"COOPETITION"

J. ADRIAN WYLIE

AFTER DECADES OF MISTRUST, THE U-M MEDICAL CENTER AND ST. JOE'S ARE WORKING TOGETHER.

BY DEBBIE EISENBERG MERION

U-M Hospitals CEO Doug Strong (left) has to turn away patients, while St. Joe's CEO Rob Casalou (above) has unfilled beds. They're talking about sharing space—and potentially much more.

Half of the lights on the tenth floor of St. Joseph Mercy Hospital are turned off, and there is an unnatural calm amidst the smell of fresh paint, curved wooden paneling, and newly tiled floors and walls. There is no hum of a Coke machine in the guest waiting area, no nurses sitting at the nurses' station, no hopeful or tearstained families whispering in the hallway.

This is a beautiful, clean space, as inviting as any hotel. But all thirty-four beds on this floor are idle. A twenty-room progressive care unit is also unoccupied, leaving one-tenth of the new, $294 million, 537-bed hospital vacant. St. Joe's doesn't have the patients to fill it.

A gaze from the spotless picture windows on the top floor reveals a possible solution in the distance: University Hospital. In March, a thunderbolt of a press release seemed to momentarily light up the dark rooms: "U-M Health System and Trinity Health–Michigan sign master affiliation agreement."

"We are starting to shrink capacity, and U-M is at capacity," says Rob Casalou, the Saint Joseph Mercy Health System's CEO for Washtenaw and Livingston counties. "I think we both see that there are great opportunities for us to cooperate there."

Doug Strong, CEO of the University of Michigan Hospitals, agrees. "We turn away adults and children on a weekly basis—we have several hundred patients a year that can't be accommodated as quickly as needed. For the adult population, the problem is physical—not enough beds. For children, we don't have enough people, mainly nurses.

"We are looking at using each other's facilities," Strong continues. "We are in conversations about whether we can commingle patients." Those conversations, he adds, are unaffected by the recent steps to expand University Hospital into the former Mott Children's Hospital. "We are eager to explore this experiment on behalf of the community."

Reconsidering their longtime rivalry is one way that the hospitals are responding to an ever-tightening health-care market. "There was a feeling that health care was recession-proof, because if you're sick you're going to go to the hospital," says Casalou. But during the recession, some people put off getting care. Others who got care couldn't pay for it—Casalou says that despite the economic recovery, the percentage of unpaid care St. Joe's provides is still rising. And many people fell back on Medicaid, the federal health insurance program for the poor.

> THE RELATIONSHIPS THAT ARE DEVELOPING ARE "VERY UNIQUE," SAYS CASALOU. "SOME PEOPLE CALL IT 'COOPETITION.' WE STILL WILL IN SOME REGARDS COMPETE, AND MANY TIMES WE'LL COOPERATE."

But more patients insured by the government doesn't always mean more money from the government. Michigan now has 1.9 million Medicaid patients, up from 1.3 million ten years ago, but state Medicaid appropriations are no higher than they were ten years ago. Another half-million Michigan residents could go on Medicaid in 2014, when the Affordable Care Act (aka Obamacare) expands eligibility rules. But the federal law provides extra funding for only two years, Casalou points out. After that, states are on their own. Further increasing the financial pressure, this summer the federal government will freeze payments for elderly patients insured by Medicare. Like a tree during a drought extending its roots, hospitals are looking at alternatives to survive.

Talk of drought may seem strange, considering the river of money flowing through the American medical system. In 2010, the U.S. spent $2.6 trillion on health care—$8,000 for every person in the country. But now the federal government is rocking the boat, and doctors and hospitals are clinging to each other for dear life.

What most patients don't know is that the way health care is delivered in America is about to change 180 degrees, and the evidence of the change can already be seen in Ann Arbor. Hospitals have always been paid to house patients, and doctors to provide specific services, from delivering babies to heart transplants. The Affordable Care Act envisions replacing that with "managed care," delivered by groups of physicians and hospitals that are financially connected, and that are willing to provide all the health-care needs for an entire population for a flat sum per person. The act calls these legal entities "Accountable Care Organizations" (ACOs), reflecting their mission to reduce spending while providing the same or better patient care.

Since hospital care is so expensive—according to hospitalcompare.hhs.gov, treating a heart attack costs an average of $5,299 at St. Joe's and $7,145 at the U-M—ACOs will need to minimize hospital stays in order to save money. And whatever happens to Obamacare—the Supreme Court is currently considering a legal challenge—the new payment model is gaining momentum. Blue Cross Blue Shield already offers an ACO-like program that it calls its Organized System of Care.

