Adaptive Strategies for Community Hospital CEOs:
Evaluating Partnerships & Affiliations to Secure the Future of Community-based Care

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Table of Contents

Assessing the Community Hospital Value Proposition ........................................ 4
Evaluating Partnerships and Affiliations .............................................................. 11
Partnership Goal—Partnership Model Crosswalk ............................................. 17
Partnership Model Assessment Guide ............................................................... 18
Argument in Brief

- **The market pressures facing hospitals today are felt most acutely by community hospitals**, who frequently lack the financial resources to invest aggressively in future growth.

- **An increasingly competitive market will only reward demonstrable superiority in outcomes, cost, or some other tangible measure.** It is not enough that community hospitals be well-respected and well-connected in their local communities.

- **Independence is possible, but isolationism is not.** Virtually all community hospitals will need to consider a range of partnership and affiliation opportunities to strengthen their value proposition to health care purchasers.

- **The exchange of value must be reciprocal.** Partners will seek and expect value from community hospitals, whether through access to desirable markets, low-cost delivery models, or otherwise.

### Expanded Exchange of Value

- **Value**
  - Market access
  - Low-cost care sites
  - Care continuum breadth

- **Community Hospital**
  - Community benefit programs
  - Familiarity
  - Low-cost, high-quality care
  - Easy access
  - Comprehensive service portfolio
  - Care management capability

- **Care Purchasers**
  - “Clinical Shoppers”
  - “Wholesale Buyers”

**Revenue for services provided**

Current Challenges Magnified for Community Hospitals

Today’s health care environment is testing the strategic acumen of provider organizations of all shapes and sizes. Slow reimbursement growth, the transition to risk-based contracting, shifting patient demographics, and of course health care reform are just some of the pressures facing the industry. Yet community hospitals—generally smaller, often independent facilities—face unique challenges. When it comes to physician recruitment and retention, contract negotiation with payers and suppliers, brand recognition, and other essential elements of competitive success, community hospitals are often at a disadvantage.

The reasons are many, but at a fundamental level, smaller organizations simply find it more difficult to generate and retain the resources needed to operate in today’s market, let alone invest more for future growth. Capital-intensive investment mandates such as meeting Meaningful Use requirements, preparing effectively for ICD-10, and building a robust care management infrastructure entail large fixed costs that often do not scale proportionally with the size of the organization.

Capital is not easy for community hospitals to acquire. According to a Moody’s report released in May 2013, the median operating revenue for an “Aa”-rated hospital is $1.48 billion and the median maintained bed size is 967, whereas the median operating revenue for hospitals ranked below “Baa” is $245 million and the median number of maintained beds is 190. While some the difference in credit ratings for smaller hospitals is based on other aspects of operational performance, it bears mentioning that hospital size is an explicit consideration in ratings agencies’ published methodologies. Even community hospitals with strong operating margins have difficulty retaining large earnings; a community hospital earning a commendable 5% operating margin on $100 million in revenue is generating less than what a $500 million organization generates on only a 2% margin.

The urgency for community hospitals to solidify a sustainable value proposition is intensified by an increasingly competitive marketplace. Traditional volume channels are becoming less predictable as payers, physicians, and patients all begin to direct care differently, and the stage is set for intense market share competition as organic pricing growth slows. Faced with this combination of both operational and market challenges, community hospital leaders must be able to envision and deliver a value proposition that ensures not only survival, but sustained relevance and long-run growth.

Historical Value Propositions Insufficient for Today’s Market

Community hospitals are, without question, important pillars of the communities in which they operate. They are often familiar, trusted providers of health care services and generally also spend significant time and resources on community benefit programs—activities such as attending health fairs, working with community groups to raise awareness about common health conditions, and supporting philanthropic activities. From a community benefit standpoint, these activities are crucial to fulfilling the hospital’s mission and promoting the hospital’s position as a valued community member. In many of the Advisory Board’s research interviews, community hospital leaders cited their long-standing community relationships and their commitment to local interests as central competitive advantages.

But small, independent community hospitals are not indispensable, at least not in the eyes of the market. The dire financial straits in which many community hospitals find themselves are evidence enough that civic-minded tradition alone carries little weight with today’s health care purchasers.

