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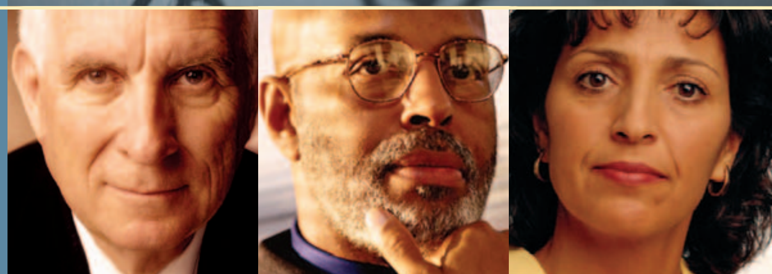

Financing the Future II

Report 5: Strategies for Financially Distressed Hospitals

hfma
healthcare financial management association

In partnership with

GE
Healthcare Financial Services

and KaufmanHall

Financing the Future II
Report 5:
Strategies for Financially Distressed Hospitals

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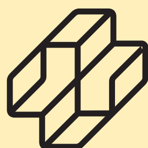
Healthcare Financial Management Association
Two Westbrook Corporate Center, Suite 700
Westchester, IL 60154-5700
www.hfma.org
www.financingthefuture.org

Correspondence: megflan@hfma.org



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Financing the Future II

Report 5:

Strategies for Financially Distressed Hospitals

Executive Summary

Healthcare organizations do not get into trouble overnight. Problems mount over an extended period of time, frequently five to 10 years or longer. Inadequate information often contributes to poor performance monitoring. In some cases, monitoring capabilities will be present and external benchmarks will be accessed, but leaders are not acting on the information they receive.

Distressed organizations frequently have a weak position in the market—a situation that often is not addressed by leadership and governance and thus exacerbated. Sacred-cow programs are another common problem. Many of the warning signs of deep trouble are financial in nature and relate to a liquidity squeeze.

Financially distressed organizations must face the facts, acknowledge the scope of problems, and obtain expert and comprehensive guidance to achieve performance improvement across all dimensions—strategic, clinical, operational, and financial. Quick fixes for incidental problems are not adequate. Concrete steps must be taken to ensure sound leadership and accountability. Accurate and timely information is a vital resource. Information on the contribution margin of every clinical program and service must be collected and evaluated. The board and management team must monitor and evaluate this information.

An improvement plan that addresses strategic, clinical, operational, and financial performance should be developed, implemented, monitored, and adjusted as needed. Such a plan often includes a strategic focus on core business; labor and revenue cycle interventions; managed care and supplier contract renegotiations; and length of stay, throughput, and other operational improvements.

Successful turnarounds require leadership, resources, and well-executed and monitored plans. If plans are not achieving targets, additional interventions must be developed and implemented.

Introduction

Financing the Future II, a six-part series published from May 2005 through August 2006, seeks to help healthcare organizations of all sizes "raise the bar" on financial performance. Its cornerstone principle is this: *Adherence to a rigorous corporate finance process is critical to a hospital or health system's ability to increase access to capital, make wise investments in the organization's future, and improve financial performance.*

Each report illustrates how actual hospitals and health systems have applied corporate finance principles to achieve successful financial performance and capital access. The lessons learned from practicing CFOs, other financial leaders, and those advising financial leaders, obtained through telephone interviews, are used to describe best practice processes.

HFMA's partners for *Financing the Future II* are GE Healthcare Financial Services and Kaufman, Hall & Associates, Inc. Both companies are deeply committed to ensuring the financial health of hospitals and health systems nationwide through the use of corporate finance principles. GE has been a leader in the application of such principles, which have guided the company for many decades and remain in force today. Throughout its 20-year history, Kaufman Hall has advised healthcare organizations on how to rigorously apply and maintain corporate finance principles to achieve enhanced financial performance. HFMA appreciates the in-depth guidance provided by these partners.

HFMA also appreciates the contributions made to *Financing the Future II*'s fifth report by the following

individuals: Kimberly Boynton, CFO, Crouse Hospital; Robert Glenning, executive vice president and CFO, Kaleida Health; Edward J. McCarthy, managing director, Navigant Consulting; William D. McGuire, former CEO, Kaleida Health; and Timothy C. Weis, managing director, Speltz & Weis, LLC, a Huron Consulting Group company. In addition, the association acknowledges the contributions of freelance writer Nancy Gorham Haiman.

