**CASE 14 Cooper Green Hospital and the Community Care Plan\***

**An Overworked CEO**

There are certain days when life seems unbearable. For Max Michael, MD, it had been one of those days. He had the difficult responsibility of balancing costs with access to care, of rationing procedures with policy, and of juggling personnel with budgets, performance, and demand. Dr. Michael, a former chief of staff at the hospital and now its chief executive officer (CEO), had spent the better part of his day fighting a losing battle in an understaffed, understocked, overflowing outpatient clinic. It was there, on the front lines, where he had first encountered the nature of the health care problem and developed his vision for its solution. As Dr. Michael left the clinic that evening, he mulled over a looming decision he was going to have to make. It was his last patient that reminded him of the importance of that decision.

**Martha James Spent Her Day at Cooper Green Hospital**

It was the second day in a row that Martha James missed work because she was running a fever and ached all over. She dared not miss another day for fear of losing the job she had with a small local business that paid above minimum wage but offered no health insurance. Her husband also was employed full time but did not receive any insurance benefits. Money was very tight for the couple and their two children, yet, based on federal guidelines, they were not eligible for financial assistance from the Aid to Families and Dependent Children (AFDC) welfare program; nor were they eligible for state Medicaid benefits. With no money to spare, the cost of a visit to a physician's office was a luxury Martha felt she could not afford. She did the only thing she knew to do: she headed for the emergency room at Cooper Green Hospital.

It was nearly 9:00 A.M. when Martha arrived after a 45-minute bus ride. She waited for more than two hours before her name was finally called. The nurse asked her about her symptoms. Barely even looking up, the nurse said Martha would have to be seen over at the Outpatient Clinic because her case was not truly an “emergency.” She was told to sign in at the Clinic desk and they would try to “work her in.”

After more than four hours of sitting in the overcrowded waiting room, Martha finally heard her name called again. The doctor who took her case was a silver-haired man with sharp eyes and a concerned demeanor. Dr. Michael quickly determined the problem: a respiratory tract infection that had been “going around” for weeks. When asked, she admitted she had been coughing for more than a week, but had hoped the severe cough would go away on its own. “Besides,” she said, “I can't afford to take a day off work to go to the doctor for just a cold.”

“The problem,” Dr. Michael explained, “is the infection is now affecting your lungs, which requires more intensive treatment than if you had come for help a week ago.”

Glancing at her chart, he realized she lived near Lawson State College, the location of one of the hospital's Community Care Plan (CCP) clinics. He asked, “Martha, are you aware of the Community Care Plan clinics and the services they offer? They have medical office visits with much shorter waiting times.”

She replied, “I have heard something about them, but don't really know what it is about or how it could help me.”

Martha still had to stop by the hospital pharmacy to pick up two medications and it was nearly 5:30 P.M. She knew she could get them much faster at a local drug store, but they would be several times as expensive. Instead, she settled in for another wait. By the time she headed back to the bus stop–some nine hours after she left home–Dr. Michael was wrapping up his afternoon in the clinic.

\* This case was written by Alice Adams and Peter M. Ginter, University of Alabama at Birmingham, and Linda E. Swayne, The University of North Carolina at Charlotte. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission from Alice Adams.

**Dr. Michael Wraps up His Day**

As Dr. Michael entered his office, Martha James was still on his mind. It had been nearly four years since he launched the Community Care Plan, but in many ways it was still struggling. In his heart, he still believed it was a good model to provide access to preventive and routine medical services to the population traditionally served by Cooper Green Hospital: the poor and uninsured of Jefferson County. It placed small outpatient clinics within local neighborhoods. They were staffed by physician assistants or nurse practitioners, who were supervised by a physician. For a quarterly fee, members could receive routine medical care at the CCP clinics. When needed, they also received care from specialists, and even inpatient hospital care at Cooper Green. To Dr. Michael it made perfect sense; the CCP offered better access to services, less waiting time, less travel time, and a better atmosphere.

But the numbers did not agree. Although some of the CCP clinics established a reasonably sized patient base, others were struggling to attract members. If Martha James had been a CCP member, she could have been seen and received treatment before the infection had migrated to her lungs and she would not have had such a long waiting time. “For her, and thousands more like her,” Dr. Michael thought, “it's important to keep the CCP running–if at all possible.” But few people knew about the CCP and even fewer had joined.

The five-year funding that enabled the hospital to launch the CCP was about to run out. Dr. Michael knew he was facing a critical decision: should he push forward with expansion plans for the CCP, maintain the clinics that existed, or fold the program altogether?

**Cooper Green Hospital**

In 1998, Cooper Green Hospital (CGH) was the current incarnation of Mercy Hospital. Built in 1972 with Alabama State and Hill-Burton funding, Mercy Hospital served the vision of the Alabama legislature to provide care for the indigent population of Jefferson County. Despite numerous organizational, structure, and name changes, the mission of the facility remained essentially the same: to provide quality medical care to the residents of Jefferson County, regardless of their ability to pay.

Mercy Hospital opened with 319 inpatient beds–a number based on an epidemiological study using the number of indigent cases reported in county hospitals during the mid-1960s. The study projected that the hospital would operate near 80 percent capacity. Occupancy never reached the initial projections.

The highest average census for the hospital was 186.3 in fiscal year 1974. The numbers of inpatient admissions, discharges, and length of stay for 1998 are shown in Exhibit 14/1.

Exhibit 14/1: Inpatient Statistics for Cooper Green Hospital, Fiscal Year 1998

|  |  |  |  |
| --- | --- | --- | --- |
| **Location**  | **Admissions** | **Discharges** | **Average Length of Stay** |
| 4 West | 1,464 | 1,518 | 4.1 |
| 7 West | 1,742 | 2,197 | 4.6 |
| MSICU | 673 | 145 | 3.8 |
| 5 East | 303 | 1,827 | 2.3 |
| Labor And Delivery | 1,596 | 75 | 1.0 |
| Nursery | 1,444 | 1,441 | 2.1 |
| Total | 7,222 | 7,203 | 3.0 |

The role CGH played in the community faced constant scrutiny from a county commission with increasing budget pressures. Media and public challenges about the quality of care provided by CGH limited its ability to attract patients with private insurance. For the first two decades of the hospital's operations, cost overruns were common, as the county's indigent population grew and medical costs soared. Facing increasing costs, Dr. Michael and the administrative staff initiated a stringent budget-cutting program that included personnel lay-offs, taking beds out of service, postponing most capital improvements, and eliminating some services. The hospital's financial statements for the fiscal years 1993–1998 are included in Exhibits 14/2 and 14/3.

Early in his tenure as CEO, Dr. Michael initiated a strategic planning program for the hospital. Mission, vision, and value statements were developed (see Exhibit 14/4), strategic goals were outlined, and plans for meeting them were created. Each year, the strategic goals for the upcoming fiscal year were developed by the “management group” (consisting of the CEO, COO, CFO, Medical Chief of Staff, and Nursing Administrator) and distributed to all departmental supervisors.

