The High Cost of Governance Dysfunction in Community Hospitals

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According to Tolstoy, "Happy families are all alike; every unhappy family is unhappy in its own way." However, if we compare the various entities that govern a community hospital to a dysfunctional family, our experience shows that unhappy families also share many similarities. In communities across the country, local newspapers cover disputes between county governments, hospital districts that may own the hospital's assets and operations, and the 501(c)(3) hospital boards that lease these properties. These stories read like a soap opera script with tales of malfeasance (founded or not), broken promises, and misbehavior abounding.

Once the relationship between a hospital board (lessee) and the county or district board (lessor) gets to the point of dysfunction, great damage has been inflicted on the hospital. In an adversarial atmosphere, physicians and staff are difficult to recruit and retain. Board and management time is consumed with responding to the latest charge and counter charge. Stated simply, attention and resources shift from sustaining the mission and advancing the vision of the health care system to addressing squabbles and disagreements.

Many communities in which we've worked over the last decade have faced similar situations, and experience shows that unless the two sides can find a way to work together on a common vision for the local health system, *all sides lose.* This article focuses on the lessons learned and strategies for stakeholders to move beyond disputes and toward a shared vision for high-quality, local health care services.

No matter how bitter the situation, stakeholders usually agree that the local hospital and associated providers are critical community assets that deliver essential health services to area residents. Despite this shared concern, the root causes of dysfunction are not hard to detect. These organizations are often subject to multiple levels of oversight and struggle with blurred lines of authority and review between the county or district and the hospital board. The complex governing arrangements are often artifacts of history that date back to the founding of the hospital. Sometimes the dispute between lessor and lessee begins with deteriorating operating results, an adverse outcome, or the termination of the contract of a popular but disruptive provider.

Based on our work in communities where relationships between the county/district and the hospital board are difficult, we have learned that certain triggering events can drive a complex governing arrangement to the point of dysfunction.

» Eroding Operating Performance. Community hospitals are uniquely challenged in the present operating environment, given the unfolding disruption in reimbursement methodologies, innovative health care technology, federal health policy, and shifting demographics. Not surprisingly, Wall Street credit rating agencies have cited these and other factors when providing the nonprofit hospital industry with a "negative" outlook in 2018 rating guidance.

For community hospitals, declining operating performance is front-page news. Given the leading economic role these organizations frequently play in their communities, a hospital's declining operating performance is a topic of broad public interest and concern. Residents and stakeholders fear the impact of potential hospital layoffs, reduced services, and deferred investment, and these fears quickly become the subject of local political campaigns. As is common in political discourse, the finer points of legal authority, lease terms, industry trends, and organizational constraints get lost or distorted, and stakeholders and the public are quick to assign blame. The blame game fails to provide insight and deeply undermines the public confidence in the hospital and those charged with its stewardship.

» Heightened Risks. Dysfunctional inter-entity relationships can explode into public view when the underlying operating risks and performance of the hospital change. Many counties and districts have grown apprehensive given the rash of hospital closings, increased stress on operating performance, difficulty recruiting needed providers, and the mounting cost of needed and deferred investment in hospital facilities, equipment, and technology (see Figure 1).

Hospital and district/county boards must appreciate that a hospital's operating and strategic risk profile is dynamic. The direction and severity of risk is affected by industry, market, and organization-specific factors. Economies of scale, technology, regulatory complexity, provider shortages, demographics, and payment changes all contribute to an adverse set of risks. Many districts and counties are wary of these changes and their exposure to the associated risks, while many hospital boards resist questions and heightened interest from districts/counties that can feel like second guessing or meddling.

Hospital and county/district stakeholders must appreciate how the risk environment is changing and how these risk factors may affect the local hospital. A common fact base regarding these operating and strategic factors is essential to creating a shared vision for local health care delivery. We often recommend that hospital boards complete an annual organizational risk profile and examine the results over multiple years across key operating and strategic metrics (see Figure 2 on the next page).

