AHA Events

35TH ANNUAL AHA RURAL HEALTH CARE | LEADERSHIP CONFERENCE

Independence or Merger: A Board's Most Difficult Decision

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February 8, 2022

Session Learning Objectives

- Identify and understand the criteria for assessing whether a hospital is capable of remaining independent financially and operationally.
- Demonstrate how and why a board should be open to an objective, quantifiable, evidence-based analysis of potential options available to the hospital, and an associated timeline tied to a financial forecast.
- Demonstrate how an objective assessment of partnership options fulfills the board's fiduciary duty to the organization regardless of the emotional impact of considering these scenarios.
- Understand the process, variables and data modeling essential to provide sufficient information for a board to make an informed and defensible decision about independence and alignment options and strategies.
- Show how a hospital will be in a better position to know what benefits they would receive from a partnership, as well as what benefits they would provide to a potential partner to use in a negotiation process.

Hierarchy of Strategic Sustainability: Where Are We?

Indispensable

Is our organization essential and integral to the communities we serve?

Relevant

Is our organization differentiated and impactful to community stakeholders?

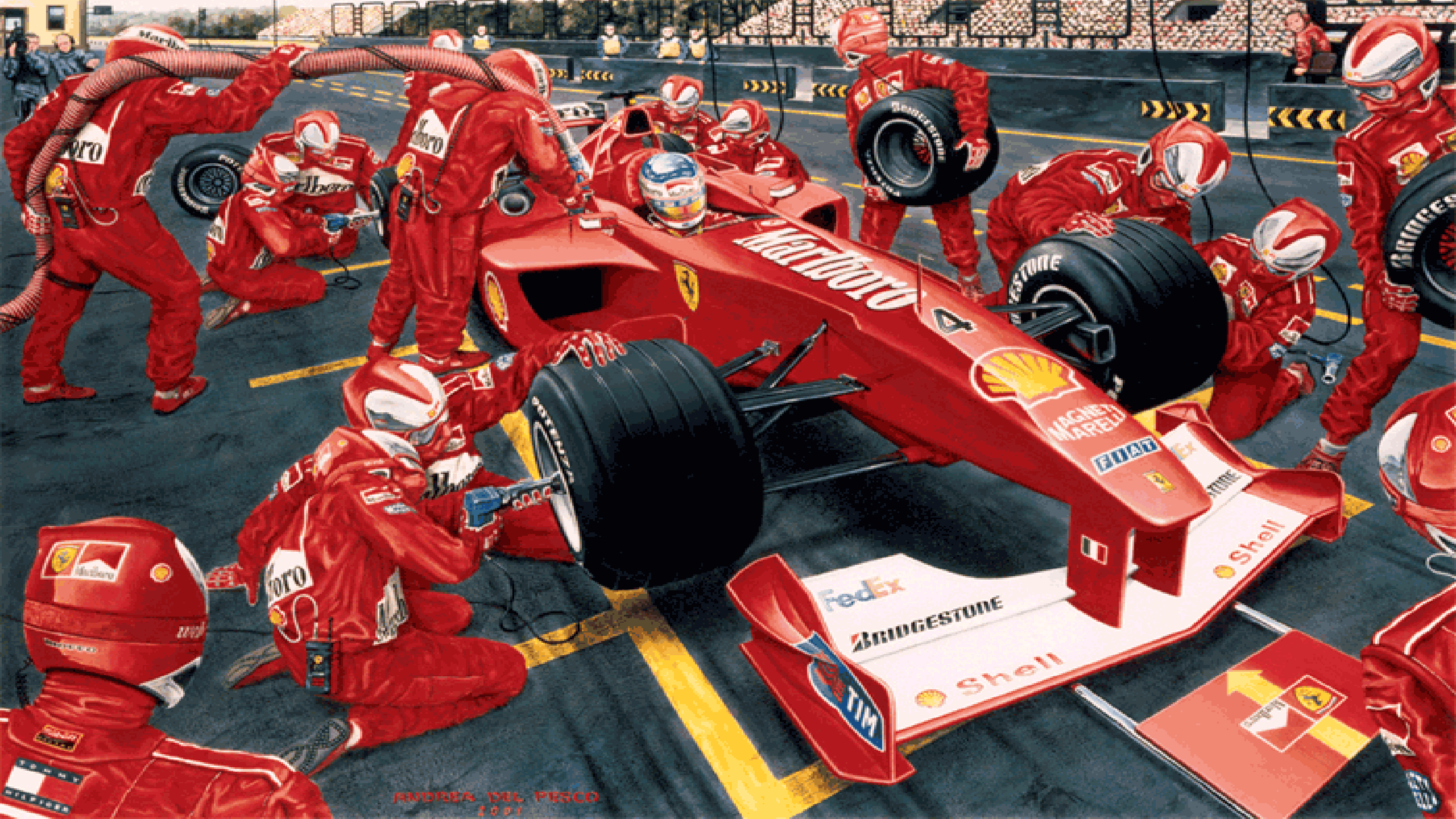
Independent

Is our organization sustainable on its own without the support of a larger system?

Survivor

Can our organization continue to fulfill its mission?

Source: Baptist Health Care (Pensacola, FL)


Marlboro
FedEx
BRIDGESTONE
Shell
TIM
ANDREA DEL PESCO
2001

Established (Washington)

1897

City Hospital& Washington Hospital Merger

1905

Bonar Ave. Facility Opened - Greene

1921

Community Outreach & Outpatient Expansion

1927

1938

1940-1999

2000 - Present

Established (Greene)

Wilson Ave. Facility Opened - Washington

Multiple expansions over the years


WASHINGTON HEALTH SYSTEM
OUR STRATEGIC JOURNEY
VISION
LOCALLY GOVERNED LEADER in HEALTH CARE QUALITY, SAFETY and VALUE.
MISSION: GREAT PATIENT CARE!
PFCC
TEAM
EFFECTIVENESS
SYSTEMS
QUALITY
WPS
GROWTH
INDEPENDENCE
INNOVATION
OUR VALUES
CONTINUOUS IMPROVEMENT
COMPASSION
INTEGRITY
PATIENT AND FAMILY FOCUS
COMMUNITY COMMITMENT
COMMUNICATION
RESPECT
Illustrated by Karina Branson - ConverSketch.com

About WHS: What Kind of Organization?