As a result of ongoing strategic planning, Dr. Michael took the initial steps to transform Cooper Green Hospital into the Jefferson Health System (JHS) in 1998. JHS consisted of CGH (the inpatient facility) and Jefferson Outpatient Care (comprised of the outpatient clinics located in the hospital and six satellite clinics of CCP). JHS provided services to patients through two plans: HealthFirst, a traditional fee-for-service plan, and the Community Care Plan (CCP), a pre-paid membership plan.

Part of the motive for the transformation and expansion of CGH was to enhance its ability to generate external revenue, including attracting patients with private insurance. If CGH could attract paying patients on the basis of quality and satisfaction, it could mold itself from a provider of last resort into a true competitor in the market.

Exhibit 14/2: Cooper Green Hospital/Jefferson Health System Sources of Revenue

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1994 | 1995 | 1996 | 1997 | 1998 |
| Indigent Care Fund | $13,126,249 | $23,168,333 | $31,638,294 | $34,824,238 | $36,199,381 |
| Disproportionate Share Fund | $4,419,644 | $8,854,308 | $3,329,871 | $3,596,076 | $3,238,323 |
| Medicare (total payments) | $10,566,183 | $9,566,505 | $9,974,860 | $10,033,547 | $7,056,823 |
| Medicaid | $7,107,137 | $11,442,428 | $8,934,432 | $7,900,835 | $15,604,803 |
| Blue Cross | $449,653 | $262,415 | $258,808 | $296,152 | $264,792 |
| Commercial Insurance | $350,978 | $307,604 | $925,646 | $458,266 | $362,785 |
| Self-Pay (payments from patients) | $915,047 | $914,589 | $1,129,513 | $1,067,686 | $1,015,164 |

**HealthFirst**

Charges for services under the HealthFirst plan were determined by a sliding-fee scale that was based on federal poverty guidelines. Depending on the number of people in the family and the family's income, patients were assigned to one of eight financial support categories. At the lowest level, patients paid as little as $2 for an office visit. At the highest level, patients paid full price for services (approximately $50 for an office visit). The HealthFirst financial support categories are shown in Exhibit 14/5. Initially, HealthFirst patients could only be seen at the outpatient clinic located at the hospital. However, in 1998 these regulations were relaxed, allowing HealthFirst patients to be seen at any of the satellite (CCP) clinics.

Exhibit 14/3: Cooper Green Hospital/Jefferson Health System Statements of Revenue and Expense

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Operating Revenue** | **1994** | **1995**  | **1996** | **1997**  | **1998** |
| Inpatient Revenue | $37,288,811 | $34,529,493 | $33,248,117 | $32,217,566 | $35,830,206 |
| Outpatient Revenue | $12,097,455 | $13,791,112 | $14,568,700 | $15,197,207 | $16,470,205 |
| Total Patient Revenue | $49,386,266 | $48,320,605 | $47,816,817 | $47,414,773 | $52,300,411 |
| Deductions from Revenue (Bad debt, subsidized care) | $28,956,540 | $25,313,448 | $26,224,910 | $28,682,168 | $33,024,781 |
| Net Patient Revenue | $20,429,726 | $23,007,157 | $21,591,907 | $18,732,605 | $19,275,630 |
| Other Operating Revenue | $2,256,812 | $2,719,377 | $3,111,157 | $2,845,788 | $3,792,735 |
|  Total Operating Revenue | $22,686,538 | $25,726,534 | $24,703,064 | $21,578,393 | $23,068,365 |
| **Operating Expenses** |
| Salaries & Wages | $19,390,676 | $20,547,467 | $20,976,332 | $21,275,798 | $23,017,889 |
| Fringe Benefits | $4,681,390 | $4,680,937 | $4,607,439 | $4,731,080 | $4,976,824 |
| Contract Services | $1,690,145 | $1,833,616 | $1,443,654 | $1,558,705 | $2,416,836 |
| Utilities | $986,035 | $921,191 | $866,758 | $844,867 | $911,943 |
| Outside Services | $1,489,785 | $1,132,401 | $826,958 | $975,837 | $1,229,699 |
| Services from Other Hospitals | $2,567,655 | $2,447,907 | $1,881,087 | $2,129,683 | $1,915,322 |
| Jefferson County Dept. of Health | $2,003,193 | $1,861,591 | $1,933,874 | $2,040,062 | $1,800,396 |
| Physician Services | $9,843,577 | $10,068,571 | $10,200,031 | $10,681,650 | $11,370,273 |
| County Maintenance | $1,059,678 | $1,094,720 | $1,045,600 | $1,032,207 | $1,619,744 |
| Indirect County Appropriation | $3,693,500 | $1,281,983 | $1,281,983 | $1,278,006 | $1,558,907 |
| All Other | $10,134,544 | $11,095,892 | $12,248,708 | $11,399,367 | $11,378,434 |
|  Total Operating Expense | $57,540,178 | $56,966,276 | $57,312,424 | $57,947,262 | $62,196,267 |
| **Gain/(Loss) from Operations** | $(34,853,640) | $(31,239,742) | $(32,609,360) | $(36,368,869) | $(39,127,902) |
| **Non-Operating Revenue** |
| Indigent Care Fund | $13,126,249 | $23,168,333 | $31,638,294 | $34,824,238 | $36,199,381 |
| Disproportionate Share Fund | $4,419,644 | $8,854,308 | $3,501,061 | $3,565,485 | $3,238,323 |
| County Appropriation | $19,581,071 |  |  |  |  |
| Transfer from County General Fund | $579,179 |  |  |  |  |
| Interest and Other Income | $70,244 | $124,406 | $117,249 | $90,577 | $144,192 |
|  Total Non-Operating Revenue | $37,776,387 | $32,147,047 | $35,256,604 | $38,480,300 | $39,581,896 |
| **Gain/(Loss) before Depreciation** | $2,922,747 | $907,305 | $2,647,244 | $2,111,431 | $453,994 |
| **Depreciation** | $1,581,901 | $1,615,024 | $2,098,569 | $1,833,237 | $2,040,682 |
| **Net Gain/(Loss)** | $1,340,846 | $(707,719) | $548,675 | $278,194 | $(1,586,688) |

**Exhibit 14/4: Mission, Vision, and Value Statements of Cooper Green Hospital**

**Mission Statement**

Cooper Green Hospital is committed to serve Jefferson County residents with quality health care regardless of ability to pay. We strive to attract and maintain a dedicated and compassionate staff of professionals who believe in the worth of our services. We seek to continuously improve our services and adapt to meet the changing health needs of the communities we serve.

**Vision Statement**

Cooper Green Hospital is the leader to an equitable and just health care system through excellence, quality, compassion, and trust.

**Values Statements**

We are committed to health and well-being of those we serve.

We expect from ourselves the highest levels of excellence.

We know the vital importance of advocacy for those we serve.

We are committed to our staff having opportunities for personal and professional growth.

