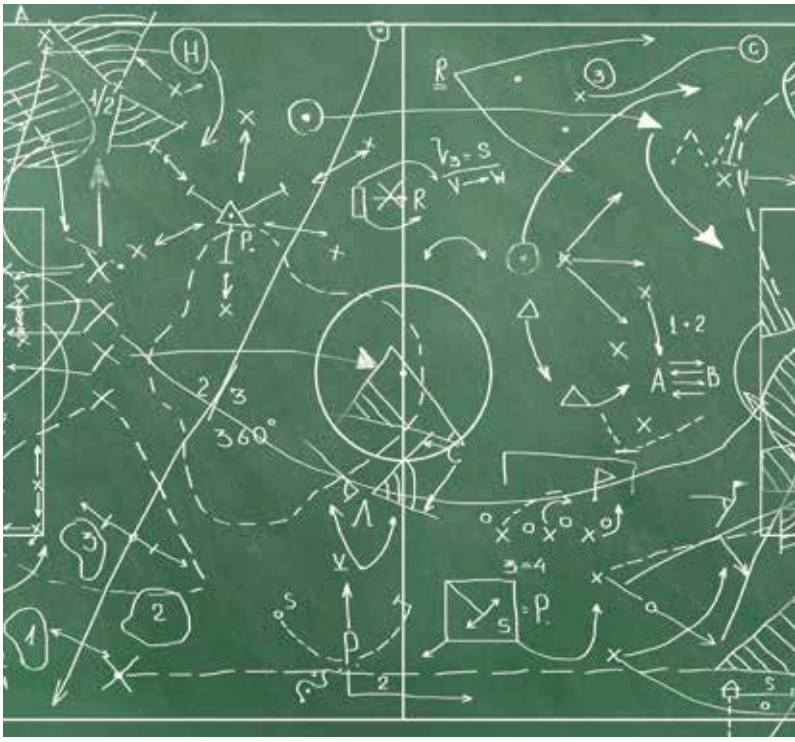
ROUNDTABLE

Life After Acquisition

Consolidation in healthcare has been the trend for many years, and it shows no sign of abating as provider organizations look to redesign care delivery models and prepare for the shift toward population health management and value-based purchasing. For those institutions that have already undertaken an acquisition, many challenges exist, including merging IT infrastructures, blending different organizational cultures, and balancing local versus corporate control. With so much at stake during the transition process, senior leaders have to set and execute the right plan in order to achieve the goals of the acquisition. HealthLeaders Media recently joined with four executives for an in-depth conversation on the trends that are driving acquisitions and the steps that are needed to ensure successful integration once the transaction is complete.



PANELIST PROFILES

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Healthcare System
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Roundtable Highlights

HEALTHLEADERS MEDIA: *What trends within the healthcare industry are driving the rapid pace of merger and acquisition transactions?*

ROBERT GLENNING, HACKENSACK UNIVERSITY MEDICAL CENTER: I think in our market it's certainly about trying to get closer to the patient. For us, we've divested some ancillary businesses so that we could concentrate on the physician, acute, and ambulatory sides of healthcare and go deeper in those areas. I think once this trend got established in our market, it really sensitized people to move rapidly.

I believe the motivation for physicians to partner or seek employment at a medical center like HackensackUMC is that the administrative requirement of running a practice has pushed them to the edge to say, "Do I really want this?" I think they are looking to partner with organizations like ours where they can hand off some of their administrative burdens and concentrate more on medicine and quality-of-life issues.

EDWARD DUDLEY III, CATHOLIC MEDICAL CENTER HEALTHCARE SYSTEM: At least in New Hampshire, I think the acute care hospitals are all fairly healthy financially. It's now more driven by trying to get our cost down and our value up and looking to leverage that with other providers, and doing it from a position of strength as opposed to a position of weakness.

It's a challenge in New Hampshire because we have world-class healthcare just an hour south in Boston that continues to expand north. ... I think the trend now is going to be looking at who is going to affiliate with which Boston teaching facility or with Dartmouth-Hitchcock. Those discussions are going on. ... I think some of the Boston hospitals look at us to see what they can offer us and what we can offer them, and that's the discussion that we continue to have.

GARY AKENBERGER, PROMEDICA: We still see the need for capital as one of the big factors to invest in technology and the IT infrastructure. We are seeing significant opportunities with organizations coming forward with interest in being acquired.

"We still see the need for capital as one of the big factors to invest in technology and the IT infrastructure."

LYNN WIATROWSKI, BANK OF AMERICA MERRILL LYNCH: I think if you look back and pinpoint where some of the more recent activity started, it was in 2008 and 2009 when the economic issues and the financial stresses in the market prompted a number of boards and hospitals to be concerned about capital-raising. ... Pretty quickly that resolved itself, but then healthcare reform created the need for a patient-centered, value-based model. Everybody just started having conversations about how to reform the healthcare delivery model. ... I don't see the pace slowing up. And it's not always that you have to merge, but you have to think about where you want to take your system of patient care.