Other community hospital leaders, particularly those in rural areas, cite a lack of local competition as the key to their success. Many community hospitals have largely been able to generate revenue through the traditional exchange of value between themselves and the purchasers of health care by being the only convenient quality provider of health care services for their communities, an industry-wide lack of transparency regarding the prices paid by health care purchasers, and patients insulated from high out-of-pocket costs by low-deductible health plans. But smooth seas never made a good sailor. Today, purchasers of all stripes are becoming more price-sensitive and more willing to redirect volume, including over long distances. As the boundaries of competition expand to include regional and national players, no hospital is likely to have a market to itself for long.

### Traditional Exchange of Value

- Community benefit programs
- Familiarity
- Reliable care

Value

Revenue for services provided

**Community Hospital**

**Care Purchasers**

“Clinical Shoppers”

“Wholesale Buyers”

Source: Health Care Advisory Board interviews and analysis.
Community Hospitals Must Meet New Market Demands

Community hospitals’ success depends on being chosen by care purchasers—the physicians, payers, and patients who allocate health care spending. But it is not enough to be merely acceptable to purchasers; a hospital must be actively preferred. Care purchasers that choose one hospital are implicitly choosing against all others. Those community hospitals that can understand and respond to purchasers’ preferences, even as those preferences change, will thrive.

It is helpful to think of health care purchasers in two groups—the “clinical shoppers” and the “wholesale buyers.”

“Clinical Shoppers”
Clinical shoppers purchase care for an individual episode of care, so patients and physicians referring their patients for care fall into this group. First, community hospitals can appeal to physicians by providing low-cost, high-quality care to the patients those physicians refer to the hospital. However, appealing to physicians on cost and quality is just the starting point. Physicians also prefer to refer patients to hospitals that are willing to collaborate with them on succeeding on quality scores and patient satisfaction—the metrics for which physicians are beginning to be held accountable.

Individual patients are the other population in the clinical shopper category. The primary driver of patient choice is physician recommendation. However, patients are increasingly considering factors beyond their physician’s recommendation. These factors include cost, clinical quality, patient experience, and convenience. As patients bear more financial risk with the rising prevalence of high-deductible health plans, they become much more concerned, and willing to choose hospitals, based on cost and quality. Convenience refers to both ease of scheduling appointments and the location, as well as easy access to ancillary and specialty services.

“Wholesale Buyers”
On the other hand, wholesale buyers purchase health care services for entire populations of patients—commercial payers, self-funded employers, and population health managers. Similar to clinical shoppers, reliably high-quality, low-cost care is just a starting point in the value proposition that community hospitals can provide to wholesale buyers. Beyond cost, convenience and access are also value drivers for the wholesale purchasers of care because the patients for whom they buy care also value those elements.

In light of the shift toward population health management, care management expertise further enhances a community hospital’s value proposition. Having the infrastructure and experience necessary to effectively care for discrete patient populations appeals to this preference. Finally, wholesale buyers of care prefer to work with hospitals that have strong relationships with other providers. For example, they value a hospital with a comprehensive network and adequate geographic reach that can provide effective care coordination across the care continuum.

Community hospitals that effectively address these value drivers broaden their value proposition to this group of care purchasers, increasing the likelihood that these purchasers will choose to do business with them.
Community Hospitals Must Meet New Market Demands

Decision Makers and Their Priorities

“Clinical Shoppers”

Referring Providers

Today’s Priority:
High-quality, low-cost episodic care

Provider Wishlist:
• Best-in-class outcomes
• Data access, connectivity
• Cross-continuum collaboration

Consumers

Today’s Priority:
Affordability, on-demand access, and tailored service

Provider Wishlist:
• Multifunctional range of access options
• Appropriate match of price level to service quality

Payers, Employers

Today’s Priority:
Low total cost of care for entire populations

Provider Wishlist:
• Comprehensive network
• Proven population health management capabilities

As depicted below, community hospitals that appeal broadly to the preferences of care purchasers create a real value proposition, which means that these care purchasers will be more likely to seek care at those organizations. Being the hospital of choice generates revenue to support the community hospital’s mission and benefit activities. In this way, community benefit becomes the end product of an effective value proposition—not the value proposition itself. The exchange of value is now productive for both parties because they each value the elements that they receive in return for what they provide—care purchasers receive the elements of care they prefer and hospitals receive revenue.

