E-Briefings

VOLUME 18 • NO. 3 • MAY 2021

THE GOVERNANCE INSTITUTE

A SERVICE OF nrc HEALTH

Post-Pandemic Provider Realignment 2.0: If the Past 12 Months Taught Us Anything…

By **Jordan Shields,** Partner, *Juniper Advisory*, **and Brian Fuller,** Principal, *PYA*

What's Inside:

Calling 2020 a challenging year for the country as a whole and for providers in particular would be a vast understatement. Disruption reigned across global, national, and local industries.

The healthcare industry found itself at ground zero of the disruption. Extended elective service moratoria, patient reticence to seek treatment, capacity and equipment shortages, staff facing crushing demand and unprecedented risk, and a flood of federal relief funding are but a few of the major, previously unthinkable, products of the pandemic. As we look back, providers have much to be proud of in their resilience and response.

As the pandemic entered the summer of 2020, we authored an article for *BoardRoom Press* that offered predictions on COVID-19's effects on provider consolidation.[1] Now, nearing 12 months and a seeming lifetime of change later, we believe we are approaching the cusp of the post-pandemic era in U.S. healthcare. As such, it is an appropriate time to revisit those initial predictions, gauge their prescience, and reassess where the industry is and where it is likely going from here.

What Was Right, What Was Wrong, and What Surprised Us

The following table summarizes our June 2020 predictions that were published in *BoardRoom Press*:

1 Jordan Shields and Brian Fuller, "Provider Realignment Post-Pandemic," *BoardRoom Press*, The Governance Institute, June 2020.

	Hospitals	Physicians	Non-Acute
Turbulent Restart *6–9 months*	• "Have not" hospitals hit hardest, some will fail • Regional systems seek growth • Turnaround for-profit operators enter	• Insurance companies and healthy hospitals acquire practices • Private equity remains active, but at lower multiples	• Post-acute hit hard by services moratorium • Facility-based providers particularly challenged • Rebuilding period
Industry Shake-Out *1–2 years*	• Distressed sales and closures, especially rural • Strong sellers prioritize quality and operations	• Pre-pandemic "physician land rush" escalates • Physicians at center of proxy war between hospitals, insurers, PE	• Ongoing shift from facility-based offerings to lower-cost settings • Verticals consolidate and systems enter
Rise of the Titans *3+ years*	• Declining reimbursement • Scaled systems demonstrate clinical and operational advantages • A select few mega-systems (~$75B+) emerge	• Integrated physician practices, not hospitals, lead health systems • ¾ of physicians employed by large practices, hospitals, payers, or PE	• Health systems and insurers increasingly compete in these sectors • Select PE-backed sector roll-ups will be taken public

➜ Key Board Takeaways

As boards and senior leadership work to develop or enhance their value-based care delivery strategy, they should:

