ROUNDTABLE

Decision Time for Community Hospitals

Where will community hospitals fit in the future healthcare landscape? Mergers and acquisitions of hospitals continue at record levels, yet many community and rural hospitals wish to remain independent. To position themselves financially and operationally for the future, these hospitals must understand the competitive dynamics of their situation. They must control costs while still offering quality services, attract and retain physicians, find their niche among competitors near and far—and consider the right partner to work with short of a merger. HealthLeaders Media convened a panel of community hospital CEOs to discuss how they can navigate increasingly difficult straits and maintain the values of their organizations and communities.

PANELIST PROFILES

TERRENCE DEIS
President and CEO
Parma Community General Hospital
Parma, Ohio

JAMES FIORENZO
President
UPMC Hamot
Erie, Pa.

JOHN SIGSBURY
President and CEO
Emanuel Medical Center
Turlock, Calif.

MIKE WILLIAMS
President
Community Hospital Corporation
Plano, Texas

JOHN COMMINS (MODERATOR)
Senior Editor, Community & Rural Hospitals
HealthLeaders Media
Vero Beach, Fla.

EDWARD PREWITT (MODERATOR)
Editorial Director
HealthLeaders Media
Danvers, Mass.

Roundtable Highlights

HEALTHLEADERS: *Is there a future for independent hospitals?*

MIKE WILLIAMS: I think the future for community hospitals, as they historically have been operated, is probably limited. We are at a point in the evolution of healthcare that is mandating that all hospitals, but particularly independent community hospitals, look at the way they're operating, look at the relationships that they are entering into, and really begin to do an internal assessment of their own viability to be independent in the future.

JOHN SIGSBURY: We did quite a bit of surveying of our population to see if anyone in the community could actually distinguish between a proprietary hospital, a faith-based not-for-profit, a not-for-profit system, and then an organized, integrated system of care. And from the consumer's point of view, they can't. They don't see a difference. They're treated virtually the same, no matter what hospital they walk into. The procedures, the billing, everything that happens to them is virtually the same. We've said to our board that in the years to come, those lines between what's not-for-profit and proprietary will be completely blurred because … if you don't operate your independent not-for-profit hospital to the same business standards that everyone else is able to achieve, there is no future.

WILLIAMS: Most community hospitals are either publicly governed or not-for-profit. One of the challenges is that most of those are the safety-net hospitals. The question that I have to come to grips with … is that we have to, in the not-for-profit sector, marry mission with business acumen with a requirement for margin. But … if there's a consolidation of facilities to just be profitable, where will the safety-net hospitals be? So that's why I'm going to be bullish on community hospitals that continue to serve a mission, but do it in such a fashion that they are operationally efficient—so that they continue to do those things that might not be profitable as long as they do enough of the things that are profitable. Because without that network of institutions, where then are we going to provide the care to those who don't have access?

TERRENCE DEIS: We're sort of an anomaly. We're sort of an island amongst system hospitals. We're the last independent hospital in Cuyahoga County. … We really, truthfully, though, are interdependent. We work with the other hospitals in the area, both community hospitals as well as tertiary care hospitals, and in that way we're able to serve a mission of providing true community healthcare. We were founded by six communities. We're the only hospital that has "community" in our name. … We're a general hospital/community hospital, sort of friends and neighbors taking care of friends and neighbors. I get letters every week that tell us: I don't know what the difference is, but they tell us there is a difference. You know, "Don't join the system." There's a hometown feel. There's something different. We like to think that is sort of our niche. It's something hard to put your finger on. So as we become more interdependent, we know that there's no future for a community hospital that doesn't change as change is needed and isn't as efficient as you possibly can be. But we want to do as much as we can to keep that hometown feel.

