

# Enlightened Interdependence

Considering a merger? Step back and take another look at the options

By Joseph R. Lupica and Carol J. Geffner

**H**ospital trustees considering a merger or other affiliation should ask themselves if they are treating a short-term problem with a long-term solution.

In the din of experts' predicting the decline and fall of the independent community hospital, trustees may feel obliged to prescribe medicine that causes more harm than the illness itself, even to the point of removing a precious asset from the community or changing its character forever. On the other hand, a decision to affiliate may actually avoid the loss of the community's precious health care asset.

## Work Together or Work Separately?

Health care leaders decide every day whether their organizations will work with other hospitals, align with community physicians, enter joint governance structures with hospitals, physicians and payers. In the past, hospital leaders often considered the combination of hospitals an all-or-nothing proposition, and a painful one to be considered only in a time of dire need.



But with a variety of models now available to promote collaboration — from shared services to shared governance — affiliation rarely means “selling out.” Boards can trade the label of independence for the best attributes of independence, achieving fruitful interdependence that more effectively accomplishes their objectives.

Traditional mergers and acquisitions represent one extreme on the spectrum of affiliations; they are not a hospital's only means of collaboration. Trustees can consider a wide range of structural alternatives, such as shared services, clinical support agreements and shared technology, all the way to full integration. The trustees are in charge. They can fine-tune the balance of local control and partner investment if they have carefully examined

the attributes of independence that matter most to their stakeholders.

If, however, trustees rush into the arms of a suitor without examining their objectives and without confidence in their organization, the other side may dictate the terms of the marriage, and trustees may discover that, in their case, affiliation meant selling out.

## What Is Independence?

In this context, independence is not an ethos to go it alone at all costs, but rather a considered, enlightened approach to mutually beneficial collaboration. Hospitals can remain independent while pursuing affiliations that address both financial concerns and the effect on employees, culture and community. They can enter deeper relationships that provide better access

to capital and other system resources but retain the attributes of independence that matter to stakeholders.

Either way, when affiliation participants maintain local authority over the decisions that matter to their communities, they can collaborate more effectively because each comes from a platform of strength supported by the people they serve.

### The Long Game

Trustees volunteer time and judgment to oversee their organization's activities, from hiring the CEO to approving major capital investments and clinical programs. In the midst of these responsibilities, they must also guard the long-term viability of their hospitals.

Industry pundits repeat alarmist phrases so often that hospital leaders are starting to believe the pitch that "consolidation is the best path to survival in today's risky environment." The mantra spreads fear across the industry and leads some independent

hospitals into ill-considered sales or mergers that sacrifice a community's best long-term interests.

Yes, the environment is changing, but it has been changing since the early days of Medicare and it will continue to change. The industry has worked through, and even thrived, in risk.

Fiduciaries have the local knowledge and obligation to examine the core questions of why their institution exists, whom it serves and how it can best serve them. Can the organization reinvent itself by itself? Can it marshal the clinical, operational and capital support it needs on its own or with the cooperation of strategic partners? Can the trustees and the management team dig under the financial data and identify what long-term needs may make a transaction the best solution? Before rushing ahead, trustees should consider these and several other questions:

#### 1. Why are we doing this?

Let's assume the challenges perceived by trustees and senior leaders

are real; they usually are. The question is whether those challenges will respond to incremental treatment or require fundamental change. Perhaps past initiatives have not helped enough. Perhaps the trustees can see that the next round of initiatives is unlikely to do much better. Perhaps the enterprise is in a stable condition but lacks access to the capital it needs to make the next leap forward in physician alignment, service line expansion, technological sophistication and physical plant improvement. And perhaps the board's relentless incrementalism of the past has worn out its welcome.

Uncovering, assessing and airing out the true reasons for considering affiliation options will help trustees approach potential solutions from a position of strength, not fear.

#### 2. What's in it for the other side?

It takes two to tango toward an affiliation. Thus, it's important for trustees to understand what their organization offers to a potential partner. It gives them an opportunity to look up from their pain to articulate their hospital's strengths. The hospital's interaction with hometown patients, its understanding of rural health clinics, the agility that comes with its smaller size or even its painful experience in learning to deliver more for less will attract a suitor. The system you want to attract may have plenty of capital, but might need a lower-cost framework, a wider geographic reach and lessons in hometown care.