Expanded Exchange of Value

Community Hospital

• Community benefit programs
• Familiarity
• Low-cost, high-quality care
• Easy access
• Comprehensive service portfolio
• Care management capability

Care Purchasers

Value

Revenue for services provided

“Clinical Shoppers”

“Wholesale Buyers”

Source: Health Care Advisory Board interviews and analysis.
Expanding the Value Exchange to Provider Partners

Independent community hospitals frequently express concern that they may not survive as standalone facilities. Understanding the role and viability of an independent hospital is a complex exercise, but one that must be undertaken. It is no doubt true that some independent community hospitals will find it necessary to join forces with another organization through a formal merger or acquisition. Others may find doing so advantageous, even if not strictly necessary. Still others will turn to alternative partnership models but maintain their independence. In reality, complete self-sufficiency is largely an illusion already. Even hospitals that are independent in a corporate sense typically participate in various partnerships or affiliations, such as clinical affiliations, co-branded service lines, and cooperation agreements for sharing expertise and best practices. Independence is possible; isolationism is not.

Translate Value from Partners into Value to Purchasers

In debating partnership alternatives, the discussion of motivation must precede discussion of means. A community hospital should not seek a partner for partnership’s sake, and it certainly should not wait until acquisition on another’s terms is the only remaining option. Rather, community hospital leaders need to recognize where the gaps in their value propositions to purchasers are and then assess how potential partners may be able to fill those gaps. For example, clinical affiliations with tertiary or quaternary hospitals can strengthen a community hospital’s access to specialist physicians. That access may in turn be used to recruit other physicians, appeal to wholesale buyers who seek comprehensive care for a population, or distinguish the hospital in the eyes of patients. The value of a partnership can take many forms, including direct financial support, intellectual capital, referral streams, branding, and more. Regardless, the support a partner can provide is only useful insofar as it strengthens the value proposition to purchasers.

Partners Expect Value in Return

Regardless of the type of partnership, community hospitals need to demonstrate that they will bring value to the partnership to get potential partners interested. They must show that they are not just taking value from the partnership, but also that they are really providing value in return. This mutual exchange of value is especially important in light of the continued trend of provider consolidation; there is enhanced competition between community hospitals for partners, which means that potential partners can be more discriminating about the hospitals with whom they choose to collaborate. Health systems themselves recognize this phenomenon; Trevor Fetter, CEO of Tenet Healthcare, remarked recently that although “opportunities [for acquisition] will be abundant” in the near future, Tenet is now trying to figure out “how to be selective and do [the acquisitions] intelligently.” Although this comment refers specifically to acquisition partnerships, the sentiment is applicable more broadly.1

Complicating the issue is the fact that many potential partners expect that community hospitals already be reasonably successful at appealing to care purchasers. In the same vein, they are largely uninterested in partnering with community hospitals struggling financially or with low quality care. Beyond this threshold of value, potential partners value opportunities to enter new markets, which helps them gain access to additional populations they can provide with health care services. Building geographic scale is still important to partners—achieved through arrangements such as those that expand access in partners’ current markets. However, health systems are not only focused on developing geographic scale, but increasingly on producing geographic reach. Lastly, a community hospital’s ability to enhance a partner’s care capabilities, either by providing a low-cost site of care or filling a gap in the care continuum, is very valuable, especially to those potential partners preparing for population health. Therefore, the productive exchange of value between community hospitals and their partners is created when both partners receive elements from the partnership that they really value.

Ultimately, however, a partner will want to align with a community hospital if it thinks that hospital can improve its value proposition to care purchasers. As depicted in the graphic below, community hospitals must use the resources from partners to make themselves more appealing to care purchasers to fuel the revenue-generating cycle of value.


Source: Health Care Advisory Board interviews and analysis.
Expanding the Value Exchange to Provider Partners

The two-way exchange of value diagrammed below is crucial for community hospital success. Community hospitals completely isolated from partnerships will likely have trouble appealing to the full spectrum of care purchaser preferences and competing effectively for their business. However, hospital partners will not indefinitely subsidize community hospital partners struggling to appeal to care purchasers and generate revenue. Therefore, community hospitals will need to ensure that the total exchange of value is efficient to secure continued viability in this new era of care purchaser choice.

