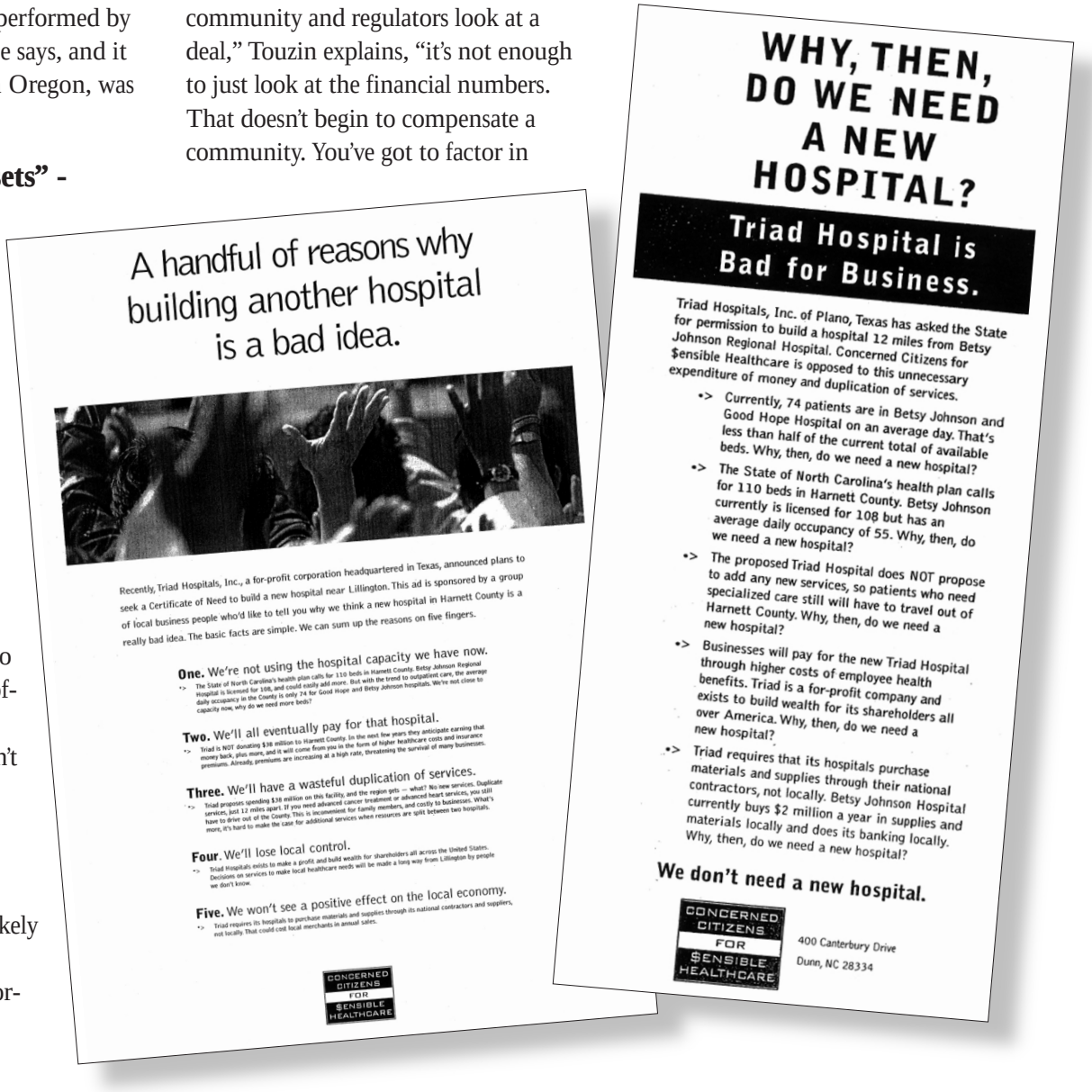
The reason a specific focus on health impacts is so critical has to do with the way in which the mission of a nonprofit hospital differs from that of a for-profit hospital, Touzin explains. "Basically, the mission of a for-profit is to make as much money as possible for its shareholders, and so it typically focuses on profitable services and downplays those that won't feed its bottom line, like having to deal with uninsured patients. The unpaid medical bill, for example, is much more likely to trigger aggressive collection activities at a for-profit. The mission of a nonprofit, on the other hand, is to serve people, and it traditionally accepts that not everything it does to serve the community can make money."

Thus, if a hospital is converting from nonprofit to for-profit, the nonprofit's less-than-lucrative obligations must be fully acknowledged and appropriately valued. That means a regulatory and community focus on preserving essential services, including access to free care for the uninsured, and it means making sure that the conversion doesn't suddenly blow local health costs sky high.

In other words, the institution's "assets" must be understood to include services to the community, and those assets must be protected. "When the community and regulators look at a deal," Touzin explains, "it's not enough to just look at the financial numbers. That doesn't begin to compensate a community. You've got to factor in overall institutional behavior including, most importantly, the unprofitable services the hospital is expected to provide because of the institution's longstanding nonprofit status."