JAMES FIORENZO: Well, I think that the community hospital is going to have a niche, but I believe that there has to be some focus on the buyer here. Who's paying the bills, and what are they going to pay for? At the end of the day … there's no way that the community hospitals in the majority of the smaller areas of the country can afford to invest in the quality equation, because that really comes back to the physicians. And you're not going to consistently get quality physicians to move to smaller communities to be able to deliver the quality that's necessary to meet the buyer's quality equation. So I think it's a problem that small hospitals continue to deliver in their message to us: We

James Fiorenzo
President
UPMC Hamot

can't adequately recruit, plus we're in competitive situations with other community hospitals who can't get their heads around the issue of transforming themselves to meet the demands of what is coming with reform. I've said before, and I heard [Cleveland Clinic CEO] Toby Cosgrove say almost five years ago, that there would be 12–14 major systems in this country in the next 15 years, and everybody would be affiliated with one of them. That was his view of the world. I think we're going to be somewhere close to that at some point, and everybody will have a relationship with one of them. Terry's already got relationships with two of the systems. He's not married to them yet, but he's dating both of them. He's been doing that for a period of time. Everybody seems to be dating somebody at this point in time and looking to attach their wagon to someone for something.

Our affiliation strategy is not just about clinically affiliating; it's trying to

find the synergies among those community hospitals so we can start influencing change and transformation of care in those markets. There's no reason for two hospitals to be 30 miles away and both of them recruit urologists, no reason for duplicating general surgeons or orthopedic surgeons if they're only 30 miles away. They should work cooperatively and think about where the physician does his inpatient work and where he does his outpatient work to create a quality quotient that the buyer is going to be attracted to. Otherwise, nobody is going to win in that scenario.

HEALTHLEADERS: *What is it that needs to be protected in the "community" part of community hospitals?*

DEIS: I think largely people feel an ownership in their community hospital. Almost every community hospital, Parma included, is one of the largest employers, if not the largest employer. ... I think people look to their community hospital still. I don't know how to say it better than that. ... We're not anybody's medical safety net, but we're an economic safety net for our community. It's almost part of the community mission for us. There's an efficiency trade-off there, because the 7% that you save by moving IT out from Erie to Pittsburgh has taken payroll tax dollars out of Erie. ... And there are certain inefficiencies around a high-overhead organization as well. Just by taking a community hospital and moving it into a system, you don't automatically get efficiencies. Oftentimes systems manage their hospitals relatively independently anyhow.

John Sigsbury
President and CEO
Emanuel Medical Center

SIGSBURY: We talk about quality of life all the time in the community. We're probably just a little smaller than Parma. We're about 70,000 [people] in the city, and our catchment area is very similar—about 150,000 through what we consider to be the primary service area. Not having a hospital there is devastating. It's like a General Motors plant closing. You don't think of yourself as a company town, but when you have 1,400 employees and you're churning a $100 million payroll over and over and over again through the economy, there is a sense of responsibility for what you're doing. Subsequently, the decision to be independent or not be independent does affect local businesses. It affects everyone downstream, no question about that. We also have a tremendous philanthropic relationship with the community, as I'm sure everybody does. ... Folks in the community are giving back to a service they want to have there. They believe they're making a difference—that they're going to have healthcare because they're taking money out of their pocket to help build a service or build a service line or build a building on campus. It's a great relationship that we have with the community.

HEALTHLEADERS: *We have a spectrum of experiences around the table. Jim, you started this process of looking ahead several years ago, and you made the decision to join with UPMC on terms that were positive for you. John, you're going through this process now and you've just made a decision to join with Tenet, which has not been easy in every aspect. Terry, you're thinking about what the future is: What are the values to protect? What are the relationships/affiliations you want to hold on to? Please summarize your processes and your thinking.*

FIORENZO: How does a board get their head around doing this in the first place? We had a couple of our key board leaders at a national forum for board governance who heard a discussion of scale and size and were intrigued by that. They were also talking about the whole structure of boards to be able to adequately lead and direct the systems of the future at that time. So [the board members] moved to a point where they were able to convince the rest of the board ... five years ago or so that we needed to kind of reevaluate what the scenario planning was for the organization going forward. For that discussion, we brought in consultants. ... Everybody's talked to consultants about their future. That process moved our board to further evaluate potential partners of the future. They made the decision based on a position of strength, that we would be no more valuable to a partner five years down the road than we were at that point in time. (With the changes that we've seen already, that was probably a pretty good analogy, because we've seen a degradation of operating margins, etc. Market forces, particularly in the northwestern Pennsylvania area, have predicated that that was probably a really good move.) ... We evaluated potential partners. The board put together a partnership committee, and that committee worked on partnership discussions with the major players in the market. They evaluated four, whittled it down to two, and took offers, so to speak, from those two. The largest insurer in our market decided to jump in at the last minute as well. They were not included in the original review because nobody felt that they could be a player in the "template" for what we were looking for.

