A Promising Form of Consolidation

Joint Operating Agreements Are Gaining Popularity

BY ALAN M. ZUCKERMAN

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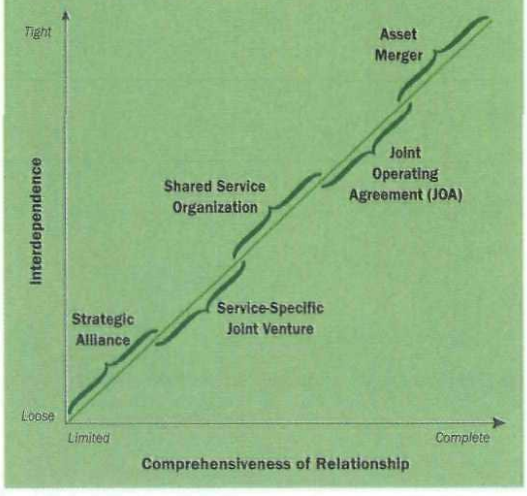
Consolidation has been the *modus operandi* for the healthcare industry in the 1990s, as hospitals, physicians, and other providers have responded, albeit cautiously, to economic pressures and excess capacity. While many permanent combinations have occurred, quite a few collaborative efforts have culminated in something short of a complete merger of assets. The range of collaborative models has grown tremendously in just a few years; **Figure 1** depicts most, if not all, of the options available today.

Of these collaborative models, joint operating agreements (JOAs) are a relatively new phenomenon, dating back only about five years. JOAs were created to shortcut the typical full-asset merger process and provide most of the benefits of a complete merger without the same degree of commitment and permanence. They have become quite popular, judging by the number of JOAs that have come into existence in the past few years and by the frequency with which this model is considered in collaborative planning processes. JOAs may be attractive to healthcare organizations when religious sponsorship of one or more of the potential partners creates difficulties with asset transfer, or when legal obstacles, such as certificate of need requirements or restrictions on public and quasi-public healthcare organizations, make a non-asset combination preferable.

Figure 1

Range of Affiliation Options for Hospitals



A Middle Ground

JOAs represent a middle ground between complete mergers and more limited arrangements such as shared services organizations and joint ventures. They are often described as a merger of income statements. At a minimum, a JOA is a legal arrangement that creates a new entity with some authority over the organizations that established it, although this authority varies widely.

While the intent usually is to create a fairly complete combination with a high degree of interdependence, most JOAs fall short of this goal. Leaders of many JOAs are frustrated because the organizations fail to deliver on the promises made during their formation and are exceedingly difficult to operate effectively. Some lawyers, consultants, and financial advisors believe that JOAs are merely a transitional model that allows independent healthcare organizations to move gradually toward a permanent merging of assets in stages rather than all at once.

Keys to Success

To determine whether JOAs have a future, I reviewed the status of several JOAs in 1998. After the initial screening, the study's focus became a few high-performing JOAs. My purpose was to

better understand how they achieved their success and what implications, if any, their success has for the vast majority of underperforming JOAs and for organizations that are considering this collaborative option. The selected JOAs were relatively mature, having been in operation since 1994. They ranged in size from $150 million to $300 million in annual revenue and included one urban entity in a small metropolitan area and one based in a small city that also extends into a rural area. Each of the selected JOAs has an interdependent organizational structure and operations with central authority and combined income statements. **Figure 2** profiles the key characteristics of the two organizations.

A site visit at each system used a format of interviews, questions, and discussion topics. When necessary, telephone follow-up garnered more information. While the research methods were uniform across the organizations, the findings are largely subjective. Neither JOA is "finished" with its development—each is a work in progress. In addition, neither JOA has done everything right but both have had relatively smooth paths to their current position and are, judging by financial and other evidence, quite successful.

Leaders at the two JOAs cited three principal factors in their success:

- A clear vision embraced by leaders
- Well-articulated organization values, embraced by all levels of the organization
- Strong board leadership and management, which complement each other in policy oversight and operations and in consistent execution of the vision and values

Each of the JOAs underwent a relatively rapid and seemingly uneventful transformation of multiple organizations into one with a unified purpose and voice. They appeared to be driven by the desire to deliver clear community benefits as opposed to institutional self-preservation or promotion. In both cases, trustees, business leaders, and physicians wanted to reduce duplication, achieve economies, and rationalize future system development with the goal of offering a quality healthcare system at the lowest cost possible to the communities served. To that end, each JOA pursued significant cost-reduction initiatives, involving both clinical and nonclinical services. In both systems, clinical integration and consolidation have resulted from unusually active physician participation. In each case, a cost-reduction plan, devel-