Many healthcare organizations are experiencing financial pressures related to increased competition, constrained reimbursement, and growing capital needs. The first four reports in this series covered strategies that hospitals can use to improve their strategic financial position.

This latest report addresses strategies for financially distressed hospitals and health systems. Its focus is on organizations that are experiencing *severe* financial stress bordering, if not representing, a financial crisis. Deeply in trouble, these organizations require a major turnaround effort to ensure survival as ongoing independent entities in their communities or to position the organization for purchase or merger with another entity.

The hope with this report is that it will enable the leaders of struggling organizations to learn from the experiences of hospitals and health systems that successfully achieved an intensive turnaround.

Characteristics of Financially Distressed Organizations

Troubled healthcare organizations typically have experienced mounting difficulties for a long time. It's common to see problems stretching back five years to a decade—sometimes more. It should come as no surprise then that short-term fixes for point-in-time problems will not be adequate for the task at-hand. "The problems related to a distressed organization are deeply entrenched and thus more difficult to resolve," says Timothy C. Weis, managing director of Huron Consulting Group. "The root of the problem most often lies in the fact that the organization's leadership has accepted an unacceptable situation over an extended period of time."

Leadership Issues

Lack of oversight and accountability by the board and/or senior management are evident in most deeply troubled organizations. The organizations might have been profitable in earlier decades, but increasing competition and constrained payment are chipping away at once-healthy margins.

As the organizations' core business starts to deteriorate, the management and the board are not monitoring performance and responding appropriately. This may be the result of neglect or distraction. Notes Weis: "Faced with many different competitive pressures, the leaders may lose focus on the core business. Without priority attention, a healthy business can turn unhealthy over a number of years."

Inadequate information often contributes to poor performance monitoring in troubled organizations, but this is a leadership issue, not a technology issue. As part of their most fundamental stewardship responsibilities, both the board and executive team must ensure that they have sufficient information with which to monitor whether the organization is accomplishing its agreed-upon mission, vision, and goals.

In some cases, monitoring capabilities will be present and external benchmarks will be accessed, but leaders are not acting on the information they receive. Edward J. McCarthy, managing director of Navigant Consulting, comments, "In distressed organizations, executives and their managers often are not managing to their targets; buy-in may be one obstacle."

Sacred-cow programs are another common problem. "We often see organizations with executives and board members who are unwilling to close or reduce in scope programs or services that are losing money over long periods of time and negatively influencing overall organizational performance," McCarthy says.

Warning Signs of Deep Trouble

When many of the following occur simultaneously, a healthcare organization may be headed toward a hard-to-reverse financial crisis.

- Board and senior management acceptance of poor financial performance
- Lack of middle management depth
- Lack of accountability or illogical reporting relationships involving managers/supervisors
- Sacred-cow programs
- Erosion of profitable payer mix
- Poor physician relations
- Inadequate information management and reporting systems and process
- Slipping market share even in growth markets
- Steadily declining operating margins or increasing losses
- No long-term budgets and plans or unrealistic/missing budget targets
- A liquidity squeeze, such as decreasing cash reserves and days cash on hand (red alert: less than 20 days), extended vendor payment (red alert: more than 80 days), or tardy payment of taxes and employee withholdings
- Increasing A/R days and bad-debt expense
- Rapidly escalating costs
- Significant throughput challenges
- Insufficient capital access, such as an inability to get debt rated; a bond rating drop into a double B, single B, or noninvestment-grade category; or a bond covenant violation
- Greater than average age of plant (10+ years)
- Audit surprise or failure

Weis comments, "Mission-critical services are vital for the community, but a financially distressed organization must first focus on ensuring its viability."

Duties of care, loyalty, and obedience owed by healthcare leaders are largely based on statutes and litigation involving corporations in fields beyond health care, but not-for-profit directors generally are held to the same standards.[1] Denial from board members and senior executives is frequently evident in financially distressed organizations, and illegal, unethical, or in the very least, questionable behavior may be manifest in some cases.

Such behavior includes the "empire-building syndrome" that occurred at Allegheny Health Education and Research Foundation in the late 1990s. The unabated acquisition of new entities that continued to miss performance targets brought the castle built by the organization's executives tumbling down.[2]

Other healthcare organizations experienced significant decline after rescuing failing entities that should not have been rescued due to the high risk involved or after buying physician practices or HMOs that did not perform as expected. "It's amazing the level of continued loss some executives and boards will tolerate without making the tough decisions that are needed," observes McCarthy.