Expanded Exchange of Value

Provider Partner

- Market access
- Low-cost care sites
- Care continuum breadth

Value

Community Hospital

- Community benefit programs
- Familiarity
- Low-cost, high-quality care
- Easy access
- Comprehensive service portfolio
- Care management capability

Value

Care Purchasers

“Clinical Shoppers”

“Wholesale Buyers”

Revenue for services provided

In order to better assess an organization’s prospects for effective partnerships, the Health Care Advisory Board has developed a Partnerships and Affiliations Diagnostic. Read on to learn what questions you should be asking when considering partnership—and what the right answers might be.

Source: Health Care Advisory Board interviews and analysis.
In response to increasing margin pressures and a shifting reimbursement landscape, many organizations are evaluating the potential advantages of partnerships or affiliations. For some hospitals, these discussions focus on long-term margin sustainability and access to capital in the face of decelerating reimbursement rates, increasing cost pressure, shifting payer mix, and deteriorating case mix. For others, collaboration accelerates development of new care transformation capabilities for population health management.

**Planning Your Response to a Consolidating Market**

Across the past few years, merger and acquisition activity has exponentially increased. Currently, 58 percent of hospitals are part of a system. Although not always as headline-grabbing, partnership models—short of full merger or acquisition—ranging from clinical affiliations to best practice sharing are becoming increasingly common.

This level of deal activity does not mean the end of independent community hospitals. But it does suggest that achieving the new performance standard requires a more collaborative health care delivery system to generate economies of scale and elevate care quality.

To prepare, many providers are exploring potential partnerships or affiliations with other hospitals and health systems. These discussions help to ensure organizations are ready to act quickly if potential partners proactively reach out or market dynamics change.

**Aligning Your Executive Team (and Board) on Three Questions**

Organizations evaluating the potential role of partnerships in advancing hospital priorities must answer three questions:

1. **What are your goals for the partnership?**
   Specific goals for partnership—with measurable metrics to evaluate partnership success—are a necessary first step. Across partnership models, goals typically align with financial, clinical, or continuum advantages.

2. **Who are your preferred partners?**
   Well defined goals help identify necessary partner characteristics. Clear goals also establish the appropriate geographic proximity between partners.

3. **What are the most attractive models for achieving your goals?**
   With goals aligned across partners, organizations can determine the most effective partnership model. The model should balance goals against desired levels of independence or integration.

This Partnership and Affiliation Diagnostic is designed to facilitate discussions across key stakeholders including the executive team, board, and physician leaders. Each section includes an overview of key considerations and a list of diagnostic questions. The final pages provide a Partnership Goal—Partnership Model Crosswalk (page 17) as well as a Partnership Model Assessment Guide (pages 18-20).
1. What are your goals for partnership?

Evaluate the Advantages of Partnership

The single most important question your executive team must answer is: What are the specific, actionable goals achieved through partnership? Because consolidation is so prevalent, partnership conversations tend to focus on potential models rather than goals. Beyond mergers or acquisitions, however, the models themselves are too flexible to anchor the partnership discussion. Instead, organizations should identify how partnership can supply necessary resources or expertise to achieve strategic priorities.

Use Strategic Planning Process to Identify Partnership Goals

Strategic planning discussions should identify specific areas where hospitals and health systems can pursue partnerships to advance goals, such as building the right scale to capture opportunities, allowing for rapid infusion of best practices, or offering additional support around key initiatives.

Partnership goals tend to focus on securing one of three competitive advantages—financial, clinical, or continuum advantage. While partnership discussions have historically focused on financial advantage, providers are increasingly pursuing partnership to improve clinical performance and fill gaps in the care continuum.

Outline Partnership Goals

Financial Advantage
- Gains financial, operational efficiencies

Clinical Advantage
- Achieves quality improvements, expands acute care services

Continuum Advantage
- Builds toward population management expertise, expands scope of services

Securing Financial Advantage

Many institutions are pursuing partnerships to gain access to capital or capture operational efficiencies. Goals range from support for back-office operations (such as revenue cycle performance) to group purchasing to capital infusion for new facilities, technologies, or other health system resources.

Those partnering for financial reasons are likely to pursue affiliation models such as traditional mergers, acquisitions, or management agreements. Targeted needs can be met through flexible models such as shared purchasing agreements.

