



# The Impact of Physician-owned Limited-service Hospitals: A Summary of Four Case Studies

## Prepared for:

American Hospital Association  
Colorado Health and Hospital Association  
Kansas Hospital Association  
Nebraska Hospital Association  
South Dakota Association of Healthcare Organizations

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McManis Consulting

# EXECUTIVE SUMMARY

- **Communities with physician-owned limited-service hospitals saw investments in targeted services and cutbacks in other services.**
  - Facilities, capacity, and numbers of physicians and staff increased in selected well-reimbursed services -- spine surgery, cardiac procedures, general surgery ...
  - The financial health of full-service hospitals declined.
  - This led to cutbacks at the full-service hospitals and placed other programs at risk -- behavioral health, trauma, outpatient clinics, health education/wellness, outreach, community medical education ...
- **Utilization and costs increased.**
  - Procedures per capita -- already high in the targeted services in these communities -- went still higher and raised concern about over-utilization.
  - Capacity -- bricks and mortar, specialized equipment -- was duplicated.
  - The costs of maintaining standby/emergency capacity at community hospitals increased as elective cases were directed elsewhere.
  - Wage rates were bid up by competition for scarce staff.
- **In two of four case studies, trauma and emergency services were placed at risk.**
  - Physician-owners reduced or eliminated their emergency call obligations, precipitating crises in call coverage.

## EXECUTIVE SUMMARY (continued)

- **Physician-owners of limited-service hospitals demonstrated their ability to direct patients from one hospital to another at will.**
  - In each case study, physician-owners quickly and easily moved selected patients to the hospitals they owned.
- **Physician-owners carefully selected the patients served at their facilities.**
  - They offered services with higher payments relative to costs.
  - They selected patients with better-paying insurance.
  - They focused on elective care – avoiding the “standby” costs of maintaining an emergency department and the EMTALA mandate to screen and stabilize patients without regard for ability to pay.
  - They served healthier patients.
- **This led to high profits for limited-service hospital shareholders.**
  - With a guaranteed flow of patients, facilities were often profitable in their first year.
  - Operating margins were up to 10 times higher than the national average for all community hospitals.
  - Profits per physician-investor were as much as \$700,000 per year.

# OVERVIEW

- **Study Goal, Methodology, and Background**
- **Patient Selection by Physician-owned Limited-service Hospitals**
- **Profitability of Physician-owned Limited-service Hospitals**
- **Impacts -- Declining Finances at Full-service Hospitals**
- **Impacts -- Service Cutbacks and Access Problems**
- **Impacts -- Rising Utilization and Costs**

# **Study Goal, Methodology, and Background**

# **Study Goal: Assess the impact of physician-owned limited-service hospitals at the community level.**

**Conducted detailed case studies of four communities with an increasing presence of limited-service hospitals:**

- Site visits
- Interviews with full-service and limited-service hospital executives, physicians, and other local health care observers
- Data acquisition and analysis

## **Sites included:**

- Black Hills region of South Dakota
- Lincoln, NE
- Oklahoma City, OK
- Wichita, KS

**Collectively, these communities experienced the opening of 18 physician-owned limited-service hospitals between 1995 and 2005.**

**This report summarizes key findings.**

# In the Black Hills region, three physician-owned surgical hospitals opened between 1996 and 2000.

## The Black Hills Region



### Physician-owned Limited-service Hospitals:

#### **Black Hills Surgery Center**

- 26 beds
- Diagnostic center
- 35 physician shareholders (including 12 neurosurgeons and orthopedists)

#### **Same Day Surgery Center**

- 6 beds
- 60/40 joint venture between regional tertiary center (Rapid City Regional Hospital)

#### **Spearfish Surgery Center**

- 4 beds
- 13 physician shareholders

### Full-service Hospitals:

#### **Rapid City Regional Hospital**

- Tertiary / trauma center
- 282 beds

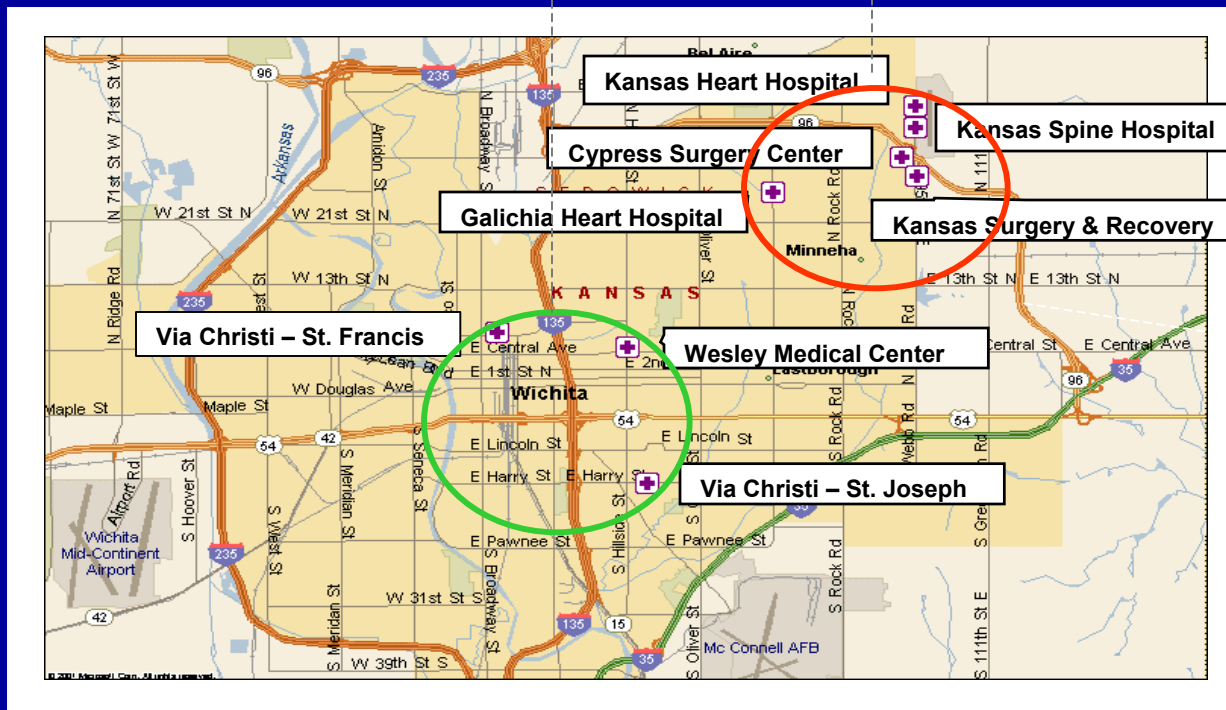
#### **Lookout Memorial Hospital**

- Community hospital
- 40 beds

The region is also served by three critical access hospitals, which are owned or managed by Rapid City Regional Hospital.

# Five new physician-owned limited-service hospitals opened in Wichita, Kansas between 1995 and 2003.

Full-service Hospitals      Physician-owned Limited-service Hospitals



Wichita's full-service hospitals are located downtown; its limited-service hospitals all located in the more affluent Northeast quadrant.

## Physician-owned Limited-service Hospitals:

### **Kansas Heart Hospital**

- 54 beds, three operating rooms
- 26 heart surgeon and cardiologist owners + local investors

### **Galichia Heart Hospital**

- 55 beds (adding 27 more), two operating rooms
- Two physician-owners + local investors

### **Kansas Spine Hospital**

- 22 beds, four operating rooms, two procedure rooms
- Nine physician-owners + local investors

### **Kansas Surgical and Recovery Center**

- 24 beds, six operating rooms, two procedure rooms
- 60/40 joint venture between Via Christi health system and nine physicians

