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INSIDE EDGE

Mergers & Acquisitions: Integration in the Key of C

Executive Summary

Like jazz, integrating mergers and acquisitions (M&As) of hospitals, physician practices and health systems is a uniquely American process of improvisation. It requires an innovative and creative touch to bring coherence to a healthcare "system" that often seems anything but systematic. Still, the trend toward M&As in healthcare is inexorable.

A 2014 Deloitte report, "The Great Consolidation: The Potential for Rapid Consolidation of Health Systems," estimates that only about half of current health systems will remain after consolidation. The deals are getting bigger even as the trend accelerates:

- The average deal size for a hospital acquisition in 2007 was $42 million;
- The average deal size in 2013 was $224 million—and it's certainly much larger in 2016.

The Deloitte report casts healthcare consolidation as similar to what has occurred in other industries, noting there are:

- 95% fewer retail department stores today than in the 1960s;
- 75% fewer airlines than in the 1970s; and
- 52% fewer banks than in 1990.

For hospitals and health systems, the report says, "Staying the course is no longer an option; organizations should prepare by either differentiating to maintain dominance in a clinical or geographic niche, or acquiring or aligning with other health systems. Those that do not act promptly and strategically may face major risks, including loss of significant market share or loss of local control as a result of being acquired."

For this issue of *Inside Edge* we talked to two CIOs at health systems—CHRISTUS Health and Providence Health & Services—to find out what the affiliation situation is 'on the ground.' We also talked to an expert at Korn Ferry to highlight the executive skills and talents required to lead us through this very tumultuous yet exciting phase in U.S. healthcare.

CHRISTUS Health: Empire of Caring

CHRISTUS Health has been pushing the M&A envelope domestically and internationally for more than a decade. CHRISTUS, an Irving, Texas-based Catholic health system with more than 60 hospitals and 175 clinics and outpatient sites in six states, Chile and Mexico, just announced a deal to expand into its third Latin American nation, Colombia, and has entered into final negotiations to acquire Trinity Mother Frances Hospitals and Clinics in Tyler, Texas.

George Conklin, SVP & CIO, CHRISTUS Health

George Conklin, senior VP and CIO at CHRISTUS, says sometimes it goes the other direction. "You also have the flip side, that is demergers. We gave up our two hospitals on the Gulf Coast to a partnership with Houston Methodist [also an SI member] which is majority partner and manages the entity."

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CHRISTUS has also acquired a majority share of St. Vincent's Hospital in Santa Fe, N.M. The degree of ownership and control vary based upon market position. In Houston, for example, CHRISTUS had only single-digit share while Methodist has a larger share, although not a majority, and competition is fierce among the health systems within the Houston Medical Center.

A discussion topic at a recent CHRISTUS board retreat centered on the drivers of M&A. "Obviously our information systems don't drive our creating a partnership or acquisition, it's what stands behind the CHRISTUS brand. Our goal is that such acquisitions move ahead quickly and my goal is to minimize IT expense," he says, by not swapping out an existing IT system, particularly EHRs, which can take as much as two years to install.

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"The drivers today are how to create network capability and build viable healthcare services. To take one, two or three years to roll out an EHR seems to us poor fiduciary judgment," says Conklin.

EHRs: commodities

"We think EHRs are more and more becoming commodities. What those systems do and how they work are pretty much the same, whether Cerner, Epic or Meditech. The guardrails are pretty much defined. Given that, why pull out a perfectly good information system? However, if you have two providers within 25 miles of each other and want them to operate as one, then you may make the business decision to unify them on a single IT platform. If one information system is badly broken and it's failed at Meaningful Use you're probably going to replace it," he says.

Also, if there's no interoperability possible with a new entity's system, the organization should replace it or run the risk of alienating users. Especially if physicians rebel against a newly acquired system, politics will drive a swap-out.

The end result of this laissez faire approach, even considering the exceptions noted, is "a varied system portfolio," says Conklin. "Most everybody says you're crazy to not standardize on a single EHR, but truly the value is in what you do in patient care. Of the traditional triad of people, process and technology, the people and process are the most important. As long as we can extract data for population health then we're ok."

That direction will get increasing traction industry-wide and drives the need to establish useful interoperability, as discussed by David Muntz at a recent AHA Interoperability Task Force meeting when he related that a varied system portfolio will become increasingly the norm.

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Still, the issues of interoperability and standardized nomenclature do not go away.

"The biggest problem is semantic interoperability. Even if you have two Epic systems, two Meditechs or two Cerners, two versions of the same-vendor EHR will define a patient having a cold differently, for example. ICD10 has helped and we're doing a lot with structured documentation, but it's awfully difficult," he says.

In the meantime, CHRISTUS is focusing on solving the problem of how to take data from systems and make it usable for population health using tools like a Teradata data warehouse, Cloverleaf integration software, IBM VIOS (virtual I/O server) and Wellcentive population health software for reporting and analytics. Says Conklin: "We want to create this big footprint to offer services to large employers or the government, so we need to have integration."

