

III. JOURNEYCARE

Horizon Hospice & Palliative Care (\$13m budget) and Midwest Palliative & Hospice CareCenter (\$35m budget) Merge with JourneyCare (2015)

*Horizon Hospice
& Palliative Care*

Midwest
PALLIATIVE & HOSPICE
CareCenter™

JourneyCare
Expanding horizons in palliative, supportive & end-of-life care

Industry

Hospice Care: Palliative, supportive, and end-of-life care.

Mission

JourneyCare: “Make every moment count for those touched by serious illness and loss.”

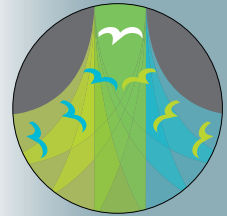
The merger created the largest nonprofit hospice provider in the state of Illinois (\$81 million combined budget) and the sixth largest in the United States. The new organization, JourneyCare, serves nearly 3,000 patients daily across ten Illinois counties through home-based services, five inpatient hospice centers, and six offices to support patient care and services.

Significance

Strategic Growth in Response to Industry Forces

This case demonstrates how powerful industry forces can shape merger. In 1982, government funding of hospice through Medicare and Medicaid made nonhospital end-of-life care available to previously uninsured persons. More recently, the 2010 Affordable Care Act caused a restructuring of the health care industry. With all the disruptions in the health care marketplace and with transition in the industry to risk-based payments, hospices must have scale to take on risk. Growth in scale (number served) and scope (service area) has become necessary for independent, nonprofit hospice providers to remain relevant.

The case also demonstrates a well-managed merger process: an experienced health care consultant helped guide a step-by-step progression that enabled three boards to arrive at a successful outcome. The case further shows how, one year post-merger, the merged entity is dealing with the challenges of integrating three organizations into one and establishing a new brand while simultaneously responding to the challenge of



servicing more patients and families efficiently and effectively in a highly competitive hospice provider market.

Background

Trends and Forces in the Hospice Industry.

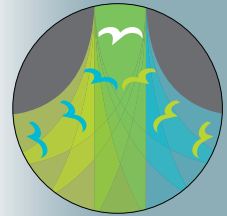
The goal of hospice is to maximize quality of life and comfort for those dealing with serious illness, not to cure. Hospice care has gradually gained acceptance as a more humane, personal, and cost-effective alternative to curative care at life's end. After Medicare began covering hospice care in 1982, support for hospice progressed throughout the health care and insurance industries. By 2010, 48 percent of Medicare dependents received hospice care compared to 22 percent in the 1990s. Hospice expanded further under the Affordable Care Act, which provided benefit eligibility and coverage to millions of uninsured.

Access to government and private insurance, increased acceptance of hospice, and a growing population of the elderly caused the industry to expand, growing from \$10 billion in revenues in 2006 to more than \$16 billion by 2015. Religious, hospital-affiliated home health agencies and nursing homes once dominated the industry, but no more. Between 2000 and 2015, the number of for-profit hospices tripled to almost 2,200; the for-profit share of the hospice market increased from 25 percent in 2000 to near 60 percent by 2016. It is a highly fragmented market: in 2012, the four largest hospice chains had 13 percent of the market, with no single provider greater than 5 percent.⁴⁵

Market turbulence accompanied industry growth. From 1999 to 2009, more than 40 percent of hospices experienced one or more changes in ownership. The entry of private equity, hedge funds, and entrepreneurs into the market increased mergers and acquisitions and accelerated expansion and turnover. Capital influx also enabled private hospice firms to invest heavily in technology and in marketing, making them more efficient than less-capitalized nonprofit providers. Meanwhile, palliative care (for those with longer-range conditions) became a growing market for hospitals and insurers because of the lower cost and higher quality services.

As government became more involved in the industry, greater regulation followed, including reimbursement rates ("caps") based on level of care provided (e.g., routine home care, continuous home care, inpatient respite care, and general inpatient care). Medicare is the dominant payment source for U.S. hospice care and accounts for 90 percent of reimbursements. States determine the number of hospice licenses and the territories in which they operate. In recent years, rapid changes have prompted public and regulatory concerns about hospice standards and service quality.

⁴⁵ Harris Williams & Co., "Hospice Industry Overview: A Research Report" (October 2013).



Pre-Merger

The three parties to this merger had much in common. Founded at roughly the same time (1978 to 1982), they were among the first to open Chicago-area facilities when hospice care was largely volunteer based. The Midwest Palliative & Hospice CareCenter was among the nation's first 50 hospices; Horizon Hospice was the first hospice in Chicago; JourneyCare was the metro area's largest and fastest-growing provider. Founders and early leaders still served on all three boards, which shared a common mission of exceptional, compassionate care. As nonprofits, all were committed to serving anyone, regardless of their ability to pay. Two of the three provided pediatric hospice, which is not reimbursed in the manner of adult hospice.

