

Hamot's 30-year March to Distinction



UPMC Hamot



A Jefferson Society Analytical Essay

Chapter 3

HAMOT'S GREAT
LEAP FORWARD

John Malone's response to the question "what now?" was a decisive one: "We have to look for new approaches to old problems ... We have to become very successful."

Malone started the revitalizing effort by taking for himself the personal responsibility to revitalize regional relationships by spending a month traveling to Cleveland, Pittsburgh, Hershey and Buffalo with four other administrators to discuss possible partnerships. He had always been convinced that Hamot's philosophy should be to "partner with whomever and wherever it makes good sense," and while he did not expect that his visits would produce "dramatic bombshells" he believed that they were essential in charting Hamot's future directions:

These visits were meant to basically come up to speed on what's happening in the market. I think it's critical we do them because during the consolidation effort, we didn't do any of that. For two years we tried to tone down our presence as we worked with St. Vincent during the consolidation. Now I think it's vitally important that we reestablish ourselves as a premier medical institution for this region and that we remind everyone of the great work that we do at Hamot.

In addition, Malone issued a "call to action" for the entire Hamot community:

There are many challenges and multiple threats that are growing daily. We need to think and act very differently and be proactive... there is a sense of great urgency and we need to develop new [strategic] actions. I am

confident that we will succeed with support of those who see the future.

Hamot’s financial statistics in 1998 certainly supported Malone’s “sense of urgency,” for Hamot’s finances had remained in a relatively stagnant position during the four years of merger talks. As the chart (on page 18) indicated Hamot’s revenue of 1995 and 1997 remained flat at \$174 million and \$173 million respectively, as did similar hospital expenses of \$167 million which yielded comparable net profits of \$7 and \$6 million respectively. This flat financial pattern during merger patterns was no surprise since it made little sense for Hamot to move forward with initiatives that might not fit in the proposed new entity.

Generating new momentum for Hamot, however, would prove to be a daunting task since one of the basic laws of physics is that “a body at rest tends to stay at rest”. Adding to the difficulty was that any serious forward movement would take three or four years before new strategies could be both adopted and implemented. The financial statements for the three years following the merger clearly indicate that substantial progress was not visible until 2002.

SUMMARY OF CONSOLIDATED REVENUES/EXPENSES
(IN THOUSANDS)

Operating Revenue	2000	2001	2002*
Net Patient Serv.	188,619	190,897	211,730
Contracted Serv.	5,249	2,173	2,071
Gifts, Bequests	2,231	305	2,153
Investment Income	4,198	3,488	2,017
Other	7,410	7,532	8,066
<i>Total</i>	<i>207,707</i>	<i>204,495</i>	<i>226,037</i>

Operating Expenses	2000	2001	2002
Salaries/Wages/Benefits	94,678	93,519	105,663
Supplies/Pur. Serv.	89,421	85,102	92,667
Depreciat./Amot.	11,837	12,508	13,351
Interest/Taxes	3,551	3,148	2,531
Bad Debt	3,185	5,029	5,872
<i>Total</i>	<i>202,672</i>	<i>199,304</i>	<i>220,084</i>
Operating Margin	\$5,034	\$5,191	\$5,953 ⁵

Hamot's Medical Center admissions picture for this period show a similar static picture with St. Vincent continuing to maintain a slight edge in patients admissions in 1999 and 2000 until Hamot finally passed them by a slight margin in 2001.

TOTAL ADULT ADMISSIONS FOR ERIE COUNTY HOSPITALS

Institution	Adm. (1999)	Share (1999)	Adm. (2000)	Share (2000)	Adm. (2001)	Share (2001)
Hamot Medical Center	13,404	40.03%	13,760	40.58%	14,649	40.55%
St. Vincent Health Center	13,623	40.69%	13,841	40.82%	14,418	39.91%
Corry Memorial Hospital	1,647	4.92%	1,844	5.44%	1,784	4.94%
Metro Health Center	1,946	5.81%	1,503	4.43%	1,796	4.97%
Millcreek Community Hospital	2,862	8.55%	2,960	8.73%	3,481	9.63%

By late 2002, Hamot's planning strategy started to take effect reflecting some important decisions. One such decision was John Malone's recommendation that Hamot should concentrate on its core functions and reduce or relinquish costly and distractive ancillary activities such as running retirement and nursing homes, behavioral health clinics, etc.. Hamot's management team was also greatly helped in creating a new 'Strategic Culture' by the efforts of a strong Trustee planning group that included: Dr. Jay Jenkins, Dr. Joe McClellan, Dr. David Kruszewski, and Mr. Mike McCormick. It was this committee that strongly endorsed the bold ideas of improving Hamot's market share by launching new, high quality programs such as a heart hospital, a trauma center, a surgery center, and a women's hospital, while at the same time increasing Hamot's regional affiliations in nearby Ohio, New York, and NW Pennsylvania and set a new course for Hamot.

