



Making a Merger Count: Hospital CFOs and Post-M&A Change Management

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Making a Merger Count

Post M&A operational change management is an added full-time job for hospital and health system CFOs

By Molly Gamble

The volume of merger and acquisition deals in healthcare hit a new high in 2015, with 1,498 transactions across 13 industry sectors, according to Irving Levin Associates. Deals involving healthcare services made up the bulk of M&A activity, with 102 transactions between hospitals, 88 involving physician medical groups and 356 involving long-term care settings. It's worth noting that this data understates the volume of activity through affiliations, partnerships and joint ventures.

When a deal is done, the real work is just beginning: operational change management. M&A is riddled with value-creation challenges, and consultants have

noted health systems' tendency to underestimate the cost of post-merger integration after a deal is reached. Roughly one in five acquired hospitals — 18 percent — actually go from having positive margins before a deal to negative margins two years afterward.

As one hospital CFO said, a clear-eyed vision of what synergies will be realized in the first 90 to 180 days post-merger is a necessity. Unfortunately, for many executive teams, the vision soon grows foggy. In a survey of hospital and health system leaders conducted by Becker's Hospital Review, 41 percent said they have made poor progress toward post-M&A operational efficiency, hardly realizing the economies they

planned for when structuring the deal.

This e-book, based on survey responses from financial executives and a roundtable discussion with five hospital and health system CFOs and a healthcare finance expert, discusses the challenges and best practices around operational change management after a merger, acquisition or affiliation.

The roundtable participants included: Tim Heinrich, CFO of Thorek Memorial Hospital in Chicago; Greg Klugherz, CFO of St. Cloud (Minn.) Hospital; Jim Dietsche, Executive Vice President and CFO of Bellin Health in Green Bay, Wis.; Michael Burke, Senior Vice

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Before managing change, the question of finding the right partner

Some of the most important work in operational change management occurs in a rigorous due diligence phase, when CFOs and other senior leaders determine a partner is a “true fit” before any commitments. This is the time for finance leaders to assess a number of operational items on the checklist, including the physical plant, deferred maintenance and how much of a capital investment is needed to get the organization’s IT infrastructure and resources standardized and up to date.

Due diligence also calls for integration planning and

behaviors well before any deal closes, such as an assessment of opportunity to streamline the revenue cycle, clinical service lines, and administrative functions like human resources to achieve the needed benefit from the upfront investment of the acquisition or merger.

In the survey of hospital and health system executives, most told Becker’s Hospital Review the operational efficiencies most sought after in a partner are those related to clinical programs and service lines, management, revenue cycle and payer contracting.

When speaking to CFOs, they are quick to point out the importance of referral patterns and physician alignment, as well. The growth in patient volume that typically follows a merger or acquisition due to expanded referral networks has been and continues to be a primary driver of M&A. Closer ties with quaternary and tertiary provider organizations are especially vied for as healthcare providers expand their care continuums. Through affiliations, health systems can also build

closer ties to what were previously independent physician practices that split referrals to different hospitals.

Mr. McDonald with Bank of America Merrill Lynch says hospitals and health systems must assess how the ultimate integration of a prospective partner would optimize their “network” in the due diligence phase. “Obviously, you have to have a network effect and benefit,” he says. “For instance, we’ve seen where those downstream referrals — the quaternary and tertiary — are important to these types of mergers, acquisitions, affiliations and partnerships.”

At UW Health, the first question Mr. O’Keefe asks when looking at a partner is whether the organization is a symbiotic clinical fit. UW Health completed a formal merger with Rockford, Ill.-based SwedishAmerican on Jan. 1, 2015. The formalized deal followed a five-year clinical relationship where UW specialists practiced in the Rockford area — roughly 70 miles south of Madison — at the invitation of SwedishAmerican health system. In return, patients

in need of tertiary and quaternary care came to Madison from Rockford.

