

All the Right Pieces

How a struggling county hospital, a for-profit buyer
and a wary community came together

BY JAN GREENE

Larry Ghan knew he was putting his job as a Bannock County, Idaho, commissioner on the line when he challenged the county hospital's plan to change its ownership and borrow money to build a new hospital. Pocatello, Idaho, is a small community and the fate of public Portneuf Medical Center really stirs people up.

"I felt like this was the most important decision and process that I would be engaged in during my public service life for this community," Ghan says. As controversy brewed, he warned his wife that he might become a political lightning rod for the community's anxiety about the hospital's future. "I told her, 'This is going to get nasty before it gets over. We're going to take the whole thing, our livelihood, and put it all on the table.'"

Things did get rough, especially when Ghan and his colleagues suggested the hospital might join forces with a for-profit hospital company. The idea of losing local control to a national corporation angered many Pocatellans. In fact, the controversy fueled a recall attempt on Ghan and cost another commissioner his job when his seat came up for re-election in the middle of the debate.

But when the smoke cleared after a couple of years of study and struggle, Portneuf Medical Center emerged as a unique hybrid—majority-owned by a for-profit company but with significant governance sharing with the Bannock County community. Its new campus is under construction and will open with no loans on the books. A community-based board shares governance of the hospital with a for-profit company called LHP (formerly Legacy Health Partners), based in Plano, Texas. LHP owns 77 percent of the hospital's assets and handles management duties.

Pocatello's journey, which involved dozens of public meetings and hundreds of column inches in the local newspaper, could be repeated in any number of modest-sized American towns, where the community hospital is having trouble coming up with the cash to pay for pressing, big-ticket items such as buildings and electronic medical records. Since the bond markets froze up in 2008, borrowing for nonprofit hospitals has become extremely difficult. More hospitals will be looking for partnerships, and the most attractive mate may end up being a for-profit company.

Hospital boards need to be prepared for these possibilities. The experience in Pocatello provides some helpful lessons.

Pocatello's Bumpy Journey

Portneuf Medical Center is a 250-bed community hospital in Pocatello, whose 50,000 citizens make it the largest city in south-east Idaho's Bannock County. The hospital is one of the area's biggest employers, with 1,225 workers.

In 2007 Portneuf faced a problem common to small community hospitals across the country: limited access to capital and a compelling need to spend money. Its facilities were unacceptably old and had been split into two campuses with the acquisition of another not-for-profit hospital in 2002. A new building was designed and the initial \$65 million phase begun. But financing for the rest of the project became more elusive in 2006 when the Idaho Supreme Court decided in an unrelated case that the county would have to get two-thirds voter approval for any future public bond issue.

Assuming a two-thirds vote would be unlikely, hospital officials scanned the fiscal landscape for a different source of money. In 2007 they came up with a plan to convert to a private, nonprofit model that could borrow money on the private bond market. Then they would borrow small amounts of money and take 10 years to finish construction on the new \$200 million hospital.

Portneuf Medical Center's board approved the plan, but it still had to pass muster with the county commission, which had ultimate responsibility for the public hospital. There it ran into a roadblock. The commissioners, including Ghan, wanted to stop and take a big-picture look at their options and find out more about the hospital's finances. The resulting power struggle between hospital leaders and skeptics such as Ghan created quite a stir in Pocatello.

Ghan was convinced the hospital wasn't making enough money to make a go of it without a capital partner with deep pockets. "We couldn't keep up with the [technical advances] as they'd been evolving in the field," he says.

But proponents of the nonprofit conversion idea argued that it was vital that the community maintain control over its hospital. They pictured a for-profit organization cutting vital services to squeeze out profits and draining the local hospital of cash to hand to investors. Fueling their fears was a purchase offer from Capella Healthcare, a Tennessee-based for-profit that owns 13 hospitals. The county commission's discussions with Capella

made many people nervous. In an opinion piece in the local newspaper, Craig Bosley, an emergency department physician wrote, "Quite simply, [Portneuf Medical Center] makes money so it can take care of patients and Capella takes care of patients so it can make money. These value systems are diametrically opposed to one another and are mutually exclusive."

