MERGERWATCH

PROTECTING PATIENTS' RIGHTS WHEN HOSPITALS MERGE

Hospital-within-a-Hospital:

A Creative Solution for Protecting Access to Reproductive Health Services in Secular/Catholic Hospital Partnerships

Since 1997, the MergerWatch Project has worked on more than 90 cases of proposed secular hospital partnerships with religiously-affiliated hospitals or health systems (mostly Catholic) in 34 states. Our goal is to ensure that community residents continue to have access to a full range of women's health services and end-of-life care options, since these services and choices can be curtailed when secular hospitals partner with Catholic facilities.

We provide technical assistance and support to local organizations as they work directly with secular hospital boards and executives to devise methods of protecting patients' rights and access to care. Our services are funded by foundations and donations. We provide assistance to communities at no charge. This memo was made possible by support from the Robert Sterling Clark Foundation.

When should a hospital-within-a-hospital be considered?

Sometimes, secular hospitals are able to largely maintain their historic missions and services when partnering with Catholic hospitals, by adopting a firm stance in negotiations prior to the partnership. But often, the CEOs and boards of secular hospitals are pressured by their prospective Catholic hospital partners to agree to adopt all or some of the *Ethical and Religious Directives for Catholic Healthcare Service (ERDs)*, which are issued by the U.S. Conference of Catholic Bishops.

Agreement to adhere to the *ERDs* means that the following services become prohibited within the formerly-secular hospital: contraception, contraceptive counseling, tubal ligations, vasectomies, abortions, artificial insemination, in vitro fertilization and any "safer-sex" prevention counseling, including discussion of condom use. In some cases, the offering of emergency contraception to rape victims and prompt treatment of reproductive health emergencies, such as ectopic pregnancies, may also be affected. End-of-life care choices may also be affected, depending on how the local Bishop interprets and enforces the *ERDs.*

In such a circumstance -- *when secular hospitals agree to adopt Catholic health restrictions in order to partner with a Catholic institution* – officials of a secular hospital should be asked to consider creating a separately-incorporated hospital-within-the-hospital to protect patients' access to comprehensive reproductive health services. This approach, referred to in the hospital industry as a "carve-out," has been successfully employed in several recent secular/Catholic hospital partnerships. Two examples include:

- Since 2004, the Austin Women's Hospital in **Texas** has provided maternity services, sterilizations, emergency contraception for women who had been raped and family planning services on the fifth floor of Brackenridge Hospital, a city-owned facility managed by Seton Family of Hospitals, a member of the Catholic Ascension Health system. The space was carved out from Brackenridge and is managed by the University of Texas Medical Branch;

- In **New York State**, the Burdett Care Center is currently under construction on the second floor of secular Good Samaritan Hospital in Troy, which is planning to affiliate with a Catholic health system. The separately-incorporated and licensed birthing center will include family planning services and maternity care and allow women delivering babies to have post-partum tubal ligations. But no abortions will be allowed within the facility.

Benefits and Risks

Creation of a "carve-out" space preserves local access to most reproductive health services typically offered in a hospital setting, including tubal ligation after birth by cesarean. Inclusion of maternity services and offering of new birthing rooms within the "carve-out" can help increase patient volume and thus improve its financial viability. However, this model does have its disadvantages. It usually cannot incorporate abortion services, due to refusal of Catholic partners to allow abortion services to be provided within the formerly-secular hospital building, even though the "carve-out" is separately-incorporated and financed. It also does not offer a solution for patients seeking assurances that their end-of-life wishes will be honored. Finally, it must be acknowledged that this is an expensive compromise that could be avoided if the secular hospital instead chooses to partner with a secular health system that does not restrict certain health services.

Governance

If a "carve-out" space is to provide continued community access to services that are prohibited by Catholic teaching, it is vital that the space be separately incorporated and have a separate funding stream and separate staff. Typically, funding for a carve-out facility cannot come from the Catholic partner, because it would be seen as cooperating with the provision of immoral services. In some states, up-front funding for the "carve-out" from the secular hospital may be mandated as a concession to the community at risk of losing services deemed vital to the public's health. Questions that need to be answered while working out governing logistics include: Who will operate this space? Will there be a separate board? How will this board be appointed? Will there be community representatives on the board? How about experts in women's health?

Menu of Services

The menu of services offered in a "carve-out" must also be carefully reviewed. It is important to ensure that a wide range of services, including but not limited to reproductive health, are offered in the space. The reasons are: a) to ensure security by making it more difficult to identify any women who may be entering the space to obtain "controversial" reproductive health services; and b) to make the space more financially viable. No entity can survive financially by offering only vasectomies and tubal ligations. Incorporating all birthing services within the space is one obvious approach to improving financial viability. Keep in mind that emergency reproductive health cases, such as ectopic pregnancy and premature rupture of membrane, typically are not treated in "carve-outs." So, community advocates need to insist that patients presenting in these circumstances will be treated promptly and appropriately, in accordance with standards of medical care, at the formerly-secular hospital's emergency department following the affiliation.