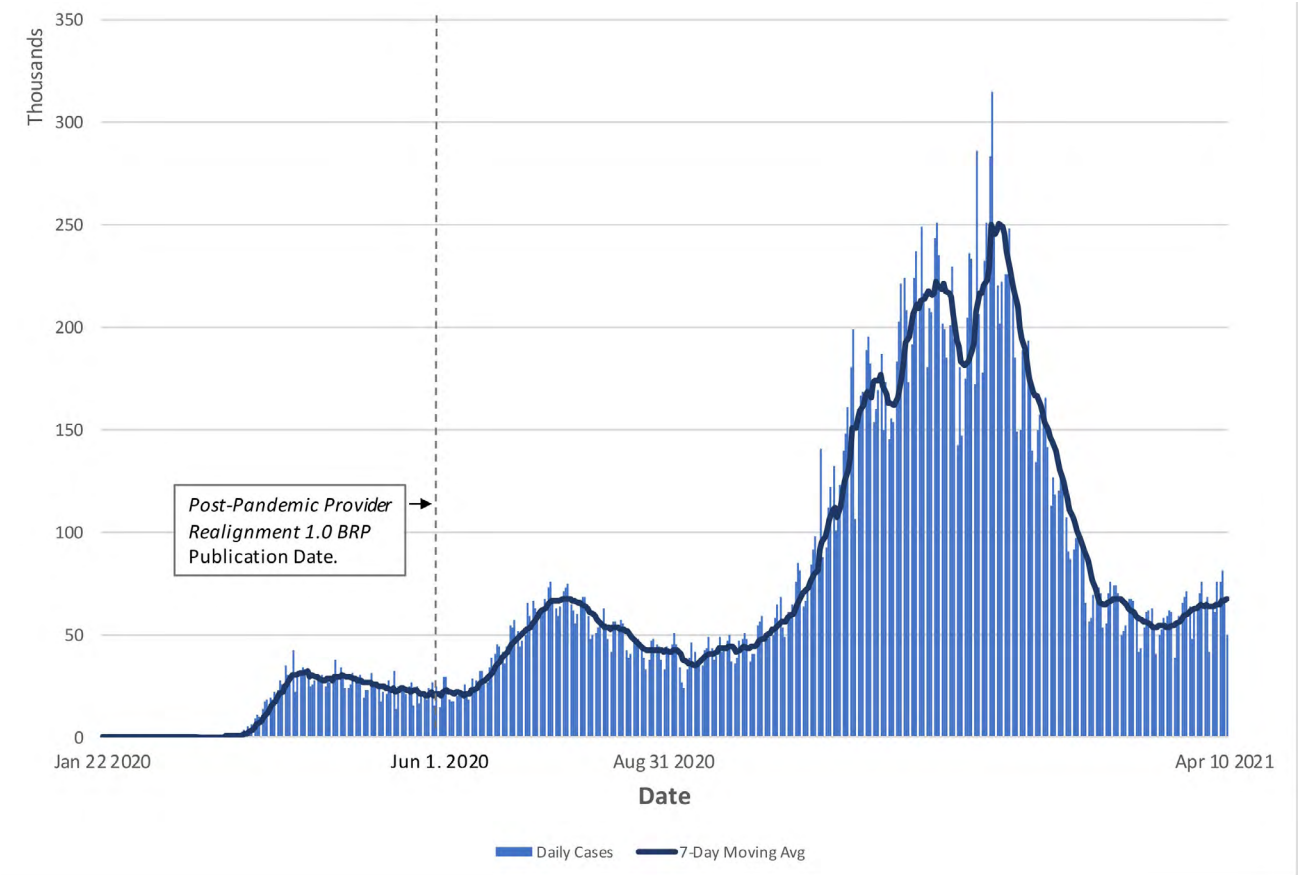
- Board members must **remain acutely and objectively aware of organizational performance**, as markets will remain tumultuous over the next five years.
- Population health, anticipated for decades, is finally here. Board members must **help determine if their organizations should pursue population health as owners/managers or participants**.
- **M&A needs to be an intentional element of provider strategic planning**. Waiting for the future to present itself is not a strategy.
- Neither consolidation nor status quo guarantees accessible, high-quality, cost-effective care. When considering the future of their organizations, board members must **push to understand opportunities, risks, and alternatives**.

Looking back on those predictions, it is clear that some proved out, while others were (the authors like to think, anyway!) impossible to forecast.

The Right

Despite two major post-June pandemic surges and their associated disruption, consolidation activity picked back up in the second half of 2020. Led by physician practices, with 208 transactions, the provider sector[2] closed 2020 within 10 percent of the number of deals struck in 2019. Hospital transactions were down by about 14 percent.[3] When one considers the reality of the pandemic taking up so much organizational focus and energy, this rate is all the more impressive.

Exhibit 1: Daily U.S. COVID-19 Cases



2 Defined as physician practices and services and hospitals/health systems sectors.
3 Kaufman Hall, *2020 M&A in Review: COVID-19 as Catalyst for Transformation.*

Sadly, for many communities, hospital failures also increased in 2020 with bankruptcies up 32 percent.[4] Despite the material inflows of relief funding, the challenges of delivering healthcare, especially in rural communities, is proving ever more daunting. Upon reaching the end of relief funds, a major spike in hospital bankruptcies, hitting rural hospitals particularly hard, may be in store.