The commissioners chose to hire a consulting firm to help them evaluate the options. They agreed to pay \$360,000 to Stroudwater Capital, a Phoenix health care consulting firm, a decision that drew fire from critics.

While Stroudwater worked on getting financial information from the hospital, a 14-member citizens panel was put together to study the hospital's options. To set a baseline for

LOCAL CONTROL

NON PROFIT

COMMUNITY

NEW HOSPITAL

TRUST



PARTNERSHIP

FUNDS

FOR PROFIT

evaluating future options, the citizens panel was asked to come up with a list of community values and priorities for the hospital's future (see sidebar).

By January 2008, Stroudwater had enough information to conclude that Portneuf could not obtain the financing it would need as a private non-profit. The month before, in fact, Standard & Poor's lowered the hospital's bond rating to below investment grade. The news marked a turning point in the public debate: clearly a financial partner was needed, but many in the community continued to be committed to maintaining as much local control over the

hospital as possible.

Stroudwater began a comprehensive search for bigger partners, both nonprofit and for-profit, and developed a request for proposals that was sent to 25 different organizations. In

June 2008 the county received a dozen responses. Those were narrowed down to two options: Legacy Health Partners, which changed its name to LHP in 2009, a privately held firm that was new but run by the same management that successfully led Triad Hospitals before it was bought by a bigger for-profit; and LifePoint, a publicly traded firm from Nashville, Tenn., with 47 hospitals.

Both firms offered attractive deals, Ghan says. The most compelling piece of each was their willingness to evenly share governance of the hospital while putting up millions of dollars in new construction. Various Pocatellans visited the firms' other hospitals, and Pocatello physicians checked in with colleagues at hospitals that had worked with Legacy and LifePoint management.

Through this process, there remained worry among local residents that a partnership would be to the community's detriment. "Overreaching, hubris and greed are wrecking our once-successful, efficient county hospital," complained one person commenting on the *Idaho Statesman's* Web site.

The ultimate choice was a close call, Ghan says, but Legacy won out, and the arrangement was finalized in February 2009. This was Legacy's first completed partnership deal as a company, though its management had experience with the shared governance model in its deals at Triad.

LHP agreed to put in about \$200 million and commit to completing the new hospital within 24 to 30 months. LHP officials

describe the hospital as opening debt-free, in the sense that no bond holders and banks are waiting to be paid back their principal. But the arrangement does assume that LHP investors will expect a return. Half of the money invested in Pocatello came from a New York private equity firm, CCNB Capital, and the other half from the Canadian pension board. "We decided to put up equity instead of debt to make [the Pocatello community] feel comfortable," says Dan Moen, LHP CEO.

He describes LHP's approach as different from many for-profit hospital corporations that prefer to purchase hospitals and maintain control over them. "Having a partner takes time, there's more care and feeding" than when buying a hospital outright, Moen says. "We believe health care is a local business and the best decisions are made locally. You have to seek the input of your partners and involve them in the management of the facilities."

LHP's goals for the hospital are to maintain its status as a full-service regional hospital and referral center for 13 critical access hospitals in rural parts of southeast Idaho. It also wants to stop the migration of patients to medical centers in Salt Lake City and recruit more doctors, particularly primary care physicians.

Three Boards Share Governance

The partnership resulted in the creation of three boards:

- **Community Benefit Organization Board of Directors.**

CONSIDERING A PARTNER? START HERE

GET PROFESSIONAL HELP. Despite criticism of the Bannock County Commission's decision to hire a consultant, commission Chairman Larry Ghan believes the assistance was essential. "Having a consultant you can trust and who puts your interests ahead of any presupposed outcome is a great aid," Ghan says. "We took a lot of heat for using outside consulting, but the local experts all had a vested interest in the outcome. It cost a little bit of money up front but ended up being the best money we ever spent."

