Managing Strategic Risk Effectively Requires Shared Beliefs

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In a recent interview, the CEO of Chevron was asked, "What business are you in?" With no hesitation he remarked, "We are in the business of managing risk." An obvious expectation of the answer might have been, "We are in the oil business." He followed by explaining that Chevron is a global player in the integrated energy business. It deals across geographic, geo-political, and financial and economic lines and is subject to a crowded and competitive marketplace driven by innovation and production efficiencies demanded by the market. The capital requirements are staggering and the costs of leadership decision failures are high. His role as CEO is one tilted to managing the risks of strategic choices, together with the board of directors, on behalf of shareholders.

What does this have to do with U.S. healthcare and, specifically, the role of the CEO and governing board of a hospital—especially in the case of not-for-profit healthcare? To borrow an oft-used and hackneyed phrase, "healthcare is changing." The magnitude and pace of change create the same requirement; i.e., healthcare leaders must manage the risks of strategic choices. While not-for-profit healthcare doesn't have shareholders, it does have community stakeholders that depend upon a CEO and board collaborating to address challenges and opportunities of the times.

This article explores the strategic risks that healthcare CEOs and boards are currently facing and provides a framework for developing a unified belief system that will help leaders work together to create a plan for successfully managing risk.

Strategic Risks for Hospitals and Health Systems

If the Chevron analogy holds, then what are the risks that healthcare CEOs and boards face that, perhaps, require a fresh look at risk and an appropriate definition, including the risk of strategy? First, it is useful to review a list of paraphrased quotes from health system CEOs:[1]

1. "I never thought I'd be this deep into the business of employing physicians."
2. "I don't have the balance sheet strength to take on my larger competitors that can afford to niche my profitable services in my markets."
3. "An increasing proportion of our revenues is coming from out-of-pocket payments and these consumers have become price and value shoppers."
4. "Too much of our financial margin is produced by a small handful of services that are challenged by volume, total cost of care, and competitive pressures."
5. "In excess of two-thirds of the care will be delivered on an outpatient basis and we can't afford the costs of systems, assets, program, and personnel transformations to serve future demand in this arena."

