



HealthLeaders^{Media}

APRIL 2016

HEALTHLEADERS MEDIA INTELLIGENCE REPORT

Strategic Partnerships: Survival in Healthcare



POWERED BY:



SUPPORTED BY:



WWW.HEALTHLEADERSMEDIA.COM/INTELLIGENCE



PERSPECTIVE

Contrary to Misperceptions, Health System M&A and JVs Have Noble Aims

**Brent McDonald**

Managing Director, Head of
Healthcare Strategic Advisory
Bank of America Merrill Lynch

It is safe to conclude that the U.S. health system has reached an inflection point as (a) multiple forces are pushing systems to deliver integrated, geographically dispersed, coordinated care (or potentially risk network exclusion) and (b) fee-for-service reimbursement gives way to value-based care and capitation. To survive and thrive, U.S. health systems must prepare for and anticipate the new responsibilities required by market forces, technology improvements, and policymakers. As reflected in the HealthLeaders Media Mergers, Acquisitions, and Partnerships Survey of 245 healthcare leaders, it is clear that M&A, collaborations, and partnerships are being used to better position for and address these industry mandates.

This transformation is not without growing pains. One area of particular note is the escalation in the activity of regulatory bodies in curbing or preventing transactions among market participants. This escalation and ensuing tension is playing out in various ways. Hospital trade associations and regulators are often unable to agree philosophically; in a microcosm of the issue, the two sides cannot even agree on the level of provider representation in forums designed to discuss related issues. There has also been a recent uptick in announced transactions pursuant to state regulatory regimes that are designed to preempt federal antitrust regulation by substituting state oversight (e.g., recent certificate of public advantage legislation passed in West Virginia).

The HealthLeaders Media survey results reflect that M&A and partnerships are an earnest response by U.S. health systems to address the many policy-driven and market forces that are creating a perfect storm of unfunded mandates and complexity. Two-thirds of respondents (66%) indicated that a main reason for mergers, acquisitions, and partnerships is to support the sustainability of their entity's long-term mission, and nearly three-quarters of respondents (70%) stated that their care delivery objective is to improve their overall positioning for population health management.

The survey results reflect that the vision of creating a patient-centered, efficient, and sustainable care coordination model (the "Triple Aim") remains a shared and noble pursuit of U.S. health systems. The beauty of this approach is that it is constantly out of reach. Health systems must continue to access scale, share costs, pool resources, and integrate access points and service lines to create a patient-centered, efficient, and sustainable care coordination model. The tension between regulatory oversight and the Triple Aim objectives should not be inconsistent. The choice of U.S. health systems to innovate and thrive or wait to be marginalized should not be limited by artificial regulatory governors on rational transactions. The regulatory environment should allow scale to be reached as in other industries and verticals, encouraging innovation and collaboration with all relevant stakeholders.



TABLE OF CONTENTS



PERSPECTIVE 2

FOREWORD 4

ANALYSIS..... 6

CASE STUDY 1 LifeBridge Health..... 14

CASE STUDY 2 ThedaCare17

CASE STUDY 3 University Hospitals 20

SURVEY RESULTS 22

 FIGURE 1: Merger/Acquisition/Partnership Financial Objectives22

 FIGURE 2: Merger/Acquisition/Partnership Care Delivery Objectives.....23

 FIGURE 3: Recent Merger/Acquisition/Partnership Activity24

 FIGURE 4: Description of Merger/Acquisition25

 FIGURE 5: Description of Contractual Relationship.....26

 FIGURE 6: Entity Involved in Merger/Acquisition/Partnership27

 FIGURE 7: Main Reasons for Considering Merger/Acquisition/Partnership.....28

 FIGURE 8: Important Considerations for Merger/Acquisition/Partnership29

 FIGURE 9: Merger/Acquisition/Partnership Plans Next 12–18 Months.....30

 FIGURE 10: Type of Organization Interested in Pursuing.....31

 FIGURE 11: Merger/Acquisition/Partnership Activity Next Three Years.....32

 FIGURE 12: Change in Dollar Value of Mergers/Acquisitions Next Three Years33

 FIGURE 13: Total Dollar Value of M&A Deals Next Three Years.....34

 FIGURE 14: Financial Reasons for Deal Not Proceeding35

 FIGURE 15: Operational Reasons for Deal Not Proceeding.....36

 FIGURE 16: Payers’ Role in Merger, Acquisition, or Partnership Strategy37

 FIGURE 17: Sources Relied on to Support M&A and Partnership Activities38

METHODOLOGY..... 39

RESPONDENT PROFILE 40



FOREWORD

Healthcare Transactions Can Enhance Local Patient Care

**Paul Tait**

Chief Strategic Planning Officer
University Hospitals
Cleveland

In 2015, healthcare transactions increased again to more than 100 across the nation. The major drivers of the activity nationally are pressure from healthcare reform, financial challenges, and the move to value-based payment/delivery models that are focused on population health management.

At University Hospitals in northern Ohio, we have added five wholly owned hospitals to our health system in the past two years through transactions that are focused on enhancing healthcare services for local communities. Delivering value for patients requires clinical leadership as well as infrastructure and financial investments in new services and care models.

These investments are significant, so many small and midsize hospitals, as well as physician practices, are looking to larger health systems to bring economies of scale and a commitment to sustain local healthcare services. At the same time, larger systems are looking to expand geographically to improve patient access, grow market share, and increase scale while developing broader networks that are capable of delivering population health management.

Results of the *2016 HealthLeaders Media Mergers, Acquisitions, and Partnerships Survey* indicate that the top financial objectives for such activities are to increase market share within the organization's geography, improve financial stability, and improve operational cost efficiencies. On the clinical side, the top objectives are related to improving population health management, care delivery efficiencies, and clinical integration.

Our experience at UH suggests that key considerations for successful transactions include the cultural compatibility of the partners, respect for local governance rights, as well as strategic planning that leverages the strengths and opportunities of the two partners in a transaction. Survey results show that the top operational reasons for a deal to be abandoned were incompatible cultures and concern about governance.

To deliver enhanced patient services for a hospital joining our system, we focus on recruiting and aligning physician practices, like many others in the industry. As a health system, we recruited more than 275 new physicians in 2015 and many of these recruitments were focused on strengthening services at the five hospitals that recently joined UH. To support the growth and development of primary care physicians, our health system has a Primary Care Institute



that shares best practices among physician groups. To strengthen patient care services locally, we extend our major institutes (Seidman Cancer, Rainbow Babies & Children's, Harrington Heart & Vascular, and others) to community hospitals and major outpatient centers.

The case study included in this Intelligence Report on the UH Elyria Medical Center transaction highlights our respect for the local culture while also leveraging our scale to make financial investments and to recruit new physicians at Elyria who are eager to have clinical colleagues at a larger health system. Our success in strengthening and integrating hospitals with the UH system has led to positive conversations with other potential partners.

In our market, there is continued interest in new affiliations and we expect that new partners will join our health system in the next couple of years, which is consistent with the national trend and survey responses in this report. As we consider new affiliations, our focus will continue to be on enhancing local patient care.



ANALYSIS

The Drive to Merge, Acquire, or Partner

**Jonathan Bees**HealthLeaders Media Senior
Research Analyst

While healthcare reform and the transition to delivering value-based care are pushing merger, acquisition, and partnership (MAP) activity to ever-higher levels, these are not the only factors responsible for driving this growing phenomenon. In fact, increasing momentum for MAP activity is noteworthy both for the range of influences playing a role in its acceleration, as well as the absence of mitigating factors slowing its proliferation.

According to the *2016 HealthLeaders Media Mergers, Acquisitions, and Partnerships Survey*, for example, the top financial objective (Figure 1) for MAP activity is to increase market share within our geography (70%). However, there is ample support for a range of objectives and the remainder of the top five—improve financial stability (60%), improve operational cost efficiencies (58%), improve position for payer negotiations (57%), and expand geographic coverage (57%)—all have response levels above 50%, indicating that no single objective is responsible for driving MAP activity.

Likewise, the top five care delivery objectives (Figure 2) follow a similar pattern: to improve position for population health management (70%) receives the highest response, followed by improve position for care delivery efficiencies (63%), improve clinical integration (61%), gain care delivery cost efficiencies through scale (54%), and expand into new care delivery areas (51%). Note, however, that a reform-related care delivery objective occupies the top spot, so its influence cannot be understated.

"I would say that in every conversation that I have about this, somebody asks me how much did the Affordable Care Act have to do with driving the decisions that this particular group of people made, that this is all in response to healthcare reform and the implications that that poses for people. My observation is that it's possible to make an argument or connect a lot of things back to that, but in our case and in others that I'm hearing, it's not necessarily any one of the elements, but it's all of them together," says Greg Devine, former senior vice president of provider strategies at ThedaCare, an Appleton, Wisconsin-based nonprofit health system, and current president and CEO at AboutHealth, a Wisconsin-based clinically integrated network.



MAP activity levels. Without question, survey respondents are bullish on the prospects for higher levels of MAP activity. Seventy-five percent of respondents (Figure 9) say they will either be exploring potential deals or completing deals that are underway in the next 12–18 months, and only one in four respondents (25%) say they have no MAP plans. Further, nearly two-thirds of respondents (63%) say that their organization's merger, acquisition, and/or partnership activity will increase within the next three years (Figure 11), and only 3% say it will decrease. Thirty-three percent say it will stay the same.

Another barometer of MAP activity is the total dollar value of the mergers and acquisitions that respondents say their organizations will be exploring over the next three years (Figure 13). While this year's survey results are comparable to last year's, there is a small shift to a higher total dollar spend on mergers and acquisitions. The \$50 million–\$99.9 million range is up three points to 17%, and \$100 million–\$499.9 million is up five points to 21% compared with last year (for a combined eight-point increase), while the lower \$10 million–\$49.9 million range is down nine points to 23%.

Interestingly, respondents indicate that it is not only total MAP spend that is increasing, but also the size of the deals being pursued (Figure 12). Nearly half of respondents (49%) say that they expect the dollar value of the mergers and acquisitions their organization will be pursuing within the next three years will increase, and only 5% say the value will go down. Sixteen percent say it will remain even.



WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders regarding how they see their organization's merger, acquisition, and/or partnership strategy changing over the next three years because of the shift to value-based care.

