ROUNDTABLE

Innovation in Hospital Governance: Joint Ventures, Partnerships, and Affiliations

As healthcare grows more interconnected, standalone community or government-owned hospitals are facing a crisis. Many need partnerships or clinical affiliations with allied healthcare providers and tertiary hospitals that can provide care, and in some cases capital, that they cannot. They may make an unattractive merger partner for larger hospitals and health systems that may also have capital constraints. Even if the local hospital is an attractive merger partner, many boards do not want to give up the local control over available services and the jobs the local hospital provides to local residents. There are other ways to reach the goals of better, more coordinated, and value-added care, and in many cases, preserve the hospital long-term.

PANELIST PROFILES

J. THOMAS JONES
President and CEO
West Virginia United Health System
Fairmont, W.Va.

KURT BARWIS
President and CEO
Bristol Hospital & Health Care Group
Bristol, Conn.

STEVEN GOLDSTEIN
Vice President, University of Rochester Medical Center
President and CEO, Strong Memorial Hospital and Highland Hospital
Rochester, N.Y.

REBECCA HURLEY
EVP, General Counsel and Secretary
LHP Hospital Group, Inc.
Plano, Texas

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Senior Leadership Editor
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Roundtable Highlights

HEALTHLEADERS: *Do you agree with the premise that partnerships or other operating alliances are necessary as healthcare makes this unprecedented transition to value-based care?*

THOMAS JONES: We do not grow for growth's sake, so we have not been overly aggressive in soliciting people to come into our system, but it's amazing the number that are knocking on our doors right now. We're also open to for-profit companies that want to partner with a nonprofit system in order to acquire hospitals that may need access to capital. We would not have been historically interested in that.

REBECCA HURLEY: We feel like the industry is coming to us. Our business model is to provide capital and expertise to nonprofit systems. We originally thought we would be engaging in transactions where a single hospital or smaller system was seeking a capital partner and we'd fill that gap. But as the industry has changed, we have found that larger systems are interested in having us as a strategic partner to make an acquisition, as Tom described. We see a tremendous appetite on the part of successful systems to expand their reach and their networks. They look to us as a desirable partner to provide the capital for that.

KURT BARWIS: Bristol is a small community hospital in a highly competitive marketplace. When I got there, it was a turnaround situation, so I had no access to capital whatsoever. It was clear we were going to default on our debt covenants. So the cash we generate from operations is all we have to spend. So similar to what Tom did, last year we converted our entire IT infrastructure and we funded the $8 million project from operations. We've also struggled with capital and the plant infrastructure. We have to rob Peter to pay Paul and make that work, and that only works for so long. About a year ago, we went through a formal process with a strategy firm to help us evaluate possible partnerships. We happen to be one of the lowest-cost hospitals in the state, so we're a value proposition. Partnering will clearly enable us to be relevant in the future. We have multiple options.

STEVEN GOLDSTEIN: We are a low-cost academic medical center. We're 89th of 91 from the top in cost. We are profitable because of our cost and our occupancy and being a regional center. But having said that, the question for us is, how do we evolve within health reform? Many community hospitals in our state that were 100–200 beds are now down to 30–50 beds and they're groping for how they form partnerships and continue to serve their community. We have affiliated with two partners and we've developed collaborating agreements with four others—these are rural sites, by and large—and they hope to take advantage of our medical staff and eventually the availability of graduates of our residencies and fellowships to serve their community. Thirty-five percent of the 660 residents stay in upstate New York for employment. We're trying to work with hospitals to stabilize their medical staff or to build programs. Our collaborating agreements stipulate that we'll try and develop three to five clinical programs for them. Should we find ourselves having a population-based insurance product of some type, we will want to admit patients to lower-cost institutions. Even though we are low-cost, we're more expensive than the average community hospital because of our teaching and research component. So we are spreading out. Potentially there will be more collaborations and affiliations. We are looking at other partners that want what we can offer, which is very highly trained, skilled medical staff to serve their local populations. We also have 23 primary care sites and multiple nursing homes.