Key Board Takeaways

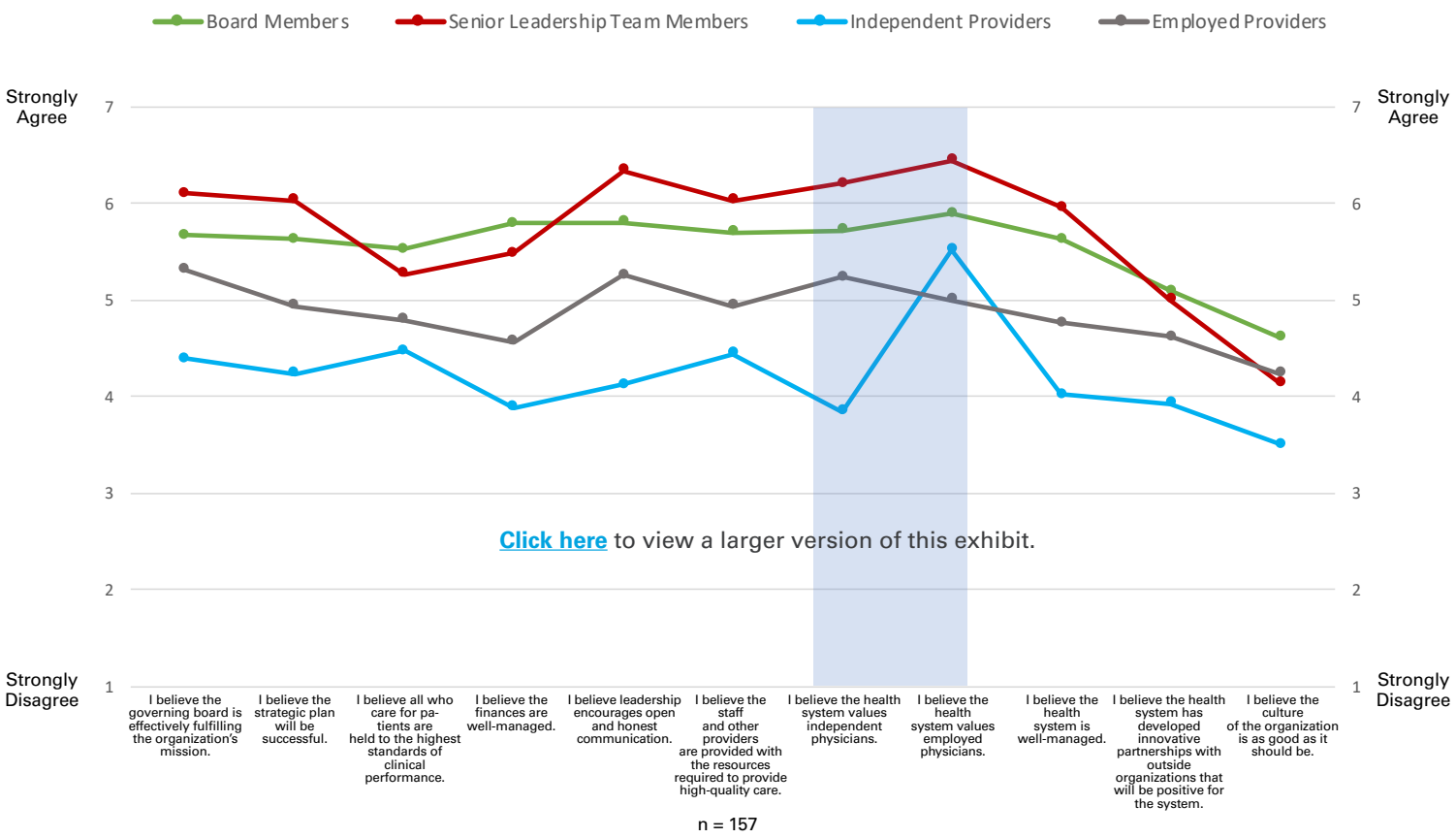
Healthcare market dynamics, and related competitive pressures, will demand that community hospitals and health systems pursue strategy types (at levels of strategic risk) that may be beyond the collective experience of boards and leadership teams. Related risks will emanate from external and internal forces. Boards and senior leadership teams must:

- Identify and understand related risks before they can be managed. Inasmuch as many of the risk categories may be novel, the work required to get the list "on the table" will be new to the working relationship.
- Develop a foundation of "shared beliefs." This is required when building a comprehensive, successful, executive-level program of strategic risk management. Shared beliefs serve to specifically identify and define the risks to be understood and managed. A system of shared beliefs unifies boards and leadership teams by binding them to a strategic risk management plan that they all own. The requirements of such plans dictate the organizational culture required to support the plan execution. The failure of organizational strategic plans can often be traced back to the lack of a system of shared beliefs pertaining to strategic opportunities and related risks.

With these observations in hand, let's dive deeper into the challenges, including the role of governance, starting with the medical staff and the risks for CEOs. In the May issue of E-Briefing, we reported on a "problematic repeating pattern of physician beliefs"[2] in healthcare organizations, based on results from the Stakeholder Alignment Survey.[3] This article addressed how, as community hospitals and health systems add to the ranks of employed physicians, potential risks associated with independent physician affiliates increase, manifesting as the independents believing the employed physicians are "valued higher" by leadership, including governing boards. The risks center on the competitive and affiliation freedoms enjoyed by the independent physicians on the medical staff; they have options of strategy other than as

1 These comments derived from interviews preceding strategic planning efforts at various health systems.
2 Daniel K. Zismer, et al., "A Problematic Repeating Pattern of Physician Beliefs in Community Hospitals and Health Systems," The Governance Institute, E-Briefings, May 2019.
3 The "Stakeholder Alignment Survey" is a proprietary organizational performance evaluation instrument developed, owned, and applied by Castling Partners, LLC (www.castlingpartners.com) and Keystone Culture Group, LLC (www.keystoneculturegroup.com).