#### 3. What does confidence get us?

It gets something far more important than money. Beyond attracting necessary capital, the trustees' confidence in their hospital's strengths can help them protect the elements of independence they value most.

The reason is that hospital partners no longer have to fit their objectives into one of two separate boxes: to merge or not to merge. The structures are as broad as the trustees' ability to discover and define their community's objectives and as achievable as the confidence they bring to the table.

Hospitals that think they have never

*(Continued on page 19)*

## Reap What You Sow

The most fruitful affiliations start with good seeds. In those cases, the community hospital:

- has an open mind toward options;
- engages in clear goal-setting and builds stakeholder consensus on objectives;
- keeps those objectives foremost throughout the search, negotiation and transaction agreement;
- balances the need to secure resources and maintain local prerogatives;
- has confidence in what it can offer the partner, not just the other way around;
- shares the core values, missions and business strategies of its partner;
- retains meaningful local power in governance and strategy;
- has good faith that will keep the transaction contract "in the drawer."

When affiliations fail to bloom, it is often because the community hospital:

- overlooks a mismatch of initial and ultimate expectations;
- is over-awed by a perception of the partner's capabilities;
- trusts the partner's current leaders over enforceable commitments;
- makes the deal without buy-in of medical staff and community;
- affiliates out of desperation (on either side);
- fails to examine all feasible options;
- affiliates with a partner who changes ownership after the deal is completed;
- finds surprises buried in governance agreements;
- fails to complete reverse due diligence on the partner.

done any kind of merger or affiliation may already be in an affiliation. “Affiliation-lite” relationships — those on the less-intensive side of the spectrum — can include anything from shared laundry or dietary services to a university’s telemedicine outreach to rural hospitals.

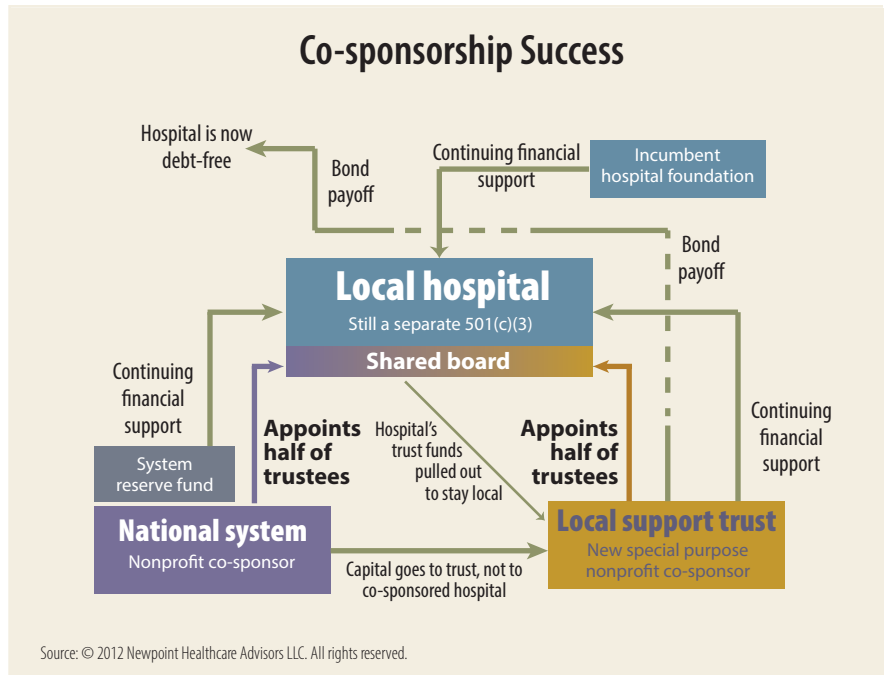
Higher-intensity affiliations (still short of full mergers) can take the form of shared services organizations, clinical service contracts, joint ventures, jointly owned limited liability corporations, nonprofit joint memberships (rather than a member substitution), joint operating agreements, operating leases with coterminous partner commitments recorded on the land records, capital-investing arrangements, and other modifications of operations or governance, or combinations thereof. Any affiliation model can and should be tweaked to fine-tune the balance of access to partner resources and various levels of local control over local health care.