The second question Mr. O’Keefe poses is whether the partner is a fit from a population health perspective. “We think there is a certain critical scale of covered lives that we need to achieve, and we’d like to achieve that through a contiguous approach — meaning affiliate with organizations that by and large have contiguous markets,” he says.

Mr. Dietsche, CFO of Bellin Health, also scrutinizes all organizational suitors under the lens of Bellin’s population health strategy and asks whether the deal would grow the number of lives Bellin serves. The system includes a hospital, psychiatric center, more than 35 primary care clinics and several retail health clinics, along with a physician-hospital organization with more than 200 specialty physician members. More recently, in June 2014, the system expanded its footprint by acquiring NorthReach Healthcare, which employs more than 25 healthcare providers throughout 10 clinics and specialty care locations in Wisconsin and the Upper Peninsula of Michigan.

“What’s really sensitive is the provider relationships,” he says. “That needs to be the cultural fit. I would say that if there’s a pecking order to how we [determine] that, it’s making sure that culture is

compatible. Once we make the acquisition, it’s integrating those providers into our overall strategy.”

CFOs are most confident in operational change management when they have history with the entity with which they are merging, partnering or acquiring. St. Cloud Hospital acquired two medical practices and three critical access hospitals, and “in every case, we actually knew these organizations very well,” says Mr. Klugherz.

“We’re in a part of Minnesota dominated by relatively small towns. Our tertiary hospital was probably the hospital that did the second-most number of admissions from those communities in all three cases. Our doctors had good relationships with the medical staffs, or operated the medical practice in those places,” he says. “Our due diligence was not based on extensive analytical work; it was based on a relatively

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CFO of Thorek Memorial Hospital in Chicago

subjective judgment that we could improve the long-term condition of healthcare in the new affiliates’ communities and the communities that were already part of our system.”

Setting and keeping the pace of change management

Most (41 percent) of hospital and health system leaders say their organizations have done a poor job of operational change management and achieving efficiencies after a deal. Some executives use the word “chaos” to describe their organizations post-M&A. This type of environment can leave executives spending a disproportionate amount of time distracted by operational predicaments and malfunctions rather than planning for new growth opportunities.

Of those executives who have made self-described “decent” progress achieving efficiencies, only about half have adhered to their original integration plan. The other half strayed.

Executives must come to terms with the time-consuming nature of operational change management if they are ever to achieve it. Pacing integration, that is setting 30-, 60-, 90- and 180-day milestones and using early wins to maintain momentum, is challenging for any organizational team that still has to continue their business-as-usual functions. This process takes years, which can also frustrate leaders who are eager to look ahead and plan their organization's next move.

“I think what you'll find is it's not as easy as you thought,” says Mr. Heinrich with Thorek Memorial Hospital in Chicago. “It will take longer than you thought. Just stick with it and a lot of times you may have to make different changes along the way. More often than not, it takes a very long time to get everything acclimated.”

NYU Langone Medical Center finalized a full-asset merger with Lutheran Medical Center in Brooklyn in January – now called NYU Lutheran Medical Center. The two organizations planned for combined savings of \$56.9 million annually through efficiencies in IT, patient care management, collection of outstanding debts and contracts with managed-care plans.

But planned savings are one thing; actually sparing millions of dollars in costs is another. Where does one begin? What is the

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Michael Burke
Senior Vice President and Vice Dean, Corporate CFO of NYU Langone Medical Center in New York City

integration activity that demands a CFO's attention the day the deal closes? The answer differs depending on who you ask.

For Mr. Burke at NYU Langone, his first priority was identifying leaders and establishing distinct integration teams to materialize the projected millions in annual savings. Oftentimes, integration teams are effective when made up of people from both the acquirer and the acquired. Experts also advise against the assumption that the same group responsible for the seeing the transaction through is necessarily the best group to oversee the integration process, as these tasks demand different skill sets and strengths. With a listing of synergies to achieve and measures for evaluation, Mr. Burke makes it very clear what each team is tasked to accomplish.