"The strategy should become more strategic and less operational."
—CEO at a medium health system

"Since we merged with a large health system, going forward the efforts will be on adding physician practices and ancillary activities."
—Administrator at a small hospital

"Though there is discussion about value-based care, it is unlikely to progress significantly in three years, and market pressures will need to be readdressed. Shifting to value-based care does not address patient requirements at this time."
—CEO at a medium physician organization

"The activity will continue, but the pace will decrease. In place of complete acquisition there will be a more creative collaborative approach/plan."
—Executive director at a large physician organization

"Will likely engage with a consultant with expertise and track record in this arena."
—CEO at a small hospital

"I anticipate we will be pushed into more M&A discussions in order to remain financially viable."
—Director of emergency services at a medium hospital

"There is an increased focus on partnering through new models to enhance access while limiting risk exposure. We see a value proposition focused on our mature health plan and cost-management for defined populations."
—Vice president of marketing at a large health system

"There is more appetite for merger with physician practices to cover a larger geographic area to leverage payers."
—Vice president of administration at a large health system

"We will more precisely look at partnerships that add actual value vs. 'in name only' collaboration that does not affect the bottom line."
—Chief compliance officer at a small hospital

"Payer reimbursement models will have an impact on whom to partner with."
—Director of reimbursement at a large physician organization



Factors driving MAP activity. As mentioned earlier, the reasons behind the high rate of MAP activity range from traditional considerations such as the need for increased market share, improved scale, and increased financial stability, which are more tactical in nature, to more strategic and far-reaching factors such as anticipating the impact of the Affordable Care Act and the transition to value-based care.

For example, survey respondents who have considered or are considering a merger, acquisition, or partnership with another organization were asked about the main reasons for doing so (Figure 7). Two-thirds (66%) say that supporting sustainability of their long-term mission is the main reason for considering a MAP with another organization, an indication that providers are mostly thinking strategically when engaged in this activity. Note that expanding market share (55%) and improving scale (49%) rounded out the top three responses, suggesting that tactical considerations also play an important role in provider strategy.

Respondents were also asked about the considerations they thought were most important to their organization when considering a merger, acquisition, or partnership (Figure 8). Mission/cultural compatibility of organization (73%) is the top consideration, while strength of new organization's network (56%) was the No. 2 response, which reflects the importance of expanding clinical reach to improve volume, scale, or expansion of care continuum capabilities.

One thing to remember is that not all providers are alike—each organization has its own unique set of circumstances



“With a lot of the hospitals that are linking up, it’s because they need access to capital or they need new investment. And in some cases, they’re just running out of money.”

—Paul Tait

that may ultimately lead them down the path to seeking a merger, acquisition, or partnership. Advisors to this Intelligence Report suggest that attributing increased MAP levels to the Affordable Care Act and value-based care alone provides an incomplete picture of the forces at work.

“The Affordable Care Act is certainly driving some of it,” says Paul Tait, chief strategic planning officer for University Hospitals, a Cleveland-based nonprofit health system. “But there’s usually a financial reason, which is the catalyst, and there’s a couple different elements to that. One is that there’s a lot more capital availability for acquisitions these days—and with lower interest rates—so if you’re a larger, well-established health system, then you probably can borrow money at a reasonable rate.

“On the other side of it, I think with a lot of the hospitals that are linking up, it’s because they need access to capital or they need new investment. And in some cases, they’re just running out of money. There’s an awful lot of financial margin pressure on hospitals, and I think that’s just going to get worse because of the payment changes that have already started and will accelerate. So as you see more



of a move to value-based payment, some organizations aren't going to be able to deal with that very well and they're going to end up with even more pressure on their margins."

Tait points out that increasing scale is a key driver of increased MAP activity because of the range of its many benefits. "You obviously get greater purchasing scale with vendors; you end up getting larger volume discounts and better rebates and all those things. You can leverage all of your business functions across a broader system and more revenue, so they become more efficient. You can leverage corporate functions, and it also improves your leverage with health plans when you're negotiating managed care contracts.

"If you have more scale, you can also afford to recruit more doctors. And you become more attractive for physicians that are looking to be employed because, if you're a larger health system, you're probably going to offer them more opportunities to grow their practice and you're more stable as an employer. And then, if you think about population health, you're spreading risk over more lives."

Devine agrees that many organizations are pursuing mergers and acquisitions to achieve increased scale, and that scale is an important element of population health strategy.

"There's a belief that there's a certain scale that's necessary to be competitive and to be able to afford investments in either process design or technology, or the ability to buy goods and services. And that target of



"I think most people would argue to be able to manage that risk effectively, price it, and manage it, you need scale."

—Greg Devine

what's the necessary scale is sort of a phantom number. It appears that people are making it bigger all the time. But I think it's the notion of scaling population health to the extent that that becomes linked to managing risk in a population, and this becomes relevant because you have to have a certain scale to that population. I think most people would argue to be able to manage that risk effectively, price it, and manage it, you need scale."

Dave Krajewski, chief financial officer of LifeBridge Health, a Baltimore-based nonprofit health system, explains the drivers behind MAP activity this way. "There are two reasons that come to mind. One is the need to expand and do more than just what we typically did as a hospital system. As we're being held accountable for the total cost of care for patients, and we are entering into risk-based arrangements, we need to have a degree of influence over what happens in the physician office, what happens at the nursing home, and what happens at an urgent care center or an ambulatory surgery center because that care increasingly ends up being, in aggregate, a larger chunk of the healthcare pie than what happens at hospitals.

"On the nonhospital side, what you're seeing is hospitals and other provider organizations acquiring parts of the



rest of the continuum of care so they can more readily control and influence the total cost of care. That's why you're seeing a pickup in hospitals acquiring physician practices, or hospitals doing joint ventures with urgent care centers or nursing homes," he says.

"On the hospital side, you're looking at an era where utilization, at least in the state of Maryland, is going to be going down per capita and not up for hospitalizations. And I think what you're seeing is hospitals trying to beef up a little bit, knowing that their scale is going to diminish over the next ten years or so," Krajewski says.

Organizational types. According to survey respondents, the top three entities involved in their most recent merger, acquisition, and/or partnership (Figure 6) are health systems (29%), hospitals (25%), and physician practices (20%).

Interestingly, responses for retail clinic/urgent care clinic (3%) place well down the list. This is somewhat surprising given the current focus by many providers on growing their ambulatory/outpatient networks, but growth in that area is expected.

Looking to the future, respondents were also asked to identify the organizations that they had a high interest in pursuing through a merger, acquisition, or partnership within the next year (Figure 10). The top five responses are: physician practices (61%), health systems (41%), hospitals (39%), physician organizations (34%), and retail clinics/urgent care clinics (26%).

Results for this question are illuminating. While physician practices are the entities mentioned third most frequently



"What you're seeing is hospitals and other provider organizations acquiring parts of the rest of the continuum of care so they can more readily control and influence the total cost of care."

—Dave Krajewski

as the most recent MAP target (Figure 6), the level of response for physician practices jumps 41 points for the coming year (Figure 10), making it the top response for MAP activity within the next year. The response for physician practices is also up 11 points over last year's survey result for activity expected in the coming year. The strong interest in physician practices is likely because primary care physicians are a key component of the continuum of care, and play an increasingly important role in population health management and clinical integration.

Also noteworthy is the level of response for retail clinics/urgent care clinics in the coming year. The response is up 23 points to 26% compared with most recent activity (Figure 6), and demonstrates the high level of interest providers have in expanding their outpatient/ambulatory care networks.

According to Devine, the high level of MAP activity involving physician practices indicates the key role that primary care physicians play in the continuum of care, making them attractive acquisition targets. As a result, providers in some areas of the country are facing tight supplies of physicians.



"I would say particularly in Wisconsin—I don't even know if there's 1% of the primary care physicians in Wisconsin anymore that are not part of some large, integrated system. So particularly at that primary care level—I think the models change with the specialty practices—I think it's not for the sake of ownership or control that's driving this. It really is being driven by the need to align the various elements of the continuum of care around delivering better outcomes and waste elimination," he says.

"And it's really important that whoever you define as your team generally shares those commitments to those outcomes and those standards. If you can't do that in a contractual relationship, oftentimes you're compelled to look at alternatives. The issue appears to be growing—at least in the markets that I'm aware of—and the challenges are greater especially in rural communities. If you step back and look at the country, there's an awful lot of rural communities that are probably pressed to fill those needs," Devine says.

Tait agrees, and explains the financial ramifications of the problem. "We're seeing some providers that are just having a terrible problem with their physician networks. We've seen a number of community hospitals that have been unsuccessful replenishing their medical staff as people leave or as people retire. In some cases, they may have lost physicians to competitors in their local market, and if they try to employ some doctors, they don't have the scale to do it well. It's very common for us to see a single community hospital that might be trying to employ



"There's an awful lot of financial margin pressure on hospitals and I think that's just going to get worse because of the payment changes that have already started and will accelerate."

—Paul Tait

anywhere from 15 to 30 doctors, and they're losing over \$200,000 per doctor."

Krajewski explains that for LifeBridge Health, physician practice acquisitions started out as a strategy for growing scale for contract negotiation purposes. Eventually, however, its focus evolved into building a network to support population health initiatives.

"Originally, we started looking at physician practices probably five or more years ago. It was more about leverage in the marketplace, making sure that down the road, we wouldn't be cut out of contracts. Our belief was that we weren't the largest hospital system in the state, but if we had a very large base of primary care doctors and specialists, that we would become indispensable from a contracting standpoint. So originally it started with that thought process in mind, but then as the Affordable Care Act hit, it became a population health play as well."

Merge, acquire, or partner? Respondents were asked to describe the nature of their most recent merger, acquisition, or partnership activity (Figure 3). The top



response is acquisition of one organization by another (38%), followed closely by a contractual relationship, but not M&A (33%). A merger of two organizations into one (9%) received the lowest response.

In a follow-up question (Figure 5) to those who had selected a non-M&A contractual relationship, respondents were asked to describe that model, and affiliation, collaboration, or alliance (46%) and professional service agreement (31%) received the top two responses. This is likely because these contractual relationships are simpler, more flexible, and require less commitment than joint operating agreements (14%) and joint ventures with change of ownership (6%).

Tait says that, while he expects MAP activity in general to remain steady over the next few years, he thinks the rate of non-M&A partnership activity will probably increase because it is typically less expensive than a merger or acquisition, and it doesn't require an exchange of assets or a change of local governance.

"You're seeing a lot more innovation in terms of the way people structure relationships and affiliations and partnerships. It isn't always just straight merger or acquisition," he says.

"First, I think the reason some of these nonownership models come together is less capital is required or no capital is required, depending on what you're doing and the scope of the agreement. Second, there's still the sense of maintaining local control. So you can get into an affiliation or a partnering agreement, and you may



"For us, it really becomes assessing whether the organization you're looking at, the hospital you're looking at, has a similar culture, a similar direction, and a similar set of goals."

