



Cover Story

How Can Small Hospitals Survive?

By Jan Greene

The board of Grinnell (Iowa) Regional Medical Center will meet in February 2009 to decide whether or not to end 100 years of independent operation.

Like many “tweener” rural hospitals, Grinnell is too big to take advantage of the federal government’s critical access program for hospitals 25 beds and smaller. But at 81 beds, it’s too small to recruit all the physician specialists it wants or to put a lot of money into the information systems it needs.

So the board began studying whether it should find a bigger hospital or system with which to affiliate. “It’s just the complexity of health care that has really caused us to look at this,” says CEO Todd Linden. “When we take a look at the huge expansion of activity in IT it’s hard to keep up with all the stuff going on.”

Access to capital is a concern as he watches creditors tighten up their standards for lending, and as Moody’s downgrades the entire health care sector. Small rural hospitals are going to be on the bottom of that heap.

Grinnell is facing an increasingly common scenario. More than a third of America’s hospitals are rural, but in the past decade 65 percent of those have chosen to become critical access.

That leaves much of the rest as tweeners, existing in an increasingly hostile economic climate. It’s hard to borrow, it’s hard to get physicians to live in small towns, and it’s hard to afford staff with the expertise to deal with such complexities as Medicare’s RAC program that will force hospitals to document their billing practices to an unprecedented degree.

Because of their role as strategists for these hospitals’ futures, boards of trustees will be leading the way toward weighing the options, whether that means putting their hospitals up for sale, seeking affiliation with a larger system, hiring a management company, networking with other small rural hospitals or staying on their own. Every small or rural hospital’s board should be having this conversation, believes Doug Rich, a Chicago-based consultant who has worked with a number of boards on this issue. “Every small or rural board ought to be looking at the opportunity or need for partnering with a larger organization,” says Rich, managing director of ASR Planning. “They’d have to look at their internal strengths and weaknesses, look at the dynamics of the marketplace they’re operating in in terms of competition and the scope of services of their competitors.”

Rich is seeing more partnering activity. Back in the 1990s systems looked to grow their balance sheets with acquisitions. But now, he says, the trend is going in the other

direction: Small hospitals are looking for partners with deep pockets and management expertise.

For McDowell Hospital, a 65-bed facility in Marion, N.C., about 40 miles west of Asheville, the tipping point came when the furniture and textile industry in the area faltered badly. The layoffs and plant closures left many more residents of the town of 46,000 without health insurance, which had a big impact on the hospital. McDowell officials had been approached in the 1990s for some kind of partnership with Mission Hospital, a larger referral hospital in Asheville. But the McDowell board preferred to hold on to independence as long as possible, says Norman Guthrie, a long-time board member and chairman of the finance committee.

“As long as we saw that our margin was strong enough to keep investing in the type of equipment that we needed to stay current, we were fairly independent and felt like we needed to stay that way,” he says.

However, by the early years of this century, the hospital’s bottom line began to feel the hit from the textile and furniture layoffs, and at the same time was having trouble recruiting doctors. The town saw some of its doctors leave and was unable to find new ones in emerging specialties.

Because many people in Marion were making the 45-minute drive into Asheville to 800-bed Mission Hospital for tertiary services, it made sense to make that connection. And McDowell officials had great respect for the way Mission ran its business and made quality of care a priority. But financial help was the real drawing card.

“We were really pleased with the fact that from a financial standpoint they could help us do things we couldn’t do on our own,” Guthrie says.

An extended negotiating period ensued, headed by hospital administration and the then-chairman of the board, John Karas. “There were two issues: control and money,” Guthrie says.

Many meetings were held and much data exchanged between the parties on finances, quality and other topics. While the two organizations got through the process without becoming adversarial, that didn’t stop some at McDowell from worrying about giving up control of their hospital.

“There became some places where we were concerned about how it would end up, but we were able to work all that out,” says Guthrie.

From Mission’s point of view, the partnership fit into its goal of ensuring that western North Carolina had a network of strong hospitals with Mission at the center, serving as a regional referral center and luring the best specialists, explains Edward Hannon, McDowell’s CEO. “Their whole belief is that strong hospitals that surround the community will make the region stronger. If they just swallowed up hospitals and wanted

everything, we would get weaker and weaker, and then we would not be here,” Hannon says.

The key to being an attractive partner is strength, and the hospitals that have been successful have found that it’s best to go shopping for an affiliation before their own bottom line is significantly weakened.

That’s what the board at Corning Hospital in Corning N.Y. discovered—trustees read the tea leaves and saw their hospital’s financials eroding, so they started looking for a partner.

This was in the late 1990s, as the 140-bed hospital started looking at the future costs of information technology and wondering where the cash would come from. “We just looked at the price tags of some of those things and said we’d never make it on our own; there was no way we could sustain ourselves over the next decade or so,” recalls Steve Albertalli, a retired Corning Inc. executive who was chair of the hospital board at the time.