The decisive hurdle that had to be jumped, however, before any of the new strategic plans could be implemented was the high cost of such ventures estimated to be around \$100 million dollars. This concern was significantly alleviated when Steve Danch, Hamot's director of finances, persuaded the board that Hamot could raise the money by floating a \$100 million bond without seriously damaging Hamot's credit rating or its operating budget. Danch's bold recommendation marked a decisive moment in Hamot's modern history with the Trustees approving in 2002 the Hamot Millennium Project that called for major construction of new facilities including:

- The Hamot Orthopedic Institute Hip and Knee Unit
- A free-standing 80,000 sq.ft. building for the Hamot Heart Institute
- Additions to the Emergency Department and Operating Rooms
- The filling of the courtyard to create 12,000 sq. ft of new space for non-invasive cardiac services, storage, and re-location/expansion of the pre op.
- New space for a \$10 million modern information system

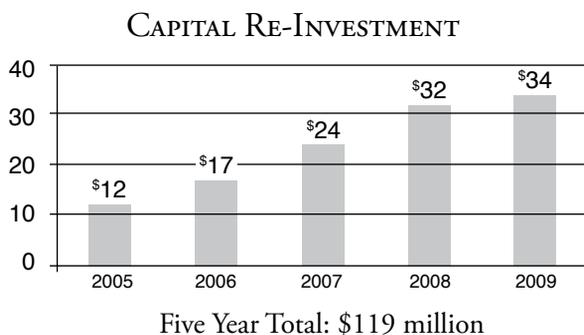
An essential force for the development, implementation, and ongoing development of the Millennium Projects was Dr. Joseph McClellan whose wide experiences at nationally recognized hospitals had gained him a stellar reputation for visionary strategic insights. As one Hamot administrator commenting on the critical importance of Joe McClellan's role stated:

Joe was the one who changed the mindset of Hamot's strategic culture by developing high volume and income specialties. He was also the driving force for the hospital developing excellence in cardiac care, building on the solid foundation laid by Dr. George D'Angelo. He and John Malone were a great team for Malone not only strongly supported Joe against his critics...but also provided the resources and board access so critical to moving the Millennium Projects forward.

Just how effective the impact of the millennium projects was in creating Hamot's dramatic financial "turn around" is quite visible

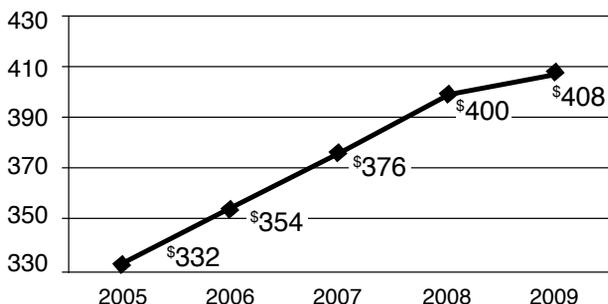
in the growing strength of Hamot's position from 2002 through 2006. For example, revenue growth significantly increased from \$266 million in 2002 to \$353 million in 2008, while the hospital operating margins jumped significantly \$10 million dollars in the same four years from \$5.9 million to a robust \$15.8 million.

The Millennium Project was also greatly aided by an important decision to include capital re-investment as a regular budget item in addition to the traditional category for plant maintenance and repair. This budgetary move provided for continuous improvement in strengthening the new strategic initiatives which fueled much of Hamot's explosive financial growth from 2006 through 2009. The chart below shows the extensive growth of capital re-investment from 2005-2009:



Re-allocating special funds for capital re-investment was, of course, made much easier by Hamot's **25%** growth in patients from 478,000 to 600,000 (2005-2009) that produced the **22%** revenue growth demonstrated in the graph below:

REVENUE GROWTH (NUMBER IN MILLIONS)



Hamot's impressive gains in economic health were not just the result of strong investment gains but were also due to its growing medical reputation, particularly in cardiac care, among national health professionals. The many prestigious recognitions awarded to Hamot since 2003 reflect its increased recognition that is contained in the following article:

For the sixth time Hamot Medical Center has been identified by Thomson Reuters as one of America's 100 top hospitals for cardiovascular care. As the only hospital in the region on the list with institutions like Cleveland Clinic and UPMC, Hamot is proud of the recognition. Only two other Pennsylvania Hospitals have made the list six times.