—Dave Krajewski

still retain your local governance and your local control," Tait says. "And probably a third broad reason is, people structure these partnerships for a more narrow purpose, meaning they're not trying to integrate everything. They may be trying to collaborate or integrate in a particular area or a particular service line."

When good deals go bad. When providers enter into MAP discussions, there are no guarantees that a formal agreement will eventually come to pass. There are a variety of hurdles that have the potential to derail the initiative.

Concern about the assumption of liabilities (29%) is the top financial reason for a deal not proceeding before or during the due diligence phase (Figure 14), and it was the top reason in last year's survey (28%). The extent of a target organization's financial liabilities may not be apparent until the due diligence phase is completed, which may explain why this can be a deal-breaker. Concern about risk/revenue sharing (23%), concern about price (22%), and regulatory issues (20%) round out the top four responses. Regulatory issues had the greatest increase in



response compared with last year's survey—up 8 points. Advisors mention the complexity of deals that cross state lines as a potential source of regulatory trouble.

Incompatible cultures (35%) and concern about governance (33%) are the top operational reasons for a deal not proceeding (Figure 15), and these were the top two responses in last year's survey. The response for mistrust between parties (24%) places it in the top three.

Krajewski says that organizational culture is one of the core elements that it considers when looking to partner or acquire. "For us, it really becomes assessing whether the organization you're looking at, the hospital you're looking at, has a similar culture, a similar direction, and a similar set of goals. Whether everything's lining up together, and then convincing the other organization that, 'Hey, you know, we're on the same path; we might as well join forces, add some scale, and help out with the economics. And maybe complement each other's strengths and weaknesses related to clinical care and the continuum.'



"That target of what's the necessary scale is sort of a phantom number. It appears that people are making it bigger all the time."

—Greg Devine

"We use the term aligned autonomy a lot around here," Krajewski says. "As an example, we'll go into an acquisition with a physician practice with the idea that they're going to still continue having a large degree of autonomy, but before we do the acquisition, we make sure that that autonomy is aligned with the direction we have at LifeBridge."

Jonathan Bees is senior research analyst for HealthLeaders Media. He may be contacted at jbees@healthleadersmedia.com.



CASE STUDY 1

Acquisition Builds Scale, Geographic Coverage



LIFEBRIDGE HEALTH

LifeBridge Health is a Baltimore-based nonprofit healthcare system that has four hospitals—520-licensed-bed Sinai Hospital of Baltimore, 249-licensed-bed Northwest Hospital, 165-licensed-bed Carroll Hospital, and the 330-licensed-bed Levindale Hebrew Geriatric Center and Hospital—as well as a wellness division called LifeBridge Health & Fitness and three LifeBridge Medical Centers, located in Eldersburg, Mays Chapel, and Reisterstown. The organization has more than 9,200 employees, including approximately 2,500 physicians. In 2015, the system reported \$1.6 billion in total patient revenue.

In early 2014, Carroll Hospital Center leadership decided that the nonprofit hospital needed to merge or partner with a larger organization in response to the many changes sweeping the healthcare industry. It began a formal request for proposal process and reached out to a number of organizations, including LifeBridge Health.

LifeBridge Health and Carroll Hospital Center were indirect competitors, operating in adjacent counties with little overlap in coverage. While they sometimes competed for physicians and staff, there was little competition for patients.

"We had been in conversations with Carroll for many years as far as looking for an opportunity for the two organizations to come together, but they actually kicked off the formal process where they sent out requests for proposals. So a number of health systems in Maryland and I think some outside Maryland as well were involved," says Dave Krajewski, senior vice president and chief financial officer at LifeBridge Health.

Krajewski explains that the strategy behind the acquisition was mostly about geographic expansion and scale. "Their contiguous service areas had a minor overlap with us, but not a significant overlap. It was more geographic expansion and scaling up for us. I wouldn't say it was a population health move because most of the patients that go to Carroll Hospital don't also come to one of the other hospitals."

LifeBridge Health ultimately offered the most attractive package, and in April 2015 Carroll Hospital Center became a subsidiary of LifeBridge Health. As part of the deal, LifeBridge Health agreed to invest \$250 million in Carroll Hospital Center and make a \$50 million donation to the endowment fund of the Carroll Hospital Center Foundation, which helps pay for patient care, scholarships, and community education. It also made a commitment to help implement Carroll Hospital Center's strategic plan to grow and advance in areas including cardiovascular, cancer, hospice/home care, surgery, women and infants care, and outpatient services.



Management structure and culture. Under the agreement, Carroll Hospital Center's leadership team remained the same and it retained its current board members. However, there were changes at the board level for both organizations. Carroll Hospital Center's board gained two members from LifeBridge Health's board—the chairman and the president and CEO—and LifeBridge Health's board gained seven members from Carroll Hospital Center's board, bringing the hospital's representation to approximately 25% of the LifeBridge board.

LifeBridge Health's management team had experience with other mergers and acquisitions, and recognized the importance of integrating leadership from the acquired organizations within the parent organization.

"We put some of their leaders in very key positions," says Krajewski. "As an example, their CFO reports to me, and he is the CFO not only of Carroll Hospital but also Northwest Hospital. I did that because I didn't want those hospitals competing with each other. So by having one CFO covering both of them, it created an environment where they're making financial decisions based on what's good for both organizations, not for just one. Leslie Simmons, president of Carroll Hospital Center, also has systemwide responsibilities over human resources.

"That's been our model since the merger with Northwest Hospital, where our belief was that senior executives should not be entirely entity based. That a good portion of their responsibilities—putting a number on it is hard, but if I just pick a number out of the air, 30% of their responsibilities—needed to be system responsibilities so that people thought system and didn't think individual hospital. In fact, all three of our presidents have system responsibilities. Amy Perry at Sinai

has responsibility for planning for the whole health system. Brian White [at Northwest Hospital] has responsibility over facilities management for the whole system."

Krajewski explains that this type of organizational structure also helps with the process of integrating the cultures of different organizations under one roof.

"Carroll Hospital has representation of one-quarter of our board. So they have significant roles on our board committees and governing board, and they have significant oversight on their local community," says Krajewski. "The cultures actually have gelled extremely well because LifeBridge Health is like a larger version of Carroll Hospital in that we're fairly mobile and able to do things quickly. We don't have a lot of bureaucracies."

Citing the formal governance rules that were set up when the organizations merged, Krajewski says, "After a period of six months or so you start forgetting what the rules are because we don't really refer to them very often. You set them up and they reassured everybody that nothing bad was going to happen, but the merger has gone so well right now that nobody's referring back to the rules and saying, 'Oh, no, no, no. This is how you have to do it.' Everybody's in the mode of just doing what's best for the organization."

Benefits of scale. Along with expanding LifeBridge Health's geographic reach, the addition of Carroll Hospital Center was also intended to convey financial benefits due to increased scale. While it is still early in the integration process, there have been some financial gains. Krajewski describes these as mostly "low-hanging fruit."

"Post-acquisition, within the first six months, we had implemented somewhere in the range of \$4 million to \$5 million



in financial performance improvement, the biggest chunk of it being supply chain management contracts, and another large contribution related to physician contracts with payers. And then there were auditing fees and actuarial fees and stuff like that. So we've probably eclipsed \$5 million in financial performance improvement."

Clinical integration. Clinical integration remains a work in progress, due to its complexity and the relatively short time period the organizations have been together. As an example, Krajewski cites the fact that Carroll Hospital Center and LifeBridge Health both have ACOs, which theoretically leaves

open the possibility of combining the two. Discussions are ongoing, and some of them are clinical in nature.

"We both have ACOs and we are currently looking at how we can bring them together. The ACOs meet at the same time and work together. So by the very nature of that, they're talking about clinical protocols and clinical practices. Conceptually, it makes sense. But the devil's always in the details."

—Jonathan Bees



CASE STUDY 2

Effort Highlights Value of Collaboration, Best Practices



THEDACARE

ThedaCare is an Appleton, Wisconsin-based nonprofit healthcare system that serves the Northeast region of the state. The organization owns seven hospitals—Appleton Medical Center, Theda Clark Medical Center, ThedaCare Medical Center-New London, ThedaCare Medical Center-Shawano, Berlin Memorial Hospital, Wild Rose Community Memorial Hospital, and ThedaCare Medical Center-Waupaca—and 34 clinics that provide care in a 14 county network. ThedaCare has approximately 6,800 employees. In 2015, the system reported \$875 million in total revenue.

Formed in July 2014, AboutHealth is a collaboration that evolved out of a series of informal relationships between the original six members: Aurora Health Care, Aspirus, Bellin Health, Gunderson Health System, ThedaCare, and UW Health. ProHealth Care joined shortly after its formation, and roughly a year later Marshfield Clinic Health became the eighth provider in the partnership.

"At the time we started, there were six organizations," says Greg Devine, who is president and CEO of AboutHealth and, until recently, also served as senior vice president of provider strategy at ThedaCare. "A couple of organizations were talking about strategic relationships, three other organizations were talking about opportunities to engage in scale-producing activities, and a third group had spent a fair amount of time reaching out around the Midwest trying to advance this notion of a system of systems.

"ThedaCare's interests were similar to the other members, but perhaps more heavily influenced by the opportunities to gain scale on the cost of care and the opportunity to gain efficiency in technology investment and capital investment," he says. "ThedaCare wasn't necessarily looking at this as an opportunity to gain significant market share in the short run, but hoping that this would happen in the longer run. There was really a recognition that these organizations are very much like ThedaCare, and that there's a good cultural fit. Most of the CEOs knew each other and recognized that a lot of good things would come from us working together, without necessarily having a laundry list of objectives."

Perhaps most important, the organizations recognized that they could benefit from collaboration without the need to merge or exchange assets.

Partnership structure and mission. AboutHealth was formed as a limited liability company and continues to operate as an LLC today. Each health system in the partnership retains its local leadership and is free to operate according to its own discretion. That said, AboutHealth has an executive board, and there are two members on the board from each of the eight member organizations. Of the two members from each organization, one must be the CEO.



The executive board meets monthly, with a face-to-face meeting on even-numbered months and a conference call on the odd months. AboutHealth's purpose statement provides an indication of the overall mission: "Through collaboration among our member organizations, we exist for the purposes of demonstrating higher quality, greater efficiency, and instilling superior confidence in our clinically integrated health services."

