

FEATURE STORY

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the *new* wisdom collaborate with the competition

Building strong affiliations with their competitors is one way for healthcare organizations to thrive in today's environment.

Bury the competition before it buries you.

This conventional wisdom has been applied liberally in health care over the years. Providers have frequently contended for resources, patients, and staff, all while trying to cut costs and improve quality.

But viewing the competition only as a threat can get in the way of a provider's primary mission of caring for patients in the most efficient and compassionate way possible. There are times when collaboration among competing providers is not only desirable, but also necessary to deliver the services patients need in a given community. Moreover, it is often through collaborations that providers can position themselves to support their medical staffs, provide a diverse array of services, and ultimately become more profitable.

In some rural communities, for example, certain essential services—such as a comprehensive cardiology program—may be out of reach for an individual hospital to provide on its own, but quite feasible for two or more hospitals that pool their resources to develop the service line. And by sharing staff resources for the service line, a hospital involved in such a collaboration can reduce its own labor costs and minimize staff downtime.

Healthcare organizations therefore should continually search for innovative ways to move beyond the conventional wisdom toward collaborating with their competition. And they should explore the full range of options, including affiliations, joint ventures, integrated management networks, as well as mergers and acquisitions.

Evolving Perspective

Although a spirit of gamesmanship has been prevalent among providers at various times over the past few decades, particularly in the early 1980s with

AT A GLANCE

Potential benefits for hospitals of collaborating with their competition include:

- > Improved quality
- > Elimination of administrative redundancy
- > Improved ability to attract talent
- > Greater access to resources for small and rural hospitals
- > Greater purchasing power through economies of scale

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the introduction of diagnosis-related groups (DRGs), the spirit of collaboration is not entirely new. The integrated delivery systems (IDSs) of the 1990s attempted to solve health care's ailments of rising costs and declining profitability by uniting hospitals, physician groups, MSOs, and HMOs under the same umbrella. Yet these mergers often did not eliminate duplication and overhead as intended, and little thought was given to the integration of cultures and the desires of consumers. As a result, many IDSs simply failed outright, and among those that did not fail, very few could live up to their promise of improved financial performance and better patient care.

Providers today have the advantage of learning from the failures of the 1990s. And they are applying the lessons learned to create smart affiliations: those that achieve a healthy balance between economies of scale and the successful integration of unique cultures and a diverse workforce. Some of the more common collaborations today include allied hospital specialist facilities, jointly owned physician-hospital ambulatory surgery centers, trauma service partnerships, and outright mergers and acquisitions between two or more organizations. The sidebars at right and on page III offer examples of two successful collaborations.

A Look at the Benefits

Providers, limited only by their imaginations as to affiliation possibilities, stand to reap a host of benefits from collaborating with their competitors.

Improved quality. Organizations that do not try to be all things to all people will have a better chance of excelling in specific disciplines because they are open to developing effective partnerships. A community hospital that tries to go it alone on providing imaging services, for instance, might find it can deliver only one or two service options, and if its competitors do the same, the result might well be a scattering of various services at different facilities. A group of hospitals that collaborate on a single imaging center, however, could offer all modalities in one location.

Elimination of redundancy. How many neurosurgeons does a community need? Although a hospital might be tempted to bring in its own specialist and go head-to-head against the hospital across town for a lucrative line of business, such an approach is most likely not in the community's best interest and certainly doesn't reflect a provider's responsibility to help control healthcare costs.

Case Study

Memorial Hospital and St. Elizabeth's Hospital

Several years ago, the southwestern Illinois medical community, anchored by Memorial and St. Elizabeth's hospitals in Belleville, identified a need to provide improved cancer treatment options to area residents. Building, equipping, and staffing a separate facility would have been too costly for one organization to handle by itself, and if the two organizations were to attempt to compete in the service line, each would have to invest in expensive equipment that would go unused much of the time.