### **Cypress Surgery Center**

- Four beds, five operating rooms
- 21 physician-owners + local investors

## Full-service Hospitals:

### **Via Christi Regional Health System**

- Two campuses, trauma center
- 965 beds

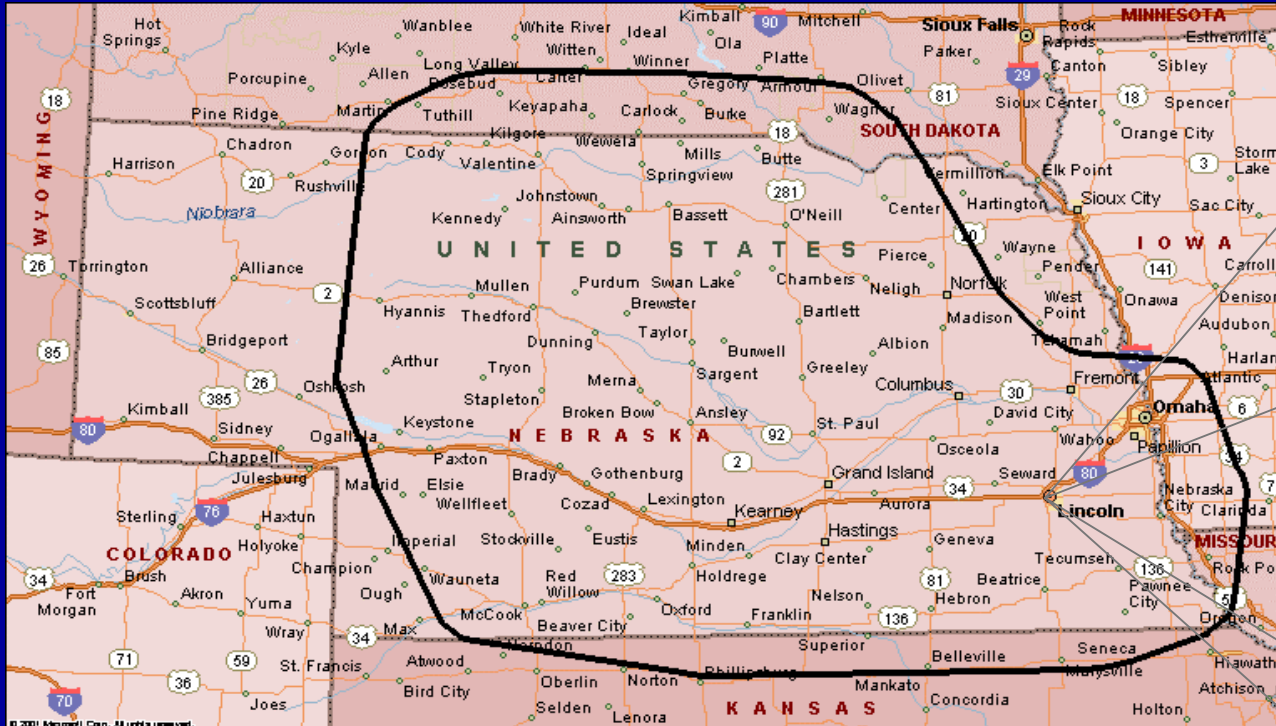
### **Wesley Medical Center**

- 469 beds



# Lincoln, Nebraska added a physician-owned heart hospital and a surgical hospital in 2003.

## Service Area for Lincoln's Heart Programs



### Physician-owned Limited-service Hospitals:

#### Nebraska Heart Hospital

- 63 beds, two operating rooms
- Opened May 2003
- Owned by the Nebraska Heart Institute (30 physicians)

#### Lincoln Surgical Hospital

- Seven beds, five operating rooms (expanding to 15 beds and five operating rooms)
- Opened April 2003
- Owned by 17 physician-investors

### Full-service Hospitals: \*

#### BryanLGH

- 2 campuses, trauma center
- 563 beds

#### Saint Elizabeth Hospital

- 240 beds

Lincoln's cardiac programs serve most of Nebraska and portions of Iowa, South Dakota and Kansas.

\* Madonna Rehabilitation Hospital, a 263-bed facility focusing on spinal chord, stroke, burns and cardiac patients, is also located in Lincoln.

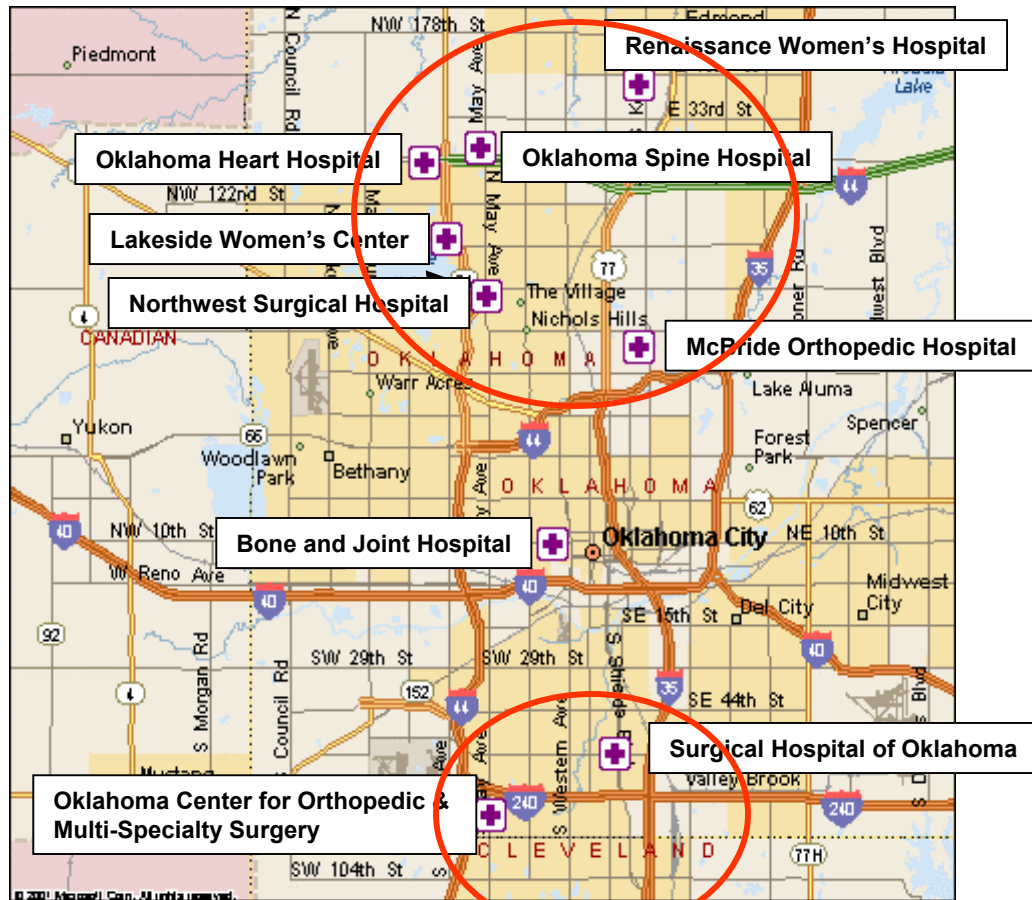
# Seven new physician-owned limited-service hospitals opened in Oklahoma City, Oklahoma between 1995 and 2005.

## One long-standing specialty hospital

- **Bone & Joint Hospital** (102 beds; started in 1920s; part of the SSM of Oklahoma system)

## ... was joined by seven physician-owned hospitals, plus another this year

- **Northwest Surgical Hospital** (orthopedics focus; nine beds)
- **Lakeside Women's Hospital** (33 beds; owned by OB/Gyn physicians)
- **Surgical Hospital of Oklahoma** (established by physicians and HealthSouth in 1996, 100% physician-owned since 2003, 12 beds)
- **Renaissance Women's Center** (80% physician-owned, 20% owned by INTEGRIS, 14 beds)
- **Oklahoma Spine Hospital** (18 beds; owned by 15 neurosurgeons)
- **Oklahoma Heart Hospital** (78 beds; 49% physician-owned; Mercy Health System owns 51%)
- **Oklahoma Center for Orthopedic & Multi-Specialty Surgery** (physician-owned)
- **McBride Clinic Orthopedic Hospital** (opening in 2005; 40 beds; owned by the orthopedic group that has traditionally practiced at the Bone & Joint Hospital)



The new limited-service hospitals located in higher-income growth areas to the Northwest and South of the core city.

# The Oklahoma City health care market was already highly competitive.

Ten full-service hospitals, representing several major systems ...

## **OU Medical Center**

- 3 hospitals in separate towers, Level I trauma center
- 727 beds
- Partially owned by HCA

## **INTEGRIS Baptist Medical Center**

- Regional tertiary center
- 469 beds
- Part of a statewide not-for-profit system

## **Saint Anthony Hospital**

- Downtown campus
- Part of the SSM of Oklahoma system
- 428 beds

## **Mercy Health Center**

- Suburban tertiary center
- 416 beds
- Part of the Sisters of Mercy of St. Louis system

## **INTEGRIS Southwest Medical Center**

- 351 beds

## **Deaconess Hospital**

- 313 beds
- Owned by the Free Methodist denomination

## **Norman Regional Hospital**

- 297 beds

## **Midwest Regional Medical Center**

- 247 beds

## **Edmond Medical Center**

- 81 beds
- Owned by HCA

## **INTEGRIS Canadian Valley Regional Hospital**

- 40 beds

had been joined by 26 ambulatory surgery centers representing over 1,300 physician ownership positions. \*\*

\* The population of the Oklahoma City MSA was 1.1 million. Several hospitals also served a secondary service area, with a population of 1.2 million.

\*\* A number of physicians had ownership positions in more than one surgery center.

## Patient Selection by Physician-owned Limited-service Hospitals

*“...the ability to schedule consecutive cases without pre-emption by emergency procedures ...”*

Competitive advantages for the Black Hills Surgery Center  
cited in the Initial Public Offering to Investors (Medical  
Facilities Corp., p. 9)

# Patient selection tactics yielded high profits for physicians and other investors, but at the expense of broader health care needs.

## Patient Selection Tactics

- Focus on Well-reimbursed Procedures

- Avoid Emergency Cases

+

- Focus on Patients with Good Reimbursement

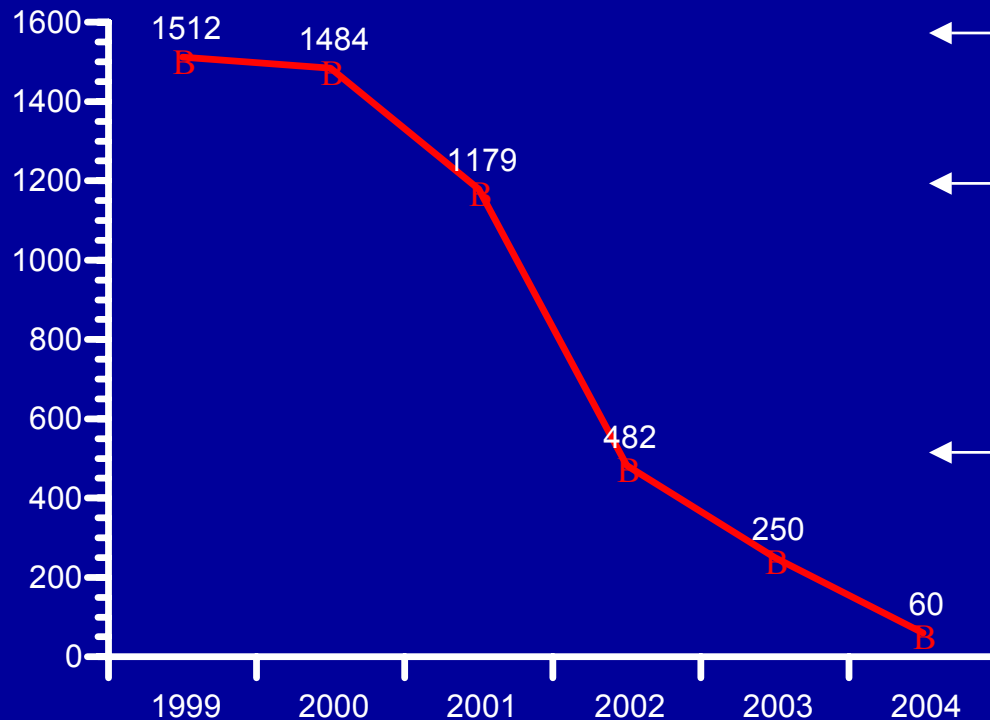
- Focus on Patients in Good Overall Health

High-return, low-risk patients led to high returns for owners ...  
but reduced resources to meet broader health care needs.