We expect for ourselves the highest ethical standards.

We understand that creativity and innovation are essential.

We recognize the importance of working with the patient and the community.

We are dedicated to all levels of education for health professionals.

**Exhibit 14/5: HealthFirst Membership Categories**

**Family Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Total family income per year** | **Membership fee per year** | **Co-payment per visit** | **Co-payment per prescription or refill** |
| Up to $1,850 | $35 | $2 | $0.50 |
| $1,851 to $3,700 | $65 | $2 | $0.50  |
| $3,701 to $5,500 | $95 | $2 | $1 |
| $5,501 to $7,400 | $130 | $2 | $1 |
| $7,401 to $11,000 | $195 | $2 | $2 |
| $11,001 to $14,800 | $260 | $2 | $2 |

**Individual Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Total individual** | **Membership fee per year** | **Co-payment per visit** | **Co-payment per prescription or refill** |
| Up to $920 | $15  | $2 | $0.50 |
| $921 to $1,840 | $25 | $2 | $0.50 |
| $1,841 to $2,760 | $40 | $2 | $1 |
| $2,761 to $3,680 | $65 | $2 | $1 |
| $3,681 to $5,520 | $100 | $2 | $2 |
| $5,521 to $7,360 | $150 | $2 | $2 |

**Community Care Plan**

An important part of Dr. Michael's vision for JHS was the CCP. His initial approach to developing the plan was best described as a “Field of Dreams” strategy: if you build it, they will come. “I envisioned offices filled with patients who were appreciative of the opportunity to receive quality medical care for a fair and affordable price–with less time waiting,” Dr. Michael remembered.

CCP was developed around the ideas that catastrophic care was more expensive, patients waited until their conditions worsened, and they were treated in the more costly CGH Emergency Department. Dr. Michael asked himself, “Why not avoid these unanticipated high health care costs by allowing patients to pay a low monthly premium for unlimited services?” This would require that CGH, as well as the patients, change the way they thought about health care. Further, for the system to survive, Dr. Michael and his executive staff would have to understand and respond to the rapidly changing health care environment.

**The Health Care Environment**

Change in the US health care system was occurring dramatically and pervasively. Managed care was altering how providers interacted with patients, funding for care was being restricted, and many health care systems were using nonphysician providers to cut costs.

**The Changing US Health Care System**

Because of its mission to provide medical care to the poor and uninsured, Cooper Green Hospital was considered one of the “safety net providers” across the United States. Safety net providers had large Medicaid and indigent care caseloads relative to other providers and were willing to provide services regardless of a person's ability to pay. Although safety net providers were the primary source of care for the poor and uninsured, they also provided critical access to health services in areas where health care was difficult to obtain.

Safety net providers faced many challenges in covering the cost of uncompensated care because they relied on Medicaid and fee-for-service reimbursement from other patients as major sources of revenue. Because of increased interest in Medicaid patients by for-profit Medicaid managed care programs, there was a decrease in the number of Medicaid patients using safety net providers, resulting in a financial drain and necessitating cuts in service levels.

Experts agreed that because of health care reform and cutbacks in funding, increased demand for uncompensated care and decreased capacity of the health care delivery system to meet this need would continue. This forced safety net providers to focus on improving operational efficiency as well as utilizing financial and staffing resources more effectively. Flexibility in the rapidly changing health care environment was essential to future survival; however, many safety net providers were unable to adapt quickly to changing market conditions, in part because of restrictions imposed by local regulations, labor relations, and dependence on politically driven funding mechanisms.

**Managed Care**

Health care costs rose at twice the rate of inflation from the mid-1980s to the mid-1990s, creating a $1 trillion industry that accounted for 14 percent of the United States’ gross domestic product (GDP). By the end of the century, the health care industry had grown to more than $1.5 trillion, or 18 percent of GDP. Health care purchasers (insurors, employers, government, and individuals) were seeking ways to curb this growing burden. Increasingly, they turned to managed care as a solution. In 1995, nearly three-quarters of American workers were insured by health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans, up from only 27 percent in 1987. By 1998, managed care was the dominant form of insurance in the United States and enrollment was expected to increase.

The central concept underlying managed care was the attempt to control health care costs by reducing inappropriate utilization of services through utilization review, gatekeeper functions such as referral requirements, and case management.

In 1999, health maintenance organizations (HMOs) were regulated in the state of Alabama by the Alabama Department of Public Health under Title 27 Chapter 21A (27–21A). The State Board of Health worked in conjunction with the Alabama Department of Insurance to license and regulate HMOs operating within the state.

**Medicare and Medicaid Funding**

Medicare was a provision of Title XVIII of the Social Security Act. The Medicare program was established in 1965 to ensure medical coverage for the aged and disabled. In the years following, Medicare expanded to encompass other population groups including persons entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, persons with end-stage renal disease who required continuing dialysis or kidney transplant. Another provision allowed noncovered, aged individuals to buy into the plan.

Medicare benefits are broken into two separate programs: Part A–Hospital Insurance and Part B–Supplemental Medical Insurance. Medicare Part A provided coverage for medical expenses incurred from hospital admissions, skilled-nursing facilities, home health services, and hospice care. Part A was free of charge for qualified Medicare beneficiaries. Medicare Part B, a supplemental coverage purchased by the Medicare beneficiary at a monthly fee, covered ancillary medical expenses such as noninpatient lab fees, physician fees, outpatient services, and medical equipment and supplies. In 1997, Medicare as a whole covered 38 million people. Utilization of Part A, Part B, or both, was 87 percent of enrollees. Medicare enrollment statistics for 1995 for the United States and Alabama are shown in Exhibit 14/6.

**Exhibit 14/6: Medicare Enrollment Statistics, 1995**

|  |  |  |
| --- | --- | --- |
| **Category** | **National**  | **Alabama**  |
| Aged (Part A and/or B) | 27.4 million | 541,225 |
| Disabled (Part A and/or B) | 3.3 million | 101,123  |
| Total Enrolled (Part A and/or B) | 30.7 million  | 642,398 |

**Exhibit 14/7: Population and Medicaid Eligibles**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Population** | **Eligibles** | **Percent** |
| 1996 | 4,127,562 | 635,568 | 15.4 |
| 1997 | 4,141,341 | 632,472 | 15.3 |
| 1998 | 4,155,080 | 637,489 | 15.3 |

In 1996, Medicare was the largest health coverage program in the nation. Benefits were estimated to be $191 billion that year; 6,273 hospitals nationwide were Medicare Certified. The Health Care Financing Administration (HCFA), a federal agency under the Department of Health and Human Services, was responsible for formulating Medicare policies and managing the Medicare program.

Title XIX of the Social Security Act of 1965 gave rise to Medicaid as part of the federal-state welfare structure to aid America's poor population. Title XIX allowed federal funding for state-run programs. To receive funding, the state programs were required to make provisions for basic health services, including hospital inpatient care, outpatient services, laboratory and X-ray services, and physician services, among others. If funding allowed, states could offer additional services, including medicine, eyeglasses, and dental care.