- **Non-profit**
- **Voluntary Board of Directors**
  - 12 to 18 members
  - Term limits: Three, 4-year terms

About WHS: Who We Are

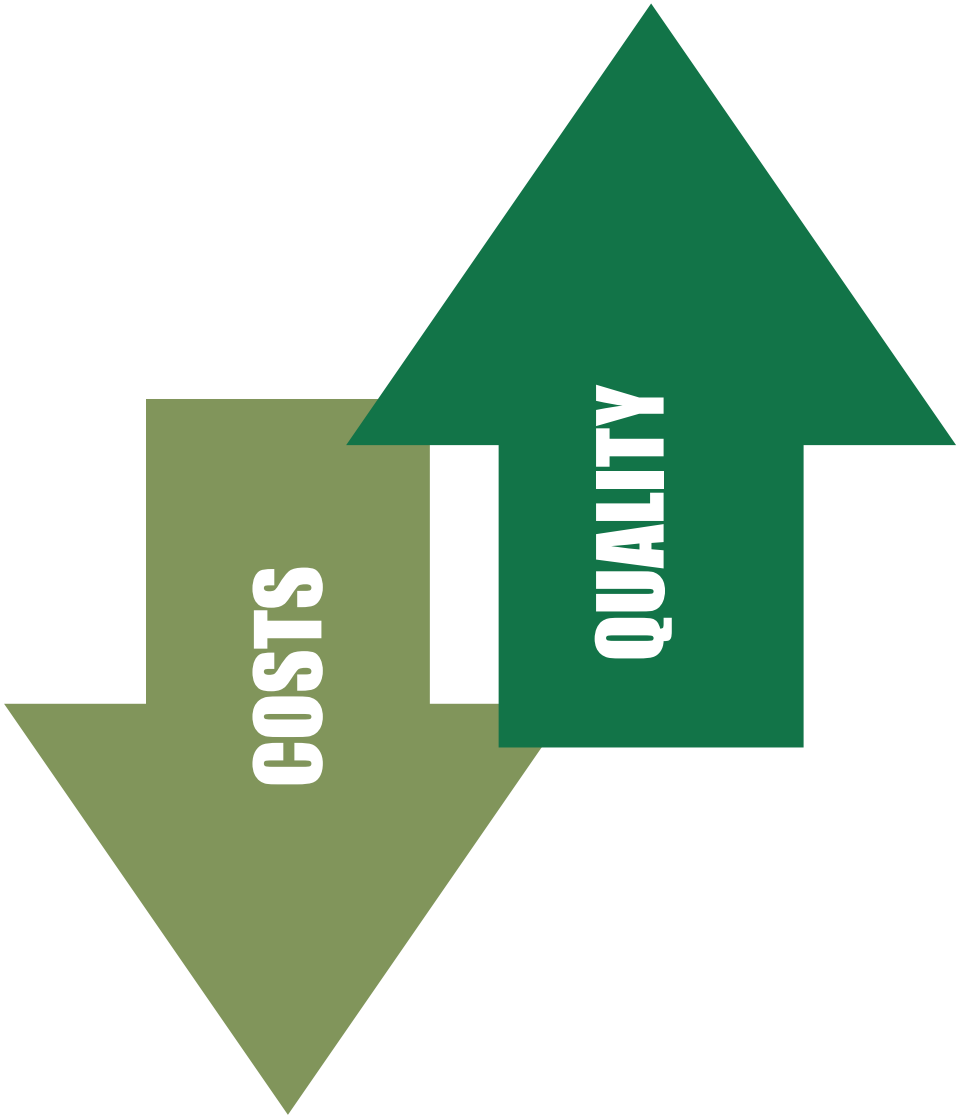
Largest Employer in Washington County, PA

- **WHS team members - 2,300**
  - Washington Hospital - 1,725
  - WHS Greene - 235
  - WPG - 265
  - Greenbriar - 175
- **Medical Staff - 300+**
  - 120+ employed
- **Volunteers - 300+**

About WHS: How Are We Different?

- What we think (“large community health system” vs reality)
- Clinical Sophistication
- Teaching Hospital