Figure 1. Hospital Closures Since 2010

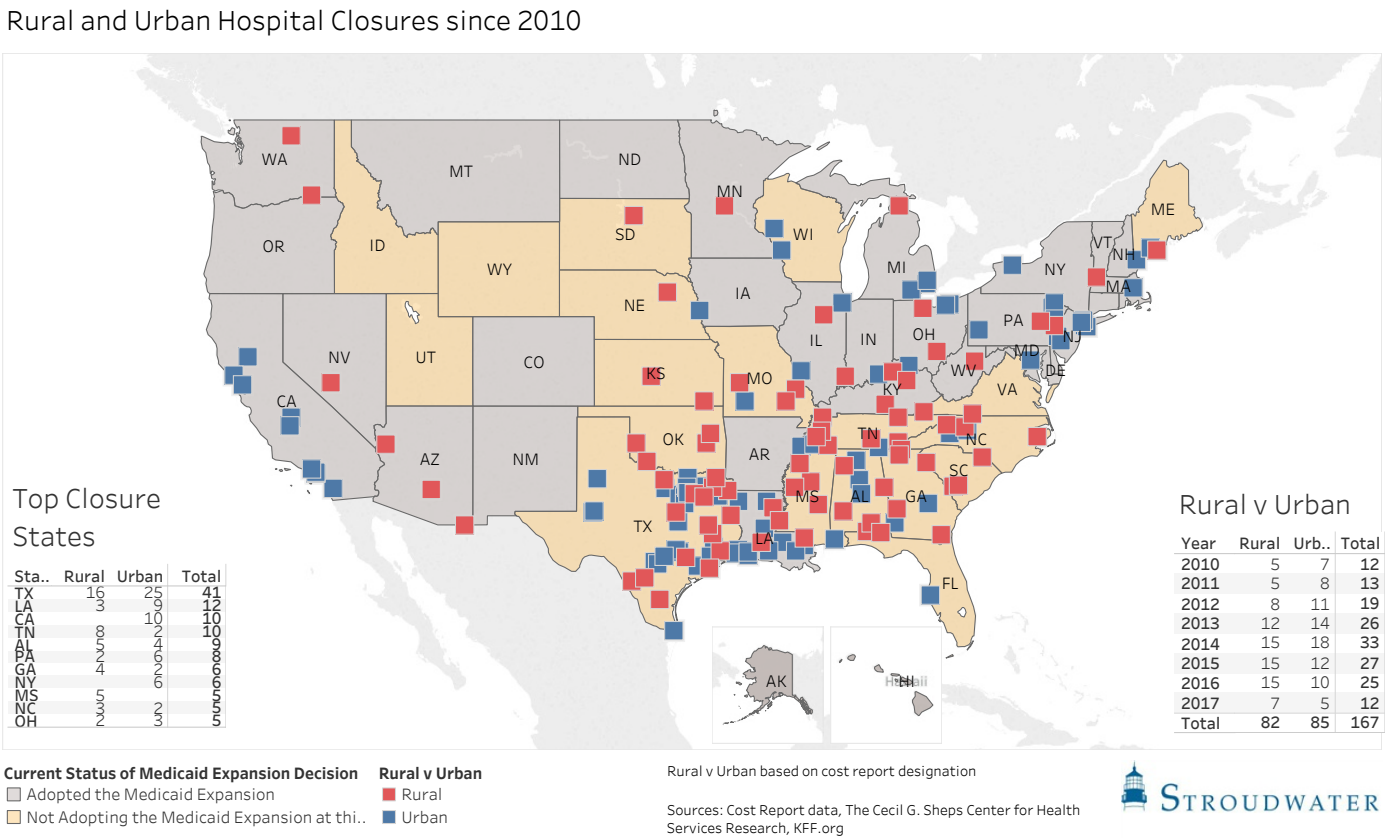


Figure 2. Monitoring Strategic and Operating Risks

Category	Indicators	Comments
Financial Performance	» Operating Revenue Trend » Operating Cash Flow & Cash Flow Margin » Days in A/R » Debt Service Coverage » Operating Margin » Days Cash on Hand	» Top line revenue growth is vital to long-term health of organization » Operating cash flow & cash flow margin critical for DSCR covenant and resources
Operating Trends	» FTEs per AOB » Case Mix Index » Payer Mix » Key Volume Trends (O/P and I/P) » Practice Operations, Production and Losses	» FTEs per AOB key efficiency metrics » Payer mix and CMI indicate how well the hospital is competing for sought-after patient populations
Value Indicators	» Medicare Cost Position » Attributed Covered Lives » Quality Scores	» Covered lives reflect key population health metric and move from fee-for-service
Market Position	» Market Share » Provider Alignment, Recruitment and Retention (vs. documented need, turnover, productivity)	» Market share is an indicator of how well the hospital is competing for patients and covered lives » Provider alignment is essential for attribution of covered lives

The county or hospital district and community may view the hospital as a growing financial liability for taxpayers. For a local government that assumes guarantor responsibility on a bond issuance or line of credit, the operational success of the hospital is suddenly an issue of political and practical importance.