Market Position and Financial Issues

Distressed organizations frequently have a weak position in the market—a situation that often is not addressed by leadership and governance and thus exacerbated. Even in growth markets, their share may be slipping due to lack of focus, poor planning, or faulty execution.

Hospitals with a higher-than-usual proportion of Medicaid and self-pay business generally do not enjoy number one or two positions in their markets. Notes Weis of Huron Consulting Group, "Erosion of a profitable payer and case mix can result in operating margins too slim to support the investment in facilities and new technology needed to attract physicians and patients, so the organizations weaken over an extended period of time." Quality of clinical care can also be a factor.

Many of the warning signs of deep trouble are financial in nature and relate to a liquidity squeeze. As an organization's cash balance deteriorates, vendor payments are stretched, employee withholdings and taxes are not paid in a timely fashion, and other risky financial practices may be evident.

Strategies for Financially Distressed Organizations

Turning organizations around involves an intense commitment to leadership, resources, and plan development, monitoring, and execution. Once financial performance is improved, a similarly intense commitment is required to sustain the discipline and best practice processes.

Leadership

Financially distressed organizations must face the facts, acknowledge the scope of problems, and obtain expert and comprehensive guidance to achieve performance improvement across all dimensions—strategic, clinical, operational, and financial. The "too little, too late" phenomenon is exceedingly dangerous, comments Weis.

For example, a failing organization's leadership team may want to hire a productivity consultant or an expert in supply cost reduction to address specific problems. "This is a woefully inadequate approach to achieving the improvement that is needed," says Weis. Full-spectrum turnaround achieved through multidisciplinary teams and comprehensive performance improvement plans is critical.

Concrete steps must be taken to ensure sound leadership and accountability. Boards and senior executive teams should be evaluated through an external or self-evaluation process, reshaped, and reconstituted. This process includes redefinition of board committees, their responsibilities, and the information they require of management. The medical staff peer review process may also require revision.

Resources

Financially distressed hospitals are "burning cash," so loans or capital from the sale of noncore assets should be secured to sustain the organization through the turnaround period. Although access to capital is much more difficult to obtain for these hospitals than it is for those in stronger positions, there are banks and finance companies willing to help meet these needs. As examples, revolving lines of credit may be secured by accounts receivables to address working capital and temporary liquidity needs, or private placement of tax-exempt bonds may be used to finance critical capital projects.

Also key is an effective monitoring process. Accurate and timely information is a vital resource. The board and management team must be continually evaluating this information. "Most organizations have daily reporting of census information, but turnarounds require much more information than that," says Weis. He cites as examples, among others, weekly reporting of cash flow information (including receivables), collections, billing backlogs, accounts payable aging, contracted FTEs paid through accounts payable, and overtime. A sample of a hospital flash report that includes typical indicators is shown on page 4.

FINANCING THE FUTURE II

Limited Performance, Limited Access to Capital

Hospitals under significant financial strain—not profitable, not liquid, and with significant debt burden—can still find financing partners. However, often access to capital is from a limited number of sources and at a higher cost than hospitals with a brighter financial picture. Those likely to fall in this position tend to share several characteristics:

- An operating margin of less than 0.0%
- Debt service coverage ratio of less than 1.25
- Days cash on hand (short term) of less than five
- Current ratio of less than one
- Debt to capitalization less than 0 percent or more than 70 percent

Source: Financing the Future I, Report I, How Are Hospitals Financing the Future? Access to Capital in Health Care Today, HFMA, 2003.