Our Health Care World: Major Trends



Our Health Care World: Region

HCWP Survey FY 2021

Admissions

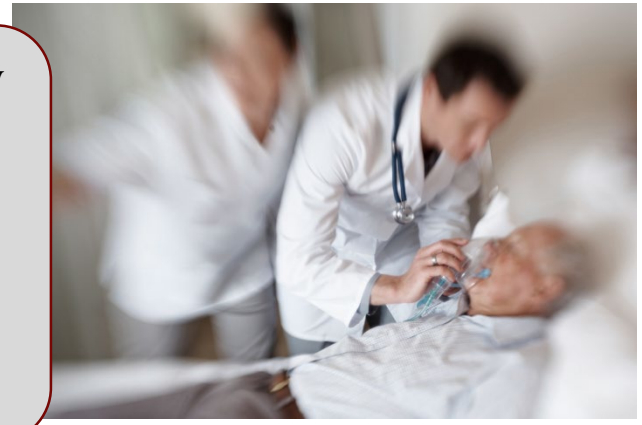
↓

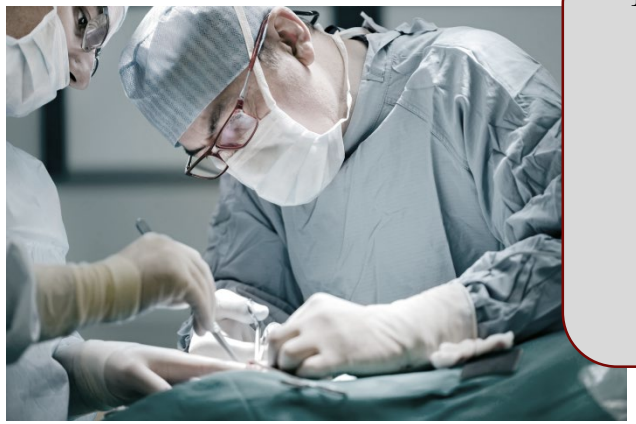
-2.55%

Emergency Visits

↓

-9.12%





Inpatient Surgery

↓

-0.05%

Outpatient Surgery

↑

5.77%

Hospital closures and acquisitions

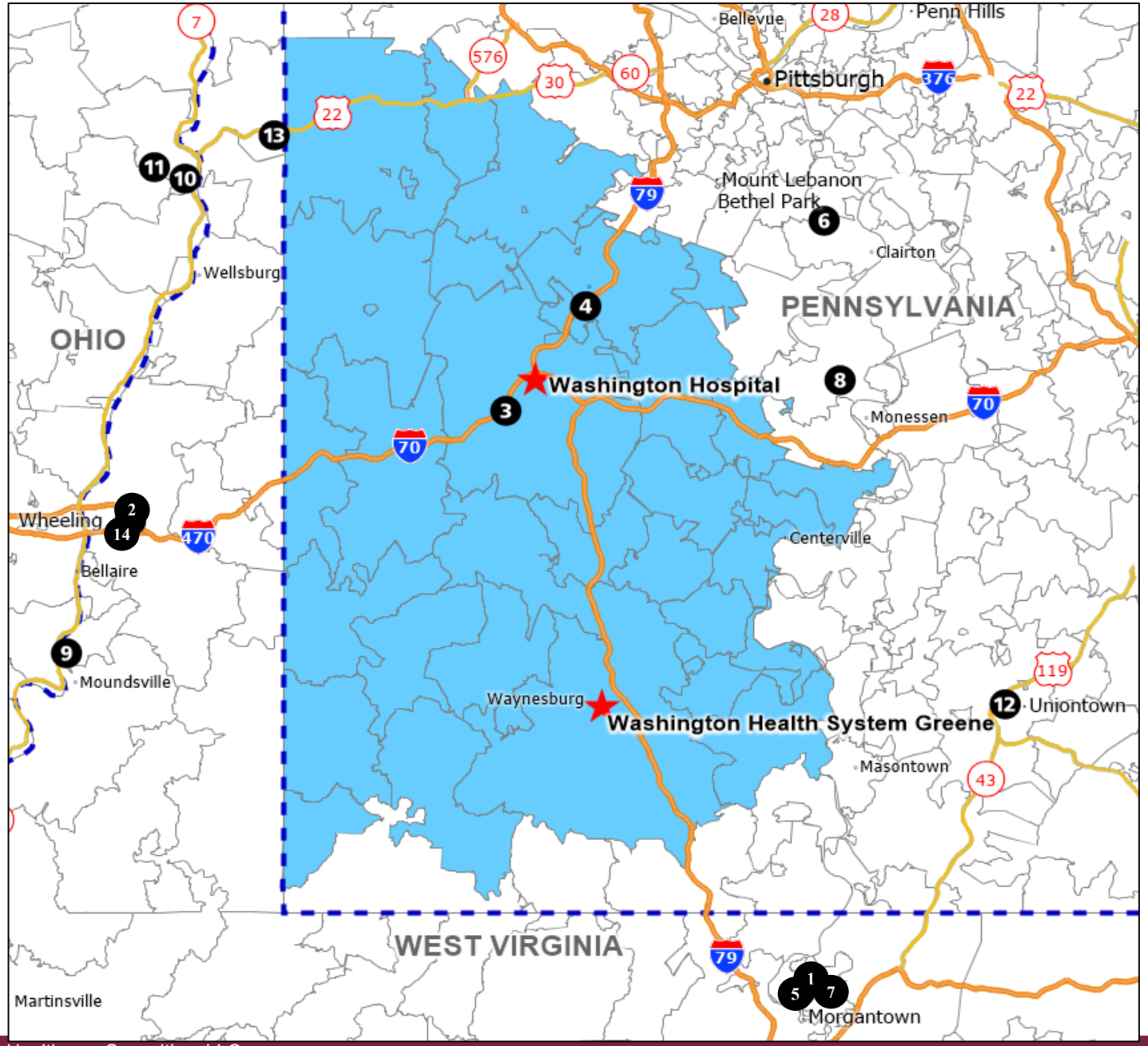
- **"More than 800 rural hospital are at immediate or high risk of closure in the near future."**

  (Center for Healthcare Quality and Payment Reform, January 2021)

- **"42 hospitals closed, filed for bankruptcy this year."**

  (Becker's CFO Report, January 23, 2020)

Washington Health System Service Area



MAP LEGEND

- Washington Health Hospitals
- State
- ZIP Code Boundary
- Service Area

Area Hospitals

1. Acuity Specialty Hospital of Morgantown
2. Acuity Specialty Hospital of Ohio Valley - Wheeling Campus
3. Advanced Surgical Hospital (Surgical Care Affiliates)
4. Canonsburg Hospital (Allegheny Health Network)
5. JW Ruby Memorial Hospital (WVU Medicine)
6. Jefferson Hospital (Allegheny Health Network)
7. Mon Health Medical Center
8. Monongahela Valley Hospital
9. Reynolds Memorial Hospital (WVU Medicine)
10. Trinity Medical Center East
11. Trinity Medical Center West
12. Uniontown Hospital (WVU Medicine)
13. Weirton Medical Center
14. Wheeling Hospital (WVU Medicine)

0 10 20 30

Miles

Source: Washington Health System, Definitive Healthcare, Maptitude

Local Market

- UPMC
- Highmark / AHN
- WVU Medicine
- Penn Highlands – Mon Valley Hospital
- East Ohio Hospital (re-opened 70 beds / 46 BHU beds to come)
- Bridges:
  - St. Clair Hospital
  - Butler Health System
  - Heritage Valley Health System
  - Excela Health System
  - Washington Health System


CRISIS
OPPORTUNITY

Board Actions

- Engaged a consultant
- Formed Steering Committee
- Set Guiding Principles
- Set a timeline with defined deliverables
- Identified and implemented a specific process

Committee's Guiding Principles

To select a vision that sets up the organization for high quality local health care that is financially sustainable

- We owe it to our community to make the right and tough decisions now
- Remember that the best model might not include the name "WHS" or the current individuals


PERONI
LIBERA
0.0%
BOMBARDIER
JCB
5
crypto.com
Sentinel One
BWT
Cognizant
JCB
EPOS
ASTON MARTIN

New Core Competencies Required: WHS Priorities

Key Evaluation Criteria

1. Finance	Increased attractiveness to capital markets and purchasers of healthcare services through revenue growth, sustained operations, balance sheet strength, and risk management capabilities
2. Physician Alignment	Clinical and economic alignment with physicians that incentivizes cost reduction, quality improvement, and financial sustainability
3. Information Technology	The ability to collect and utilize clinical and business data for advanced analytics to inform clinical, strategic, operational, and financial decision-making
4. Clinical Program Alignment	A comprehensive healthcare delivery network (hospitals, physicians, ambulatory, and post-acute) ensuring real-time access to high performing provider organizations with superior quality and competitive cost
5. Care Management	Use of care management and care coordination tools and processes by a clinically integrated provider workforce to ensure seamless transitions of quality and cost-effective care within the WHS provider network
6. Leadership and Governance	A deep bench of physician, clinical, administrative, and Board leadership to drive the WHS's mission, vision, strategy, and operations within a culture that promotes intra-organizational collaboration and value-based care
7. Quality and Safety	Superior quality and cost-effective care with reporting and tracking capabilities to optimize health as evidenced by outcomes and patient experience, that includes the development of consumer relationships and patient engagement
8. Operations	An efficient organizational approach that exhibits continuous operational improvement highlighted by competitive performance across KPIs compared to national, regional, and peer group benchmarks

Washington's Core Competencies Will Need to Evolve With the Market

Where Do We Think WHS Stands?