Providers of services for Medicaid recipients received payment directly from the State Medicaid Agency. Providers were required to accept the Medicaid reimbursement as payment in full. Medicaid agencies could require cost sharing by the recipient in the form of co-payments, but the recipient's inability to meet the co-pay could not be used to deny services.

In 1998, the Alabama Medicaid program provided some benefits for a variety of populations, but the majority of expenses were for indigent women and children, indigent elderly persons in nursing homes, and the disabled. Exhibit 14/7 shows the percent of Alabama residents who were eligible for the Medicaid program from 1996 through 1998. In fiscal year 1998, 15.3 percent of Alabama's population was eligible for Medicaid services, up nearly 5 percentage points from FY 1990 (10.4 percent). Medicaid expansion to cover more populations (particularly children) and the increase in the elderly population increased the budget.

The population actually enrolled in the Medicaid program averaged 267,258 recipients per month in FY 1998. Of the 637,489 individual Medicaid eligibles in FY 1998, approximately 83 percent actually utilized services.

**Balanced Budget Act**

The Balanced Budget Act of 1997 was labeled the most significant change to the Medicare and Medicaid programs since their inception. A significant change for Alabama hospitals was the CHIP (Children's Health Insurance Program) initiative that infused an additional $23 million into Alabama's health care reimbursement for children under the age of 19. Phase I of the Alabama plan was a Medicaid expansion that funded Medicaid coverage to children from age 16 through 18 whose family income was less than 100 percent of the poverty level. Phase II, known as the ALLKIDS program, provided payments for insurance coverage of Alabama children through age 18 if the family income was under 200 percent of the poverty level and the child was not eligible for any other Medicaid program. The ALLKIDS program was a little different in coverage because a third-party payor was responsible for provider reimbursement, not Medicaid. ALLKIDS was not an entitlement program like Medicaid or the CHIPs Medicaid expansion; coverage was on a first come, first served basis. Therefore, if funding ran out to pay the insurance premiums for the ALLKIDS program, applicants were put on a waiting list.

**Nonphysician Providers**

Nonphysician providers (NPPs) such as physician assistants, nurse practitioners, certified nurse midwives, nurse anesthetists, and clinical nurse specialists, were health care professionals licensed to practice medicine with physician supervision. Nurse practitioners were registered nurses who received additional education and clinical training in the “nursing model.” Physician assistants were trained by physicians in the “medical model.” Physician assistant programs were structured similar to–but were shorter in duration than–medical school programs.

Although the scope of services that they could legally perform varied by state, most NPPs provided primary care services such as well-care physical examinations, tests, diagnosis and treatment for acute illnesses, as well as diagnosis, treatment, and monitoring of chronic conditions (such as diabetes and hypertension). In addition, in most states they were licensed to write prescriptions (with some limitations that varied by state). For more complex tasks and cases, NPPs sought consultation from their supervising physician or referred patients to a specialist.

Nurse practitioners and physician assistants were often viewed as more appropriate for primary care services because these professionals tended to take a more holistic view of patient care, focused on health care prevention and education, and spent more time with their patients than most physicians. It was estimated that NPPs could perform 60 to 80 percent of services traditionally done by physicians in family practice settings. In addition, NPPs were viewed as good economic alternatives for primary care physicians because their salaries were usually 50 to 65 percent of those earned by physicians. Although they were required to be “supervised” by a physician, one physician could supervise three to four NPPs. Thus, NPPs were often referred to as “physician extenders.” In 1998, there were estimated to be over 48,000 nurse practitioners and over 34,000 physician assistants in clinical practice in the United States.

**The Local Environment**

Once known as a center of the steel-making industry, Jefferson County, Alabama, boasted a diversified economy by the 1990s. Biotechnology, health care, research, engineering, and a vast array of financial and service industries had supplanted much of the industrial core that had built the city in the early part of the twentieth century. As of 1998, the Birmingham metropolitan statistical area (MSA) population was approximately 875,000; Jefferson County population was approximately 652,000.

According to a 1993 survey conducted by CGH's Center for Community Care, more than one-third of Jefferson County residents were uninsured. Many poor residents delayed getting necessary medical care because they had no health insurance; an estimated 48,000 residents had been denied care within the past 12 months because they lacked health insurance. When asked what issues were most important to their community, low-income residents overwhelmingly listed crime, violence, housing, and drugs as the highest-priority issues. On average, health care was listed as the sixth most important issue, despite the fact that more than 64,000 residents reported their health status as fair or poor.

**Exhibit 14/8 provides additional demographic and socioeconomic data for Jefferson County.**

**Exhibit 14/8: Selected Jefferson County Statistics**

|  |  |  |
| --- | --- | --- |
| **Total Population** | 1997 | 659,524 |
| **Births** | 1997 | 9,352 |
| **Deaths** | 1997 | 7,096 |
| **Urban and Rural** | Urban | 581,973 |
| Rural | 69,552 |
| **Sex** | Male  | 303,713 |
|  | Female | 347,812 |
| **Race** | White  | 417,881  |
|  | Black | 228,187 |
|  | American Indian | 1,242 |
|  | Asian | 3,643 |
|  | Other | 572 |
| **Household Income** | Less than $5k  | 22,749 |
| 5k–10k | 27,477 |
| 10k–15k | 24,802 |
| 15k–20k | 24,294 |
| 20k–30k | 42,879 |
| 30k–40k | 34,373 |
| 40k–50k | 25,108 |
| 50k–60k | 17,124 |
| $60k+ | 32,488 |
| **Median Household Income** |  | $32,632 |
| **Per Capita Income** | $21,915 |
| **People of all ages in poverty** | 105,779 |
| **Under 18 in poverty** | 40,006 |
| **Medicare Beneficiaries** | Aged | 93,443 |
|  | Disabled | 32,503 |

**Other Health Care Providers in Birmingham, Jefferson County**

Twelve acute care hospitals were located in Birmingham, the largest city in Jefferson County. In 1998, 8 of the 12 hospitals reported a decline in admissions; inpatient capacity in the area exceeded demand. As a result many Jefferson County hospitals were scrambling to earn a share of the rapidly developing outpatient market. In their efforts to reposition themselves to respond to these and other changes in the health care environment, several hospitals had entered into alliances. For instance, Brookwood Medical Center, Medical Center East, and Lloyd Noland Hospital formed an alliance in 1995.

Exhibit 14/9 provides a brief description of each of the other acute care hospitals in Jefferson County. Exhibit 14/10 contains selected operating statistics for each of them. Exhibit 14/11 provides enrollment and ownership information for each of the managed care organizations that were operating in Jefferson County in 1998.

**Exhibit 14/9: Descriptions of Other Jefferson County Hospitals**

**Princeton Baptist Medical Center**

As part of the Baptist Health System (http://www.BHSALA.com), Princeton Baptist served primarily those citizens located on the west side of the Birmingham MSA.