The two hospitals—independent facilities to this day—decided to collaborate by jointly funding The Cancer Treatment Center, a freestanding outpatient cancer facility. The partnership offered three distinct financial advantages:

- > Shared capital costs, which ensured that neither organization would bear a financial burden that was greater than it could handle^a
- > Overhead spread over a larger base, which ensured that operational costs—often underestimated in the planning stage—would not overburden a single provider
- > Evenly distributed revenue and the assurance that both providers would jointly reap the profits or share the loss

Today, with pooled resources, Memorial and St. Elizabeth's can invest in state-of-the-art equipment. The center currently offers PET/CT imaging services, traditional radiation therapy, and even cutting-edge intensity modulated radiation therapy (IMRT). The collaboration enables the hospitals to bring together the best oncology clinicians and staff in the area, helping each to avoid having to jockey for talent on its own.

Moreover, by operating independently, The Cancer Treatment Center has become a valued community asset and is able to offer many unique services not offered at the two hospitals, such as nutrition, counseling, massage therapy, educational resources, and even a wellness and therapeutic learning program complete with yoga classes. The center has built a reputation as a top-notch care facility on par with larger, better-known institutions; its patients come from all over southern Illinois, even though they have other options across the river in the bigger St. Louis market.

a. Of course, any partnership can be structured as the collaborators see fit, with one organization supplying more of the capital costs on start-up.

Improved ability to attract talent. Health care's most important resource, and perhaps the most difficult to acquire, is high-quality staff.

Regardless of the position—nurse, physician, phlebotomist, financial analyst, executive—organizations are increasingly finding value in joint recruitment activities and shared-staff arrangements.

Greater access to resources for small and rural hospitals. Affiliations with large, urban facilities give rural centers a plethora of services and specialty programs they would otherwise not be able to access, such as pediatrics, cardiology, orthopedics, neurology, and oncology.

Case Study

Memorial Medical Center and St. John's Hospital

A charity partnership between Memorial Medical Center and St. John's Hospital in Springfield, Ill., provides an excellent example of how providers can join together for the common good of their patients and the community. In support of the Capital Community Health Center (CCHC), a federally qualified health center that provides medical care and dental services to the community's uninsured and eligible under-insured residents, the two organizations have assumed shared responsibility for providing uncompensated services to patients throughout the year. They even supply laboratory, imaging, and outpatient surgery services at low or no cost to patients in need of additional services that Capital Community does not offer.

In FY08, St. John's provided services to CCHC patients totaling approximately \$2.9 million in gross charges covering 2,900 hospital visits/admissions. Many of these patients might otherwise have sought treatment in St. John's or Memorial's emergency departments, without the hospital receiving compensation. Moreover, because these patients were not patients of St. John's, the hospital saw a measurable decline in bad debt.

The program is a community benefit for Springfield residents and part of the two hospitals' charity care efforts; no funding is provided to Memorial or St. John's by Capital Community. To keep the administration of services as simple as possible and eliminate confusion on where to send patients, responsibility for providing the service rotates between the two hospitals from quarter to quarter.

Economies of scale. With the right mix of strategy and tactics, larger organizations can leverage their size for greater purchasing power and influence over insurers when it comes time to negotiate contracts.

Physician-Hospital Relationships

Physician-hospital alliances are a type of affiliation that is gaining popularity. A 2004 survey of more than 1,000 physicians conducted by the Irving, Texas-based hospital alliance VHA, Inc., found that 50 percent either "somewhat" or "strongly" approve of joint ventures owned by physicians and 44 percent "somewhat" or "strongly" approve of physician-hospital owned joint ventures (*Physician Hospital Relationships: Forging the New Covenant*). Of those physicians investing in joint ventures, a relative minority (21 percent) indicated that the financial benefits had not met expectations.

A few years ago, surgeons at a hospital in the Midwest decided to leverage their skills and experience into greater independence and ownership of their own for-profit ambulatory surgery center. They sought help from hospitals in the area to launch the venture and share the risk that would accompany it. Viewing the center as a competitive threat, the hospitals declined. Regardless, physicians went ahead with their plan, and eventually one nearby medical center expressed interest in becoming a minority partner and was approved by the board.