Clinical integration and collaboration. AboutHealth functions as an extended clinically integrated network. Its service coverage area includes more than 90% of Wisconsin's population, and its 48 hospitals are responsible for 41% of the state's hospital volume. The organization also includes 85 walk-in clinics, 550 medical clinics, and 100 pharmacy locations.

According to Devine, AboutHealth is driving improved clinical quality through best practices. "The nature of clinical integration is really the sharing of clinical practices, identifying what is a best practice, and then agreeing to implement that across your organization. So it is that recognition of best practices, but then you have to also make those changes together."

Devine says that clinical information is monitored and analyzed with an eye toward establishing best practices that can be exported across the entire organization. "We have a lot of information about our collective and individual performance, and we use that information to identify opportunities where variation exists among the eight systems. Where is there a higher performer, and lesser performers? We test that against the impact. Is it on something that matters? And then we make choices about where to focus our energy."

The AboutHealth partnership objectives are:

- **Value creation.** Continuously improve and demonstrate our position on clinical quality, service, and efficiency
- **Payment reform.** Transitioning from volume to value
- **Decision informatics/analytics.** Create the shared platform for value creation and population health
- **Build shared services.** Realize the benefits of scale and know-how

"One of our common practices is using a collaborative learning event. We'll bring clinicians and other subject experts together for a day or a day and a half, share all the information and performance data and work through a process of identifying what is the best practice, and then how to implement that. And then the attendees take that back and begin the work of implementation. We establish targets and measures, and we track and share their performance. And we've been seeing improvement across the organizations as a result of that."

AboutHealth also has initiated smaller-scale learning opportunities via webinars provided by member systems, and is in the process of creating specialty communities of practice.

Metrics and data. AboutHealth collects clinical data from a variety of internal and external sources to support its measurement efforts. Early focus has been on improving performance on chronic conditions that can be expensive to treat and manage.

"Where you have expensive chronic conditions that are prevalent across markets and demographics, we identify that as an opportunity," says Devine. "We've got a database



in Wisconsin called the Wisconsin Collaborative for Healthcare Quality, and systems around the state submit their performance on the 33 Wisconsin Collaborative quality measures. This organization collects that data and produces a report that is publicly available for folks to go in and see who's doing well."

Between January 2015 to December 2015, AboutHealth diabetes results increased for optimal testing (up 3.69 points from 65.66% to 69.35%), A1C testing (up 1.57 points from 74.12% to 75.69%), kidney function test (up 3.35 points from 83.19% to 86.54%), diabetes optimal control (up 3.07 points from 38.33% to 41.40%), and A1C control less than 3% (up 1.87 points from 71.27% to 73.14%).

Along with clinical quality, AboutHealth also looks at efficiency. "We also use a claims information exchange,"

says Devine. "In Wisconsin, this data is available through the Wisconsin Health Information Organization, and they produce information that has quality measures, but their primary performance data is based on efficiency. So you can look at the efficiency of your performance against your quality. It's great to be high in quality, but if you're also high cost, maybe it's not so great."

Additional partnership benefits. Along with clinical improvements, AboutHealth is identifying opportunities for savings through shared services. It currently offers optional small-scale programs for laundry services, credit card fees, courier services, freight management, and contracted or shared IT support.

—Jonathan Bees



CASE STUDY 3

Population Health Synergy, Network Expansion Drive Acquisition



UNIVERSITY HOSPITALS

University Hospitals is a \$4-billion Cleveland-based nonprofit healthcare system that serves the northeast region of the state through an integrated network of 18 hospitals, and more than 40 outpatient health centers and primary care physician offices. The system's University Hospitals Case Medical Center is an affiliate of Case Western Reserve University. The organization has approximately 26,000 employees, including the medical staffs at all system hospitals.

University Hospitals and Elyria Medical Center had collaborated informally for a number of years prior to the acquisition of Elyria in January 2014. The organizations knew each other, yet were not typically competitors because they are located in different counties.

"We had collaborated with them on service lines, physician recruitment and staffing, and sharing information, before they even went through the RFP process. And so at some level they knew who we were and they were familiar with our culture and with some of our leadership team," says Paul Tait, chief strategic planning officer at University Hospitals.

Even so, Elyria didn't rely on that relationship alone in deciding its future. "They went through a very thorough process and used an outside consultant. I think they started by sending their RFP out to about 10 folks as I recall, and I believe they got six or seven proposals back and they cut it down to the Cleveland Clinic, University Hospitals, and the Summa Health System out of Akron," says Tait. "In the end, they thought that their three best choices were partnering with one of the local systems here in northeast Ohio that already had a presence in the market."

University Hospitals' strategy. University Hospitals' interest in Elyria was based on a number of different factors: It filled a geographic need for network expansion, it complemented its population health strategy, and it provided additional scale. More than anything, the acquisition was a good fit because it addressed such a broad range of needs.

"We thought that Elyria would be a good addition to our system because of its location. Prior to Elyria joining, we had no hospital presence in Lorain County, which is the next county going west of Cleveland," explains Tait. "We've been talking to hospitals mostly in the northern half of Ohio because, if we're going to focus resources—in terms of financial and human and management resources—on working with other hospitals, we'd like the possibility for the most complex cases to come into Cleveland to our academic medical center."

University Hospitals has embraced population health as part of its strategy, and adding Elyria helped the organization expand its physician care network west of Cleveland. "The Elyria hospital had some physicians affiliated with our hospital,



which strengthens our physician network. There were a fair number of physicians that they had either employed or they had contracted with at large physician groups,” says Tait. “They had a very large outpatient center and freestanding ED in a desirable community, a growth community that we were happy to see become part of our outpatient network—this is their outpatient facility in Avon, Ohio. And they were the market share leader on hospitalizations in Lorain County.”

Besides offering an 18-bed ED, the Avon location included a fitness center and more than 50 acres of land. Additional locations included a freestanding ED in Amherst, Ohio; the Sheffield Health Center in Sheffield, Ohio; and 23 acres of land in North Ridgeville, Ohio.

According to Tait, adding Elyria also advanced another core objective—building scale. “This is a sizable hospital, with over \$200 million in annual revenue. So it helps us build scale. But it’s mostly the integration, and the scale matters in the sense that it builds scale in our physician network. It builds scale in the outpatient center network. And obviously, we have included Elyria in all of our accountable care organizations now, so they are part of our ACO/population health strategy, and that’s good from a scale standpoint, too.”

Elyria’s strategy. From the beginning, Elyria’s strategy for acquisition was well-defined. Internal leadership had begun considering the organization’s future in 2010, and used an outside consultant during the process. The formal letter of intent with University Hospitals was signed in June 2013.

Tait explains, “They were looking for a partner that would bring a series of capabilities, and the things they were most interested in were a financial investment so they could continue to grow; strengthening physician recruitments; service line expertise where we could strengthen some of their service lines and services at the hospital; and then

ACOs and population health strategy was really the fourth category.”

Delivering on the objectives. Over the course of the first two years of the merger, Elyria has been the recipient of significant investment. University Hospitals has announced it is building a \$32.4 million outpatient health center and freestanding ED in North Ridgeville, with an expected completion date in 2017. And it has just opened the 50-bed University Hospitals Rehabilitation Hospital in Avon as part of a joint venture with Louisville, Kentucky–based Kindred Healthcare.

Physician recruitment and staffing was a particularly acute need at Elyria, and University Hospitals had a productive first year in this area. In 2014, University Hospitals recruited 12 new physicians to Elyria, seven in primary care, and one each in general surgery, breast surgery, orthopedics, rheumatology, and otolaryngology.

Tait says that work on service lines is ongoing. “From a service line standpoint, we’ve taken our Harrington Heart and Vascular Institute—the protocols, the branding, the whole program—and added Elyria to the program. And on the pediatrics side, through Rainbow Babies & Children’s Hospital, we now have a pediatric track in the Elyria ED. We’re working on some other service lines as well, but those are two obvious ones that we’ve already gotten implemented.”

The organizations have benefited from the new relationship in other ways, says Tait. For example, operating revenue at University Hospitals Elyria Medical Center increased 7% in 2015 compared with 2014, as a result of merger integration. And University Hospitals has seen a 34% increase in patient cases from the Elyria market area going to University Hospitals Case Medical Center since January 2014.

—Jonathan Bees

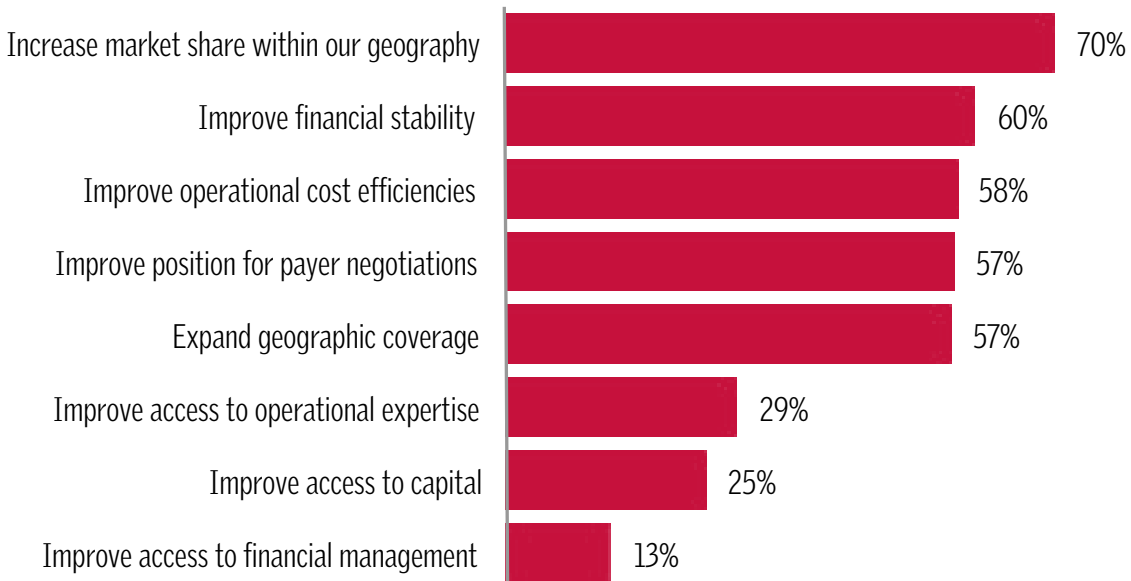


SURVEY RESULTS

FIGURE 1: Merger/Acquisition/Partnership Financial Objectives



Which of the following are among the financial objectives of your overall merger, acquisition, and/or partnership planning or activity?