# Physician-owners of limited-service hospitals demonstrated that they could move patients from hospital to hospital at will.

**EXAMPLE**  
Lincoln Case Study

## Heart Surgeries by NHI Physicians (Owners of Nebraska Heart Hospital) at Full-Service BryanLGH



- ← BryanLGH and NHI physicians built a large, successful cardiac program
- ← NHI decided to build own heart hospital, moved many of its patients to full-service Saint Elizabeth's
- ← NHI directed patients from BryanLGH and Saint Elizabeth's to its new heart hospital as soon as it opened and negotiated contracts

Source: BryanLGH administration.

# Physician-owned limited-service hospitals focused on well-reimbursed procedures.

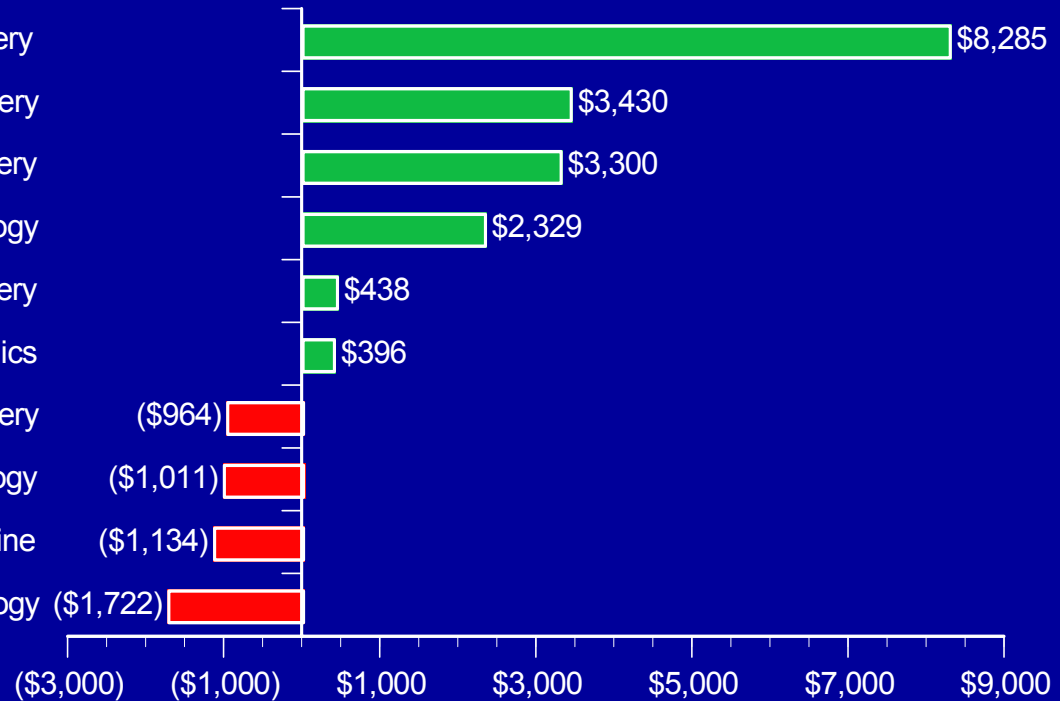
## Specialties Targeted by Limited-service Hospitals, All Four Case Studies

- 4 Heart Hospitals →
- 3 Neurosurgery Focus\* →
- 6 General Surgical Facilities →
- 2 Women's Hospitals →
- 4 Orthopedic Focus\* →

- Cardiothoracic Surgery
- Neurosurgery
- General Surgery
- Neonatology
- Gyn Surgery
- Orthopedics
- OB Delivery
- Pulmonology
- General Medicine
- Nephrology

**EXAMPLE**  
Oklahoma City Case Study

## Net Income per Case, Selected Diagnostic Groupings, INTEGRIS, 2003



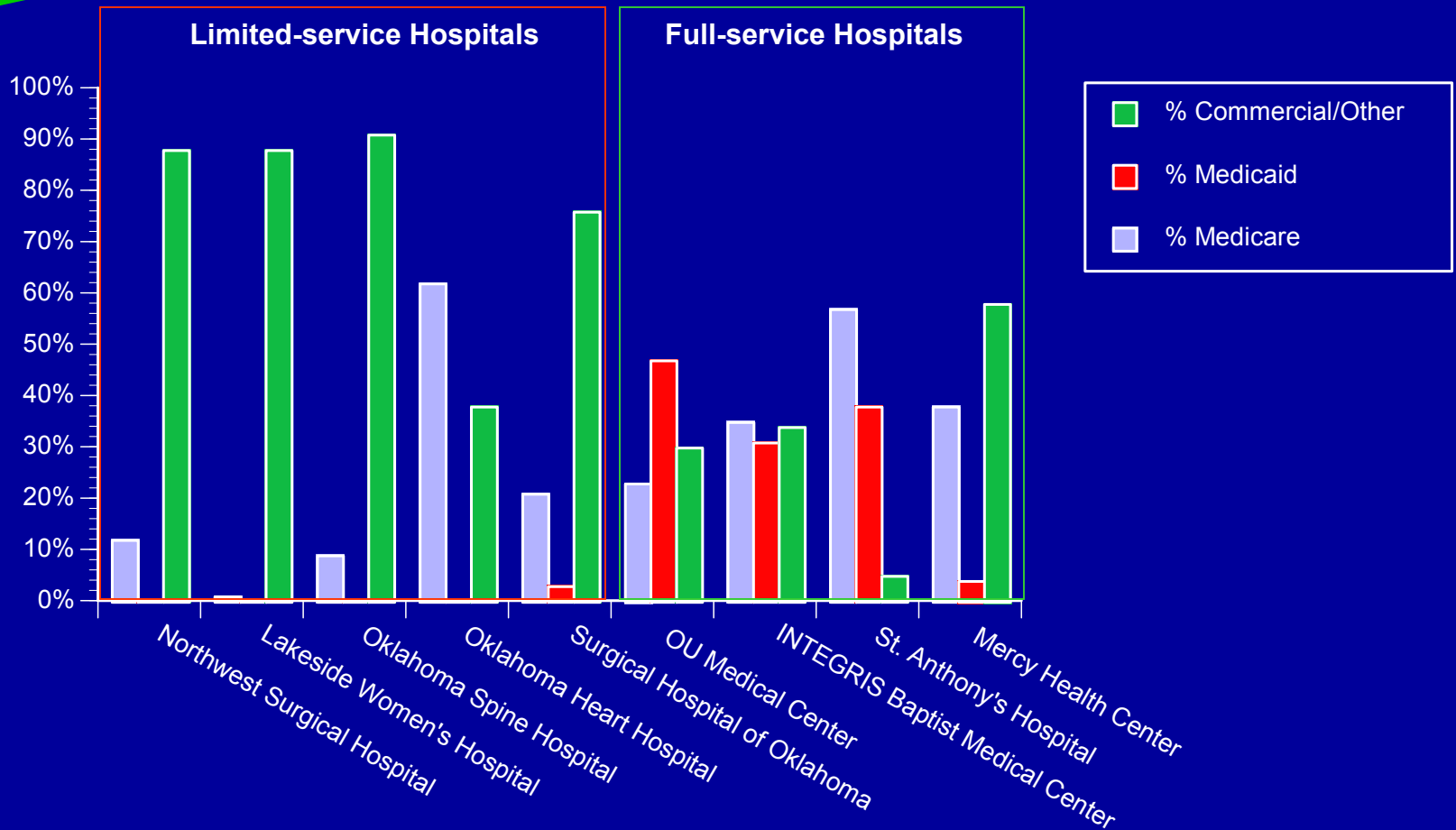
\* Black Hills Surgery Center counted as neurosurgery and orthopedics.

Source: INTEGRIS administration (INTEGRIS is a community hospital system operating in Oklahoma City).

# Physician-owned limited-service hospitals served more commercial and fewer Medicaid patients relative to full-service hospitals ...