Blue-eyed, fortyish, and trim from long-distance cycling as he trains for a 300-mile Make-a-Wish fundraiser this summer, Casalou describes these pressures with the same calm approachability and clarity of the message he's been giving to St. Joe's staff: This is urgent, but don't panic. We have a plan.

More money is supposed to flow into the health-care system in 2014, when all Americans will be required to buy health insurance as part of the Affordable Care Act. But Casalou says that St. Joe's can't and won't wait for the Supreme Court's decision on that.

"The mantra we have is we are managing through a transition, and we can't let the transition kill us," says Casalou. "They could repeal the health care reform act tomorrow, and it would not change one thing that we're doing."

The flutter of hospital helicopters cutting through the air overhead is both frightening and comforting—a resource you hope you never need but are happy is there if you need it. For St. Joe's, a chopper's blades were similarly a double-edged sword: a sign of its independence and strength, and also a money loser to the tune of $1.6 million a year.

Though the U-M and St. Joe's are just five miles apart, for more than twenty years each operated its own air ambulance service. The duplication of Survival Flight and Midwest Medflight reflected the deep mistrust between their parents. When the hospitals sat down to discuss combining the services, Doug Strong recalls, "we had to overcome concern from St. Joe's that they would not be first-class citizens" in the alliance.

"Those with long memories thought the U-M would steal all of our patients," Casalou confirms. Nonetheless, last September, Midwest Medflight ceased operations. Air ambulance patients bound for St. Joe's, now travel on Survival Flight. And according to Casalou, the "U-M has completely lived up to their end of the deal. They bring the [patient] transports here that are supposed to come here. If there are field traumas out there, depending on the geography, they bring them here, instead of the university—so they haven't used it as a [competitive] mechanism. They get our business, but they have not used it to inure themselves at our expense."

And the gain in efficiency is incredible. Midwest Medflight made 600 flights a year and had two dozen staff and contract employees. Yet Survival Flight was able to take over all its responsibilities with its existing staff and equipment. "We didn't buy a new helicopter, we had no new expense," says Strong, while St. Joe's "savings were considerable."

Another example of the growing trust is St. Joe's relationship with the U-M in pediatric cardiology. Until recently, when children hospitalized at St. Joe's needed advanced heart surgery, the operations were performed by doctors from the Detroit-based Children's Hospital of Michigan rather than from the U-M. Casalou says that the university insisted that young heart patients be transferred to its hospital before their doctors would operate; Children's was willing to come to St. Joe's.

Casalou says that when cooperating with the U-M was proposed, there were people who said, " 'it will never work. They [U-M] won't provide the same services as Children's, they just want every [patient] shipped over there.' " But Casalou says the U-M not only provides that same service that Children's did, it also added a pediatric cardiology clinic at St. Joe's, and streamlined its admissions procedures so doctors and patients can easily move between the two hospitals. "They have really gone out of their way to extend themselves into here, and that has made the difference," says Casalou.

"We've waxed and waned in terms of thinking collaboratively and thinking competitively," says Strong. Gray-haired, sturdy, and soft spoken, his well worn U-M ID hanging from a chain over the middle of his full chest, he meets a reporter at a round table in his conference room at 300 North Ingalls. The building, ironically, housed St. Joseph Mercy Hospital until 1977. Now the U-M is again considering using space built by St. Joe's.

Beds are just the beginning of what the university wants from this new relationship: it's also looking for referrals from St. Joe's parent, the Trinity Health System. Strong says that only one-third of their patients live within thirty miles, the radius where they compete with St. Joe's. Two-thirds come from farther away. While the U-M is "comfortable" with its ability to compete with St. Joe's locally, Strong says, "we are less confident of the other two-thirds." That's where Trinity's forty-seven hospitals in seven states, including sixteen in Michigan, look very attractive.

"Our competitor there is not St. Joe's, because they are not in the referral business," Strong explains. "Our mutual presence could strengthen the Trinity brand—we could collaborate and earn referrals back here. Even if U-M and St. Joe's were in an active phase of competition [locally], there would still be a logic for this statewide Trinity agreement," says Strong. "We can't own everything."

"I've been here for thirteen and a half years, and I've seen the pendulum swing," the U-M CEO continues. "But we're at a point now where both organizations believe that there is enough business for both organizations to thrive. What the nation and the state and our citizens are asking [of] us is improving quality and efficiency at the same time, and we are learning and believing that a lot of this can be done through collaboration, as opposed to just flat-out competition."