Exhibit 1

Sample Hospital Flash Report

		Budget Target	7-Jan	14-Jan	21-Jan	28-Jan	4-Feb	11-Feb	18-Feb	25-Feb	4-Mar
Volume	Adult admissions										
	Pediatric and neonatal admissions										
	Total adult, pediatric, and neonatal admissions										
	Newborn admissions										
	Average daily census										
	Adjusted daily census										
	ED admissions										
	ED admissions as % of total admissions										
	ED visits										
	ED diversion hours										
	ED transports										
	Observation patient days										
	OP short stay cases										
	Births										
	Long stay patients—Medical/Surgical										
	Long stay patients—NICU/Obstetrics										
	Inpatient surgeries										
	Outpatient surgeries										
	Main operating room utilization										
	Surgery center operating room utilization										
	Physician office building operating room utilization										
	Inpatient cardiac catheterization patients										
	Outpatient cardiac catheterization patients										
Financial	Gross revenue										
	Gross inpatient revenue										
	Gross outpatient revenue										
	Cash collections										
	A/R inhouse										
	A/R discharged, not billed										
	Accts with no diagnosis > 5 days after discharge										
	Total billed A/R										
	Total A/R										
	Percent A/R > 90 days										
	Undesignated cash balance										
	Designated cash										
	Total cash										
	Net operating cash flow surplus (deficit)										
	Days cash on hand—Undesignated										
	Days cash on hand—Total										
	Accounts payable										
	Third-party liabilities—Total										
LOS and Acuity	Average length of stay, excluding new borns										
	Average LOS—NICU										
	Average LOS—Other (adult and pediatric)										
	Case mix index										
	Medicare case mix index										
Payroll	Total paid FTEs										
	Nonproductive FTEs										
	Overtime FTEs										
	Agency FTEs										
	Total payroll dollars										
	Total agency dollars										
	Total FTEs/AOB										

** Note all dollar amounts should be given in $000s.*

Source: Huron Consulting Group. Used with permission.

Exhibit 1 (continued)

Sample Hospital Flash Report

	Total Admissions	Total Adjusted Daily Census	ED Diversion Hours	Inpatient Revenue	Outpatient Revenue	Cash Collected ($000s)	Net Operating Cash Flow	Total A/R	Average LOS	Case Mix Index
2005 Average										
2006 Budget										
Four-Week Rolling Sums										
Feb 6-Feb 27										
Feb 13-March 5										
Feb 20-March 12										
Feb 27-March 19										
March 5-March 26										

Source: Huron Consulting Group. Used with permission.

Information on the contribution margin of every clinical program and service must be collected and evaluated. "Monitoring of benchmarks for each department, such as costs as a percentage of total expenses adjusted for depreciation, interest, and bad debt are critical, but so is the exploration for why there may be variance," comments McCarthy of Navigant Consulting.

Improvement Plan

An improvement plan that addresses strategic, clinical, operational, and financial performance should be developed, implemented, monitored, and adjusted as needed.

Weis uses an EBIDA (earnings before interest, depreciation, and amortization) improvement plan to identify improvement opportunities and monitor performance. "Every senior executive and middle managers with operating responsibility get involved in developing this plan, which is presented to the board and when approved, to creditors who review and approve the resources required to implement the plan and achieve its benefits," says Weiss.

Improvement plans typically are developed during a period of a few weeks to a few months and implemented over a period of six month to two years, depending upon the organization's size and complexity. They generally include the following:

A strategic focus on core business. "Not all volume is good volume. The core business and all components of that business must be under scrutiny for carrying their own weight," observes Weis. McCarthy indicates that organizations should not be afraid to change their basic vision or major strategies if doing so is what is required for continued viability.

Labor and revenue cycle interventions. Often a focus of efforts during the first year, these initiatives have a major impact on cash flowing in and out.

Managed care and supplier contract renegotiations. Often requiring longer lead times, these interventions typically occur later in year one or in year two.

Length of stay, throughput, and other operational improvements. These interventions can have significant positive impact on patient flow, resulting in reduced costs and improved revenue.

Many interventions help to improve liquidity and debt capacity. "We start getting benefits as quickly as possible from the low-hanging fruit interventions that are easier to implement and have higher returns," says Weis. "We also put in place a tracking mechanism to monitor the implementation status and performance of all plan initiatives."