**EXAMPLE**  
Oklahoma City Case Study

Payer Mix of Major Limited and Full-Service Hospitals in Oklahoma City



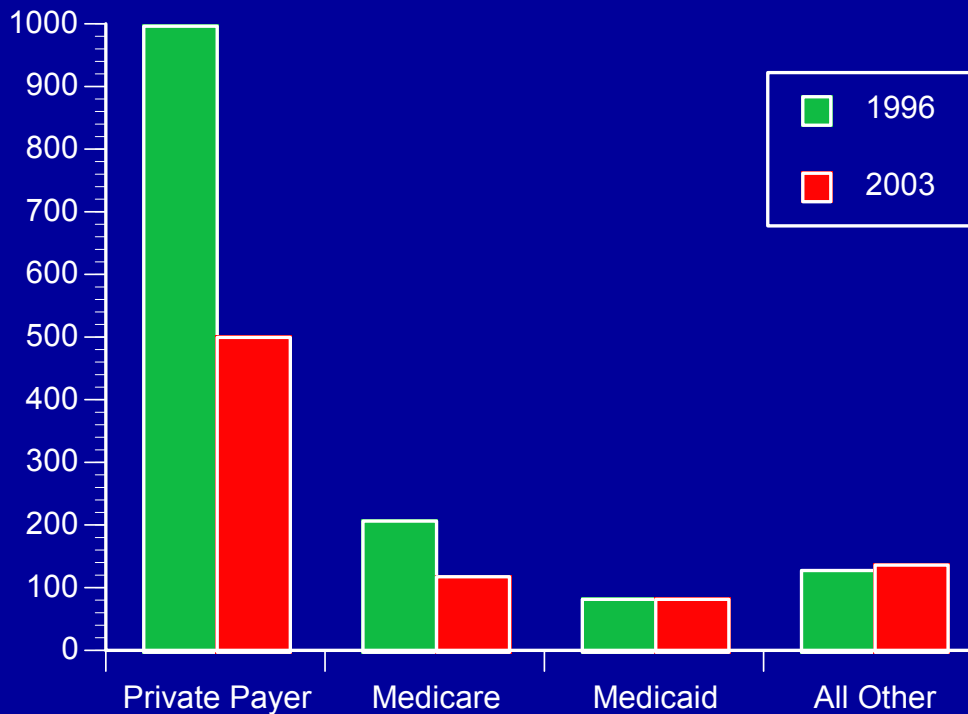
Source: Medicare cost reports. Data are for 2003.



... leaving the full-service hospitals serving the patients with the lowest reimbursement rates.

EXAMPLE  
Black Hills Case Study

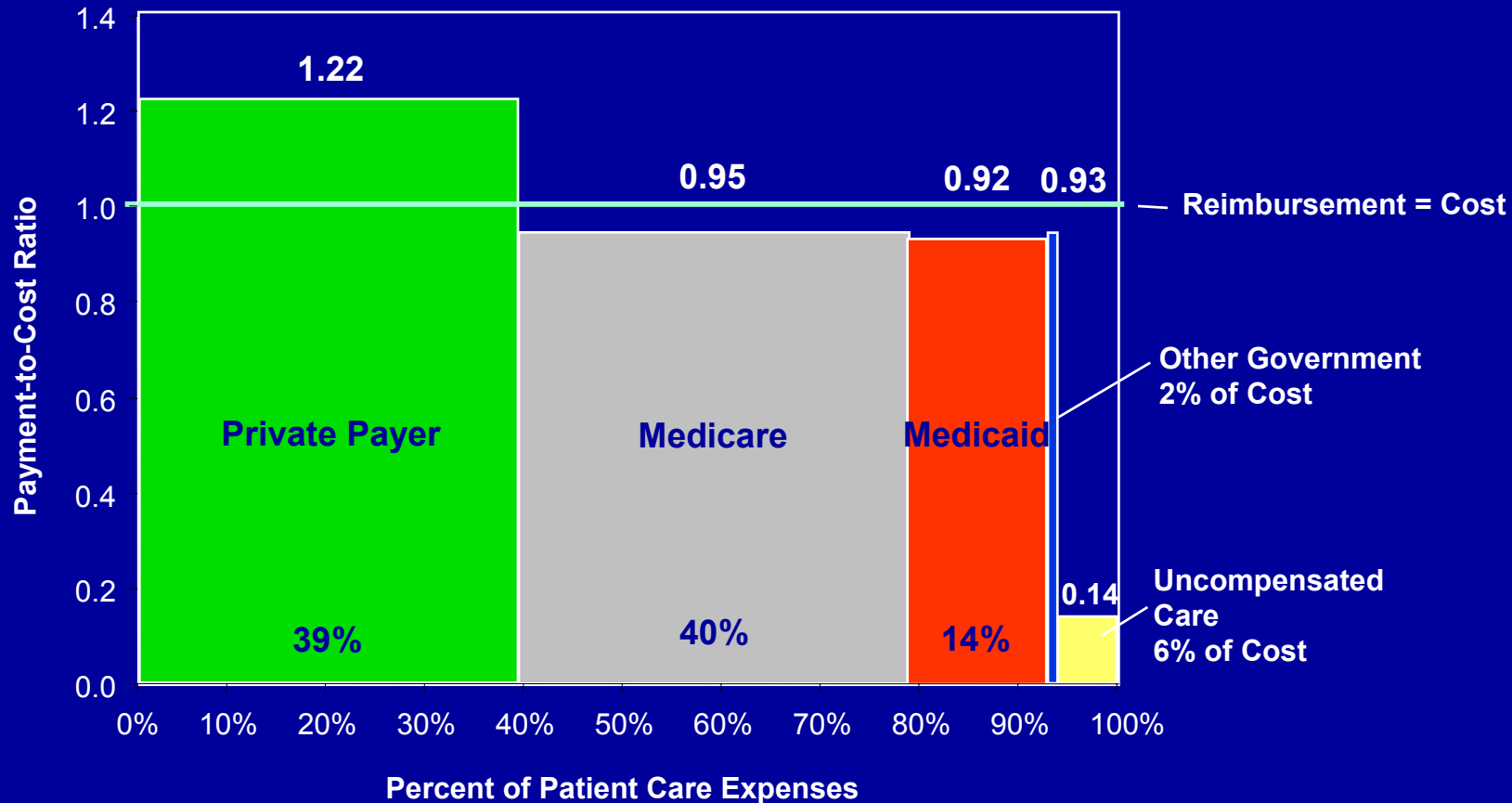
Changes in Outpatient Orthopedic Case Volume at  
Rapid City Regional Hospital, 1996-2003  
(coinciding with the opening of the Black Hills Surgery Center in 1997)



*"Private payer" includes BCBS, workers compensation, commercial insurance, managed contract care, and other insurance. "All other" includes CHAMPUS, self-pay and public health insurance.*

# Selecting patients based on payment source strongly affects profitability. Some payers reimburse more than cost and others do not.

Reimbursement Relative to Cost By Payer and Payer Mix  
All U.S. Community Hospitals, 2003



Source: The Lewin Group, analysis of 2003 AHA Annual Survey of Hospitals. Includes reported and imputed data for U.S. community hospitals. "Payment" for uncompensated care represents tax subsidies.

# The physician-owned limited-service hospitals offered limited or no emergency services.

EXAMPLE  
Wichita Case Study



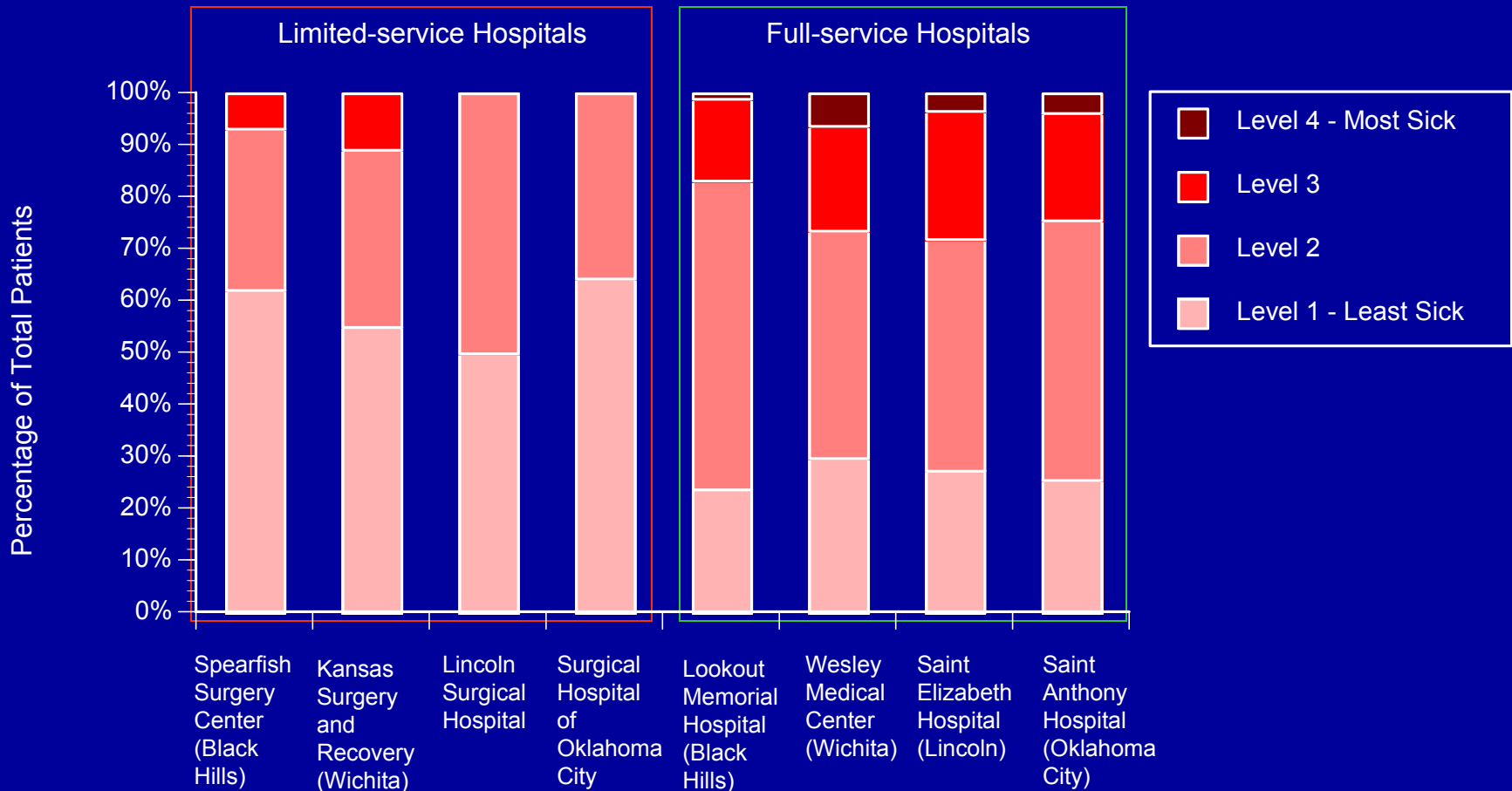
# Not offering emergency care avoids costs and gives physicians more control over their time and patient mix.