Exhibit 1: Stakeholder Alignment Survey—Average Score by Respondent Category



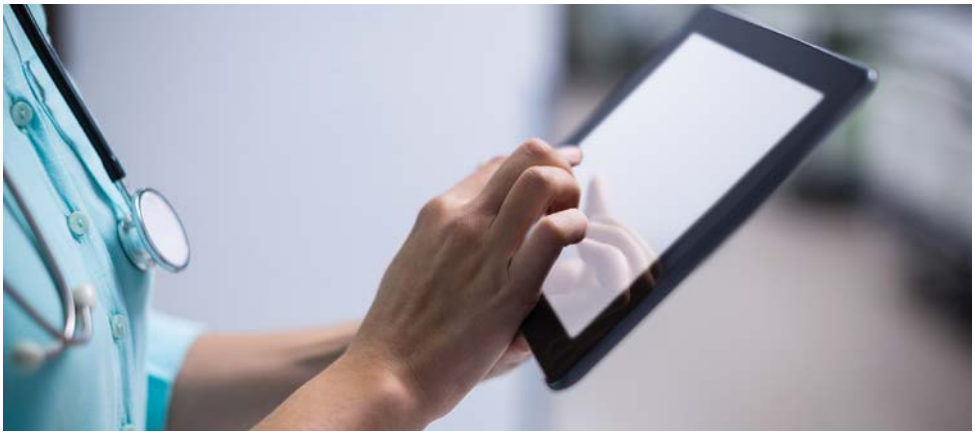
The Stakeholder Alignment Survey is a proprietary culture performance evaluation tool provided through Castling Partners, LLC and Keystone Culture Group, LLC.

partners of community hospitals. (See **Exhibit 1**. Where highlighted, stakeholders were asked about their "beliefs" as they relate to how "the health system values independent physicians" and how "the health system values employed physicians.")

Community hospitals and health systems that have pursued paths of aggressive acquisitions have, for the past several years, struggled with the economics and financial performance of their strategy. A number of organizations on this path have scaled up "dis-economically."[4] Governing boards of the acquirers haven't always been clear on the strategy for creating accretive acquisitions and those acquired have moved forward with transactions believing that the promised "economies" existed, somehow, in the roll-up of the revenues over multiple acquisitions. Examinations of the results of these roll-ups have, for a significant proportion of larger health systems, demonstrated declining free cash flow productivity[5] and increasing pressures on financial performance of the acquiring health systems, overall. Restoration of these health systems' balance sheets to positions of strength will be a challenge moving forward. Managing balance sheet risk will rise to the top of CEO and board risk management strategies—especially as care models move to outpatient settings at accelerating rates.

Not-for-profit hospitals and health systems in the U.S. are facing financial headwinds while taking on more leverage due to increasing debt levels.[6] At the same time, credit agency downgrades are outpacing upgrades.[7] Stated reasons for credit rating downgrades are attributable to financial headwinds driven by "per unit" operating expense rate trajectories that are on a steeper, upward trend when compared with "per unit" earned revenue rate trajectories, increasing dependence on fixed-price governmental payer contract volumes, declining inpatient bed-day rates, and the mounting costs of amassing increasing numbers of employed physicians. All of this is

4 Daniel K. Zismer and David Schuh, "Clinical Service Line Strategy; Managing the Risks of Geographic Expansion," *HFM,* Healthcare Financial Management Association, July 2016.
5 Daniel K. Zismer and Carsten Beith, "Free Cash Flow Productivity and Its Connections to U.S. Health System Financial Performance and Strategy in Current and Future Markets: A 'Macro View' of a Potentially Systemic Problem," The Governance Institute, 2014.
6 Daniel K. Zismer and Kevin J. Egan, "Special Section: The Board's Accountability for Complex Healthcare Strategies: Exercising 'Due Care' in the Face of Unfamiliar Organizational Strategy and Strategy in Action," The Governance Institute, *BoardRoom Press,* August 2016.
7 Daniel K. Zismer and Kevin J. Egan, "'Rational Thinking' and Community Healthcare Governance: A Core Competency of a Board," The Governance Institute, *BoardRoom Press,* April 2017.



