

HealthLeaders

THE PATIENT OF THE FUTURE

Physicians suggest. Patients ignore. Technology alone won't bring them together. But a new relationship just might. p 16



Certifiable
Stroke Care p 33

The Art of
Balancing Risk p 47

Real-World
Bundling p 53

ROUNDTABLE

CHALLENGES AND OPPORTUNITIES FACING COMMUNITY HOSPITALS

Many community hospitals experiencing financial difficulties or capital deficiency see only a few unappealing options for securing their future: selling outright, merging with a large chain or non-profit system, or continuing to struggle as they fall further and further behind the competition. HealthLeaders Media recently convened a panel of experts for a high-level discussion on a third choice for such hospitals: Union with a well-capitalized partner that allows the hospital to retain significant operational control.

Panelist Profiles



PHILIP BETBEZE,
senior leadership editor,
HealthLeaders Media,
Brentwood, TN,
moderator



DENNY SHELTON,
chairman of the board, LHP
Hospital Group, Inc.,
formerly Legacy Hospital
Partners, Inc.



DAN MOEN,
CEO, LHP Hospital Group,
Inc., formerly Legacy Hospital
Partners, Inc.



MARK BUCKALEW,
chairman of the joint venture
board, Pocatello Health
System, LLC



DOUG HAWTHORNE,
CEO,
Texas Health Resources



MONTE DUBE,
partner,
Proskauer Rose LLP

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Roundtable Highlights

HEALTHLEADERS: *Mark, as a leader on the board of a county-owned hospital system that was looking to consolidate into a new facility, what factors contributed to Portneuf Medical Center's inability to access capital?*

BUCKALEW: We started out using municipal bond financing about two years ago and we were able to get the first phase of what would have been three to four more phases of funding. We were in preparation for the second phase in March 2008 and we were still fairly confident we could get financing—that basically was about the only market open to us. The citizens of our county were not going to approve a revenue bond.

HAWTHORNE: Many of us were looking at our capital allocation in a way that continued to provide growth for our systems. Part of it was a prioritization process. Beginning last summer, things shifted a bit in terms of factors that affected one's

15% to 20% of healthcare systems are doing well financially. It becomes a priority of spending. How do you take care of the community assets that you are entrusted with and how do you prioritize capital and be responsible, especially given the tightening economy? Even before the economy started to tighten we had the other group of providers that were already struggling. That's 50% to 60% of the facilities. They haven't had access to capital because they haven't had the income statement or the balance sheet to support it. They're faced with how do we meet the needs of our community that we are entrusted with and how do we provide the services that our community needs given the fact that we don't have the financial income statement or balance sheet to support getting resources. Mark's group was at that point.

HAWTHORNE: When you think about the governance of hospitals and health systems, their influence on this kind of decision with respect to growth and development or retrenchment or independence is critical because that's where the decision ultimately is made. So you get back to the issue of board education, board knowledge, board loyalty. Unless there's some sense of thinking toward the future in a proactive way, you can easily restrict what a hospital or health system can do.

DUBE: It's the rare independent community hospital board or community health system board that decides it wants to give up local control and join a larger system, whether nonprofit or for-profit. Local control has often trumped mission for a lot of independent community hospitals.

HEALTHLEADERS: *So what does local control mean?*

DUBE: A lot of boards have trouble explaining that. But who typically are the folks who decide to give up independence? The folks who are in financial distress and who are looking for a white knight. The worst time to do a deal is when you have to.

HEALTHLEADERS: *Mark, what were some of the concerns that your fellow board members had with the inability to access the capital markets?*

BUCKALEW: The goal was to be a full-service hospital representing that community. There were always discussions about being bought out or merging, but we wanted to go our own way. We didn't know that there was a partnership-type model out there. We were looking at building that new hospital within an eight-year time frame. For physicians, that's a lifetime. And they didn't want to wait eight years. As we explored how we could build this facility quicker, it became evident that the amount of money that we'd have to have to accomplish this in a shorter period of time became the major issue, and that split the board. Some people said let's go find a partner.