Source: Health Care Advisory Board interviews and analysis.
Building Clinical Advantage

In response to increasing scrutiny on the value of services provided, organizations are leveraging affiliations to spur clinical performance improvement. Partnerships may focus on recruiting physician talent, connecting service lines across providers, or sharing evidence-based best practice treatment pathways.

Those whose goals are largely clinical in nature can pursue a wide range of partnership models such as service line affiliations, shared staffing models, or physician support. Common partnerships also include best-practice networks or consulting relationships.

Creating Advantage Across the Care Continuum

As providers increasingly look to population health to deliver on value-based contracts and secure market share, they are increasingly looking to partner with other organizations to gain competencies or access to more patients. Affiliations may help with outlining the transition path for new care models, implementing care coordination tactics, or contracting for population health management.

Deals range from loose affiliations based on consulting or best practice sharing to tight affiliations for joint contracting.

Discussion Questions for Identifying the Goals of Partnership

Financial Performance

- Do our 10-year operating expenses and top-line revenue fund our strategic priorities?
- Can we obtain necessary capital in the future without partnership?

Clinical Needs

- Do we have outstanding facilities, technology, and/or staffing needs to remain competitive and offer high-quality care?
- Is our specialist physician recruitment a significant challenge now or in the foreseeable future?

Continuum Building

- Is population health management a significant opportunity/challenge now or in the foreseeable future?
- Is our primary care physician recruitment a significant challenge now or in the foreseeable future?

To complete a formal assessment of your organization’s 5- and 10-year margin performance, please see the Total Margin Scenario Planner, available on advisory.com.

To evaluate your organization’s readiness for population health management, please see the Care Transformation Capability Assessment, available on advisory.com.

Source: Health Care Advisory Board interviews and analysis.
2. Who are your preferred partners?

Selecting Complementary Partners to Advance Partnership Goals

With a clear articulation of goals, the next step is evaluating potential partners. This discussion can either focus on a list of ideal characteristics or a short list of preferred institutions. Four criteria should help refine the list: market dynamics, cultural synergy, operational compatibility, and the commitment to partnership.

Assessing Market Dynamics and Geographic Proximity

Previous collaboration and prior experiences with physicians or staff can inform evaluation of local partners. But depending on the specific goals of partnership, many organizations have also expanded their partnership search to include regional or even national partners. For example, providers seeking clinical expertise, but who are unlikely or unwilling to share patient populations, can look much further than organizations that are looking to collaborate on a specific patient population.

Even when today’s partnership goals allow for further geographic reach, providers should consider whether future goals will increase the importance of geographic proximity or if local competitive dynamics encourage local alliances.

Considerations Influencing Geographic Proximity of Partner

Local Partner

Partnership goals encouraging local partner evaluation:

- Sharing population management contracts, participating jointly in local payer contracts
- Completing local care continuum, ensuring that travel is easy for patients
- Sharing physician talent

National Partner

Partnership goals encouraging expanded geographic evaluation:

- Information sharing, quickly building expertise in an area
- Limited plans for sharing of individual patient cases, travel not an important consideration
- Unlikely to ever pursue joint contracting

Evaluating Cultural Synergy

Any discussion of potential partners must include an evaluation of cultural synergies across organizations. Regardless of the goal, cultural compatibility underpins a strong start to partnership as well as long-term success. Hospitals and health systems may leverage previous experiences or the experiences of other partner organizations to inform compatibility of the leadership teams, staff, and physicians.

Determining Operational Compatibility

Along with cultural compatibility, providers must evaluate key operational characteristics contributing to overall partnership success. For example, given the significant amount of capital invested in EMRs, consideration should be given to the necessary steps to integrate systems to share data. While having the same EMR vendor is not a requirement, partners operating on different IT platforms must plan for additional steps to support information integration.
Ensuring Equal Commitment to Partnership

As organizations develop a short list of potential partners, two additional considerations emerge:

1. Is there a clear benefit for both my organization and our partner?
2. Can both partners commit the necessary resources—such as capital, executive attention, and physician leadership?

Partners may benefit in different ways—for example a shift of low-acuity cases supporting growth for one provider and a case mix improvement for the partner. But if the deal is one-sided, hospitals or health systems may have trouble engaging partners to drive results.

Similarly, concerns early in the process about commitment of time or resources risk having the partnership lose momentum and fall short of intended goals.