Washington's Readiness Position Summary – Sample

Leadership and Governance

- Limited set of engaged formal and informal physician leaders contributing to the organizational strategic and operational imperatives
- Some skill-set gaps related to value-based competencies outlined and defined in this assessment
- Competent leadership has been able to maintain overall market and financial position in a competitive landscape surrounded by large IDNs
- Engaged and dedicated organizational governance

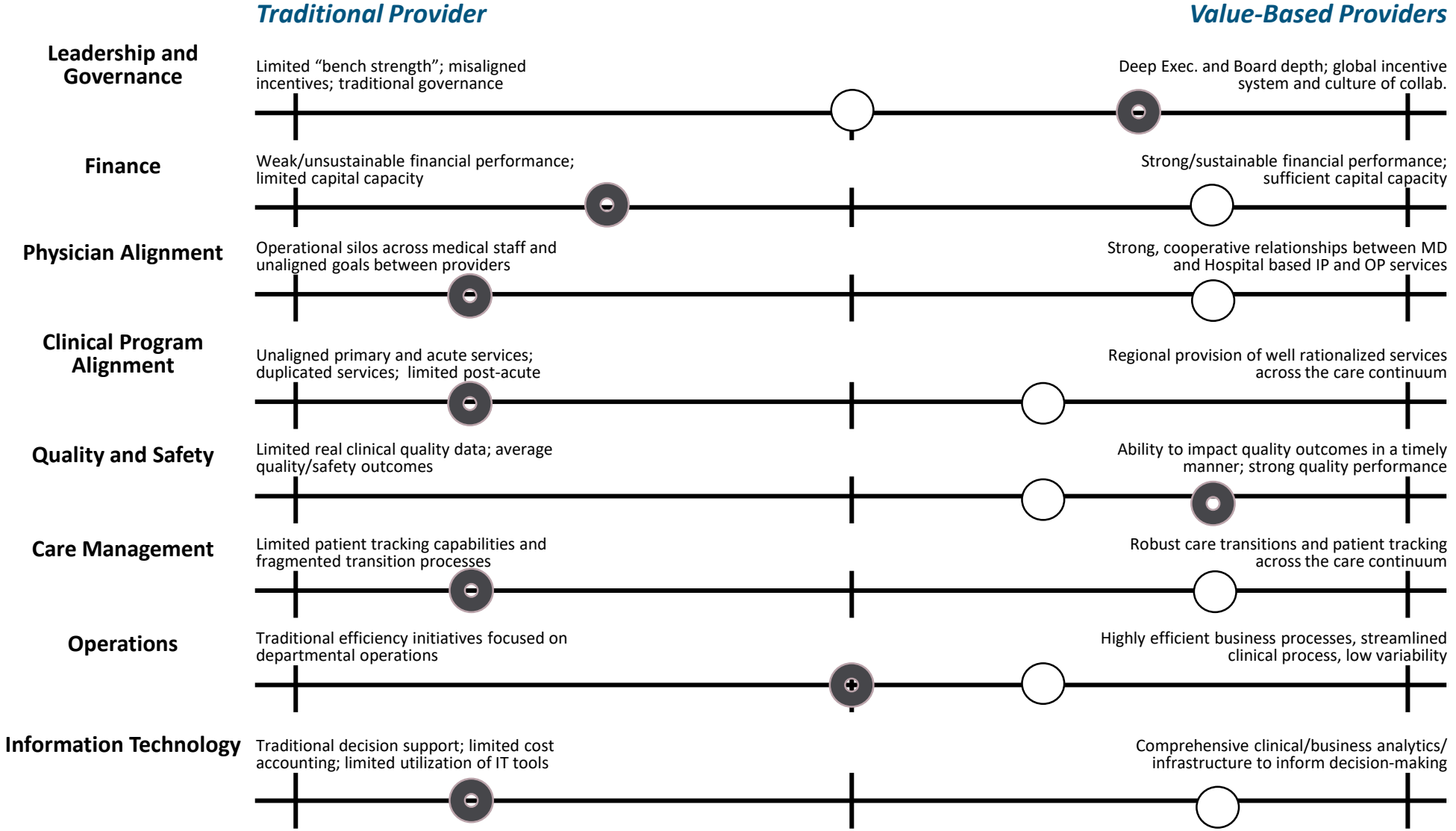
Finance

- Inability to quantify and monitor total cost of care and define value proposition to major payers
- Limited success in value-based contracting
- Weak operating EBIDA margins
- Solid investment grade credit rating
- Participation in the Rural Health Model demonstration program gives WHS experience in managing finances from a global budget perspective
- Currently has direct-to-employer contract in place with Alliance Coal Company

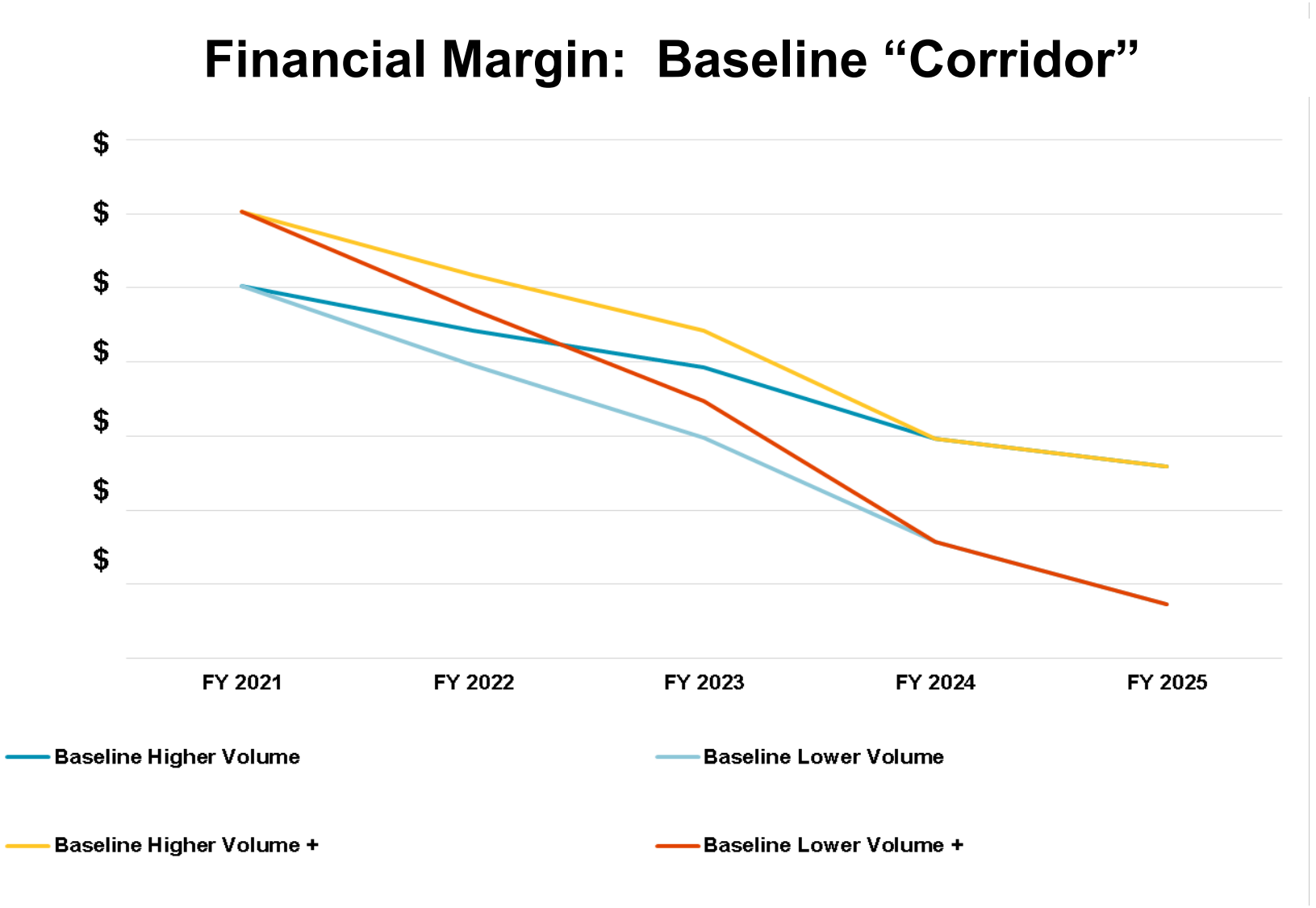
Traditional Characteristic	Neutral/Notable Characteristic	Value-Based Characteristic
Limited	**How far can we move the needle (without a partner) over the next 3-5 years?**	**Moderate**

