



# The Partnership Playbook for Hospital CFOs

*A Guide to Collaborative Relationships that  
Enhance Operational and Clinical Effectiveness*

**Bank of America  
Merrill Lynch**



**BECKER'S  
HEALTHCARE**

Isadore Rivas, CPA  
Chief Financial Officer,  
Hendricks Regional  
Health

William Fenske  
Chief Financial Officer,  
Rice Memorial Hospital

Mark Bogen, CPA  
Senior Vice President &  
Chief Financial Officer,  
South Nassau Communities  
Hospital

Brent McDonald  
Managing Director and  
Head of Healthcare  
Strategic Advisory, Bank  
of America Merrill Lynch

# The Partnership Playbook for Hospital CFOs

*A Guide to Collaborative Relationships that Enhance Operational and Clinical Effectiveness*

By Molly Gamble

Hospitals and health systems today must operate on the principle that their organizations cannot be all things to all people. Margin pressures are increasingly prompting organizations to reassess their core mission and capabilities, and subsequently turn to partners who can execute or strengthen the disciplines outside the realm of high-quality patient care.

This Becker's Healthcare e-book, based on survey responses from financial executives and a roundtable discussion with three hospital and health system CFOs and a healthcare strategy expert, discusses clinical and nonclinical partnerships. You will read CFOs' perspectives on how they identify the "right" collaborative partner,

considerations for optimum negotiations and agreements, how to best assess a working relationship and broad lessons about partnerships and affiliations irrespective of market, sector or size.

CFO participants in this report include:

- Isadore Rivas, CPA, Chief Financial Officer, Hendricks Regional Health (Danville, Ind.)
- William Fenske, Chief Financial Officer, Rice Memorial Hospital (Wilmar, Minn.)
- Mark Bogen, CPA, Senior Vice President & Chief Financial Officer, South Nassau Communities Hospital (Oceanside, N.Y.)
- Brent McDonald, Managing Director and Head of Healthcare

Strategic Advisory, Bank of America Merrill Lynch

## Identifying a need

Well before a CFO begins a search for a partner, he or she will have identified a core need or deficiency within their organization. Only a select tier of health systems today possess the scale, critical mass, expertise and financial resources to manage the majority of services and functions themselves. Most all health systems rely on strategic, clinical or nonclinical partnerships to function at their highest level.

When examining service lines or departments, CFOs and their executive teams pose the question: Are we the best at this one function? If not, is it possible to become the best on

our own? If not, how can we partner with an organization that possesses that expertise and will drive improvement in our organization?

“Certainly our role as healthcare providers — that’s our No.1 issue, concern and focus,” says Mr. Rivas.

“So qualified medical professionals — whether it be physicians, nurses or allied health associates — are absolutely critical for us as a core competency. Those other areas that support that — that’s where we really challenge whether in fact we need to have that in-house or can we in essence ‘rent’ it through these relationships.”

Partnerships — versus mergers — are attractive to a range of hospitals for a variety of reasons. For independent, small- to mid-sized organizations, partnerships are one way to achieve economies of scale and clinical excellence without executing a full-on merger or acquisition with a larger health system. For large, integrated hospitals or health systems, partnerships can expand the organization’s foothold in ancillary lines, diversify revenues and

---

**“Those other areas that support that — that’s where we really challenge whether in fact we need to have that in-house or can we in essence ‘rent’ it through these relationships. ”**

Isadore Rivas, CPA  
Chief Financial Officer, Hendricks Regional Health

---

expand its market presence, among other benefits.

Hospitals and health systems strike partnerships with multitude of organizations for a number of needs that fall into one of two categories: clinical or nonclinical. This report covers principles and ideas applicable to both.

Many clinical partnerships today involve lab services, specialty pharmacy, dialysis, behavioral health, hospice and home health. Other partnerships are provider-centric but more strategic for hospitals and health systems, such as relationships shared with freestanding emergency rooms, urgent care centers, microhospitals and ambulatory surgery centers. On the nonclinical side, hospitals commonly seek support, expertise and resources for revenue cycle management,

group purchasing, IT support and services, environmental services, data analytics and population health management. Insurance-related partnerships, direct-to-employer agreements and branded health apps are more strategic in nature.