"Many community hospitals in our state that were **100–200 beds are now down to 30–50 beds** and they're groping for how they form partnerships and continue to serve their community."

Steven Goldstein
President and CEO
Strong Memorial Hospital and Highland Hospital

HEALTHLEADERS: *Are you getting competition for these collaborations?*

GOLDSTEIN: UPMC, Cleveland Clinic, Guthrie, and Geisinger are all interested in the upstate New York market. It's become very competitive, but we are not going to put the university's capital at stake, so that's a limiting factor for us. What happened at one of our affiliates, Highland Hospital,

is instructive. It was in a deficit situation. I was brought over to either save it or close it, and what I did was move programs from the university and then backfilled Strong Memorial particularly from enhancement of our regional programs. It's harder now with some of the other affiliates that are located farther away, but our goal is to help these places with clinical programs and allow them to create their own capital. What we don't want to do is build new hospitals. We're going to focus on population management.

HURLEY: Legally, what's the relationship that you have with these outlying hospitals?

GOLDSTEIN: We call it a collaborating affiliate—an agreement where we agree to develop clinical programs. It could be cardiology. It could be orthopedics. It could be radiology. They agree only to give us an opportunity to provide that service and if we can, great. If we can't, they go elsewhere. They have no requirement to take anything from us. So it's a very loose relationship.

Rebecca Hurley
EVP, General Counsel and Secretary
LHP Hospital Group, Inc.

BARWIS: We have been through those kinds of relationships, and obviously you set the expectation. One of my biggest concerns has always been, if I get in that relationship, the patients, for the stuff I can't do, go to the mother ship, and they don't come back. I think the strategy is perfect if, in fact, you can keep the business where the business should be.

GOLDSTEIN: I think the way it's going to work over time is that the insurance products and our integrated structure will help dictate where our people have the advantage of admitting patients at lower-cost hospitals because they'll be a part of the economics of that. If they admit all their patients to the most expensive hospital, they won't do well in those products. That becomes a big issue for Strong. We spend a lot of time talking about what we are going to look like in 10 years. Are we going to need the same number of beds? We push our faculty to understand that under health reform, they're going to want the most economical sites for their patients so they can take advantage of whatever opportunities exist.

JONES: In our academic center, we've formed a joint operating agreement between the hospital and the academic practice group. We share a common management team for both and a common bottom line. They remain legally separate with their own boards, but we adopt a common budget so that the physicians have motivation to reduce costs. Also, the practice group has formed a division within the school of medicine, just as they have a department of orthopedics or urology or surgery, called a community service group. Instead of having three missions of service, research, and education, the physicians that go in that department are placed in community hospitals and they have primarily the mission of service only. We think it will work better because the people that are truly academic physicians really don't want to go into community hospitals and just do service. If you believe in medical homes and focusing on prevention and getting the right care at the right time, the average daily census at hospitals is going to drop 20% by the year 2020. You don't have to be smart to figure out that every hospital is not going to survive. There will always be a place for the academic medical center because that's where the sickest patients will go. Many community hospitals, if their census drops 20%, are not going to survive. Do they have the vision to partner with somebody to create a large ambulatory center that maybe has 24-hour emergency services, outpatient surgery, diagnostic services, but when you need to be hospitalized, you're going to go 10 miles away?

HEALTHLEADERS: *How successful has that sell been?*

JONES: We are talking to people about it, but it's a hard sell. People don't want to give up their hospital. Historically, as hospitals started to fail, at least in West Virginia, there was always a for-profit system that would buy it and turn it around. They've become more selective now. A couple of these hospitals have done RFPs with major merger specialists and nobody wants them. There's no bids. So that tells you that somebody's making a judgment that they're not going to be a player in the long-term and they still have a difficult time accepting it.