SHELTON: Whatever the strategic process, the education process is time-consuming. But they all have one thing in common, the history of the facility. Most people don't go on those boards for pay, because none of them get paid. They're there because they care about their community and they care about the healthcare in their community. They struggle with what the options are, given their strategic position.

DUBE: Most local nonprofit boards presume that the only folks who can make the decisions about how best to deliver care and what care to deliver are local and not somebody from out of town. And

Dan Moen
CEO
LHP Hospital Group,
Inc.



thought process with respect to capital expenditure, such as declining reserves, changes in patient payment mix, and increases in charity and bad debt. So all of a sudden, your operating performance started to back off. Philanthropically, people were beginning to look at scaling back their giving as well.

SHELTON: You're seeing the segmentation of the healthcare industry. Maybe

that's an inhibitor considering aligning with the nonprofit across the street or the nonprofit across town or, God forbid, the for-profit from out of town.

BUCKALEW: Our first decision was to go to a 501(c)(3) status, which would still be a tax-exempt organization hospital locally controlled but not owned by the county. But we encountered difficulties with that because the county didn't want to give up the asset. That was understandable.

HAWTHORNE: Even when it's been privatized, they still see it as the community hospital, the county hospital.

BUCKALEW: We were hell-bent to do what we could to stay independent. Becoming a nonprofit 501(c)(3) corporation was our first thought because at that time, we didn't know what else we could do.

HEALTHLEADERS: *That is compelling about your model, Denny. Mark and Monte, I know you have plenty of experience with hospitals that have looked at options that didn't quite work for them. So where do they find out about other possible options?*

BUCKALEW: Professionals can answer those questions. Had we known of this resource, it might have saved us some valuable time in our search. Even though we had a good attorney that understood the issues, we came to appreciate Monte's large picture of



Doug Hawthorne
CEO
Texas Health Resources

what we needed to think about as the future of the hospital.

DUBE: There are a lot of resources out there, but many communities, for reasons that I don't fully understand, are insulated from best practices.

HAWTHORNE: Which really surprises me because our boards are made up of many people who run big companies. That's one of the issues I've constantly worked on with our board. I request of them to not leave their business experience at the door when they walk in the boardroom of our hospitals or our systems because we need all their knowledge and experience.

DUBE: That's true, but the nonprofit board is different. Mission is very different than margin. Stakeholders are very different than shareholders. And I think there is a need for highly specialized expertise. If you have a brain tumor, you don't go to an internist. You go to a specialist. Specialists in investment banking and health law do these deals day in and day out. A lot of times, local communities believe their local lawyer who's never done a deal like this ought to do the deal, or the local investment banker. Sometimes that can work, but I've come in a lot of times to clean up messes and the community suffers because the deal was insufficiently structured or negotiated.

SHELTON: The general theme is that it is the community's assets and that's what most boards ultimately struggle with. I look back on some communities that have sold their hospital and it hasn't worked out so well. They didn't consider what the long-term repercussions would be. At the time, the idea was just to monetize it. Look, everybody has their own opinion, but around LHP we believe it is the community's asset and we will be best served by finding ways to work

with the community to preserve input into the delivery of healthcare.

HEALTHLEADERS: *LHP's strategy involves capitalizing the hospital in return for some level of ownership stake, but the board is still 50% controlled locally. This type of deal is messy and complicated, right?*

SHELTON: And time-consuming.

HEALTHLEADERS: *So why take on this extra responsibility?*

SHELTON: If your sole purpose in this business is to make money—to maximize



Mark Buckalew
chairman of the Joint
Venture Board
Pocatello Health
System, LLC

margins—you're in the wrong business. That's how LHP got formed. We could just buy hospitals, but we found out in our careers that it's a lot more fun working with local people about local healthcare. It's a good business because it's rooted in a strong culture of taking care of patients and working with people who have a shared vision.

