COMMENTARY 1

Dan Pellegrini

*Blake Memorial’s long-term viability is at risk. Reid must make substantial cuts immediately, and eventually the hospital must relocate.*

I see Bruce Reid making the following presentation to Blake Memorial’s board of directors:

Six months ago, I came to this hospital because of the challenge it offered. Blake certainly has not disappointed me: It has rising costs, a healthy operating deficit, a high percentage of Medicaid low-scale reimbursement, forceful physician demands, potential physician defection, and a poor location and reputation.

In its current state, Blake’s long-term viability is at risk. Although we must immediately address the operating deficit, the core issue is the hospital’s long-term direction. I believe that we can solve the immediate financial crisis, but the board must decide Blake’s future so that an orderly planning process can begin.

I recommend eliminating 260 staff positions immediately, bringing staffing more in line with my former hospital. I see no reason why we cannot achieve comparable quality of care at that level of staffing, assuming that effective management procedures are put in place. I am confident that our management is capable of doing this. I calculate that such personnel reductions will save close to $5.9 million, rather than the $2 million originally forecast. I do not know the net inpatient revenues that the clinics generate, so I cannot make a recommendation about closing the clinics, but if we do, I expect little opposition from the city. The appalling conditions of the city-supplied facilities and the funding reduction make me believe the city is no longer committed to the clinics.

The cuts I am suggesting will generate sufficient working capital to examine available options. However, over time, serving the same patient population—with its high proportion of Medicaid patients—will eat away at the surplus generated from these personnel reductions. Because of our present location and negative image, Blake cannot hope to change its patient mix.

As I see it, the hospital has two options. One is to gradually abandon this neighborhood. Blake could open free-standing care centers in a more affluent suburb of
Marksville, in conjunction with our staff doctors. At the same time, I recommend construc-
tion of a minihospital in that neighborhood, with an emergency room, an oper-
atting room to perform same-day surgery, a neonatal unit, and a sufficient number of
inpatient beds to handle uncomplicated matters from the emergency room, surgical
center, and obstetrics.

We could open a physicians’ office near the minihospital, which eventually should
generate a good profit, primarily because of higher insurance reimbursement rates
that come with serving a more affluent population. Such relocation would satisfy our
admitting physicians, who would receive both higher reimbursements and the newest
and best technology.

Initially, both the care centers and the minihospital would feed more serious cases
to Blake’s current location, helping to increase margins. Through phased expansion,
however, the entire operation eventually would relocate to the suburban site. We
could then convert the old hospital to a nursing home or other specialized center, de-
pending on what is more advantageous from a reimbursement perspective. Blake’s
name would be changed to reflect our more upscale image. Quite simply, this strategy
is to out–St. Barnabas St. Barnabas.

The alternative is not as dynamic, but it is one that I am obliged to put forth be-
cause you are directors of a not-for-profit institution. As with other hospitals, when
Blake was established as not for profit, it was chartered to carry out a societal need not
served by either government or for-profit enterprises. We were created to serve the
medical needs of the community, especially those who could not receive such care
elsewhere.

If we opt to move from this neighborhood, we will be abandoning that societal mis-
sion for a more financially sound and technically advanced hospital. Instead of seek-
ing insured reimbursements, we could look to serve our present patients’ needs,
knowing that in the present reimbursement climate our financial position will always
be precarious.

If we decide to stay in our present location, we will need to cut costs ruthlessly and
accept serviceable rather than cutting-edge technology. We will provide adequate and
otherwise unavailable medical care to a section of the population that has no other
options. Inevitably, this will result in the defection of a significant number of primary
admitting physicians, with an attendant loss of profitability from insured patient refer-
rals. In 5–7 years, rather than celebrating the opening of a new hospital, we will, in all
likelihood, be wondering how to keep the existing hospital open.

The only justification for staying put is that we are meeting a societal need for
which we were created and that no one else is meeting, certainly not St. Barnabas.