Both organizations realized significant benefits as a result of the partnership. With humble beginnings as a tiny ambulatory surgery center, the organization experienced rapid increases in patient volume driven largely by the medical center's referrals. Before long, the three-bed facility became a 20-bed surgical specialty hospital. Physicians even found the means to build their own medical office building adjacent to the facility.

Leveraging the benefits of a larger scale, the organization was able to negotiate more favorable contracts. For instance, the physicians agreed to

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use orthopedic implants from one manufacturer 90 percent of the time, lowering implant costs by about \$1,000 per case. Although some physicians might have preferred other manufacturers for such devices, they were generally more willing to compromise when the savings were applied directly to the bottom line. Of course, the hospital reaped its share of the financial windfall as an equity partner.

Perhaps also contributing to the surgery center's success is the assumption by patients that a specialty organization is likely to have greater

expertise and produce better outcomes—e.g., fewer complications, infections, and follow-up procedures—than a multidiscipline medical center. And often, this assumption is correct.

Hospitals should therefore be open to physician partnerships, even if it means giving up some control and a significant portion of the profits.

The Senior Financial Executive's Role

The responsibility that financial executives play in a successful collaboration cannot be overstated. Responsible for maximizing the finances of their organizations, healthcare senior financial

Resource Sharing

Mergers and acquisitions are far from being the only ways for hospitals to collaborate with their competition. Here are some other ways.

Disaster preparedness. Today, hospitals have a great opportunity to collaborate with other providers in the best interest of the community by maximizing medical resources in a disaster response scenario. To encourage this practice, the Department of Health and Human Services in September 2007 awarded more than \$18 million in grants to help hospitals prepare for public emergencies. Organizations such as the King County Healthcare Coalition, WakeMed Health Care System, and Boston University School of Public Health will use their funding to improve regional public health emergency coordination through joint training and communications activities and conduct public health emergency exercises with other facilities to evaluate community and hospital preparedness.

Advocacy. Organizations with no desire for an official affiliation nonetheless can collaborate with others through their state hospital associations. In this way, institutions can put aside their day-to-day competitiveness and speak with one voice in the areas of health-care policy, regulation, government reimbursement, and other important issues. Associations also provide a great means for health-care providers to connect with local businesses and community leaders that often participate as associate members or sponsors.

Special issues. On a smaller scale, physician and interhospital councils unite competing organizations and provide resources to help their members deal with issues unique to their region or community, such as clinician or staff shortages. As an example, in addition to providing community needs assessment evaluations, the Hospital Council of Northern and Central California, whose tagline reads "Excellence Through Collaboration and Leadership," developed its Healthcare Laboratory Workforce Initiative to find solutions for the critical shortage of laboratory professionals in its area.

Education. Often under sponsorship of local universities or community colleges, healthcare organizations can participate in or lead healthcare educational courses on CPR, medical coding, and nursing education. Other programs are designed to bring the health-care community together to pool knowledge sources for training in specialized areas such as trauma and public health emergencies. For example, the Healthcare Education Industry Partnership Council hosted by the College of Allied Health and Nursing at Minnesota State University in Mankato brings together higher education, the healthcare industry, professional and trade associations, and state agencies to address critical healthcare workforce issues in the state of Minnesota.

Operational services. Although outsourcing is certainly the trend in health care, many organizations retain ownership over critical support functions such as laundry, catering, maintenance, landscaping, and environmental services, believing they can do it better and at a lower cost. With the equipment and staffing already in place, healthcare providers have little reason not to collaborate in a win-win scenario with the competition in this area.

executives have a fiscal responsibility to shepherd those alliances that make sense and derail the ones that don't. Alliances, joint ventures, and mergers and acquisitions are often tricky propositions and must be scrutinized carefully. The senior financial leader should be aware of the following challenges when considering a collaboration.