**Montclair Baptist Medical Center**

As one of 13 tertiary care and acute care hospitals in the Baptist Health System, Montclair served those residing on the east side of the Birmingham MSA.

**Brookwood**

The medical center (http://www.brookwood-medical.com) was part of the Tenet Healthcare System (http://www.tenethealth.com) and had a staff of more than 300 physicians, representing every major specialty. Brookwood also had a Women's Medical Center, specializing in OB/GYN and other health services for women.

**Carraway Methodist**

As the flagship of the Carraway system (http://carraway.org), Carraway Methodist placed special emphasis on emergency medicine, laser surgery, cardiology and cardiac surgery, cancer treatment, diabetes care, hyperbaric medicine, and other high-tech services.

**Children's Hospital**

Children's Hospital (http://www.chsys.org) was the leading provider of comprehensive pediatric services in Alabama.

**HEALTHSOUTH Medical Center**

Home of the corporate headquarters, HEALTHSOUTH (http://www.healthsouth.com) was the nation's leading provider of comprehensive outpatient and rehabilitative health care services.

**Lloyd Noland Hospital**

Affiliated with Tenet Health System, this hospital became the South's first industrial medical experiment. As one of the state's first teaching hospitals, Lloyd Noland (http://www.tenethealth.com/LloydNoland) continued to provide excellent disease control and health care maintenance.

**Medical Center East**

This hospital was Birmingham's most modern medical center. As the flagship of Eastern Health System (http://www.ehs-inc.org), there were more than 300 physicians on staff, representing nearly 70 medical specialties.

**Saint Vincent's Hospital**

As a member of the Daughters of Charity National Health System, St. Vincent's (http://www.stv.org) was dedicated to providing quality health care to the public by offering patient-centered, economical services, with a special emphasis on the sick and poor. They focused on cardiology, maternal and pediatric, neurological, oncology, and occupational health services.

**University Hospital of Alabama**

As a major teaching and research institution, University Hospital (http://www.health.uab.edu) provided patients with the most advanced health care available. University Hospital offered a comprehensive range of primary care and specialty services.

**Bessemer Carraway Medical Center**

As part of the Carraway Medical System, Carraway Bessemer was the principal provider of tertiary care services to the residents of the city of Bessemer (in Jefferson County).

**Exhibit 14/10: Selected Operating Statistics for Jefferson County Hospitals**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hospital** | **No. beds** | **Admissions in 1996** | **Discharges to SHPDA in 1997** | **Status** |
| Baptist Medical Center–Princeton | 499 | 14,103  | 1,143 | Not-for-Profit Church Affiliated |
| Baptist Medical Center–Montclair | 534 | 19,650 | 1,510 | Not-for-Profit Church Affiliated |
| Brookwood Medical Center | 586 | 20,651 | 1,586 | For-Profit |
| Carraway Methodist Medical Center | 617 | 13,449 | 1,174 | Not-for-Profit Church Affiliated |
| The Children's Hospital of Alabama | 225 | 10,727 | 950 | Not-for-Profit |
| Cooper Green Hospital | 319 | 5,938 | 451 | Not-for-Profit County Owned |
| HEALTHSOUTH Medical Center | 219  | 6,615 | 494 | For-Profit |
| Lloyd Noland Hospital | 319 | 5,095 | 411 | For-Profit |
| Medical Center East | 282 | 11,467 | 1,172 | Not-for-Profit |
| Saint Vincent's Hospital | 338 | 14,540 | 1,281 | Not-for-Profit Church Affiliated |
| University Hospital | 908 | 37,226 | 3,176 | Not-for-Profit State Owned |
| Bessemer Carraway Medical Center | 300 | 6,452 | 564 | Not-for-Profit |

**Source**: Compiled from SMG Marketing Group, Inc. data for 1998.

**Exhibit 14/11: Jefferson County Managed Care Organizations**

|  |  |  |
| --- | --- | --- |
| MCO  | Commercial Enrollment\* | Ownership |
| UnitedHealthcare of Alabama | 82,485 | UnitedHealthcare, Inc. |
| Health Partners of Alabama | 80,386 | Baptist Health System |
| CACH HMO | 36,562 | Children's Hospital |
| Viva Health | 25,610 | University of Alabama at Birmingham |
| Apex Healthcare | 5,855 | DirectCare, Inc. |

**Source**: Compiled using data from Harkey Associates, Health Maintenance Organizations (Managed Care Research and Publishing, March 1999).

\* Commercial enrollment includes self-insured covered lives under HMO-style medical management by region. The Birmingham region includes Blount, Calhoun, Etowah, Jefferson, Shelby, St. Clair, and Tuscaloosa Counties.

**Jefferson County Department of Health**

CGH and the Jefferson County Department of Health (JCDH) established a working alliance to improve continuity of care for the county's indigent patients. JCDH physicians were accorded staff privileges at CGH and JCDH agreed to refer to CGH its patients who needed diagnostic testing or acute care. CGH andJCDH maintained a close working relationship, at times partnering on individual projects. They also explored the idea of a more comprehensive alliance, but no such plans had come to fruition by 1999.

JCDH operated an extensive health care network, providing pediatric and adult health care services to approximately 80,000 people every year. The JCDH network consisted of 8 community-based health centers and 19 school health programs. Health care services were available to any resident of Jefferson County, with the cost of services based on the patient's ability to pay. Services available at the centers included maternity care; family planning; well- and sick-child care; adult primary care; the Women, Infants, and Children (WIC) nutritional program; social services; dental care; pharmacy; and sexually transmitted disease testing and treatment. In addition, health centers sponsored seminars on disease prevention and health promotion topics. The locations of the JCDH clinics are shown on the map in Exhibit 14/12.

**County Government/Authority for CGH**

The Alabama State legislature granted county governments the authority to develop, own, and operate hospitals and other health care facilities for the benefit of county residents. Jefferson County was governed by a five-member county commission that was elected for four-year terms. The Commission was responsible for administering finances, collecting taxes, allocating resources, and providing for the delivery of services such as law enforcement, sewer services, and health care

 In 1998, the Commission oversaw the reorganization of Cooper Green Hospital into the Jefferson Health System (JHS). County Commissioner Jeff Germany assumed responsibility for governmental oversight of JHS as its Commissioner of Health and Human Services, a position he had held for Cooper Green Hospital during the past 12 years.

Whereas some county hospitals operated as independent organizations or under the auspices of independent “health authorities,” JHS was an operational department of the county government. Although Dr. Michael, as the CEO, had operational and administrative control over the hospital, it remained very closely tied to the county government system. The most restrictive aspects of this were regulations that mandated the hospital's use of the county's personnel system as well as its financial services system.

**Hospital Operations**

Prior to the 1998 reorganization, the hospital was broadly divided into outpatient and inpatient divisions. All department managers reported to then-COO, Antoinette Smith-Epps. The 1998 reorganization into the JHS structure created distinct inpatient and outpatient divisions. Ms. Smith-Epps was named Hospital Administrator and remained in charge of inpatient services and most of the support and administrative services. Responsibility for outpatient services was assigned to Jerome Calhoun, who was named Administrator of Jefferson Outpatient Care. The organizational chart for the JHS (reflecting changes made in the 1998 restructuring) is shown in Exhibit 14/13.