Taking such an approach can be highly effective. For example, in a West Virginia bankruptcy court, advocates who, in consultation with Community Catalyst, raised the issue of health impacts saw the sale price of troubled Logan General Hospital increase by more than $15 million. Additionally, the presiding judge required the buyer to maintain charity care levels, keep the emergency room open, and establish a community health foundation.

For-profit encroachment into communities until now wholly served



A handful of reasons why building another hospital is a bad idea.

Recently, Triad Hospitals, Inc., a for-profit corporation headquartered in Texas, announced plans to seek a Certificate of Need to build a new hospital near Lillington. This ad is sponsored by a group of local business people who'd like to tell you why we think a new hospital in Harnett County is a really bad idea. The basic facts are simple. We can sum up the reasons on five fingers.

One. We're not using the hospital capacity we have now.

-> The State of North Carolina's health plan calls for 110 beds in Harnett County. Betsy Johnson Regional Hospital is licensed for 108, and could easily add more. But with the trend to outpatient care, the average daily occupancy in the County is only 74 for Good Hope and Betsy Johnson hospitals. We're not close to capacity now, why do we need more beds?

Two. We'll all eventually pay for that hospital.

-> Triad is NOT donating $38 million to Harnett County. In the next few years they anticipate earning that money back, plus more, and it will come from you in the form of higher healthcare costs and insurance premiums. Already, premiums are increasing at a high rate, threatening the survival of many businesses.

Three. We'll have a wasteful duplication of services.

-> Triad proposes spending $38 million on this facility, and the region gets -- what? No new services. Duplicate services, just 12 miles apart. If you need advanced cancer treatment or advanced heart services, you still have to drive out of the County. This is inconvenient for family members, and costly to businesses. What's more, it's hard to make the case for additional services when resources are split between two hospitals.

Four. We'll lose local control.

-> Triad Hospitals exists to make a profit and build wealth for shareholders all across the United States. Decisions on services to make local healthcare needs will be made a long way from Lillington by people we don't know.

Five. We won't see a positive effect on the local economy.

-> Triad requires its hospitals to purchase materials and supplies through its national contractors and suppliers, not locally. That could cost local merchants in annual sales.

CONCERNED CITIZENS FOR $ENSIBLE HEALTHCARE

WHY, THEN, DO WE NEED A NEW HOSPITAL?

Triad Hospital is Bad for Business.

Triad Hospitals, Inc. of Plano, Texas has asked the State for permission to build a hospital 12 miles from Betsy Johnson Regional Hospital. Concerned Citizens for $ensible Healthcare is opposed to this unnecessary expenditure of money and duplication of services.

-> Currently, 74 patients are in Betsy Johnson and Good Hope Hospital on an average day. That's less than half of the current total of available beds. Why, then, do we need a new hospital?

-> The State of North Carolina's health plan calls for 110 beds in Harnett County. Betsy Johnson currently is licensed for 108 but has an average daily occupancy of 55. Why, then, do we need a new hospital?

-> The proposed Triad Hospital does NOT propose to add any new services, so patients who need specialized care still will have to travel out of Harnett County. Why, then, do we need a new hospital?

-> Businesses will pay for the new Triad Hospital through higher costs of employee health benefits. Triad is a for-profit company and exists to build wealth for its shareholders all over America. Why, then, do we need a new hospital?

-> Triad requires that its hospitals purchase materials and supplies through their national contractors, not locally. Betsy Johnson Hospital currently buys $2 million a year in supplies and materials locally and does its banking locally. Why, then, do we need a new hospital?

We don't need a new hospital.

CONCERNED CITIZENS FOR $ENSIBLE HEALTHCARE

400 Canterbury Drive
Dunn, NC 28334

by nonprofits has made it increasingly difficult to ensure that nonprofit community health obligations are fulfilled. Regulatory oversight is the only instrument for shaping institutional behavior in ways that go beyond mere profit-seeking activity. In addition, as communities seek to preserve the viability of their nonprofits, it's up to the public sector to set new "rules of the game" that are fair to all institutions, including community-minded nonprofits, while ensuring that community health needs continue to be met.

Preserving the Humanitarian Mission

Notwithstanding such successes, the job of preserving the humanitarian mission of vulnerable nonprofit hospitals is far from over. According to Lopes, one crucial yet often neglected question is whether a particular institution might be able to survive without converting. Even the best foundation cannot compensate for the loss of services that nonprofit health care facilities provide.

"As we've come to depend more on more on the marketplace to control access to and quality and cost of medical care, it's become difficult for many people to distinguish nonprofit hospitals from for-profits. They often behave in the same way," observes Betsy Stoll, Director of Development and Policy at Community Catalyst. "But there are some very important differences. At least with nonprofits, there are specific things you can hang your hat on that dictate the way they should behave." What that means is that when marketplace issues interfere with the community's health care, citizens have recourse. They might appeal to mission-conscious hospital leadership or complain to state regulators. With a for-profit hospital, far fewer such checks are available.

