Evaluating Health Care Partnerships: A Best-Practice Process

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INTRODUCTION

A New Business Model for Health Care

The business model for U.S. health care is transforming from a volume-driven model to a consumer-centric, value-driven model. The value-based care model’s objective is to improve quality, access and outcomes, while reducing costs through the effective management of a population’s health over the continuum of its health and health care needs.

“Anywhere care” is the new modus operandi for nonacute, low-intensity services. Such care will occur primarily in ambulatory or home settings through in-person or virtual means—whichever best meets the consumer’s needs and goals.

To manage a population’s health, new competencies are required of hospitals and health systems, including clinical integration; consumer, clinical and business intelligence; operational efficiency; customer engagement; and efficient network development (see Sidebar 1). According to a recent national survey by the Health Research & Educational Trust, more than 90 percent of responding hospitals agree or strongly agree that population health is aligned with their mission. However, the survey also indicates that only 19 percent of responding hospitals believe that they have the financial resources available for population health.

Many hospitals and health systems will need to partner with other organizations to gain the capabilities and efficiencies required to provide services under new care delivery and payment arrangements. Their focus with population health management will be extended to the full or defined portion of the provider care continuum (see Figure 1). Additionally, partnerships with public and community agencies likely will be needed to address and improve the nonmedical social, economic and environmental factors that influence health status at the population level in the nation’s communities.

As always, financial integrity continues to matter significantly, differentiating organizations that can afford to assume higher levels of risk through partnership arrangements that meet the needs of growing patient populations.

Increasing Partnership Activity

Due to the cost and time required to develop population health management capabilities on their own, many hospitals and health systems are establishing collaborative partnerships and affiliations with providers, health plans and other organizations to gain the needed expertise and scope. As a result, both traditional and nontraditional partnerships are proliferating nationwide. The wide range in arrangement types spans from less integrated contractual affiliations to highly integrated asset purchases. Stakeholder lines continue to blur. The arrangements may be between:

» Traditional providers: for profit, not-for-profit, public hospitals, academic health centers, Catholic or children’s hospitals, rural or community hospitals, large physician groups and large health systems

» Other stakeholders: payers, employers, retailers, technology firms and other entities

Additionally, partnerships increased across the broader health care industry, including insurers, retail pharmacies and clinics, biotech companies, device manufacturers and others.

Among hospitals and health systems, announced provider-provider transactions nearly doubled from 2007 to 2015. Additionally, the percentage of announced nontraditional partnership transactions, such as management services agreements, joint operating agreements, joint ventures and minority investments, among others, rose to 16 percent in 2015, up from 7 percent in 2007.
Additionally, although not in this article’s scope, hospitals and health systems are increasingly collaborating with community partners to expand their scope of services to address nonmedical factors that influence health status, including obesity, preventive and screening services, access to care, behavioral health, substance abuse and tobacco addiction. A recent survey by the Association for Community Health Improvement and the American Hospital Association revealed that more than three-fourths of surveyed hospitals had partnerships with school districts and local public health departments.  

With hospital-hospital partnerships, the latest HealthLeaders survey indicates that 38 percent of responding hospitals were recently involved with partnership activity, while 34 percent were involved with an acquisition of one organization by another, and 10 percent with a combining of two organizations into one.  

During the past decades, many provider partnerships have been traditional arrangements. These transactions often were driven by the needs of a smaller organization, which required the help of a partner to improve its clinical programs and facilities.  

For many organizations, the rationale for partnership is now moving toward a longer-term strategy for meeting consumer/patient needs under a value-based care delivery model. Many drivers now center on gaining the core competencies required to manage population health, as described fully in Sidebar 1.  

As organizations partner with other organizations, benefits to patients and efficiencies can be achieved through:  

» Centralization of functions such as IT, purchasing and human resources  
» Rightsiting or rightsizing service and resource distribution across the service area  
» Process re-engineering, clinical variation reduction and increased care management and coordination  

The partnering organizations can achieve much more efficiencies that benefit patients through the approaches indicated in the first two bullets, compared to more limited gains indicated in the last bullet.
Sidebar 1. Organizational Capabilities for the Value-based Business Model

**Clinical Integration.** Clinical and economic alignment of physicians, nurses and other providers across the care continuum furthers organizational goals around quality improvement, efficiency, and strategic and financial sustainability. Considerations include shared hospital-provider incentives, and relationships between physicians and other care team members.