Our template for a partnership was based on what we always identified during this whole process: "the five C's." ... The first one is culture. How does their culture match with ours? Was it going to be a good fit, etc.? Commitment: What was the commitment to the investment, not only in the community but also on the clinical and access issues? Number three was capital. How much money were they really going to bring to the table and

be able to support us long term? Fourth was the clinical investment: Did they have access to physicians? We talked about the medical school, the fellows, the residents. UPMC has 1,500 residents and fellows, so they could assist in populating physician specialties. The last one was the community: How was the community going to be affected? This [led] into a foundation discussion. Was a foundation going to be created to assist in reinvesting in Hamot … and be a longstanding entity after all the dust had settled? So the five C's were what we brought into our discussion, our evaluation, and then looked to see how each one of the proposals matched inside those categories. Ultimately, UPMC was identified. Then it was just pretty much putting the deal together, and then that's when the lawyers came in to make it all happen.

SIGSBURY: I don't think the process is a whole lot different, even a few years later. Every market has its unique characteristics. Our market is as competitive as anyone's market and is dominated by lots of highly integrated systems. Sutter is an integrated model. Kaiser is an integrated model. The Tenet hospital that is north of us has a 500-physician IPA and relationships with Blue Shield and Blue Cross. So for us, it became an issue of exactly how are we going to do everything on our own? If we want to create a pathway for medical residency, we're doing it on our own. There is no help, there is no intellectual capital, and there is no other capital. We have to generate it ourselves. If we want to start a service line, we have to be the one that invests in the service line. There's no rationalization across a larger marketplace. With our board, who has been very supportive of our growth strategy over the nine-plus years I've been there, we have to be as transparent and as realistic as possible over what the long-term prospects are with the emphasis on beds. When beds are being deemphasized, beds become an expense. When someone can compete effectively in your area with outpatient facilities, their cost of entry in the marketplace is very low. Building beds in California is an expensive proposition, [but] you don't need to any longer. There's not a capacity issue in any hospitals in our area. So you find yourself as the independent hospital with a loosely organized medical staff, mostly of independent physicians competing against highly organized groups of physicians. We looked at the organization that we had the most clinical overlap with, where there was as much synergy with the physicians as possible. That helped with the acceptance of the choices amongst the medical community; our board was able to evaluate a known quantity.

Now, the one area that we're going to struggle with is, this is going to be a clash of cultures. There is no question that the two organizations are going to be 180 degrees apart. Our role is to bring those organizations and those cultures together over the next couple of years so that the community sees the value … and also sees a sustainable hospital operation in the community so we can retain as much as we can. We've gotten great protections—not quite as good as Jim—but we've gotten what we think are pretty good industry standards on the protection for service lines and the hospital. But nothing works unless you get to that level of super-efficiency that we hope we can achieve with now almost 700 beds between the two facilities and a fairly significant physician organization.

DEIS: Our situation is different as far as where we're at, but I don't think we're not doing things very similarly to the rest of the group. In our strategic planning process around this issue, our board did a couple of things. One is they defined the term: As opposed to trying to sell at your peak [or] cut the transaction at your peak, philosophically our board decided [to focus on] the last responsible moment—not the last possible moment, but the last responsible moment. We set up some criteria around at what point in time we should look more seriously at something that gives up governance and management of the organization.

Terrence Deis
President and CEO
Parma Community General Hospital

That's where our board's head is at. So quarterly we look at criteria: quality, growth, people, recruitment of physicians, recruitment of executives—very specific. And if we trip them, it's sort of like a bond covenant. If we trip more than one of those, then it's time we think seriously whether it's the last responsible moment. We have done fairly well keeping the bond covenants or the triggers at bay, but we still continue to have discussions where we are looking at our current [relationships].