Another major recognition came from Reuters 100 Top Hospitals List which praised the general institutional excellence of Hamot's management:

Chosen from over 3,000 hospitals Hamot Medical Center was recognized for superior performance overall

in providing high quality health care, superior financial management, and proven value.

U.S. News & World Report joined the recognition parade in 2007 by naming Hamot as among the top American hospitals for heart surgery and neurosurgery in their 2007 health issue.

Such a successful renaissance of Hamot after the St. Vincent setback was due to the presence of a veteran president and administrative team that had been in place for the last several decades, and whose Hamot experience actually totaled an amazing 129 aggregate years. The major players of this leadership group were:

HAMOT'S LEADERSHIP TEAM:

John Malone – 35 years

Jim Fiorenzo – 35 years

Steve Danch – 30 years

Don Inderlied – 24 years

Richard Long, MD – 5 years

It was this team's Hamot experience plus their institutional attachment which provided the institutional memory and deep commitment necessary for Hamot's re-invention to occur rather than just continuing 'business as usual.'

Certainly the years 2005-2009 marked a time when Hamot's resources reached an economic peak reflecting the effect of a different physics maxim that "a body in motion tends to stay in motion." But, as so often happens in human history, climbing higher on the economic mountain usually creates a whole new set

of challenges that in 2009 brought a sudden end to a decade of increasing financial prosperity.

OPERATING RESULTS FOR 2009
(NUMBERS IN MILLIONS)

Revenue	\$408
Expense	\$405
Salaries/Supplies	(\$374)
Uncompensated Care	(\$31)
Net Before Investment Losses	\$3
Investment Losses	\$4
Net After Investment Losses	\$1

**Uncompensated Care has Tripled Since 2003*

No doubt the great economic recession confronting the country was a major factor in ending Hamot’s ‘go, go years’ creating significant investment losses reflected in the data of the 2009 audit. The 2009 financial turn of events was due not only to institutional investment loss but was also the result of a \$6.1 million (or 3.8%) increase in salaries and wages coming from raising the number of full time Primary and Specialty Care physicians staff to a record level of **179**. Although this rapid growth in full-time medical staff was simply reflective of a growing national trend in hospital staffing, it clearly added to Hamot’s financial pressure since hospital employed physicians seldom create enough revenue to cover their total employment costs.

Moreover, higher patient volume also usually results in higher costs that are associated with costly implants, devices and drugs. Another strain on the hospital’s balance sheet was the continuing growth in

bad debt collections almost doubling in five years from \$16 to \$31 million. Only the implementation of strong cost controls kept Hamot's 2009 loss from being much worse. The following chart illustrates both Hamot's rapid growth in financial strength from 2005 and the sudden end of financial 'good times' in 2009.

SUMMARY OF CONSOLIDATED REVENUES AND EXPENSES
(IN THOUSANDS)

Operating Revenues	2005	2007	2009
Net Patient Services	316,284	358,995	394,307
Other Revenues	8,836	5,263	5,939
Income Equity	4,918	5,028	4,308
Investment Income	2,245	5,627	(2,040)
Contributions	222	154	1,070
<i>Total</i>	<i>*333,000</i>	<i>*376,048</i>	<i>*404,658</i>
Operating Expenses	2005	2007	2009
Salaries, Wages, Benef.	151,068	180,171	202,208
Supplies and Expenses	129,350	137,321	149,567
Doubtful Collections	16,449	25,413	31,656
Depreciation	16,424	16,979	17,184
Insert Paid	2,601	3,711	3,897
Loss on Property Sale	193	679	696
Disposal of Equip.	-	-	-
<i>Total</i>	<i>*317,389</i>	<i>*364,274</i>	<i>*405,274</i>
Revenue In Excess of Expense	15,611	11,774	(1,192)

**Smaller revenue and expense items are not listed but are included in revenue/expense totals.*

Chapter 4

HAMOT'S FUTURE –
RE-INVENTING
ITSELF AGAIN?

The sudden change in Hamot's financial position was not a complete surprise to the management team. There had been warning signs that 'all was not well' despite the good times. A 2008 analysis of Hamot's position by a consulting firm, Navigant, contained these sobering words:

Hamot has successfully outpositioned the local competition but its ability to continue the trajectory is at risk. Share trends do not reflect perceived quality (as compared with Cleveland or Pittsburgh). Current trajectory suggests that Hamot may become the next St. Vincent's and the region is at risk of losing their tertiary care provider.