#### 4. If we affiliate, how do we preserve our local essence?

A decision to pursue an affiliation kicks off the hard work of integrating a lot more than balance sheets. It should begin a careful, detailed process for securing the resources the hospital needs without giving up the attributes of independence its stakeholders demand.

Financial needs often drive these transactions. Overlooking other critical integration issues can harm one or both parties after they are locked into a marriage. So often these issues could have been resolved or avoided if the parties had engaged in a more thorough discussion before striking a deal.

In one case, the city and county owners of a hospital losing \$1 million per month opted not to sell their public asset but to enter into a long-term lease with a well-capitalized hospital system. A careful discussion of the local essence of the hospital led to carefully defined covenants for preservation of key services like obstetrics and inpatient behavioral health. The covenants last as long as the 40-year lease term, regardless of financial losses in those service lines.



As soon as it was announced, the arrangement brought the financial crisis to a halt, but more importantly preserved local authority. The board remains almost entirely local, with active membership by the city and county managers. Just four years later, the hospital not only had survived, it had thrived: surgical volume increased by 36 percent and outpatient visit volume increased by 73 percent. Financial success and enthusiastic community involvement continue to this day.

Trustees should explore a series of operational and cultural integration issues early in their affiliation process, including the following:

- Do our organizations share compatible cultures and values?
- Will a transaction alter our institution’s ability to carry out its mission?
- Will it change our mission?
- Are our technology systems compatible? Or will we need to invest in expensive new systems to achieve business objectives?
- How will we integrate our service lines and physician/professional staff with those of our new partner?
- Will there be any reduction, increase or consolidation of services that could impact our patients, physicians and employees?
- What might the combined board

and executive teams look like? Are their styles and values compatible?

- What kind of talent synergy or fall-out might occur among the medical, clinical and administrative teams?

In some cases, the answers will result in a decision not to pursue a transaction that looked good on paper, but would not have created a stronger, community-responsive organization. The purpose of the exercise, however, is not to blow up deals — it’s to make them work. Exploring these issues early on will help trustees anticipate, navigate or avoid major problems that could arise after a transaction.

#### 5. What are the long-term implications of the affiliation?

In addition to the integration issues that hospitals may face shortly after the ink is dry on the transaction documents, trustees must also consider the long-term implications of an affiliation for both the hospital and its community before they approve a deal. Five questions can guide that discussion.

- Will the affiliation preserve needed services?
- Will local stakeholders maintain or lose control of the hospital’s destiny?
- Will the delivery of care improve or become more difficult to execute?
- Which, if any, services will the system pull from the local community

into the mother ship?

- Will this transaction ensure the long-term viability of the hospital or result in a consolidation or closure that hurts patients?

Trustees can't see the future, of course, but they can examine structures and outcomes of other transactions around the country and identify practices that have proven successful.

Another case in point: A non-profit community hospital created a 501(c)(3) joint membership solution with a national health system. The hospital trustees directed the large system's initial capital contribution to a new local supporting trust, which evenly splits voting rights with the national co-sponsor. When the local trust invests the capital back into the co-sponsored hospital, the national system overmatches the local contribution by at least 2-to-1. This affiliation structure bears attributes of both the independence and capital resource

objectives that the trustees developed at the start of their process.

The lesson of this case is that the local trustees kept their eyes on the attributes of independence, local control and capital partnership, not simply on the resulting labels. In addition to 50/50 voting, the local trust has meaningful input into capital investments with the force of dollars, not just words (see Co-sponsorship Success, page 19).

Though the circumstances of every hospital and community are different, gaining perspective from cases across the country can help local leaders assess what long-term implications and unintended consequences likely will arise from various elements of the transaction structure (see Reap What You Sow, page 14).

### Challenges and Opportunities

Though we all may succumb to clichés at times, there's no reason to let any single trend dictate an overreaction

that may solve short-term problems but fail to secure long-term success. Instead, trustees can view today's challenges as opportunities to reaffirm their commitment to the attributes of independence that matter most to their stakeholders.

If they can work interdependently with others, hospitals can retain the best parts of independence and truly flourish. By working through questions like those above, the leaders of those hospitals have the best chance to create a balanced affiliation, fine-tuned to the needs of their community. They are the leaders who will preserve and enhance health care services for their neighbors and keep those services close to home. **T**

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