**Quality and Care Management.** To continue meeting the increased health and health care needs of patients in their communities, hospitals must achieve high-quality and consistent care outcomes. Considerations include quality and care-management infrastructure and use of team-based and coordinated care delivery models to improve quality metrics, reduce readmission rates and meet other expectations of networks that are forming.

**Network.** A network that includes hospitals, physicians, post-acute providers and other delivery system partners—enables an organization to provide the full continuum of services in its community or participate as a contracted provider in a network offered by another entity. Issues that require consideration include breadth of specialist and primary care service offerings, relative size of operations, referral sources, service area and overall network accessibility.

**Operational Efficiency.** Operational efficiency is required for sustainable financial performance in the short and long term. Considerations include operating cost, structural costs, service network and clinical variation.

**Clinical and Business Intelligence.** Collecting, analyzing and using clinical and business data are critical to setting appropriate goals and intervention targets and to performance management. Considerations include acquisition of clinical and administrative tools, ongoing data collection and management, data analytics and the integration of findings with organizational plans.

**Financial Position.** A sound financial position enables organizations to make the investments needed to manage population health in their communities.

**Customer Engagement.** Organizations that can innovate in network development and contracting, attracting employers, payers and consumers, can enhance their essentiality.

**Leadership and Governance.** Deep bench strength of clinical, administrative and governance leadership drives operational and strategic change. Considerations include current and prospective physician leadership, administration depth and succession, incentive alignment and board health care expertise.

*Source: Kaufman, Hall & Associates, LLC*
EVALUATING POTENTIAL PARTNERSHIPS

Achieving a best-fit partnership is more critical than ever for hospitals and health systems. The process for achieving such a partnership is based on strategic-financial assessment and planning. The integration of strategic planning and financial planning involves:

» Analyzing the current field and local service area conditions
» Forecasting of changes related to payment arrangements, demographics and many other factors
» Defining the role the organization will play in its community based on these factors

Strategic financial planning that uses solid data and analytics proactively prepares the organization to direct its resources to best-fit partnership options. This approach has two major phases:

» Pre-partnership assessment and planning
» Making and executing the strategic partnering decision

Phase 1: Pre-partnership Assessment and Planning Service Area Assessment

This phase answers questions including: What is the current state and trajectory of the provider field nationally and locally? How well is our organization positioned for the future operating environment? What does our future look like as a stand-alone organization without a partner? What are our big-picture strategic options? Figure 2 shows the four major activities of this first phase.

Figure 2. Pre-partnership Assessment and Planning

Source: Kaufman, Hall & Associates, LLC
Service Area Assessment

As described earlier, the U.S. business model for health care is moving away from a *sick care* model to a value-based system focused on the provision of *health* care in ambulatory and home settings. Service delivery areas are transforming at different speeds. Regions may be at a low or high stage of evolution toward value-based care, but an increasing pace of change is likely and presents significant risk to even the best-prepared organizations.

The organization’s current position in its service area can be assessed relative to information on the pace of change in its service area. Pace of change is a function of seven factors: level of organization among hospitals and physicians; employer health care benefits structure; enrollment in public exchanges and level of product and network sophistication; amount of vertical collaboration and new-entrant activity; demand for services; supply of providers; and regulatory environment.

Rapidly moving service areas typically have characteristics, including:

- Large organized groups of physicians and other providers
- Penetration of managed care products and services, including narrow or limited network products
- Relatively high utilization of services and costs of care, on a per-unit and/or total medical expense basis
- Familiarity with capitated payment, including delegated risk models
- Pricing variation across plans and products

- Unused capacity in the service area relative to beds and/or specialists
- New entrants and/or disruptors, including private equity-backed and retail companies
- State legislation encouraging new payment and care delivery models

All of these elements need not be working at the same time to shift a service area rapidly for its providers. In some regions, initiatives by one type of stakeholder may move the needle significantly (for example, a payer which offers a new narrow-network product). In other areas, new entrants accelerate the process. A single decision by a physician group, payer or employer can weaken or completely undercut hospital and health system efforts to gain covered populations through clinical network development, targeted community outreach or other initiatives.