The three hospices had previously worked together, forming a collaborative purchasing affiliation in 2006 and sharing best practices on a continuing basis. All had similar patient referral characteristics: 50 percent from hospitals, 30 percent from doctor referrals, and 20 percent from other sources (human service agencies, religious organizations, and community care operators). JourneyCare primarily served northwest Illinois. Horizon served Chicago and four southeastern Illinois counties. Midwest Palliative, which earlier had purchased Northwestern University Hospital's hospice operations, had a more fragmented service area. Some footprint overlap of service care existed between Horizon and Midwest, but little existed with JourneyCare.

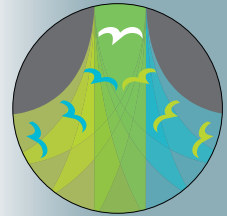
These hospice providers recognized that once the Affordable Care Act of 2010 went into effect, their organizations would be transformed. The opportunity to expand their collective impact through a broader and more customer-focused footprint prompted collaboration discussions.

Profiles of the Merger Candidates (2013)⁴⁶.

Company	Revenues	Employees	Volunteers	Market Share
Midwest Palliative	\$33.2m	383	589	6%
JourneyCare	\$34.8	295	601	6%
Horizon Hospice	\$12.9	172	148	2%
Total	\$80.9m	850	1,338	14%

Seeing a mutual need to better understand what would be required of their organizations under a more regulated, resource-constrained environment, the three CEOs began meeting in 2012. Horizon CEO Mary Runge had worked 38 years in the business, mostly with Horizon. Jamie O'Malley, CEO of Midwest Palliative, joined Midwest in 2010. Sarah Bealles became JourneyCare CEO in 2012 after serving as COO. The three CEOs began merger conversations ahead of engaging all their boards. They received their

⁴⁶ Ellen Jean Hirst, "Merger To Form Largest Hospice," *Chicago Tribune*, March 31, 2015, B1.



boards' approval to jointly hire a consultant, so that they could scan the health care/hospice future together. In response to an RFP, the boards selected well-respected, Skokie-based health care consultant Kaufman Hall. The consultant provided critical advice on planning for the health care future and prospects for the hospice industry under the ACA. These discussions brought board conversations around to merger as an option to consider.

Merger Process

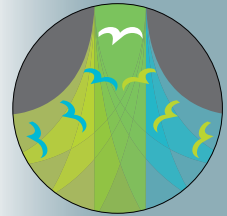
Board members did not start with merger in mind, but the concept gained momentum as the conversation progressed. All three boards understood the risk that small community-based models of hospice care confronted in the new health care environment. Insurers were pressuring them to expand as a means to become more efficient and reduce risk. Not only would growth enable them to achieve economies of scale, but more critically in the new environment, it would enable them to manage risk. Health care reimbursements were changing from fee-based service to risk-based service. To offset risks associated with limited pools of participants, health care providers needed to acquire a larger base of participants. This could be achieved by acquisition, internal growth, and merger.

Hospices primarily receive patients through referrals. Each of our the partners had its own referral base consisting of lead hospitals and senior living centers. Joining together constituted a critical risk-mitigation step because it enabled them to protect this referral base. For-profit providers were picking off market segments and attracting paying customers from nonprofits. For community-based providers who offered their services regardless of ability to pay, the challenge was to navigate through a new marketplace in which for-profit providers had greater capital and often provided more cost-effective services.

Moreover, a new model was emerging that would be an industry game-changer. Accountable Care Organizations (ACO), known as payer-run markets, emerged out of the Affordable Care Act and would likely become the dominant model for managing set population groups. Payers would develop their own health care networks, including hospice care providers, who would compete to participate in these networks. Merging would help the organizations compete.

However, as merger discussions progressed, the boards also came to understand the issues and challenges they faced:

- Three organizations with various levels of financial strength
- Integration of different cultures, accounting systems, and IT
- Deeply committed legacy founders still involved with boards
- Attachments to their accomplishments and brand equity after decades of operation
- Single CEO position; two or all three CEOs would lose their jobs



- Considerable legal and regulatory costs
- Lengthy merger process that would take many months
- Board representation decisions in the new organization
- Selection of location of new headquarters and main offices
- Naming and branding of new organization

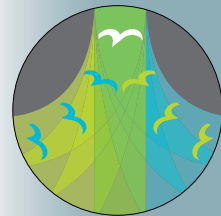
The three organizations created a joint merger committee consisting of 12 members: the three board chairs plus another board member from each organization and the three CEOs plus another executive staff member from each organization. Each had its own legal team. The administrative teams talked weekly; the full 12-member committee met less often. The consultant, Kaufman Hall, moved the merger process through three stages, each three months in length. Each stage produced agreement before moving to the next.

