If you’re a community hospital, the variable costs of providing care can be a lot lower in that local setting,” Lupica says. Second, they’re often better at patient engagement. “A patient might feel more engaged because his or her sister-in-law works there,” Lupica says, by way of example. “Or patients remember that their primary care physician is right down the street.” Third, their quality scores may be just as good as the larger system that’s courting them. They may have worse quality as well, and in that case, resources at a system level can bring value, but meeting two of the three

**Affiliate or Perish?**

Local hospitals and small health systems are motivated to survive in an era in which they’re increasingly at risk for patient outcomes, marginalized in health plan negotiations, and starved for investment capital. Increasingly, that means closer ties with larger, better-equipped competitors. However, all is not bleak, because to sell or not to sell is no longer a binary choice for hospital leaders.

**BY PHILIP BETBEZE**

Small systems and stand-alone hospitals are frequently in the news announcing a new affiliation agreement. Typically, these agreements are about seeking partners with deep pockets and strong reputations. That’s nothing new in healthcare, where a merger and acquisition market has always existed. But any link to previous eras of consolidation is difficult because the creativity surrounding partnerships among hospitals and health systems is expanding rapidly.

“What really exists is a long spectrum of affiliations,” says Joseph R. Lupica, chairman of Newpoint Healthcare Advisors, who works out of the Phoenix office of the Denver-based company that has locations across the country. “A lot of that is motivated by local hospitals getting smart and realizing they don’t have to give up control entirely—they can do the least necessary to accomplish their goals and keep the most possible control.”

Even so, that’s easier said than done. As healthcare incentives slowly turn toward a focus on keeping groups of populations healthy rather than treating their immediate illness, a host of forces is applying partnership pressure. The good news is that the strategic and operational tie-up options are endless. A few recent examples are extremely different, and can prove illuminating for leaders seeking the best partnership option to ensure their organization’s long-term viability.

**Know your advantages**

First, dispense with the contention that the smaller entity is necessarily at a disadvantage in negotiations with a bigger system. For one, smaller facilities often can deliver care at lower costs.

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Second, they’re often better at patient engagement.

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**POSITION OF STRENGTH. Richard Reynolds is president and CEO of Mid-Michigan Health, a four-hospital system in Midland, Mich. He says that the strong financial standing of the organization enabled it to be selective in developing a relationship with a partner that includes retaining local control.**
categories of the Institute for Health-care Improvement’s so-called “triple aim” isn’t a bad place to start.

In most cases, the smaller system is suffering from a lack of capital resources. Capital feeds some capabilities that, generally, bigger systems are good at, including depth of clinical knowledge, rate negotiations, quality monitoring regimes that utilize technology, and high-level specialized labor. Otherwise, hospitals or small systems may be thriving, but unsure of how they fit in to narrowing commercial networks, for example, especially if a local competitor already has scale.

Sometimes, it makes sense to start slowly, as MidMichigan Health did with a cancer partnership with the University of Michigan Health System.

“ ’We actually started in an affiliation for cancer as part of the UM cancer consortium,” says Richard Reynolds, president and CEO of the four-hospital system based in Midland. “That’s a loose affiliation where we have access to some of their clinical protocols and some of their other resources as one of the major cancer centers in the country.”

But it quickly became apparent that as health reform matured, the amount Mid-Michigan was going to have to increase revenues or decrease costs to get to profitability under the Medicare program (what many CEOs consider a good proxy for all future reimbursement rates) was unrealistic. The cancer collaboration would have to be built upon, if possible.

“We concluded with many other regional peers around the state that the critical mass and the competencies required are going to be different,” Reynolds says. MidMichigan, which also owns urgent care centers, home care, nursing homes, and medical offices, was “very financially strong (300 days cash on hand), so we could go on just like we were and would have been fine, but as we looked at how we could gain competitive advantage, a collaborative partnership with a larger organization made sense,” Reynolds says.

The process of working collaboratively with other regional health systems instead of UM, while attractive in various ways, would require a much slower and laborious process to develop the kind of clout Reynolds and his board were seeking.

“So we looked at UM,” he says. “They are the preferred referral destination for physicians on our medical staff by a long shot, and were the biggest visible presence in our part of the state.”