occurring at a time when available balance sheet capacity should be directed to ambulatory care assets and related programming. Moreover, inasmuch as the majority of hospitals in the U.S. are under 200 beds and upwards of a third remain independent, peer group comparisons of relative balance sheet conditions are of little practical use when the real question for any one hospital or health system is, "Can we afford what we need to do to reposition our organization for success in an uncertain future?"

Developing a Unified Belief System

So, let's return to the going-in proposition that not-for-profit community hospital and health system CEOs and governing boards need to shift emphasis to comprehensive, corporate, financial, and strategic risk management for their organizations. What are the areas of "deep thought" that may lead to more effective management of risk as a component of organizational transformations? More specifically, it's important to look at what issues must be addressed through the lens of leaders' unified "belief system." This includes addressing the question, "What do we believe to be true about our organization's future performance in a changing marketplace?" Boards and senior leadership teams, together, must develop a unified belief system to successfully pursue any strategic path.[8] A sample framework for the development of a unified belief system follows:

1. **The movement of physicians from independent practice to hospital/health system employment platforms**. By the end of 2016, more than 40 percent of all physicians in the U.S. reported being employed by organized health systems—a 60 percent increase from mid-2012. All geographic regions in the U.S participated in this trend.[9]
2. **Physician specialties and/or independent groups in our market that will be encouraged to mount strategies that are competitive with community hospitals/health systems**. While it is true that an increasing number of physicians will seek employment, opportunities for entrepreneurial pursuits will remain for certain clinical specialties—specialties that will remain important to the mission, strategy, and financial performance of community hospitals and health systems (such as orthopedics, GI, ENT, cancer care, urology, ophthalmology, and other procedural services that lend well to larger-scale ambulatory strategies). Private equity investors are aggressively pursuing these specialties for partnerships.
3. **Ambulatory strategy investment requirements, including facilities, will require significant investments over a short timeframe**. For many healthcare organizations, in excess of 70 percent of all care will be delivered from sophisticated, high-tech ambulatory facilities, staffed by highly specialized providers and support staff. Many community hospitals and health systems do not have the balance sheet capacity to create such "platforms" while they invest sufficiently in required inpatient and related care system upgrades and asset replacement investments.[10]
4. **Information technology investments will be required in parallel with other large-scale strategic investments**. Integrated information strategies, including electronic healthcare records, can consume extraordinary proportions of available investment capital capacity. While essential to the cause, most hospitals and health systems experience declines in financial productivity during implementation of an EHR, and for the first few years thereafter. Few have experienced enhanced financial productivity beyond the baseline.
5. **Workforce challenges will increase**. All healthcare providers will experience a shortage of highly trained and skilled staff, especially those with technical skill sets that are transferable across industries. The risk is that the "best and brightest" will not be attracted to healthcare at all, much less community healthcare delivery where the speed of innovation often lags behind other healthcare market sectors and other industries.
6. **Likely competitor strategies and effects on our future success**. As noted here, private equity is chasing key clinical specialties in service areas where hospitals are less important to care models. Likewise, physicians will find less traditional partners to pursue their visions for their future world. Community hospitals and health systems need to take stock of who their competitors might be. They may not be the hospital in the adjacent county.
7. **Our real balance sheet capacity framed in a context of the most likely strategic investment spending requirement profiles**. This includes the costs related to the funding of the community hospital/health

8 Daniel K. Zismer and Ben Utecht, "Culture Alignment, High-Performing Healthcare Organizations, and the Role of the Governing Board: Part One: Culture and Culture Alignment—The Foundation of a Board's Culture Game Plan," The Governance Institute, E-Briefings, March 2018.

