# Top Tools to Assess & Mitigate Strategic Risk in an Era of Uncertainty

Jeffrey Sommer, Managing Director
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July 11, 2019

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# Agenda

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A Framework for Assessing Your Organization's Risk Profile

Sources of Strategic Risk

The Industry's Dynamic Risk Environment

Tools and Approaches for Mitigating Risk

# Board Functions and Blind Spots

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The fiduciary duties of *duty of care*, *duty of loyalty* and *duty of obedience* for not-for-profit boards should be applied to the primary functions below:

- Approving budgets, financial plans and financial statements; reviewing and approving material capital allocations and expenditures; ensuring the integrity of the organization's financial reporting and processes; hiring the independent auditor (if any) and assuring itself of the auditor's independence
- Selecting, monitoring, evaluating, compensating and, if necessary, replacing the CEO
- Ensuring compliance with all applicable laws, regulations, policies and ethical standards of the organization
- Establishing the composition of the board and its committees, and determining governance practices
- ***Defining, reevaluating and monitoring the long-term strategy by which the organization fulfills its mission***
- ***Understanding the organization's risk profile and reviewing and overseeing the organization's management of risks***

Source: The Guide to Not-for-Profit Governance, Weil, Gotshal & Manges LLP

# Do You Know Your Organization's Risk Profile?

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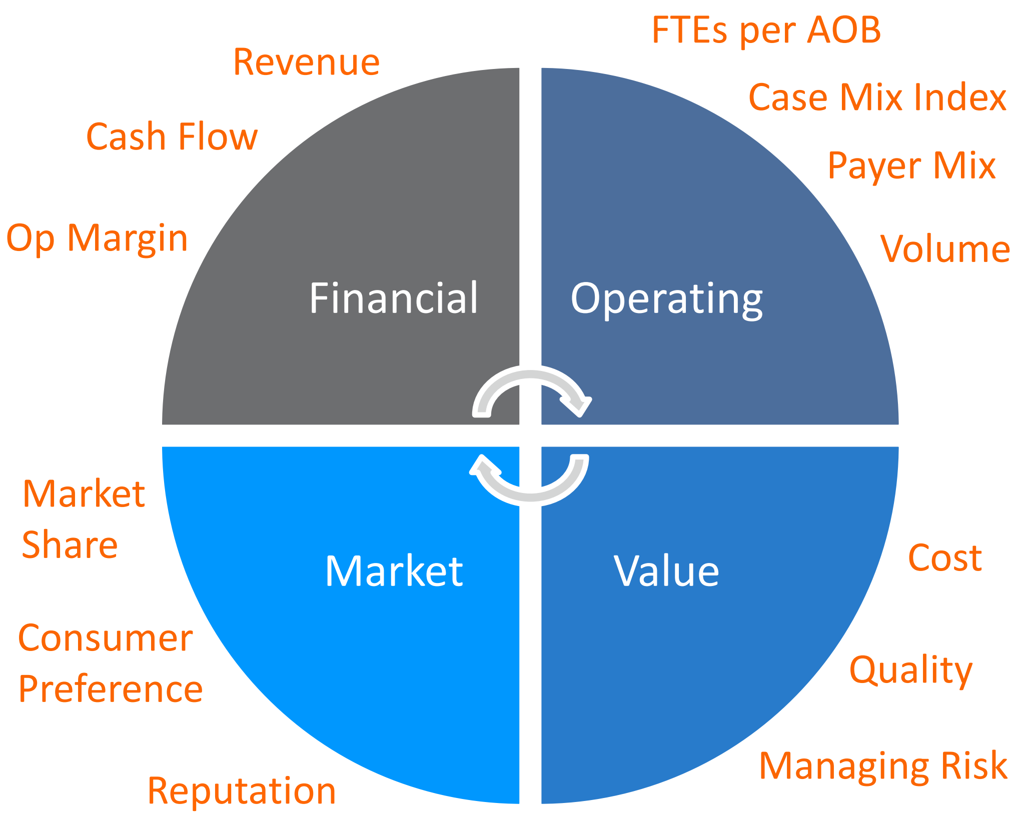


- The strategic risk profile for most hospitals and health systems is quite dynamic
- The four risk domains depicted to the left describe the major sources of strategic risk in today's environment
- Poor performance in one domain will have collateral or "spill over" effects on one or more of the other domains
- Key trends within each risk category should be monitored annually and long-term trends quantified

Boards may not appreciate the cumulative effects of changes in risk factors that can take place over several years.