HEALTHLEADERS MEDIA: *Who among the leadership team should be involved in the beginning stages of the negotiations?*

DUDLEY: For us, the discussion really starts with the board, which is made up about 25% by physicians. We actually engage them in our strategic process, which would include potential discussions with potential suitors. From the beginning, we engage the board, and then senior leadership will then devise strategies around who to approach and how to approach them. At that point, it's really a CEO-to-CEO conversation to see if there's bona fide interest.

AKENBERGER: We have a similar process within ProMedica. We also have physician leadership involved in our governance. Our executive team, which would consist of the CEO, legal counsel, finance, and strategic and marketing, would be the team that would

Gary Akenberger
Senior Vice President Finance
ProMedica

come together and work on developing the initiative, and then conversations with CEO to CEO, as well as the boards. Both boards would have conversations making sure there is some fit in terms of expectations.

WIATROWSKI: There are premerger conversations that take place, and they come in all different shapes and sizes, but very often it's CEO to CEO that begins the dialogue, and we've seen this approach work pretty well. After the merger agreement is a really important time when you think about, "Okay, how do we set this up for success? How do we set this up so that we get the right merged culture?" ... You've got to have clear accountability. Who is going to be the lead? There will be one CEO, but then you bring in other players from both sides and lay out clear leadership responsibility, and it's important to think that through carefully because you are setting the tone from the top all the way down.

Edward Dudley III
Executive Vice President & CFO
Catholic Medical Center
Healthcare System

HEALTHLEADERS MEDIA: *How does your organization integrate IT systems after an acquisition?*

GLENNING: If it's a smaller organization, it makes sense to standardize. We have found even though we have standardized on certain IT packages, there are still people who pine away and push for smaller boutique software packages that don't really provide an advantage. Now if we're looking at a larger transaction where it would be a merger of equals, and there are different IT platforms, we'll go through a thorough joint collaborative process to make that decision.

By standardizing on IT, we've eliminated many choke points on data flow, making the information available to a broader group of users in a timelier manner. It has proven disconcerting to some that controlled the flow and liberating to those now receiving the flow. It's been an interesting dynamic because you have a small number of people saying, "No, not everybody should have access to it," and the business intelligence team providing access to the end users directly.

AKENBERGER: We evaluate the existing systems in terms of the entities that are being acquired, look at where they are in their life-cycle replacement needs, and then develop a risk summary. We identify what systems are at risk, and then from there we develop an action plan and identify which systems are going to be maintained, which systems are going to be converted, and move down on a specific plan of action to identify where we are going.

> **"Culture trumps financial benefit, efficiencies, and everything else,** and the process isn't done overnight. It really starts with just the cultural fit between administrations."

DUDLEY: We started at Catholic Medical Center probably two or three years ago ... to do some due diligence to evaluate our IT system. ... What is challenging for an organization of CMC's size is scale. These systems run into the multimillion dollars, and it's really just not affordable for a stand-alone facility to take on some of those systems. We're again trying to position ourselves where we can have an IT system that will lend itself for easy conversion to a potential partner down the road yet to be defined and named. We've narrowed it down to two IT vendors, but trying to make that final call has been a bit of a challenge because of the uncertainty of affiliation and cost. It's probably one of the most important decisions next to an affiliation, if that were to occur, for this organization.

HEALTHLEADERS MEDIA: *After an acquisition, which decisions are made at the corporate level and which are made at the local level?*

AKENBERGER: With the exception of certain reserved powers that ProMedica retains, the management of the local hospital and the community assets stay at the local level. In terms of some of those reserved powers, ProMedica appoints board members on their boards. If there are expenditures above

a certain budget level, both from a capital and an operating standpoint, those items would then need to be approved by the corporate or the system board. Most of the decisions stay at the local level.

WIATROWSKI: Shared service functions such as finance, treasury, and human resources are at the corporate level. Capital expenditure decisions can start with local recommendations that bubble up to the corporate level for approval. However, anything that is "client-facing," such as clinical and patient-facing activities, should be kept as local as possible until you determine if there is an opportunity for more hardcore integration.

GLENNING: We'd like to have all the back office–type functions done at the corporate level, but in all instances, the clinical decision-making needs to be kept at the local level.

HEALTHLEADERS MEDIA: *What is involved with successfully merging two cultures into one organization with a single mission?*

DUDLEY: Culture trumps financial benefit, efficiencies, and everything else, and the process isn't done overnight. It really starts with just the cultural fit between administrations. Even if both administrations may not be the surviving administration, there has to be that sort of coming together in terms of why we're doing it and what's the benefit.

I think one of the skills that we can't forget is that transparency doesn't end when the merger is completed. The communication and employee involvement has to be ongoing.

WIATROWSKI: What's interesting on the culture front, when you go through multiple mergers, as we did in banking, you learn that when you bring two organizations together, there's definitely an us-versus-them culture when you start, and I think that's what you just have to be open-minded about and aware of. It is honesty, transparency, and communication that bridge a culture.