Organizational Position Assessment

To make the significant changes required for the future, hospitals and health systems need to have as much flexibility as possible. Flexibility will be built through strengthening existing competencies and developing new competencies needed under a value model, as described earlier in Sidebar 1. Each of the eight capabilities is important, but usually a few require significant focus in order to establish the organization’s value for payers, employers, consumers and other stakeholders. Key capabilities typically include clinical integration, operational efficiency and quality, and care management infrastructure and protocols.

For the most part, hospitals are aware of the amount of work that needs to be done and
the financial resources required to develop the necessary capabilities. But provider readiness for value-based care varies widely nationwide and leans toward less prepared (see Figure 3). The proportion of health systems that are innovators in linking care quality and outcomes with financial incentives upstream, downstream or across the enterprise will need to increase. Even organizations most frequently cited as examples of the best prepared indicate that they have significant work to do for effective positioning.

Hospital and health system leadership teams should ensure thorough evaluation of the organization’s current position relative to the eight critical capabilities, using both qualitative and quantitative data. Each has specific indicators. For example, clinical care management can be assessed based on availability and, importantly, the degree of use of protocols and clinical orders sets for high-cost clinical procedures and high-incidence/high-impact chronic conditions. Financial position can be assessed through profitability, liquidity and leverage ratios, among others. Based on such assessment, the organization’s readiness can be compared to providers nationwide and to specific organizations in defined service areas.

Figure 3. Nine Attributes and Estimate of Organizational Readiness on a National Basis

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Traditional Organization</th>
<th>Value-based Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Integration</td>
<td>Siloed</td>
<td>Strong</td>
</tr>
<tr>
<td>Quality and Care Management</td>
<td>Little to None</td>
<td>Robust</td>
</tr>
<tr>
<td>Network Development, Configuration and Relevance</td>
<td>Limited</td>
<td>Robust</td>
</tr>
<tr>
<td>Operational Efficiency</td>
<td>Dept. Focused</td>
<td>Enterprise-wide</td>
</tr>
<tr>
<td>Clinical and Business Intelligence</td>
<td>Traditional</td>
<td>Integrated</td>
</tr>
<tr>
<td>Financial Position</td>
<td>Challenged</td>
<td>Strong</td>
</tr>
<tr>
<td>Purchaser Relationships</td>
<td>Limited/Local</td>
<td>Strong/Local</td>
</tr>
<tr>
<td>Brand Strength</td>
<td>Limited/Local</td>
<td>Strong/National</td>
</tr>
<tr>
<td>Leadership and Governance</td>
<td>Limited/Depth/Alignment</td>
<td>Deep M.D. and Admin/Strong Alignment</td>
</tr>
</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC
Development and Testing of Baseline Projections

Once competency gaps have been identified, organizations can do the analytic work needed to develop a baseline path to close those gaps. The baseline includes strategic, geographic, clinical, financial and operational considerations. These considerations enable the organization to assess the implications of “staying the course,” i.e., remaining independent and without the assistance of a partner.

Because past baselines are no longer appropriate, especially those projections related to future utilization, executives should give careful thought to planning assumptions, including:

» Service area definition: patient origin, demographics and other factors
» Clinical considerations: physician group and staff profiles, programs and service performance, facilities assessment
» Stakeholder environment: payers, hospital providers, ambulatory providers
» Capital considerations: capital/debt capacity, sources and uses of capital, routine capital expenditures, strategic capital requirements
» Utilization: inpatient, outpatient, patient mix, length of stay
» Operating revenue: payment mechanisms (shared risk, bundled, pay-for-performance, capitation, etc.), payment rates (Medicare, Medicaid, commercial, managed care), self-pay net revenue rate, bad debt and charity levels, pricing
» Operating expense inflation: pay increases, medical supplies, interest expense and other expenses

Many hospitals and health systems face significant risk in preparing for performance under a value-based business model. Higher risks typically include volume declines, expense growth, payer rate reductions, and capital expenditures for physician practices and practice losses. It is not unusual for projected baseline financial performance to have a downward trajectory.