It actually is possible to resist a hospital conversion. Kathy Goss, founder of Save Our Slidell Memorial Hospital (SOSMH) in Louisiana, has proven that. When Tenet HealthSystems came to town, intent on buying tapped-out Slidell Memorial, the general feeling was that it was a done deal. But Goss noticed that the papers were publishing quite a few letters to the editor against the sale. Intrigued, she called all the letter writers whose numbers she could find, and those people became the core of her group. With support from Consumers Union, and some community organizing assistance from ACORN (the Association for Community Organizations for Reform), they were soon on their way.

"We started meeting, and I gave out a booklet on community forums[5] that I got from Community Catalyst," Goss remembers. "And one man, who is the president of a homeowners' organization, took that booklet and ran with it. We held these forums, and we had the people who came sign in so we could generate a phone list and a mailing list. Then another guy, who is a webmaster, put together a website for us virtually overnight. We worked constantly to provide links to things that were important, and I took a lot of the research I had been doing and turned it into charts that people could look at on the site. We also, just in our own social circles, spread the word about SOSMH." In the end, Goss and her cohorts were able to stop the conversion. This spring, in a public vote, Tenet's bid to purchase the hospital was roundly defeated.

More recently, Triad itself has run into serious trouble in Alabama, where it had applied for a license to move Crestwood Medical Center out of Huntsville, an area with high rates of uninsured, into Madison, a city full of young professionals, such as engineers and computer experts, with enviable health insurance. Triad pulled out all the stops, hiring a former Democratic state senator-turned-lobbyist to push the deal, paying for a bus to carry supporters to the license hearing, and overwhelming hearing officers with 13,000 petitions in favor of the new hospital. But community members came together and handily defeated Triad's well-oiled machine. The license was denied, and access was maintained for the medically underserved.

Triad has also faced a setback in Birmingham, where the board of the city's Baptist Health System called off a deal. Local people wanted to retain control over their hospitals, and they were reluctant to relinquish Baptist's faith-based principles.

A Call to Arms

To be sure, valiantly beating back Triad does not make sense in every situation. "If a conversion is denied, but then a hospital goes out of business and there's reduced access to health care, that's not a victory for us," says Patten. "Our main goal is to maintain and increase access."

Lopes and Stoll would be among the first to agree. And the fact that conversions really are unavoidable in some cases may be the biggest reason why the conditions set forth in the Oregon AG's ruling are so important. They hold out the hope that communities and regulators can secure specific protections against the most harmful effects of the current trend toward for-profit conversion.

As these cautionary tales make clear, overtures from a corporation like Triad should trigger certain protective moves. Its focus on the bottom line and its obligation to its shareholders are bound to clash with a small community hospital's mission. Its strategy, of siphoning off the best-insured patients while avoiding those who are sicker, lower-income, and often less-insured, actively undermines nonprofit hospitals that are

trying to fulfill a community health mission. The overemphasis on state-of-the-art technology, the discontinuance of essential but unprofitable services, and the relocation of facilities may leave a community without options, access, or oversight—or even without a hospital.

Nor is this a question of a single company or a single transaction. Other predator companies share the kind of "haves and have-nots" analysis that drives Triad's approach. The public sector must respond in kind. Health care regulators must ground their oversight on the premise that the health system must meet the health needs of the whole community.

Just as the for-profit Triads have looked at our health systems and figured out how to make the numbers work for their shareholders, regulators must also engage in system-wide calculations. But they must undertake the "algebra" of health impact: services needed that generate little revenue; families working but unable to afford health insurance; and communities affected if their services are eliminated.

We are all at risk without this kind of public sector oversight. And it must be proactive intervention, driven by regulators committed to protecting community health systems. Nor is it enough to rely on state and local regulators. Community members themselves must get the facts, raise questions, and demand public sector action. Only if they are armed with information and empowered to speak can they ensure that their own best interests will be served.

Notes

[1] The newly-enacted Medicare drug benefit law might change that somewhat, especially for rural hospitals.

[2] Required State Agency Findings Regarding Certificate of Need Application from Good Hope Hospital, North Carolina Department of Health & Human Services; September 26, 2003; Project Analyst: Andrea C. Phillips; Chief: Lee B. Hoffman; Project ID No. M- 6801-03; Good Hope Health System, L.L.C.; Replacement of Existing Hospital; Harnett County. The exact language of the Certificate of Need requirement is: "…the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and must demonstrate] the effect of the reduction, elimination, or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care."

[3] See "Conversions: A Compendium of State Laws," Community Catalyst, September 2003; http://www.communitycat.org/acrobat/Conversion-Laws-2003.pdf

[4] "Looking at the Full Picture: Analyzing the Community Health Impact of Hospital and Insurer Transactions," Community Catalyst; November, 2003; http://www.communitycatalyst.org/acrobat/Health-Impact.pdf.

[5] "A Guide to Organizing Community Forums," Community Catalyst; July, 2002; http://www.communitycat.org/acrobat/Community_Forums.pdf.

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