Navigant cites as a major reason for concern, a pattern of growing patient outmigration that is usually a significant indicator of market vulnerability. Supporting this conclusion were statistics showing a 26% outmigration of cases from SSA with Pittsburgh as the main benefactor. Moreover, they stated, the pattern over the past decade was that "the share of Erie County cases diverted to Pittsburgh has grown from 7-17% in cancer; from 5-13% in neuro; and 9-13% in other surgical areas."

Navigant also found that orthopedics was also affected by out-migrating and that the Hamot-St. Vincent joint cancer center program was "struggling." More ominously they listed additional risk factors especially in the hospital's potential to generate a large enough operating margin and sufficient cash flow to fund Hamot's capital needs. Adding to the operating capital difficulty was Navigant's belief that Hamot would not be able to assume additional debt without risking a rating downgrade. This

potentiality, Navigant warned, would “limit the organization’s ability to quickly invest in addressing current gaps in key signature programs.” For example, Navigant believed that Hamot’s projected capital need in 2013 for cardiac programs of \$29-\$36 million would be seriously hampered by an inability to obtain incremental capital. Neither was Navigant optimistic about Hamot’s annual financial prospects and its effect on generating capital sayings, “Current five year plans indicate reduction in operating income and reduction in cash which further limits access to new capital.” Adding weight to Navigant’s warnings was their belief that the local health care market faced stagnant population growth.

Navigant was not alone in their pessimism about Hamot’s position. An analysis completed in 2010 by consultants at Shattuck Hammond stated, that while Hamot remained the market and franchise leader in the Erie area, it was, nevertheless, “environmentally vulnerable . . . as Hamot’s service area continues to demonstrate weak socio-economic trends that may constrain Hamot’s strategic options.” Shattuck Hammond also had concerns about the financial pressures growing on Hamot stating:

Hamot has a weakened financial profile and declining operating metrics. . . Hamot’s EBIDA has declined from \$35 million in 2005 to \$31 million in 2006, to \$27 million in 2007, to \$21 million in 2008 to \$21 million in 2009. . . but now appears to be stable.

Shattuck Hammond further was concerned that “several key buildings are approaching the end of their usefulness and will need to be replaced:”

Hamot has an above average age of plant of 11 years⁶ with significant capital requirements of \$150 million over the next five years. . . Hamot's internal resources are modestly sufficient to fund [some] plant needs . . . but additional leverage or asset sales will likely be required which will prove problematic as a long-term survival strategy.

The PricewaterhouseCoopers Accounting firm in another 2010 report agreed that, “Hamot has a weakening financial structure . . . which will put pressure on the current debt structure and make it difficult to obtain future financing at low rates.” In addition, PricewaterhouseCoopers, noted another significant financial pressure in that “Hamot will need to make investments in information technology to be compliant . . . of \$12 million in 2011.”

The PricewaterhouseCoopers Information Technology estimate actually came from the Hamot administration which developed a detailed picture of the areas (listed below) that needed to bring their information systems up to the level expected of ‘a top 100’ hospital:

INFORMATION PRIORITIES FOR FY 2011

- Replacement of 18 year old Billing and Electronic Health Record in Hamot Physician Network (50% complete) \$1,350,000
(in progress)
- Replacement, upgrade Emergency Department system \$850,000
(not started)
- Implementation of new anesthesia document system \$750,000
(not started)

• Other departmental system replacement upgrades	\$750,000 <i>(in progress)</i>
• Microsoft licensing-upgrade to next level	\$500,000 <i>(not started)</i>
Total Needs	<u>\$12,450,000</u>
Unfunded Need	<u>(\$10,300,000)</u>

The PricewaterhouseCoopers report also affirmed that all these financial challenges had begun to affect, “Hamot’s credit rating which was downgraded by Standard and Poor’s from the single A rating that Hamot had for a number of years to an A- and then to a BBB+ in 2009.” Moody’s ratings followed a similar downward pattern. The change in Hamot’s credit score was not solely due to Hamot’s financial status. It was strongly influenced by a decision of these agencies to significantly ‘tighten up’ their standards in the wake of heavy criticism for their being too lenient during the boom years of the last decade.

Other financial factors significantly affecting Hamot’s margin were declines in investments and charitable contributions as well as the costly task of recruiting high quality physicians to the Erie area. Navigant was particularly emphatic in stating that:

The number one indicator for risk is the physician recruitment challenge. A local bidding war further exacerbates recruitment/retention challenges . . . for recruiting and retaining the physician complement to support high acuity business coupled with regional providers

[starting to] target this profitable business. Recruitment costs [could reach] \$10-\$15 million cumulatively in the next few years.