“We often see clients collaborate with a third party where they cannot alone handle a clinical or back-office need,” says Mr. McDonald. “Whether the need is information and data centric like population health management or in meeting the community’s needs for a convenient, consumer-focused clinical access point. Many health systems don’t necessarily do well at meeting consumerism requirements in the small box, ambulatory setting, so they may partner with a third party operator or management company

that specializes in urgent care, freestanding emergency rooms or outpatient surgery.”

In conversations with *Becker’s*, the three CFOs described an array of partnerships held between their organizations for different needs. Here are overviews and examples for each hospital:

***Hendricks Regional Health (Danville, Ind.)***. Hendricks is a midsized health system with one hospital. The majority of the organization’s revenue is related to its ambulatory care centers, physician offices, immediate care centers, diagnostic services and other ancillary operations. Hendricks has approximately 50 partnerships for clinical and operational purposes. “As a smaller organization, it’s a real challenge to have a depth of resources,” says Mr. Rivas. “To the extent that you need a certain level of expertise for a specific project for a specified period of time, we typically look outside.” In November 2014, the health system struck an agreement with a vendor to take over collection of payment for self-pay patients. Hendricks retained oversight and execution of the

remaining processes within the revenue cycle.

***South Nassau Communities Hospital (Oceanside, N.Y.)***. South Nassau Communities Hospital is a 455-bed nonprofit teaching hospital with decades of experience in provider-provider partnerships. The hospital has been a member of the Long Island Health Network, a 10-hospital clinically integrated health network, for nearly 20 years. More recently, South Nassau Communities Hospital recently entered a period of exclusive negotiations with the 3,468-bed Mount Sinai Health System in New York City. If finalized, the formal affiliation would create “a number of potential clinical joint ventures,” says Mr. Bogen.

***Rice Memorial Hospital (Wilmar, Minn.)***. Rice Memorial is the largest municipally owned hospital in Minnesota, and includes a regional cancer center, dental clinic, private birth center and a short-stay rehabilitation facility. The 95-bed hospital has roughly five clinical or operational partnerships. “They are fairly longstanding

**“The No. 1 thing for us was someone who had a similar vision of wanting to bring as much expert, tertiary-level care to the 900,000 people we serve. It really was about quality, culture and a vision about the services that people on the South Shore of Long Island are entitled to.”**

Mark Bogen, CPA  
Senior Vice President & Chief Financial Officer, South Nassau Communities Hospital

partners,” says Mr. Fenske. The hospital outsources radiology readings to a regional strategic partner, and it also partners for hospitalist and anesthesia services. On the nonclinical side, Rice Memorial partnered with a local tertiary care provider for health IT support, since both systems use Epic.

### ***Finding the right partner***

Once a clear need is identified, hospital and health system CFOs, executive teams and boards solicit and evaluate potential partners to meet the

**“We only want to work with people who value high quality, high patient satisfaction. If that’s not something that is front and center to you, it’s probably not a relationship that is going to work for us.”**

William Fenske  
Chief Financial Officer, Rice Memorial Hospital

objective at hand. This process can take as little as 4 months to a couple of years depending on structure of transaction, regulatory issues, stakeholder must-haves, and relative leverage of parties.

We asked CFOs what traits set partnership candidates apart in their eyes. As CFOs field requests and interest from dozens of parties on a daily basis, it’s interesting to learn what they consider game-changing.

- **Likeminded vision**  
— South Nassau Communities Hospital took one year to evaluate potential partners before proceeding with Mount Sinai Health System. What tipped the scale? “The No. 1 thing for us was someone who had a similar vision of wanting to bring as much expert, tertiary-level care to the 900,000 people we serve,” says Mr. Bogen. “It really was about quality,

culture and a vision about the services that people on the South Shore of Long Island are entitled to, without having to travel long distances.”