Providence Health & Services

You could say Renton, Wash.-based Providence Health & Services, a Catholic health system, with 34 hospitals in five states in the West, has honed its abilities to affiliate with new organizations.

"Our approach has been to evaluate each affiliation we enter into and determine how fast, how slow and how much integration each affiliation calls for," says Janice Newell, senior VP and CIO. "The fact is we are still integrating across Providence."

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Just five years ago Providence was a holding company when leadership decided to implement the Epic electronic medical record across all regions, which had independently been selecting their own EHR platforms. The strategy made sense from an overall healthcare system perspective—but it immediately had bigger implications.

"The decision to move to a common EHR was one of the catalysts to change the overall organizational structure from a holding company to an operating company. Until then, every region had its own CIO and IS shop, HR department, revenue cycle functions, all operating independently. We've been in the process of becoming shared services organizations that serve the entire Providence system," she says.

Spectrum of integration

One of Providence's first affiliations, with Swedish Health Services in Seattle, was integrated into that centralized administrative model, including a single ERP platform. However, Swedish's Epic system had been in use longer, was more mature than Providence's. So, the decision was made to leave the Swedish Epic in place for many years and not worry about getting to one Epic platform there. "One Epic doesn't necessarily look like another Epic," says Newell parenthetically.

Janice Newell, SVP & CIO, Providence Health & Services

On the other hand, another health system, St. John's in Santa Monica, Calif., that became a part of Providence, needed more resources toward further EHR implementation for Meaningful Use and ICD10. As a result, Providence replaced the majority of their IT infrastructure and many applications including ERP and installed the Providence Epic. "Within a year they were live on Epic," she says.

An example in the middle of the IT-integration spectrum is an affiliation with Pacific Medical Center (PacMed) in Seattle, a 90-physician multispecialty group practice that had their own Epic system. When PacMed started doing their inpatient work at Swedish facilities, it made sense from a patient-safety perspective to move them to the Swedish Epic system. It also made fiscal sense to combine the two as the PacMed system was relatively small.

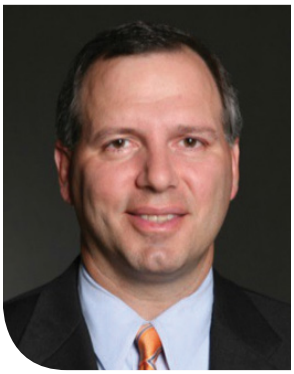
"We look at the infrastructure to find opportunities for improvements and savings, but also the best process and timing to avoid disruption," says Newell.

Last summer Providence and St. Joseph Health, a 16-hospital, Catholic system in Orange County,

Calif., announced their intent to join together. "We're just at the very beginning and are still in the regulatory process," she says. "We are both successful organizations and know there is a lot of value in working together. This is still very early on and we'll be thoughtful in our approach."

Strategy, risk-taking, innovation, people

Nothing tells the story of ongoing health-system consolidation better than expanding fiscal prowess. "Fifteen years ago," says Tom Giella, Chicago-based managing director for healthcare services at Korn Ferry, "there were a few $1-billion health systems. Today there are 250 of them over $1 billion. Economies of scale, market leverage and building a bigger regional footprint are the main drivers of consolidation. It's hard to do population health in a standalone facility."



Tom Giella, Managing Director, Korn Ferry

Health-system aggregation is coinciding with retirement of many Baby Boomer executives, he says, and driving the need for executives with new skill sets. "They need to be very strategic, to look beyond the here and now. This is not a case of just fine-tuning but of managing fundamental change marked by increasing levels of risk. It's not a matter of doing more with less but of doing less with lesser," Giella says.

In addition to being highly strategic thinkers, health-system executives need to be innovative. "Hospitals traditionally have been risk-averse, but large health systems are investing heavily in telehealth and retail, which would have been risky in the past," he notes. The threat of disintermediation is everywhere including Walmart stores, some of which are adding MRIs and other medical imaging centers to increase foot traffic. "If you're a $200B operation and can increase foot traffic by just 1 percent you've added $2 billion in revenue," he says.

> *"It's hard to do population health in a standalone facility."*

The ability to develop people is another key asset for value-based executives. "The workforce is nervous because there's lots of duplication that consolidation is aiming to eliminate. So, having the right leader to instill confidence and rally associates is also key," says Giella.

"The easy part of M&A is the financial deal. What's really difficult is establishing trust and cultural integration. There are organizations that have acquired physician practices and then found they were still referring outside the network. These things take time. You have to do a lot more selling than telling."

Conclusion

We're in the middle of an historic consolidation among hospitals and health systems that will result in half the organizations today disappearing. Larger corporate entities are emerging that will standardize processes, protocols and technology while centralizing administrative services. IT is playing a major role in this integration, but the real driver is value. IT-enabled value.

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