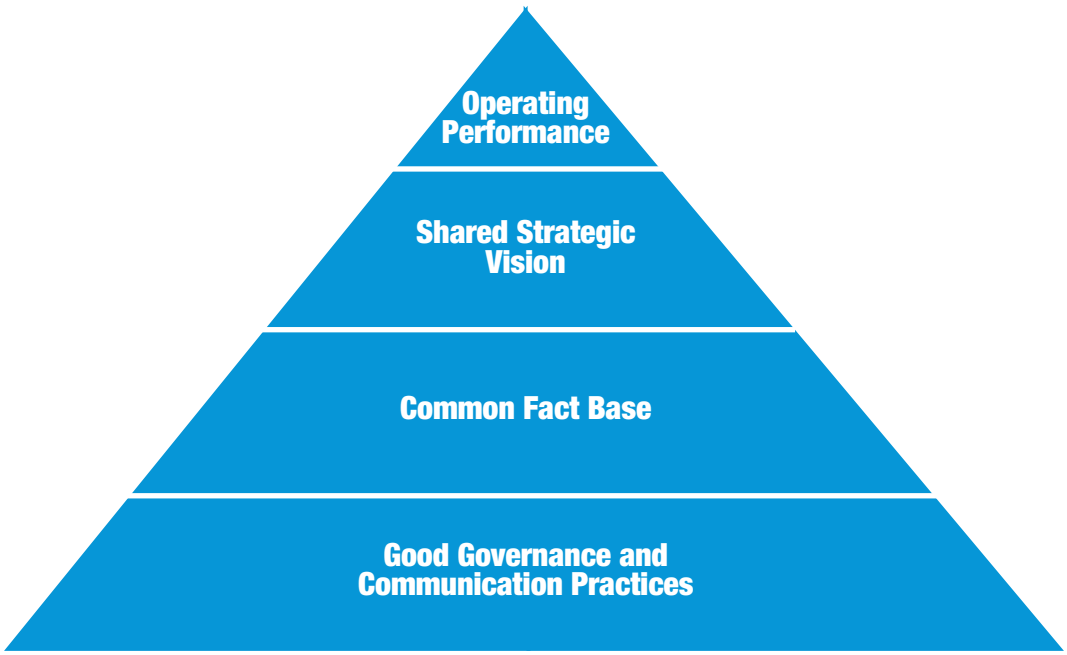
A local government's direct financial interest in the operating success of its community hospital quickly blurs the lines concerning the hospital's effective fiduciaries. In our experience, the bond or loan documents that describe the local government's financial liability may fail to provide adequate guidance regarding reporting requirements, accountability, or roles in addressing deteriorating operating performance that may put the hospital at risk. In the absence of clearly defined roles and responsibilities for each entity, the individual expectations of the parties govern. When these individual expectations misalign, conflict is inherent and dysfunction looms.

» Eroding Trust. Building and maintaining community trust in the hospital as an institution is critical to the success of any community hospital. For most 501(c)(3) hospitals, the organization must nurture the trust of the community and stakeholders, including providers, staff, and area employers. For county and district-owned hospitals, trust must also extend from the hospital board to either the country or district board. It is vital that district/county members and hospital boards develop constructive working relationships. If personal agendas become the board's agenda, good board candidates will decline to serve on the hospital board. A myopic focus on personal agendas can hamstring a board's ability to provide hospital management with the governance and oversight it needs to address urgent strategic priorities.

A lack of transparency, poor communication, personal agendas, and personality conflicts all undermine the trust needed for effective county/district and hospital board oversight functions. In some cases, local governance approaches must be updated to ensure that best practices regarding conflicts of interest, participation, confidentiality, and board renewal are adopted. Like the old adage about making and losing a reputation, trust in a hospital and its governance is built from decades of quality patient care and service but can be damaged significantly with one bad outcome or public and political rancor regarding stewardship of these vital assets.