“We usually have a table of synergies that we're attempting to

achieve as a result of the affiliation or merger,” says Mr. Burke. “What we do is include people from both the acquirer and acquired hospital or affiliation hospital on a team to make sure we have game plans to achieve the synergies we originally planned, and then benchmark, measure and monitor our progress to ensure we achieve the transformational benefit we were planning to experience. That's the very first thing.”

When UW Health merged with SwedishAmerican, Mr. O'Keefe says his organization took a “gentle” approach that emphasizes interpersonal relationships, keeping teams and services largely intact post-affiliation, and a comfortable pace of change. “Comfortable in the sense of not overloading people's calendars to try to do their day job and incorporate a new affiliate. Comfortable from

the standpoint of just being good partners with a new affiliate and working collaboratively,” he says. “So we anticipate there will be economies of scale eventually, and at some point in time there may be a burning platform to get those synergies — but there isn’t yet.”

At Bellin Health, Mr. Dietsche and his team gets measurement tools in place as soon as possible post-deal to set the baseline for both financial and clinical measures. “All of that has to be embedded in that measurement process and part of our normal processes as quickly as possible,” he says. This requires individual accountability and full engagement from leadership. “Part of that is making sure we have our leaders in those areas making sure they bear the ultimate responsibilities for the integration of a practice or facility into the organization.”

The unavoidable burdens of IT integration

IT is one of the most significant, yet necessary, challenges in the operational change management

process. Since it touches virtually all aspects of a hospital or health system’s operations, it is difficult to integrate many functionalities without some level of IT integration. Further, a shared EHR platform is of growing importance as health systems move to manage the health outcomes for populations of people under value- and performance-based reimbursement models. “It’s literally a requirement of managing the health of a population, is how we view that,” says Mr. Dietsche.

Unfortunately, the transition doesn’t come risk-free. Consultants have estimated the costs of integrating IT systems during a merger or acquisition could add 2 percent to total operating costs for each year of the integration.

When it merged with NYU Lutheran Medical Center, NYU Langone committed \$190 million to the 450-bed hospital. Specifically, the agreement included a \$100 million loan for NYU Lutheran to go live on the

Epic EHR platform, a go-live scheduled to take 8 months.

Time and pace are especially important with IT integration. Organizations that tend to underestimate the time required to integrate IT functions run the risk of overwhelming IT teams with responsibility for integrating several systems at the same time. NYU Langone, for instance, has staggered several go-live dates months apart. NYU Lutheran’s enterprise resource planning system will be replaced in March, and the payroll system will be replaced in April. Overall, NYU Lutheran is slated to be on the Epic platform by August, as the result of a transition process that started soon after the deal was finalized.

“Critical to NYU Langone’s mission is to ensure we don’t have disparate systems. With an ever growing health system, we need to be able to share information to manage lives,” says Mr. Burke with NYU Langone. “We’d rather everyone be on Epic, which is what we’re doing now.”

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A single EHR is not a always a component of mergers, acquisitions or affiliations. In fact, more than half of survey respondents told Becker's Hospital Review that their deal did not require a change in EHR. They may have retained disparate EHRs and imported data to a data warehouse or accessed platforms through a health information exchange. For 29 percent of executives, however, an EHR change was necessary. Fifteen percent said an EHR change was actually a prime driver for their partner choosing them or vice versa.

Although technology is pervasive in hospitals and health systems, CIOs are not fixtures in post-deal integration activities. Sixty percent of executive respondents said their CEOs and CFOs are most involved in driving operational efficiencies after a merger, while zero respondents indicated their CIOs were involved.

Negotiating decisions about consolidation and right-sizing

Certain functions make up the low-hanging fruit of operational change management, such as consolidation of senior corporate management, elimination of duplicate contracts, consolidation of administrative departments and renegotiation of contracts for certain supplies and services.

