HealthLeaders
a Simplify *Compliance* brand

69%
of healthcare executives say that their organization will be exploring or completing deals underway within the next 12–18 months.

INTELLIGENCE REPORT

JULY/AUGUST 2020

HEALTHCARE M&A: MOVING FORWARD IN A POST-COVID-19 LANDSCAPE

An Independent HealthLeaders Report Powered by:

HealthLeaders Council

SPONSORED BY:

BANK OF AMERICA

ARE DEALS AMONG U.S. HEALTH SYSTEMS UNWINDING DUE TO COVID-19 OR SOME OTHER "VIRUS"? IS THERE A CURE?

Brent McDonald
Head of Healthcare
Strategic Advisory Services,
Managing Director
Bank of America

One does not need to be a full-time observer of the health system mergers, acquisitions, and partnerships (MAP) landscape to see that there are a significant number of previously announced (and even some previously closed) merger and partnership transactions that have been announced as or reported to be dissolving or unwinding. The question senior executives and members of the board of trustees must ask is, "What is causing these transactions to not be successful?" Is the culprit simply COVID-19? That may be a popular excuse. Or have other cracks in the deal foundation fundamentals caused the somewhat significant uptick in deal unwinds? While COVID-19 provided a pause and forced decision-makers to analyze and reevaluate, it does not seem to be the primary cause.

Based on public rationales and other diligence on the subject, the non-regulatory reasons for these deal failures fall generally within the following buckets:

- **Mission/focus/governance misalignment.** Due to a real or perceived lack of alignment, certain key stakeholders of organizations participating in MAP activity believe a fatal divergence exists in key values. These diverged values may relate to allocation of capital spending, centralized governance, faith-based considerations, teaching/research missions, physician influence, or other mission focuses that are viewed as being in conflict.
- **Risk tolerance adjustment.** The decision-makers for certain organizations engaged in MAP collaborations have shifted their relative view of acceptable risk tolerance. Whether based on declining balance sheet reserves, investment returns, rating agency viewpoints, or other execution risk inherent in the calculus of the cost-benefit analysis associated with a MAP evaluation, the risk tolerance of some governing bodies has shifted.
- **The uncertainty of the pandemic.** Concerns caused by the pandemic include increased operating costs; decreased ED, outpatient, and inpatient volume; liquidity stressors; lower reimbursement; reopening risks; and uncertainty as to the new normal. In addition, macro-economic forces are combining to increase the uninsured and Medicaid populations.

Clearly, most deals announced (or actually closed) that are unwinding were originally formulated for solid, sustainable reasons, including complementary geography, value-based care competencies, service lines, physician alignment strategies, back-office opportunities, and mission/culture (collectively, the "deal premises"). The number of deals unwinding is a concern and appears to be caused by more than just normal industry headwinds or diligence findings. Instead, it appears that key stakeholders' underlying belief in the fundamental deal premises is being lost or marginalized with the passage of time.

What should senior executives and boards do to keep a merger or collaboration affiliation discussion from failing due to skepticism of the fundamentals?

- **Properly frame the deal premises/recognize the reality of ongoing scrutiny.** The deal premises of the combined organization must resonate with the communities/regions served by the combined organization and serve the greater good via sustainable, Triple Aim–focused care. The leadership must remember that pre-closing and post-closing, key stakeholders may continue to evaluate and second-guess whether the key premises of the deal are being met from their perspective, and may even attempt to refine or renegotiate the deal premises. Of course, the underlying structure of the merger or collaboration must serve to align all component parts/geographies.
- **Provide effective and ongoing stakeholder education.** The deal premises and the mission of the new organization must be the focus. Governing bodies and key stakeholders should be able to articulate the important goals and objectives of the transaction. These articulated goals and objectives must be more than typical MAP concepts of integration, synergies, and scale—those are cold, clinical terms that may not give rise to the proper enthusiasm regarding the transaction benefits. Keep in mind that human psychology may cause silence, omissions, or misunderstandings to fester. Senior leadership should ensure both organizations are *continuing* to discuss the benefits of the deal both locally and on a combined organizational basis.
- **Keep selling to stakeholders/providing transparent reporting.** Leadership should continue to court the new affiliates' stakeholders after approval of an LOI or definitive agreement and even post-closing. Keep selling the fundamentals and remind parties of the local benefits. Avoid the "us vs. them" paradigm. Show respect, take voiced concerns seriously, schedule joint meetings of governance representatives, and ensure an opportunity for real feedback. Where appropriate, keep the long term in mind and be open to revisions or compromises to address *reasonable* viewpoints that are consistent with the spirit of the deal. Pre- and post-closing, senior leadership should continue to present original objectives and report out key deal premise metrics. This will hold leadership accountable and allow impacted stakeholders to have an opportunity to bring up solutions rather than permitting a situation to fester.
- **Consider outside assistance.** Many times, high-stakes transactions require difficult conversations, compromises, and strong leadership to be successful. Sometimes certain voices or styles can create fatigue, be associated with an opposing legacy organization, or be diminished due to goodwill used during the negotiation phase. In our experience, it is often very valuable to have an experienced and well-rounded advisor involved to perform shuttle diplomacy, de-escalate misunderstandings, or even be a relief valve to avoid permanent harm to the goodwill between the legacy parties.