Discussion Questions for Identifying Ideal Partner Characteristics

Market Factors
- Do partnership goals require a local partner?
- Is the market or region consolidating?
- Is there a risk of a competitor partnering with this institution?

Cultural Synergies
- Is the culture of the institution similar to that of our hospital?
- Are our physicians comfortable referring to and working with physicians from this institution?

Operational Compatibility
- Do we have the necessary resources to ensure IT integration, interoperability across organizations?
- Is there a defined operational plan for integrating (as needed) shared services such as information technology, quality improvement, finance, marketing and/or human resources?

Commitment to Partnership
- Are there aligned expectations for integration, timeframe, accountability, and success metrics?
- Does each executive team or physician leadership team have the time to devote to ensuring the affiliation’s success?

Questions for Potential Partners
- What are your primary objectives in seeking a partner? What is your vision for the future of your organization, and how will this partnership fit into that vision?
- Are your physicians on board? Your community?
- Who on the leadership team will be responsible for overseeing this partnership, and how will we structure communication and coordination between our organizations?
- How do you plan to evaluate the success of this partnership?
3. What are the most attractive models for achieving your goals?

Identify the Right Model to Formalize Partnership

With the goals and potential partners identified, organizations can evaluate the appropriate model to formalize the affiliation. The goals for partnership should help identify the potential degree of independence versus integration as well as the effectiveness of more financially driven models relative to more clinically driven models.

In addition to these considerations, organizations should evaluate how different models allow for an expanded partnership or affiliation going forward. Flexible deal structure ensures the model can grow with the partnership. Partnerships tend to become more tightly integrated over time, as organizations are more willing to integrate when working with a proven, trusted partner.

Align Model to Partnership Goals

<table>
<thead>
<tr>
<th>Degree of Independence</th>
<th>Financial</th>
<th>Clinical</th>
<th>Continuum</th>
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<tbody>
<tr>
<td>Low</td>
<td>Lease</td>
<td>Merger/Acquisition</td>
<td>Service Line Affiliation</td>
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<tr>
<td>Medium</td>
<td>Management Agreement</td>
<td>Consultative Support</td>
<td>Physician Support</td>
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<tr>
<td>High</td>
<td>Regional Clinical Network</td>
<td>Best-Practice Collaboration</td>
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Diagnostic Questions for Identifying Partnership Model

- Does the model reflect the desired level of independence for both partners?
- Does the model require the appropriate level of exclusivity of the partnership based on the strategic goals?
- Is there a shared vision of how the affiliation will evolve over time?
- Does the legal structure support key initiatives such as joint contracting with payers, if necessary?

Source: Health Care Advisory Board interviews and analysis.
# Partnership Goal—Partnership Model Crosswalk

Map Partnership Goals to a Partnership Model

To determine the appropriate model, please check all appropriate goals for partnerships. A majority of checkmarks in one row suggests models for further review in the Partnership Model Assessment Guide. Additionally, given some goals require more integration, organizations should also review models associated with the lowest degree of independence.

<table>
<thead>
<tr>
<th>Degree of Independence</th>
<th>Goal of Partnership</th>
<th>Potential Models</th>
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<tr>
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<td>Telemedicine support for specific specialties</td>
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<td>Medium</td>
<td>Support for back office operations</td>
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<td>Support for revenue cycle</td>
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<td>Support with building and/or renovation</td>
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<td>Low</td>
<td>Capital infusion</td>
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Source: Health Care Advisory Board interviews and analysis.
# Partnership Model Assessment Guide