Continued on page 16

Figure 2

Profile of Two Leading JOAs*

	JOA 1	JOA 2
Size		
Annual revenue	$150 million	$300 million
Beds/Number of hospitals	500/3	700/4
Location	Small city in the East	Small metro area in the Midwest
Number of years in operation	4	4
Basis of collaboration	50:50 (system of two hospitals joined with another hospital)	50:50 (two founding hospitals later joined by two smaller hospitals)
Economic integration	Shared bottom line	Shared bottom line
Operating revenue increase, 1996-1998	Would not disclose	25%
Operating margin increase, 1996-1998	Would not disclose	50%
Major accomplishments	Combined bottom line	Combined bottom line
	Significant cost reductions (350 positions eliminated without layoffs)	Significant cost reductions
	Expansion of tertiary services, particularly cardiovascular and cancer	Expansion of tertiary services (cardiovascular) and the continuum of services provided

*These data were originally collected in 1998. In June 2000 a review of each JOA indicated that both continue to perform well operationally and financially.

JOINT OPERATING AGREEMENTS

Continued from page 15

oped at the outset, was executed largely as planned. The systems agree that the greatest potential for cost reduction lies in the clinical areas.

The JOAs have, at the same time, aggressively pursued ways to increase revenue, including tertiary service development, continuum of care expansion, and provision of services to more distant communities. The result has been the development of a broader range of services. Each JOA has rapidly proceeded to execute its plans. They both indicated that speed is an important factor in the success of both revenue growth and cost-reduction initiatives. Finally, they repeatedly emphasized the importance of ongoing, frequent communication to physicians, employees, and the community about changes that occur in the first few years of system development.

To test the broader applicability of these findings, I reviewed a number of high-performing JOAs that were formed more recently, in 1997 and 1998. Telephone interviews with the CEOs of these systems supported the findings from the earlier research, with minor exceptions. These JOAs were launched during the more difficult financial environment of the late 1990s and were aggressive in planning both ways to increase revenue and cost-reduction initiatives.

This research produced encouraging results. First, some JOAs do work and are comparable in performance to similar, fully merged systems. While a more integrated relationship appears necessary for sustained high performance, that alone is not sufficient. Strong leadership at the board and management levels is also imperative. Finally, a clear shared understanding among leaders of the benefits of the single organization is critical, as is aggressive pursuit of the key goals of consolidation. □

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NET GAINS

Continued from page 12

phone, *typing* offers a certain barrier to rambling," he notes.

Confidential Messages Could Be Read by Others

Most confidentiality breaches are the result of human error, not of the technology used. As for e-mail, the huge volume of Internet traffic makes it highly unlikely that messages between physicians would be intercepted. A breach of e-mail confidentiality typically occurs because the message was incorrectly addressed or routed, or the sender forgot to log off, thereby allowing others to read it. Such breaches are the result of common carelessness, just like indiscreet talk or erroneously addressed letters or faxes.

But, when used carefully and effectively, e-mail can give a physician a competitive advantage. It can, for example, increase satisfaction among patients who become comfortable using it by cutting out time wasted in annoying "telephone tag" and reducing the number of phone messages overlooked, forgotten, or lost. E-mail is, as noted, a self-documenting medium; it creates a record that both physician and patient can keep. And e-mail messages can piggyback *other* messages; for example, the physician could embed in his or her messages standard patient care instructions or links to educational Web sites.

Tips on Getting Started

Physicians interested in using e-mail in their practices might follow these tips, offered by Sands and the American Medical Informatics Association:

- Decide whether you will offer e-mail to all of your patients or only some of them.
- Decide whether to adopt the triage method of receiving e-mail and, if you do adopt it, assign a staff member to do the screening.
- Establish turnaround times for messages. Do not use e-mail for urgent matters.
- Establish guidelines for the appropriate use of e-mail and discuss this with patients. The major points can be summarized on a sticker attached to the back of a business card (see **Box**, p. 12).
- Print all messages to and from patients and place them in patients' charts.

Sands says that physicians who are uncomfortable using e-mail with patients may choose to experiment first by sending e-mail messages to various staff members.

Physicians and Hospitals

The quality of the relationship between a physician and patient eventually has an impact on the mission of the hospital where the physician is on staff. The same is true of online physician-patient relationships. Because this is so, hospitals should examine the role they might play in facilitating the understanding and use of Internet-based tools among staff members. In my next column, I'll talk about what physicians can do to help make a hospital Web site successful. □

Dr. Sands's Web page can be found at http://clinical.caregroup.org/ePCC/. The American Medical Informatics Association and its "Guidelines for Patient-Provider E-mail" is at http://www.amia.org/pubs/pospaper/positio2.htm. The Annals of Internal Medicine's "Electronic Patient-Physician Communication: Problems and Promise" is at http://www.acponline.org/journals/annals/15sep98/eleccomm.htm.

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NOTES

1. Advisory Board Daily Briefing, November 11, 1999.
2. Forrester Research, April 2000.