In closing, remember at the end of the day that all deals (large or small) are in essence partnerships among proud and previously independent organizations. Keeping this in mind may pave a way for long-term transactional success.

HEALTHCARE M&A: MOVING FORWARD IN A POST-COVID-19 LANDSCAPE

One of the most enduring trends in the 21st century for the healthcare sector has been consolidation.

Payers gobble up payers. Health systems consume competitors and physician practices. Even retail has gotten into the game, with 2018's $70 billion merger of CVS Health and Aetna, Inc., the biggest healthcare consolidation of that year.

There are several reasons why consolidations have been accelerating, such as synergies, economy of scale, care coordination, population health, reductions in redundant services, etc.

But everyone knows the primary reason for consolidations has always been to create a larger market share when negotiating contracts. Regardless of whether you are the payer, the provider, or the retailer, the bigger the footprint, the better the deal.

John Commins

Senior Editor
HealthLeaders

Well into the first quarter of 2020, there was nothing to indicate that healthcare sector consolidations were slowing.

Then, the coronavirus pandemic emerged in mid-March and bulldozed the landscape.

Hospital and physician practice volumes and revenues plummeted amid a mandated shutdown of nonessential care. The American Hospital Association estimated that the nation's hospitals lost $50 billion a month during the shutdown. Many providers stayed afloat only with the help of more than $170 billion in federal emergency stimulus funding.

A report in April from Kaufman Hall found that M&A activity in the first quarter of 2020 was in line with historical averages but dropped off in mid-March, right at the time the pandemic was flexing its muscles.

Kaufman Hall concluded that the disruption caused by the pandemic will be "an uncertain predictor of activity" for M&A for the rest of the year.

Several mega-consolidations were called off this spring, including the merger of Advocate Trinity Hospital, Mercy Hospital and Medical Center, South Shore Hospital, and St. Bernard Hospital on Chicago's South Side, and Beaumont Health's acquisition of Summa Health.

The South Side merger was rejected because of regulatory hurdles imposed by Illinois. But the demise of the Beaumont-Summa merger was blamed on financial issues exposed by the pandemic.

ANALYSIS AND SURVEY RESULTS

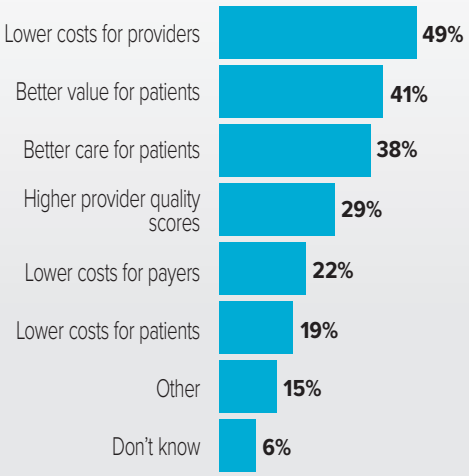
"We were working with Summa on some changes we needed to make to the agreement between us, particularly related to the pandemic and the financial realities around the pandemic," Beaumont Health CEO John Fox told reporters in mid-June.

"Ultimately, we could not come to agreement on those and we elected to not proceed with the transaction," he said.

At the same time, Beaumont and Advocate Aurora Health announced plans to merge and create one of the largest, nonprofit healthcare systems in the nation, although Fox said COVID-19 was not a factor.

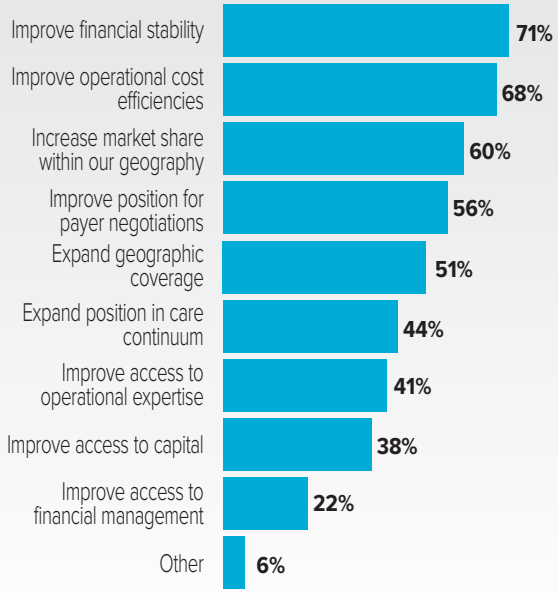
"Our discussions were paused by COVID-19, but in no way are they caused by COVID-19," he said. "This announcement would have come sooner if we had not gone through the pandemic."