Exhibit 2

Report for Tracking Status of Turnaround Improvement Plan Initiatives

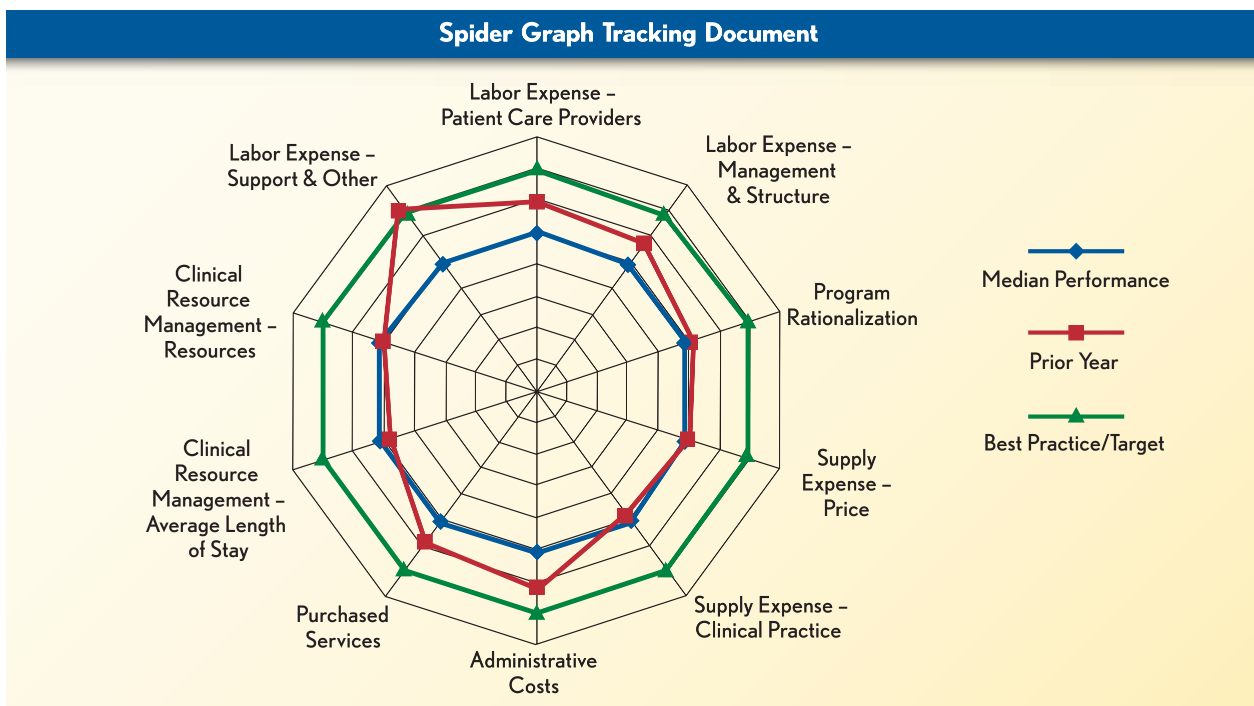
(In Thousands $)

Initiative	Full Year 2005				Annualized Rate Run			
	Target Amount	Achieved to Date	Yet to be Achieved	Percent Complete	Target Amount	Achieved to Date	Yet to be Achieved	Percent Complete
Reduction in Billing Denials (#1)								
Charge Capture (#2)								
CDM (#3, #4)								
Other Revenue Cycle (#5, #6, #7, #8, #10, #11)								
Managed Care Contract Compliance (#12, #14)								
Managed Care Contracting (#13)								
Subtotal Revenue Cycle Initiatives								
Facility A Closure (#15)								
Facility B Divestiture/Closure (#16)								
Subtotal Strategic Initiatives								
Labor Efficiency (#17, #18)								
Physician Productivity Improvements (#9)								
Case Management (#19)								
Supply Chain #20								
ER Initiatives (#22, #23)								
Other Expense Reductions (#21, #24, #25)								
Subtotal Expense Saving Initiatives								
Total Turnaround Initiatives								

Source: Huron Consulting Group. Used with permission.

Exhibit 3

Spider Graph Tracking Document



Source: Navigant Consulting. Used with permission.

An example of such a tracking mechanism is shown in Exhibit 2. Exhibit 3 illustrates another type of tracking mechanism. Clear accountability for each intervention should be established.

Successful turnarounds require leadership, resources, and well-executed and monitored plans. If plans are not achieving targets, additional interventions must be developed and implemented. Pursuit of best practices for improving operations, open internal communication, and full disclosure to creditors are vital attributes of organizations that have successfully turned from failing performance.

Full disclosure of actions taken to improve the organization and the setbacks that are encountered during the turnaround—because there are always setbacks—will help ensure continued adequacy of the funding required to implement the turnaround, notes Weis.

The capital markets, particularly the rating agencies, are going to be cautious in declaring an organization as out of its troubles. In its special comment on turnaround consulting engagements, Standard & Poor's comments:[3]

> It is often the case that positive gains are made in the initial months of a turnaround engagement, but quickly backslide once the consultants—and, accordingly, a good percentage of the concentrated focus—exit the organization. Unfortunately, there are many examples of initially successful turnarounds that showed significant slippage over the short-to-medium term.

