



## **Holy Cross Hospital – Chicago, Illinois**

### **Providing OB-GYN Care and Medical Homes through FQHC Partnerships**

**Overview:** Holy Cross Hospital, a 274-bed hospital located in the inner city on Chicago's southwest side, is a private, non-profit, religious-affiliated community hospital and the

only hospital in a four-mile radius. The hospital serves approximately 450,000 residents, a working-class and indigent, predominantly Hispanic and African-American population that is medically underserved. Some of its neighborhoods have seen a 20 percent drop in population in the last 10 years as people move closer to jobs and away from crime. Other neighborhoods are experiencing a large upswing of Latino residents. Overall, the community's payer mix is roughly 35 percent Medicare, 30 percent Medicaid, 30 percent uninsured, and 5 percent commercially insured.

Holy Cross Hospital could be characterized as an emergency department (ED) with critical care units. The hospital sees about 45,000 visits annually in its ED, with by far the highest number of ambulance runs in the state of Illinois, about 60 per day. Acuity of its patients is high, averaging almost 1.4 for its Medicare patients, despite doing little surgery. The hospital has 20 ICU beds, 45 telemetry beds, a rehabilitation unit, a hospice unit, and general medical beds. The average census is about 130 patients per day.

The hospital's medical staff is largely private; the typical physician has a solo practice and has been at the hospital for decades. Despite their advanced age, many physicians still rely on the ED to feed their practices, and they willingly take voluntary ED call to do so. The community does not have an extensive primary care network in place.

By fall 2008, Holy Cross had 3.5 days cash on hand. Management implemented a series of drastic cost-saving measures such as 15 percent staff cuts, 10 percent wage cuts to executives, frozen wages for others, reduced benefits, reduced cafeteria services, and other actions to stem the hemorrhaging of money. The staff cuts were accomplished in part by suspending the labor and delivery unit and closing the pediatric service. Labor and delivery had a breakeven volume requirement of about 1,200 deliveries per year but was experiencing about 650 deliveries per year.

The hospital was able to get a bill passed in the state legislature that provided a one-time payment of \$10,000,000 from the state to the hospital, in recognition of the volume of uncompensated and undercompensated care the hospital had been providing, and its role as a vital safety net provider. This stop gap measure provided breathing room to allow the hospital to develop other structural opportunities for long-term survival and growth.

One strategic issue was the lack of a viable primary care network in the community. Because of the payer mix of the community, the hospital did not expect new physicians to acquire the practices of retiring physicians. In addition, the demands on private practitioners no longer

support the solo practice model, and physician groups were unlikely to come to an area where reimbursement was so problematic. A second issue was the suspension of labor and delivery; the unit had to be reopened both for community service reasons and because it was a requirement of the disproportionate share funding on which the hospital was heavily dependent.

**FQHC strategy:** Hospital officials sought out a large federally qualified health center (FQHC), one that had some sites already operating in the periphery of the hospital's service area. With the assistance of a federal Emergency Department Diversion grant, funneled through the state of Illinois, the FQHC opened a primary care site on the campus of the Holy Cross in fall of 2009.

In February 2010, Holy Cross Hospital's Family Birth Center reopened. The FQHC agreed to an innovative contract in which the FQHC provided the 24/7 OB hospitalist service, structured so that the volume of OB patients from the FQHC's own practice plus the deliveries arriving via the ED combined to provide enough volume – along with concomitant gynecology consultations and procedures – to pay for the expense of round-the-clock staffing. The hospital subsidizes this expense until the service breaks even; breakeven is coming more quickly than anticipated.

A key feature of this strategy has been the insistence by the hospital, from the beginning, that a competitive environment be developed and maintained in the hospital's service area. This policy ensures that patients have a choice of providers; it also keeps the hospital from being overly dependent on one FQHC affiliate. To further this policy, the hospital recruited a second FQHC to open about one mile from the hospital, and is in conversations with other FQHCs in the area.

**Impact:** From a strategic point of view, this affiliation provided critical resources at a time when resources were otherwise unavailable. Labor and Delivery could not have been reopened without the FQHC fronting the costs, and using its FTCA benefit, to recruit obstetricians. The FQHC had primary care marketing expertise the hospital did not have. As a group, the FQHCs have been able to attract quality primary care providers who would likely not otherwise be available to our community. The hospital has been free to focus on rebuilding its core business while the FQHCs strengthened the primary care network.

On the other hand, dependence on another entity one does not control carries its own risks. Key performance targets important to the hospital but not to the FQHC have been missed. Key market opportunities important to the hospital but not as key to the FQHC partner have been missed. Customer service expectations – such as phone wait times – have varied significantly. To a slight degree, some of these issues have been moderated by the presence of other FQHCs and private providers in the market.

Finally, a challenge of affiliating with multiple FQHCs, as well as a contingent of private practitioners, is the management of referrals. Private OBs have significantly reduced opportunity to build their practices from unaffiliated patients coming to the ED. Patients have significant choice, but often do not exercise choice. The multiple options create complexity, and all the options likely require co-pays, which still make the ED an attractive alternative for primary care to our population. The hospital is still working on creating means to effectively usher ED non-urgent patients into viable primary care relationships.

**Future direction/sustainability:** Given the economic challenges of the hospital's community, we expect there will continue to be a role for multiple FQHCs. As performance requirements for all participants in the health care system – patients and providers alike – rapidly increase, the hospital's expectations of its FQHC affiliates will change and its relationships will be reevaluated. There will be opportunities to craft integrated, multi-provider strategies to reduce population-based incidence of disease and to work with other community entities to challenge unhealthy aspects of local community culture.

**Advice to others:** Our market is large enough to support an open, competitive market. Patients should have a choice, and there is enough volume for more than one FQHC. FQHCs have been able to attract quality providers who might otherwise be unavailable to our communities. Multiple partnerships encourage mutual accountability and spread risk. Different providers have different competitive advantages (such as price, language capacity, ease of use, and location). However, risks include an inability to control decisions vital to your own success. High-trust relationships can be constructed, but each organization will ultimately make decisions based on their unique calculus of the opportunities and risks before them. As access to scarce resources shifts, or the constraints on integrated provider relationships change, the hospital's "make vs. buy" or "partner vs. do-it-yourself" decisions will be revisited.

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