Elements of a Successful Hospital Board and County/District Relationship

- For community hospitals, effective governance is essential to a hospital's long term success. Effective governance becomes even more critical when more than one board has a vested interest in the hospital's performance. In such circumstances, a community hospital's board and board leadership must learn to manage these multi-entity relationships and properly engage leadership from these stakeholder groups.
- Communication and trust among the parties are central to the success of these inter-entity relationships. Most often, the relationship between the county/district and the hospital board is under-developed or neglected and is now activated in a moment of crisis. Whether it is deteriorating operating performance or an unexpected need for financial assistance, county/district stakeholders are provoked to engage due to a crisis rather than as part of a proactive, strategic initiative. These critical relationships should be cultivated through a combination of joint executive sessions, regular and routine dialogue between board leadership and the leadership of the other entities, and special committees of the hospital board with outside stakeholders serving on those committees.
- Regardless of the process upon which a hospital board relies, it is critical that decision-making begin from an agreed set of facts and a shared vision for health care in the community. Developing agreed-to facts and a shared vision allows both the hospital board and other stakeholders to build their inter-entity relationship on a stable foundation and provides all involved stakeholders with direction and purpose.
- For many community hospitals, deteriorating operating performance is the source of tension between the hospital board and other entities. There is often great interest in and scrutiny of how the hospital board and management address the hospital's operating performance gap. It is critical that the performance improvement plan specify the performance gap, the specific initiatives that will close this gap, and an agreed-upon set of interim milestones and timeline for determining if the plan is on track. Frequent and routine updates with external stakeholders to share progress, milestones achieved, and difficulties encountered and overcome are essential to preserving trust and maintaining alignment among stakeholders.



Case Studies

Not all Fun in the Sun

In a large and growing southern state, Stroudwater was retained to work with a $250M health system and its local hospital district to develop a shared vision for the future of the local health care system. The foundation of this effort was the good working relationship between the new hospital district president and the hospital board president.

Stroudwater worked with both leaders to convene a small committee that included community, district, and hospital board members. The committee vetted and reviewed a common fact base of strategic market and operational data and findings. The members also explored alternative strategic options for the local delivery system. All of this work was done within the context of a highly dysfunctional relationship between the district and hospital. With effective leadership and a commitment to make a fact-based set of recommendations, members of the committee were able to put aside the history of distrust and develop a unanimous vision for the future of the local delivery system. This vision, which was adopted by both the hospital board and district board, ultimately brought the hospital into an affiliation agreement with a leading not-for-profit academic health system.

A Second Opinion Leads the Way

The two hospitals in this community had merged recently. The resulting combined entity had committed to the phased development of a consolidated replacement hospital facility. Bonds were issued and construction completed on the initial phase of the new campus. Unfortunately, just as the hospital began operating Phase I of its new campus (while continuing to operate its larger legacy campus), operations deteriorated. The county, which owned the hospital assets and leased those assets to a 501(c)(3), became concerned about the feasibility of the hospital's plan.

The hospital board was fiercely critical of this unwelcome oversight. The board decried the negative impact that such public scrutiny imposed on the hospital. The county, as steward of the public asset, felt obligated to examine the feasibility of the hospital's apparently stalled replacement project. Stroudwater was retained to conduct an analysis of the project's feasibility. Shortly before the Stroudwater report was shared with the county and hospital boards, the hospital's bond rating was downgraded two levels. The Stroudwater report raised significant concerns about the feasibility and timeline of the phased replacement project. These concerns were based on three factors: (1) the overcall cost of the project relative to the hospital's baseline cash flow; (2) the large, necessary investment in non-revenue-producing infrastructure comprising a large portion of the initial phases of the project that compromised the feasibility of subsequent phases; and (3) deteriorating operating results that limited the hospital's access to capital for subsequent phases of the project.

Based on the ratings downgrade and Stroudwater's analysis, the county and hospital board agreed to examine the hospital's strategic options and find the best path forward. As a result, the county, hospital, and a health system entered into a joint venture that ensured completion of the project and uninterrupted local access to essential health care services.

Loose Lips Sink the Strategic Ship: County and Hospital Authority Power Struggle in the Midwest

Stroudwater was retained to assist a community hospital in the Midwest to undertake an affiliation process. The $50-million-net-patient revenue organization was an authority-structured hospital with a board appointed by the local county government's elected officials. Before Stroudwater was retained, the county backed a significant bond issuance. This debt refinancing provided the authority with significant debt relief, shifting debt payment responsibilities from the authority (i.e., the hospital) to the county (i.e., county taxpayers). Any transaction of the hospital would provide the county with some level of debt relief.