Figure 1 | **Based on your experience and research, what result(s) do you think merger, acquisition, and/or partnership (M&A) activity among healthcare providers usually delivers?**



Base = 107, Multi-response

Figure 2 | **What are the financial objectives of your M&A planning or activity?**



Base = 107, Multi-response

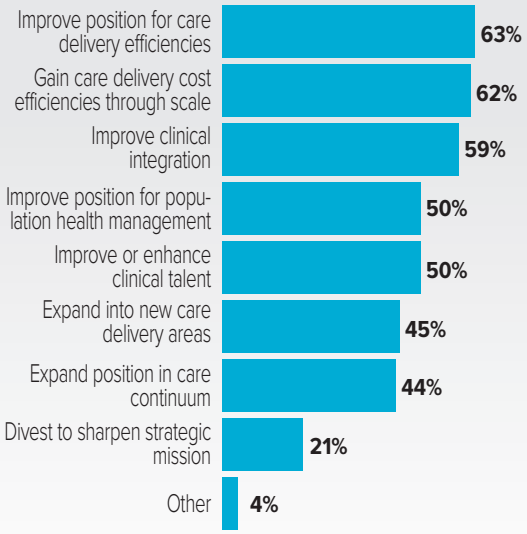
Pandemic vs. M&A

The question then is, how much of a disruption will the pandemic prove to be for healthcare M&As? Will the pandemic create a sustained headwind changing the motivations for consolidations, or will it create a short, albeit intense tempest that may cause payers and providers to take cover before resuming business as usual when the winds calm?

Results from the *2020 HealthLeaders Mergers, Acquisitions, and Partnerships Survey* suggest that stakeholders strongly believe that consolidations will continue to be a significant trend in the healthcare sector, regardless of the pandemic.

According to the survey, which was compiled in April 2020 during the COVID-19 surge, 69% of respondents

Figure 3 | **What are the care delivery objectives of your M&A planning or activity?**



Base = 107, Multi-response

say their organization will be exploring or completing deals underway within the next year to 18 months (**see Figure 10**).

Alan Levine, CEO of Ballad Health, a 21-hospital health system serving four states and based in Johnson City, Tennessee, says consolidations will accelerate in the coming months and years because the underlying economic pressures that prompt consolidations are still there, regardless of the pandemic.

"Hospitals that were on the borderline of struggling before the pandemic are going to be seeking partners," he says.

"Non-urban and rural hospitals are facing a real problem, but I don't know that there will be as much M&A activity with those hospitals."

For-profit hospital chains such as Community Health Systems and LifePoint Health used to have large footprints in rural markets, "but those hospital systems are moving out of those rural markets. CHS is offloading all of their rural hospitals," Levine says. "A number of those hospitals will struggle and close unless there is some major change made to the reimbursement system."

Tim Putnam, CEO of Margaret Mary Health, an independent, community-owned, critical access hospital in Batesville, Indiana, says many smaller, independent hospitals were already searching for a white knight before the coronavirus surfaced, and that the pandemic will accelerate those efforts.

"Sadly, 700 rural hospitals are considered in financial jeopardy across the country, and more than one rural hospital closes every three weeks in this country," Putnam says. "There's no doubt that this is an acute situation on top of a chronic issue with rural hospitals."

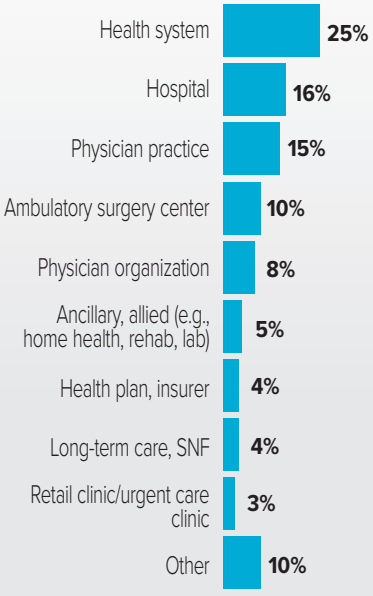
Figure 4 | **Please describe the nature of your most recent M&A activity.**

Base = 107

"How many will be pushed into mergers? How many health systems will be willing to merge at this point in time because they're facing their own problems?" he says. "The costs that we've incurred by having to shift our organizations to be able to deal with a pandemic, on top of the revenue we've lost just over the last couple of months, will push many hospitals who have less than 20 days of cash to the brink."

However, when asked whether survey respondents who are exploring potential deals expect their organization's M&A activity to increase, decrease, or remain the same within the next three years, 68% say they expect their M&A activity to increase (**see Figure 12**).

Figure 5 | **What kind of entity was involved in your most recent M&A activity?**



Base = 73, Of those involved in recent M&A activity

Improving care delivery efficiencies

When asked what their care delivery objectives are for a merger, 63% of the *HealthLeaders* survey respondents say their No. 1 goal is to improve their position for care delivery efficiencies (**see Figure 3**).

Peggy Sanford, system senior vice president of strategic growth, partnerships, and joint ventures for CommonSpirit Health, and primary advisor for this Intelligence Report, says care delivery efficiencies in the post-pandemic healthcare world may not necessarily rely upon traditional mergers and acquisitions.

"There's going to be a significant pivot in new resources. There'll be much more investment and acquisition in alternative types of care that support less brick and mortar," Sanford said during the *HealthLeaders* editorial webinar, "M&A in the Post-COVID-19 Landscape: Where Do We Go From Here?" in late May. "There will be an effort to invest in new digital technology and point-of-care solutions, and there'll be a stronger preference to create a cohesive continuum that can address a potential pivot to value-based care solutions that I would expect to see coming out of this."