It's also important to use specialized attorneys when drawing up an agreement with a for-profit partner, argues Bill Baker, an attorney and national leader for KPMG's health care advisory services. "It's critically important that a not-for-profit board get consultation from an attorney with deep experience in not-for-profit hospital transactions," he says. It's not enough to get someone with mergers and acquisition background from an industry other than health care, he says. "The entire future of the organization will be guided by that joint venture agreement. The rules of the relationship are contained in that agreement."

PREPARE TO SHARE THE WEALTH. A key provision in any partnership agreement is how to handle profits. When the hospital generates cash, it is usually shared by both parties. What that split is and how it's spent should be determined ahead of time.

PLAN FOR DIVORCE. When writing an agreement with a for-profit partner, nonprofit boards need to be sure it is clear how the

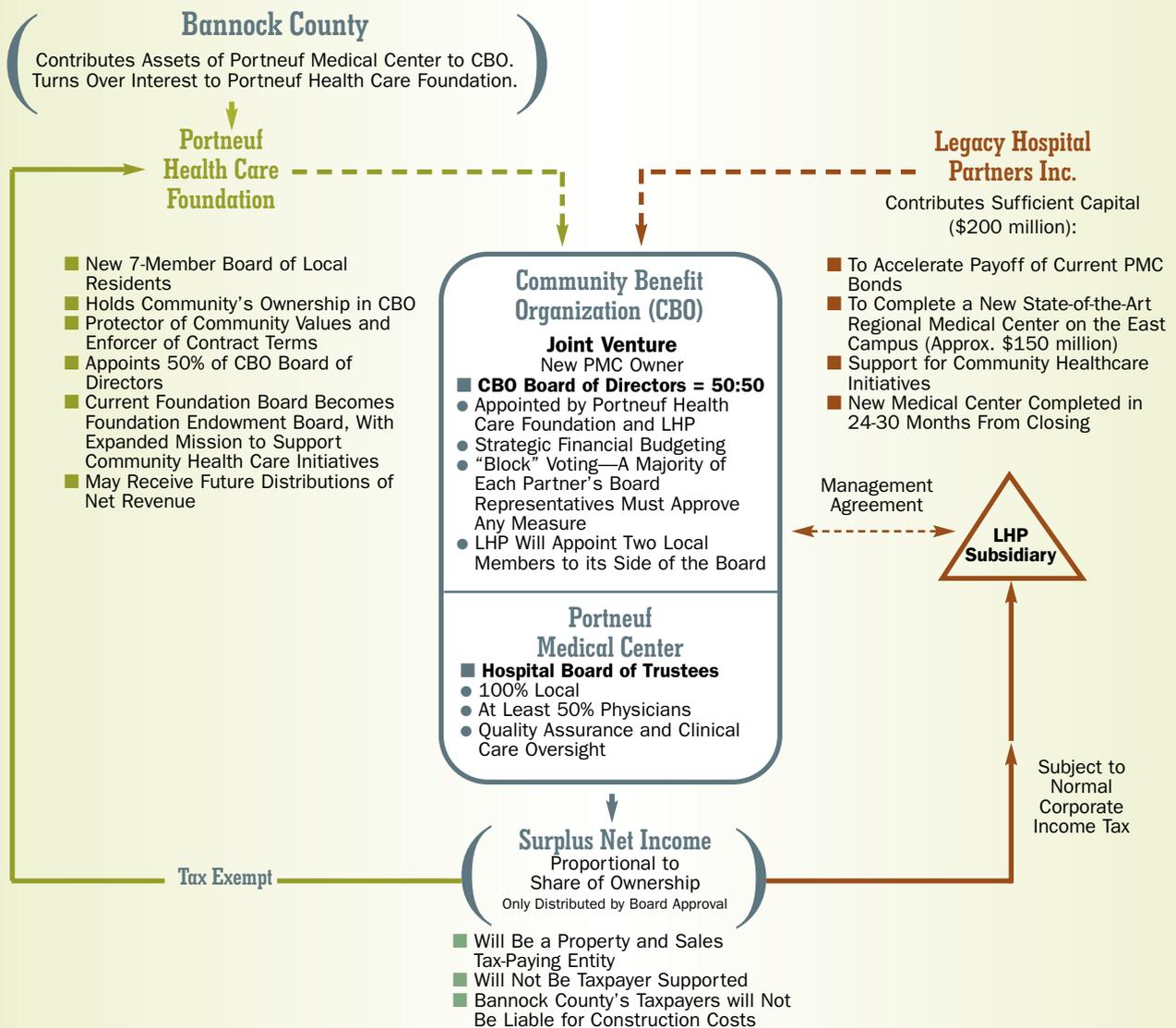
arrangement could be pulled apart if it isn't working, Baker says.