Base = 245, Multi-Response

Although increase market share within our geography (70%) is the top financial objective, there is ample support for a range of objectives, and the top five all have levels of response above 50%, indicating that no single objective is responsible for driving MAP activity.



SURVEY RESULTS

FIGURE 2: Merger/Acquisition/Partnership Care Delivery Objectives



Which of the following are among the care delivery objectives of your overall merger, acquisition, and/or partnership planning or activity?



Base = 245, Multi-Response

A reform-related care delivery objective occupies the top spot—the response for improving their position for population health management (70%) makes it the No. 1 care delivery objective.

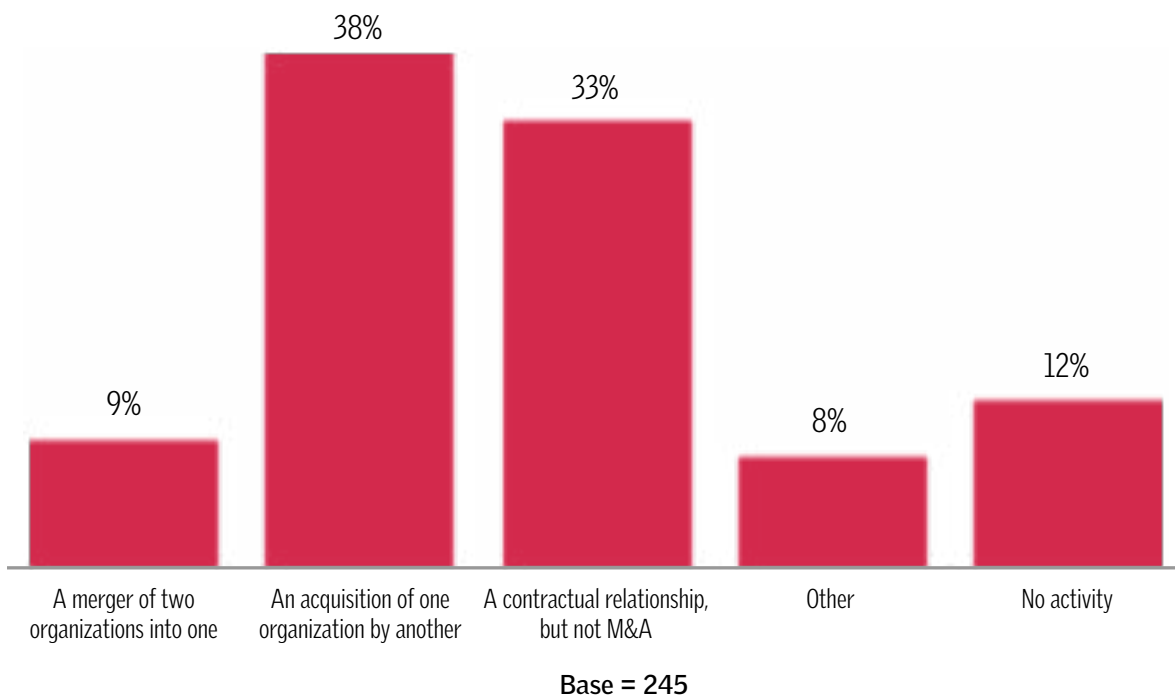


SURVEY RESULTS

FIGURE 3: Recent Merger/Acquisition/Partnership Activity



Please describe the nature of your most recent merger, acquisition, and/or partnership activity.



Responses for acquisition of one organization by another (38%) and a contractual relationship, but not M&A (33%) are nearly equal, and advisors say they expect non-M&A activity to grow over the next few years because it is typically less expensive than traditional M&A and doesn't require an exchange of assets or a change of local governance.



SURVEY RESULTS

FIGURE 4: Description of Merger/Acquisition



Which of the following describes that merger/acquisition?

	Percent
We acquired: Membership substitution	17%
We acquired: Asset purchase/conversion	43%
We acquired: Other transaction type	4%
We were acquired: Membership substitution	6%
We were acquired: Asset sale/conversion	18%
We were acquired: Other transaction type	1%
Other acquisition type	5%
Other sale type	4%

Base = 115, Among those with recent M&A activity

The top three merger/acquisition types in our survey are that the entity was acquired through asset purchase/conversion (43%); the entity was acquired through asset sale/conversion (18%); and the entity was acquired through membership substitution (17%). Other types of activity received lower response.

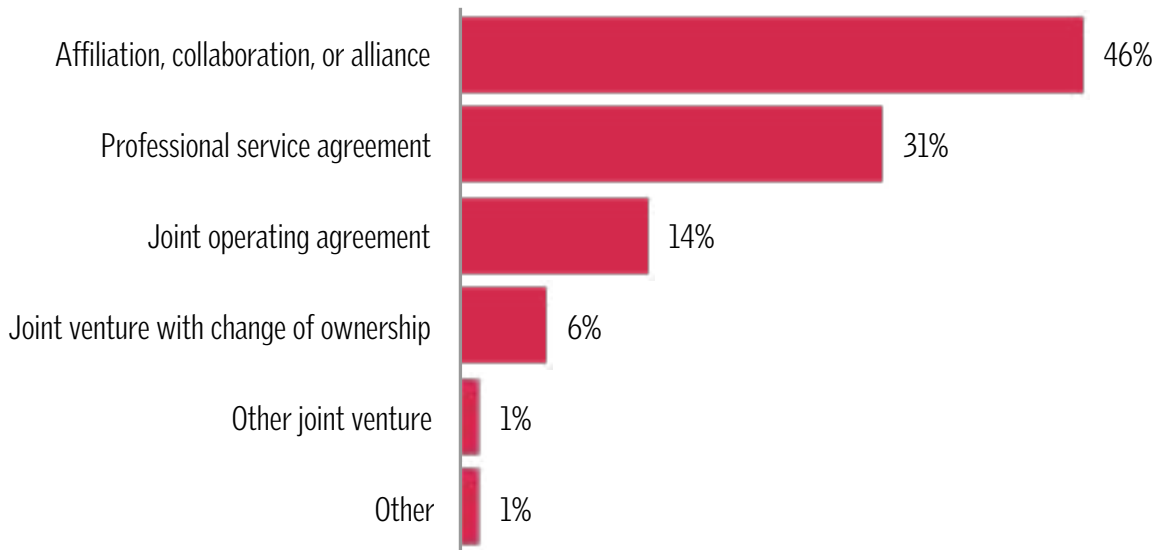


SURVEY RESULTS

FIGURE 5: Description of Contractual Relationship



Which of the following best describes that contractual relationship?



Base = 80
Among those with recent contractual relationship

Affiliation, collaboration, or alliance (46%) and professional service agreement (31%) receive high responses likely because these agreements are simpler, more flexible, and require less commitment than joint operating agreements (14%) and joint ventures with change of ownership (6%).

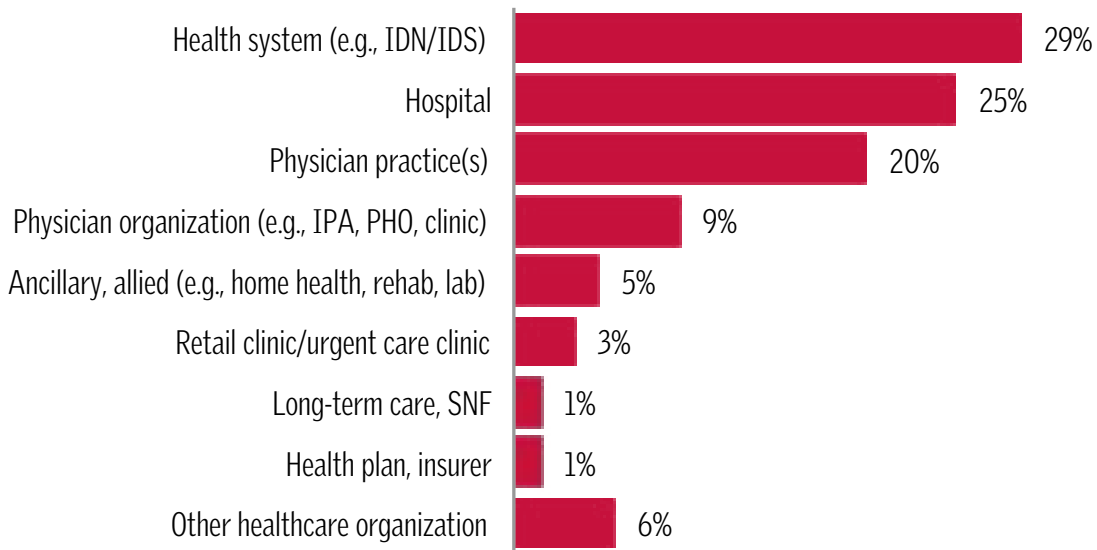


SURVEY RESULTS

FIGURE 6: Entity Involved in Merger/Acquisition/Partnership



What kind of entity was involved in your most recent merger, acquisition, and/or partnership activity?



Base = 215
Among those with recent activity

Health systems (29%), hospitals (25%), and physician practices (20%) topped the list of entities involved in survey respondents' most recent merger, acquisition, and/or partnership activity, which represents 74% of the activity.



SURVEY RESULTS

FIGURE 7: Main Reasons for Considering Merger/Acquisition/Partnership



If you have considered/are considering a merger, acquisition, or partnership with another organization, what were/are the main reason(s)?



Base = 215, Multi-Response
Among those with recent activity

Two-thirds (66%) of respondents say that supporting sustainability of the long-term mission is the main reason for considering a merger, acquisition, or partnership with another organization—this indicates that providers are thinking more strategically (and less tactically) when engaged in MAP activity.