Merger risks were identified. For example, one of the merger partners was acknowledged to be relatively financially weak. Also, a merger would result in some service disruption and possible referral loss. Accordingly, the merger pro forma indicated a prospective financial loss during the first merger year.

At the end of the second stage, nearly six months into negotiations, JourneyCare board representatives introduced a “deal breaker.” They asked that their CEO, Sarah Bealles, be named CEO/President of the merged organizations or they would exit the negotiations. Some Horizon and Midwest board members were surprised by the condition. However, once the boards compared the financial health of each organization, supported by consultant metrics, the stronger financial position of JourneyCare became apparent. The consultant also told the board members that the largest, most financially stable party to a merger often moved to elevate its CEO as a condition of merger acceptance.

Midwest Palliative and Horizon board members, several with merger business experience, apparently understood the condition, and CEO succession did not become an obstacle. From the outset it had been understood that Horizons CEO Mary Runge would be retiring. However, Jamie O’Malley, a well-respected health administrator, who came to Midwest Palliative from the University of Chicago Medical Center, could have been a candidate. In the end, Midwest and Horizon agreed to name Bealles as the merger successor CEO. In addition to her training (in finance and as a Certified Hospice and Palliative Care Administrator) and professional experience, Bealles had compiled an impressive record of accomplishments at JourneyCare.

The decision around the CEO position notwithstanding, the parties proceeded through all three stages in agreement. All saw value in the merger: markets, services, cost structure, and competitive positioning. The parties did their own due diligence under their



respective lawyers' oversight. They also agreed to parity in the new board composition but did not finalize board membership until after the merger. After nine months and three discussion stages, a public announcement of the planned merger occurred in March 2015 with a final agreement three months later.

Before the merger was formally announced, the CEOs and boards started on an integration plan which included a new organization structure and reporting chart. With a sense in the organizations that change may be underway, leaders wanted to come out of the gate with as many organizational questions answered as possible. Given deep emotional attachment to mission and culture—dignity and respect for end of life—no losses were expected among volunteers; however, Midwest's CFO and two vice presidents left during merger discussions (positions were filled on a temporary basis with the help of retention bonuses). Senior management felt that employees needed to know what their new jobs would be and what the organization would look like. It was agreed that there would be no layoffs and, instead, staff reduction would come from attrition over time.

Structurally, Midwest and Horizon merged into JourneyCare. It was structured that way to maintain the tax-exempt status of the existing JourneyCare Foundation.

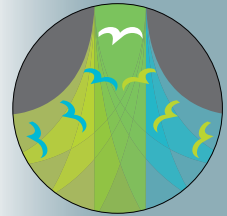
Branding/naming issues would be considered early in the post-merger phase with help from outside consultants. All three organizations were known in their service areas, but not widely known outside of them. They agreed that there was nothing immutable about their current names or identities—"Midwest," "Horizon," or "JourneyCare."

In the formal merger announcement, Bealles stated that the merger was being driven by the Affordable Care Act and ensuing health care consolidation, "Our health care partners are consolidating and at the same time narrowing their networks, looking for those that provide best value, outcomes, and cost... . The ability to be that partner of choice in your community is really what's driving this." Jamie O'Malley (who would soon depart) noted, "The health care industry is not standing still and neither are we." Mary Runge concluded, "We are proud to be part of this merger, which truly forms the premier palliative and end-of-life provider in the region."⁴⁷

Post-Merger

Consultants recommended, and negotiators agreed, that board representation would be equally apportioned among the three parties. Each board polled its members to see who wanted to serve going forward. Together, they compiled a final list and agreed upon methods for apportioning terms of service. The new Board of Directors Chair would be selected either from Midwest or Horizon; JourneyCare's board chair was ready for a transition and agreed to head the JourneyCare Foundation board of trustees. Julia

⁴⁷ Press release, "Three Chicagoland Palliative and End-of-Life Care Organizations Merge to Enhance Care: Horizon, JourneyCare and Midwest Care," July 24, 2015.



Cormier, who had served on Midwest's board since 2009, stepped up to be the new chair. A Northwestern University Kellogg School MBA with private equity experience, Cormier was a 10-year hospice volunteer and had led Midwest's strategic planning committee. All parties were comfortable with the choice.