We have relationships with both major systems in town [Cleveland Clinic and University Hospitals]. We have a separate relationship with one very independent hospital much like us, Elyria Memorial—EMH Healthcare is their new name—and then Southwest General, which actually has a partnership with UH already. But that partnership is at the system level, and the hospital is actually ready to do some things out on their own. So we've created this collaborative in order to get some economies of scale on things like purchasing, EHR, high-cost items, potentially back-office things. In the meantime, from our clinical relationships we're looking at how much benefit would there be to, instead of having relationships with multiple tertiary providers, what if we had a relationship with one single provider—essentially going from dating two people to dating one person, and what is the benefit of that. We're trying to determine currently whether the

benefit of doing that outweighs the cost. It's not free to do that, actually. You can be Switzerland as long as you're Switzerland, but once you choose a side, then ... the next thing you know, people who have not competed with you because you're Switzerland will [have] a competitive response.

Mike Williams
President
Community Hospital Corporation

WILLIAMS: One of the most interesting things we've talked about is that decision point of when you go. I've heard too many execs wait until it becomes a distressed situation and not take a responsible view—"This is what I'm burning on a month-to-month basis." Every dollar that gets burned never comes back, so it doesn't ever get reinvested in the community. It's not a part of a future scenario. At what point do you recognize the trajectory of the organization to say, "We can't burn through any more of this, and we have to create a responsible legacy in the community"? ... What are the motivating factors that cause a board and a management team to say, "This is the last responsible moment"? ... Many boards, like those that I think you guys work for and work with, are proactive, thinking ahead, looking for that last responsible moment. But I tend to see across the country the exception to that thinking. It's a reaction, most often to fiscal failure. At that point, the organization is not in the best position to sell, to partner, to do whatever. They're [acting] from a position of weakness, and many boards think that the only option they have left is to sell the asset or to merge with another organization. Many times it's difficult for a CEO or a management team who has been responsible, at least partially, for that fiscal failure to go to the board and say, "We now need to be proactive," because it's a time of reaction. More often than not, it's a default on a bond covenant that causes the board to be made aware of the challenges that they're facing. Then a third party comes in and begins to take control away from that group, saying, "We will now dictate your future because you haven't managed effectively, nor has your management team been accountable to a board who has assumed their fiduciary responsibility in an ongoing way."

HEALTHLEADERS: *How do you get boards of community hospitals to come around to a way of thinking that isn't based on the last possible moment?*

FIORENZO: I think the board makeup is critical to any of these types of decisions—their histories, their knowledge base, etc. Unfortunately ... everybody is all over the place in regards to term limits. The recruitment process is different. ... It's crazy stuff in regards to how we actually repopulate our board makeup. ... These are the kind of things that all of the small community hospitals have to deal with in some way, shape, or form, and there's no good answer. But for you to make the most reasonable decision at the most responsible time, that board dynamic is critical. And many CEOs are somewhat reluctant to challenge their boards in regards to what really has to be done.

SIGSBURY: We often talk about how one of our most important roles is the development of our senior executive staff, and the recruitment, the motivating, and the training of that group. I don't think the responsibility is any less for a CEO in working with your board chair in recruiting and retaining a board of directors. ... But it takes as much or more work on that side as it does with finding and developing senior executive talent in the hospital side.

DEIS: We have an 18-member board. Sixteen members are made up of the community. They're appointed by the mayors of our six founding communities. We also have two physicians on our board. We do have term limits, and that hasn't always been the case. But that's added some value. ... They're a committed board. They're engaged, they're committed to the community, first and foremost. One thing they do a very good job at is not being parochial about their own community. They look at the broader community, which sounds trivial, but you could spend a lot of time in that kind of environment arguing about whether we're doing something for this city or that city, and that almost never happens. They look at the broader community. And they have been pretty proactive about this whole idea of partnership and so forth. So in that way they've been very strong.

WILLIAMS: It's been said that the role of a hospital or a health system CEO is one of the most challenging in any business by virtue of the different audiences that have to be served. You've got the staff, the community, the employees, the board. When I look around and see those boards ... that are most progressive in their thinking, it's the board that has a very positive relationship with their CEO. The CEO has to be confident in his or her abilities to the extent that he or she can educate the board about the challenges that lay ahead. ... That relationship skill ... allows that board and that CEO to say together, "We're going to walk into the future."