The pandemic and stay-at-home mandates have advanced consumer awareness and use of telemedicine, particularly for vulnerable populations. Sanford said providers have taken note.

"Most hospitals and health systems have some versions of a video visit or a digital platform, but there was a rapid increase in the use of those platforms and the deployment of those platforms," she said. "There will be continued enhancements to those and a continued higher percentage

Figure 6 | **Please describe the financial impacts your organization experienced after its most recent M&A activity.**

Financial Impacts	Increased	Remained the same	Decreased	Don't know
Net patient revenue	52%	29%	7%	12%
Operating margin	42%	30%	19%	8%
Cost of providing care	14%	45%	30%	11%

Base = 73, Of those involved in M&A activity

Figure 7 | **Please describe the clinical impacts your organization experienced after its most recent M&A activity.**

Clinical impacts	Increased	Remained the same	Decreased	Don't know
Patient readmissions	11%	58%	14%	18%
HCAHPS scores	21%	41%	8%	30%
Quality outcomes	34%	49%	4%	12%

Base = 73, Of those involved in M&A activity

of use of a virtual visit in lieu of a face-to-face visit as we move forward."

An enhanced emphasis will also be placed on at-home services and advanced home care models. "A big area of focus that we're really going to have to dive deep on are residential homes for our seniors and the impact that this has had on skilled nursing facilities and custodial care situations where these populations were so significantly impacted by this virus," Sanford said.

"That approach will become much more preferred, particularly for clinically vulnerable populations who may want to receive more care services in their home versus the hospital-based program," she said. "Programs like hospital-at-home or home recovery care that give, for certain patient populations, the opportunity to receive acute care–level services in their home through a combination of digital or telehealth support with home-based nursing care."

However, the survey shows that bigger is not necessarily better when it comes to clinical outcomes. When asked to assess the clinical impact of their most recent M&A (**see Figure 7**), only 14% of respondents say readmissions have decreased, while 58% say readmissions have remained the same, and 11% say readmissions have increased.

Likewise, 53% of respondents say quality outcomes have either remained the same (49%) or decreased (4%), while 34% say they have improved.

"It depends on the mindset of the health system. If they're leaning into a value-based care [model], then they're likely to come at it from the perspective of M&A that drives down total cost of care," Sanford tells *HealthLeaders*.

"They'll be looking at acquisitions that can pivot costs to a lower-cost setting. They'll be looking at opportunities to position for a global payment or a sub-cap that allows them to manage dollars and utilization rates," she says. "But, a large percentage of the United States still doesn't have a significant portion of their business that's driven off of a value-based care concept."

Financial objectives

When asked what are the financial objectives for M&A planning or activity, 71% of the *HealthLeaders* survey respondents say it is to improve financial stability, followed by improving operational cost efficiencies (68%) (**see Figure 2**).

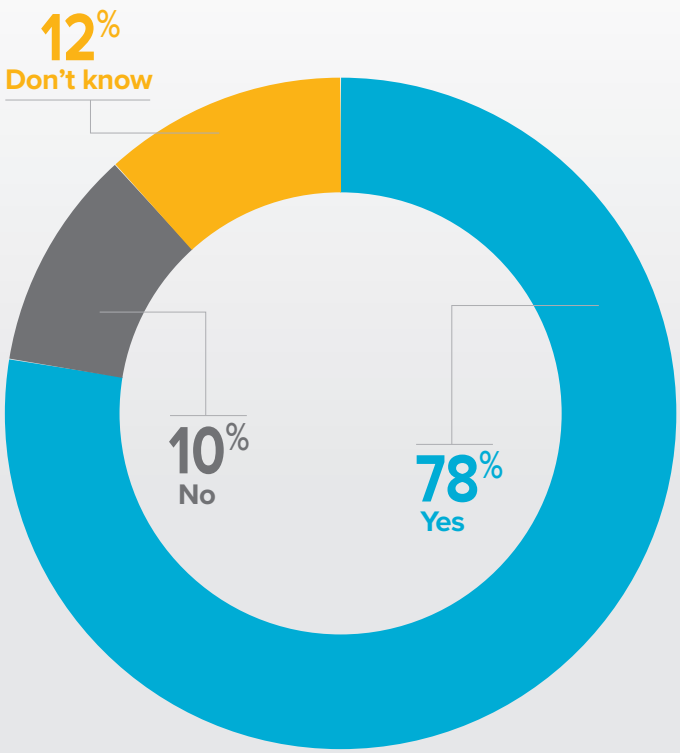
Those factors came into play in Beaumont Health's decision to merge with Advocate Aurora. Even though Beaumont is already the largest health system in Michigan, Beaumont Health CEO John Fox said they shopped for a larger partner because Beaumont didn't have the financial assets it needed to realize its potential.

"The new organization would look to make new investments in Michigan that, frankly, we don't believe we can do alone," Fox said.

A merger with Advocate Aurora would allow Beaumont to invest in clinical programs, facilities and technology improvements, and pay for the cost of relocating the Beaumont School of Medicine from Auburn Hills to Royal Oak.