Lynn Wiatrowski
Executive Vice President National Treasury Executive, Specialized Industries
Bank of America Merrill Lynch

Some of the toughest decisions happen many months later or a year or two after because the way to get most of the savings from a merger is through staff integration, technology, or other synergies, which often mean reductions and changes that can create hugely negative perceptions. Communicating around those so people understand that the decisions will have the long-term benefit of leading to better access to care and better cost of care is critical. It's really important to keep that communication going.

"There are premerger conversations that take place, and they come in all different shapes and sizes, but **very often it's CEO to CEO that begins the dialogue,** and we've seen this approach work pretty well."

GLENNING: Sometimes cultural issues are proxies for things people don't want to say, and it's hard to get them to put the real issue on the table because the proxy issue sounds compelling. Sometimes people just don't want to say, "Hey, listen, I'm concerned," or, "I don't like what's going on."

I think people appreciate knowing with some certainty where they stand, and sometimes that means you lose people a little bit sooner than you'd otherwise want, but you work through it. Everybody understands it's a process.

AKENBERGER: You can work through most things, but if you can't work through the culture and mission issues, it's not going to work. Those points are critical. Also at the highest levels, from the executive leadership as well as physician leadership, engaging with employees early on in the process and managing expectations is important. Leaders have to set the tone and say, "This is what this merger means to us and the communities we serve." There also needs to be transparency in terms of ongoing communication to both internal and external stakeholders.

One of the things we have found that is also important is to begin building relationships by having face-to-face meetings among counterparts at merging entities so they can begin to put a face with a name. We've found that this helps to ease the transition. It provides that more personal touch and encourages engagement.

HEALTHLEADERS MEDIA: *While going through an acquisition or partnership process, what issues concern you other than the transaction itself?*

GLENNING: One concern is becoming too inwardly focused during a large transaction. In order to guard against being too inwardly focused, we expect we would actively discuss how we might split the management team to have a group that will manage the entity, and a group that will be responsible for the transaction.

WIATROWSKI: The concept of setting up a merger and integration team is really, really important. Here's a discrete group of people, with reasonably equal representation from both sides, that are doing a whole lot of work behind the scenes so you can let the people that are in the field still operate and stay focused on the day-to-day. Because it's true that the minute you begin going through a merger, every competitor out there is saying, "Oh, they're going to take their eye off the ball."

DUDLEY: I think it brings up something that we're also very cognizant of, which is if the affiliation doesn't go well, your formerly affiliated partner may now become your competitor. They know maybe more than they should know, and that puts you at a little bit of a disadvantage.

HEALTHLEADERS MEDIA: *How do you measure the success of an acquisition or affiliation?*

WIATROWSKI: A great measure of success with a merger or integration is the lack of publicity. A quiet, uneventful joint coming together of two organizations is important. If there is no drama, no publicity, it's really good.

AKENBERGER: Aligning cultures from the physician, governance, and the employees' perspectives. When we go through a merger, we identify integration targets, and we set expectations from an integration standpoint, be it a system implementation or the centralization of services. Then we monitor and report back. That to me also defines whether we've been successful or not in terms of implementing.

DUDLEY: With everything that we do, we look at four attributes, and affiliation would be no different. So it's patient satisfaction, employee satisfaction, growth of the organization, and financial strength. Those are really the pillars by which we measure all projects. We look at affiliated partners through the eyes of those attributes, and if they all line up, then we realize we've got potentially the right track to go down, then we'd continue to measure that ongoing. Also, it has to be about high-quality outcomes. I think if you deliver the message that you are leading with finance, it doesn't work. You lose people right away when you start out with the financial reasons for an affiliation. It really has to be driven by value and outcomes.

HEALTHLEADERS MEDIA: *Looking at the direction in which the healthcare industry is moving, is consolidation unavoidable?*

GLENNING: In our market, I think so. I believe that everybody will be aligned in some fashion in the next five years. There might be one or two holdouts, but I believe as organizations assess their market position, they're going to acknowledge probably what they've tried to forestall, and that is while healthcare is local, it's going to be best delivered through a system of care, not in a fragmented manner. That may not exist in other parts of the country, but here in this market, I think it's moving in that direction.

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AKENBERGER: I would say that in terms of mergers, if you include affiliations, I think it is inevitable that healthcare organizations are looking at new ways to work together—whether it is some type of an affiliation arrangement, a joint venture, or full merger. It is already happening and will continue to happen in our market. I think you'll see more and more of the larger health systems coming together to establish maybe not full mergers, but affiliations to be able to gain some economies of scale.

WIATROWSKI: I've heard it referred to as the "systemness imperative." If the goal is to be sure that every patient gets the right care at the right time in the right setting, to drive both excellent patient-centered care and enough cost efficiency to bend the cost curve in healthcare, I think there has to be a broader system that gets you there. It doesn't mean you've got to merge. There are many other ways to build affiliations and collaborations, but I think that the system orientation is here to stay.

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