:lare Moylan

Q&A TROUBLED HOSPITALS

DIMINISHING DISTRESS

Healthcare Management's Clare Moylan helps hospitals tackle turnarounds

BY LINDA BRYANT

Healthcare Management Partners moved its Philadelphia-based operations to The Gulch this year with an eye on growth and accessibility to clients.

And in steps Clare Moylan

Moylan serves as managing director of the Nashville office for the company, which specializes in turnaround work with distressed hospitals and senior living facilities. At press time, she was working on the Chapter 11 bankruptcy of Oneida, Tennessee-based Pioneer Health Services.

The *Post* spoke with Moylan about the fine details of assisting small hospitals struggling to stay stable.

When you start working with a hospital, how much of the effort is truly financial vs. the processes in place that might be wasteful and impeding success?

In theory, you can have an efficient company that is over-leveraged and only needs financial (debt) restructuring. But in companies we work with, there are always huge opportunities for operational improvements. Typically, those operational deficiencies have driven the company to financial distress.

The first thing we do is assess the business to diagnose what the problems are and set up an action plan to turn things around. Management teams are often focused on the [profit and loss statement], whereas it's a cash shortage that turns it into a crisis. So, in a crisis we focus on cash flow, which is real, instead of profitability, which can be misleading. The key is prioritizing your initiatives to make the most impact and pulling together the right team to implement them.

How often are a hospital's troubles primarily clinical? And do patients get a sense of when a hospital is not working well and, as such, take their business elsewhere?

Financial and clinical problems don't always go hand in hand. Though in a struggling organization, it is much harder to keep your top clinical talent. In most distressed situations, the hospital's troubles are not primarily clinical. The health care environment is changing rapidly and financial pressures, particularly on standalone providers, are extreme. There are many "links in the chain." And one

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broken link — such as a failed electronic health record installation or ineffective billing and collections processes — can bring the organization to its knees.

Patients certainly "vote with their feet." That's why communication and transparency is such an important part of what we do. The community — and certainly hospital staff and physicians — generally have a strong interest in seeing their local hospital do well. We come in and lay out our findings because we need everyone to understand what the issues are and help work together towards their resolution. Building up trust between different stakeholders is critical to putting the hospital back on track and improving financial and clinical performance.

You have worked with various rural hospitals. How different are the problems at a struggling rural hospital compared to those at an urban facility?

Rural hospitals face several issues that many urban facilities avoid. Rural populations are declining as young people migrate to cities, which means the local hospital's market is declining. This is somewhat offset by an aging rural population and the higher use rates of health care in those over 65. Nonetheless, [health care] markets in general, are trending away from rural areas.

This has a serious impact on the talent pool, too. The recruitment and retention of experts needed — for example, physicians, nurses, IT techs, billing specialists and executive management — is a real challenge in rural areas. The younger generation of newly qualified doctors do not tend to like the idea of being a sole practitioner in their specialty area, which historically was the way things were done. Rural hospitals need to assess opportunities for some type of clinical integration with larger hospital systems in order to address these staffing challenges.

How much of a share of Healthcare Management Partners' revenues are from its financial advisory and expert witnesses services?

It fluctuates year to year. When we get a litigation support job, they tend to be large, complex cases. Scott Phillips is our guru in that department. This year we worked on a very large case where a hospital system claimed damages against a national health insurer for being locked out of network for over 20 years. We calculated damages of over $600 million and the case settled before going to trial. So this year, the litigation work makes up about 25 percent of revenue. Financial advisory is usually less than 20 percent, and the majority of our work is in turnaround, or chief restructuring officer, engagements.

You offer a proprietary data analytics service called HMP Metrics. Thoughts?

HMP Metrics is a data warehouse of the HCRIS cost reports filed by every Medicare-certified hospital in the country. We have data for each quarter from 2015 going back to 1996, so it's a monster on the server. The most powerful use of this data is in benchmarking and trending key operational metrics. It very quickly points us to where opportunities lie. We rely heavily on this data for our expert testimony work, and it is also used by private equity firms and banks to source opportunities and conduct due diligence.

In addition, HMP Metrics contains the hospital Medicare claims data (MedPAR) for several states, which enables us to run patient migration studies showing where patients in a certain market are choosing to go for their hospital care. Outmigration of patients (i.e., patients choosing not to use their local hospital for care) is often an issue for many hospitals that we deal with.

Our director of HMP Metrics, Dr. Aaron Wells, is working diligently to relaunch the product on a new server and revamp the code so that it works faster. The most exciting part is the addition of data from other health care disciplines. We are working now on a test product that matches the Medicare hospital and skilled nursing facility claims data to trace patients through the care continuum. This establishes a level of market understanding that we haven't seen before. And with the move toward bundled payments, this kind of analysis will be very powerful. We are in discussions with a clinical care group that can analyze the HMP Metrics data from a quality standpoint, which will bring a new angle to the analysis.

What might a turnaround process look like for a client?

I'll give you an example of a Tennessee client we helped turn around this year. The company is a large provider of post-acute care services (skilled nursing, behavioral health, rehab, homecare, hospice, pharmacy, etc.) with over 4,000 employees and around $300 million annual revenue. When we first looked at the company, it was on the verge of bankruptcy with only eight days' cash on hand and in default on loan covenants. We were engaged to conduct an assessment and develop a turnaround plan. In an unprecedented move, the company's board unanimously voted to support our recommendation to replace the entire executive team.

We needed to send a message to the organization that the culture was really changing, and it was the right decision. We brought in a new CEO (Bruce Buchanan) and CFO (Derek Pierce), and I was project director. I later took the role of the head of home health and hospice. Within a matter of weeks, we identified necessary staff cuts and implemented them quickly. Then we could reassure the rest of the staff that they were the "go forward" team. In this case, we made no significant cuts at the facilities, but there was huge overspend on overhead. We pulled together the leadership of every department and strategized together about the key areas of dysfunction. They worked in inter-disciplinary teams to develop initiatives. Some of these people didn't know each other's names — such silos had built up over time. We encouraged cooperation and empowered leaders to "right their own ship." Many had just been waiting to be told what to do, but we encouraged them to figure out their own solutions and become leaders.

After getting through the cash crunch, operations quickly turned around and the company went from (earnings before interest, tax, depreciation and amortization) of $11 million in the year before we arrived (2014) to EBITDA of $50 million and 83 days cash on hand in 2015. In the meantime (and into 2016), we refinanced the distressed debt with a new lender and, at the end of our engagement, transitioned to a new management team. NP

'IN MOST DISTRESSED SITUATIONS, THE HOSPITAL'S TROUBLES ARE NOT PRIMARILY CLINICAL'

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