If you choose the option of continuing to serve the same patient population, I will,
for the good of my career, be forced to submit my resignation. I could not, with a clear
conscience, remain committed to a hospital that knowingly courts financial insol-
vency. My peers would think of me as a social worker, not a bottom-line manager. I
await your decision.

COMMENTARY 2

Ellen Schall

The solution lies outside Blake and in the community as a whole.

To paraphrase Sister Irene, CEO of Daughters of Charity National Health Sys-
tem, Bruce Reid is caught in the margin–mission trap. He imagines he has to choose
between fiscal survivability of the hospital and meeting community needs. He sees
only unappealing options—closing clinics, cutting staff, freezing salaries. Framed in
such narrow terms, the decision is as simple as it is hopeless; Reid will no doubt make
the cuts. Instead, with creative leadership and a willingness to reach out, Reid could
develop a service mission that also meets the concerns of margin.

The mission will best be developed not by Reid alone but in cooperation with his
staff and in conversations with the community. Reid should lead this process and
authorize the contributions of others.
Reid may have a willing ally in Clara Bryant, Marksville’s commissioner of health services, and he should focus on bringing her into the decision-making process. He needs to lower his guard and make use of Bryant’s leverage and insight. He can use his decision not to close the clinics—at least not for now—but to build cooperation and get her to help search for a long-term solution.

That solution lies outside the confines of the institution. Working in concert with the community, Reid must begin the difficult process of identifying the unmet health care needs of Marksville’s underserved residents and then explore and introduce innovative solutions.

The New York City Department of Correction faced a related challenge years ago when I served as deputy commissioner. Like many correction departments across the country, New York City had enormous overcrowding problems in its jails. Narrowly defining our options—that is, including only choices over which we had control—got us nowhere in solving the long-term problem. We searched for beds much the way Reid is searching for ways to cut costs: alone and with bad choices, inadequate information and resources, and increasing frustration.

With the problem approaching crisis proportions, we started to reach out for help. We convened monthly meetings of all the actors in the criminal justice system—the judges, prosecutors, police, the defense bar, probation, the pretrial service agencies, the mayor’s office of criminal justice—most of whom had a much more direct influence on the jail population and many of whom had definite ideas about what was wrong and what needed to be done.

By involving them and getting wider ownership of the problems, we got better solutions. Judges gave priority to cases in which the defendant was incarcerated, probation hired typists to speed up preparation of presentencing reports, and the police changed their booking procedures so people who had been arrested saw a judge more quickly. The changes freed up hundreds of jail beds.

My experience with solving the problems of jail overcrowding involved only the public sector. In health care, as in many other fields, the reach needs to be broader. Reid needs to include both the public and the private sectors in his coalition, not just the hospital and city hall but the business community, social advocacy agencies, community-based self-help organizations, and the medical community. He must charge the group with creating solutions that go beyond the routine—new ways of solving old problems.

The Marksville coalition does not need to begin from ground zero. Many communities have struggled with similar problems and have found innovative solutions. Reid needs to call on all the networks of his coalition members to make sure his group begins with a good understanding of what has been tried already. He could also take advantage of groups such as the National Civic League, which maintains an index by subject matter of local solutions to pressing urban problems, or the Ford Foundation–Kennedy School of Government Innovations Award program, a repository of innovative approaches to pressing state and local concerns. Two interesting models come to mind:

- In Montgomery County, Maryland, the local health department and the local medical society formed a partnership to treat high-risk indigent women who had been spurned by local hospitals in part because of the high cost of obstetric malpractice insurance. Three of the four hospitals had stopped providing obstetrical care to these patients. With both the health department and the medical society pushing, all four agreed to an equitable patient distribution plan, and private obstetricians agreed to serve as part-time health department employees during labor and delivery. The doctors are paid by the county and covered by the county’s self-insurance program.
In Fairfax County, Virginia, the Medical Care for Children Project tackled a significant unmet need: At the time, there was no comprehensive and consistent countywide medical or dental care available for children of the working poor. The project persuaded private medical providers—HMOs, physicians and dentists, pharmacies, and laboratories—to provide services at 50% of actual cost or less. Business leaders were invited to contribute funds, and the county paid administrative costs and subsidized the cost of care.