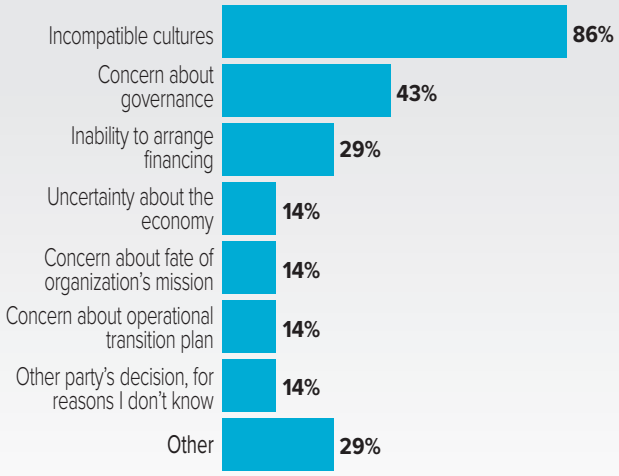
These are some things we've been talking about for a long time, and this transaction, we think, will enable that to finally happen," Fox said. "Our goal is to grow market share for Beaumont Health and to have a bigger impact in Michigan. By virtue of synergies in the benefits of this

Figure 8 | **Looking back, would your organization choose to participate in its most recent M&A activity again?**



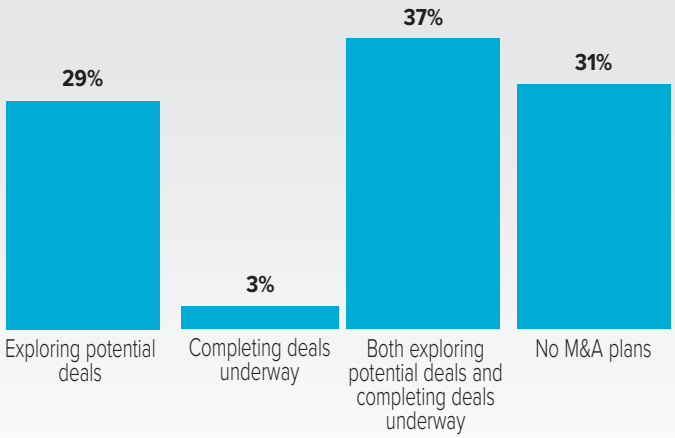
Base = 73, Of those involved in M&A activity

Figure 9 | **Among these financial and operational reasons, which of them describe why your organization's most recent M&A activity fell short of expectations?**



Base = 7, Multi-response, Of those who say they would not participate again in M&A activity

Figure 10 | **Please describe your organization's M&A plans for the next 12–18 months.**



Base = 107

combination, we think we will be in a great position to do so."

Although consolidations are often justified as a way to widen margins, M&As provide no guarantees that they'll improve the bottom line or lower the cost of care. The survey (**see Figure 6**) found that 42% of respondents report that operating margins increased after their most recent M&A activity, while 30% say they remained the same, and 19% say they decreased.

"It depends upon what the M&A activity is," Sanford tells *HealthLeaders*.

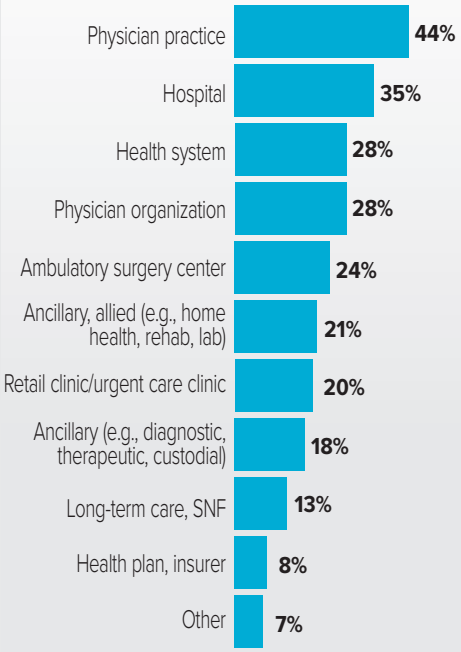
"Some things can initially, post-close, cause an additional burden on a health system as they're perhaps engaged in a turnaround initiative, or there's a significant transition of leadership, or operating structure," she says.

The results were also mixed for the cost of providing care, in which lowering the costs is often a primary justification for consolidations. Less than one-third (30%) of respondents say their most-recent M&A activity decreased the cost of care, while 45% say the cost of providing care remained the same, and 14% say costs increased.

"A lot of times when a hospital makes an aggressive acquisition, let's say of a smaller system that has been struggling, there can be a real impact that you would describe as negative to the acquisition in the near term, with the aspirational goal of getting it to be positive," Sanford says.

"Position acquisitions can initially be a struggle as you're integrating them, perhaps changing alignment structures,

Figure 11 | **What entities does your organization have a high interest in pursuing through M&A activity within the next year?**



Base = 71, Multi-response, Of respondents exploring potential deals

etc., with a big cash stream before they have an operational pickup. But again, it very much depends on the type of acquisition," she says.