But as the low-hanging fruit is picked, CFOs must weigh the potential pains or gains of closing underperforming facilities, consolidating service lines, relocating services or eliminating certain positions. Decisions about right-sizing are not taken lightly. Labor and staffing is just as much a political consideration as an economic one. For many hospitals — particularly nonprofits — workforce decisions are complicated by their service-oriented missions and close community ties.

Depending on a hospital or health system's size and market, they may be one of the largest employers in the community. That's how Mr. Klugherz characterizes 489-bed St. Cloud Hospital, which is part of CentraCare Health. As the largest healthcare system in its rural region, the system employs more than 9,000 and more than 260 professional providers. The hospital employs roughly 5,000 full and part-time staff and more than 450 physicians.

Most (37 percent) the survey respondents have not consolidated or eliminated staff after merging, and they have no plans to do so within the year. Thirty percent of respondents told *Becker's Hospital Review* that their organizations did eliminate staff, but no further staffing changes are expected this year.

At UW Health Mr. O'Keefe has

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come to believe more fully in the characterization of benefits of scale versus economies of scale. “I believe most organizations will find there is very little savings to achieve at the staff level because typically a staff is sized,” he says. “The resources are sized to the work.” For instance, if two organizations send out 100,000 bills per year each, and they merge together to now send 200,000 bills in aggregate, the number of people it takes to manage that process is still scaled to the amount of work involved.

NYU Langone pledged to not reduce FTEs or positions as a result of the merger. With that

agreement in place, they've observed staffing changes driven by something else. "The synergies are really coming not necessarily from a result of the merger — because like you say, the work is the work. It's really from the use of technologies and the communication now enabled by the technology between the physicians and the hospital, and the better coordination of service for a patient," Mr. Burke says.

For example, a "quasi-electronic" health information management department that previously trucked paper between ambulatory practices and the hospital gained newfound efficiencies when those settings were moved onto an integrated and shared platform. This is where job elimination becomes unavoidable. "You put them on an Epic platform and obviously those jobs, they end up moving," says Mr. Burke. "Those people have to do something else because you're not going to be moving paper back and forth anymore."

Lessons learned: CFOs in their own words

Looking back on the operational change management process, CFOs recalled several of the lessons they learned and conjured advice they would offer any colleagues entering or closing a deal.

Mr. O'Keefe with UW Health

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Greg Klugherz
CFO of St. Cloud (Minn.) Hospital

encourages larger health systems and academic medical centers to challenge the status quo and not act as an inherently aggressive partner, particularly with smaller organizations. "I am a big fan of one of the Stephen Covey principles, which is to seek first to understand, then to be understood," he says. "Sometimes when you're a larger enterprise, you presume you are better at something. In my years of being involved in affiliations, it's been humbling to learn that that's not the case. Bigger does not translate to necessarily more capable or smarter."

One point of passion for Mr. Burke is documentation. He and his colleagues zeroed in on this behavior among medical residents to drive a noticeable improvement in reimbursement at NYU Lutheran. When physicians, residents and care teams completely document what's done, the hospital is better positioned to code it and bill for it. Mr. Burke says the hospital was previously losing \$20 million a year and is

now making \$13 million a quarter via improved reimbursement.

"You have to systems in place to be able to nudge physicians and residents to make sure they complete their documentation at the end of a busy shift. Obtaining this information and acting on it is really important. You have to emphasize that more than anything, and then you can get the benefits. Without it, you're dead."

Mr. Klugherz, CFO of St. Cloud Hospital, encourages leaders from the new affiliates to maintain their drive and sense of purpose at their own franchises. After entities are acquired or folded into larger systems, some leaders sit back and wait for solutions to be delivered to them. He advises against this. "I think shared accountability will increase the probability of success, if they're not sitting back waiting for a solution to be delivered, but are contributing and becoming a protagonist," he says. ■