Naming and Branding a New Organization

Before a new name was chosen, the three legacy names remained visible along with a unifying logo and messaging: Moving Forward Together. The new board began the naming process by eliminating the legacy organization names from consideration, but then the process took an unanticipated twist: members (comprised of equal representation from the previous boards) returned to a familiar name—JourneyCare. The process by which legacy avoidance turned into legacy naming is instructive:

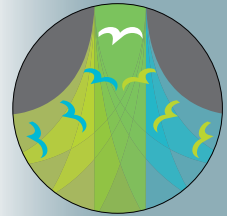
- Board members learned that internal stakeholders cared more about the naming than external stakeholders, who cared most about responsiveness of the new organization and about patient referrals.
- More than 300 names were vetted, including hyphenated mixes of legacy names such as Horizon-Midwest. These options either caused confusion or failed to resonate as hospice-type names.
- A shorter list of proposed hospice names were run through existing trademark designations; most names were eliminated because they already had been trademarked.

Finally, a legacy board member (not from JourneyCare) put the name of JourneyCare back on the table and it was overwhelmingly approved. In November, the newly merged organization announced the JourneyCare name, noting that it conveyed “excellence and innovation in care, expertise and leadership, and a responsiveness that the organization delivers to patients and facilities every day.” The more difficult task of building a new culture lay ahead.

Integrating Three into One

Prominent signs in the major locations of the three legacy organizations reading “Moving Forward Together: OneTeam, One Mission, Same Exceptional Care” aptly captured the task of integration. Twenty to thirty integration work groups operated along with multiple program integration teams. Lists of priorities were worked through: HR and benefit plans; compensation systems; IT-electronic records; common vendor and purchasing lists; financial integration and a single reporting system; common employee communications. There were team-building activities throughout the new organization.

JourneyCare CEO Sarah Bealles worked to overcome legacy issues through a three-part strategy: a communications plan built on transparency; frequent staff meetings with



open question-answer sessions; and representation by each legacy organization on every integration team or task force.

Beginning with intake, JourneyCare methodically began nurturing a culture based on best practices. This did not mean taking the best practice from among the three legacies, but rather the best practices in the hospice field. Important issues emerged; for example, different interpretations of some terms existed among the three. “Same day admit” to one meant that those informed of admission were, in fact, admitted on the same day. To another, it meant that a patient was informed that they would be admitted.

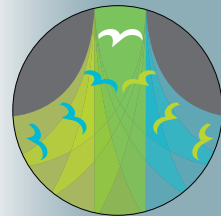
Cultural fit had not been a major issue of concern earlier because boards and leaders knew one another, had experienced positive partnering, and were philosophically and mission compatible. Nevertheless, “there was fallout.” Staff turnover increased in 2016, not by more than industry levels, but enough to suggest that some were not comfortable with the new organization culture. A board member noted that some staff left because they felt they were victims of a “hostile takeover.” Others suggested that turnover increased because some did not fit new expectations regarding performance.

Other issues cropped up. One of the merger partners turned out to be less solvent than originally thought. Receivables turned into a financial challenge. Increased phone volume and electronic record transfers resulted in difficulties in meeting 24/7 customer response. As one observer of the integration/transition period observed, “There is no such thing as a seamless integration.”

Success Indicators

Integration of three volunteer-based organizations with nearly 1,000 employees spread across multiple locations proved to be more challenging than anticipated. The new organization had to simultaneously engage in “cleanup operations” while pivoting to new goals and a new strategic plan. “We had to fly the plane while remodeling it” was how one board member characterized the situation. Nonetheless, only one year into merger integration, JourneyCare showed remarkable stability, with growth prospects ahead:

- Number of patients served remained steady.
- Referrals remained steady.
- Patient/family satisfaction held its own with improvements in sight.
- Employee retention remained above industry averages.
- Business/risk metrics (operating margins, cash, and reserves) on target, with break-even possible for the year (first-year losses had been forecasted).
- Strategic plan updated and a new business plan in place for the fall.
- Designation as one of the nation’s 11 Palliative Care Leadership Centers and as one of 141 hospices nationally to participate in the Medicare Care Choices Model.



Takeaways

- Vision of an integrated organization is needed before one starts down the merger path.
- Provide a compelling reason for the merger, and create excitement throughout the organization (e.g., “survival” in a new health care industry).
- Create and set board member expectations. Changes and surprises will inevitably occur along the merger path for which the board may not be prepared.
- Assess the risks. The three could have continued in their own limited markets, but they understood and responded to the risks to their longer-term sustainability of standing pat.
- Given emotion of stakeholders attached to organizations that would merge, dedication to mission brought founders and legacies around to merger support.
- Experienced professional consultants helped lead the three to a successful outcome. They provided a template that moved the process to completion.
- Mergers are more expensive than anticipated, especially in highly regulated markets.