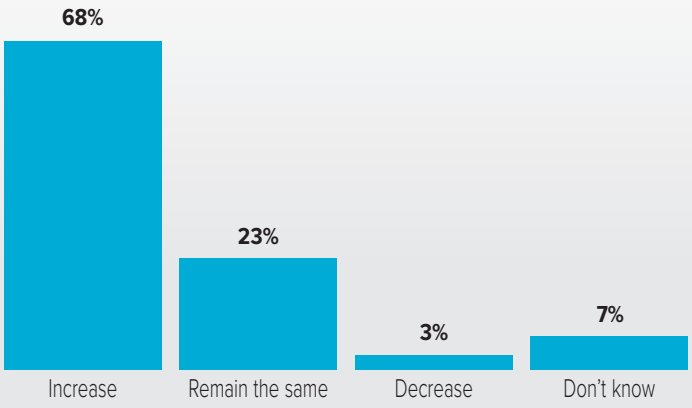
The survey found that physician practices or physician organizations are the top acquisition target for 72% of respondents in the coming year (**see Figure 11**).

Sanford says the coronavirus pandemic exposed the risks of having high-salaried physicians on the payroll idled by the months-long shutdown of elective and non-urgent procedures.

"We saw the huge investments in hospital-based providers or urgent care platforms and other areas where they have significant physician liability, but without any volume they found themselves upside down very quickly," she says.

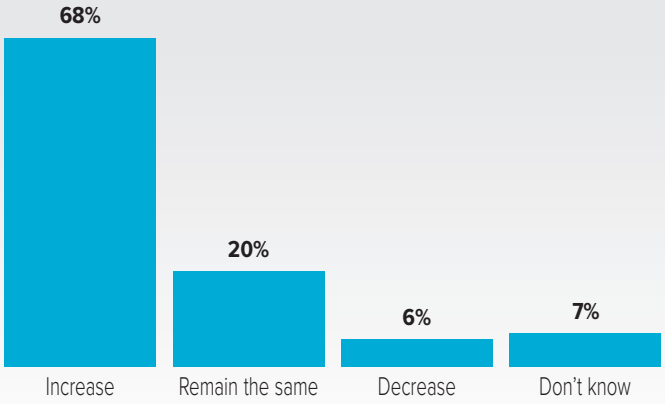
Beyond that, Sanford says physician employment models "are going to continue to be a challenge to find a mechanism that aligns the incentives between the parties to ensure that success is achievable. I don't know that we found necessarily the ideal model."

Figure 12 | **Within the next three years, do you expect your organization's M&A activity to:**



Base = 71, Of respondents exploring potential deals

Figure 13 | **Within the next three years, do you expect the dollar value of your organization's M&A activity to:**



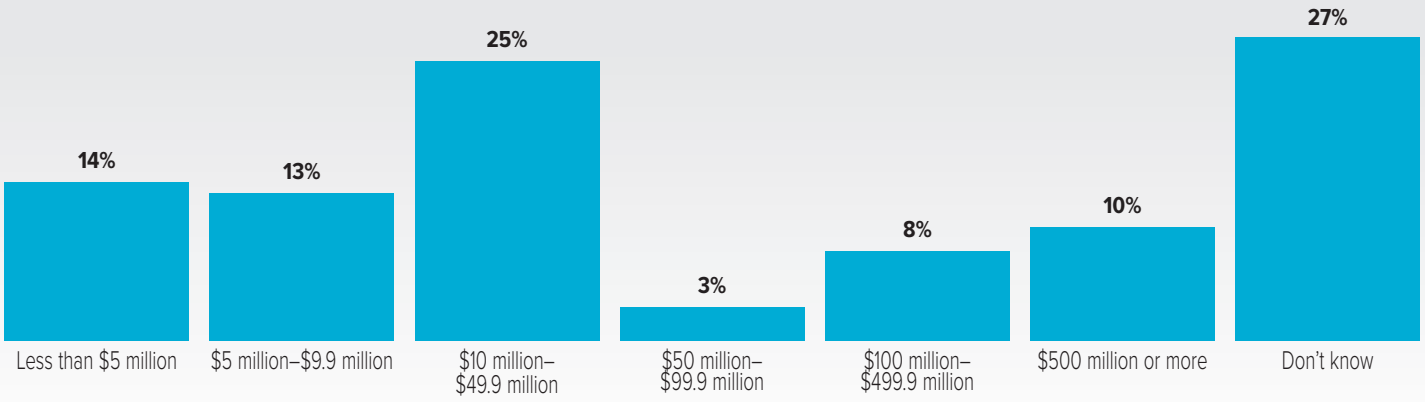
Base = 71, Of respondents exploring potential deals

Value vs. cost

When asked what results M&A activity among healthcare providers usually delivers (**see Figure 1**), 49% of respondents to the survey say that it lowers costs for providers. While 41% say M&As provide better value for patients, only 19% say they lower costs for patients. Sanford says trying to explain the difference between value and cost to patients could prove challenging.