Although visions may differ between clinical and operational needs, CFOs also stressed that a shared vision is the foundation for a sustainable relationship with a partner versus one that is more episodic and transactional in nature. The difference between these relationships is discussed in greater detail later in this e-book.

- **Experience and credibility**  
— Mr. Rivas says a reference and referral by someone he knows and trusts is the largest influencer when evaluating a partner. Companies that are not vetted by his peers receive little attention. “I likely get 20 emails a day, minimum, that are

cold calls from vendors soliciting, in essence, their services,” he says. “I try to be courteous and polite, and unless there is some kind of reference or I know the organization or individual, I respond, ‘No interest at this time.’”

Mr. McDonald says he considers an organization’s experience and reputation before he would ever propose them as a partner to a hospital or health system. “I’m much more comfortable introducing my clients to a vendor or partner when that potential third party has a credible, disciplined well-recognized health system client that has already vetted the vendor and been satisfied,” he says. “No one wants to be a pilot client, unless there are limited other alternatives or they intentionally want to jointly create a new competency.”

- **Cultural compatibility** — “We only want to work with people who value high quality, high patient satisfaction. If that’s not something that is front and center to you, it’s probably not a relationship that is going to work for us,” says Mr. Fenske.

Mr. Fenske’s CFO colleagues each says shared values and a common culture are critical for the success of partnerships in the long-term. In fact, this was the second criterion Mr. Bogen and his team set out to fulfill in their quest for an affiliate: “Does the affiliation partner have a culture that is more closely aligned with ours and our medical staff than not?”

- **Financial commitment** — Partners must agree on the way in which dollars will support or achieve their shared vision. For example, Mr. Bogen says when examining affiliates, South Nassau Communities Hospital needed an organization able to share capital and dollars “to a level that even we could not singularly raise.”

**“When the economics change, does the model allow for that change to be fair to both sides? When it tends to tip to one of the venture partners versus the other, is everyone willing to sit down and redistribute appropriately to keep the venture going?”**

Mark Bogen, CPA  
Senior Vice President & Chief Financial Officer,  
South Nassau Communities Hospital

### **Negotiating with partners and striking an agreement**

After a hospital or health system’s executive team and board agree on the partner with whom to proceed, the negotiation process — a determinant of how the relationship will ultimately come to fruition — shortly follows. This is a time for relentless definition. Irrespective of industry, business professors recommend all partnership agreements contain definitions of what is and is not grounds for collaboration, the responsibilities and roles of each partner and processes for decision-making.

It is also the time to fine-tune and cement the partnership’s financial model, which CFOs said is one of the prime drivers of many failed partnerships.

“It hasn’t been operational and it certainly hasn’t been clinical or quality issues; it’s really been how do you divvy up the pie? Sometimes you’re divvying up a shrinking pie, other times it’s you’re trying to re-divvy up a growing pie,” says Mr. Bogen.

There are as many ways to slice the pie, so to say, as there are partnerships in healthcare. Whether it is a performance-based agreement, subscription-based model, capital investment, leased-space arrangement or joint venture in which each party owns a stake, CFOs advised their colleagues to ensure to the best of their ability that the fiscal plan will hold in next 2 to 5 years. Executive teams may also consider contractually building in an opportunity to reassess and recalibrate

the agreement 1 year in, if necessary, to account for any drastic economic changes.

“The shortcoming of any joint venture tends to be on the financial arrangement and what may have looked good starting out,” says Mr. Bogen. “When the economics change, does the model allow for that change to be fair to both sides? When it tends to tip to one of the venture partners versus the other, is everyone willing to sit down and redistribute appropriately to keep the venture going?”

CFOs shared mixed perspectives on whether the current political environment and policy uncertainty around the Affordable Care Act will change their approach to partnerships. In a survey conducted by *Becker's*, 56 percent of health system and hospital executive respondents said political uncertainty

has not affected their organization's partnership strategy, while a combined 45 percent of respondents said the political environment has either prompted greater interest within their respective organization to find partners or greater interest from potential partners to formalize a relationship.