The reports from the various consultants simply affirmed and strengthened Hamot's own strategic assessment which recognized 10 main challenges that had to be met if Hamot was to continue as the region's top hospital:

1. Inadequate Capital availability/ Access to Capital
2. Costs increasing faster than inflation
3. Meeting federal mandates in information technology
4. Reduced federal reimbursement
5. Increasing bad debt expense
6. Dependence on downlink/tertiary referrals critical for profitability
7. Market share threatened by bordering larger health systems
8. Difficulty in physician recruitment and retention
9. Growth in uninsured/underinsured patients
10. Independent regional hospitals struggling, looking for assistance, will look elsewhere if Hamot cannot help them

In addition, Hamot was also faced with a changing Health Care environment that emerged from the passage of the national Health Reform bill in the spring of 2010. The key components of the new legislation included expanded coverage, changes to Medicare and Medicaid payments, and changes in the Health Care delivery systems. The latter two changes posed the greatest challenge to Hamot's future prosperity since the Medicare and Medicaid

programs generated approximately half of Hamot's patient revenue. Another significant potential threat to Hamot's revenue base was contained in these changes to Medicare/Medicaid provisions:

- The restructuring of Medicare payment to managed care plans
- The reduction of annual market basket updates for hospital and other Medicare providers
- The implementation of new payment policies regarding readmissions and hospital-acquired conditions
- The reduction and possible elimination of Medicare and Medicaid disproportionate share payments

Additional threats to Hamot's revenue base were contained in the new provisions for delivery of care which called for shifting from a fee-for-service structure to payments based primarily on medical outcomes, a new bundling of payments for services, and the creation of medical homes to reduce hospitalization time. The estimate on the total impact of Health Care reform on Hamot's revenue base over a ten year period was a negative \$80 million from losses in the following areas:

- Medicare/Medicaid reductions- (\$50 million)
(Inpatient - \$40 million Outpatient - \$10 million)
- Disproportionate share cuts - (\$20 million)
- Bundling (Home Health, other)- (\$10 million)

Offsetting a portion of this loss were some positive revenue factors amounting to about \$4 million annually as the new law provided for adding 17 million patients to the Medicaid rolls and increased the coverage for poverty patients from 33% to 133% of the poverty

level.⁷ But, far more significant than the projected economic loss was the pattern of sharp acceleration in the deficits that rose over the decade from manageable losses in the early years to a series of catastrophic ones from 2015-2020. The chart below suggests just how unsustainable the deficit would be after 2015:

HEALTHCARE REFORM IMPACT BY YEAR ON HAMOT

2011	\$0 M	2016	\$12 M
2012	\$2 M	2017	\$14 M
2013	\$3 M	2018	\$16 M
2014	\$5 M	2019	\$18 M
2015	\$10 M	(Total) \$80 Million	

Obviously in the event that such a scenario actually materialized, drastic cost cutting would be necessary with resulting negative effect on the capital and human resources needed for quality Health Care.

Moody’s report (April 2010) on the long time credit challenges of health care reform was quite emphatic that the negative impact from the new Health Care laws on not-for-profit hospitals significantly outweighed any short-term benefits because of three major factors:

1. Cost savings provision to be implemented will weaken revenue with negative credit affect.
2. Many stand alone hospitals will not have the resources to invest in information technology necessary for greater reporting requirements or manage effectively bundled payments.

3. Many of the most efficiently managed systems will take advantage of opportunities afforded to leverage economies of scale to broaden their market reach.

Moody's, conclusion that the Health Care reform would not only prove to be "a long term negative but would also contribute to more consolidation of the industry with bigger health systems emerging in the coming years," was a warning Hamot ignored at its own peril.

Shattuck Hammond supported Moody's predictions stating:

It is clear that integration and scale will be the key to survival ... smaller hospitals will be at a disadvantage... Health care reform changes everything leading hospitals and health systems to more actively engage in revenue growth strategies . . . these include mergers.

The Advisory Board, a Washington based Health Care 'think tank,' also described the national situation for hospitals in equally gloomy tones in their 2010 report which suggested that the impact of national health care reform would most likely lead to an "uptick in mergers, joint operating agreements, and more hospital consolidations." They based their opinion on the same Health Care trends affecting hospitals described in the Navigant, Shattuck Hammond, and PricewaterhouseCoopers studies including:

Declining cash reserves; decreasing investment income; tighter access to capital; reduced consumer spending ability; lower reimbursement and margins; median expense growth out paces median revenue growth for third consecutive year;

hospital profitability on the decline; payment bundling may drive integration.