HEALTHLEADERS: *You and Dan got started with this model years ago at HCA, correct?*

SHELTON: We did a number of them with HCA and later, Triad, that have been hugely successful and we enjoyed doing them. But it takes a lot of time and effort. I did a partnership with Doug, but when it came down to it, it wasn't just Doug and me. We could sit down and work out a business agreement. But the process took a year or so

Monte Dube
partner
Proskauer Rose LLP



because Doug wasn't going to do anything unless his board was completely on board with the idea of having a partner that was a for-profit entity. But it's well worth it because you end up with good partners and allies that you're going to have for a long time.

MOEN: There are two components of our growth strategy. They work hand-in-glove. One is the joint venture strategy where we share ownership with non-profit hospitals. The other is our way of doing business. Culture is very important to our success. I think culture trumps strategy every time. We have a collaborative culture, which means working with others is the way we do business. This means that we're going to share the ownership, governance, and decision-making with our hospital stakeholders. Most capital partners don't want to share these important attributes of their hospital. LHP does well in these joint venture hospitals because we grow patient volumes. Growing volumes means working with local stakeholders: our nonprofit partner, the community leaders, the medical staff, and integrating all of them into decision-making. Increasing patient volumes is the hardest way to grow the business. The easiest way is to cut expenses or raise rates. But neither one of those options are very good strategies in the long run. It's easy to find somebody to share the ownership with. What's very difficult to do is find somebody to share control. We have found a way to do this with our partnership.

BUCKALEW: They bring an expertise we needed in knowing how to run a hospital. Not to say that the previous people who ran the hospital didn't know what they were doing, but there's a confidence that they know how to run a hospital and they provide some of the means for us to make decisions that we couldn't make before.

DUBE: Joint ventures are more complicated than outright sales because you have to live together. The other thing

that complicates it immensely is the fact that many boards don't understand that you can joint venture your entire hospital and maintain your tax exemption as a minority equity partner, take out dividends and not have to pay taxes on it, and have 50% of the board even though you may only own 20% of the equity.

HEALTHLEADERS: *And in terms of decision-making, is it a collaborative mechanism as opposed to the experts telling the local folks how they ought to do it?*

BUCKALEW: They're not telling us. They're advising the board. We have one vote and LHP has one vote.

HEALTHLEADERS: *What if you disagree?*

BUCKALEW: It dies unless we both agree. And I think that's the one thing that we had a hard time believing. We own 23% of the hospital. So that's a wonderful position to have when you're 23% owner. Another interesting thing is that it was a win-win because now the county is receiving taxables off the hospital property itself. And we as a foundation will receive moneys down the road once the hospital is completed to do healthcare initiatives in the community.

HEALTHLEADERS: *What differentiates LHP from other potential acquirers?*

MOEN: Eighty-five percent of the hospitals in our country are nonprofit, and that percentage hasn't changed in 30 years. So if you want to grow, you must find ways to work with them. Our strategy is focused on partnering with these hospitals in such a way that they don't have to sell their assets or give up control of their hospital to accomplish their goals. The other differentiator is our collaborative culture, which makes our joint venture strategy work. Our board consists of a real "braintrust" of nonprofit hospital executives. Doug is

on our board because he had been our partner at Triad at a partnered hospital in Denton, Texas. He's also running the biggest health system in Texas. We also have Gary Mecklenburg, former AHA chair and former CEO at Northwestern Memorial in Chicago; George Lynn, president emeritus at Atlanticare in New Jersey and the former two-time chair of the American Hospital Association; David Bernd, the CEO of Sentara in Norfolk and also a former AHA chair. Jim Tinker, the former CEO of Mercy Health Systems in Iowa, is also on it. We also have Don Halverstadt, MD, former chair of the University of Oklahoma Board of Regents, and Uwe Reinhardt, PhD, James Madison Professor of Economics at Princeton University, as LHP board members.