"Value for our patients is not purely an economic-plus-outcome evaluation," she said during the *HealthLeaders* webinar. "Many times, in the patient's mind it's about, 'How was I treated, and did I feel better after the encounter? And even if they couldn't cure me, was the encounter overall satisfying to me?' "

Figure 14 | **Please estimate the cumulative total dollar value of the M&A activity your organization will be exploring over the next three years.**



Base = 71, Of respondents exploring potential deals

"That comes back to whether or not we can create access to care that is much easier for our patients. The challenge here is really creating an ease of access and connectivity that will feel like value to the patient," she said.

"So, as we add components to our care, we can make it seamless for them to move from one site of care to another, to have that portable medical record and those ready results for providers to access so that we're not repeating testing or creating delays in care. That's going to feel like value to them. That's different than the way we calculate value from the health system side."

No regrets

The survey found that 78% of respondents say they would choose to participate in their most recent M&A activity again (**see Figure 8**).

Ballad Health CEO Alan Levine shares that sentiment.

In 2018, Levine oversaw the merger as CEO of Mountain States Health Alliance with Wellmont Health System that essentially doubled the size of the new merged system.

"There's been such an enormous benefit to the region by doing this," he says. "It's been challenging because we basically agreed to very aggressive regulations, which has made it a lot harder. But even with that, this was the right thing to do."

"Now, our goal is to operationalize what we've created and, so far, we're doing a good job of it," Levine says. "Our quality metrics have improved dramatically. Five of our 17 quality measures are now in the top-performing decile in the country, and that happened after the merger."

"We've improved our margins. We went from basically a zero percent margin to a 1.6% margin, so our margins have improved but they're still well below what the industry expectation should be."

ANALYSIS AND SURVEY RESULTS

The margin improvements have come, Levine says, even as Ballad has reduced physician charges by 17% across the system.

"The most important access point for patients is urgent care and their doctors, and we did a 17% average charge reduction," he said. "In fact, in some cases, it was a 50% decrease in out-of-pocket costs."

"We also expanded our charity policy. Prior to the merger, if you were up to 200% of poverty, we wrote off all the cost of your care. After the merger, we increased our charity policy up to 225%, and we provide deep discounts for up to 400% of poverty," he says. "So, we actually expanded pretty dramatically either the number of people that are eligible to have their care completely written off, or we apply deep discounts to it that weren't available before the merger."

Tim Putnam, CEO at Margaret Mary Health, says he's not surprised that few stakeholders are willing to express post-merger buyers' remorse.

"Everyone who answered that was probably employed by whomever was acquired," Putnam says. "It's not surprising that people would say that because they've got to get up in front of their communities and say this was a good thing for our community."

"One of the things that I hear from my colleagues is that you can only sell your hospital once, and you've got to do it right," Putnam says. "I'm not saying it's not the right move, but you can only do it once."

Of those respondents who were involved in M&A activity, only 10% say they would choose not to participate in their recent M&A again (**see Figure 8**). Of that 10%, 86% cited "incompatible cultures" as the reason their M&A fell short of expectations (**see Figure 9**).

"There's something we refer to in M&A circles called 'deal fever,' " Sanford said during the *HealthLeaders* webinar. "Many times the excitement about the opportunities that a deal represents for the organizations coming together and all the possibilities they see, as well as the enthusiasm for successfully completing a transaction, can blind us to the critical review of whether or not we actually have a fit."

"It requires quite a bit of leadership time talking about what it means to come together and exploring the vision and values and mission of the organizations very carefully and discussing the difficult issues quite openly, and either agreeing that those are things that clearly can be navigated or they may be real barriers to success," she said.

"We tend to avoid those difficult conversations during the M&A process because we're focused much more on the tactical issues or the economic impact issues or the legal and risk issues associated with the transaction," Sanford said.

John Commins is a senior editor for HealthLeaders. He can be contacted at jcommins@healthleadersmedia.com.

METHODOLOGY

The *2020 HealthLeaders Mergers, Acquisitions, and Partnerships Survey* was conducted by the HealthLeaders Intelligence Unit, powered by the HealthLeaders Council. It is part of a series of thought leadership studies. In April 2020, an online survey was sent to the HealthLeaders Council and select members of the HealthLeaders audience at healthcare provider organizations. A total of 107 completed surveys are included in the analysis. Base size varies between 7 and 107 according to respondents' knowledge of the question. The margin of error for a base of 107 is +/-9.5% at the 95% confidence interval. Survey results do not always add to 100% due to rounding.

What Healthcare Leaders Are Saying

Here are selected comments from leaders regarding the advice they would give an executive at an organization considering a potential M&A.

"Be as transparent as possible. Keep your board of directors at both agencies completely and regularly updated about the process. Make sure local and state authorities and legislators are involved in the process. Keep your teams informed. Rebranding is important and should begin ASAP, even prior to the actual merger/acquisition, if possible, in terms of media coverage and website communication. Listen, listen, listen. Communicate, communicate, communicate. Be decisive in your decisions, move forward, and keep the faith. Never, ever look back! "

—CEO/President/Board member at a small health system

"Identify the goals and stick with them, and don't be afraid to back away if the transaction is unlikely to achieve the goals, benefits, and economies of scale anticipated."