The long-term viability of a hospital or health system often will be judged by the capital markets as well as other external and internal constituents on how the executive team and board respond to unanticipated problems. Consistency and commitment to sustained performance are critical.

Turnaround Examples

Highlighted here are two organizations that successfully regained competitive market and financial performance through comprehensive turnaround initiatives. Although both case studies involve organizations based in New York, the lessons learned are widely applicable and are not reflective of market factors specific to this geographic location.

Crouse Hospital

Crouse Hospital, a 556-bed facility in Syracuse, N.Y., achieved a notable turnaround. In 2001, the organization filed for bankruptcy protection with debts of $91 million, and by 2003, it emerged as a financially viable and still independent hospital.

Although Crouse Hospital was well respected in its community, the hospital's problems were deeply entrenched, many of them dating to the 1990s. These included leadership decision making that occurred without proper financial analysis and input, high management turnover, heavy losses from acquired physician practices, and inadequate information systems and performance monitoring. Serious challenges for the hospital included faulty review of hospital charges, inadequate capital investment in a rapidly aging physical plant, and a poorly implemented accounts receivable system that had interrupted billings in 1999 for a multi-month period. Although annual depreciation was $8 million, the hospital could afford to invest only $1 million per year in its facilities.

The hospital's financial crisis also was evident in its rapidly deteriorated cash position, which fell to as low as two to five days cash on hand in 2001. Kimberly Boynton, now Crouse Hospital's CFO and on staff in 2001 as a finance manager, spent a lot of time on the telephone "making sure we could make the payroll, pay our debts, and keep supplies coming into the hospital."

With bankruptcy filing, the hospital hired accounting and legal consultants as well as the turnaround consulting firm of Speltz & Weis. The principals of the latter, Tim Weis and David Speltz, joined Crouse Hospital in spring of 2002 to assume the CFO and CEO positions, respectively.

Turnaround improvement initiatives focused on the following:

Board restructuring. The hospital's board declined in size from 20 to 12 directors.

Implementation of appropriate information systems. Technology was introduced to better monitor organizational performance.

Productivity and staffing. "We had to take a very significant look at our full-time equivalents per adjusted occupied bed and bring these down to industry standards," comments Boynton. Union wage increases of 8 percent to 9 percent were reduced to about 3 percent through concessions.

Debt restructuring. Crouse Hospital negotiated a five-year deferral of debt from secured creditors. "This process took a while but the deferred payment of principal was expected to save the hospital $12 million during that period," says Boynton. "This money could be reinvested in the facility."

Revenue cycle improvements. A revenue cycle improvement group ensured that the hospital was charging properly for procedures, performing reconciliations, and renegotiating payer contracts.

Supply expense reductions. Led by the director of materials management, a team standardized supplies and renegotiated supplier contracts to reduce expenses.

FINANCING THE FUTURE II

Turnaround Tips

- Don't be afraid of changing basic vision or major strategies
- Communicate goals internally and insist on open and full disclosure with capital markets
- Seek a financing partner who will work with you through tough times
- Share best practices
- Don't allow sacred cows
- Assign responsibilities for targets and initiatives
- Monitor and revise plans as needed to achieve goals

New contracts and capital equipment approval processes. All contracts, whether involving an emergency department renovation or an equipment service agreement, and all requests for capital equipment were required to be properly evaluated and reviewed by senior management.

All directors attended biweekly (now monthly) responsibility reporting meetings to track and address budget variances covering volume, productivity, and expenses. "These meetings brought the directors together as a team," says Boynton. "No one had to hang out there on his or her own."

Under the leadership of its new CEO, Paul Kronenberg, MD, Crouse Hospital has improved market share and continues to make financial and operational progress. Results to-date have been promising. The hospital has been "in the black" and ahead of budget for each of the two full years following Chapter 11 filing. Days cash on hand is now 60 (up from two days), and A/R days is 45 (down from 80 days). "Crouse has achieved marked improvements in physician and employee satisfaction, has been recognized by JCAHO and CMS for exceeding national standards in a number of clinical areas, and recently received the Greater Syracuse Chamber of Commerce Business of the Year Award," says Boynton.