The Wrong

As **Exhibit 1** illustrates, we stand guilty of underestimating the pandemic's staying power. While we considered June the industry's effective restart date, the pandemic had other ideas.

As a result of the pandemic's persistence, it is likely the industry still finds itself in the "turbulent restart" phase. Despite that reality, however, the number of transactions in an uncertain 2020 demonstrated a significant appetite for growth across sectors.

The Surprises

We did see an uptick in distressed transactions, but a wholesale "rush to the exits" in acutely challenged sectors never emerged. This was particularly noticeable among physicians. While many practices transacted in 2020, even more, in our experience, continued to pursue their independent growth strategies. Between the loosening of telehealth payment rules and the injection of significant relief funding into the sector, operations were buoyed, and practices made deliberate decisions to hold on and not to sell amidst the uncertainty, and depressed valuations, of the pandemic.

Looking Ahead: 2021 and Beyond

With the increasing clarity of our post-pandemic future emerging, we believe a number of issues will drive provider activity going forward, including:

- "Hardening" of the business model: Providers will move to minimize fee-for-service payment risk through aggressive pursuit of population health strategies, leading to:
  - Increased participation in risk-based payment arrangements
  - Continued investment in clinical and operating efficiency, through care and cost management, respectively
  - Pursuit of growth to access attributed lives and offer comprehensive delivery networks

4 Ayla Ellison, "22 Hospital Bankruptcies in 2019," Becker's Healthcare, January 6, 2020; Ayla Ellison, "29 Hospital Bankruptcies in 2020," Becker's Healthcare, June 3, 2020.

- Ascendance of access as a differentiator: The pandemic provided a peek into a future of "disperse demand" that will advantage those that can deliver care across locations, platforms, and channels.

The rebasing of provider competition around networks, risk, and access will advantage the scaled, and serve as the rationale for continued industry consolidation across provider sectors well into the next decade. As distance between the pandemic and the industry grows, boards need to be asking their management teams the pace at which these phenomena are affecting their markets, as well as management's plans for addressing them.

1. Acceleration of the "Have and Have Not" Phenomenon

The pandemic took an outsized toll on under-capitalized hospitals, though the impact was blunted by emergency federal and state aid. Regardless of the amount of aid, there was a 32 percent increase in bankruptcies and distressed sales in 2020. As we proceed through 2021 and beyond, under-capitalized facilities, especially those in rural areas, will continue to face mounting pressure. We do not anticipate that pressure subsiding.

Meanwhile, large, well-capitalized health systems have performed at record profit levels, despite elective procedure and other utilization drop-offs. While we expect margin compression across the industry as relief funding ends and governmental payers seek to rein in costs, systems that can demonstrate efficiency and that have the resources for continued investment will thrive and grow. This will further the divide in the nation's hospital sector.

2. Mega-Systems Are Coming

The 2020 prediction that received the most debate, the rise of $75-billion+ mega-systems, remains on the medium-term horizon as we exit the pandemic. We still consider the arrival of these mega-systems a virtual certainty. Growth will come both in geographic expansion and acute-care acquisitions, as well as investments in care integration, like physicians, post-acute services, community health, and more.

To be clear, we are not predicting the end of stand-alone providers or that a handful of systems will own all hospitals and physician practices. On the hospital side, small organizations will need to run faster to keep up, but well-positioned independent organizations will find ways to compete, often through partnerships and contractual affiliations that do not require a change of ownership. Among physicians, we are

already seeing groups make investments to create lower-cost ambulatory health networks in a bid to outrun large systems.

3. Value Propositions Matter More than Ever

While we firmly believe health systems will grow materially over the coming decade, we were reminded in the last 12 months of the importance of the value proposition—simple, credible, quantified—as the critical underpinning of successful growth by acquisition. As combinations grow larger, complexity multiplies, losing sight of (or lacking) clear and quantifiable reasoning behind their pursuit is a sure path to failure.