Washington's Value-Based Care Readiness Position

Washington vs. Greater Pittsburgh Market Leader(s)



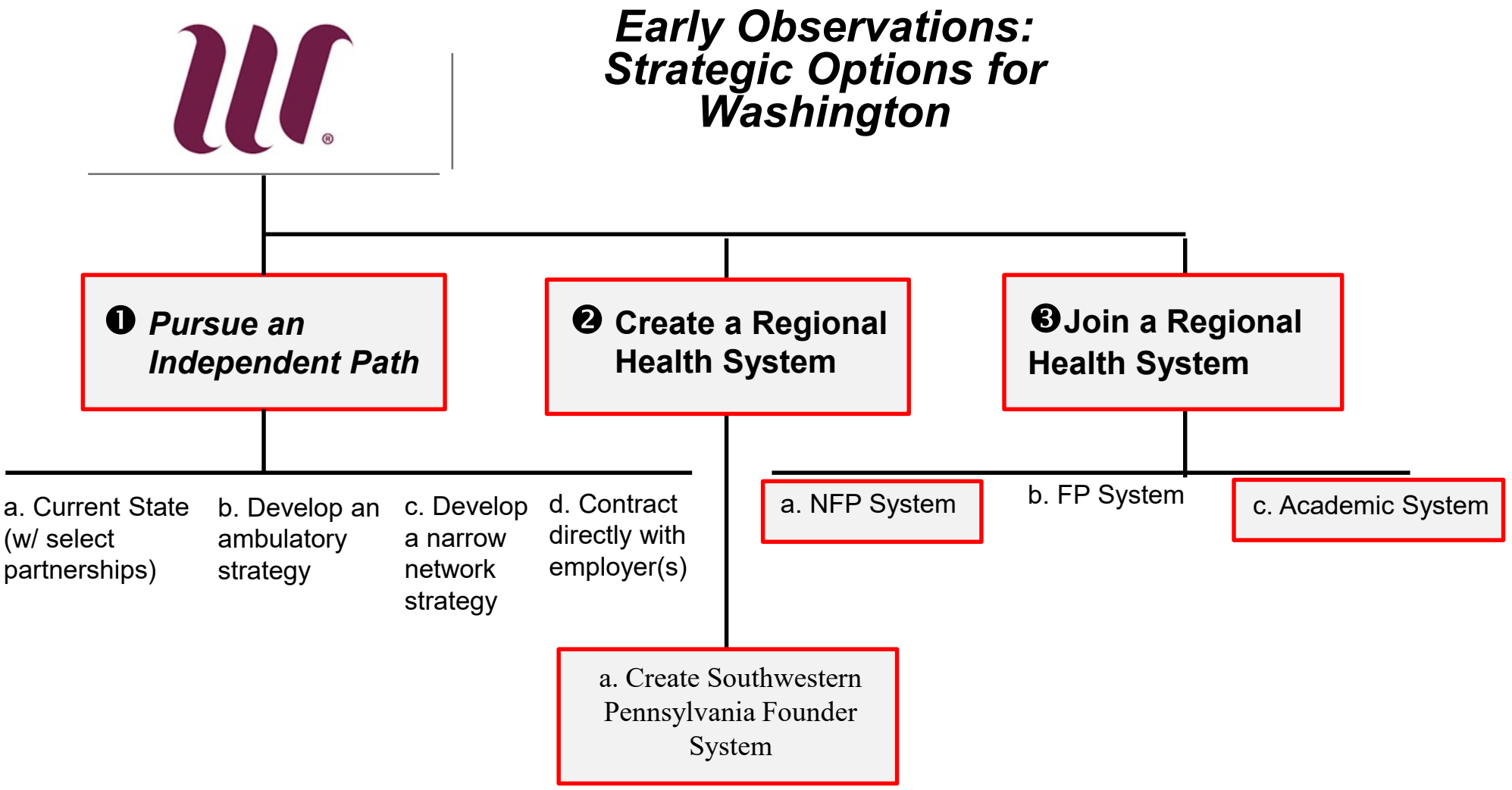
Baseline Financial “Corridors”



It All Starts with Organizational Objectives

- **Key objectives used to evaluate WHS's options:**
  - **Test A**: Does the potential option provide Washington with access to capital and the ability to enhance the organization's regional market essentiality with payers and purchasers of healthcare?
  - **Test B**: Does the option provide access to a physician infrastructure that will support Washington's care management and clinical objectives and incentivizes cost reduction, quality improvement, and financial sustainability?
  - **Test C**: Will the option provide Washington with an advanced business intelligence platform with robust clinical, strategic, operational, and financial analytics?
  - **Test D**: Will the option position Washington as a preferred acute provider as part of a broader integrated healthcare delivery network with real-time access to high-performing provider organizations across the continuum of care?
  - **Test E**: Does the option provide Washington with a clinically integrated provider workforce with care coordination and care management tools to ensure seamless transitions of care?

WHS's Universe of Potential Strategic Options Based on These Objectives



Three Potential Options

Option 1: Remain Independent (Financial Implications)

Option 2: Create "Southwestern Pennsylvania Founder System" (Opportunities and Implications)

Option 3: Partner with a Non-Profit Academic Health System

Option 1 – Independence: Findings/Conclusions

1. WHS outperforms the market in terms of inpatient market share, operating margins continue to be razor thin with limited cost reduction opportunities.

2. The COVID-19 pandemic and encroachment from regional competitors may challenge WHS's ability to sustain the current level of volumes and operating margins and jeopardizes its ability to continue to carry out its mission as an independent community provider over the near-future.

3. WHS may not exhibit significant value-based core competencies consistent with major market integrated delivery networks ("IDNs").

4. If WHS continues its current trajectory (with or without corporate restructuring), the organization may be challenged to generate the capital capacity necessary to support long-term strategic investments for key priorities (e.g., physician alignment, IT, clinical program alignment, and care management).