Financial Stability

Safeguards are needed to ensure the future financial viability and stability of the carve-out space. In addition to offering a broad array of services, as noted above, a-hospital-within-a-hospital can be made more financially viable in three important ways: a) ensuring adequate start-up funding, such as through a grant from the secular facility or public funding; b) through mechanisms that permit use of the space by the

jointly-governed hospital on a leased basis for other services, thus providing revenue to the carved-out entity; and c) through mechanisms that permit sharing of staff, such as by having staff of the carved-out entity 'rented' to the main facility when needed. (We can provide access to a health care financing expert who can review proposed financing of a carve-out to determine its feasibility.)

All of these avenues need to be carefully thought through and negotiated with the Catholic partner ahead of time, to ensure that they do not violate partnership agreements. Typically, it is most helpful for the secular hospital to engage an attorney with experience in canon law to guide these discussions.

Ensuring an Exit Strategy

What if the partnership is formed, the "carve-out" space is created and then the arrangement simply is not working? What happens next? It is essential that an exit strategy be carefully considered and spelled out. This exit strategy should prohibit the Catholic partner from being able to buy out the secular facility. It also should ensure that assets of the secular facility are protected and should spell out what will happen to the assets of the secular "carve-out" entity.

Gaining Support

In order to win support for this model, it is important to actively engage key stakeholders, especially those directly affected by the secular/Catholic partnership. This can be done in three distinct ways:

- Working directly with medical staff and community advocates to influence the terms of the hospital consolidation: It is vital that hospital administrators work with medical staff and advocates to coordinate efforts in assessing which reproductive services could be vulnerable in this transaction and what could be done to protect community access to those services.
- Assisting the community in organizing and co-sponsoring a community forum to educate the public about the agreement: It is in the best interest of hospital administrators to provide a public forum to educate the public about the agreement, ideally before a final decision is reached. Community members should be given the opportunity to ask advocates and the hospital leadership questions about service changes and the scope of the "carve-out" solution.
- Maintaining an open door policy throughout the process: Hospital officials can benefit from suggestions made by medical staff, advocates and community members regarding what services would be permitted in the new "hospital within the hospital" and which emergency reproductive services must continue to be provided within the hospital's emergency department. Topics that also need addressing include how to continue to provide contraceptive coverage to the employees of the secular hospital following the affiliation, and how to protect the ability of the hospital's physicians to continue to inform patients about all reproductive health options.

The Hospital-Within-a-Hospital Model: **Case Studies**

Texas

Brackenridge Hospital in Austin, Texas, is a public hospital managed for the city by the Seton Family of Hospitals, a member of the giant Catholic-sponsored Ascension Health system, under a 30-year lease. When Seton assumed management of the hospital, city employees (contracted by an independent company) were allowed to provide reproductive services in the hospital, which is a key point of access for many low-income women. The local bishop, five Catholic ethicists and the City Council unanimously approved the agreement in 1995. However, the U.S. Conference of Catholic Bishops revised its *Ethical and Religious Directives for Catholic Health Care Services* in 2001 to adopt a stricter policy on sterilization services, and Seton then informed the city that it could no longer allow sterilizations at Brackenridge, which performed 400 a year.

The city decided to create a separately incorporated "hospital within a hospital" on the fifth floor of Brackenridge to provide all maternity services, sterilizations, emergency contraception for sexual assault survivors and family planning services. The city contracted with the University of Texas Medical Branch to operate the new **Austin Women's Hospital**. This facility has a separate entrance and can be reached only through a dedicated elevator constructed on the outside of the hospital, in accordance to what the bishop determined was an appropriate "separation of structures." The city spent more than $9 million to accommodate Seton's objections.

New York State

In the spring of 2009, the **Foxhall Ambulatory Surgery Center** opened in the parking lot of Kingston Hospital in Ulster County, NY. This "hospital-beside-a-hospital" is the first separately-incorporated alternative provider of reproductive health care created in a New York State religious-secular hospital merger case. Funded by a $4 million state grant, the Foxhall Center is providing abortions, sterilizations, vasectomies and contraception, following the state-mandated merger of secular Kingston Hospital with Catholic Benedictine Hospital. Post-partum tubal ligations continue to be provided to women delivering babies within Kingston Hospital through a special dispensation secured from the Catholic Archdiocese. Kingston Hospital also has no restrictions on emergency terminations of pregnancies, such as in the case of premature rupture of membranes or ectopic pregnancies.

As an immediate result of the Kingston success, hospital executives in another upstate New York community actively worked with local advocates to achieve a variation on the Kingston model. Northeast Health has agreed to abide by Catholic health restrictions upon completion of its affiliation with two Catholic systems, St. Peter's Hospital (part of Catholic Health East) and Seton Health Care (part of the Catholic Ascension Health system). That change in hospital policy will mean an end to abortions, tubal ligations, contraceptive counseling and other services at Samaritan Hospital in Troy and Memorial Hospital in Albany. The impact would be particularly severe in Troy, where the only other hospital is St. Mary's, part of the Seton Health Care System with which Northeast Health is affiliating.

Currently under construction, the **Burdett Care Center** will be a 20-bed maternity facility on the second floor of Samaritan Hospital. As part of the state approval, the center must be completed prior to the secular hospital's planned merger with the two Catholic health systems. The Burdett Care Center will consolidate all maternity services and allow women delivering babies to have post-partum tubal ligations. The New York Department of Health approved the Certificate of Need for the Center and provided $6 million in funds

from a state grant. It will be the first such hospital-within-a hospital solution to a religious/secular merger in New York State, providing an important model for future religious/secular merger situations.