- **Avoiding emergency cases helps to maximize profits and creates physician-owner satisfaction. Managers can:**
  - Avoid purchases of seldom-used equipment
  - Plan in advance without the potential for emergency cases disrupting staff, physician and operating room schedules
    - Match staffing to cases, avoiding the costs of standby capacity
    - Offer an attractive schedule for physicians (predictable, free of interruptions)
    - Provide physicians with a practice environment without the responsibilities of night and weekend call
  - Exert more control over acuity and payer mix by avoiding the EMTALA\* mandate
- **This provides substantial cost and control advantages over community hospitals, which must be prepared to handle any emergency.**

\* *The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to screen and stabilize all patients, regardless of ability to pay.*

# Patients treated in physician-owned limited-service hospitals were seldom as sick as those in the full-service hospitals they competed with.

## APR-DRG Mix of Physician-owned Surgical Hospitals and Competing Community Hospitals (Surgical Cases)

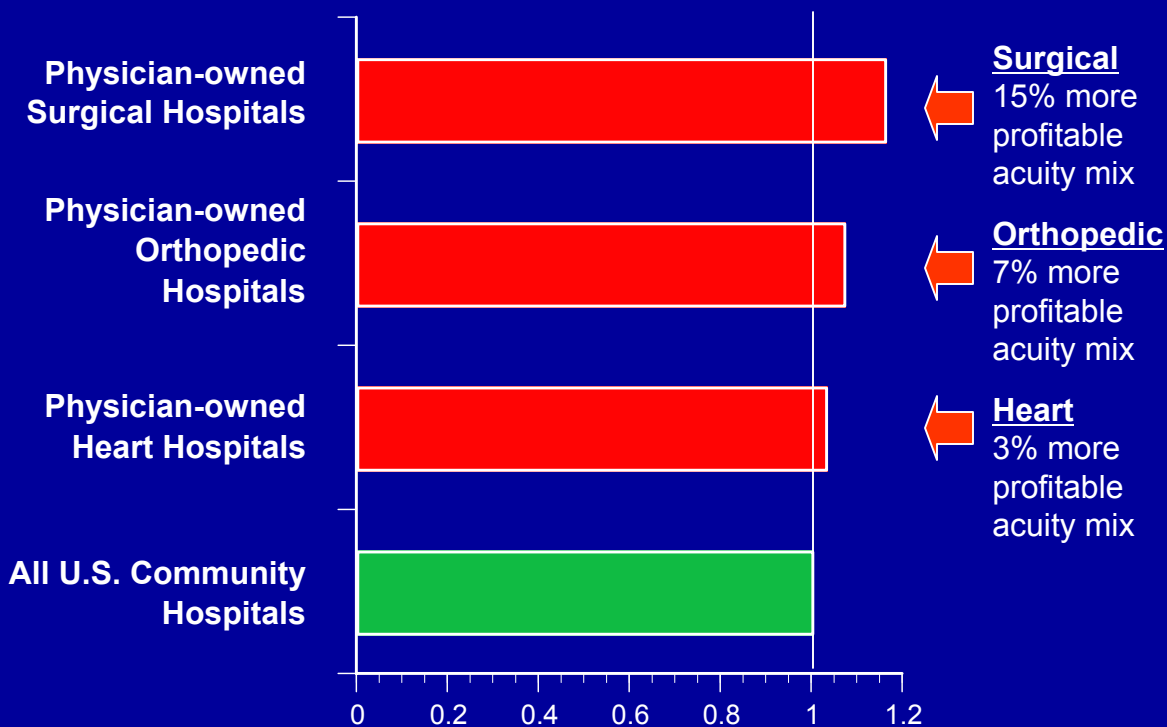


Source: The Moran Company, analysis of 2003 MEDPAR data. Data are for all surgical DRGs other than open heart, cardiology, vascular and thoracic surgery.

# Serving healthier patients leads to higher profit potential.

MEDPAC  
FINDINGS

## Expected Relative Profitability of Physician-owned Hospitals Given Lower Acuity Mix (Within DRG)



- Medicare pays a flat average rate for a specific type of case.
- In this system, patients who are healthier are paid *more* relative to the cost of care than patients who are sicker.
- This system assumes a typical hospital will serve a balance of less sick and more sick patients.

Source: MedPAC, *DRG Relative Profitability and Patient Selection in Specialty Hospitals*, preliminary data, presented at Med PAC meeting, October 29, 2004 .

## The tactics used by physician-owned limited-service hospitals were common across the case studies. \*

Tactic	Black Hills, SD	Lincoln, NE	Wichita, KS	Oklahoma City, OK
Steer selected patients	✓	✓	✓	✓
Focus on well-reimbursed services	✓	✓	✓	✓
Focus on best payers	✓	✓	✓	✓
Avoid/limit emergency cases	✓	✓	✓	✓
Treat healthier patients	✓	✓	✓	✓

\* While these trends were present in all four case studies, there were individual hospital exceptions. For example, the Oklahoma Heart Hospital provides full emergency services.

## Profits of Physician-owned Limited-service Hospitals

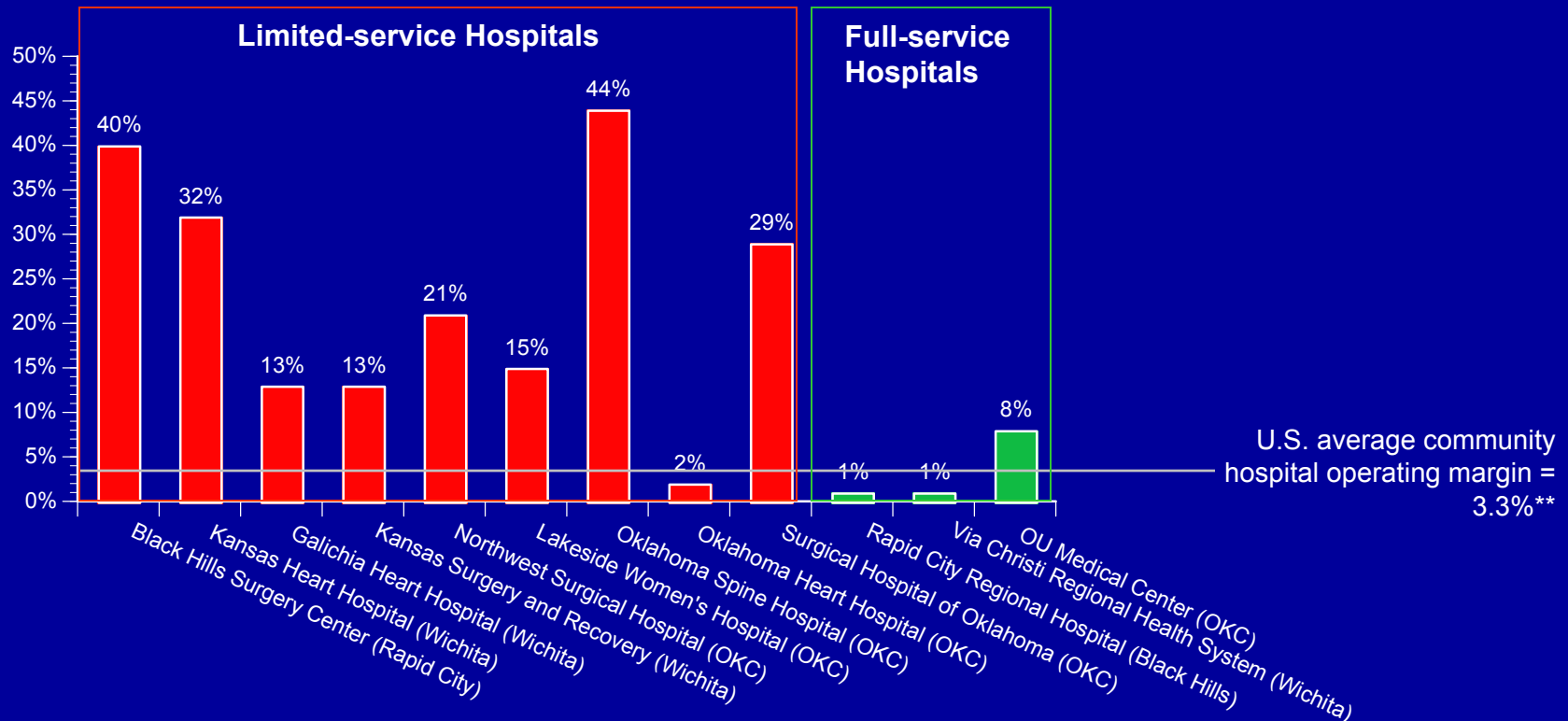
*“And the last thing and the easiest thing is money. There’ll be a lot of money out there.... Why go to a surgical facility? Profit, profit, profit.”*

Larry Teuber, Founding Partner of Black Hills Surgery Center, addressing the American Association of Neurological Surgeons Annual Meeting, 2000.