Given the growth in these negative health care patterns, Navigant recommended that the strategic risk for Hamot in adopting a ‘wait and see’ policy was serious enough that they advised Hamot that it should strongly consider “defining a way to mitigate the risk of [becoming] the ‘last man standing.’”

Shattuck Hammond also urged Hamot to consider launching a redefining strategic initiative stressing that, “timing is critical . . . There is a need to capitalize on Hamot’s current attractive franchise for first mover advantages,” one that would keep Hamot “the market leader in Erie in spite of a deteriorating financial profile.” In support of their recommendation, Shattuck Hammond pointed to Hamot’s pattern of increasing dependence on referrals from regional downlink hospitals and [Hamot’s] vulnerability to declines from those hospitals due to market consolidation or other industry changes.”

By the spring of 2010, the national drum beat that stand-alone hospitals needed to consider some type of partnership, affiliation, or merger, especially to meet increasing capital needs, was becoming a refrain. For instance, on April 5, 2010 an article in **Modern Health Care** reported that Caritas Christi Health Care and Detroit Medical Center had turned to for-profit partnerships for capital infusion. The article stressed that “not a system in the country [can ignore capital needs] because the more capital the more that can be done in adding service lines, recruiting high quality physicians, meeting the new federal standards for technology requirements.”

The authors concluded that, “Stand-alone, not-for-profit, and smaller hospital systems should be considering all of their options . . . The day when independence is [a given] assumption may be over.”

In addition to reviewing all these consultant reports and media analyses, Hamot’s administration completed its own study of both the local and national health care conditions and concluded that it might be time once again to Re-Invent Hamot. The search for a new Hamot strategic position actually began early in 2008 with a strategic visioning discussion between Hamot Administrators and Trustees Phil Garcia and Scott Kern. In April of 2008, Navigant Consulting (David Burik) was hired to scan the changing Health Care landscape followed by a July board retreat on Hamot’s future direction. Then in January of 2009 after Navigant presented its observations to the Board of Trustees, Shattuck Hammond Consultant (Joe Beck) was brought on board in March to further confirm or challenge Navigant’s recommendations. Hamot Institutional change really became serious in April of 2009 when a Partnership Affiliation Committee was appointed following a July Board retreat to review and approve the Affiliation Committee’s recommendation that discussions on possible affiliation with the Cleveland Clinic Foundation (CCF) or the University of Pittsburgh Medical Center (UPMC) should be undertaken.

After receiving Board approval to seek formal proposals from these two institutions, Hamot received, in December of 2009, a proposal from UPMC and a month later another one, from the Cleveland Clinic. On February 8, 2010 the Partnership Affiliation Committee formally approved the 4 C’s, Clinical, - Commitment,

- Community – Control⁸, which would govern the discussions with both Cleveland and Pittsburgh hospitals. The four C’s assumptions included the following guidelines:

I. CONTROL (OF HAMOT)

Assumes that the Erie Community members can influence that Hamot continues to go forward to provide high quality Health care to the communities it serves.

Imperatives

- Majority of local board appointed by Hamot Trustees
- Board Chair elected by local Board
- Hamot CEO selected by Hamot board
- Hamot Board to oversee Hamot operations
- Hamot to continue as a full service acute care hospital
- Hamot to have authority to control endowment/capital funds
- Hamot to have strategy/unwind provisions if affiliation deemed unsuccessful

II. COMMITMENT (CASH VALUE)

Assumes that the affiliating partner will provide appropriate level of capital and resources to support Hamot as a top hospital in its service area.

Imperatives

- Hamot will have access to capital to keep Hamot current with the latest technology and facilities
- Cash value to Hamot totaling \$250-300 million (Hamot Community Fund - \$100 million and Capital Funds not less than \$150-200 million).

III. COMMUNITY (IMPACT)

Assumes that the desired affiliation strategy will be viewed by key constituencies as satisfying five major criteria.

- Affiliation will provide access to quality health care
- Affiliation will maintain physician relationships
- Affiliation will both protect and build Hamot brand
- Affiliation will maintain employment levels (no job loss)
- Affiliation will minimize patient and physician outmigration

IV. CLINICAL/COMMITMENT

Hamot will retain the ability to provide high quality health services to the communities it serves.

- Clinical decisions and technology will remain under local control
- The Hamot name and culture will be preserved
- The Primary Care Network will be supported

Although not officially a ‘4C,’ John Malone believed that a fifth ‘C’ should also be considered and that was the importance of a ‘good culture fit’ if an affiliation was to be truly effective.

