Case Study | North Shore-LIJ

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North Shore-LIJ Sets Sights on Care Coordination

North Shore-LIJ Health System was already one of the largest health systems in the nation, with 5,600 beds in its 15 hospitals. And even with 42,000 employees making it the ninth-largest employer in the city, North Shore-LIJ had an identity problem as far as New Yorkers were concerned, says president and CEO Michael Dowling.

"There is part of the world that believes if you're not in Manhattan, you don't exist," Dowling says. "I mean, people who live in Manhattan think that Manhattan is the only New York."

So when Lenox Hill Hospital on East 77th Street in Manhattan came looking for a merger partner, the North Shore-LIJ team saw it as an opportunity to get a footprint in a coveted borough. With 652 beds, a 153-year-old brand, and strength in key service lines including cardiac and orthopedic care, Lenox Hill was a good strategic fit. North Shore-LIJ’s analysis had found that its existing hospitals drew well from residents on the east side of the Van Wyck expressway that splits Queens, but those on the west side often went into Manhattan for care.

At the root of North-Shore LIJ’s growth and merger strategy is the drive to get scale—size that allows the health system to coordinate care and chop off costs that come from overlapping markets and gaps in care. Itself the product of a 1991 merger of North Shore University Hospital and Glen Cove Hospital, the system now has a service area of more than 7 million people.

Robert S. Shapiro, North-Shore-LIJ’s chief financial officer, says Lenox Hill was a standalone hospital in need a stronger financial partner. (The deal technically was a no-cash assumption of assets and a promise of capital.) “Some merge from a position of strength, and some merge from a position of weakness. Unfortunately for Lenox Hill, they went through many years of struggling financially. It was and is a world-class institution, providing high-quality healthcare with known and named physicians.”
Shapiro's financial due diligence requires looking at the balance sheet, sifting through debt, analyzing if the population base is strong enough to support positive revenue performance. With Lenox Hill, he found that the hospital had tried to negotiate with payers back in the 1990s on its own, and without the leverage of a large system their resulting revenue per discharge was lower than they needed to operate. As a result, investment in capital had been down for some time, including the loss of some administrative staff and the loss of some key physicians.

But not all the news was bad. While the revenue cycle needed work, the hospital’s balance sheet was good, Shapiro says. “There were some areas that had to be improved, but all in all, it was in pretty good condition. There are many books that describe how organizations fail, and the various stages they go through; they were not near the end.” While some investment to replace key positions would come, the need was more for investments that could be made over time and not a large, immediate infusion of cash, Shapiro says. Mark Solazzo, North Shore-LIJ’s chief operating officer, says as with many of the system’s 14 previous mergers, they found Lenox Hill understaffed.

“Because Lenox Hill was struggling to survive financially, they pulled staff out of the mix that they would deem non-core, and that we deem extremely core, for example, nurse educators, supervisors on off shifts, unit clerks that help the nurses stay at the bedside, those types of positions,” Solazzo says.

So Solazzo’s team released 110 new positions at Lenox Hill for hire and plans to add 100 more over the next year. On the outside it might seem counter-intuitive. Mergers in non-healthcare fields usually lead to a net loss of employees, as redundancy is eliminated to gain efficiency. Solazzo sees the opposite.

“On the one hand, I think the net employment usually rises when we take on an acquisition, but where we create the value is that we create additional throughput and efficiency, so we are able to serve more people and get more volume in a place with that increment of staff. Because usually what happens is that when you take those people out of the mix, the hospital operations get a little gummed up and less efficient.”

**Physician ties**

Mergers live and die by the will of the physicians involved. But that does not mean that North Shore-LIJ seeks to “own” all physicians on staff. Of the more than 9,000 physicians at the system, approximately 1,600 are salaried, says Dowling. North Shore-LIJ’s strategy is to create as much cultural and virtual alignment as possible with physicians, including a lot of leadership face-to-face time. The same was true when the Lenox Hill merger became a possibility.