# The physician-owned limited-service hospitals had profits substantially higher than the full-service hospitals.

Operating Margins for Selected Physician-owned Limited-service and Full-service Hospitals, 2003\*



\* Includes all limited-service hospitals where data are available and the largest full-service hospital in their communities. Sources: Medicare Cost Reports, IPO Prospectus including Black Hills Surgery Center. Data are for 2003. Cost report data not available for limited-service hospitals in Lincoln, NE.

\*\* Source: AHA Annual Survey, 2003.

## **Impacts – Declining Finances at Full-service Hospitals**

*“The Nebraska Heart Hospital doesn’t provide anything we don’t already have in the community ... fragmentation spreads out the business, erodes margins and puts quality at risk ...”*

Lincoln physicians practicing at BryanLGH in Lincoln, NE

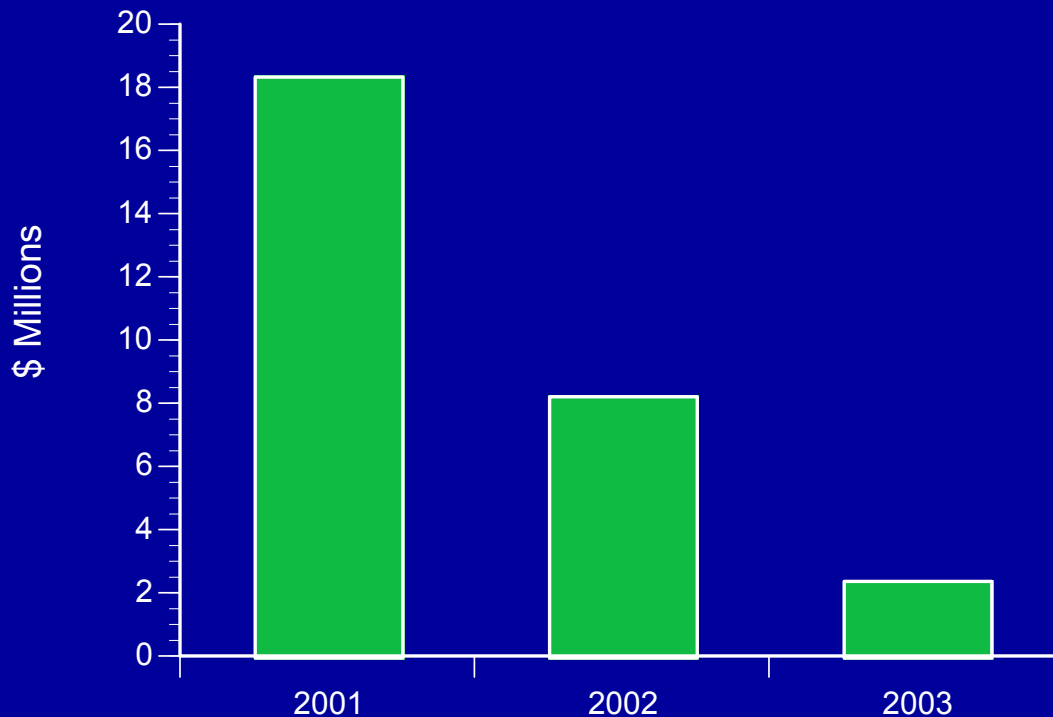
## **The financial health of the full-service hospitals declined.**

- **The patient selection tactics of the physician-owned limited-service hospitals were not available to the full-service hospitals, which**
  - Cannot provide financial incentives for physicians to steer patients (illegal)
  - Provide a broad range of services needed in the community, not just the profitable services
  - Serve patients with a range of reimbursement sources
  - Provide emergency care and often trauma care
  - Serve a mix of patients – some more sick, some less sick
- **Revenues from the “best” services, payers, and elective cases plummeted.**
- **Costs increased.**
  - Operating rooms and staffing are less efficient without elective cases
  - Recruiting costs rose to replace departing physicians and staff
  - Higher salaries and other incentives were required to retain staff in services targeted by limited-service providers
  - Lower bond ratings increased borrowing costs

# Full-service hospitals saw their net income from targeted services drop rapidly.

**EXAMPLE**  
Wichita Case Study

Net income from Wesley Medical Center's Heart Program

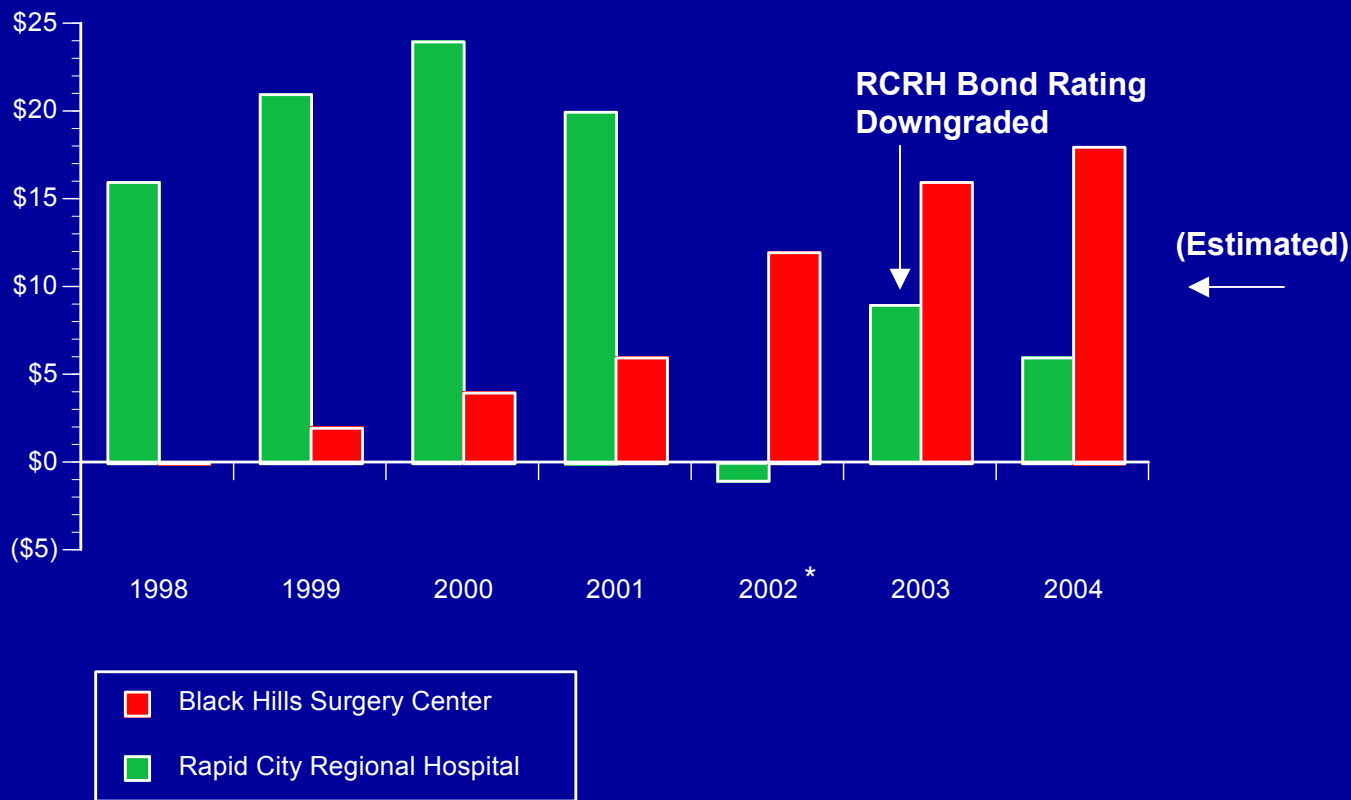


Wesley's net income from its heart program fell by \$16 million after the opening of Galichia Heart Hospital in 2001.

In Rapid City, the surgical hospital's net income grew ... and the full-service hospital's net income fell ... by the same amount (approximately \$18 million).

**EXAMPLE**  
Black Hills Case Study

**Net Income, Rapid City Regional Hospital (RCRH) and the Black Hills Surgery Center, 1998-2004**



Sources: IPO (2004) and RCRH (2004). RCRH has a 7/1-6/30 fiscal year; BHSC uses a calendar fiscal year. BHSC's 2004 net income is an estimate based on data contained its investor-owners' 2nd quarter report.

\* RCRH had one time write-off of \$6 million dollars in 2002.