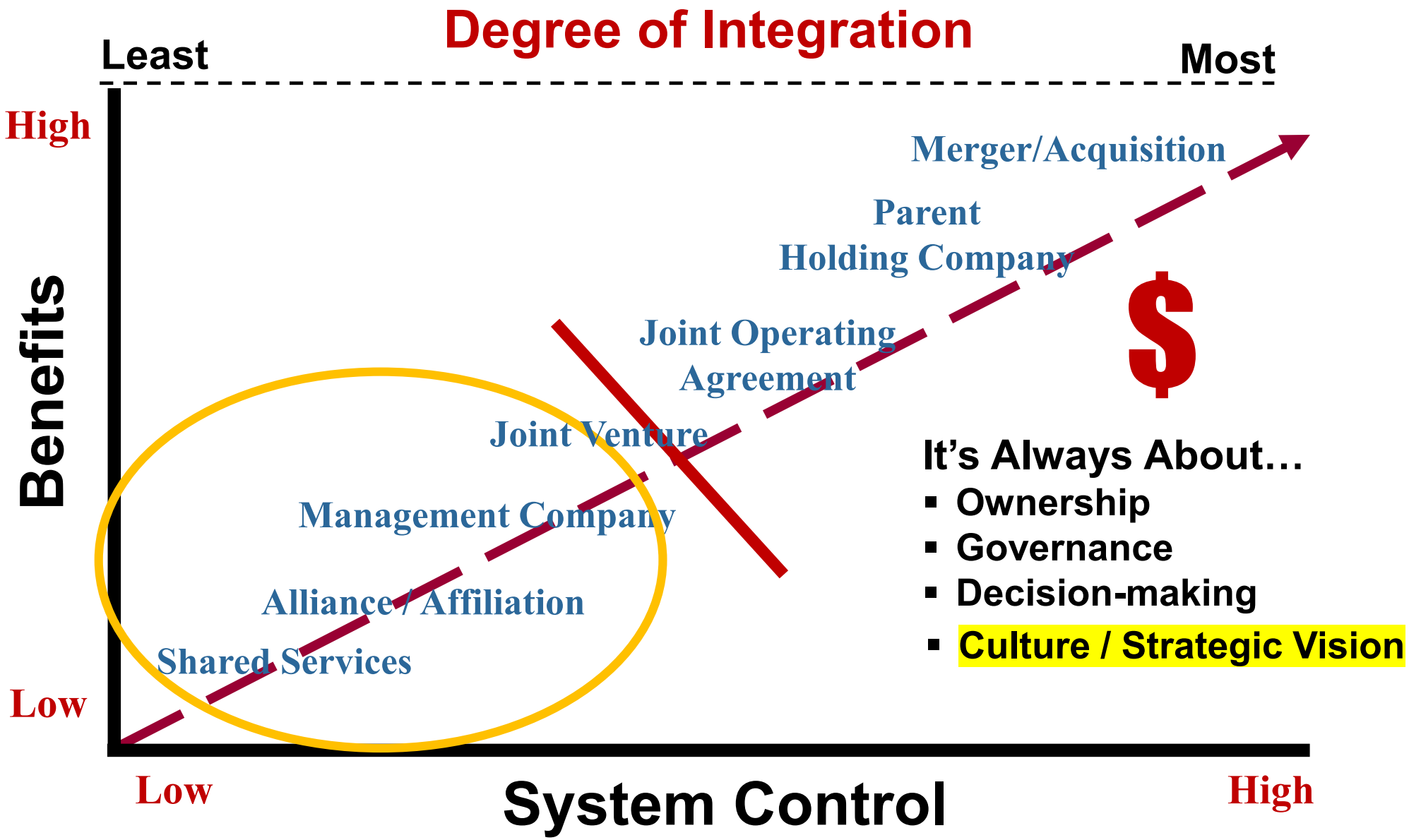
(continued next page…)

Option 1: Independence (continued)

5. WHS is at an inflection point in the organization's history:
   - Large-scale competitor organizations have the value-based care infrastructure (e.g., provider-owned health plans) and capital to encroach upon WHS's attractive service area and steer patients away.
   - WHS is currently not a meaningful player (or essential participant) in the management of population health.
   - The value of acute care hospitals may have already reached its apex.
   - The "essentiality" of acute care services threatens to diminish over time as inpatient volumes continue to decline at the expense of outpatient business.

6. The present organizational state may not fulfill WHS's strategic and financial imperatives. WHS needs to act on this inflection point by identifying a set of strategies in partnership with another provider(s) that will reposition the organization for success in a value-based care environment.