The relationships that are developing are "very unique," says Casalou. "Some people call it 'coopetition.' We still will in some regards compete, and many times we'll cooperate … The nice thing is we talk about just about everything."

Both hospitals hope that coopetition will be just what the doctor ordered as they adapt to the new economics of medicine. And as their discussions continue, sharing beds could be just the first phase of the treatment.

In December, the federal Center for Medicare and Medicaid Services announced that the U-M was one of thirty-two medical centers around the country chosen to launch the "Pioneer ACO Model." It's a pilot project testing the new "shared savings payment policy," so called because hospitals and physicians will both benefit if the ACO delivers care more efficiently. And the university invited the doctors at St. Joe's corporate cousin, Integrated Health Associates, to join them.

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"We were not looking to be bought," says Mary Durfee, medical director of Integrated Health Associates. But with new managed-care plans coming, "we needed better partnerships with a hospital." Since its 2010 merger with Trinity Health, IHA has added eighty providers, including Jay Winegarden and his colleagues at Ann Arbor Oncology Associates.

> WHEN MIDWEST MEDFLIGHT CEASED OPERATIONS LAST FALL, U-M'S SURVIVAL FLIGHT TOOK OVER ITS RUNS WITHOUT ADDING EQUIPMENT OR STAFF. THE SAVINGS: $1.6 MILLION A YEAR.

Casalou is on the steering committee for the Pioneer project. "If our experience is good there, we can envision a more community-wide ACO," he says. "Maybe, for primary care, we could all end up together, in one big giant ACO." Not only could local patients move back and forth between the competing hospitals in the future, they could even get their primary care from the same physicians' network.

St. Joe's has been adding doctors to its fold in record numbers in the last two years. In back-to-back deals at the end of 2010, its corporate parent, SJMHS, acquired Michigan Heart with thirty-four cardiologists, while its corporate grandparent, Trinity, merged with Integrated Health Associates, a mega-practice with 192 primary-care docs and specialists and more than 260,000 patients.

"We were not looking at being bought," says Mary Durfee, IHA's medical director. But with ACOs on the horizon, they knew "we needed better partnerships with a hospital, and we were discussing what was the vehicle to partner our skills, people, and leadership."

And St. Joe's needed doctors, not only to solidify their patient base, but because physicians will be the decision makers and the key to saving money in future ACOs.

Since the merger, Trinity's cash has fueled rapid growth. "IHA had a goal to double their size by 2019," says Casalou. "We said we wanted to cut that to 2015, and it looks like we are going to accomplish it by 2014 … we're up to 270 providers—I say 'providers' intentionally, because it is a mix of doctors and mid-level providers. Probably at this time next year that number will be well [over] 300."

Last fall, Paul Harkaway, then president of the independent Huron Valley Physicians Association, compared the national rush to form large medical groups to "a feeding frenzy. Hospitals aren't ringing doorbells," he said. "Largely, physicians are offering themselves to hospitals." (Harkaway has since been consumed himself—he now works for Trinity, overseeing its relationships with independent doctors—see box, p. 29).

Jay Winegarden understands the urge to merge. "It was clear there was a problem with our current model of generating revenue," says the managing partner of Ann Arbor Oncology Associates. "My salary had dropped by nearly 50 percent of what I was making five years ago."

The problem was not Obamacare, but the Medicare and Medicaid Act of 2003. Provisions in the law that were intended to prevent fraud had the effect of restricting payments to oncology physicians, who deliver cancer treatments such as chemotherapy.

"This is a producer-based system," says the slim, forty-two-year-old physician. "You are not reimbursed for thinking. It's a lot easier to show that you took out an appendix, as opposed to me coming up with a chemotherapy plan."

Winegarden talked to St. Joe's, the U-M, and IHA—"not to start a bidding war, but to find the best thing for the doctors I represent." The best thing meant not only what they'd earn, but "who will allow us to deliver the best patient care."

His group decided to accept IHA's offer, Winegarden says, because they wanted to stay in place in the Reichert Building, and "IHA had the economics to make it work so that we could retain the physicians we have and recruit good physicians." IHA also brought the doctors' salaries back to the median levels reported by professional groups. But while the checks are larger and more stable, Winegarden notes, "provider compensation is based upon productivity and patient surveys that are given two times a year."

Casalou says his own performance is judged similarly. "More of my evaluation is not-financial than financial," he says. "It's more around patient satisfaction, safety scores, how satisfied our employees are and how satisfied our doctors are—and 'by the way, did you make your budget?'"