Oversight of due diligence. While there may be several strategic motives for collaboration, from a financial leader's standpoint, the alliance, joint venture, or merger should at the very least make fiscal sense—by reducing overhead or eliminating duplication, for instance. Yet there are many details that individually must be well thought out before proceeding. In particular, the financial executive should make sure that the due diligence team considers the following points in its evaluation.

First, the team should review all departmental contracts within both organizations that will be parties to the arrangement. What are the terms? When do they expire? How are the contracts to be terminated if need be?

Second, the team should examine the partner organization's revenue cycle to identify its strengths and weaknesses. Is eligibility verification a recurring problem? How long does it typically take claims to be paid? What's the denial rate? Are there significant payer contract issues that need to be addressed? Are the information systems up-to-date?

Third, the team should consider bonding capacity and covenants. What are the interest rates? Is a refinancing in order? What is the prospective partner's credit rating, and where does it need to be to achieve strategic objectives?

Loss of identity. All individuals involved in health care, from administrators to clinicians to support staff, have a great deal of pride in what they do. As such, they are very much driven by their identity, both in the community and among their peers. Institutions themselves are no different, particularly organizations with a religious affiliation.

Many alliances that make good fiscal sense are unsuccessful or simply not even considered due to fears of losing a long-standing identity.

Such fears can be allayed, however. Collaborations are bound to fail when one party is made to feel at a disadvantage. When entering a partnership, financial executives can play an important role in making sure all parties have proportionate representation on the board and in the executive suite. The senior financial executive may be just the individual to identify whether the cultural mix isn't right. And if it isn't, he or she shouldn't be afraid to recommend changes, including bringing in new blood and a fresh approach, possibly in the form of new leadership or a third party for consultation that can bring an objective perspective.

Integration challenges. In addition to cultural integration, healthcare organizations should acknowledge the technical ramifications of a merger or acquisition, including what policies and procedures will need to be instituted, how to comply with regulations under the Health Insurance Portability and Accountability Act, and how to integrate disparate information systems and patient data. Even if the collaboration stops short of a consolidation, there are still many points to consider, such as who has access to patient data and how to protect the data. Given that integration is invariably a difficult and extended process, the team leading the effort should be experienced and have a track record of success with change management, organizational dynamics, and operational integration.

Administrative redundancy. The unpleasant reality of a merger or acquisition is that in many cases, executives face the prospect of losing their jobs. The senior financial leader is in the particularly awkward position of justifying an alliance on the basis of financial practicality, knowing full well that his or her own position is at stake, either to eliminate redundancy or, in the worst case, if the deal turns out to be a bust.

A broader perspective on the nature of health care is mandatory for executives, and they should

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recognize that sacrificing their jobs may be in the best interest of the hospital and the community. It therefore may well be that in planning for the collaboration, senior executives should also give some consideration to next career steps. The key is for the executive team to remain focused and moving forward—and to remove personal issues from the table to the greatest extent possible. This objectivity can be achieved with frank discussions of after-merger roles, and the possibility of retention bonuses and severance packages, as necessary.

Legal counsel. Healthcare organizations should seek outside, objective counsel regarding any proposed collaboration. An adviser is critical to separate executives' possible emotional attachment to a proposed alliance from the reality of the situation. Often, a deal may progress so far that participants are all too ready to brush aside significant financial, integration, or other potential problems. Also, an independent third party can get a deal back on track that has stalled in negotiations or is at risk of failing over matters that are insignificant to end objectives.

It is also important that legal representation be well versed in health care as well as joint ventures or mergers and acquisitions. In addition to helping navigate the industry's complex regulatory nuances, legal counsel can steer the arrangement clear of problems that could attract the attention of antitrust regulators.

Mission Comes First

Learning from past mistakes, healthcare providers have an unprecedented opportunity to uphold their values and missions through collaborative arrangements. Although some may consider the senior financial executive's role in collaboration as simply one of number crunching, the truth is this leader is as strategically positioned—if not more so—as anyone in their organization to identify and propagate smart affiliations that perfectly balance the business requirements of their organizations with the medical needs of their communities. ●

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