HEALTHLEADERS: *Denny, talk about some of the joint venture projects you did at HCA and at Triad.*

SHELTON: Every one of the projects we did was financially viable. It's a heck of a lot more fun when you're talking about doing right by the community than sitting around saying I wonder if we can squeeze another 1% or 2% on our margins. There's not a good hospital administrator in the country who can't squeeze margins. But you know what? Most guys who are really good administrators, that's not how they think.

HEALTHLEADERS: *Imitation is the highest form of flattery. There are some other for-profits out there that are starting to say they love the joint venture model. Has that caused you concern?*

SHELTON: No. I haven't seen anybody who's done it the way we've done it. And so I don't know that there's a single healthcare system out there that would do a deal where 20% equity would equate to 50% of the governance.

HEALTHLEADERS: *You've structured LHP as a private company with deep-pocketed investors. How do you protect your partners if your company is ever sold?*

MOEN: Our sponsors have a long-term view of the healthcare industry and are patient investors. They understand that our partners are choosing us for the long term.



Denny Shelton
chairman of the Board
LHP Hospital Group,
Inc.

DUBE: It's really important for the nonprofit board that's considering doing a deal with LHP to realize they're tough negotiators. And there are lots of negotiations in these deals. They're complicated joint venture transactions. So issues like rights of first refusal, buy-up rights and dilution provisions if there's a capital call are all very important and need to be considered in advance.

HEALTHLEADERS: *Mark, when you were trying to make these decisions, what did you know about your other options?*

BUCKALEW: We got to the point where our only conclusion was that we were

looking for a partner that had the same cultural philosophies that we had.

HEALTHLEADERS: *But did you know those partners existed?*

BUCKALEW: We didn't have a clue. In fact our first experience with a hospital system was not a good one. When we went through the review of all the companies that we asked to provide information, I was shocked. In fact one of the things that surprised me was that there were not more nonprofit hospital systems doing deals. We were going to stay nonprofit no matter what it took. So we got Monte's help to clarify what those options were.

HEALTHLEADERS: *How did you identify Monte?*

BUCKALEW: Monte represented the county.

DUBE: Lots of independent community hospitals, especially those that are in financial distress or No. 3 in a three-hospital town, tend to undervalue themselves. So there's nothing like an RFP or auction process to enable a nonprofit board to get better educated about their value in the marketplace.

HEALTHLEADERS: *So is that what you did for Portneuf?*

DUBE: There was an RFP process in which we solicited from nonprofit and for-profit companies their interest. You learn a lot about companies during the process. Denny and Dan spent a lot of time in public meetings. And there was an enormous amount of due diligence done, not just legal, but also operational. Many members of the medical staff were doing extensive phone trees to check with other community hospitals on the three finalists to see whether, in their experience, they walked the walk or just talked the talk.

BUCKALEW: It was one of the great periods of my existence on the board that I felt like it was a team effort by doctors, physicians, the board, the county commissioners, and the community. And the vote was a 77% approval rate, which we would have never gotten on a bond issue.


HEALTHLEADERS: *How many proposals did you get back in the Portneuf situation?*

DUBE: We started with about a dozen.

SHELTON: We've always felt that a strong due diligence process helps us. When we were doing these projects at Triad, we weren't the high bidder on a number of projects we ultimately got. They have to decide what constitutes value. Part of it is money and part of it is culture. So you have to balance that and when people go through the process they end up making a much more informed decision. The problem is some guy like Monte Dube comes in and then tries to squeeze you on price [laughter].

HEALTHLEADERS: *Dan, explain how your joint venture model helps the community.*

MOEN: Portneuf's foundation had minimal assets and their job each year was to have fundraising events to raise money to support Portneuf Medical Center. Today, the foundation has approximately \$60 million in assets, which includes a substantial interest in a new \$150 million hospital, which the community badly needed. Going forward, that foundation is focused on doing other good works in the community with its assets. They have created the fifth largest foundation in the state of Idaho. In addition, the foundation did not sell its hospital or give up control of it.

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