The list of 2020 "pulled" mergers, those that would have served as the cornerstones of the mega-systems described above, was long and full of notable names. While the announcements confirm the desire of the country's largest systems to continue growing, the failures underline the complexity in doing so. In this environment, board members must be willing to challenge conventional wisdom and assumptions, push management teams to quantify value, and, most certainly, demonstrate cultural fit.

4. The Physician "Land Rush" will Recommence…Led by Insurers

Despite the pandemic, physician practices transacted at impressive rates in 2020 and that trend appears to be accelerating in 2021. While acquirers will come from many corners—hospitals, second generation physician management companies, and private equity—we expect the insurers to continue leading the pack. We think this trend deserves mention, in part, because of how insurers have been talking about these investments as licensed-based vs. market-based. Insurers are already leveraging physicians to deliver telemedicine services, often in locations far from the doctor's office. We expect that trend to continue and, with it, pressure on imaging, laboratory, proceduralist, inpatient service, and other costs.

While we believe physician practice consolidation will increase, we are not spelling the end of the independent practice of medicine. 2020 found large primary care and multi-specialty groups learning a lot about their critical importance to their markets, their ability to shift business models to truly manage care and overcome market disruption. Heavily capitated primary care groups, in particular, reported less financial disruption, as revenue continued to arrive regardless of patient volume levels. At the same time, multi-specialty groups with significant investments in primary care found themselves capable of pivoting quickly into telehealth, frequently going from zero to thousands of virtual visits per week, seemingly overnight. We expect these groups to vigorously pursue their own growth prior to considering consolidation going forward.

What's Next?

Historians will view the COVID-19 pandemic as a great accelerator of change in U.S. healthcare, but not change's root cause. The industry's ails, apparent for decades, lacked a catalyst for change. In COVID-19, and its fundamental disruption to the healthcare business model, that catalyst has arrived. If one looks to industry reactions throughout 2020 and into 2021, it is clear that M&A will be a material tool in industry re-imagination and re-creation. The reshaping of the provider industry, underway prior to the pandemic, has reached an inflection point.

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The Value of Liquidity—the Financial Kind

By **Brian Haapala, FACHE,** CEO**,** *StroudwaterGCL Rural Healthcare Capital*

Liquidity is to a hospital what altitude is to a parachutist, water depth is to a boater, and gasoline in the tank is to a NASCAR driver. Without liquidity, activity and movement in each of these situations come to a halt, sometimes with catastrophic results. This article helps boards better understand the value of liquidity, the importance of establishing a liquidity safety net, and the risks of not having the appropriate level of reserves.

Defining and Understanding Liquidity

Liquidity is a financial term reflecting the availability of the organization's resources on a short-term basis. According to Investopedia, liquidity represents "how easily assets can be converted into cash. Assets like stocks and bonds are very liquid since they can be converted to cash within days. However, large assets such as property, plant, and equipment are not as easily converted to cash."

A practical way to think about this topic is to ask: How much cash could we raise quickly if we needed to? The most evident—and important—sources of liquidity are the organization's unrestricted (i.e., can be used for any purpose) cash and short-term investments (such as CDs). To understand if these reserves are adequate, some math is required to express the balances in relation to the organization's scale.

Days cash on hand (DCOH) is calculated by expressing the organization's operating costs into an average of the expenses per day and then comparing that result to the total unrestricted operating cash and short-term investment balances. An organization with average daily expenses of $50,000 and a balance of $1,000,000 in the bank account therefore has 20 days cash on hand ($1,000,000/$50,000=20). The higher the DCOH, the more of a "safety net" that exists.