The leadership team of one community hospital evaluated such a situation and strategies the organization could use to change the trajectory. The executive team and board were not comfortable with the required magnitude and types of changes, and the associated implementation risks. Leadership wanted to preserve mission-critical services in the community. Sensitivity analyses were performed to indicate potential risks of an improvement plan under different scenarios.7

Evaluation of Strategic Options

The hospital’s management team and board concluded that achieving the desired performance would be unlikely within the context of regional realities, financial capability and overall desired risk profile if the organization remained independent. Partnership arrangements might help the hospital preserve its mission in the community and position it to play a future role in managing population health.

The independent option becomes the guidepost against which to consider big-picture strategic alternatives. For example, a small independent health system might identify and assess options to:
1. Remain independent and drive aggressively to support its vision, possibly incorporating nontraditional partnership arrangements, such as best-practice or purchasing collaboratives

2. Position itself, either independently or with a for-profit partner, as a regional system that could acquire smaller facilities needing a partner

3. Partner with another health system that shares its vision, creating a new health system

4. Integrate into a much larger health system, perhaps one that is geographically contiguous, or a regional or national system, or a for-profit health system

5. Pursue nontraditional and less integrated partnerships (joint ventures, payer partnerships, etc.)

Having ruled out the financial feasibility of #2, Figure 4 illustrates this organization’s high-level analysis of the ability of the other four options to meet strategic priorities. As shown in the right-hand column, option #4—integrating with a larger system—offered the best potential.

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**Figure 4. Comparison of Four Strategic Alternatives along Eight Priority Dimensions**

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Remain Independent</th>
<th>Pursue Non-Traditional Less Integrated Partnerships</th>
<th>Form New System</th>
<th>Integrate with a Larger System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment of mission and commitment to communities served</td>
<td><img src="alignment.png" alt="Alignment" /></td>
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<td>Employees</td>
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<td>Financial sustainability</td>
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<td><img src="financial.png" alt="Financial" /></td>
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<tr>
<td>Strategic vision</td>
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<tr>
<td>Dedication to quality improvement</td>
<td><img src="dedication.png" alt="Dedication" /></td>
<td><img src="dedication.png" alt="Dedication" /></td>
<td><img src="dedication.png" alt="Dedication" /></td>
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<tr>
<td>Medical staff alignment and physician practice management</td>
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<td><img src="medical.png" alt="Medical" /></td>
<td><img src="medical.png" alt="Medical" /></td>
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<tr>
<td>Value-based accountable care infrastructure and capabilities</td>
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<tr>
<td>Governance</td>
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</tbody>
</table>

**Potential ability to fulfill identified priorities:**
- **Limited**
- **Fair**
- **Good**

*Source: Kaufman, Hall & Associates, LLC*
Sidebar 2. Topics for Guiding Principles for Exploring Strategic Partnerships

1. **Mission, vision, values and culture:** What are the critical elements, and is there alignment between potential partners?

2. **Community goals:** How will a partnership assure service access and patient satisfaction, handle charity care, as well as promote and deliver health services to meet emerging demographic and service area needs?

3. **Strategic plans for value-based care:** What are the critical elements, and do the initiatives mesh well together?

4. **Clinical programs and services, quality and outcomes, and costs:** What are the goals and how will partners collaborate to achieve these? How will a partnership govern the delivery of existing programs and services, develop new services, right-size and right-place major service lines, and increase the quality of care while improving its efficiency?

5. **Contracting arrangements, clinical integration, delivery network, IT and other considerations:** What contracting arrangements will be sought, and how will the physician and delivery network be shaped to participate in those arrangements? How will IT support the delivery platform? How will a partnership set priorities and timelines for capital initiatives related to managing population health?

6. **Physician relationships and commitments:** What are the goals and timing expectations related to physician employment, recruitment, contracting and governance?

7. **Employees:** How will a partnership handle workforce issues, including the retention of executives, managers and employees?

8. **Governance considerations:** What are the expectations and the desired degree of local-level involvement? How will a partnership involve trustees in setting strategic direction and strategic plans, create operational and capital budgets, and make decisions about the range and scope of health services?

9. **Philanthropic and foundation considerations:** What are the specific goals? If a new community foundation is to be established, what are the expectations related to its funding?