Reynolds says concerns about continuing independently centered on costs, how well MidMichigan could recruit physicians, and most important, how it could develop the expensive infrastructure surrounding management of populations. Reynolds, who will retire in early 2013, says he discussed with the board whether a full merger, which was an option, was the smartest move.

“We looked at the range of opportunities,” he says. “We could continue programmatic collaboration. We took a look at a minority position. We could have gone anywhere up to full affiliation. We concluded that we’re strong, well regarded, with a strong balance sheet, so we didn’t have to give up local control. Give us access to needed tools for the future.”

As part of the clinical and business affiliation, MidMichigan agreed to a deal that should close by the end of the year that would grant a 9% ownership stake to UM and retain local control. More important than any financial transaction was the agreement to provide preferred referral and coordination among physicians at both systems. The affiliation also enhances MidMichigan’s ability to recruit physicians to the region, but most important, it allows for clinical collaborations among groups of physicians affiliated with either system to design new models of care that incorporate populations of patients.

Such clinical collaborations are most importantly addressed in the new world of affiliation agreements, says Newpoint’s Lupica.

BUILDING RELATIONSHIPS

Are you embarking on collaborative care relationships with other providers and organizations to form a community of care?  

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician practices</td>
<td>68%</td>
<td>32%</td>
</tr>
<tr>
<td>Home healthcare</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Outpatient clinics</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>Short-term acute care hospitals</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Long-term acute care hospitals</td>
<td>34%</td>
<td>66%</td>
</tr>
<tr>
<td>Rehabilitation hospitals</td>
<td>28%</td>
<td>72%</td>
</tr>
</tbody>
</table>

“Whether they own or don’t own each other doesn’t matter as much as coming up with a structure for sharing those value-based purchasing points together,” he says. “What matters is you win or lose together.”

That’s a sea change compared to prior affiliations or mergers. In the past, such deals were driven by traditional aims around increasing market share and increasing bargaining power, which is very different, for example, from the July announcement of a partnership between Minnesota’s prestigious Mayo Clinic and Dartmouth-Hitchcock, a highly regarded New Hampshire system whose flagship, Dartmouth-Hitchcock Medical Center, has 371 beds. In the past, any collaboration between the two would have made little sense, says Gregg Meyer, MD, Dartmouth-Hitchcock’s chief clinical officer.

“The old iron triangle of running a healthcare enterprise had three levers: volume, rates, and the ability to decrease unit costs,” says Meyer.

By contrast, the new model, announced in late July, is really much more about influencing—you guessed it—the care of populations. Under the agreement, Dartmouth-Hitchcock (which will remain independent) is a member of the Mayo Clinic Care Network. This type of arrangement involves no ownership changes, and Dartmouth-Hitchcock is the latest among several top regional health systems that have joined Mayo’s network.

So why did a health system more than a thousand miles away, with a great reputation of its own, partner with Mayo?

“Not because it’s going to gain us market share,” Meyer says. “Not for higher rates, because there’s no consolidation of vendors. And not because we need to control the marketplace. It’s about our ability to improve our value and help us take care of populations.”

But why Mayo?

“Because we know that patients who come to us for care will often seek a second opinion,” says Meyer. “In the past, that meant going to Boston or New York, and we lost out on that because we lost the ability to keep that care local. Now we can have a virtual second opinion with arguably the most famous health system in the world.”

**Know your disadvantages, too**

New York is the 49th most profitable state in the country for hospitals, says Jonathan Lawrence, president and CEO of Lake Erie Regional Health System of New York, a two-hospital system located in Irving and Dunkirk, N.Y., about halfway between Buffalo and Erie, Pa. Only about half of New York’s hospitals are breaking even or better. The state’s population, especially in rural areas outside New York City, is declining and aging.

“Those are margins that are insufficient given our aging infrastructure and medical staff and difficulty in physician recruitment, where 90% of new residents are seeking to be employed and the investment needed to employ them outpaces the revenue they can generate in most models,” Lawrence says. That’s why LERHSNY is trying a new model with UPMC Hamot in Erie. Announced last May, it’s not a merger, but it assures the two systems will work collaboratively to determine the service needs of the area.