The power of DCOH as a financial metric is that it allows us to compare the amount of assets available to fund operating cash requirements to the "cash burn rate" at which the organization would consume those assets if no operating revenue were being generated. Fifty million in cash and investments does not go very far if the organization has annual operating cash needs of $250 million, but that same $50

million in liquid assets tells an entirely different story for an organization that may only have annual operating cash needs of $75 million

Ensuring Adequate Reserves

As a lender with the USDA Guaranteed Loan Program, one of our first tasks is to partner with the borrower in combining an affordable amount of debt with an appropriate equity contribution to fund a long-term capital investment. Since the USDA Community Facilities Program does not have a required equity contribution, we are often asked about how best to determine the amount of equity an organization should contribute toward a project.

There is a tendency to think that, as a lender, our interests are in maximizing the amount of debt the organization can take on; however, the 30-year fixed rate loans that we make represent a long-term relationship with the borrower. As such, a plan of finance that limits equity and increases debt at the expense of the project's viability is a much larger risk than any increased upfront fees or interest payments that may be lost if a borrower elects to increase equity and reduce debt. In other words, it's in the best interest of both the lender and the borrower to find a balance between the amount of debt and the amount of equity that keeps debt future service payments

➜ Key Board Takeaways

- What is the organization's "cash burn rate" or average operating expense per day?
- What is the organization's days cash on hand (DCOH)? Have the board and management agreed upon the target DCOH needed for operations (i.e., the "rainy day" fund)?
- Are there resources above the minimum operating DCOH threshold that are available for reinvestment back into the organization?
- What has DCOH been over the past in the organization?
- Are the organization's *short-term annual* equipment and/or capital investments needs being fully funded?
- Does the organization have a strategic master facilities plan in place for identifying *long-term capital needs* that can be funded with some equity reserves and a sustainable, affordable amount of debt?

affordable and sustainable while also ensuring adequate reserves and liquidity for the future.

A case study from a past client helps illustrate this balance. The client hospital applied for and was awarded a financing commitment to construct a new medical office building on its existing campus using the USDA Community Facilities Program financing. As background, the USDA financing is for enhancing credit on the permanent loan and the USDA loan guarantee does not take effect until after the project has been completed. This means that borrowers need to utilize a separate, non-guaranteed loan for interim or construction financing to complete the project (at which time the USDA guarantee takes effect).

As the new building was being constructed, the hospital was pursuing its other strategic improvement initiatives, which included an upgrade to its financial systems and electronic medical record (EMR). At the beginning of this project, the hospital had 65 days cash on hand; halfway through the construction project, DCOH had decreased down to 18 days. By the end of the project, the hospital was operating with only eight days of cash on hand, a major threat to its ability to meet operating requirements in a timely basis.

Because the USDA financing is contingent upon no "material change" in the underlying credit of the organization between the time the initial commitment is issued and when the project is completed, this decline in liquidity represented a risk to the total financing package if USDA would have withdrawn its initial commitment. In this case, that outcome was thankfully avoided through staffing changes and an intense effort with the hospital's leadership to correct the system deficiencies that were created from the new EMR and billing platform.

The Challenges and Risks of Poor Liquidity

Rural hospitals tend to operate with tighter operating margins than their urban and suburban counterparts, often resulting in a "pay-as-you-go" or "pay as much as possible" mentality among board members for both strategic and capital investments. While it may appear that this is a more conservative, less-risky approach, it comes with downstream risks that expose the organization in several ways.

First, the lack of availability of liquidity and the challenges in accumulating enough resources and cash to fund investments—including regular routine capital expenditures—often leads to under-investment in modernizing the facility's

infrastructure (buildings and equipment) over time under the "pay-as-you-go" approach. In addition, when an organization invests much of its cash into non-liquid facilities or equipment, the lower "safety net" of liquidity exposes the organization to future operating risks such as disruptions to the hospital's revenue cycle or billing process as described in the case study above. Even without the change of the IT systems responsible for capturing medical information and generating accurate bills, this type of disruption can take place for many other reasons, including:

- Loss of a key staff member in the billing department
- Third-party payers slowing down payments
- The need to refinance or replace debt structures that are not long-term, fixed-rate debt
- The need to pay back Medicare in a cost report settlement (for critical access hospitals)
- Failed contract negotiations that reduce service income