The coopetition between the U-M and St. Joe's is a harbinger of what will happen throughout the country. "The State of Michigan is a national leader in learning how to take off competitive hats and put on collaborative hats," says Doug Strong. "I think what is happening in Ann Arbor is a microcosm of that overall effort."

But will the prescribed treatment work?

And if it does, how will it affect patients?

"One of the drivers is [that] the government thinks this industry is too fractured, and they think bigger will be better," says David Butz, a U-M Business School faculty member specializing in health-care economics. "But I see no reason to think bigger will be better."

The history of an earlier federal effort to promote managed care isn't encouraging. "Health maintenance organizations" were supposed to reduce the need for acute and emergency treatment by providing better preventive care. When that didn't happen, HMOs were reconfigured to make primary-care docs "gatekeepers" who had incentives to limit unneeded care. But spending continued its relentless growth. Most European countries, Canada, and Japan spend about half as much per person as the U.S., and in most of those countries, people live longer.

One way that supporters think ACOs can save money is by doing a better job of outpatient care. If chronic conditions like diabetes and congestive heart failure are not well managed, they can lead to frequent and expensive hospitalizations. So hospitals are teaming up not only with primary-care doctors, but with home-health-care networks as well. Treating people in the least-intensive possible setting, Casalou says, is in everyone's best interest: "I've never seen a patient who argues that they want to be in the hospital."

The other plan to save money is to make patients take more responsibility for their own health. Though most doctors already encourage healthy habits like losing weight and getting more exercise, the message is often tuned out—or rejected outright. One local woman who goes to a very fitness-minded doctor tells how, after confirming her blood pressure was under control, she scolded him, "That's all you need to know. Don't go closing that door and lecturing me" about healthier living.

"If they won't listen to advice, then it's going to have to be out of the pocketbook," Casalou says. "If you look at obesity rates in this county, only 2 percent is explained by thyroids or other medical conditions. That means 98 percent of obesity is controllable." Knowing that saving money can be a motivator, insurance plans such as Blue Cross Blue Shield's Healthy Living already give financial incentives to people with good health habits, such as not smoking and controlling their weight. Patients can expect a lot more of that in the future.

Casalou practices what he preaches. Not only is St. Joe's sponsoring the Make-a-Wish Foundation's 300-mile bicycle tour in July, but Casalou will be riding in it as part of "Team Joe's."

His personal goal is to raise $10,000. But first, he's going to challenge the U-M to create their own team. The fundraising bike ride could be just one more phase in their growing coopetition. ■

THE WAR OF INDEPENDENTS

At least one local medical practice has no interest in merging or being purchased by a hospital. Like a shy but pretty girl at a party, Washtenaw Medicine (WM) is still getting noticed while sitting alone at the sidelines.

"There is always going to be someone who will talk to you, especially in this environment," says WM founder Michael Sanson.

Sanson worked at St. Joe's for eleven years before he and his wife, Sherrie Tefend, also an internal medicine physician, started WM in 2003. It's since grown to include twenty-four providers in five offices who send patients to the U-M, St. Joe's, and Beaumont Hospital in suburban Detroit. But Sanson says he's committed to staying independent of any one hospital, because he likes being nimble. St. Joe's, he says, is "a good organization, and it's a larger organization, and sometimes smaller details are not addressed in a timely manner." When he worked there, he says, if he needed a new medical assistant the authorization and budgeting process could take several months. Now, when he needs a new assistant, he just hires one.

Sanson is able to stay independent in part through the support of the Huron Valley Physicians Association. Created by a small group of St. Joe's doctors in 1973, HVPA has grown to include 750 physicians who pool resources in areas such as informational technology and billing. But now change is in the air for HVPA.

"HVPA is in the middle of a lot of long weekend retreats trying to decide what their future looks like," says St. Joe's CEO Rob Casalou.

Will HVPA's physicians be able to remain independent, or will they find themselves pulled into the "coopetition" between St. Joe's and the U-M? While it's too soon to know for sure, it may be telling that the group's immediate past president, Paul Harkaway, is himself no longer independent. In January, Harkaway started work at St. Joe's parent, the Trinity Health System, as vice president of clinical integration and accountable care. His job, a PR person emails, includes "determining the best structure for our relationships with our external physician network.

He'll have plenty to do. Harkaway was hired, Casalou says, "because what we are talking about here [creating physician-hospital networks] is happening with Trinity in every market from here to California to Maryland."

—D.E.M.