<table>
<thead>
<tr>
<th>Description</th>
<th>Regional Clinical Network</th>
<th>Best-Practice Collaboration</th>
<th>Physician Support</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Hospital within a region collaborate to develop protocols to coordinate care, improve quality, streamline operational efficiencies, and achieve economies of scale</td>
<td>Hospitals collaborate to identify and disseminate best practices around clinical and operational protocols</td>
<td>Specialists travel from primary service area to provide services to patients unable to access care in their own communities</td>
</tr>
<tr>
<td>Goals</td>
<td>• Hospital seeking to fill service gaps for patients and enable provision of comprehensive care</td>
<td>• Hospital seeking limited support to strengthen existing programs by identifying and adopting select best practices</td>
<td>• Hospital seeking to expand on range of services available to local community</td>
</tr>
<tr>
<td></td>
<td>• Desire to achieve economies of scale without financial integration</td>
<td>• Desire to increase quality of care, volumes, brand perception</td>
<td>• Need to fill service gaps created by inability to recruit, retain physicians within the local community</td>
</tr>
<tr>
<td>Ideal Partner Characteristics</td>
<td>• Geographically-distant enough to prevent direct competition</td>
<td>• Able to provide access to protocols, data necessary to identify best practices</td>
<td>• Has adequate capacity to provide coverage to outlying areas to expand existing practices, programs</td>
</tr>
<tr>
<td></td>
<td>• Improving care coordination part of larger effort to improve quality</td>
<td>• Physician, staff resources available for collaboration</td>
<td>• Seeking to build relationships with providers in outlying areas</td>
</tr>
<tr>
<td>Example</td>
<td>Case Example: BJC HealthCare (MO), Saint Luke’s Health System (MO), CoxHealth (MO), and Memorial Health System (IL) have partnered to form the BJC Collaborative, a network encompassing 31 hospitals across 3 states. The hospitals will leverage economies of scale to streamline back office operations, reduce costs, share clinical and operational protocols, and connect clinicians to coordinate care. Ownership and finances will not change.</td>
<td>Case Example: To prepare for health care reform and enhance brand reputation, Sparrow Health System (MI) is participating in the Mayo Clinic Care Network (MN). Sparrow leadership and physicians are able to communicate regularly with Mayo leadership and physicians, sharing clinical and operational efficiencies across multiple specialties and programs. The goal is to enable Sparrow to deliver high-quality, advanced care while remaining independent.</td>
<td>Case Example: To gain needed support in certain key specialties, Harrison County Hospital (IN) has formalized an affiliation with Norton Healthcare (KY). Norton physicians from specialties such as oncology and cardiology travel to Harrison County locations several times a week to provide care. HCH also received a grant from Norton that allows Harrison County physicians to connect with Norton physicians via telemedicine.</td>
</tr>
<tr>
<td>Other Examples:</td>
<td>• Streamlining referrals • Joint programs/facilities</td>
<td>• Quality monitoring • Networking events</td>
<td>• Primary care support • Physician recruitment</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
<table>
<thead>
<tr>
<th>Service Line Affiliation</th>
<th>Consultative Support</th>
<th>Joint Venture</th>
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</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td></td>
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<tr>
<td>Hospital collaborates to</td>
<td>Partner staff, leaders serve in advisory role to elevate quality, improve clinical/operational/financial protocols of hospital</td>
<td>Hospitals share risks, benefits of partnership; costs of any new acquisitions, construction, and management of jointly-owned facilities are all shared</td>
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<td>improve care within a specific clinical area; patients are able to receive more care locally, while partnering institution receives high-acuity referrals</td>
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<tr>
<td><strong>Goals</strong></td>
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<tr>
<td>• Hospital seeking support within specific clinical areas</td>
<td>• Hospital looking for targeted support around specific protocols, outcomes-based objectives for existing programs</td>
<td>• Hospital has sufficient capital to operate, but needs additional resources to expand services and/or move into new markets</td>
</tr>
<tr>
<td>• Need to build out certain services that are underdeveloped due to financial constraints or lack of sufficient volumes to justify investment</td>
<td>• Seeking to increase volumes, enhance brand perception, care quality</td>
<td>• Looking to prevent market entry from outside competitors</td>
</tr>
<tr>
<td><strong>Ideal Partner Characteristics</strong></td>
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<tr>
<td>• Widely-respected within clinical area(s) of focus</td>
<td>• Has adequate staff to support outlying providers</td>
<td>• Interested in expansion in same clinical areas and/or geographic regions</td>
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<tr>
<td>• Sufficient resources to devote to providing training and physician support</td>
<td>• Strong research program able to leverage existing protocols to provide guidance around outcomes-based approaches</td>
<td>• Geographically-distant enough to prevent direct competition</td>
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<tr>
<td>• Has access to high-quality research and clinical protocols in area(s) of focus</td>
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<tr>
<td>• Geographically close enough to accept referrals when necessary</td>
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<tr>
<td>• Strong brand reputation</td>
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<tr>
<td><strong>Examples</strong></td>
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<tr>
<td><strong>Case Example:</strong></td>
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<tr>
<td>To enhance local delivery of heart and vascular care, Presbyterian Hospital (NC) has established a service line affiliation with Cleveland Clinic (OH). The hospital will gain access to Cleveland Clinic research, clinical protocols, and training resources. Patients will also be able to travel to Cleveland Clinic to receive care when necessary.</td>
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<tr>
<td><strong>Other Examples:</strong></td>
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<tr>
<td>• Co-branding</td>
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<tr>
<td>• Telemedicine support</td>
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<tr>
<td><strong>Case Example:</strong></td>
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<tr>
<td>To prepare for health care reform, Crittenden Regional Hospital (AR) has expanded and formalized a pre-existing consulting relationship with Methodist Le Bonheur Healthcare (TN). Methodist Le Bonheur has recruited new leadership for the hospital, and will guide Crittenden in streamlining operations and improving financial performance.</td>
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<tr>
<td><strong>Other Examples:</strong></td>
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<tr>
<td>• Quality improvement planning</td>
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<td>• Quality assurance review</td>
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<td><strong>Case Example:</strong></td>
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<tr>
<td>To expand on the range of services offered and strengthen local care delivery, Dameron Hospital (CA) will establish a joint venture with UC Davis Medical Center (CA). The two organizations will partner to create a new company that will own and operate Dameron Hospital; UC Davis is expected to have a 29% interest, while Dameron Hospital will have 71%.</td>
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<tr>
<td><strong>Other Examples:</strong></td>
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<tr>
<td>• Joint ownership of facilities</td>
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<tr>
<td>• Shared investment in outreach sites</td>
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</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
## Partnership Model Assessment Guide (cont.)