Also plan for the possibility that the for-profit company could change hands, which happens with some regularity with publicly traded firms. All of the deals at Triad Hospitals, LHP CEO Dan Moen says, included language that one partner could buy the other out if the company changed hands. Those clauses get used. When Triad was purchased by Community Health Systems in 2007, two of the hospitals that had joint ventures going with Triad chose to buy their assets back. One, Texas Health Resources, bought back its Denton, Texas, hospital when it learned Triad was being absorbed; a Texas Health spokesman said the nonprofit system "wanted to maintain the community-focused philosophy" that it had in partnership with Triad.

PARTNER ONLY WITH A CONSISTENT CULTURE. Identifying your own organization's values will help you determine whether a partner organization is a good fit. "It truly is a marriage," Baker says. "You want to go into it with eyes wide open. It's important for those nonprofit management teams and boards to get comfortable with who they are partnering with and ensure that they are aligned and incentivized appropriately moving forward."

One symbol of that common vision is tested when choosing a CEO, and that's an important one to get right, Baker notes. "At the end of the day, the vast majority of the decisions are made by the CEO of the hospital," he says. Often the for-profit partner will choose and oversee the CEO but the nonprofit partner has veto power.—J.G.

OWNERSHIP AND GOVERNANCE STRUCTURE



Source: Portneuf Medical Center

Known as the joint venture board, or CBO, it has 12 members. Half are appointed by the local foundation board and half by LHP.

• **Portneuf Health Care Foundation Board.** A new, seven-member board of local residents that holds the community's ownership in the CBO.

• **Portneuf Medical Center Hospital Board of Trustees.** Consists of 10 members, all local and half of them physicians, who carry out quality assurance and clinical care oversight.

Ghan is pleased with the amount of local control on the boards. "Between them there are 29 positions, and 26 are from this community. They're less prone to being captured by an administration or a specific interest," he says.

One downside to losing the public part of the county hospital is that there is no legal requirement that financial and other information be shared with the public, Ghan acknowledges. But LHP has committed to producing public quarterly reports to the com-

munity, which he hopes will provide sufficient transparency.

Ghan admits that when he first became a county commissioner in 2006 he declared he would "never support anything that would take away our community hospital." Now he says, "Romantically, that's where most of us are. But month after month, four years on the commission and as county clerk 22 years before that, never once do I recall [the hospital] meeting our monthly goal to fund the debt that would be needed to fund a new hospital on our own."

The boards' unique power-sharing arrangement is "a work in progress," says Shaun Menchaca, president and CEO of the Portneuf Health Care Foundation. "When you invent something, you have to figure out what works and what doesn't."

So far, so good, reports Benjamin Call, a longtime Pocatello cardiologist and chairman of the hospital's new board. "You could anticipate there would be a honeymoon period, but if things were going to go sour they'd go really sour by now and they

haven't," he says. Physicians in general have a positive attitude toward the change and look forward to having a new hospital to work in, he says.

Even Craig Bosley, the emergency department physician who penned a doubtful piece in the *Idaho State Journal* the year before, supported the Legacy partnership when it came to a vote, arguing that it would offer the community "the best of both worlds."