HEALTHLEADERS: *So what is the risk of waiting too long to partner up?*

HURLEY: There is a tipping point after which, even for a company with a business model like ours, they're not attractive.

JONES: You're going to see some go into bankruptcy, and then you acquire them in bankruptcy and do what has to be done.

HEALTHLEADERS: *Where does this trend leave the community hospital ultimately? Are they just pieces of the whole, or does the low-cost provider argument hold water?*

BARWIS: When I play it forward, I see the value of the community hospital. But what scares me is that I have little leverage with the commercial payers. So let's say you get to population management in your system and I'm a small

community hospital in your system—how do I get good value for what I deliver? What I worry about is, I'm in the same situation five, 10, 15 years from now that I am today, only it's just a different player. I'm delivering value, and I may not have the ability to say, "I don't want to be a part of your system." I want to be a part of that system because they're going to give me more for what I deliver. It will take people being honest about how to share that pie. We went through this with managed care. I've revised my plans for capital investment dramatically around trying to shift the focus to the ambulatory strategy and building niche programs that I know can do well.

HURLEY: That's what prompted my question about Strong's relationships to community hospitals.

BARWIS: Steve, do you require them to participate in your network in the future?

GOLDSTEIN: No.

HURLEY: That's really the question we're talking about—governance. Kurt, if you and your board and your management team decide that Steve's a good guy and you like their approach, how you ensure you get value is you have to have a voice somehow in what's going to happen going forward.

GOLDSTEIN: When I came to Strong 15 years ago, we were 20% ambulatory as a percentage of our revenue. We're now 50%. We have built ambulatory programs all over. When I talk to boards, I know they're focused about how they maintain their hospital, but I don't know that that is the right question. [The right question] is, how do we provide care to the community? I wouldn't be surprised to see multiple institutions within rural areas talking to each other about how they develop programs for a wider net of patients. We're not at a point yet in understanding how all of this is going to play out to suggest how folks will link. We are trying to work with insurance carriers to meet our goals, which is to take care of our population in a way that's affordable. We know that a certain percentage of clinical activity and diagnostic tests that's done is not necessary, and with the right information and coordination and handoffs, patient care can be made more efficient and eventually the cost of care to a population will be reduced.

JONES: There are niches community hospitals fill. Affiliations can help where you simply enhance what they already have, but some are on a downward spiral and you're not going to rescue them with just a clinical affiliation. They need a major overhaul. An example: If they don't have an up-to-date IT system, you're not going to give them one. You're not going to replace their building or spend $1 million developing a new service. That's where they've got to have vision to say, "I'm willing to give up some control over governance in exchange for survival and to prosper." So you have to decide, is the hospital viable or is it not? If it is viable, what do you have to do to turn it around? When consolidation occurs, you also to some extent get a caretaker there, not a true leader. So it has an impact on the community in that regard. It has an impact on the community in terms of supporting various charitable causes in that community. So there's lots of things to look at with the hospital, but if it's not viable, the sooner they make the decision to change, the better off they're going to be.

"When I play it forward, **I see the value** of the community hospital."

GOLDSTEIN: But to that point, they have to decide what they are looking for. People are affiliating with us or collaborating with us not because they view us as nice guys. It has everything to do with the fact that we train doctors, and they view that as one of their great needs.

Kurt Barwis
President and CEO
Bristol Hospital & Health Care Group

JONES: That's what vision is all about. Everybody wants those physicians, but the fact of the matter is putting a half dozen docs down there on a part-time basis to rotate through is not going to turn around an institution that's spiraling downwards. They've got to have the vision to recognize that. Communities are extremely supportive of their hospital—they love it, they own it, but at the same time, they have to face reality.

GOLDSTEIN: That is the most important point. I've had a collaborating institution ask, "When do we become an affiliate?" My answer is, "When you can articulate your strategy within health reform." We are not about taking over hospitals. What is it that you want to do for your community, and what is it that we can provide that will add value?