And if you bring the third leg, the medical staff, into that relationship, those are the organizations that are going to be most successful in the future, when month by month they are thinking together about what's coming and how they can deal with whatever those challenges are. I really believe it's the relationship skill that's going to allow the CEO to educate, be transparent with, and be proactive with the board to address the issues.

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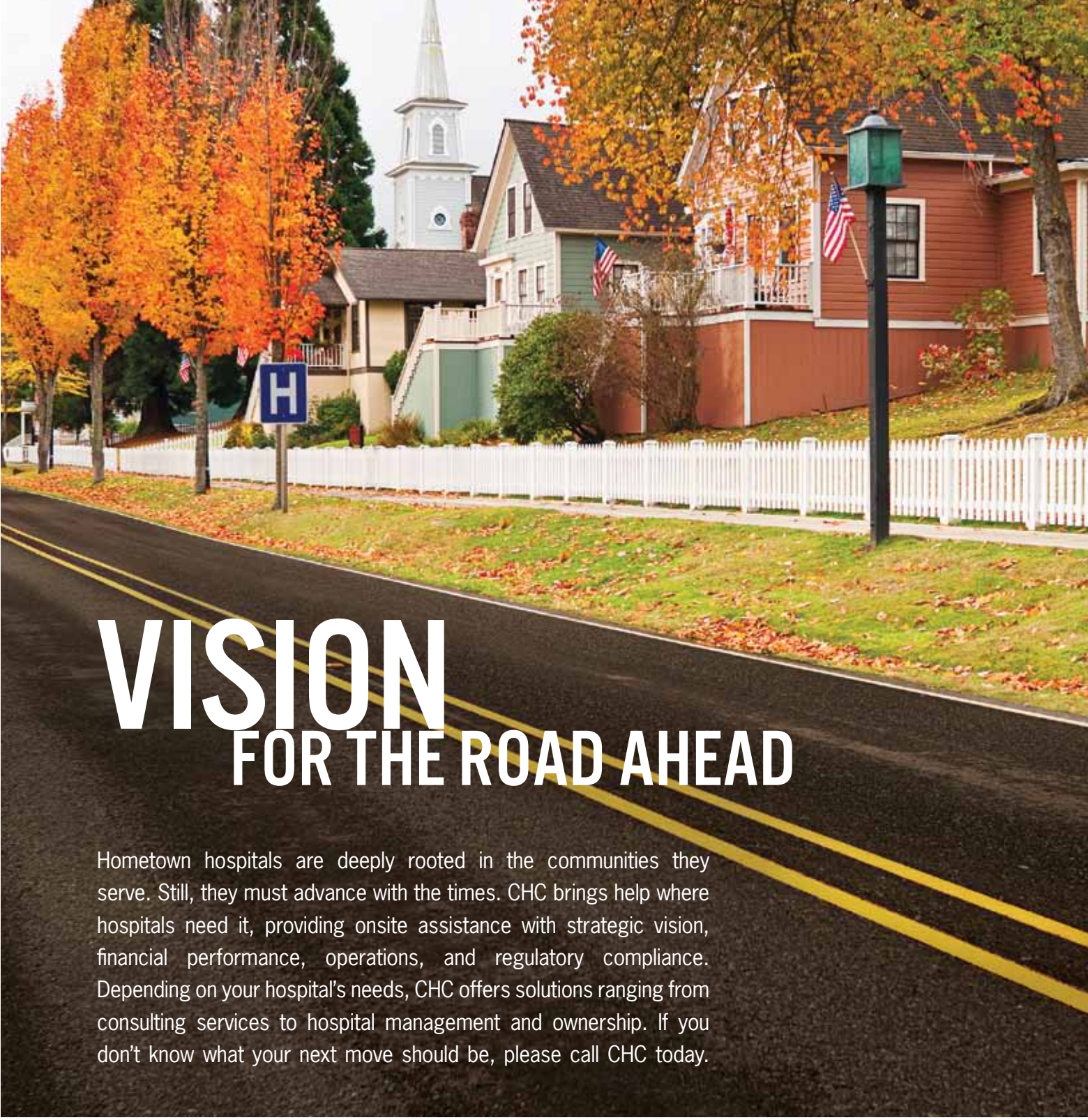

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