*Source: Kaufman, Hall & Associates, LLC*
Figure 5. Making the Strategic Partnering Decision

Phase 2: Making and Executing the Strategic Partnering Decision

Phase 2 has five key activities (see Figure 5) that collectively answer questions including:

» What are the guiding principles and objectives of a partnership?
» What are the partnership options and how do they compare?
» Which organization is likely the best-fit partner?
» What partnership structure would enable both partners to meet their objectives?
» How can an organization help to ensure the timely execution of the partnership agreement and a successful transition post-partnership?

Principles and Goals to Guide Partnership Exploration

The recommended strategic partnering process begins with development by consensus of guiding principles. With oversight and involvement by the board and senior management team, this first step is likely the most important component of this phase. Guiding principles define what the organization wants to achieve through a partnership.

Every organization will arrive at a different set of guiding principles, but current big-picture categories in which health systems develop principles typically include: long-term vision; commitment to partnering organization’s community; culture; value-based infrastructure and capabilities; physician engagement; physician practice management; commitment to teaching programs; governance; employees; economies and efficiencies; and financial position. Sidebar 2 outlines nine topic areas for principles that the board and senior management team might consider when initiating the strategic partnership process.

Goals and objectives define the business purposes of the prospective partners. They also provide the framework for all other steps in the partnering process, including the evaluation of potential partners and the selection of the partnership structure. Objectives need to be as specific as possible so that prospective partners can be evaluated on their ability to meet identified needs.

Goals and objectives can be defined at many levels as the partnership exploration process advances, for example:

» The 100,000-foot view might be defined as, “Position the organization to effectively manage population health in specified communities in a value-based care model while maintaining local autonomy for decisions related to health care and medical management.” This might be helpful at the stage when an organization is developing guiding principles and overall goals.
» The 10,000-foot view might be defined as, “The partnership will focus on using each other’s best practices and infrastructure through the creation of a specific affiliation arrangement.” This might be helpful at the stage when the
The organization is identifying and assessing best-fit partners.

» The 100-foot view focuses on the business and operational terms of the partnership that will allow the parties to achieve their objectives. It might be defined as, “The combined entity will migrate to one vendor’s IT platform within three years.” This would be helpful at the stage when the partners are developing a letter of intent, as described later in this guide.

» The ground-floor view defines the specific, enforceable legal terms that will govern the partnership in a manner consistent with the goals and objectives of the parties. This would be helpful during development and negotiation of the definitive agreement.

Realistic objectives increase the likelihood that a partnership will progress smoothly and achieve benefits for both parties. Hospitals and other providers cannot expect to structure an arrangement under which they continue operating exactly as they have in the past. Their boards and executive teams must be willing to be flexible with some aspects of operations, whether it be strategic planning and direction, operating and capital budgets, service continuation and enhancement, or other considerations. Leadership teams should try to put as much on the table as possible and actively manage expectations throughout the partnering process.

At this early stage, the organization typically establishes a structure for exploring a partnership arrangement. A small group or team of key decision makers can speed the exploration and transaction processes and maintain the required confidentiality. The team typically includes:

» Senior management and financial and legal advisers who manage the day-to-day-details

» Small task force of board members, which measures and tracks performance against objectives, provides critical advice on the development of the transaction and reports to the full board at specific stages in the process

Hospitals and health systems should thoughtfully consider the role of the board, management and physician leaders, including both independent and hospital-employed or contracted physicians. Embarking on a thorough leadership and governance redesign process is a major undertaking for internal stakeholders. Advisers may be able to guide leaders through a process that has been successful for organizations in various regions nationwide.

Assessment of Partner Options

In geographies where organizations work closely with each other and know each other well, the choice of a partner may seem clear. Unless the organization plans to undertake an exclusive negotiation process with a single prospective partner, multiple potential partners generally should be identified. These include both obvious candidates in the locale or region and what might be considered “outside-the-box” candidates. Depending upon the partnership goals, potential partners may be in noncontiguous geographies or be a vertical participant, such as a health plan, area employer or retail company. But a realistic rationale for wanting to partner should be apparent for each partner prospect.

Consideration of five or more potential partners as a starting point allows the partner-seeking entity to think broadly. The number of candidates then can be narrowed into a competitive field, as partnership with each candidate is assessed individually and comparatively.