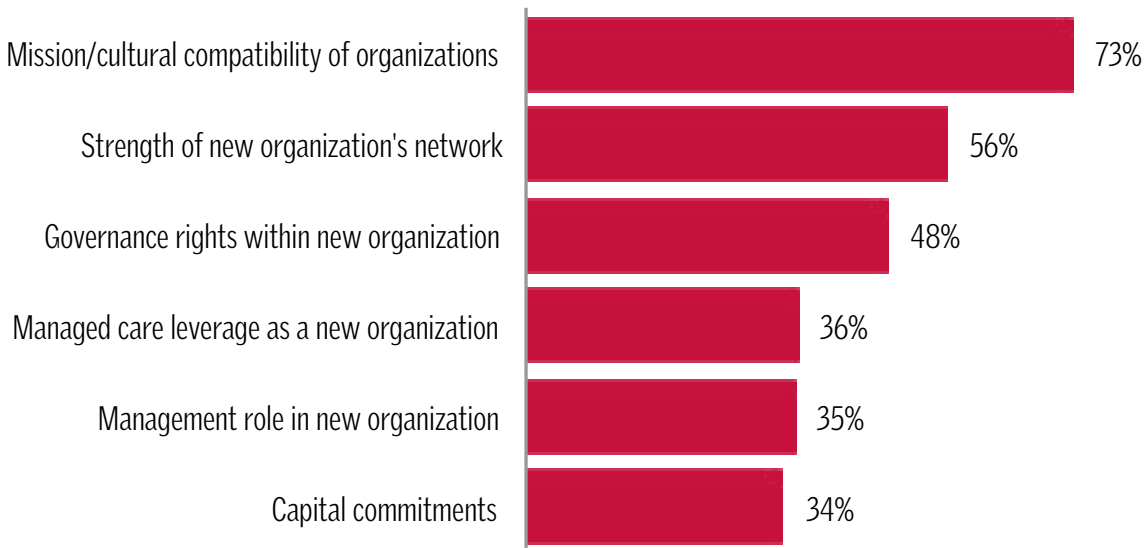


SURVEY RESULTS

FIGURE 8: Important Considerations for Merger/Acquisition/Partnership



What considerations are most important to your organization when considering a merger, acquisition, or partnership?



Base = 215, Multi-Response
Among those with recent activity

Mission/cultural compatibility of organizations (73%) is the top consideration for survey respondents considering a merger, acquisition, or partnership, while strength of new organization's network (56%) was the No. 2 response.

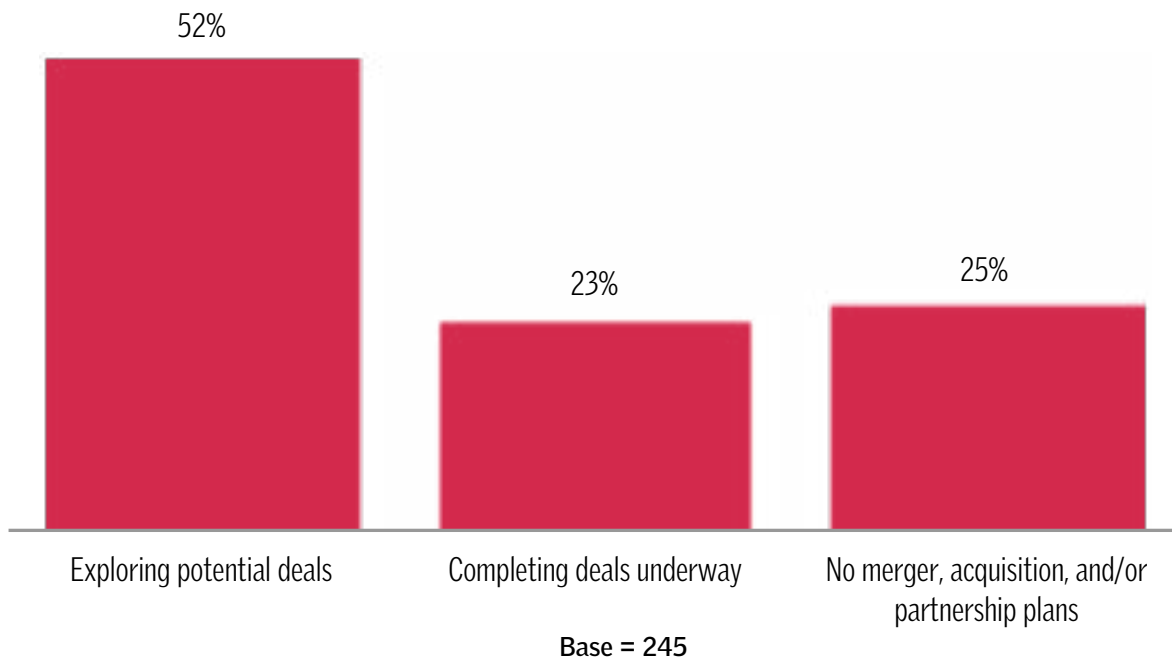


SURVEY RESULTS

FIGURE 9: Merger/Acquisition/Partnership Plans Next 12-18 Months



Please describe your organization's merger, acquisition, and/or partnership plans for the next 12-18 months.



Three-quarters (75%) of respondents say they will either be exploring potential deals or completing deals underway in the next 12-18 months—only one in four respondents (25%) say they have no MAP plans.

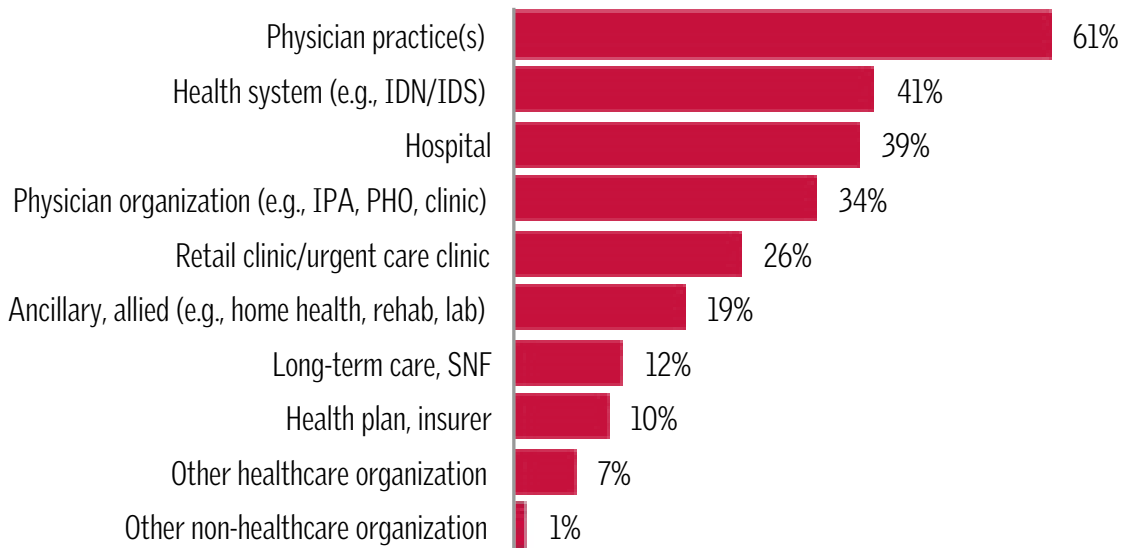


SURVEY RESULTS

FIGURE 10: Type of Organization Interested in Pursuing



Which of the following would you say your organization has a high interest in pursuing through a merger, acquisition, or partnership within the next year?



Base = 184, Multi-Response
Among those with MAP plans within next 12-18 months

Physician practices are the top organization (61%) respondents say they have a high interest in pursuing, up 11 points over last year's survey result, likely because primary care physicians are a key component of the continuum of care, and play an important role in population health management and clinical integration.

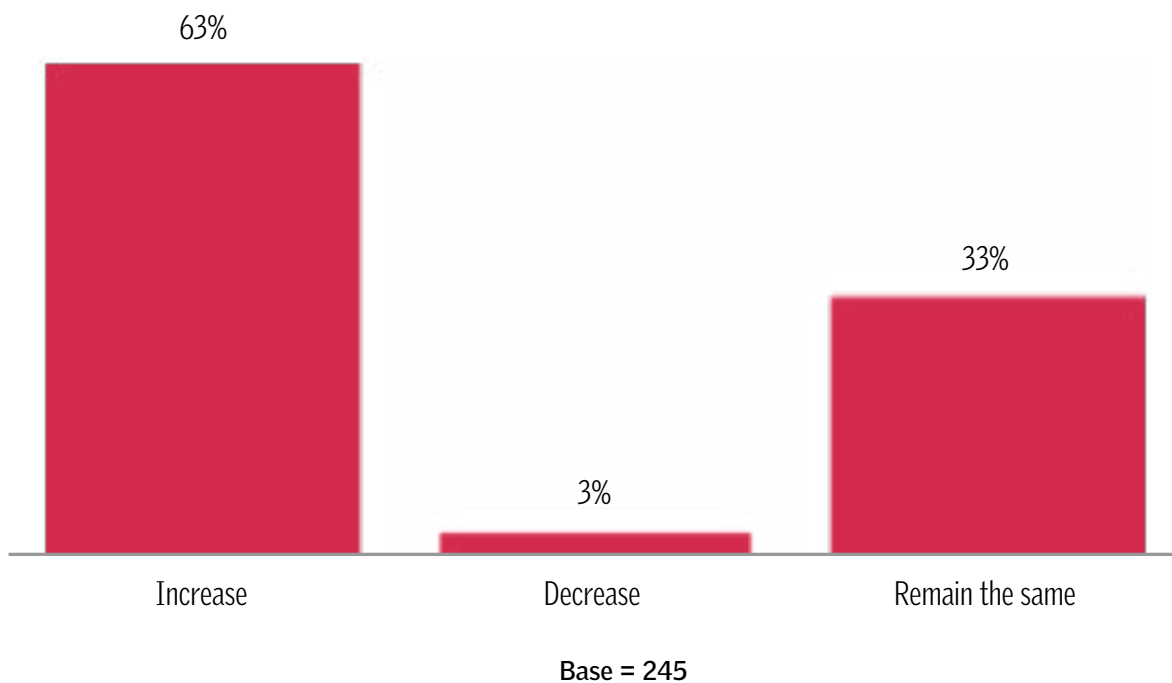


SURVEY RESULTS

FIGURE 11: Merger/Acquisition/Partnership Activity Next Three Years



Within the next three years, do you expect your organization's merger, acquisition, and/or partnership activity to increase, decrease, or remain the same?



Nearly two-thirds of respondents (63%) say that their organization's merger, acquisition, and/or partnership activity will increase within the next three years—only 3% say it will decrease and 33% say it will stay the same.

