EXCERPTS OF RECENT MEDIA COVERAGE

HEALTHCARE PRACTICE

A SAMPLING OF BDO THOUGHT LEADERSHIP IN THE MEDIA FOR Q3 2013

BDO's national team of professionals offers the hands-on experience and technical skill to address the distinctive business needs of our healthcare clients. We supplement our technical approach by analyzing and advising our clients on the many elements of running a successful healthcare organization.

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BUY-SIDE DUE DILIGENCE: TAILORING YOUR APPROACH FOR SUCCESS

By **Hank Galligan, Jim Johnson, Kevin Kaden** and **Steven Shill, BDO**

Due diligence is a critical step toward completing any private equity transaction. Today, more than ever, many private equity funds are subjecting their targets to greater scrutiny as they seek out companies with a compelling growth story that can withstand the ever-changing business environment. While all buyers should conduct a thorough assessment of the financial, operational, technological and human resources health of a potential portfolio company, there are also key diligence considerations that emerge based on the industry in which each target company operates.

To help fund managers navigate these issues, we took a look at the key diligence considerations in three of the sectors that, based on the BDO PErspective Private Equity Study, private equity professionals believe will provide the greatest opportunities for new investments in 2013: technology, natural resources and health care…

Health Care

The health care industry is experiencing a complete shift as new reimbursement models, a new paradigm for the uninsured, an aging population and changes mandated under health care reform have all combined to reshape the industry. As hospitals and health systems consolidate, physician practices are acquired and new industry players emerge, private equity sponsors face many new challenges and considerations that impact the buy-side due diligence process.

When evaluating a potential acquisition target in the health care industry – regardless of the specific sector – it's critical to fully understand the organization and its value proposition, and determine if the leadership team's long-term vision is sustainable within the new health care environment. It's also crucially important that the leadership team have the knowledge base and foresight to steer the organization where it needs to go within this rapidly evolving industry. The same cadre of health care organizations that have thrived historically will not necessarily succeed in the future as reimbursement models change and the relationships

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between payers, providers and patients evolve.

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PROVIDERS GETTING CREATIVE WITH NEW HEALTHCARE DELIVERY MODELS

By Debra Wood

The times are changing, and healthcare providers are discovering new models to more efficiently deliver quality care while reducing costs.

"Reimbursement is changing to be more focused on outcomes than fee-for-service," said **Patrick Pilch, managing director with BDO Consulting and member of the firm's healthcare practice in New York**. "You are seeing more initiatives as hospitals focus on population health management."

Settings for healthcare delivery continue to move from acute care to networks in the community, and care is becoming more consumer-centric and more coordinated, Pilch said…

Accountable care organizations

While not new, the Affordable Care Act (ACA) brought accountable care organizations (ACOs) to the forefront of new delivery models. ACOs manage a population with the triple aim of reduced cost, improved health and a good patient experience…

Patient-centered medical homes

Patient-centered medical homes, which deliver care in a more coordinated fashion with a whole-person orientation, also received a boost from the ACA…

More than 5,500 practices with nearly 27,000 providers have earned patient-centered medical home recognition from the National Committee for Quality Assurance (NCQA). The organization recently added Patient-centered Specialty Practice recognition…

Telehealth

Patrick Pilch said care models are changing to reflect a transition to outcome-focused reimbursement.

Pilch also reports an increased use of telehealth, particularly monitoring patients with chronic illnesses with data returning to the provider, who often can prevent a trip to the hospital…

"It's almost like a virtual house call," Pilch said. "Telemedicine will be a key component of this."

Retail clinics

Pilch expects to see more retail clinics, because they afford great access to care for minor illnesses and a less-expensive alternative to after-hours care. The professional staff can recognize an urgent matter and refer the patient to the nearest emergency department. Many of the established retail clinics, such as Walgreens' Healthcare Clinic, have expanded into diagnosing and treating chronic illnesses…

Greater integration

Providers--from hospitals and physicians to long-term care--are becoming more adept at managing patients with chronic diseases, including "dual eligibles," whose average annual spending far exceeds either Medicare or Medicaid beneficiaries, Pilch reported.