Another issue was physician recruitment. “I saw an excellent physician who left us and told me he just didn’t have enough colleagues to interact with in his specialty,” Albertalli says.

The hospital was doing well on operations, he says, “but we could see the beginnings of a little deterioration. We wanted to move early enough while we still had some power. The time you don’t want to move is when you are desperate.”

The Corning Hospital board researched the issues themselves, devoting two retreats and parts of several board meetings to the question of affiliating.

One trustee set up a grid for the group that separated the hospital’s “wants” from its “must haves” in a partner and started prioritizing. A top priority was an organization that had its own physicians or a strong recruiting program. Six or seven organizations in the region met the criteria, and the board ended up interviewing four of them.

Through the scoring system the board developed, two potential partners rose to the top: Strong Health in Rochester, N.Y., and Guthrie Health in Sayre, Pa. Both had their own advantages, but, ultimately, the board chose Guthrie Health, in part because it wasn’t so large that Corning would be a small fish in a large pond. Guthrie Health’s central hospital is Robert Packer Hospital, a 238-bed tertiary center, while Strong’s core is the University of Rochester Medical Center, a 739-bed major teaching hospital. Another advantage for Guthrie Health was that it already had 40 physicians in the Corning area, so it would be a simple transition for them to do more work at Corning Hospital. The physicians are part of the 100-year-old Guthrie Clinic.

For the Guthrie Health system, the partnership has helped support its role as a medical anchor in a large geographic area 100 miles wide, explains Mark Stensager, co-CEO for administrative affairs at Guthrie Health.

“By being involved in community hospitals, we are able to gain the perspective of the health care needs in each of our communities,” he wrote in an e-mail. “This perspective helps us to align our efforts and tailor our investments in large-scale projects, such as where we deploy specialists or how we implement a systemwide electronic medical record.”

Choosing a Model

When it comes time for specifics of an agreement, there’s a wide range of possibilities—from loose arrangements where the larger partner provides some services for a fee, to a near-merger.

McDowell Hospital found its comfort spot someplace in the middle when it connected with Mission Health System in late 2004. The smaller hospital received, over three years’ time, \$8 million in low-interest loans.

That money was used for an MRI and the expansion of the emergency department from six beds to 10, increasing ER visits from 14,000 a year to 20,000. McDowell also renovated its obstetrics area and operating rooms.

Just as significant were the economies of scale that McDowell was able to obtain by piggybacking on its bigger partner’s operations. Under the agreement, McDowell placed its 400 employees under Mission’s health benefits and payroll systems, allowing for the reduction of one full-time position in payroll; it began using Mission’s materials management department, laundry services, legal department, managed care contracting clout and employee education programs, including orientation; and it became part of Mission’s clinical quality improvement initiatives, which have now been rolled out over the system’s three hospitals.

Staff from Mission’s foundation were able to help McDowell establish its own foundation, which saw immediate success. “In the first 15 months, the foundation obtained four grants worth nearly \$600,000 and raised another \$80,000,” says Hannon. “That never would have happened without the support of Mission’s foundation to get ours off the ground.”

Overall, the affiliation has turned McDowell’s financial prospects around, Hannon says. Profits went up as patient volume increased—the average daily census is now twice what it was in 2004—and help from Mission with billing and collections shaved 60 days off McDowell’s accounts receivable.

In the marriage of Corning and Guthrie Health, there was also a combination of cash, physician recruitment and management help. As the parties sat down to work out an

agreement, Corning's board had a couple of main requests—that Guthrie Health agree to continue growing the number of physicians working at Corning, and that it provide an immediate \$15 million infusion to Corning Hospital.

The trustees sought an agreement that would retain the independence of the 100-year-old institution. So they agreed to a five-year “engagement” during which time either party could pull out of the deal. From 1999 to 2004, Guthrie Health provided both the financial capital Corning wanted and some management services, including financial, billing, facilities and grounds operations. When Corning went through a debilitating strike, Guthrie Health helped keep the hospital running.

Guthrie Health has also been helpful in long-range planning, carrying out area surveys on physician trends, equipment needs and patient satisfaction. In addition, Corning has benefited by tagging along on a major information technology upgrade that would have cost the hospital \$2 million if it had gone it alone. Instead it cost \$300,000.

The process was nerve-racking at times, Albertalli acknowledges, as the larger organization learned about the Corning marketplace and worked out a top-level shakeup of its own. The “getting-to-know-you” process was helped along, however, by having a few members of each organization sit on each other's board. In 2004, the parties made the arrangement permanent, and Corning Hospital is now part of Guthrie Health's system.

Albertalli's advice: “Take your time. Make sure you are completely open with your board so they know the pitfalls and potential rewards.” The Corning board, with more than 20 members, took some time to come to consensus when it was deciding between Strong Health and Guthrie Health. Guthrie was leading by a small majority, and Albertalli took his time helping the minority accept the final outcome. “We just hammered it out and finally the 40 percent who said, ‘While it's not my first choice, it's a perfectly acceptable choice,’” he recalls. “Nobody left the board because of it.”