## Impacts – Service Cutbacks and Access Problems

*“The state of Oklahoma had to increase our Medicaid rates by \$5.7 million a year for us to continue to operate our Level I trauma service. If we hadn’t lost the income from cardiac services, we wouldn’t have needed this state money. So, the taxpayers are paying extra.”*

Chief Financial Officer, OU Medical Center

## **In two communities, patient access to emergency/trauma care was put at risk.**

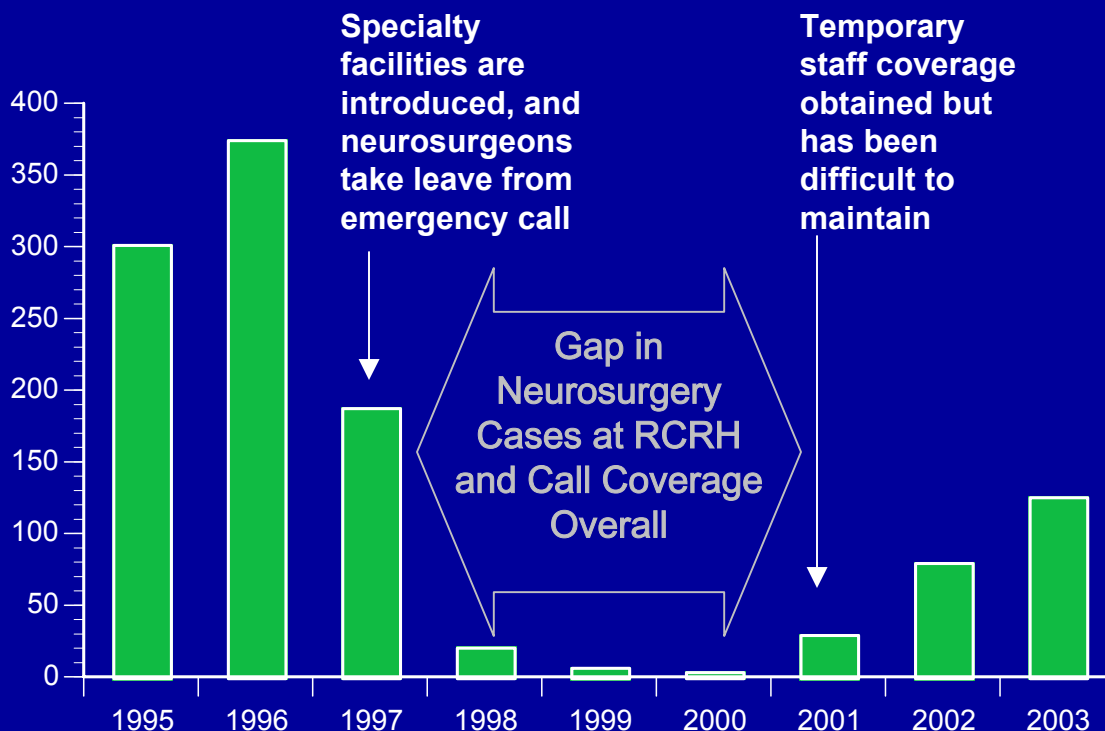
- **In the Black Hills region and Oklahoma City, a critical mass of physician-owners in key specialties opted out of community emergency call obligations.**
- **The Black Hills region provided an example of how emergency and trauma services can be compromised in sparsely populated areas.**
  - The region had a small number of physicians in many sub-specialties.
  - When a relatively small number of physician-owners opted out of emergency call, trauma services were threatened.
- **Oklahoma City's experience demonstrated how the development of a large number of limited-service facilities can threaten trauma and emergency services.**
  - Many physicians centered their practices at limited-service facilities and avoided emergency call altogether.
  - This put the trauma system for the state of Oklahoma at risk.

# In Rapid City, emergency and trauma coverage for neurosurgery suffered for the region at large.

## EXAMPLE Black Hills Case Study

### Number of Outpatient Neurosurgeries at Rapid City Regional Hospital, 1995-2003

- The lead organizers of Black Hills Surgery Center, who were the most active neurosurgeons in the region, no longer provide emergency coverage at the full-service hospital.
- And, no emergency service is offered at the surgical hospital.
- The result: a significant access problem for the region for emergency neurosurgery.





# Oklahoma faced a statewide crisis in trauma coverage as a result of so many physicians opting out of emergency call coverage.

## EXAMPLE Oklahoma City Case Study

- **In pre-existing arrangements, several Oklahoma City hospitals provided Level II trauma coverage.** Oklahoma University Medical Center (OU) provided the only Level I trauma coverage for the state.
- **As neurosurgeons, anesthesiologists and other critical specialties removed themselves from call coverage, the Level II trauma hospitals could no longer meet state standards for specialty coverage.** They began to downgrade to Level III status.
- **This placed unsustainable burdens on OUMC, which threatened to drop its Level I coverage unless others reinstated Level II coverage.**
- **In the face of public pressure, the county medical society, state hospital association and others brokered a compromise ...**
  - Neurosurgeons and other critical sub-specialists who had dropped off call agreed to provide coverage for one Oklahoma City hospital each night. Thus, there would be a rotating Level II trauma service.
  - Meanwhile, OUMC and the University physicians would continue to provide Level I coverage. But this had to be supported by a \$5.7 million subsidy from the state.
  - Thus far, the compromise, which is voluntary, has held up. Most physicians in the critical sub-specialties are participating.

## The withdrawal of specialists from call coverage also placed a greater burden on physicians at inner-city hospitals with busy emergency rooms.

### EXAMPLE Oklahoma City Case Study

- Many physician-owners reduced their admissions at the acute-care hospitals below the levels where they were required to participate in call coverage.
- This increased the call coverage obligations for remaining surgeons, which
  - Increased stress and reduced control over their time and patients.
  - Reduced their earnings potential. Emergency patients bring poor reimbursement in most sub-specialties. As emergency cases “crowd out” elective cases on a physician’s schedule, physician income falls.
- This has caused additional surgeons to leave these hospitals, and has made it difficult to recruit replacements.

*“They take the elective cases, but not the emergencies ... then the rest of us have our calendars filled with emergencies. Many of us can’t make a living that way.”*

## **The loss of net income from key services forced cutbacks in under-reimbursed services in all four case studies.**

- **Programs most at risk included:**
  - Behavioral health
  - Trauma
  - Subsidized services for low-income populations (outpatient clinics, outreach)
  - Health education/wellness
  - Medical education
- **Hospitals also had less ability to invest in new services and technology.**
  - Fewer dollars from operating income to invest in improving services
  - Declining financial performance can increase the costs of borrowing, e.g. Rapid City Regional Hospital's bond rating was downgraded
- **Medical communities were divided, with many expressing discomfort with adverse impacts on other health care services.**

# **In Rapid City, the loss of revenue left the full-service hospitals with difficult choices.**

## **EXAMPLE Black Hills Case Study**

- **Both full-service hospitals have experienced substantial financial declines.**
- **Although the effects have not fully played out, the choices open to the full-service hospital system include:**
  - Reductions in subsidized and/or poorly reimbursed community services (e.g., wellness)
  - Reductions in services in outlying areas (e.g., support for critical access hospitals)
  - Staff lay-offs
  - Reductions in non-paying or low-margin services
  - Curtailments in plans for expanding services that would require subsidies (e.g., endocrinology / diabetes)
  - More dependence on philanthropy
  - Price increases

# In Wichita, Wesley had to spend more to sustain its cardiac service and cut back on other services.

**EXAMPLE**  
Wichita Case Study

## Wesley Medical Center's Actions Following the Opening of Galichia Heart Hospital and the Kansas Spine Hospital

### Competing to Retain Resources Targeted by Limited-service Hospitals

- Increased cath lab staff salaries an average of \$2 per hour (cost \$2.5 million a year) and paid retention bonuses of \$7,500 each

### Cutting Back on Other Subsidized Services

- Laid off 120 full-time equivalent (FTE) employees in 2001 and another 54 in 2003
- Sold Occupational Medicine Clinic
- Closed Electron Microscopy Research Center
- Closed research program in pharmacy
- Closed outpatient pharmacy
- Downsized outreach and medical education departments

# In Oklahoma City, St. Anthony's had to cut back or close several subsidized programs.

**EXAMPLE**  
Oklahoma City Case Study

## Actions by St. Anthony Hospital in Response to Financial Losses Associated with Limited-service Hospitals

- Closed outpatient clinics around the city
- Reduced community medical education program
- Reduced the eye surgery program
- Closed the child behavioral day treatment program

*Source: St. Anthony's administration.*

# Impacts – Rising Utilization and Costs

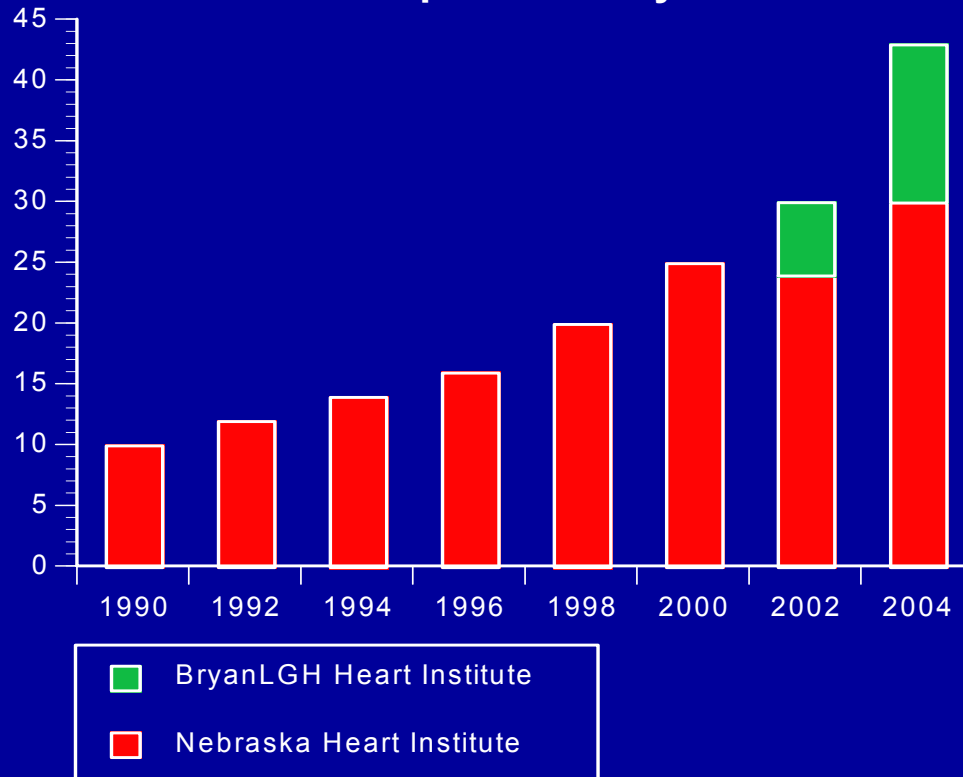
*“This now doubles (or more) the capital investment in the community ... to provide the same services.”*

Senior Manager, Blue Cross Blue Shield of Kansas

# The total resources (physicians, staff, facilities, equipment) devoted to providing the targeted procedures increased.

**EXAMPLE**  
Lincoln Case Study

## Number of Cardiovascular Physicians at the Nebraska Heart Hospital and BryanLGH



Some Nebraska Heart Institute physicians joined BryanLGH. Together, the Nebraska and BryanLGH Heart Institutes are adding physicians.