There is no easy blueprint to offer Reid, but there are workable alternatives. Changing the way a community defines and meets its health care problems is tough and complicated work that requires imagination and encourages creativity and persistence. Reid will ultimately have to chart his own course, but he will be more likely to succeed if he reaches out beyond the walls of Blake Memorial.

**COMMENTARY 3**

Keith R. Safian

Reid needs a market-niche strategy if he expects to turn the clinics around and eventually expand them.

I know what Bruce Reid is up against. After trying for more than a year to turn around an evening clinic in a low-income community, I was forced to replace it with a bus service to the hospital a few miles away. Under the circumstances, closing the clinic seemed to be the only rational solution. In retrospect, however, it was less than optimal. I know now that Bruce Reid should pursue other options. On all fronts—political, social, and economical—an expanded network of clinics is Blake’s best long-term strategy.

First, closing a clinic is a serious blow to the community it serves. When I closed the evening clinic and provided bus service in its place, I was surprised to see patient visits fall off so precipitously, especially among adult males. Some patients went to a local daytime clinic run by the county, but many others simply opted not to seek early treatment for health problems.

Although the closure of my clinic was painful, it was not a public relations disaster for the hospital. From the outset, the county government was aware of the financial problems we faced and participated in developing the interim solution. When it became clear that the clinic would always lose money, government participants helped make the final decision to close the clinic. Consequently, negative publicity was deflected from the hospital.

Unfortunately, the financial benefits were modest. The clinic was losing $50,000 a year, but the eventual savings amounted to only $15,000. As it turned out, $35,000 of the loss was overhead that had to be redistributed to other cost centers.

Reid can learn from this. First, he should not underestimate the value of cultivating a strong relationship with local government. His current relationship with Bryant is neither supportive nor trusting. He should address this immediately. Even though Blake is financially responsible for the clinics, Reid should work toward establishing a partnership with Marksville City Hall in general and with Clara Bryant in particular. He should open the clinics’ books for public scrutiny and let Bryant participate in long-term planning to restructure the clinics.

On the social front, Reid needs to accept that the clinics are necessary for the reasons Dr. Susan Russell gives. The shuttle bus service that Dr. Winston Lee suggests could never serve the community in the same way. Neighborhood clinics provide an important social function as well as a medical need, especially in low-income commu-
nities. They give residents a sense of ownership and self-determination that they cannot find in a large, hospital-based clinic. At a local clinic with which I was involved, the indigent community sponsored a successful fund-raising event.

Economically, it is possible for Reid to turn the clinics around so they continue to generate crucial inpatient referrals and still run efficiently. He needs to think in terms of a market-niche strategy because Blake will never be in a position to compete head to head with St. Barnabas. It makes sense to think in terms of extending the reach of the clinics to include low- and middle-income communities in other Marksville neighborhoods, as well as in the surrounding suburban and rural areas. This reach would give Blake the coverage it needs for more inpatient referrals and give it a near monopoly on the services it can operate economically.

Blake Memorial—and Blake Memorial alone—is responsible for serving the health care needs of East Marksville's low-income community in the absence of a publicly funded city or county hospital. If Reid closes the clinics, the city would be justified in canceling Blake's grants and other support.

Reid's best bet is to deal with the immediate financial problems through belt tightening—balancing staffing and patient volumes—while concurrently developing a longer-term plan to expand the clinic system and make it more cost-effective.

He needs to take decisive action now to ensure that the clinics become revenue generators for Blake as quickly as possible. First, he should evaluate the clinics' productivity. He should limit clinic hours by consolidating sessions and by cutting staff positions accordingly. Other short-term measures can be taken: centralize record keeping, assist more patients to enroll in Medicaid, increase charges to sliding-fee patients, add clinics staffed with social workers or other lower cost providers, and phase out one or two clinics that lose too much money.