Degrees of Partnership

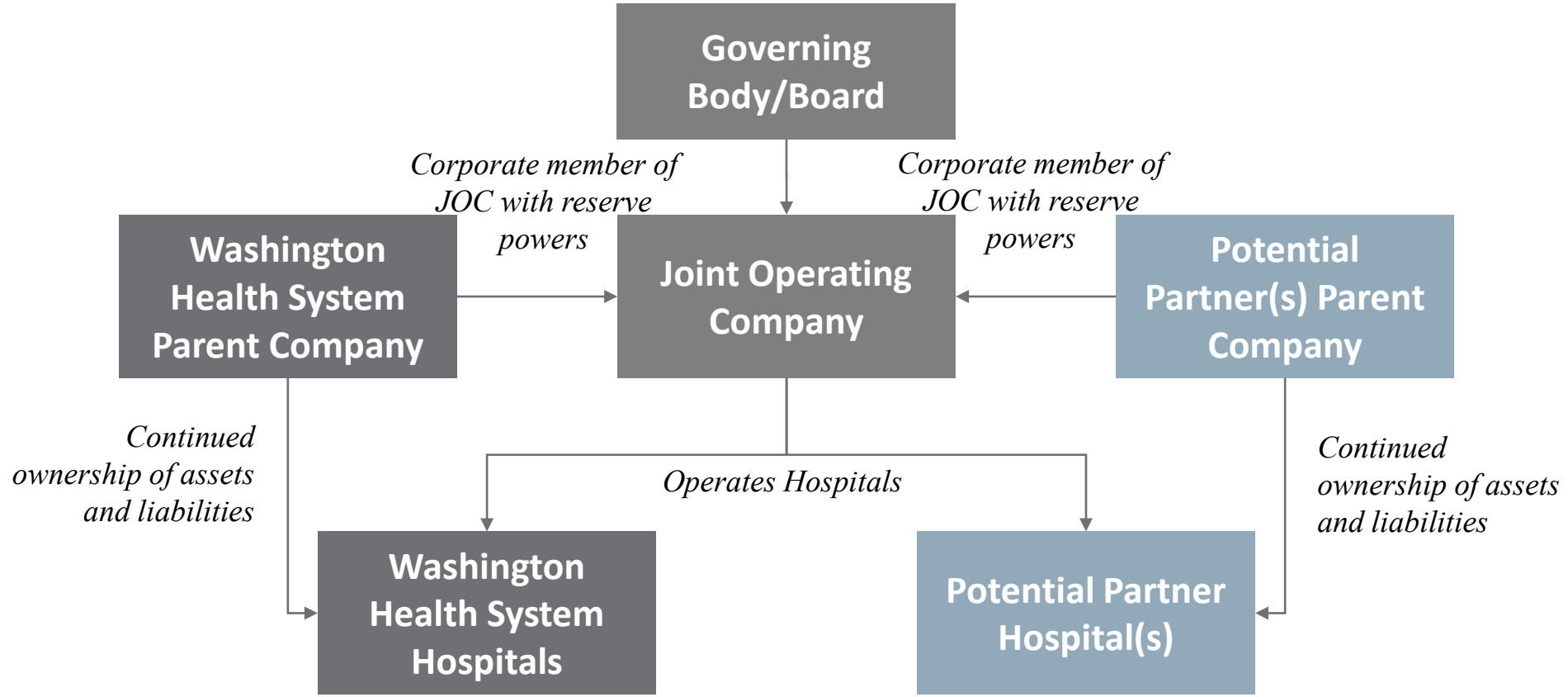


It's Always About…

- Ownership
- Governance
- Decision-making
- Culture / Strategic Vision

How The System Can Be Structured

- A joint operating agreement ("JOA") establishes a board which governs the relationship and management of a joint operating company ("JOC") in which all parties retain control and ownership of their respective assets but cede operational control to a joint entity.
- This model could provide the parties with significant alignment through joint governance and shared economics.



Joint Operating Agreement – Key Characteristics

- **A JOC involving WHS and potential partner(s) would likely include the following characteristics:**
  - The parties appoint representatives to the JOC's board
  - The JOC manages the operations of the facilities
  - Each hospital retains legal ownership of the respective assets and liabilities
  - A single executive leadership team will be established that manages centralized services and operations across divisions
  - The JOC will follow a combined strategic plan and budget, with major operational and clinical decisions being made for the JOA parties by the JOA's management team
  - Existing human capital resources would be employed by JOC
  - No change to medical staff relationships
  - Typical JOC operations include: finance and revenue cycle management; capital planning; payer contracting; clinical services configuration; quality; strategic planning; legal; risk management; human resources; IT; GPO

Potential consolidation savings opportunity is estimated to be $5.5M to $8.0M

Joint Operating Agreement – Key Considerations

- Enables operations of each hospital under single management and governance structure
- Major contractual terms would need to be agreed upon, including:
  - Scope of JOC services and subsidiaries included
  - Term of the JOA and renewal terms
  - Financial implications
    - Sharing (P&L, distributions vs. retained capital)
    - Single vs. multiple credit
  - Deadlock and disputes
  - Unwind provisions and terminating events
  - Procedures for wrapping-up the JOC at the end of the JOA term
  - Geographies served

Findings/Conclusions

1. The difficulty of partnership execution increases exponentially with each additional party; while multiparty partnerships are not impossible, the execution risk is high:
   - Competing cultures, community politics, and physician alignment dynamics compound the difficulty for Washington.
   - Agreement will need to be reached on critical issues such as governance, asset integration, physician alignment, and service rationalization.

Even if successful, this may not have sufficient position to serve as the "end game" given the lack of key competencies exhibited by potential hospital partners.

Potential Partners in a Forming a New Health System

Key Operational Indicators – FY 2019	System A	System B	System C	System D	System E
Number of Hospitals	2	3	1	3	3
Inpatient Discharges	13,263	24,286	14,445	17,751	10,671
ALOS	4.7	4.1	4.0	4.4	3.8
Staffed Beds	323	401	303	397	284
Bed Occupancy Rate	50.6%	67.5%	49.1%	51.0%	36.6%
Outpatient Visits	408,483	509,588	198,633	415,215	201,843
Key Financial Metrics – FY 2019					
NPSR	$323.3M	$447.8M	$308.1M	$401.2M	$359.8M
Operating Margin	3.6%	3.9%	8.7%	(10.6%)	(1.1%)
Days Cash on Hand	60.9	1.1	37.9	2.9	23.4
Debt to Cap Ratio	0.37	0.47	0.26	0.28	0.47
Debt to Equity Ratio	0.58	0.89	0.36	0.40	0.89

Source: Definitive Healthcare, www.defhc.com

Non-Profit Academic Health System – Benefits and Drawbacks

Potential Benefits	Potential Drawbacks
+ Additional access to capital + Economies of scale and purchasing power + Leverage infrastructure (e.g., IT, purchasing, etc.) to enhance capabilities + Elimination of duplicative services (clinical and non-clinical) + Better positioned for population health management with owned or contracted assets across the continuum	- Shared governance and leadership - Limited power and decision-making ability - Change of identity/brand to key community stakeholders - Change of organizational culture

Findings/Conclusions

1. After thorough evaluation of the options, it is recommended that WHS pursue a partnership with a nonprofit health system at this time (including academics).

2. This recommendation reflects WHS's objectives and strategic requirements, along with the competitive and market dynamics facing Southwestern Pennsylvania hospital providers.

3. It will be vital that WHS seek a partnership in a timely manner while operating from a position of strength – a position that will allow Washington to have significant influence in determining its future role in the community at large.

4. It is recommended that WHS develop a structured and controlled partnership process with the expectation that a predetermined number of potential partners will be solicited.

What happened:

- Elevated level of comprehension (robust discussions!)
- Board split evenly
- Triggers and thresholds to monitor regularly
- Current State – the process from here

Lessons Learned

Board management:

- Pull towards status quo
- Fear of losing authority, independence, “control”
- Board member Conflict of Interest
- Consultant bias
- Personal businesses vs. health system

Executive Team management:

- Potential to lose my job?
- Do I want to be labeled a “Loser”?

Anxiety management!

Essential Board Discussions

Can We Remain Independent?

Should We Remain Independent?

Be willing to have *ongoing* robust board discussions about affiliations, alliances, partnerships, regional networks

(Process vs. Event)

"You can remain independent, but you shouldn't do it alone."

– Jack Hill, COO, Union Health, Terre Haute, IN (August 2019)

Where to Begin: Essential Strategic Questions

- **What is our current and projected financial position?**
  - **Debt capacity**
  - **Capital needs (5+ years)**
    - ***Very difficult to fund short- and long-term strategic investments and capital requirements from operating cash flow and/or cash reserves***
  - **Key financial indicators: Revenue/expense projections, payer mix shifts, volume estimates, inpatient/outpatient, breakeven level (expressed as inpatient census), others**
- **What current (and future potential) market shifts and industry trends will impact our sustainability?**
  - **Scenario analysis and discussions (explore *"What ifs…"*)**

Where to Begin: Essential Strategic Questions

- What are our goals/needs (considering Mission)?
- Can we do this ourselves?
- What criteria will we use to assess potential options?
- What are the pros/cons of the options? (Gain/Give up?)
- What resources do we bring to the table?

Should we be the integrator or the "integratee?"