The Board's Role in Getting Started

Choosing whether to seek an affiliation with a larger entity goes straight to the heart of a hospital trustee's role in determining the strategic future of the organization. The idea may come from administration or it could come from the board, but either way trustees are going to be deeply involved in the decision-making.

How do you know if your hospital is a candidate for partnership? By looking at the fundamentals of the business: Do you have the right numbers and right kinds of physicians referring to the hospital? Do you have enough money to pay for capital projects that are essential to providing quality, efficient care? Are your financial benchmarks slipping with no turnaround in sight?

Of course, these are questions that every board should analyze at each meeting. If you don't know those kinds of things, then the hospital has bigger governance problems than deciding whether to affiliate.

McDowell's Guthrie sees a clear demarcation point for when it's time to seek a bigger partner. "As long as [the board] sees the capability of being able to generate enough of a margin to keep up with the change in retooling and equipment that's necessary to give [the community] the best secondary care they can get, then there's no particular need to affiliate," says the finance chair. "But if that disappears, affiliation can be a lifesaver for you."

Several of the boards that have made successful partnerships have found it useful to make affiliation the center of a board retreat to get a chance to step back from the day-to-day financials and see the bigger picture of the hospital's future. This is particularly important given some of the recent changes in the financial picture of rural hospitals, such as the commercial credit crunch and the rush by the smallest rurals to become critical access hospitals. Moderate-sized rural hospitals must find other ways to survive. This might be a good time to pick a date for that board retreat.

Some hospitals have gone through the process with the help of a consultant, and some have not. Chicago-based consultant Rich acknowledges that outside help isn't always necessary, but it can provide an unbiased outside view.

Rich helps his clients consider all the options. For instance, if things are really bad—multiple years of operating losses, declining market share, the need for a significant infusion of capital in coming years—they might want to consider an all-assets merger rather than a partnership.

At the other end of the spectrum are loose networks that many rural hospitals have put together for joint purchasing or IT services. "It's very spotty," he says of those arrangements. "Some of them are very effective, and some are not very effective."

If the middle ground, an affiliation, is the goal, Rich has some suggestions:

- **Examine geography.** The ideal distance between partners is about an hour's drive—not so close that they are essentially in the same market, but not so far that it's difficult to refer patients to the tertiary center, and hard to send staff to meetings.
- **Pay attention to culture.** If one partner has a participatory culture for its staff and the other is more autocratic, it may be difficult to work together.
- **Consider all options.** Boards should not focus on only one potential partner that may be an easy match. It might not be the best one.

How to Live Together Peacefully

While McDowell's board is pleased with how its partnership has worked out, trustee Guthrie notes that some things could have gone more smoothly, such as physician recruitment. Mission was able to provide guidance on many management issues, but given that it was located in a town sizable enough to draw doctors, the hospital had little experience with the tough job of recruiting physicians to a smaller town. Hannon, who started as McDowell's CEO in 1997, has helped recruit staff and seven new physicians; two others had been recruited before that.

One key to making it all work is to give the affiliate smaller hospital what it needs without suffocating its sense of independence. Even as McDowell depends on Mission for many management functions, its management and board make their own decisions. For instance, McDowell maintains separate contracts from Mission for pathology, anesthesiology, emergency physicians and hospitalists. "I have bottom line accountability so I have to be able to make those independent decisions," Hannon explains.

Many partnerships swap trustees so members from each entity gets one or more places on the others' board. McDowell's board chair and CEO attend Mission's board meetings. "We participate," says Hannon. "We have a voice at the table when decisions are made. They consider the impact on us."

And Mission has places for three people on McDowell's 15-member board. "Our local board has responsibility for making the major decisions," explains Guthrie. At the same time, he adds, "we wouldn't go off and make a major decision without the understanding and approval of Mission."

Guthrie describes the arrangement as essentially giving Mission a voice commensurate with its investment in McDowell, and the ability to take over if its management isn't dealing with declining financials. Fortunately, that hasn't been a problem—so far, the numbers have been trending decidedly upward.

Guthrie sees Mission's involvement as saving McDowell from extinction. "If we didn't have the source of capital we had, we wouldn't be in business," says the finance chair.

Hannon looks around North Carolina and sees a number of other rural hospitals in the same boat, pondering their future in an increasingly complex, low-margin world. McDowell's options included going it alone, integrating with Mission, or signing with a contract management firm such as Quorum (now QHR), which manages almost 200 hospitals, or Brim, which manages 35. Guthrie sees them too and wonders if those hospitals will survive. "There are some small hospitals within an hour's drive from our place that I don't think will make it," he says.

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This article 1st appeared in the January 2009 issue of Trustee Magazine.