Changes in the healthcare marketplace or local competitive environment are also future risks to the organization with a poor liquidity position. This includes:

- Loss of volumes as a result of a provider group leaving or (even worse) moving to a competitor
- Exclusion from payers' narrow network
- Entry into the market by a new competitor that decreases volumes or requires resources to respond effectively
- A "black swan event"—defined as unforeseen, extremely rare events with severe impacts

The "black swan event" of the COVID-19 pandemic both increased operating costs and reduced revenues simultaneously for healthcare organizations of all sizes. Thankfully, the CARES Act and accompanying Paycheck Protection Program (PPP) funds provided the healthcare system a liquidity lifeline, but not every disruption will provoke such a strong response and assistance from the government; organizations must be prepared to weather the impact of the myriad threats to the organization's future sustainability with adequate liquid resources available.

It's critically important for directors to align with management around the risks specific to their organization and market to establish the organization's appropriate level of reserves for operating needs (aka, the "rainy day" fund). For rural providers, this is typically in the 40 to 60 days of cash on hand range at a minimum. Certain higher-risk situations, such as being in a competitive market or depending on a small group of providers, for example, may warrant targeting a liquidity safety net

above these minimums to protect against future operating uncertainties. Maintaining liquidity is some of the best insurance your organization can have against the unpredictable and uncertain future.

The Governance Institute thanks Brian Haapala, FACHE, CEO of StroudwaterGCL Rural Healthcare Capital, for contributing this article. He can be reached at bhaapala@stroudwatergcl.com.

Governing Health Systems at the Intersection of Mission Ethics and Business Practice

By **Daniel K. Zismer, Ph.D.,** Co-Chair and CEO**,** *Associated Eye Care Partners, LLC***,** Professor Emeritus, Endowed Scholar, and Chair, Health Policy and Management, School of Public Health**,** *University of Minnesota*

There are more than 4,000 private and governmental, not-for-profit, tax-exempt hospitals in the U.S.[1] A growing number are becoming members of larger secular, faith-based, and governmental health systems of varying sizes. State and federal tax-exemptions provide these health systems financial advantages, such as exemptions from paying state and federal income tax, exemptions from certain property tax obligations, and access to lower-cost, tax-advantaged debt. In exchange, these health systems must serve a defined and qualifying community need or common good. Stated mission examples include charity care, research and education, and the training of clinicians. Failures to meet legal, regulatory, and tax code requirements have resulted in not-for-profit health systems losing their tax-exempt status.[2] Loss of tax-exemption represents a colossal failure of governance, which can result in legal consequences for the health systems, leadership, and directors.

The focus of this article is not on the legal, regulatory, and tax issues related to the governance of not-for-profits, but rather on an underlying topic that gets little or no attention during health system board meetings: the ethics of business strategy as it relates to the stated, institutional mission. The central question here is, **"What is the responsibility of directors of not-for-profit health systems to understand, oversee, and exercise governance over the ethics of business practice as it relates to mission strategy?"**

The central theme is tax-exempt, not-for-profit health systems have requirements of mission that differ from for-profit providers. It is the job of governance to ensure that mission requirements are observed as organizations define, design, and execute on business strategies of the organization. The job requires boards to use their bests efforts to ensure the alignment of mission ethics with business strategy.

1 "Fast Facts on U.S. Hospitals, 2021," American Hospital Association.
2 "Revocation of Tax Exemption," National Council of Nonprofits.

The COVID-19 pandemic shines a bright light on this requirement (see sidebar, "Pandemics, Public Health, and Mission"). A number of key board-level questions should be brought to the fore. Three of several are:

- What role do we play in community public health practice, including crisis preparedness?
- Given our size, scope of clinical competencies, and availability of financial resources, is our business strategy reasonable and responsible?
- Are the risks required of our business plan prudent as we consider them in the context of our ongoing mission accountabilities to all communities served?