As deliberations continued on the exact path of re-invention, significant differences developed between the proposals from the Cleveland Clinic and that of UPMC. Essentially, the Cleveland Clinic was more interested in a complete merger of institutional assets rather than an affiliation or partnership envisioned by UPMC. In sum, Cleveland Clinic was not interested in capital infusion without asset merger which would end any local control. UPMC, on the other hand, was willing to invest significant cash and resources in a long term affiliation that maintained local identity in return for extending their influence in the Erie NW PA area. Since the first ‘C’ emphasized the importance of Hamot’s operation retaining some local character, the choice between the two proposals was a clear-cut one - Hamot would negotiate with UPMC alone.

On April 13, 2010, Hamot’s list of key conditions for considering affiliation were sent to UPMC. On April 26, meetings were held with UPMC representatives, and on May 4, 2010, an encouraging written response from UPMC was received by Hamot. A series of informational sessions were next held in May with County Executive Barry Grossman, Mayor Joe Sinnott, Congresswoman Kathy Dahlkemper, and with Hamot Incorporators. Throughout May and June, several meetings were also scheduled with the Hamot Medical Staff. In July, Special Legal Counsel, Cliff Stromberg, Esq., was appointed, and an informational luncheon for past Board Chairs was held.

The main document utilized to make Hamot’s case for considering such a dramatic Re-Invention was a power point presentation entitled, “Why We Are Investigating Affiliation Strategy.” In explaining their position, Hamot stated three essential reasons why the time was now to consider a dramatic strategy initiative:

1. Hamot is approaching the process from a position of strength.
2. An affiliation [with a strong ally] would mean that Hamot could continue to provide high quality care for the Erie region.
3. There is a first mover advantage.

In this, and other announcements, Hamot officials strongly stated their conviction that larger hospital systems would weather the financial challenges in a new health care environment better than smaller systems for they outperformed smaller hospitals in terms of operating margin, were growing faster, achieved lower supply costs, had better access and lower costs for securing capital. They also stated that in upgrading information technology systems, smaller systems could not compare with the dollars available for the larger systems, and that larger systems had better ability to enhance managed care contracting with allied physicians. For example, the difference in the information technology capital budgets between UPMC and Hamot’s operation was a rather dramatic one as illustrated in the following chart:

	Number of Hospitals Operating	Annual Capital Budget	5 year Capital Spending	Hospital Listing – Most Wired
UPMC	19	\$240 M	\$1.2 B	8 of last 8 yrs.
HAMOT	1	\$3.3 M	\$16.5 M	5 of last 8 yrs.

There were other significant advantages in opportunities for cost savings that were present in an affiliation strategy such as:

- Increased leverage on existing software licensing agreements with an uplink partner.
- Increased leverage on existing hardware contracts and vendor relationships.
- Consolidation and/or centralization of some or all data center equipment and staffing.
- Greater access to best practices.

The investigative process that began in January 2008 reached its definitive moment 20 months later on August 27, 2010 when the Hamot Board approved a non binding letter of intent (LOI) with UPMC that was signed four days later on August 31. Both parties then agreed on a 60 day period of conducting due diligence to negotiate a definitive agreement with the first meeting between the two held on September 9, 2010. Simultaneously both UPMC and Hamot conducted legal and regulatory reviews as a part of their due diligence which finally resulted in a definitive agreement for Hamot's Board of Trustees to consider at their October 21, 2010 meeting.

The details of the proposed agreement contained many of Hamot's 4 C's goals and imperatives that were intended to preserve both significant integration and local control. The most critical area, that of governance, contained the key elements of advancing UPMC partnership with Hamot while also maintaining Hamot's control of its regular operations and its long-term destiny. The significant provisions stipulated that:

- Hamot would be governed by its Board
- Hamot would appoint 2/3 of the Board, 1/3 of the Trustees would be UPMC designees.
- The Hamot Medical Center Chair would be appointed to both the UPMC Board and the UPMC Executive Committee.
- There would be a defined integration period for the integration of HMC as an equal participant into the UPMC system.

In considering the critical areas of what clinical programs would remain at Hamot and what would be done to strengthen them, the agreement stated:

- Hamot specialty programs would be maintained for at least the next 20 years in trauma (level 2 or higher), Cardiac service, neurosurgery, neurology, oncology, orthopedics, plastic surgery, women's and children's health and other service lines mutually agreed.
- Benchmarks would be set to continuously improve clinical quality and Hamot Medical Center programs would operate at least to equivalent quality, effectiveness, service, and recognition of other UPMC facilities...the achievement of which would be evaluated after 5 years.
- Existing clinical residency and fellowship programs would be maintained . . . while exploring the feasibility of establishing 1-3 additional programs including internal medicine.

