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2 Case Examples: Choosing Partnership Over Merger

Through partnerships and affiliations, some hospitals and health systems are creating clinically integrated networks and regional payer strategies that facilitate population health without disrupting balance sheet independence.

Many financially strong community hospitals and small health systems are feeling the pressure to merge with or sell to a larger system—not necessarily for financial reasons, but to access skill sets that support population health management goals and the coming payment shift from volume to value.

It's not surprising that so many stand-alone community hospitals still see merger and acquisition (M&A) as the only alternative: The capabilities required for value-based care are complex. In addition, balance sheet transactions are big money, and they dominate news headlines. That said, only 12 percent of hospitals were involved in an M&A transaction over the past five years, according to the American Hospital Association.

In a sign that the meaning of “independent provider” is changing, many forward-thinking hospitals and health systems are making quiet, intense movements toward partnerships and affiliations (P&A). They are choosing P&A over M&A. They are finding that they can gain the population health skills they need without relinquishing control of their physical assets, local cultures, and charitable missions.

Case Study: Salem Health

A-rated Salem Health serves a population of 450,000 and is the primary referral organization between Eugene and Portland, Oregon. In 2010, Salem Health saw the time had come to position itself for a new future. The two-hospital system added “merger” to a board retreat agenda.

The conversation didn't go very far.

“The term ‘M&A’ has a very narrow scope that sends a very direct message. It limits your opportunities by saying ‘we’re either doing a balance sheet merger or nothing,’” CEO Norman Gruber says of his board’s shift to discussing P&A. “The terminology of affiliating and partnerships gives you a much broader horizon to look at. P&A says there’s a variety of models out there, and they can still get you most of the way there, if not all the way.”

With this shift in mindset, Salem Health’s board took a hard look at its strengths and gaps, as well as its future place in the evolving care delivery model. They began exploring partnership opportunities two years ago with the intent of creating an efficient, clinically integrated network.

“The board has agreed this is the time to look at what’s in the best interest of the community, but in a model different from the model we’ve had in the past,”

Gruber says. “We’re going to need to find partners if we’re going to play in a new world. We need to do this. We can still serve our community. We can still serve our mission. But we probably can’t do it in the framework we did before.”

Salem Health approached potential partners from a position of strength and knew its own long-term goals going into the discussions. Besides knowing its own gaps, it also knew how it could be a complementary solution to issues faced by other health providers and businesses.

Salem Health initially sought to create a larger Oregon system with similar-sized providers. Finding little interest but knowing it had to move forward in pursuit of population health goals, it switched tactics and identified seven larger systems in Oregon and California based on their cultures, missions, and

ability to provide complementary skills and features—a payer strategy, a clinical integration strategy, a physician alignment model, and scale. After formally requesting information on potential partnerships, Salem Health spent much of 2013 meeting and visiting with each health system to discuss goals and strategies. Salem Health is currently in the process of narrowing down its options for a new, non-balance-sheet dependent relationship.

Case Study: Eastern Kentucky Healthcare Coalition

When seeking potential partners, don’t count out individual members of larger systems or assume that P&A with one member leads to M&A with the entire organization.

For example, in Kentucky, the five-hospital Eastern Kentucky Healthcare

Coalition is structured as a “super Physician-Hospital Organization” with the purpose of creating a clinically integrated network of autonomous providers to help improve healthcare quality and reduce costs. Its five Kentucky facilities include St. Claire Regional Medical Center, Highlands Regional Medical Center, UK HealthCare (part of the University of Kentucky), St. Mary’s Medical Center, and Our Lady of Bellefonte. The latter is a 200-bed member of Bon Secours Health System; its nearest Bon Secours sister is several hours away.

“We’re still on a journey. This won’t happen overnight. But what’s different is we feel like we’re a part of a local system now. Before, we were part of a system that was outside our market,” says Kevin Halter, FACHE, CEO of Our Lady. “It’s probably working better than we thought. I think the clinical integration is where we’re going to see the most cost savings.”

Identifying the Right Partners

Hospitals and health systems that approach partnerships and affiliations (P&A) knowing their gaps and the solutions they offer to potential partners will have a better picture of where to start seeking relationships and how to position themselves in those conversations.

As hospitals think about their assets, a good place to start is with geography, skills, and reputation:

- > Can you create a better “system of care” through more direct referrals to a tertiary or quaternary system?
- > Do you cover a population or geographical area that is of interest to a payer?
- > Does the organization have specific expertise in a particular area (e.g. medical homes, clinical communication, Lean, EHRs, or behavioral health management)?
- > Do you have particularly strong clinical skills in a specific area?