Reid's dilemma is fundamentally about balancing short-term financial constraints against long-term strategic goals. It is a problem faced by virtually all hospital administrators in this era of cost containment. Without imaginative and bold leadership, however, the outcomes will be stopgap at best.

By publicly committing himself to creating a clinic network as the centerpiece of a long-term strategy to rejuvenate Blake Memorial, Reid will satisfy the board of directors, the city government, and the community.

COMMENTARY 4

Jane Delgado

Instead of playing with figures and becoming pessimistic, Reid should take charge. He must frame an effective strategy that treats the clinic as a resource, not a cost.

Bruce Reid must act swiftly and decisively to define the goals of Blake Memorial. He has already spent too many months playing with figures and becoming pessimistic, rather than taking charge and reframing the hospital's long-term strategy. He has to rethink the framework on which the hospital operates. His challenge is to develop a new understanding of whom the hospital will serve, change how the clinics operate without incurring unreasonable costs, and develop more tailored analyses of the hospital's operation.

Whom the Hospital Will Serve As it stands, Blake serves only the east side of Marksville, comprised primarily of low-income residents. St. Barnabas, on the west side of the city, serves the more affluent communities. Reid's primary objective must be to broaden the hospital's base to include more paying patients, while continuing
to serve the local low-income communities adequately. To do so, he must redefine the hospital’s niche and rethink the competitive relationship between Blake and St. Barnabas.

Fundamentally, Blake cannot and should not try to compete with St. Barnabas because they differ in both market and mission. Reid should break out of a narrow comparative analysis and attempt to assess Blake’s mission independently. He can then more precisely determine the community’s needs and create the appropriate services for satisfying those needs.

**How the Clinics Should Operate**  The clinics play a crucial role in developing Blake's mission. Reid must embrace Dr. Susan Russell's prescription for creating locally based preventive health care centers for the entire Marksville metropolitan area, regardless of income or geographic location. Such a network would be both politically correct and financially lucrative. A clinic network would provide a different approach to delivering care: Blake would provide “high-touch” health care, while St. Barnabas would focus on “high-tech” care. Financially, a more extensive clinic system would enable Blake to expand its patient base, increase revenues, and reduce its losses.

A careful analysis would quickly reveal that the clinic system as it is run now is both mismanaged and underutilized. To correct this, Reid needs to think of the clinics as an extension of the hospital, rather than as an optional appendage. This calls for positioning them as part of a cooperative system rather than as a peripheral cost center that drains resources.

The clinics must become the point of entry into the Blake system. Once patients—both paying and nonpaying—have entered the clinic system, Blake benefits by providing many of the routine follow-up services either at the clinics or within the four walls of the hospital. For those services involving high-technology diagnostics or treatment, the patient would be referred to St. Barnabas.

An important first step in implementing the new strategy is to renovate the existing clinics. Above all, this is an opportunity for Reid to build relationships with local community and political groups and to ensure community ownership of the clinics.

**Developing Analyses for Operation**  Of course, none of this is possible unless Reid rethinks his role as an administrator. He must recognize that he is no longer at a university-based hospital where research takes precedence over service. Improving the “quality of service” at Blake is central to his mission and goes far beyond counting beds and comparing numbers of employees. Reid needs to look beyond gross figures and identify the types of patients Blake serves and the types of employees necessary to satisfy those needs.

Reid must analyze the cost and revenue of the different categories of health professionals and services at Blake. The megacomparisons on which he previously relied will not give him enough information. Moreover, in the analyses of potential cuts, he must try to project future trends in both client population and reimbursement strategies.

At the same time, Reid must avoid the use of across-the-board cuts because they are unfair and generally seen as a sign of weakness. Decisions must be based on the actual care that's needed. It may be inequitable, for example, to cut 2% from a department that has three physicians and 2% from a department that has 20 physicians.