▶JOURNAL OF CORPORATE RENEWAL

4 Rs OF HEALTH CARE REFORM: RIGHT CARE, RIGHT PLACE, RIGHT TIME, RIGHT COST

By **Patrick Pilch** and **Dr. David Friend**

Faced with the rising total costs of care, the cost of caring for chronic illnesses, and shrinking reimbursements, hospitals must transform. Health care is disaggregating in a powerful way as the traditional hospital-centric operating model that was once "investible" becomes less viable. Given that hospitals are not always the most appropriate places for providing much of the care that is needed, hospital-centric models are now splitting into components to provide a continuum of care and move toward population health management models.

Thus, the new mantra has become providing the right care, for the right amount of time, at the right place, and for the right cost…

But what exactly should this new model look like…

Implementing Change

The redesign of payer models is intended to provide hospitals with an incentive structure to promote the right care, for the right amount of time, at the right place, and for the right cost. Put another way, the financial incentives in the system need to drive providers to change their focus to patient-centric care offerings—i.e., moving from volume to value—and from hospital-centric to integrated care operations. While most hospitals and health systems understand the necessity to change the way they deliver care, too many were not designed or built to do so. With legacy issues in mind, how do health care systems adapt their operations to true patient-centric care? To reach this destination, it is helpful to first understand the goal of the health care model in the context of health care reform and then create a road map to guide implementation. The new model will require a higher level of accountability during the evolution from hospital-centric to accountable care organizations and to a population health management delivery system…

Viable, Sustainable Networks

Meeting health care reform's goals of providing high-quality care and better patient outcomes while lowering the cost of care is challenging. However, significant clinical, operational, and financial opportunities result from a successful transformation. Health care providers must focus on coordination, collaboration, and communication in the transformative process with a goal of achieving population health management rather than higher volume.

Some early indicators of potential success include being adaptive and flexible in achieving incremental savings and improved margins, improving patient outcomes, and strengthening the coordination of care through population health and improved

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quality metrics. By building a connected, clinically integrated, and financially viable network guided by the goal of providing the right care, for the right amount of time, at the right place, and for the right cost, restructuring to a new operating model is both achievable and sustainable.

▶ JOURNAL OF CORPORATE RENEWAL

REENGINEERING THE HEALTH CARE TURNAROUND PROCESS

By **Steven Shill**

The landscape of health care is shifting dramatically. Long-standing health care institutions across the U.S. are being forced to make some hard decisions as the effects of the Affordable Care Act (ACA) take root. Many of these organizations have been pillars of their communities, and now they are being asked to do more with fewer resources.

To an even a greater extent now than in the past, many hospitals are assessing their prospects for long-term sustainability. Can they survive the continuous onslaught of reimbursement cuts from Medicare, Medicaid, and commercial payers? Can they effectively reduce operating costs through deals with their suppliers? As significant employers themselves, hospitals also will contend with double-digit increases to health insurance costs for their own employees. What are their alternatives? These are just of a few of the questions that boards are asking hospital management.

The permutations of the risk analysis and threats to hospitals' existence are endless.

Of course such a fact pattern assumes that management and the boards of hospitals have proactively identified these bumps in the road. However, in many cases reimbursement cuts have occurred with such speed that virtually overnight once self-sufficient organizations have found themselves facing liquidity crises. At this point, there may only be a few options open to hospitals:

1. An organization can choose to do nothing—that is, it can continue down the path it has been following…
2. A hospital or health system could try to alleviate its liquidity shortfalls through borrowing…
3. Health care organizations can merge or consolidate…
4. Health care organizations can look to establish strategic alliances…

Redefining a Turnaround

What is the alternative to these four options? The answer may be found through a turnaround that includes an immediate reengineering of broken processes, implementation of a new strategic plan, and, when possible, a hasty operational and financial restructuring of an organization to meet the demands of the paradigm shift in health care delivery systems.

For such a turnaround to succeed, however, key factors need to be considered. Perhaps most important is buy-in by an existing board and management. They need to acknowledge that the hospital has problems that must be fixed as soon as possible. In some cases, this acknowledgement may require facilitation by an independent party to help drive reality into the process.

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