The assessment criteria focus on the organization’s ability to meet the agreed-upon partnership goals and objectives. A side-by-side comparison of key elements can facilitate objective review and decision making. The ultimate goal of this stage is to narrow the group of potential partners to entities that have the greatest likelihood of fulfilling the partnership goals and objectives.
Sidebar 3 outlines the formal steps typically taken by the team or task force during this stage. These steps depend upon the level of confidentiality.

In the final analysis, the key elements for assuring good-fit partnerships include:

» Strategic position: The partnership must be able to improve the organization’s ability to meet core goals, such as managing population health.
» Operations: The partnering organizations must accurately estimate the investment of time and money required to implement operational change.
» Execution/Implementation: The partnering organizations must make the changes required to achieve the projections used to evaluate the partnership.
» Cultural compatibility: The organizations must assure cultural fit.

The importance of culture cannot be overemphasized. The top reason cited for nearly half of partnership terminations is lack of cultural compatibility. A well-designed partnership exploration process allows for appropriately timed and confidential interaction between key constituents, including boards, management, physicians and community leaders, in order to gauge cultural fit.

Figure 6. The Continuum of Strategic Partnership Structures

<table>
<thead>
<tr>
<th>Contractual Relationship</th>
<th>Joint Venture/Operations</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affiliations</td>
<td>Sale of Minority Interest</td>
<td>Whole Institution Lease</td>
</tr>
<tr>
<td>Corporate Services Support</td>
<td>Joint Operating Agreement</td>
<td>Change of Corporate Member</td>
</tr>
<tr>
<td>Shared Clinical/Ancillary Services Agreement</td>
<td>Sale of Majority Interest</td>
<td>Asset Sale/ Acquisition</td>
</tr>
<tr>
<td>Management Services Agreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO/CIN development</td>
<td></td>
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</tbody>
</table>

Source: Kaufman, Hall & Associates, LLC
Assessment of Partnership Structure

The structure for a strategic partnership is critically important to achieving expected partnership benefits. Structures range from loosely integrated contractual arrangements to fully integrated arrangements, with varying levels of commitment and financial alignment possible in many structures (see Figure 6).

At the most integrated end of the continuum, for example, Baylor Health Care System and Scott & White Healthcare merged, creating a fully integrated health system called Baylor Scott & White Health. Trinity Health and Catholic Health East consolidated as Trinity Health.

Less fully integrated structures include affiliations, purchasing and best-practice collaboratives, clinically integrated network arrangements, management services agreements and others.

For example, the BJC Collaborative is an arrangement that enables multiple health systems to retain their independence, but to partner with BJC and other organizations to increase purchasing efficiencies and share best practices. Carolinas HealthCare System and Cone Health are partnering under a management services agreement. Duke University Health System and LifePoint Health have a joint venture arrangement called Duke LifePoint to build a network of hospitals, physicians and other providers through acquisitions and shared ownership and governance of community hospitals.

An increasing number of hospital arrangements are noncontrol transactions, in which there is no transfer of the majority of a hospital’s governance control. Some of the more common noncontrol transactions include:

- Branding arrangements designed to leverage the name, clinical expertise or physician platform of a health system or academic medical center on behalf of an unaffiliated hospital or health system
- Joint ventures targeting a specific service or site
- Management and joint operating arrangements, either for discrete service lines or whole hospitals

Noncontrol transactions usually involve financial commitments in the form of an investment by one of the organizations in the other, or in a joint venture entity. The nature of the investment can take the form of a loan, a membership interest stake or a contractual right to share in earnings. Many noncontrol transactions also often include specific clinical and programmatic commitments by one or both organizations.

Noncontrol transactions may be attractive to community health systems because they offer an opportunity to partner with a larger organization to help support programmatic needs, while allowing the community health system to maintain more control over its assets and future than under control transactions. In some cases, a noncontrol transaction allows a community health system to get to know a larger partner, recognizing that a more integrated transaction between the parties can occur only after further bridges of trust and collaboration are built between and proven within the organizations.

Choosing the most appropriate partnership structure depends on the objectives of the partnership. If a principal objective of a smaller hospital is to obtain capital support for infrastructure and development, the most likely transaction structure would be a merger with a large organization. If a major objective is to enhance specific service lines or build a clinically integrated network, less highly integrated transaction structures, such as a joint venture or clinical affiliation, may be more appropriate.