9 Daniel K. Zismer and Ben Utecht, "Culture Alignment, High-Performing Healthcare Organizations, and the Role of the Governing Board: Part Two: Setting a Culture of High Performance and the Responsibility of Governing Boards," The Governance Institute, E-Briefings, May 2018.

10 Daniel K. Zismer, "How Might a Reforming U.S. Marketplace Threaten Balance Sheet Liquidity for Community Health Systems?," Integrated Health Systems, *Journal of Healthcare Management,* May/June 2013.

system. The "real story" of the balance sheet is not told by the balance sheet. The balance sheets of community health systems and hospitals never reflect an accurate and reliable picture of the future investment needs of the organization. "Old school" formulae used to forecast future capital asset spending requirements are no longer helpful.

8. **An in-depth analysis of the historic and existing mission spend and its sustainability**. "Mission" is defined variously across community hospitals and health systems. Consequently, the related cost structures differ, as do the expected methods of funding mission plans. Mission plans that are dependent upon cost-shifting (i.e., increasing costs of health services to a handful of commercial insurance or managed care plans) are not sustainable. An informal survey of community health system CFOs indicated that the net profit margin performance on commercial payer reimbursements was required at a 36–42 percent level to offset the operating losses realized from governmental reimbursements. Missions requiring such a cost shift are, undeniably, non-sustainable.
9. **The sensitivities of the organization's financial model as it relates to existing clinical programming** (i.e., where and how the financial performance is sensitive to the organization's clinical portfolio composition). The majority of free cash flow productivity for hospitals and health systems is often concentrated with a small handful of clinical programs (e.g., cardiovascular services, orthopedics, and a few surgical and procedural specialties).[11] When aggregate operating margin is sensitive to a small number of clinical specialties, the overall financial performance structure of the organization is at risk.
10. **The organization's real value as perceived by payers, employers, and other influential stakeholders**. The most sophisticated commercial payers and self-insured employers, along with governmental payers, will turn a substantial amount of their attention to total costs of care

performance of contracted providers—meaning, the cost profiles of community health centers, related specifically to the management of chronic conditions by affiliated providers. One multi-state provider of community health services recognized that when depression is a secondary diagnosis for any patient with a chronic condition, total costs of care, over time, were on average 25 percent higher than that same condition without this concomitant diagnosis. All payers will have more data on a health system's total cost of care profiles than the large majority of all health systems. Healthcare organizations with high total cost of care profiles for expensive chronic conditions will become targets for cost-reduction strategies, including the diversion of patients to lower-cost providers.

The position presented here can be summarized as CEOs and boards of hospitals and health systems will need to shift an increasing proportion of time, energies, and resources to "strategic risk management"—the definition of which must be developed beyond that familiar to most healthcare boards. The way to begin is the development of a "shared belief system" built from the framework provided. This shared belief system answers the important question relating to "What, together, do we believe will most affect the future of the organization we lead and how are we going to pursue an effective strategy, while managing the risks that pertain?" The answer lies with the corresponding strategy. A unified and shared belief system and a culture of shared performance accountability[12] becomes the bedrock of the governing board and senior leadership team partnership for hospitals and health systems in today's world of community healthcare.

The Governance Institute thanks Daniel K. Zismer, Ph.D., Co-Founder and Managing Director of Keystone Culture Group, LLC, Co-Chair and CEO of Associated Eye Care Partners, LLC, Co-Founder and Managing Partner of Castling Partners, LLC, and Professor Emeritus and Chair, Healthcare Administration, School of Public Health, University of Minnesota. He can be reached at daniel.zismer@castlingpartners.com.

11 Daniel K. Zismer and Donald Wegmiller, "Clinical Service Lines: Mapping the Future of Community Health," C-Suite Resources Report, July 2012.
12 Daniel K. Zismer and Ben Utecht, "Belief Systems and Healthcare Strategy," Keystone Culture Group, The Keystone Way, Vol. 1, Issue 2, November 2018.