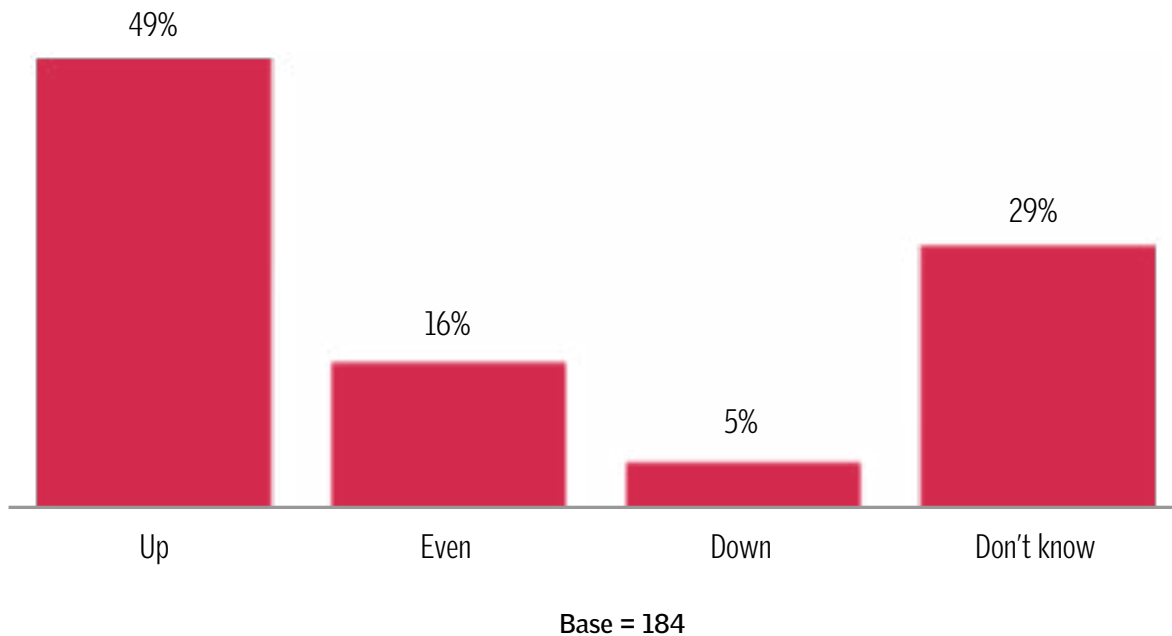


SURVEY RESULTS

FIGURE 12: **Change in Dollar Value of Mergers/Acquisitions Next Three Years**



Within the next three years, do you expect the mergers and acquisitions your organization will be pursuing to go up in dollar value, remain even, or go down?



Nearly half of respondents (49%) say that they expect the dollar value of the mergers and acquisitions their organization will be pursuing within the next three years will increase—only 5% say the value will go down and 16% say it will remain even.

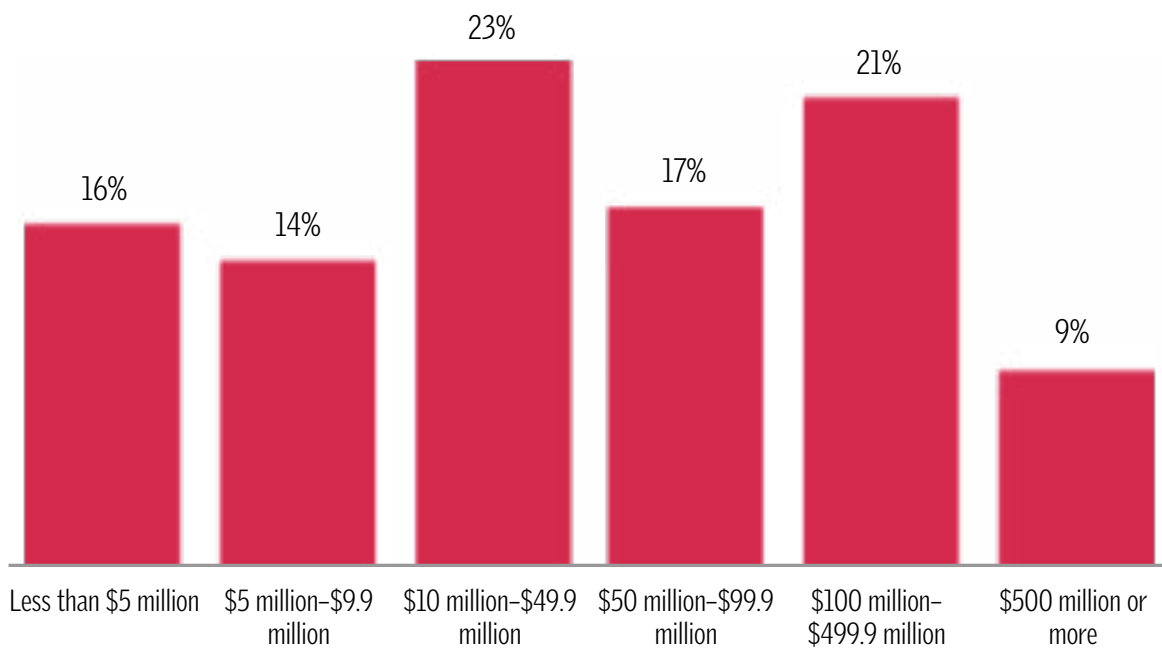


SURVEY RESULTS

FIGURE 13: Total Dollar Value of M&A Deals Next Three Years



Please estimate the cumulative total dollar value of the mergers and acquisitions your organization will be exploring over the next three years.



Base = 121

Among those who expect to explore and have MAP plans within 12-18 months

While this year's survey results are relatively comparable to last year's, there is a small shift to higher cumulative total dollar value—\$50 million–\$99.9 million range is up three points and \$100 million–\$499.9 million range is up five points. The lesser-valued \$10 million–\$49.9 million range is down nine points compared with last year.

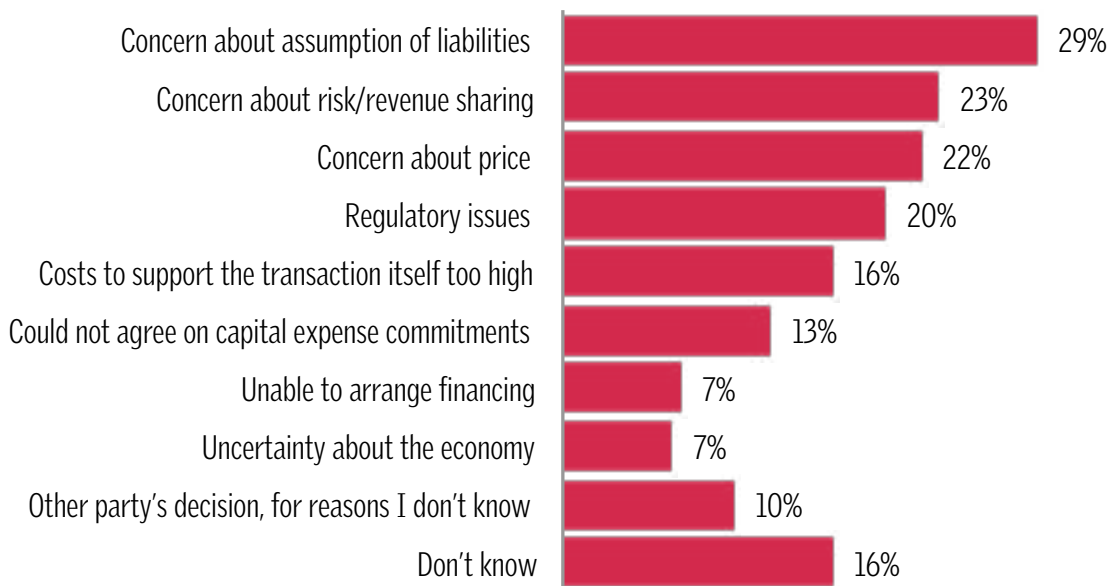


SURVEY RESULTS

FIGURE 14: Financial Reasons for Deal Not Proceeding



Thinking back to the last time a merger, acquisition, or partnership involving your organization was abandoned before or during the due diligence phase, which of the following were among the financial reasons that the deal did not proceed?



Base = 182

Multi-response

Among those who have recent activity and abandoned for financial reasons

Concern about assumption of liabilities (29%) is the top financial reason for a deal not proceeding—it was the top reason in last year's survey (28%) as well. The extent of a target organization's financial liabilities may not be apparent until the due diligence phase is completed, which may explain why this key aspect can be a deal-breaker.

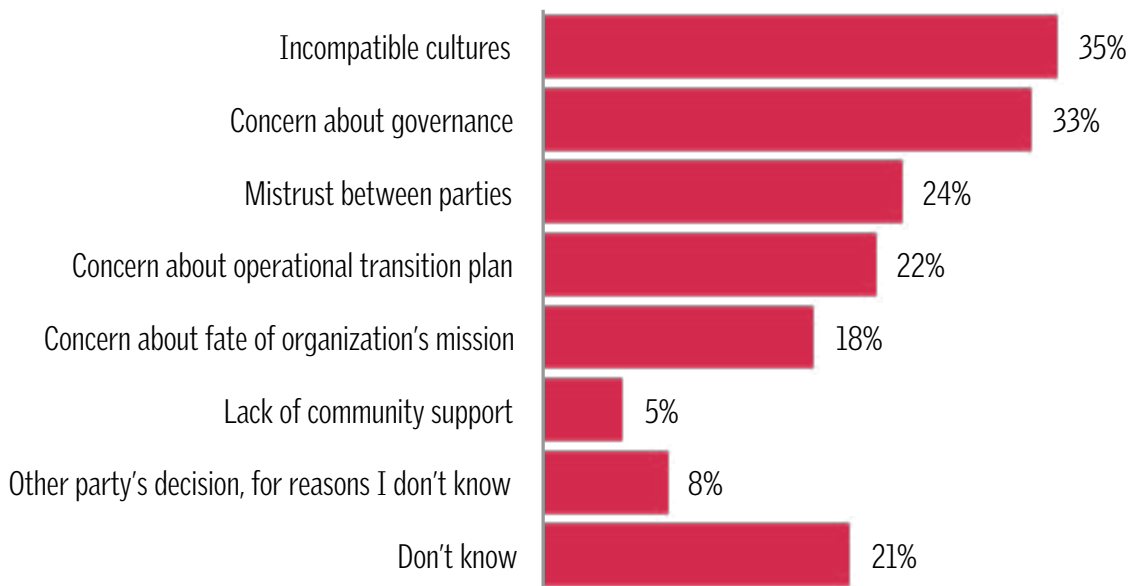


SURVEY RESULTS

FIGURE 15: Operational Reasons for Deal Not Proceeding



Thinking back to the last time a merger, acquisition, or partnership involving your organization was abandoned before or during due diligence, which of the following were among the operational reasons that the deal did not proceed?



Base = 169

Multi-response

Among those who have recent activity and abandoned for operational reasons

Incompatible cultures (35%) and concern about governance (33%) are the top operational reasons for a deal not proceeding—these were the top two responses in last year's survey, although the response rates were nine points and seven points lower, respectively.