—Chief financial officer at a medium health system

"Senior leaders at both organizations need to be committed to one message throughout the process. Transition leadership immediately after the acquisition is finalized to expedite the financial stabilization and growth plans."

—Chief operations officer at a small health system

"Have agreement on the vision/strategic imperative for the M&A activity. In other words, have a plan. Do not engage in M&A activity unless there are clearly articulated goals for the outcome of the M&A activity. This would be true even if the M&A activity was strictly a defensive maneuver in the marketplace."

—Chief strategy officer at a small health system

About the HealthLeaders Intelligence Unit

The *HealthLeaders* Intelligence Unit, a division of *HealthLeaders*, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

Senior Manager, Content & Product
ADRIENNE TRIVERS
atrivers@hcpro.com

Manager, Content
ERIKA RANDALL
erandall@healthleadersmedia.com

Research Editor
JOHN COMMINS
jcommins@healthleadersmedia.com

Intelligence Report Contributing Editor
JACK O'BRIEN
jobrien@healthleadersmedia.com

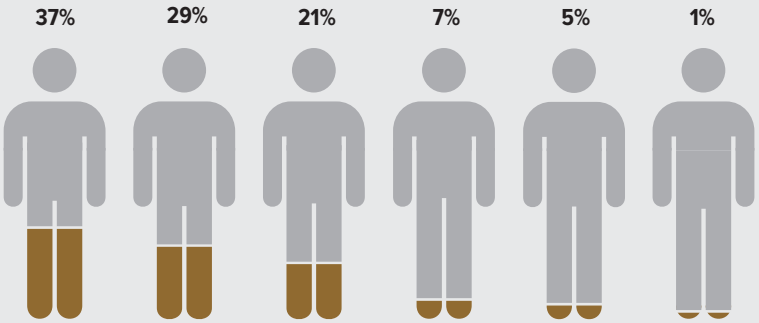
Senior Client Services Manager
CATHLEEN LAVELLE
clavelle@healthleadersmedia.com

Art Director, Intelligence Report Design and Layout
DOUG PONTE
dponte@simplifycompliance.com

RESPONDENT PROFILE

TITLE

Base = 107



CEO, PRESIDENT

- CEO, President
- Chief Executive Administrator
- Chief Administrative Officer
- Board Member
- Executive Director
- Managing Director
- Partner

OPERATIONS LEADERSHIP

- Chief Operations Officer
- Chief Strategy Officer
- Chief Compliance Officer
- Chief Purchasing Officer
- VP/Director Operations Administration
- VP/Director of Compliance
- Chief Human Resources Officer
- VP/Director HR/People
- VP/Director Supply Chain/Purchasing

FINANCIAL LEADERSHIP

- Chief Financial Officer
- VP/Director Finance
- VP/Director Patient Financial Services
- VP/Director Revenue Cycle
- VP/Director Managed Care
- VP/Director Reimbursement
- VP/Director HIM

CLINICAL LEADERSHIP

- Chief Medical Officer
- Chief Nursing Officer
- Chief of Medical Specialty or Service Line
- VP/Director of Medical Specialty or Service Line
- VP/Director of Nursing
- Chief Population Health Officer
- Chief Quality Officer
- Medical Director
- VP/Director Ambulatory Services
- VP/Director Clinical Services
- VP/Director Quality
- VP/Director Patient Safety
- VP/Director Postacute Services
- VP/Director Behavioral Services
- VP/Director Medical Affairs/ Physician Management
- VP/Director Population Health
- VP/Director Case Management
- VP/Director Patient Engagement, Experience

MARKETING LEADERSHIP

- Chief Marketing Officer
- VP/Director Marketing
- VP/Director Business Development/Sales

IT LEADERSHIP

- Chief Information Technology Officer
- Chief Information Officer
- Chief Technology Officer
- Chief Medical Information Officer
- Chief Nursing Information Officer
- VP/Director IT/Technology
- VP/Director Informatics/Analytics
- VP/Director Data Security

TYPE OF ORGANIZATION

Base = 107

Hospital	36%
Health system (IDN/IDS)	23%
Physician organization (MSO/IPA/PHO/clinic)	21%
Ambulatory surgical center	5%
Skilled nursing facility/nursing homes	4%
Home health agency	3%
Convenient care/retail clinic (including retail pharmacies with clinics)	2%
Payer/health plan/insurer (HMO/PPO/MCO/PBM)	2%
Ancillary services provider (diagnostic/therapeutic/custodial)	2%
Urgent care center	1%
Hospice	1%
Inpatient rehabilitation facility	1%
Third-party administrator, pharmacy benefits manager	1%

NUMBER OF PHYSICIANS

Base = 107

1–9	10%
10–49	21%
50+	66%
N/A	3%

NUMBER OF BEDS

Base = 107

1–199	38%
200–499	13%
500+	20%
Do not have a standard number of beds	29%

PROFIT STATUS

Base = 107

For-profit	43%
Nonprofit	57%

NET PATIENT REVENUE

Base = 107

$1 billion or more (large)	18%
$250 million-$999.99 million (medium)	7%
$249.9 million or less (small)	63%
None of above	13%

RURAL STATUS

Base = 107

Yes	45%
No	55%

RESPONDENT REGIONS