The first lesson for not-for-profit health system boards is that the mission is everything the organization does, including how everything gets done. It's not simply the portion of revenues allocated for charity care, financial contributions to community services and agencies, and the organization's willingness to serve patients funded by governmental programs that pay less than commercial payers. Nor should directors categorize all clinical service programs that "lose money" as mission activities. The whole of the business strategy of the organization reflects the mission strategy of the organization. Governance holds the responsibility for the ethics of mission, as it is executed through business strategy.

➜ Key Board Takeaways:

- "Mission" of not-for-profit healthcare organizations is everything the organization does. It's not just free care provided, contributions to community services, or special programming for the underserved.
- A principal and fundamental responsibility of a governing board of a not-for-profit organization is to ensure that the business practices of the organization readily align with the mission ethics of the organization, as defined by governance.
- A practical approach to testing mission ethics is for boards to engage with leadership in discussions of the approach to the execution of the organization's strategic plan with a focus on how expected business practices will reflect upon the organization's values and mission accountabilities to those values.

"Organizational ethics" can be defined simply as a set of principles that guide the "right behaviors" as defined by institutional values and moral imperatives. Faith-based organizations such as health systems sponsored by the Catholic Church derive such guidance, in part, from the "Ethical and Religious Directives of the Catholic Church."[3] Secular organizations may derive the basis for ethical practice directly from the governing body of the organization. Regardless of corporate sponsorship, governance of not-for-profit health systems bears the responsibility and real-world accountability for mission ethics as executed through business practice.

Virtually every not-for-profit health system in the United States has a publicly available mission statement. Here are two examples:

- "Inspiring hope and promoting health through integrated clinical practice, education, and research." —Mayo Clinic
- "Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care, which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words." —Ascension

Ascension goes on to define its healthcare ethics as "Aligning with Catholic healthcare ethics practices, which helps foster disciplined decision-making processes that promote our mission, vision, and values."

Both Mayo and Ascension qualify as private, not-for-profit, tax-exempt healthcare organizations, with all rights and obligations that apply, as provided through U.S. and state tax code regulation and guidance. Based upon the differences between their declared missions, it can be inferred that each will go about serving their missions by way of different strategies. Regardless, each is obligated to align business practice with the implied moral and ethical imperatives of their stated missions.

Making a Clear Connection between Mission Ethics and Governance Oversight of Business Practices

Healthcare in the U.S. is an estimated $4-trillion industry. It certainly qualifies as a "business." Business ethics, at the level of governance, can be defined as: A set of

3 *Ethical and Religious Directives for Catholic Health Care Services*, Sixth Edition, United States Conference of Catholic Bishops, June 2018.

➜ Pandemics, Public Health, and Mission

The COVID-19 pandemic has sent health system boards reeling with questions that go beyond the agenda of the typical board meeting. A few that loom large are:

- Should we have been better prepared?
- What is our future role with the public health programming for the communities we serve?
- Should we restructure and redirect our approach to the stewardship of organizational resources and mission of the organization in the direction of public health practice?

While there are no easy answers to these questions, they bear attention by a board. A reasonable approach to this discussion is framed by more questions:

- What is the difference between effective public health practice and the delivery of healthcare, including the treatment of the infirmed and injured?
- Do we have the institutional knowledge and competencies to mount an effective plan of preparation and action in the direction of public health practice?
- What could/should we do alone and with partners to responsibly serve an adjustment to mission, while remaining good at our core competencies and essential services?
- How will we resource, fund, and afford any adjustments in this direction?

While the missions of medical care delivery and public health practice intersect and overlap, they are not one and the same.* Before boards allocate organizational resources to public health programming as mission, a substantial amount of board education, discussion, and discernment is required.

* D.K. Zismer, "An Argument for the Integration of Health Care Management with Public Health Practice," *Journal of Healthcare Management*, Vol. 58, July/August 2013.

principles or standards of human conduct that govern the judgement and behavior of organizations.

It follows then that the governing boards of private, not-for-profit health systems hold the ultimate responsibility for how their organizations conduct business, including the mission strategy. Let's dive deeper into this central thesis with a case vignette.