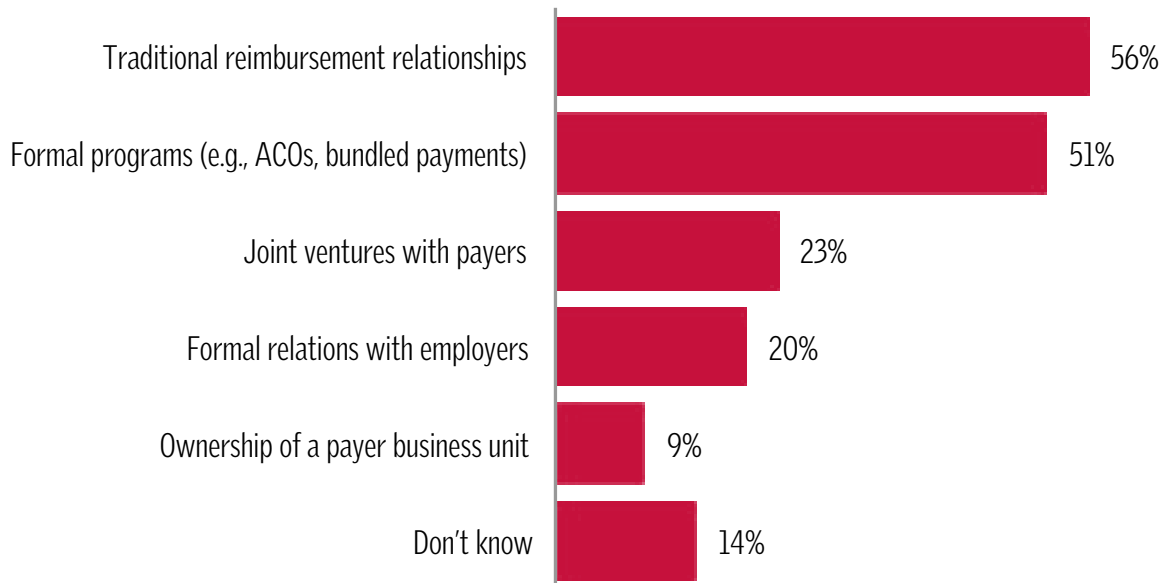


SURVEY RESULTS

FIGURE 16: Payers' Role in Merger, Acquisition, or Partnership Strategy



Which of the following describes how payers fit into your organization's merger, acquisition, and/or partnership strategy?



Base = 245, Multi-Response

Traditional reimbursement relationships (56%) and formal programs (51%) are the top ways that payers fit into respondents' merger, acquisition, and/or partnership strategy—these results are similar to last year's survey, although the response rates were one point and eight points lower, respectively.

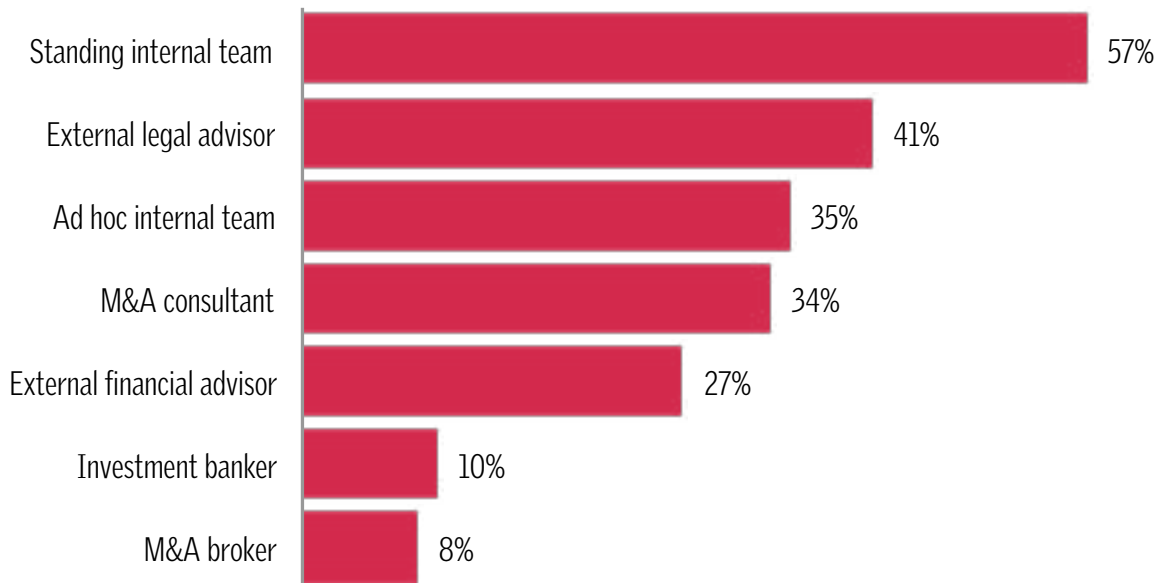


SURVEY RESULTS

FIGURE 17: Sources Relied on to Support M&A and Partnership Activities



On which of the following does your organization rely to support your merger, acquisition, and/or partnership activities?



Base = 219, Multi-Response

Standing internal team (57%), external legal advisor (41%), and ad hoc internal team (35%) make up the top three responses—results are comparable to last year’s survey, although the percentages were four points, two points, and five points higher in 2015, respectively.



METHODOLOGY

The *2016 Mergers, Acquisitions, and Partnerships Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In January 2016, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 245 completed surveys are included in the analysis. The margin of error for a base of 245 is +/-6.3% at the 95% confidence interval.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Greg Devine

President and CEO
AboutHealth
Former Senior Vice President for Provider Strategies
ThedaCare
Appleton, Wisconsin

Dave Krajewski

Senior Vice President and Chief Financial Officer
LifeBridge Health
Baltimore

Paul Tait

Chief Strategic Planning Officer
University Hospitals
Cleveland

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

Intelligence Report Senior Research Analyst

JONATHAN BEES

jbees@healthleadersmedia.com

Executive Vice President

ELIZABETH PETERSEN

epetersen@blr.com

Publisher

CHRIS DRISCOLL

cdriscoll@healthleadersmedia.com

Editorial Director

BOB WERTZ

bwertz@healthleadersmedia.com

Intelligence Unit Director

ANN MACKAY

amackay@healthleadersmedia.com

Assistant Managing Editor

ERIKA BRYAN

ebryan@healthleadersmedia.com

Custom Media Sales Operations Manager

CATHLEEN LAVELLE

clavelle@healthleadersmedia.com

Intelligence Report Contributing Editor

CHRISTOPHER CHENEY

ccheney@healthleadersmedia.com

Intelligence Report Design and Layout

KEN NEWMAN

Intelligence Report Cover Art

DOUG PONTE

dponte@healthleadersmedia.com

UPCOMING INTELLIGENCE REPORT TOPICS

MAY

Emergency Department Strategies

JUNE

Strategic Cost Control

JULY

Value-Based Readiness



Copyright ©2016 HealthLeaders Media, a division of BLR, 100 Winners Circle, Suite 300, Brentwood, TN 37027

Opinions expressed are not necessarily those of HealthLeaders Media. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.



Click for information on joining.

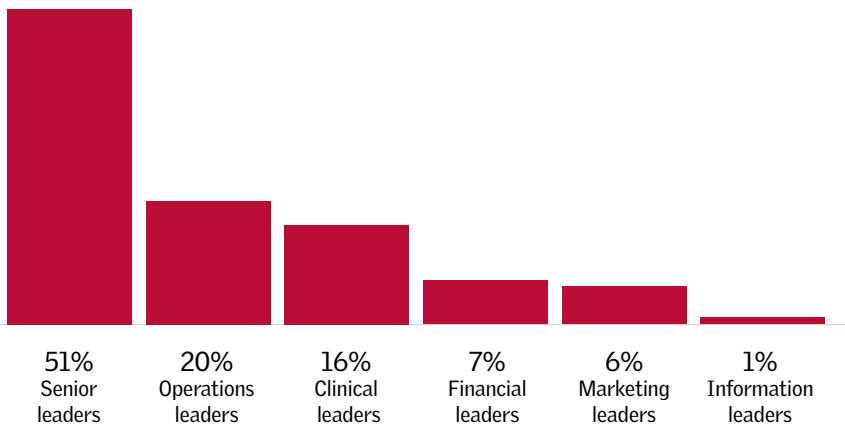


RESPONDENT PROFILE

TITLE

Respondents represent titles from hospitals, health systems, and physician organizations.

Base = 245



SENIOR LEADERS

CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer, Chief Nursing Officer, Chief Medical Information Officer

CLINICAL LEADERS

Chief of Cardiology, Chief of Neurology, Chief of Oncology, Chief of Orthopedics, Chief of Radiology, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Inpatient Services, Dir. of Intensive Care Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/ Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD), VP Nursing

OPERATIONS LEADERS

Chief Compliance Officer, Chief Purchasing Officer, Asst. Administrator, Chief Counsel, Dir. of Patient Safety, Dir. of Purchasing, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

FINANCIAL LEADERS

VP/Dir. Finance, HIM Director, Director of Case Management, Director of Patient Financial Services, Director of RAC, Director of Reimbursement, Director of Revenue Cycle

MARKETING LEADERS

VP/Dir. Marketing/Sales, VP/Dir. Media Relations

INFORMATION LEADERS

Chief Technology Officer, VP/Dir. Technology/MIS/IT

TYPE OF ORGANIZATION

Base = 245

Hospital	41%
Health system (IDN/IDS)	39%
Physician organizations	20%

NUMBER OF BEDS

Base = 101 (Hospitals)

1-199	46%
200-499	29%
500+	26%

NUMBER OF SITES

Base = 95 (Health systems)

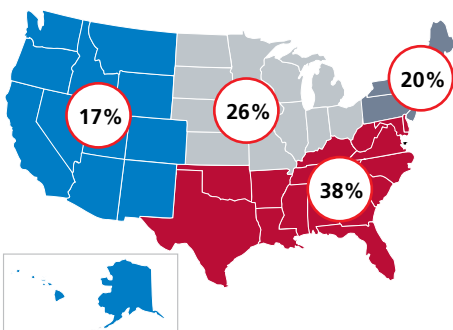
1-5	12%
6-20	35%
21+	54%

NUMBER OF PHYSICIANS

Base = 49 (Physician organizations)

1-9	39%
10-49	27%
50+	35%

REGION



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, D.C., Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

Access.
Insight.
Analysis.

Council

The nation's most exclusive
healthcare intelligence community

Be a voice
Gain insight from your peers
Shape the direction of the industry

Join today at www.healthleadersmediacouncil.com