Throughout the 1990s the number of outpatient visits continued to increase at CGH. This followed the national trend, in which there was an increasing emphasis on outpatient care driven by the need to reduce costs, coupled with new technology that enabled more types of care to be delivered on an outpatient basis. Exhibit 14/14 contains outpatient visits, by specialty, for fiscal years 1993 to 1998.

According to Ms. Smith-Epps, JHS faced several problems. The first was one that most health care providers confronted in the late 1990s: the problem of tight revenue. The Balanced Budget Act of 1997 had reduced the revenue of most providers and had affected CGH significantly because CGH served the indigent population and had few sources of revenue. Fortunately, during the late 1990s losses had been somewhat offset by an increase in the county's indigent care fund (ICF). Funded by county tax revenues split among several organizations, including CGH, Children's Hospital, and JCDH, ICF revenues were distributed on a straight percentage basis, so when the economy was good (and therefore tax revenues high), the hospital received more income.

A second issue was the lack of resources to invest in capital projects such as upgrades and enhancements to the information system, new medical equipment, or renovations to improve patient flow and access. Because the facilities were constructed in the late 1960s, when the focus was on inpatient services, the physical layout of the hospital and the outpatient clinics was not conducive to providing outpatient services efficiently. The shortage of examination rooms, work space for nurses and clerks, and waiting room space was particularly acute in the outpatient clinics. This resulted in very long waiting times to get an appointment as well as very long waiting times to be seen by a health care provider on the day of the appointment.

 The frustration experienced by the patients was sometimes compounded by discourteous staff members. JHS employed over 600 staff, all part of the “civil service” structure of the county personnel system. Compared to other health care providers, staff turnover at JHS was low. There were many very dedicated, talented staff members who could have easily worked elsewhere, in better working conditions and for more money. They chose to work at JHS because they believed in its mission and enjoyed serving those in need. However, the hospital had its share of employees who were primarily attracted by the job security of the civil service system. Some of these employees tended to perform at minimally acceptable levels and display negative attitudes to patients and others. The administration had made several efforts to improve the morale and customer service orientation of the staff, although with limited success. Annual employee satisfaction surveys indicated there had been a slight improvement from 1993 to 1998, but there seemed to remain a core of “negative” individuals whose attitudes demoralized other staff members and angered patients.

Exhibit 14/14: Outpatient Visits for Cooper Green Hospital

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | FY 1993 | FY 1994 | FY 1995 | FY 1996 | FY 1997 | FY 1998 |
| Cardiac | 1,164 | 603  | 795  | 846 | 670  | 0 |
| Medicine | 21,723 | 23,361 | 25,340 | 24,690 | 23,903 | 22,873 |
| Neurology | 1,239 | 1,300 | 1,488 | 1,260  | 1,182 | 1,273 |
| Pulmonary | 828 | 1,081 | 1,242 | 1,221 | 1,155 | 1,033 |
| Renal | 431 | 443 | 593  | 659 | 861 | 907 |
| Rheumatology | 1,183 | 1,160 | 1,286 | 1,295 | 1,206 | 1,415 |
| Dermatology | 1,713 | 1,791 | 1,677 | 1,666 | 1,562 | 1,678 |
| Ear, Nose, Throat | 2,991 | 2,760 | 2,726 | 2,469 | 2,402 | 2,474 |
| Ophthalmology | 5,812 | 5,368 | 6,120 | 7,148 | 7,110 | 6,561 |
| Coagulation | 422 | 581 | 669  | 820 | 831 | 683 |
| Gynecology | 6,472 | 6,756 | 8,015 | 9,453 | 9,965 | 10,128 |
| Chemotherapy | 361  | 279  | 353  | 518  | 558  | 867 |
| St. George (AIDS Clinic) | 1,332 | 1,331 | 1,904 | 2,124 | 2,566 | 2,505 |
| Genitourinary | 1,495 | 1,563 | 1,764 | 1,616 | 1,414 | 1,558 |
| Hematology/Oncology | 1,453 | 1,508 | 1,828 | 2,048 | 2,425 | 2,364 |
| Surgery | 9,193 | 8,999 | 8,716 | 8,017 | 8,609 | 8,196 |
| Orthopedics | 4,932 | 4,748 | 4,706 | 4,207 | 3,813 | 4,108 |
| Teens First | 0 | 0 | 0 | 28 | 28 | 15 |
| Total Clinics | 62,744 | 63,632 | 69,222 | 70,085 | 70,260 | 68,638 |
| Emergency | 39,262 | 37,982 | 36,959 | 33,736 | 34,124 | 34,671 |
| Labor & Delivery | 3,420 | 3,997 | 3,169 | 2,903 | 3,018 | 3,228 |
| Same Day Surgery | 2,147 | 2,106 | 2,199 | 2,045 | 2,169 | 2,195 |
| Referred Testing (from JCDH) | 14,103 | 14,680 | 17,994 | 14,155 | 13,745 | 15,127 |
| Physical Therapy | 0 | 0 | 0 | 3,914 | 3,968 | 5,251 |
| Community Care Clinics | 0 | 0 | 0 | 1,706 | 3,025 | 4,997 |
| Total Non-Clinics | 58,932 | 58,765 | 60,321 | 58,459 | 60,049 | 65,469 |
| Grand Total | 121,676 | 122,397 | 129,543 | 128,544 | 130,309 | 134,107 |

Patients at Jefferson Health System had widely varying views about the service and quality of care received. Overall patient satisfaction with JHS, as measured by patient surveys, averaged about 90 percent. Patients recorded the most satisfaction with aspects related to the health care providers; they recorded the least satisfaction with issues related to making appointments, waiting times, and the facility. On the surveys, many patients expressed gratitude for the care they received at the hospital and had high praise for various staff members. They often remarked that without JHS, they would have no way of obtaining health care. One of the most common phrases seen on the written responses was “God Bless Cooper Green Hospital.”

Some patients, however, expressed frustration over long waiting times and poor customer service. Some complained about specific staff members, often citing a lack of respect or a lack of caring about patients. Other complaints involved poor coordination between departments that sometimes resulted in patients experiencing long waits in two or three different departments and difficulty in scheduling appointments in a timely manner. Many patients had to wait three weeks to see a doctor, and when they arrived at the hospital on the appointment date they experienced long waits before being seen. Patients also cited the small, uncomfortable waiting rooms and the overall layout of the hospital as sources of frustration.

**The Community Care Plan**

When Dr. Michael assumed the position of CEO of Cooper Green Hospital in 1992, managed care was growing nationwide. Through coordinating health care and creating an organized system for receiving medical care, “managing care” was supposed to reduce costs. Managed care reached into every sector of health care–investor-owned health plans, not-for-profit organizations, Medicare plans, and state-run Medicaid projects.