To assure that the affiliation would bring the additional capital necessary to achieve integration goals, the following financial commitments were agreed upon:

- UPMC agrees to commit not less than \$300 million for the strengthening of HMC apportioned in the following manner:
 1. \$100 million to the Hamot Medical Center balance sheet for support of Hamot and its entities, 50% which would be expended in 10 years, 50% in the future, (all monies controlled by the Hamot Board), called the Hamot Fund.
 2. UPMC also agrees to set up a \$200 million enhancement fund to be fully spent within 10 years pursuing plans and budgets fully approved by both Hamot Medical Center and UPMC. (Monies not spent would be transferred to the Hamot Fund).

The two parties also agreed that existing and future donor funds would remain dedicated to the use of Hamot Medical Center and would remain under the control of the Hamot Medical Center Board.

One of the most interesting aspects of the proposed affiliation was the development of a joint business plan over a 5 year period that UPMC would work out with the Hamot Board, leadership, and medical staff that would include (but not limited to):

- Clinical Resource Development
- Physician and Medical Staff Development
- Capital Needs

- IT Upgrades
- EMR/Network Access and Integration
- Employee Development

The crucial question of the long term impact of affiliation on Hamot's regional network was satisfactorily resolved in this manner:

- Hamot would continue to serve as sole regional referral center and tertiary hub for its 13 county area.
- The Hamot Medical Center Board would be involved in decisions about other UPMC affiliations in the Northwest services area.
- UPMC agrees that it will not interfere with referral decisions or dictate patient flows to the disadvantage of Hamot Medical Center.

Perhaps most significantly for those concerned about Hamot's future following an affiliation was UPMC's agreement that Hamot would operate as a full service, acute care tertiary hospital for at least 25 years and that any change in this regard after 25 years would require a report to Hamot Medical Center's Board.

Adding further support about Hamot's potential for continued growth and development with a UPMC partnership were the impressive statistics which demonstrated dramatic growth after UPMC affiliation in both admissions and personnel at Shadyside and Passavant Hospitals:

ADMISSIONS GROWTH

	FY – 1996	FY – 2010	% Growth
Shadyside	18,355	25,598	39%
Passavant	9,027	17,018	89%

PERSONNEL GROWTH

Shadyside	2,031	2,808	38%
Passavant	1,001	1,795	79%

The final piece in the affiliation puzzle was the question of its effect on the current medical staff and physician relations. In this regard, the affiliation agreement emphasized that the “medical staff structure will **continue** . . . The role of community physicians is **recognized** . . . [and] the Hamot Medical Center Physician Network will be **supported** and maintained.”

A number of steps, however, still remain before an affiliation between UPMC and Hamot Medical Center becomes a historical reality. Hamot’s Board must approve the affiliation agreement at their October 21, 2010 meeting and following that, the Hamot Corporators need to review the proposal at their November meeting. If these meetings produce a ‘Green Light,’ then the process must seek regulatory approval and must fully inform both Hamot’s key constituents and the communities they serve. Assuming that all these steps go well, the historic affiliation transition between the two parties could begin as early as January of 2011 just three years after Hamot first started to consider institutional revitalization.

As Hamot approaches perhaps the most significant historical milestone in its 129 year old history, it once again must choose between two different paths (Affiliation or not) to best fulfill its mission. If its past history is any indicator in deciding when is the correct time for another institutional reinvention, it is highly likely that Hamot will “take the road less traveled by and that will make all the difference” in furthering its storied history. As John Malone has often said, “What comes after? What comes next? Why not Erie? Why not Hamot?”

Epilogue

On January 10, 2011, the Hamot Health Foundation Board of Trustees voted unanimously to approve a definitive agreement to affiliate and integrate Hamot with UPMC. On January 21, the Hamot Board of Corporators adopted the UPMC Hamot plan of integration and affiliation. On February 1, UPMC Hamot, a new entity, was made official.

Charged with securing and advancing the future of UPMC Hamot is the UPMC Hamot Board of Directors. In accordance with the terms of affiliation, two-thirds of the new organization's governing body will be represented by members of the Erie community and one-third are to be made up of representatives selected by UPMC.

The creation of UPMC Hamot represents a fitting capstone to Hamot's drive for distinction over the past 30 years, truly three decades of progress driven by foresight, imagination and visionary leadership. Within this tradition of continuous improvement, the UPMC Hamot affiliation was both conceived and accomplished, establishing a stronger foundation upon which the new organization can be expected to evolve and thrive.