In interviews, most hospital and health system executives have expressed intent to stay their course with their strategic plan, but Mr. Rivas said he is accepting the reality that, should his system's Medicaid revenue seriously decline in the next few years, he will have to pick up the phone and initiate conversations with some vendors around price.

“A reduction to the Medicaid program would have significant impact on us, as well as other hospitals,”

he says. “That will require us to address our vendors and partners in a different way from a financial perspective. A need for, quite frankly, concessions in pricing are going to be necessary.” He said those conversations would consist of a combination of directly requesting reduced prices and proposing performance-based agreements.

Irrespective of the political climate, Mr. Rivas shared an anecdote that underscores how CFOs have ample opportunity to ultimately broker a lower — and fairer — price when armed with data. In Mr. Rivas' case, he reviewed blinded comparison data from a partnered group purchasing organization to discover Hendricks was charged 50 percent more for orthopedic supplies and devices than competitors in the local area.

---

**“In my career, I have seen situations where vendors have noted that the reason things didn't work was because their main client didn't really act like it was in a partnership. They acted like it was a win-lose on every point, and this ultimately undermined the goals of both parties.”**

Brent McDonald  
Managing Director and Head of Healthcare Strategic Advisory,  
Bank of America Merrill Lynch

“Through that knowledge, that information, I brought that and had a conference call with all three vendors and disclosed that to them. I said, ‘Please make me understand why pricing to Hendricks Regional Health is at this level versus what it is to others in this local marketplace, based on data that’s been provided,’” he says. “They couldn’t provide an explanation.”

Mr. Rivas underscored how coming to the negotiating table with that information made his argument doubly more effective than simply asking for a price break.

As important as the agreement process may be, CFOs say they have seen many partnerships go south after one party negotiated too hard at the table. Overnegotiation occurs when one side possesses more power than the other and pushes that leverage to their advantage by stacking the deal heavily in their favor.

“I’ve seen some vendor relationships where the hospital system negotiated too hard and their terms were too one-sided, where the vendor could not realistically provide the service required

**“And we view it as, ‘This is a partnership that, we are going to make it work, come hell or high water. And we just take that attitude and the partner does, too. So, when issues come up and we have strategic directions we want to go, we just communicate them.”**

William Fenske  
Chief Financial Officer, Rice Memorial Hospital

and still have a reasonable margin,” says Mr. McDonald. “So, that ended up causing lots of operational problems. Someone ended up negotiating a really good contract, but it wasn’t sustainable.”

Experts suggest negotiating parties consider the long-term success of the relationship, which often comes down to a deal structured in a manner that enables both sides to have their “wins” — even when the arrangement could have easily been more one-sided. Willingness to compromise is a necessity in partnerships.

“In my career, I have seen situations where vendors have noted that the reason things didn’t work was because their main client didn’t really act like it was in a partnership,” says Mr. McDonald. “They acted like it was a win-lose on

every point, and this ultimately undermined the goals of both parties.”

### **Assessing the partnership**

It is difficult if not impossible to form and implement a standardized assessment of partnerships across the board — most relationships differ from one another in objective, scope and priority. In the survey conducted by *Becker’s*, 91 percent of health system and hospital executive respondents said they assess a partnership’s performance every 1 to 3 months.

Mr. Fenske and his team conduct monthly meetings with partners to discuss or review initiatives and progress. He also views this as an opportunity for the partner to share concerns or frustrations.

“This is not a one-sided thing, so we have scheduled meetings to discuss any issues that get brought up or any direction that we want it to go,” says Mr. Fenske. “And we view it as, “This is a partnership that, we are going to make it work, come hell or high water. And we just take that attitude and the partner does, too. So, when issues come up and we have strategic directions we want to go, we just communicate them.”

CFOs generally agreed: Clinical outcomes are more difficult to measure and assess than financial or operational metrics, which they find more straightforward. “You can demonstrate pretty clearly return of investment, pay back, effectiveness and increases in productivity,” says Mr. Rivas. “I think the more difficult one is quality regarding patient care and the ability to move the needle in respect to outcomes. That is more challenging.”