Kaleida Health

Formed in 1997, Kaleida Health is a five-hospital health system in greater Buffalo, N.Y. It includes 511-bed Buffalo General Hospital, 70-bed DeGraff Memorial Hospital, 189-bed Millard Fillmore Gates Circle Hospital, 201-bed Millard Fillmore Suburban Hospital, 190-bed Women and Children's Hospital of Buffalo, and numerous community healthcare centers, long-term care facilities, behavioral health programs, and home health services.

The 1997 full-asset merger of the five hospitals, undertaken to achieve cost-efficiencies and eliminate duplication, created considerable cultural turmoil. Robert Glenning, the system's executive vice president and CFO who joined Kaleida Health in January 2001, notes that, "As a result of the internal focus on absorbing the merger, the system lost its way in the highly competitive western New York marketplace."

Moreover, within a year of the merger, the system lost total control of its numbers due to a computer conversion that was aimed at getting all hospitals on the same platform. "Kaleida executives had limited information on where they stood financially because data were very scarce, and if available, were suspect because of the information system problems," says Glenning.

An organizationwide service line management strategy where directors of departments, such as radiology and the operating room, reported to a system head for that service had effectively stripped individual hospital presidents of line authority to address problems at their sites. "As organizationwide revenue deteriorated and expenses climbed, it was impossible to determine the sites contributing to the negative trends," says Glenning.

Significant financial deterioration occurred almost from the beginning of the merger, with losses mounting each year, from $9 million in 1999 to $16 million in 2000. By 2001, Kaleida Health was losing $62.5 million on revenue of $665 million. Losses in 2002 were forecasted to be $85 million unless interventions occurred. At that point, the CEO was terminated, and the organization's leadership hired The Hunter Group, a unit of Navigant Consulting, to analyze the situation and develop a turnaround plan.

In February 2002, a new CEO skilled at leading turnarounds of large, complex health systems, William D. McGuire, was brought on board. "When I parachuted into Buffalo, the organization had been mismanaged for quite some time," says McGuire. "There was no system of accountability and no real follow up. The board, although well-intentioned, was doing almost all of the wrong things."

McGuire faced considerable challenges: "We had eight days of cash remaining, morale was very low, and physicians had left and were continuing to leave the organization in droves."

Glenning indicates that all of Kaleida Health's constituencies were nervous about what the turnaround company might be recommending. "One of the first things McGuire did was to put the full improvement report on our Web page for everyone to read," he comments.

McGuire, who was at Kaleida Health's leadership helm up through the end of 2005, describes the following seven strategies used to turn the organization around.

FINANCING THE FUTURE II

Who Is Most Vulnerable?

A review by the Office of Inspector General of rural and urban hospitals closures between 1990 and 2000 revealed that those affected had several characteristics in common.

- Rural and urban hospitals that closed were generally smaller and treated fewer patients than their peers nationally.
- Rural and urban hospital closures generally resulted from business-related decisions or a low number of patients. Competition was also a significant factor in urban hospital closures.
- Following a closure, alternative forms of health care were often available within the community.

Source: Trends in Urban Hospital Closure 1990-2000 and *Trends in Rural Hospital Closure 1990-2000,* Department of Health and Human Services Office of Inspector General, May 2003.

Build partnerships with physicians. The organization's 1,800 physicians were deeply disenfranchised with, and distrustful of, Kaleida Health management. To address these concerns, McGuire met with a group of 600 physicians. "I told them that I wasn't new to turnarounds," he said. "I gave them the names of the organizations I'd turned around, and encouraged them to ask the physicians in those places whether I was genuinely physician-friendly, able, and could be trusted." McGuire also asked for a month grace period and gave the physicians his cell and home phone numbers, setting the tone for ongoing partnership discussions.

Put in place a top-notch management team. McGuire gave pink slips to all but one of the top executives in place. "When you actually do clean out the old, the docs sit up and take notice," comments McGuire. "More important, when you replace them with managers who work well together and who are proactive in genuinely hearing physician complaints and fixing the things that need fixing, you quickly gain partners in the turnaround." Because physicians are the key to volume and expense control, McGuire took great care to ensure that the chief medical officer was someone who was respected by the medical staff and could represent them fully and fairly with management.