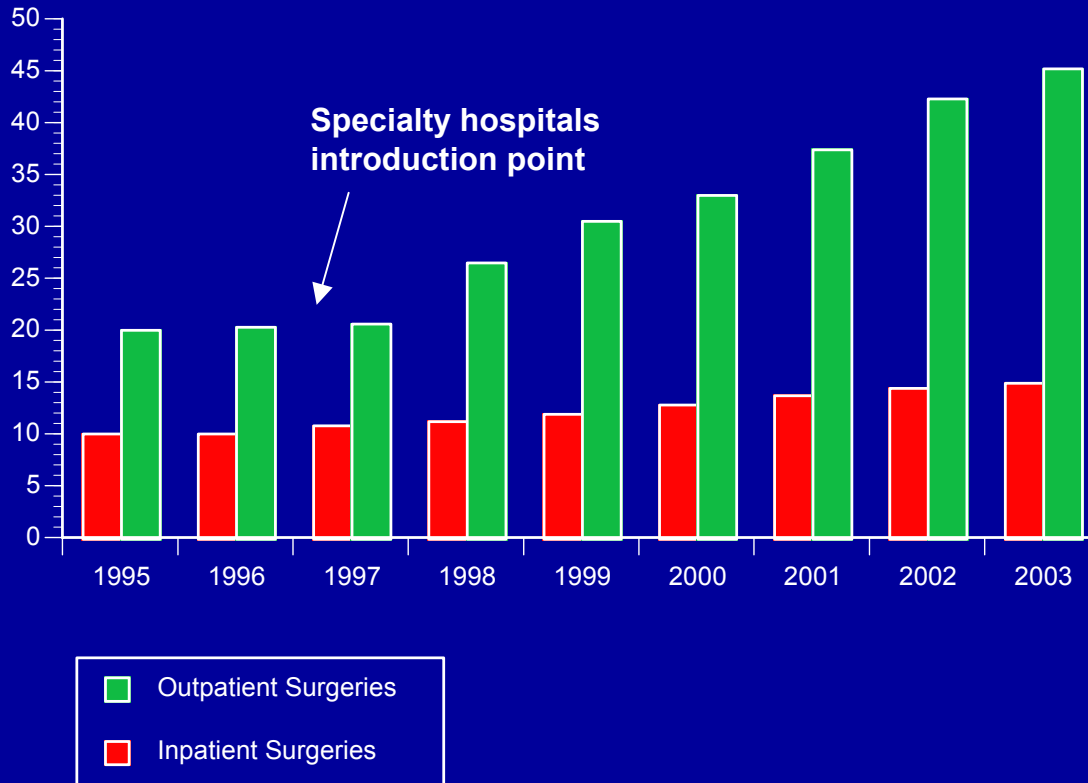
Source: Interviews with the BryanLGH and NHH managers, Web site reviews. Note: While NHI had 30 physicians in 2004, only 21 were based in Lincoln.



# Added capacity and volume has raised concerns about over-utilization.

**EXAMPLE**  
Black Hills Case Study

## Total Surgeries in Rapid City per 1,000 Service Area Residents



**In the Black Hills Region:**

- Outpatient surgeries up 120%
- Inpatient surgeries up 50%

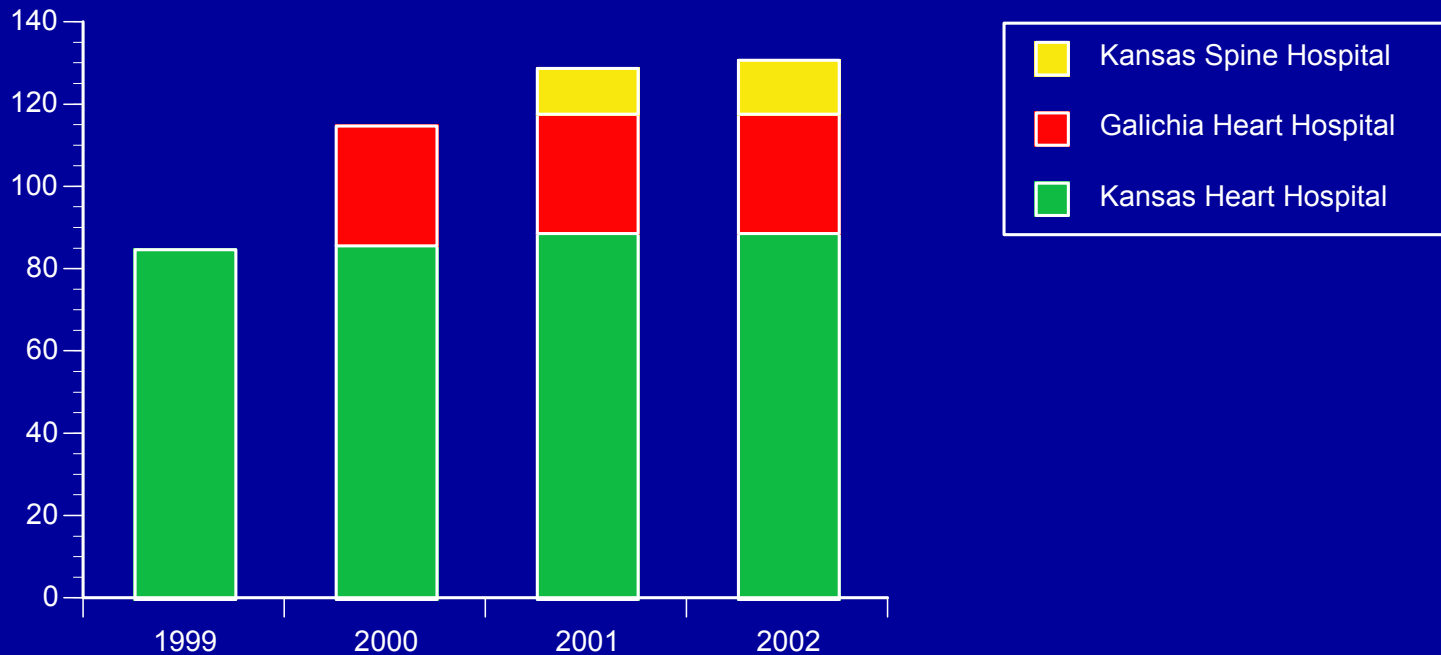
**The Dartmouth Atlas places all four case study areas above the 65<sup>th</sup> percentile for targeted procedures (e.g., back surgeries, coronary by-pass surgeries, hip replacements).**

**Rapid City is in the 99<sup>th</sup> percentile for back surgeries.**

# When key staff left the full-service hospitals to join the limited-service hospitals ...

**EXAMPLE**  
Wichita Case Study

## Cumulative Staff Losses by Via Christi to Three Limited-service Hospitals, 1999-2002



Source: Via Christi administration.

**... labor costs increased for full-service hospitals which had to raise salaries, pay retention bonuses, and fund turnover costs.**

**EXAMPLE**  
Oklahoma City Case Study

**Staff Turnover and Inducements to Avoid Turnover at OU Medical Center**

	<b>Lost Staff</b>	<b>Cost of Turnover</b>
<b>Registered Nurses</b>	<b>40</b>	<b>\$ 1,664,000</b>
<b>Respiratory Therapists</b>	<b>3</b>	<b>\$ 41,600</b>
<b>Other</b>	<b>13</b>	<b>\$ 459,680</b>
<b>Subtotal</b>	<b>56</b>	<b>\$ 2,165,280</b>
<b>Bonuses to Prevent ICU Closure</b>		<b>\$ 466,000</b>
<b>Total</b>		<b>\$ 2,631,280</b>

Source: OU Medical Center administration.

# Conclusions

## Case studies of four communities with a total of 18 physician-owned limited-service hospitals found that:

- Physician-owners demonstrated an ability to move patients from one hospital to another at will.
- Physician-owners steered selected patients to their hospitals (better reimbursed services and payer groups, elective cases, often lower acuity cases).
- This led to high profits.
- The host communities experienced
  - Decline in the financial health of full-service hospitals
  - Higher use rates for the services provided by the limited-service hospitals
  - Cutbacks in other, less well-reimbursed health care services
  - Access problems for emergency and trauma care
  - Divided physician communities



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