Hospitals should look at partnership opportunities both in their geographic area and beyond it.

Consider the following:

- > Who is doing well with what you need and with measurable results?
- > Who wants what you have?
- > Who needs what you need?
 - Financially strong community hospitals may not be so strong that they can buy or contract for physician management or data analytics skills on their own, but they may be able to combine purchasing power with like-minded providers.
- > How will the organization transition to new reimbursement models that pay for value and population health management instead of volume?
- > Most important, who believes in your goals and mission and is actively pursuing them?

Source: Kurt Salmon. Used with permission.

So far the Coalition’s members are sharing learnings from Our Lady’s experience with its development of 10 patient-centered medical homes and from Bon Secours’ accountable care organization. They are also engaging in a physician manpower study to determine, for example, potential efficiencies in joint recruitment of needed specialists into the communities served by the providers.

“There’s no loss of individuality. We’re not telling anyone how to manage their organization. We all do our own thing—we just find ways to share efficiencies,” says Halter. “If I’m going to be paid in the future for efficiency and effectiveness, then this can only be helpful going forward.”

P&A Versus M&A

M&As are often prompted by financial efficiency or financial scale needs and

generally involve a larger entity subsuming a smaller competitor. In contrast, P&A activity is pursued by strong organizations that seek to increase efficiency and improve outcomes for their populations by integrating clinical care and adding skills beyond the clinical continuum (e.g., data partners with resources to identify and better treat high-use patients).

These clinically integrated networks have become the goal in certain proactive community hospital boardrooms, where the question on the table has become not “How can we increase market share,” but “Do we have access to the tools, talent, and skills necessary to provide efficient, effective care to the population we serve, and if not, how do we gain it?” The answer varies for every organization,

and it frames the pursuit of the right P&A relationships. ☞

Jeffrey R. Hoffman is a senior partner in Kurt Salmon’s Healthcare Group, San Francisco, and a member of HFMA’s Northern California Chapter (jeff.hoffman@kurtsalmon.com).

Population Health Skills

Three key skills are needed to succeed in population health management. Population health management requires more than a comprehensive set of clinical skills. It requires more than scale. To create a sustainable clinically integrated network and truly fill in the gaps in the care continuum, hospitals must have or partner to access:

Physician alignment and practice management experience. Physician alignment is the first and most crucial step in pursuing population health as a goal. Clinical integration cannot happen without it, nor can payer partnerships succeed unless physicians are on board with the process. Some past arrangements have failed because providers purchased multiple physician practice groups and then failed to integrate the diverse cultures and billing practices and establish physician leadership structures in a population unaccustomed to following employee handbooks.

When filling this gap, seek a partner that has experience employing or contracting with large groups of physicians from diverse specialty groups.

Clinical integration skills. Aggregating diverse strengths across geographies can (but doesn’t always) require combining documentation,

records, IT and other systems, and performance, outcome and other metrics, not to mention coordinating communication and treatment across multiple practitioners. And clinical integration is more than just doing something together—it’s organizing to deliver clinical care differently.

Chronic conditions are a prime example: Proactive management of chronic congestive heart failure patients could mean, for example, that nurse practitioners remotely monitor patients daily via electronic tools. If a patient gains weight suddenly, the practitioner can call to check in, learn the patient had a dietary change, and help the patient return to a more manageable state before they show up short of breath in the emergency department. (Compensation becomes a political issue here if fee-for-service is still the name of the game: Once again, physician alignment must come first so better care is properly incented.)

Seek a partner that is actively working toward healthcare transformation by creating processes that improve care, cost and value, and that has established metrics to measure outcomes. Hospitals can also look at care efficiency within their own facilities by examining recurring admissions and other data. Such “hotspotting” requires analyzing data across

providers and physician offices—which is where payer partnerships fit into the clinically integrated network model.

Payer skills. Hospitals have one set of patient records and treatments, and physician offices have others, but only payers have aggregate data on patient treatment across the continuum. In partnering with payers, clinically integrated networks gain access to data they can analyze to identify high-use patients. In doing so, they can proactively manage patient care by seeking patterns that indicate, for example, that a patient could benefit from behavioral health care to address issues impeding the treatment of chronic conditions.

Further, such partnerships can facilitate the creation of narrow networks and eventually allow for the network to shift its pay model to one based on shared savings or a partial capitation rate that further incentivizes value-based care. Across the country, commercial insurers with access to comprehensive treatment data are interested in partnering with health networks that can demonstrate improved value in care delivery and provide them with access to insurable populations.