Understandably, the county was keenly interested in the success of the affiliation process. Unfortunately, the long-standing personal relationships between individual county representatives and hospital authority board members made trust and effective communication between the two entities exceptionally challenging. Additionally, members of the hospital authority had grave concerns that confidential information concerning the affiliation process could not be shared with key county representatives without eroding the integrity of the process. This distrust between key leaders was further compounded with hardline negotiation tactics by the prospective buyer.

Suspected leaks of confidential deal information and the hospital's own declining operating performance led the prospective buyer to rescind its offer. Unfortunately for all local stakeholders, internal distrust, poor communication, and a loss of focus on the hospital's operations resulted in a lost opportunity to secure commitments to maintain the local delivery of health care services and address the county's need for debt defeasance.

Performance Improvement as a Prerequisite: Distressed Rural Community Hospital in Southeast

After receiving funds from the local county government as a part of a bond issuance, the board of directors of a community hospital in the Southeast with $40 million net patient revenue asked Stroudwater to assess its strategic options and identify performance improvement opportunities. The hospital was losing several hundred thousand dollars each month, had a negative EBIDA, and had cash reserves only sufficient to fund six months of operations at its then-current loss rate. Officials with the local county government provided the hospital board with a mandate to realize performance improvement and provide the hospital with a sustainable path forward.

Stroudwater's team undertook a strategic options and operational assessment. As part of this assessment, Stroudwater analyzed the hospital's operations and identified over $5 million in performance improvement opportunities. These performance improvement opportunities included both cash and revenue

enhancements through revenue cycle improvement, clinical efficiency designed to improve the hospital's length of stay and other quality-based reimbursements, and staffing efficiency. Given the hospital's limited management resources, Stroudwater also identified a specific leadership resource to oversee the implementation of the hospital's performance improvement plan.

Additionally, Stroudwater assisted the board in developing a set of strategic objectives. The board determined that these strategic objectives would best be realized via an affiliation with a larger health system. To support that affiliation process, the board immediately began necessary efforts to realize financial and operational performance improvement.

As part the engagement, Stroudwater presented its strategic options and operational assessment to the county government's leadership. This presentation provided the county with the assurance that necessary and corrective action was being taken and established a transparent and continuous open dialogue between the hospital's board leadership and county leadership. This dialogue aligned the county government with the hospital board's efforts to improve the hospital's operations through necessary performance improvement initiatives that supported the strategic direction established by the board.

The Need for Functional and Effective Governance

The health care industry's current period of disruption is contributing to tension and anxiety between county and hospital district lessors and their community hospital board lessees. Declining reimbursement and stagnant or increasing operating costs are exposing community hospitals to increasing levels of stress and distress. Out-of-date governance practices, poor communication, and fraught personal relationships can fan the flames of these challenges.

Navigating this difficult terrain necessitates key commitments from all involved stakeholders. Sound leadership and effective governance and communication are essential. Parties must be willing to engage one another in collaborative and constructive ways. In addition, stakeholders from the various entities must work from a common set of facts to arrive at a shared vision for the future of local health care delivery. It is this shared vision that provides the basis for a consensus on how best to address the challenges that confront the local health care system.

The challenges facing community hospitals in the present environment are significant. These challenges require hospital boards to focus on the specific issues facing their organizations and increasingly require collaboration and assistance from district and county governments. While this assistance may carry issues of broad public or political interest, all stakeholders can and should find alignment on the primary strategic objective: preserving and enhancing access to quality health care services in their community. ◆

Endnote

1 *See* Ayla Ellison, *Fitch Issues Negative Outlook for Nonprofit Hospitals*, Becker's Hospital Review (Dec. 16 2017), *available at* https://www.beckershospitalreview.com/finance/fitch-issues-negative-outlook-for-nonprofit-hospitals-4-things-to-know.html; *see also Ellison Moody's: Outlook is Negative for Nonprofit Hospital Sector*, Becker's Hospital Review (Dec. 4 2017), *available at* https://www.beckershospitalreview.com/finance/moody-s-outlook-is-negative-for-nonprofit-hospital-sector.html.