Lawrence says at $90 million in annual revenues, and with about 1,000 employees, LERHSNY had no choice but to affiliate somewhere, because bigger institutions, at half a billion dollars in annual revenue, are forming relationships with insurers, investing in EMRs and increasing transparency to compete in the intermediate- and long-term. The agreement will improve his staff’s ability to recruit physicians, invest in equipment and new technology, and eliminate red tape that put limits on the number of foreign physicians it can recruit, for example.

**Take charge of your destiny**

The pressure is ratcheting up, but the deal with UPMC Hamot shows local control is highly negotiable, even though Hamot, which is four times as large as LERHSNY, gave up that control when UPMC bought it in 2010.

Time is of the essence, Lawrence says he tells fellow CEOs. Being halfway between Buffalo and Erie makes LERHSNY highly desirable, which allowed the system to take its time to craft a deal, he says, but others may not have such advantages.

“Because we’re almost equidistant, we’re something of a battleground area,” he says. “We’re essentially like the independent voters. We’re who the candidates are fighting over.”

Still, don’t move in desperation, he says.
“You need to come at this from a position of relative strength—not that you don’t have problems, maybe some serious ones,” he says. “If you don’t have an effective, credible leadership team, and you’re not able to bring something unique to the table, there’s no reason for a larger, more capable entity to partner with you. They’ll just come in and take the volume away and let chips fall where they may.”

Newpoint’s Lupica says small hospitals and health systems need to take charge of their own destiny in the same way that people are in charge of their own careers.

“I had an old boss tell me that once and it shocked me,” he says. “The hospital is in the same place. They need to define themselves for the next decade. What do you want to be outside the deals? Put a face on it.”

One chief concern from smaller hospital and health system chief executives is that affiliation will eventually kill their hospital as the larger parent exerts increasing levels of control and removes volume locally.

“I’m not worried about all the patients going to the mother ship,” says Reynolds of MidMichigan. “We send a fair amount of business to them anyway. In fact, their problem is they are trying to push business back to local organizations because they have more than they can deal with. For example, they would like to keep more volume away and let chips fall where they may.”

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Smaller hospitals often can treat patients at lower cost, too, a fact not lost on Reynolds. He hopes to improve his system’s already strong financial profile through the affiliation with UM.

“This was opportunistic. I was looking to gain competitive advantage. Certainly the market is moving so we wouldn’t have waited forever to do it, but we have 300 days cash on hand,” he says. “This is not a move made out of desperation.”

Typical of such agreements, both MidMichigan and LERHSNY have joint operating committees with their bigger partners that meet on a regular basis on projects they have agreed to at a higher executive level, but they maintain local board control.

“If the ‘mother ship’ sees the smaller affiliate as a way to suck volume out of the community, the relationship is doomed from the start,” Lawrence says. “The only way the smaller entity will survive and the way the larger one will gain support is by demonstrating that patients can be kept locally and making sure that the smaller entity has the resources necessary to accomplish that.”

Dartmouth-Hitchcock’s Meyer is looking into other innovative partnerships locally: for instance, with retail clinics that are springing up. For some people, such clinics are their only point of contact in healthcare. By developing a partnership, Meyer thinks Dartmouth-Hitchcock can develop an opportunity where patients will come in with their sore throat, and the clinic will recognize that patient has no medical home. Their blood sugar may be out of control, for example—something for which the retail clinic is poorly equipped to treat, but for which Dartmouth-Hitchcock has many resources.

“What’s changing is the conditions and drivers are very different,” he says. “Finance people used to get behind closed doors to see if a partnership made financial sense. In accountable care, and taking risk for large populations, health systems are looking at things from a different lens. Clinicians will decide whether an intervention is going to improve access to the population we ought to be serving, and whether it will improve value and leverage new population risk reimbursement models.”

Meyer says the pace of deals will only get more frenetic before it levels off.

“I’ve been involved in healthcare for about three decades,” he says. “Partnerships that in the past took months to evaluate and consummate are now moving along at much greater pace. In some ways a lot of things that have made sense for many years are now finally actually happening.”

Philip Betbeze is senior leadership editor with HealthLeaders Media. He can be reached at pbetbeze@healthleadersmedia.com. Reprint HLR1212-5