Reshape governance. The board in place when McGuire arrived had 30 members—six trustees from each of the five hospitals—with board leadership rotated each year to a different hospital and a plethora of committees. "It was too large, too diffuse, and too constituency-based," comments McGuire. Through a self-nomination and voting process, the board downsized to eight members plus McGuire (as the ninth), added three new members from outside the region, and eliminated about half of the committees.

Redefine vision. The board revised its previous vision as a comprehensive integrated delivery network offering "all things to all people." Instead, the health system concentrated on being very good at specific things, genuinely efficient, and a partner with other entities to round out the service offerings. "We thought that the community could ill-afford more competition between healthcare providers and that more collaboration would be less costly," says McGuire.

Glenning comments, "The new two-word vision—advancing health—was easy to understand and hence easier to operationalize."

Ensure accountability. "In the former organization, as long as you had a good explanation for why you didn't meet your budget, that was good enough," notes McGuire. With the participation of the leadership team, McGuire converted Kaleida Health from a culture of "explain-ability" to a culture of accountability. "In the new organization, managers are held accountable for keeping to their budgetary promises," says McGuire.

Improve payment and reimbursement. McGuire's team focused on leveraging the system's strength as the market's largest provider to improve its payment rates with managed care organizations.

Grow volume and market share. Volume does not appear quickly, notes McGuire, especially in a mature market area. Physicians are key to growth. "We were able to slow and then stop physician attrition altogether and gradually build volume through joint ventures and other endeavors," says McGuire.

Also key to carrying the organization through the tenuous period was a solid financing plan. Kaleida Health worked with GE Healthcare Financial Services to secure a working capital line of credit and tax-exempt financing for its equipment needs.

Other specific initiatives, cited by Glenning, include the following:

- Established site accountability
- Closed noncore corporations, including physician practices
- Eliminated more than 1.2 million square feet of space by terminating leases, closing buildings, and consolidating spaces
- Decertified approximately 650 beds and reduced FTEs
- Implemented a contract management program and a charge system
- Upgraded the coding and documentation system
- Cut debt service in half by refinancing debt
- Implemented data-rich cost accounting and executive information systems
- Centralized finance and information system functions

The executive team tracked 38 specific indicators, including current ratio, days in A/R, and debt service coverage ratio. "Our main focus really was on two indicators, however: the bottom line and cash reserves," notes Glenning.

During McGuire's four years of service, Kaleida Health strengthened its balance sheet by more than $125 million, met its budget in 2002, and posted consecutive surpluses of $2 million in 2003 and $7.5 million in 2004. Days in A/R have declined from the 70s to 30s. Cash reserves have increased $65 million in the past 12 months and $100 million in the past two years. "Without borrowing more, we've increased cash by doing a better job with inventories, payables, and accounts receivable," comments Glenning.

Results for 2005 showed a $26 million surplus. "My turnaround job completed, I've re-retired to Texas, and James Kaskie was appointed CEO effective January 1, 2006," concludes McGuire.

Mitigating Financial Distress

As the experiences of healthcare organizations that have come back from financial distress show, turnarounds take tremendous dedication; sound leadership; and a comprehensive, cohesive, and continued approach toward addressing strategic, clinical, operational, and financial performance. While there is no fast fix, healthcare executives can take heart in the knowledge that early intervention often can head off the need for such efforts.

Yet how to ensure the organization does not get off track? As discussed, hospitals are best positioned for success in an environment of structured information sharing that relies on systems of accountability for continued monitoring of operations and performance improvement. Focusing on core businesses—although very important—is not enough. Significant attention also must be paid to labor and revenue cycle interventions, managed care and supplier contract renegotiations, as well as length of stay, throughput, and other operational improvements. When hospitals are not meeting targets, it is critical to intervene early and develop a timely response to address underlying issues.

References

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3 Standard & Poor's, *Turnaround Consulting Engagements: Assessing the Impact on U.S. Not-for-Profit Health Care Ratings.* New York, July 11, 2005.

Financing the Future II

HFMA's *Financing the Future* series began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital through successful financial planning and execution. *Financing the Future II* continues this process. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second *Financing the Future* series seeks to help healthcare organizations of all sizes "raise the bar" on financial performance. *Financing the Future II* is being developed in partnership with GE Healthcare Financial Services and Kaufman, Hall and Associates, Inc., and will include six reports for healthcare financial leaders, their staffs, and healthcare executives and board members. For more information about *Financing the Future II,* visit www.financingthefuture.org.

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