Case Vignette: Ethical Questions in a Health System Mission Strategy

A health system holds a dominant position in a regional geographic market. It is a preferred source of care for high-revenue clinical service lines such as cardiovascular services, cancer care, and trauma care. One sub-section of its mission statement makes reference to "being good stewards of community healthcare resources." Leadership proposes that increased investments be made to expand branded primary care satellites at greater distances to enhance access to care, particularly in rural areas. The strategy will be expensive and the expanded primary care network will, on a fully cost-accounted basis, "lose money." The effects will be negative on future financial margin performance, which, over time, will be compensated for by increased specialty referrals to the system's tertiary care center, and by increasing prices to third-party payers (e.g., insurance companies and larger, self-insured corporations). Likewise, the organization has significant cash reserves that can be applied with no material effects on the organization's credit rating. These cash reserves provide an advantage over smaller regional competitors that may have designs on the same markets.

Are there ethical questions directors should ask of this business strategy, given the implied ethics of the organizations mission strategy? In addition to a range of related business plan questions, two of the important mission ethics questions that pertain include:

1. To what extent will the strategy be financed by way of disproportionate cost-shifting to commercial payers, self-insured corporations, patients with individual insurance coverages, and philanthropic benefactors of the organization?
2. How will hospitals, physicians, and other providers located in the target market geographies be affected by the strategy; i.e., is the success of the strategy dependent upon shifting market share away from provider organizations, and if so, at what cost to the providers who lose in the execution of the strategy?

The main issue here is not necessarily the specific answers to the questions, or the final strategic plan decisions, but that the board knows to ask them, is sufficiently

prepared to discuss them, and has a framework for the required ethical decision making that follows.

The Decision-Making Framework

If governance is responsible for overseeing the ethics of the business strategies executed to serve the organizational mission, then a framework for the process is required. There is no "off the shelf" guide for this. The framework provided here is an example intended to stimulate conversation between directors and senior management as each strategic plan unfolds.

This framework is presented in the form of seven practical questions that, with the right conversations, can satisfy a board's obligation to best ensure that the ethics of a business strategy comports with the mission accountabilities of the organization:

1. Can governance directly align the tactics of the organization's strategy with the mission responsibility of the organization?
2. Could the financial resources invested in the strategy unreasonably risk or compromise the organization's total financial health, including putting essential services at-risk?
3. Will the costs of the strategy be disproportionally shifted to specific patient populations or payers in the form of higher prices or increased total cost of care?
4. Will the strategy unreasonably target the required markets of other community healthcare providers locally or regionally, such that others who serve targeted markets must lose in order for us to win?
5. How will the strategy affect physician affiliates of the organization, whether employed or independent?
6. Do we have the requisite competencies and experience within the organization, such that the board can reasonably trust that management can sufficiently shepherd the strategy to success—in other words, do we have senior leaders who are experienced with what we intend to do?
7. How will we evaluate the expected outcomes of the strategy against other mission accountabilities?

Conclusion

Some experienced health system leaders and boards may say "we do talk about mission when deciding strategy for the organization," and while that may be true, mere discussion may not substitute for the application of a rigorous, focused process of board and leadership discourse and discernment.

Experience demonstrates that it is often a challenge for directors of not-for-profit organizations to intellectually integrate the concepts of strategy, business practice, and ethics with mission, whether for secular or faith-based health systems.

Boards can get off to the right start with governance oversight of mission ethics of business strategy by addressing each plan of action by asking four questions:

1. What are we doing?
2. Why are we doing it?
3. How do we expect to do it?
4. What are potential consequences of our efforts that may be inconsistent with our organizational values and related mission accountabilities?

The Governance Institute thanks Daniel K. Zismer, Ph.D., Co-Chair and CEO, Associated Eye Care Partners, LLC, Professor Emeritus, Endowed Scholar, and Chair, Health Policy and Management, School of Public Health, University of Minnesota, for contributing this article. *He can be reached at dzismer@aecpmso.com.*