Constraints also should be considered. Some structures and agreements have organizational, legal or other operating prohibitions that affect how a partner can participate in this or other arrangements.
Transition Planning and Integration Structure

Hospital management and governance teams often assume that partnerships occur through sequential steps, the first group of steps consisting of transaction activities (e.g., identifying a partner, conducting due diligence, and developing and executing the agreement), followed by the second group of steps consisting of transition and integration activities (e.g., integration planning and execution).

When this traditional approach to partnering and integration processes is applied, it may be driven by the current leadership, and may focus primarily on speed and compliance over organizational buy-in. When this occurs, the partnership objectives are less likely to be achieved during the integration stage and thereafter.

In an effective and sustainable integration process, transaction and transition activities are overlapping, rather than sequential. Figure 7 illustrates the recommended partnership life-cycle, with integration work streams often proceeding simultaneously and involving:

» Strategic planning prior to signing of a letter of intent
» Transaction development and execution through the definitive agreement
» Detailed transition planning and execution, from the letter of intent through complete execution of integration plans

This integrated approach is vision-driven and sponsored by leadership, but accomplished collaboratively within and across the organizations. It emphasizes buy-in while attending to compliance, grows new leaders and is sustainable over time, with results that last. Transition planning involves many people, and thus for confidentiality reasons is best started when the partnering organizations are ready to go public with their partnership intent.

Execution of Partnership Agreement and Transition Plans

Before a partnership arrangement is finalized, many successful partnerships have a solid business case or plan that includes financial, operational, strategic and capital rationale, along with qualitative measures of success, including
cultural fit and stakeholder buy-in (see Figure 8). These elements are critical to internal buy-in and support, and important for any regulatory process with significant implications for the ability to meet quality, cost and other objectives across both partnering organizations.

Elements of the transaction-execution process for more integrated arrangements (as shown also in Figure 7), include reviewing and negotiating a letter of intent, conducting due diligence, negotiating and finalizing definitive agreements, meeting preclosing and regulatory review requirements, and closing. Due diligence ensures a more complete understanding of the issues, opportunities and risks associated with the partnership agreement in advance of its execution. Legally binding documents are created to describe the terms of the partnership and the respective rights and obligations of the partnering organizations.

Following execution of the agreement and regulatory approval, the partnership process can go into “full implementation mode” based on the plans developed earlier in transaction and transition planning.
CONCLUDING COMMENTS

Partnerships in health care have accelerated, as participants in the field position themselves for a value-based delivery system. Traditional lines and roles of what were once distinct and separate verticals are now blurring. All types of innovative transactions are occurring.

Providers are showing increased flexibility around partnering arrangements. As larger players combine in unique ways, the pace of change in geographic areas will quicken nationwide. How the business of health care is conducted could be redefined in fundamental and dramatic ways, bringing significant improvements.

What partnerships does your organization need to establish to be an essential provider in your community going forward, navigate the population health management agenda and reposition for a fee-for-value environment? Is your organization moving fast enough now to develop these partnerships?

Partnership discussions are complex and multifaceted, often involving a significant amount of time before coming to fruition through a thoughtful process. As described in this guide, that process includes thorough pre-partnership assessment and planning, in-depth partner assessment and decision making, and development and execution of win-win transaction structuring that meets partners’ goals and objectives. Successful partnerships will have in common the elements outlined in Sidebar 4. Forward-thinking health systems are taking a proactive approach to partnership conversations.

Sidebar 4. General Characteristics of Successful Strategic Partnerships

- Common vision on direction and mission of organization and alignment of objectives
- Clear value proposition and compelling strategic, clinical and business plan that can be achieved
- Cultural compatibility, constituency support and implicit trust (boards, management, medical staff)
- Governance, corporate and management structures that support the implementation plan
- Higher degree of “all in” integration
- Strong board and management leadership
- Ability to make difficult decisions upfront
- Organizational champions for key initiatives
- Capability to deliver on commitments related to resources
- Employer and payer support (or, at least, lack of opposition)
- An effective implementation plan that achieves anticipated synergies

Source: Kaufman, Hall & Associates, LLC
ENDNOTES