“I don’t own them, but there is a core body of physicians at Lenox Hill that are unbelievably loyal to the institution and have stayed loyal even during a period of time when the hospital was having some trouble, so there is a great foundation there,” Dowling says.

Much of the work with physicians is done during an extensive due diligence, where the team analyzes how the physician partners really work, says Solazzo.

“The part that you have to be most careful of is how you seek to integrate the physicians into your clinical programs. We take a very
cautious and deliberate approach, really trying to understand the physician medical staff network, because a medical staff of a hospital is very unique—how they operate, how they function, how their referral network exists, who are the influence makers, and who are the people in leadership positions, Solazzo says.

Dowling and Solazzo take a “go to them” approach in creating the physician communication for a merger.

"Since we started this process a number of months ago, I think I have had about another thousand dinners and breakfasts,” Solazzo says. “You have got to go to their office to understand where they live and what they face. It gives you a sort of sense of who they are and their work environment. Bringing a dozen doctors into a boardroom tells you very little.”

Once the integration process starts, the merged physicians and clinical staff are brought to system-level expectations of quality and performance, but with the understanding that not everyone will get to those standards in the exact same way, says chief medical officer Lawrence G. Smith, MD.

“If you look at how we manage quality and how do we really actually function as a system instead of a bunch of independent hospitals, the approach is very clear, which is that we set standards centrally, and then we allow local solutions,” Smith says, “We are pretty cognizant of the fact that you can't impose solutions on an individual place, because the local culture, the resources, and the traditions can be very different, hospital to hospital. But you can't compromise on standards. Everybody has to get to excellence.”

North Shore-LIJ has seen a lot of interest from private practice physicians looking for the safety of linkage with a health system. While the system is in no rush to necessarily employ in large numbers, Smith believes offering options for integration will serve the private practitioner and North Shore-LIJ.

“We are trying very hard through this electronic medical record initiative to build synergies and linkages with physicians without them having to become a full-time employed physician, so that there’s the option of working together and being able to function in an integrated healthcare delivery system without them having to give up their own personal business and become fully employed.”

"From the very beginning we developed our system differently than anybody else in this region, where we have single administration, single clinical leadership, single board structure, and everything is owned. We not only have hospitals but we have the whole continuum of care.”

Michael Dowling, President and CEO, North Shore-LIJ
Integration

Dowling and his team say they are acutely aware of the downside of mergers where hospitals add size without integration. “There are many hospital systems, even in this region, that’ll tell you they’re integrated where there is no integration at all,” Dowling says. “People collect hospitals so that they can put them on letterhead. The alternative is that you have hospitals join you and you integrate them fully.”

As with all hospitals in the North Shore-LIJ system, administration is centralized. Systems from finance to procurement to IT are all integrated. Governing boards at the merged hospitals are kept but are converted to advisory boards only.

“We don’t have sponsorship agreements that provide for, I’ll call it, ‘separateness,’ Shapiro says. “We have one CEO over all the hospitals, one CFO and one COO. And I’m also very proud to say that the management team here has worked together at a minimum of 15 years together, and many of us have been in the organization for much longer than that. And so we know each other, we know how we operate, and we’re all singing the same tune together.”

Dowling says that from the beginning of the system North Shore-LIJ has been moving toward a fully-integrated system “that manages and coordinates care.” So Dowling says federal healthcare payment reform and the creation of accountable care structures is not a major shift for his organization.

“From the very beginning we developed our system differently than anybody else in this region, where we have single administration, single clinical leadership, single board structure, and everything is owned. We not only have hospitals but we have the whole continuum of care,” Dowling says.

In addition to hospital mergers like Lenox Hill, Dowling has been buying other pieces of the continuum, including placing a winning $17 million bid on the homecare license left from the bankruptcy of Saint Vincent Catholic Medical Center’s Certified Home Health Agency based in Manhattan. The one piece of the continuum missing from North Shore-LIJ is a health plan, which Dowling says is “something we are definitely planning for.”
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Paul Mattioli, Senior Director of Sales
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