Finally, Reid must be prepared for the inevitable loss of staff that occurs when there is a change in how an organization conducts business; some will welcome the new relationship with the community, others will be appalled. The work will be in discerning staff allegiances and building an agenda for those who remain. I suspect that Winston Lee, the chief of surgery, would be one of the first to leave Blake.
The financial viability of the hospital depends on Reid's ability to make fundamental changes in the institution's mission; those members of staff who cannot accept these changes will have no choice but to leave. In the long run, this will be best for Blake Memorial and for the community it serves.

**COMMENTARY 5**

**Bernard Lachner**

*Reid cannot and should not solve all of Marksville's social and health needs. His job is to run an economically healthy hospital.*

Bruce Reid should close the clinics. He does not have to apologize for doing his job. He was not hired—nor does the hospital have the available resources—to solve all of Marksville's social and health needs. Blake Memorial's mission in the community is to provide acute inpatient and some outpatient care within its four walls, and it can only succeed in this role if it is economically healthy.

It may sound callous, but Reid would be doing the community a service by closing the off-site clinics. If nothing else, such a bold move would bring the issue to a head and mobilize Marksville's political and community leaders to search for an alternative solution—one owned and operated by the public sector.

Above all, Reid must lead Blake by defining a clear role for the hospital. Although an off-site clinic system is a noble pursuit, it must be discontinued because of poor financial return. Unlike before, when it was fashionable and financially feasible for hospitals to assume an interest in and responsibility for a broad range of community, social, and health needs, the present time calls for a leaner approach. Instead of offering non–revenue-generating services, private hospitals like Blake should return to the basics of serving specific acute health care needs.

Reid should argue that it is a mistake to make Blake the hub for the coordination, provision, and financing of the community's social and health needs. In the era of inadequate Medicaid coverage for the uninsured, such a business philosophy by a private hospital is an inappropriate use of resources. Clearly defined agencies established by the city, state, and federal governments have these responsibilities.

Reid should fight for the best in-house acute care services he can afford, in line with what is appropriate for the community's needs. If demographic projections indicate that the child population in East Marksville will grow over the next few years, for example, then upgrading Blake's neonatal wing would be appropriate. At the same time, Reid needs to evaluate other internal services with an eye to eliminating as much waste as possible. If a patient stays in the hospital over the weekend because the physical therapy department is closed, for instance, then something must be done to reform the way those services are delivered, possibly keeping a physical therapist on call on Saturdays and Sundays, for example.

Of course, Reid should play a pivotal role in leading the transition to a publicly run clinic system. His first step is to convene a meeting with Clara Bryant, Marksville's commissioner of health services, and Richard Tuttle, CEO of St. Barnabas Hospital. If Tuttle is unwilling to meet with Reid, Reid should make sure that another member of St. Barnabas's administration or board of directors is present—preferably someone more sympathetic to the needs of low-income neighborhoods. Ideally, the meeting would lay the groundwork for transferring responsibility for the clinics from Blake to the city government. Reid should make it clear that Blake would relinquish control of the clinics and both Blake and St. Barnabas would participate in planning them. Both hospitals should be involved because both will draw on the clinics for their patient
referrals. Also, it is only right that such an important public health care service receives input from all parties.

Blake’s present financial problem typifies the bankrupt policies of government at all levels. Since the 1980s, the federal government has passed the cost of health care along to the states, which passed it along to the cities, which, in turn, passed it along to the hospitals and the communities they serve. In addition, the cost shifting has raised the expense of health care to the insured—both businesses and individuals—who now must pay for the uninsured.

As a consequence, hospital emergency rooms and outpatient clinics have become the repositories for a variety of underfunded and ill-fated government programs. The stress on the system is exacerbated by the needs of uninsured mental health patients released from facilities and an increasing number of homeless people, all victims of poverty, poor education, and crime.

Reid is in a position to turn the tide on the buck passing and put the responsibility back on the government’s shoulders. It will take courage and strong leadership to fashion a response, but maybe a more equitable and humane solution to the health care needs of communities like Marksville can be devised.