“One, measuring clinical outcomes is not as mature as measuring financial outcomes. So, we don’t always agree on what the best clinical outcome is,” says Mr. Fenske. “The other

thing is, clinical outcomes are still based on people, and I would argue it’s not an exact science on how to measure benefits with the human body, of what you’re able to get out of a clinical initiative that you can looking at a checkbook.”

Grading clinical outcomes according to patient experience and other qualitative data is tricky, but assessing financial data can be just as complicated, Mr. McDonald says. Identifying true savings can prove difficult, as costs may not really go down but are instead shifted elsewhere in the organization.

“Interestingly enough, financial savings can be really difficult to measure,” says Mr. McDonald. “There’s cost allocations and or substitutions, you have a yin and a yang — you may save money on one item, but then your vendor causes you to use greater FTEs or more expensive inventory somewhere else. I think all around it can be fairly difficult, particularly in a new outsourcing arrangement, to have certainty of outcome.”

**“The underlying matter or issue where I’d consider: Who are those partners that truly have the best interest of Hendricks in mind? Those organizations that think about it every day and contact us, not to sell us business, but contact us to make us better, whether it’s clinically or operationally.”**

Isadore Rivas, CPA  
Chief Financial Officer,  
Hendricks Regional Health

The timing of assessments will ideally put each party in a position to more nimbly repair problems brought to the table. For instance, Mr. Rivas recently brought forward his concern that a partner heading up the health system’s collection of self-pay patients’ payments was charging the organization three-times the going market rate. “We indicated our dissatisfaction, my dissatisfaction, and their response — they charged us what they did because they could. It was in their best interest and not in our best

interest.”

Seven months after that discussion, what he once classified as the system’s “worst” partnership radically pivoted to become one of its best. The vendor not only readjusted its pricing agreement with Hendricks, but overhauled its approach to customer service and the vision it shared with its client.

“That relationship completely changed — they took an approach of, in essence, better understanding our practices, our billing methodology and our collection efforts,” says Mr. Rivas. “They took an approach of better understanding our operations, our objectives and our business.”

### **Lessons learned from partnerships, in retrospect**

When CFOs imagine their organization’s healthiest partnership and most disappointing partnership, what differs between the two? *Becker’s* set out to answer that question.

Overall, CFOs expressed disappointment in “transactional” partnerships,

**“If it really is an important strategic initiative, you don’t want it to be unwound in three years. It shouldn’t be a contract, it ought to be something more permanent. It’s got to have a strategic network benefit and it’s really got to be a win-win, so you don’t want to over-negotiate it.”**

**Brent McDonald**  
Managing Director and Head of Healthcare Strategic  
Advisory, Bank of America Merrill Lynch

which they say have a short lifespan. Mr. Fenske says transactional relationships, regardless of objective, eventually underperform or break down.

“It’s viewed more as a vendor relationship than a partner relationship, meaning it comes across as both parties don’t have skin in the game,” says Mr. Fenske. The transactional relationships rarely span beyond anything that was not explicitly stated in the contract. “It’s, ‘We need this, we need you to provide this service.’ Then it’s like, ‘That’s how the contract reads, and then we’re done,’ versus continually looking at how we enhance a relationship.”

Mr. Rivas agreed. “The underlying matter or issue where I’d consider: Who are those partners that truly have

the best interest of Hendricks in mind? Those organizations that think about it every day and contact us, not to sell us business, but contact us to make us better, whether it’s clinically or operationally.”

The idea of permanence or longevity was another factor that stood out between high-performing and troubled partnerships. “I would tell my clients, no matter what the partnership is, you have to have a stickiness to it, you have to have permanence,” says Mr. McDonald. “If it really is an important strategic initiative, you don’t want it to be unwound in three years. It shouldn’t be a contract, it ought to be something more permanent. It’s got to have a strategic network benefit and it’s really got to be a win-win, so you don’t want to over-negotiate it.” ■