It was within that context that Dr. Michael began to formulate his idea for a means of providing affordable, quality care to the poor, underserved residents of Jefferson County. Just as other managed care plans were using primary care physicians as gatekeepers to monitor the health of their patients on a long-term basis, the local CCP clinics would serve as the members’ first stop for receiving health care and preventive services. Specialists at Cooper Green Hospital would serve their needs for services that extended beyond the capacity of the clinics. Dr. Michael envisioned this concept as a coordinated hub-and-spoke configuration for the provision of more effective and efficient health care.

**Funding**

Given the financial pressures facing the hospital, Dr. Michael had known that funding CCP would be a challenge. With pledges of $250,000 from funding partners, including local businesses, foundations, and government agencies, CGH was awarded a matching grant from the Robert Wood Johnson Foundation (RWJF) for $500,000 for the development of six clinics over the four-year project period.

In 1995, the first CCP clinic opened. It was located in the public housing community of Cooper Green Homes (neither affiliated with nor located next to the hospital). The second clinic opened shortly thereafter in Pratt City (approximately 10 miles southwest of the hospital). The Cooper Green Homes site was chosen for the first clinic for three reasons: (1) as a public housing community its residents clearly had a need for affordable health care; (2) the housing community's Resident Advisory board was very active and supported the placement of the CCP clinic; and (3) the Birmingham Housing Authority had pledged to provide and renovate space for the clinic. The third and fourth clinics, Southtown (2 miles northeast of the hospital) and Bessemer (15 miles southwest of the hospital), were opened in the fourth quarter of 1997. In early 1998, the Cooper Green Homes clinic was closed because of continuing problems with vandalism, gang violence, and low enrollment; it was relocated to the Lawson area.

Exhibit 14/15: Community Care Plan Membership Fees and Co-payments

Family Plan

|  |  |  |  |
| --- | --- | --- | --- |
| Total family income per year | Membership fee per year | Co-payment per visit | Co-payment per prescription or refill |
| Up to $1,850 | $35 | $2  | $0.50 |
| $1,851 to $3,700 | $65  | $2  | $0.50 |
| $3,701 to $5,500 | $95 | $2 | $1 |
| $5,501 to $7,400 | $130  | $2 | $1 |
| $7,401 to $11,000 | $195  | $2 | $2 |
| $11,001 to $14,800 | $260  | $2 | $2 |

Individual Plan

|  |  |  |  |
| --- | --- | --- | --- |
| Total individual | Membership fee per year | Co-payment per visit | Co-payment per prescription or refill |
| Up to $920 | $15 | $2  | $0.50 |
| $921 to $1,840 | $25 | $2 | $0.50 |
| $1,841 to $2,760 | $40 | $2 | $1 |
| $2,761 to $3,680 | $65 | $2 | $1 |
| $3,681 to $5,520 | $100  | $2 | $2 |
| $5,521 to $7,360 | $150  | $2  | $2 |

**CCP Member Services**

To receive services, patients were required to enroll in the CCP. Only residents of Jefferson County were eligible for membership. Members paid an enrollment fee that was due at the beginning of each year or could be paid in four installments. Co-payments were required to receive services (see Exhibit 14/15). Similar to the HealthFirst program, co-payments and membership fees were based on a sliding scale determined by family income. Those covered by Medicaid, Medicare, or certain qualified insurance plans did not have to pay a membership fee.

Membership began with a complete physical (at no extra charge) that served as a health assessment. In addition, the CCP wellness program, HealthPoints, was an incentive plan to keep members healthy. It provided participants with discounts on their co-payments and membership fees. The program's motto was With HealthPoints, it pays to improve your health. To participate in the HealthPoints program, members set quarterly goals and visited their health care provider every three months to monitor progress. Members received “points” for met goals. Examples of HealthPoints goals included getting regular check-ups, obtaining referrals before visiting the ER, exercising 20 minutes three times per week, eating a balanced diet, following the “well baby” schedule, quitting smoking, and losing weight.

CCP membership included both outpatient and inpatient services. Satellite health clinics provided primary care outpatient services such as immediate treatment of illnesses and minor injuries; lab tests; care for chronic illnesses (diabetes, arthritis, high blood pressure); yearly check-ups; immunizations; family planning services; special health classes; and prescription drugs from the JHS pharmacy (located at the hospital). Members were referred to specialists when necessary. With a written referral, members were also eligible to receive home care services, hearing tests, eye exams, and glaucoma screenings. Additionally, social services and other programs were provided through JHS, JCDH, and other local agencies.

**Staffing**

Each clinic had at least three full-time staff members: a nurse practitioner or a physician assistant, a registered nurse, and a receptionist/licensed practical nurse. The RN and LPN were employed by the county and reported directly to Bill Floyd, manager of Outpatient Services at JHS. The nurse practitioners and physician assistants were employed by Jefferson Clinic (the physician practice group affiliated with CGH through a contract with the Jefferson County Commission), and reported to Mark Wilson, MD, Medical Director of Outpatient Services (Jefferson Clinic). As medical director and supervisor for the nonphysician providers, Dr. Wilson rotated throughout all of the clinics.

Turnover rate for employees at each of the outpatient clinics was extremely low and morale was generally high. Staff members at the clinics tended to be satisfied with their work and remained employed at the CCP for extended periods. When new positions opened up at a CCP site, many employees from JHS applied to work there.

For the first three years, the CCP did not have any full-time administrative staff; administrative duties were handled by a team of JHS staff and interns who each devoted part of their time to the CCP. As manager of the JHS Outpatient Clinic and the CCP clinics, Bill Floyd spent approximately 25 percent of his time on CCP matters. In mid-1997, Jerome Calhoun was hired to oversee all outpatient operations and could devote approximately 30 percent of his time to CCP.

**Costs**

Each CCP site required approximately $225,000 for start-up and general operating expenses during its first year. The estimated ongoing operating costs for one clinic with 1,000 patients were $170,000. During the initial years of CCP, approximately 30 percent of costs was provided through the RWJF grant. The remaining 70 percent was provided through local matching funds (30 percent), in-kind support from JHS (34 percent), and operating revenues (6 percent). The program was designed so that as individual sites increased enrollments, a greater percentage of operating expenses would be covered by operating revenue. The break-even point for a given clinic was estimated to be 1,000 members, although that number was somewhat low because the calculation did not include in-kind support or subsidies from JHS in the form of administrative resources and specialist physician services. It was expected that each clinic would reach the break-even point by its third year of operation; however, by mid-1999, none of the Community Care Plan Clinics had done so.

**Enrollment and Utilization**

Enrollment for the CCP generally fell below expectations, although the experiences of the clinics were varied. The first clinic, initially located in a public housing community, experienced the slowest growth. Although somewhat expected because of its “pioneering” role, this clinic's growth continued to be slow even after other clinics opened. The clinic and administrative staff felt that growth at that site had been limited by the problems with gang violence and vandalism. The other clinic located within a public housing community, Southtown, experienced somewhat slower growth as well. The clinics in Pratt City and Bessemer appeared to be on track to reach 1,000 members by their fourth year of operation. Enrollment for each of the clinics as of March 1999 is shown in Exhibit 14/16.