Portneuf's local leaders remain positive even in the face of layoffs that took place in September 2009, when 3 percent of the hospital's staff lost their jobs. Officials said the layoffs were the result of a tight economy, not because of any restructuring by the new owner. They said those who lost jobs were in middle management, and that the decision was made in Pocatello, not Texas.

Lessons for Other Hospitals

Portneuf's situation is fairly typical of modest-sized community hospitals around the country. They struggle a bit financially on operations, but aren't in the red. The real trouble comes from needing capital and sources disappearing. "The tax-exempt bond market has pretty much dried up for not-for-profit hospitals," says LHP's Moen.

Bill Baker, Dallas-based national leader for KPMG's health care advisory services, agrees. "The bond market is really tight, and I don't see it changing substantially in the near term," he says. "It probably won't get back to the way it was for three or five years."

At the same time, hospitals continue to need infusions of cash for a variety of projects: construction, expensive medical technology, electronic medical records.

The strategic landscape continues to become more complex, requiring sophisticated skills from administrators of smaller hospitals. "All these things lead you to need to be a very savvy operator of a hospital," Baker says. "Sometimes a lot of the tools to operate a facility properly just aren't available to a stand-alone small to medium hospital."

That means partnering not just for cash, but for management experience.

At the same time, partnering means giving up some amount of control. The keepers of nonprofits and public hospitals naturally feel strongly about maintaining their commitment to their communities, which was at the center of the debate in Pocatello. "In the best of all worlds, people don't want to sell their hospitals to somebody from out of town," says Monte Dube, a Chicago attorney with many mergers and acquisitions under his belt. He advised Bannock County in the Portneuf situation. "What is often an impediment to community hospitals doing transactions is their concern about local control. The joint venture model ensures meaningful local governance and decision-making on the control issues that often matter most, such as quality access and continuing services."

Once they decide to seek a partner, many of these hospitals naturally look to a bigger nonprofit organization to pair with, assuming their cultures are similar and they'll get along well. But those kinds of ideal mates aren't always available.

For-profit hospital companies, for their part, are looking at a national marketplace with plenty of opportunity—small com-

COMMUNITY GUIDANCE

To guide decision-making for Portneuf Medical Center's future, a citizens committee in December 2007 identified the following community values and priorities:

- **Commitment to physicians**
- **Local and regional strength**
- **Clinical excellence**
- **Commitment to future capital investment in Pocatello**
- **Public and not-for-profit hospital characteristics**
- **Access regardless of ability to pay**
- **Community care beyond Portneuf's facilities**
- **Commitment to the community**
- **Reporting community benefit**
- **Commitments to employees**
- **Governance and local control**
- **Experience**
- **Compliance**
- **Financial resources**

munity hospitals that are making money but could make more if better managed and that need a financial shot in the arm to get to the next level. Hospital boards need to understand the wide range of potential partners, and their cultures, before making a choice. For-profit companies can vary widely in the way they approach a deal and manage a hospital.

Joint Ventures a Growing Trend

Joint ventures between nonprofits and for-profit companies have been going on for years, particularly with individual lines of business, such as outpatient surgery centers. But now, more such pairings are focused on sharing the futures of entire hospitals, Baker says.

"In the past, the majority of not-for-profits wanted to be independent and the majority of for-profits wanted to own. Now we're seeing a blending of those markets in the middle," he says. "It's definitely a growing area because the for-profit side of the equation realizes they will have a very difficult time growing their business if they demand 100 percent ownership in every facility." Fewer nonprofits are selling out completely to for-profits. Those sales, he says, are often distressed hospitals that need complete turnarounds to survive.

While these partnerships can have their benefits for either side, the process to getting there can be challenging. As Larry Ghan says about the experience of introducing his community to the possibility of working with a for-profit entity: "It was like opening a door and seeing a big dark abyss and a lot of sharp things that could cut you pretty badly and some growly people."

To get through it, he suggests, you should have a good grasp on your hospital's finances and your community values. "Let the facts take you where you need to go," he says. **T**

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