<table>
<thead>
<tr>
<th>Management Agreement</th>
<th>Lease</th>
<th>Merger/Acquisition</th>
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</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Managing entity takes over back-office function and often employs hospital leadership; hospital ownership does not change</td>
<td>Leasing entity pays hospital ownership a fee to take over hospital operations for a pre-determined amount of time</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>• Hospital financially stable, but in need of resources or expertise to streamline back-office functions, improve operational efficiencies, and prepare for changing health care environment</td>
<td>• Hospital finances are manageable, but additional cash flow needed to prepare for changing environment</td>
</tr>
<tr>
<td></td>
<td>• Leadership and/or community seeking opportunities without dramatic structural change</td>
<td>• Desire to improve operational efficiency but lack of time, resources, and/or expertise</td>
</tr>
<tr>
<td><strong>Ideal Partner Characteristics</strong></td>
<td>• Has demonstrated expertise in improving efficiency of back-office operations</td>
<td>• Leadership has time and resources to devote to running additional hospital, experience in handling operations at community hospitals</td>
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<td></td>
<td>• Has demonstrated expertise in or willingness to experiment with new care, payment models</td>
<td>• Willing to accommodate preferences for leadership structure</td>
</tr>
<tr>
<td></td>
<td>• Willing to accommodate preferences for leadership structure</td>
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</tbody>
</table>

### Examples

**Case Example:**
In light of declining reimbursement rates and emerging payment models, Ivinson Memorial Hospital (WY) has entered into a management agreement with University of Colorado Health (CO). The hospital will maintain its board and existing leadership structure, but the organization will gain support in physician recruitment, group purchasing, and access to expertise regarding payment reform and new care models.

**Other Examples:**
• Running of back-office
• Recruitment of executive, physician talent

**Case Example:**
Facing financial difficulty following drastic Medicaid cuts in their state, University Medical Center (LA) will be leased by Lafayette General Medical Center (LA). Advance lease payments will allow University Medical Center to continue operating without previously anticipated reductions in beds, services, and jobs.

**Other Examples:**
• Running daily operations
• Recruitment of executive, physician talent

**Case Example:**
Due to financial struggles and market consolidation, Holy Cross Hospital (IL) will merge with Sinai Health (IL). The two Chicago-based organizations hope to create a system that will allow them compete effectively against larger systems in the area, as well as potentially prevent entry by out-of-market competitors. The partnership will also pool the two organizations’ expertise and resources in caring for high-risk populations.

**Other Examples:**
• Leadership restructuring
• Roll out of clinical, operational best-practices

**Source:** Health Care Advisory Board interviews and analysis.