According to Bill Floyd, members tended to readily use the services available to them. As of March 1999, the average patient load per day at Lawson was 15 patients, at Pratt City 20 patients, at Southtown 10 patients, and at Bessemer 13 patients. One nurse practitioner or one physician assistant was located at each site and could handle seeing between 22 and 25 patients per day. Mr. Floyd expected patient loads to increase as HealthFirst members became aware of the option to receive services at the CCP clinics.

Exhibit 14/16: CCP Enrollment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SITE (opening date) | Oct. 1995 | Oct. 1996 | Oct. 1997 | Oct. 1998 | As of March 1999 |
| Lawson (4/95) | 143 | 262 | 323 | 560 | 700 |
| Pratt City (10/95) | N/A | 242 | 498 | 728 | 852 |
| Southtown (9/97) | N/A | N/A | N/A | 219 | 350 |
| Bessemer (9/97) | N/A | N/A | N/A | 355 | 424 |
| TOTAL | 143 | 504 | 821 | 1,862 | 2,326 |

**Marketing and Market Research**

Marketing for the CCP was still largely a work-in-progress. In an effort to publicize the first clinic, a health fair was scheduled at the site approximately two months before opening. However, because of construction delays, the clinic did not open for several months after the fair, nullifying the impact of the publicity efforts. The primary approaches to marketing during the first two years were appearances by Dr. Michael, Mr. Floyd, and staff members at community organizations, church groups, and schools along with promotional materials placed within the hospital.

A more formal marketing effort began in 1997. The intention was to educate the staff of Cooper Green Hospital, neighboring communities, county health departments, Social Services, uninsured populations, small businesses, and other hospitals in the area regarding CCP and how to access the services. Clinic staff members, interns, and administrative staff made appearances at schools, churches, neighborhoods, and local shelters, and held or attended 12 to 15 health fairs each year. Additionally, promotional materials were placed more prominently at Cooper Green Hospital in hopes of raising awareness among patients. Printed materials were often used because they could be printed at low cost, but CCP staff members realized they were beyond the reading level of many of the patients and potential patients. Word-of-mouth had proven to be the most promising and reliable avenue of enrolling and retaining patients.

Because of limited administrative staff, no one person was responsible for coordinating the marketing effort. Although Bill Floyd, as manager, set the tone for the marketing activities, specific duties were handled by a number of different people. Radio spots were placed sporadically with stations serving a predominantly African-American audience. In late 1995, eight billboards were placed on the western side of town, in the general vicinity of the first two clinics; they remained for approximately two months. Later, in conjunction with St. Vincent's Hospital, a television advertisement was developed that aired once a week for eight weeks. According to Mr. Floyd such promotions generated a great deal of interest, but it was not clear how effective they were in recruiting members.

Prior to opening the first clinic, focus groups were used to assess the printed membership information packet, but there were no surveys to assess patient awareness, attitudes, or understanding about CGH or CCP specifically, or about prepaid health plans generally. Additionally, although some information from the 1993 HealthWatch needs assessment survey was available to guide placement of CCP clinics, that process was driven more by long-standing political promises and community lobbying than systematic data analysis.

**Coordination Efforts between CCP and CGH**

Coordination efforts between the CCP and CGH developed slowly. The first challenge was staff education and training for all hospital employees regarding the purpose and function of CCP. Although progress was slow during the initial years of CCP, Antoinette Smith-Epps felt that by 1999, most hospital employees were aware of CCP and had a basic understanding of its purpose.

A second challenge involved coordinating the administrative functions of CCP with those of CGH. For example, billing functions were carried out both at CCP and in the business office of CGH, resulting in overlapping systems and confusion about patients’ accounts. As CCP grew, communication of employee concerns, issues, and suggestions became more complex. Whereas the staff members of the first clinic had been part of a tightly knit team that included both clinical and administrative staff members from CGH and CCP, each new clinic presented the challenge of developing effective channels of communication.

The CCP experienced “growing pains” in the area of information services. It outgrew current hardware capacities and enhanced software was needed to link the clinics and CGH. Because CGH and CCP shared the same computer and medical records system, this modernization was vital to the success of the project. Another complication was the need for compatibility with the information system of Jefferson County.

**HMO License**

Alabama state law required any organization operating a health maintenance organization (HMO) or similar health plan to have an HMO license. The CCP development team did not consider the plan to be a true HMO or insurance product because it was essentially just a different way of offering the same health services to the same population for which the county had always provided services. Nonetheless, preferring to err on the side of caution and prior to opening the first CCP clinic, Dr. Michael inquired with the appropriate agency. Because of the uniqueness of the CCP model in a public hospital, the agency was not able to immediately determine whether the CCP would be required to obtain an HMO license, and essentially “tabled” the matter indefinitely. The first CCP clinic opened shortly thereafter.

Following favorable press coverage of the first CCP clinic, the state agency received a complaint from a Birmingham health plan alleging that Cooper Green Hospital was operating an HMO without a license. Although the agency had previously declined to make a ruling on whether a license was required, following the complaint it informed CGH that CCP would be required to obtain an HMO license or shut down within 90 days. Unable to complete the complex and expensive application process within the allotted time frame, Dr. Michael instead entered into an agreement with United Healthcare of Alabama to operate CCP under its HMO license. JHS paid United Healthcare approximately $20,000 each year to operate the plan under its HMO license, but JHS retained all operational control over the plan. The affiliation with United was not marketed, so members were not aware of any affiliation. Although United Healthcare underwent several leadership changes that created some administrative delays in processing renewal applications for CCP, Dr. Michael described the situation as “a good working relationship and a bargain for JHS. If we tried to obtain our own HMO license, I estimate that it would cost JHS between $750,000 and $1,000,000.”

**Issues for the Future**

As Dr. Michael left his office that evening, he glanced at his calendar–May 1999. He thought, “In less than a year, the RWJF funding will run out and the CCP clinics will have to make it on their own. There isn't enough excess in the JHS budget to subsidize their operations to any greater extent. Yet, I believe that CCP represents the system's best chance to improve the delivery of care for the underserved population, as well as ease the strain of overcrowded waiting rooms at CGH.”

The original plan, as funded by RWJF and the local funding partners, had called for six clinics to be opened within five years. “We only have four now,” he mused. “Should we forge ahead with expansionplans to try to achieve a critical mass, hold steady until we work out the ‘growing pains,’ or give up on the plan altogether?”

As he pulled out of the parking lot, he noticed the crowd from the ER waiting room had spilled out onto the sidewalk…

Swayne, Linda E. Strategic Management of Health Care Organizations, 6th Edition. Wiley-Blackwell (STMS), 11/2008. VitalBook file.