Financial Benchmarks for Hospitals (sample)

Key Ratios: *The medians are based on an analysis of audited fiscal 2018 financial statements for 284 freestanding hospitals, single-state health systems and multistate health systems, representing 79 percent of all Moody's-rated healthcare entities.*[1]

- Maintained bed occupancy: 66.6 percent
- Operating margin: 1.8 percent
- Excess margin: 4.3 percent
- Operating cash flow margin: 7.9 percent
- Return on assets: 3.6 percent
- Three-year operating revenue CAGR: 5.6 percent
- Three-year operating expense CAGR: 6.4 percent
- Cash on hand: 200.9 days
- Annual operating revenue growth rate: 5.5 percent
- Annual operating expense growth rate: 5.4 percent
- Total debt-to-capitalization: 33.7 percent
- Total debt-to-operating revenue: 33.3 percent
- Current ratio: 1.9x
- Cushion ratio: 21.6x
- Annual debt service coverage: 4.7x
- Maximum annual debt service coverage: 4.4x
- Debt-to-cash flow: 3.1x
- Capital spending ratio: 1.2x
- Accounts receivable: 45.9 days
- Average payment period: 61.4 days
- Average age of plant: 11.7 years

Hospital Margins by Credit Rating Group[2]

AA+ rating
- Operating margin: 5.5 percent
- Operating EBIDA margin: 12 percent
- Excess margin: 9.2 percent
- EBIDA margin: 14.8 percent

AA rating
- Operating margin: 4.4 percent
- Operating EBIDA margin: 10.1 percent
- Excess margin: 6.7 percent
- EBIDA margin: 12.4 percent

AA- rating
- Operating margin: 3.4 percent
- Operating EBIDA margin: 9.5 percent
- Excess margin: 4.0 percent
- EBIDA margin: 10.4 percent

A+ rating
- Operating margin: 1.6 percent
- Operating EBIDA margin: 7.4 percent
- Excess margin: 3.3 percent
- EBIDA margin: 10.1 percent

A rating
- Operating margin: 2.1 percent
- Operating EBIDA margin: 7.6 percent
- Excess margin: 3.3 percent
- EBIDA margin: 8.6 percent

[1]Sources: Moody's Investors Service, "Not-for-profit and public healthcare – US: Medians" report, September 2019.
[2]S&P Global Ratings "U.S. Not-For-Profit Health Care System Median Financial Ratios — 2018 vs. 2017" report, September 2019. Becker's Hospital CFO Report, January 24, 2020

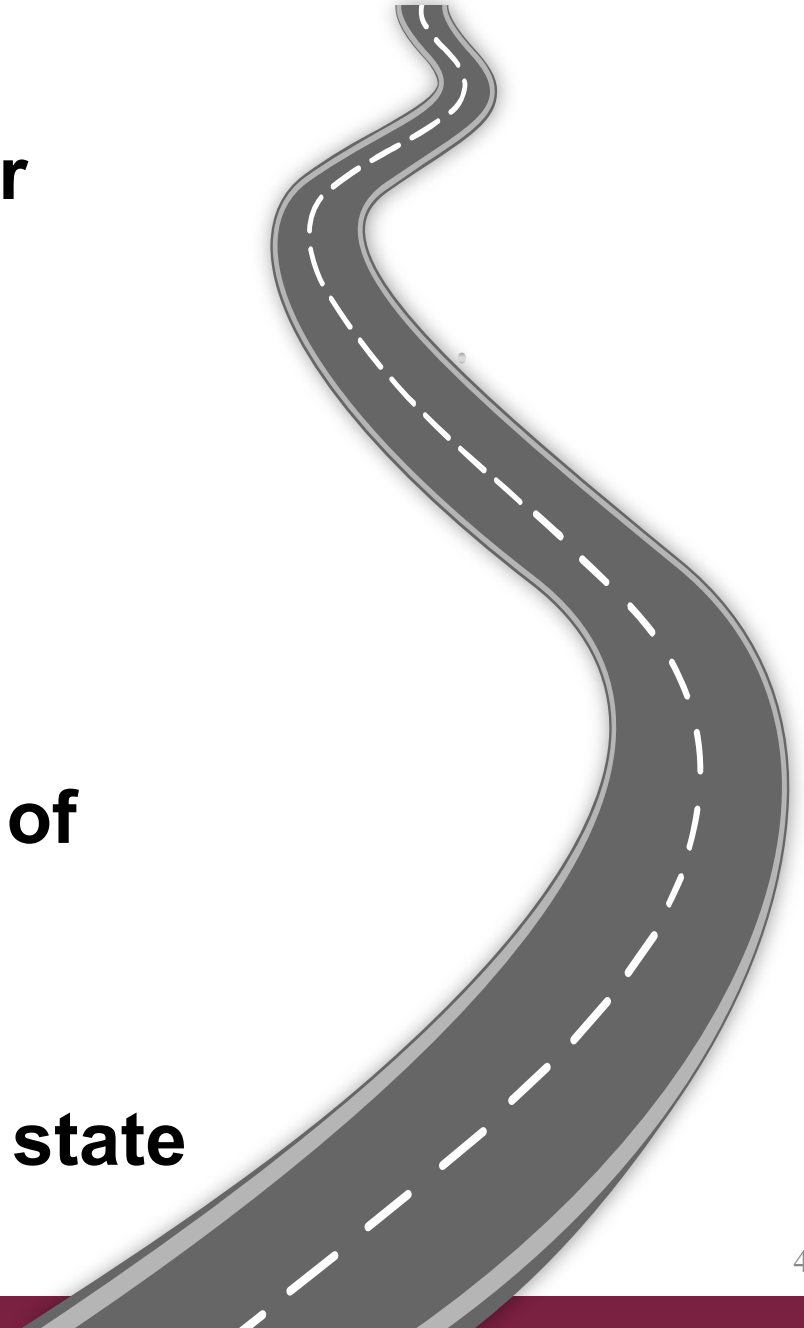
Essential Action Items

1. Build into board meeting agendas discussion of issues impacting independence:
   - Market intelligence and trends/implications updates ("heard on the street")
   - Which organizations in the region are facing challenges; which provide interesting opportunities?
   - Capital needs, debt capacity, priorities and trade-offs that might be necessary
   - Consider possible what-if scenarios
   - Explore ***"What would it take"*** to make a partnership arrangement work?
2. Define what **"independence"** and **"control"** really mean to the organization
   - What are negotiable and non-negotiable elements?
3. Identify/monitor threshold metrics, criteria, triggers for making alliance and partnership decisions
4. Does your strategic plan address alliances, partnerships, other relationships?

"No decision" is a Decision

Other Strategic Activities

- Maintain open communications with other appropriate organizations
- “Skunk Works” team to conduct ongoing analysis
- “Competitor Board” exercise (put board members in competitor’s position and brainstorm how to “put your hospital out of business”)
- “Vision-by-Design” exercise – small workgroups create visuals of ideal future state



Board Perspective

Every board meeting is a referendum around two issues:

- **Do we have the right strategic plan; if so, is it being implemented effectively?**
- **If not, do we have the right leadership team?**

Richard Umbdenstock
Former CEO, American Hospital Association

Tale of Two Independent Hospitals

350	127
75	92

Questions?

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