JONES: And neither are we. Instead of climbing the ladder one rung at a time, they say they can take two or three steps up that ladder in one jump. But we sit down with them and very clearly say, "You need to understand what you're giving up and what you're getting back and to see if that's what you want for your community. If it's not, we don't

have any ill will toward you. We'll still help you with clinical affiliations, but you're probably not a good match for our system."

GOLDSTEIN: And we have to work in concert with the local medical community, because they will make this transformation work, not us. We can work with practices to provide the facilities and the resources necessary to make it happen, but it's really about the physicians coming together within a model of care that works for a community.

J. Thomas Jones
President and CEO
West Virginia United Health System

BARWIS: I've done a couple of hospital turnarounds, and it's really about working with the board and helping them understand what's going on and holding them accountable for it. A lot of my focus at Bristol has been working with my board chairs and getting them out to discussions. It might be going to Massachusetts and listening to the presidents of Atrius or Steward talk, and then having them rebut and ask questions. One of the key things for community hospitals is to be relentless in demanding that your board get educated.

JONES: In fairness, though, how much can a board absorb when they're really not in the business? The one thing that worries me the most is making a major decision that's wrong and you don't find out for three to five years. Should we start an ACO? I could sell my board on that or I could not sell it on that. That's the weakness, because if I lead them off the cliff, they're going to fall. What I did was I [recruited] a retired healthcare CEO onto the board. We actually identified three who had recently retired, who are nationally known, and they were all willing to serve if asked.

BARWIS: We worked to find the people within our community who were going to ask those kinds of questions. We don't just have people get on the board because they're a friend of so-and-so. They put in a resume and there's a vetting process. We just had a senior executive from ESPN join the board. ESPN's culture is completely different than what you typically would see in hospitals. This person came in the boardroom the first day, starts asking challenging questions about strategy. You get the right people around the table and you force the committee members to do their job.

GOLDSTEIN: I'm on the strategic planning council of a system in Florida. They are a multihospital, multidimensional system, and we spend a great deal of time with their management talking about their strategies. While in a different part of the country, the issues are all the same. How do we structure ourselves to provide healthcare services to populations?

JONES: CEOs that are retiring—they miss the field. They love to just keep a little hand in it. It's not for the money. It's just to stay current. It's a tremendous talent that hasn't been tapped.

HEALTHLEADERS: *We've talked a lot about the community hospital that is looking for a deep-pocketed capital affiliation. Are bigger systems looking for that too?*

HURLEY: We've found several opportunities to acquire community hospitals in situations in which there were strategic network hospital systems in the area that wanted to expand, but either were already overcommitted with their capital or didn't want to spend their existing capital to acquire that target. Essentially, we were able to put together a partnership between us as the capital source, a strategic network partner with the brand name, and a target organization in an area where that partner wanted to expand. For example, Hackensack University Medical Center is our partner in two facilities in New Jersey. We started our relationship with them when a hospital went bankrupt in northern New Jersey. Hackensack owned the property, but needed a capital partner to assist in redeveloping it and operating it. In the meantime, another opportunity arose in Montclair to acquire a hospital there. So that's been a way for Hackensack to change the strategic thinking in terms of being more of a network and extending its footprint.

GOLDSTEIN: There's no single approach that either an academic medical center or a community hospital can take. It's about the needs of their community, what their capabilities are, and what the environment provides to them. With health reform, we know we have to get to more cost-effective care; we have to get to a point where we as a society can afford healthcare and, frankly, can provide it to all universally. But it may not be based around the model that we currently have.

HURLEY: Models that are nimble and can accommodate the different needs of individual communities are the ones that will be successful.

JONES: For nonprofits to expand without a partner, the only way you can come up with the capital is you have to earn it. You have to earn a dollar and then you can spend a dollar, so you're limited. I don't care how successful you are: You're only going to raise so many dollars that way. So you have to find others—maybe for-profits—to partner with. Frankly, with more people being insured, the role of the not-for-profit is going to change down the road anyway.

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