# Understanding Strategic Risk

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## Maritime Disasters and Distressed Hospitals: What Every Board Should Know About Assessing Risk

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On September 30, 2015, the cargo ship *El Faro* left port in Jacksonville, Florida, bound for Puerto Rico and aware of Tropical Storm Joaquin and its projected path. The ship's captain, an experienced seaman, had charted a course that would allow *El Faro* to reach San Juan while maintaining a safe distance from Joaquin's destruction. With *El Faro's* owner approving that course, the ship and crew left port despite forecasts from the National Hurricane Center that Joaquin would develop into a hurricane the next day.

Twenty-six hours after setting sail, battered by the winds and seas created by Category 3 Hurricane Joaquin, *El Faro* sank off the coast of a Bahamian Island, losing her entire 33-person crew. As the ship's recorded bridge audio and other intelligence would later determine, a confluence of events—some within the captain's control and some beyond it—ultimately contributed to making this voyage one of the worst disasters in the modern history for the U.S. Merchant Marine. With the benefit of advanced weather forecasts, satellite imagery, and modern communications, it's easy to ask: how did a disaster like the *El Faro* happen?

With the swells increasing in size and frequency, *El Faro's* Captain was asked about altering course. "No, no, no. We're not gonna turn around."
*–El Faro Bridge Audio Recording*

Across the United States, hospital management teams and governing boards are facing their own gathering storm. Since 2010, approximately 190 hospitals across the country have closed. Similarly, and by these authors' count, approximately 85 hospitals have sought the protection of the U.S. bankruptcy courts since 2011. While the number of hospital closures and bankruptcies may seem small compared to the 4,862 community hospitals in the United States, the hospital industry has experienced fundamental structural changes that make closure or bankruptcy a risk that is now visible on the horizon for many hospitals.

**Table 1: Hospital Closures in the U.S.**

| 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|
| 15 | 18 | 23 | 26 | 41 | 37 | 27 |

*Hospital closures per year based on industry reporting and internal data*

Like the captain and crew of *El Faro*, many hospital management teams and governing boards are increasingly struggling just to keep their ships afloat, let alone make it safely to port. With hindsight, we can ask of a hospital that has closed, "Why didn't it change course, away from the threat, when it had time?" The speed of most cargo vessels and approaching storms provides ample time to gather new data, react, and change course. Yet the Captain and owners of the *El Faro* did not take steps to keep the ship and crew out of harm's way. Likewise, in most instances, hospitals that close or go bankrupt struggle for many years with deteriorating market position, poor operating results, and eroding balance sheets. We scratch our heads and ask, how could *El Faro* sail into harm's way without changing course? In a similar light, it's not difficult to ask of a now-defunct hospital, how did it progress from being a stable institution to a stressed, and

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American Health Lawyers Association, Transactions Conference, May 2017.

Strategic risk lurks in the background and can go unrecognized until it is too late.

The attached article employs the metaphor or a modern maritime tragedy, the El Faro disaster, to illustrate the important of proactive risk recognition and timely action to steer both ships and hospitals clear of disaster.

A risk assessment speaks to an organization's constraints and the inherent dynamic risk profile of the healthcare industry and every hospital's strategic and operating risk profile. It is a tool to facilitate board decision-making.

A common fact base on key industry trends provides important context for the Board.

# Key Takeaways

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- The *El Faro* did not have to be at the center of a category III hurricane
- In a little less than two hours, the El Faro crew went from riding out an avoidable hurricane to abandoning ship with the loss of the ship and entire crew
- An accurate assessment of the risks involved and early action - delaying or detouring the voyage - would have kept the ship out of harm’s way
- Ultimately, human judgment and flawed assessment of risk was the most critical factor in this tragedy
- For hospitals, early action is essential to keep your organization out of harms way
- If you wait until everyone around the board table agrees that the situation is dire, you have waited too long
- Quantifying how your risk profile is evolving year-to-year and over multiple years is critical to appreciating relative risk and taking timely action

# INDUSTRY TRENDS

# Industry Overview: Disruptive Trends

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### Affordable Care Act
- More insured
- Reduced FFS price (relative to costs)
- Accountable care payment models

### MACRA
- Reduced FFS payment to physicians
- Value based incentives (MIPS)

### High Deductible Health Plans
- Increased focus on value with patients becoming consumers
- Value = Quality/Cost

### Underinsurance
- Increased bad debt/charity care

### Recovery Audit Contractors (RAC)
- Focus on reducing short stay inpatient admissions

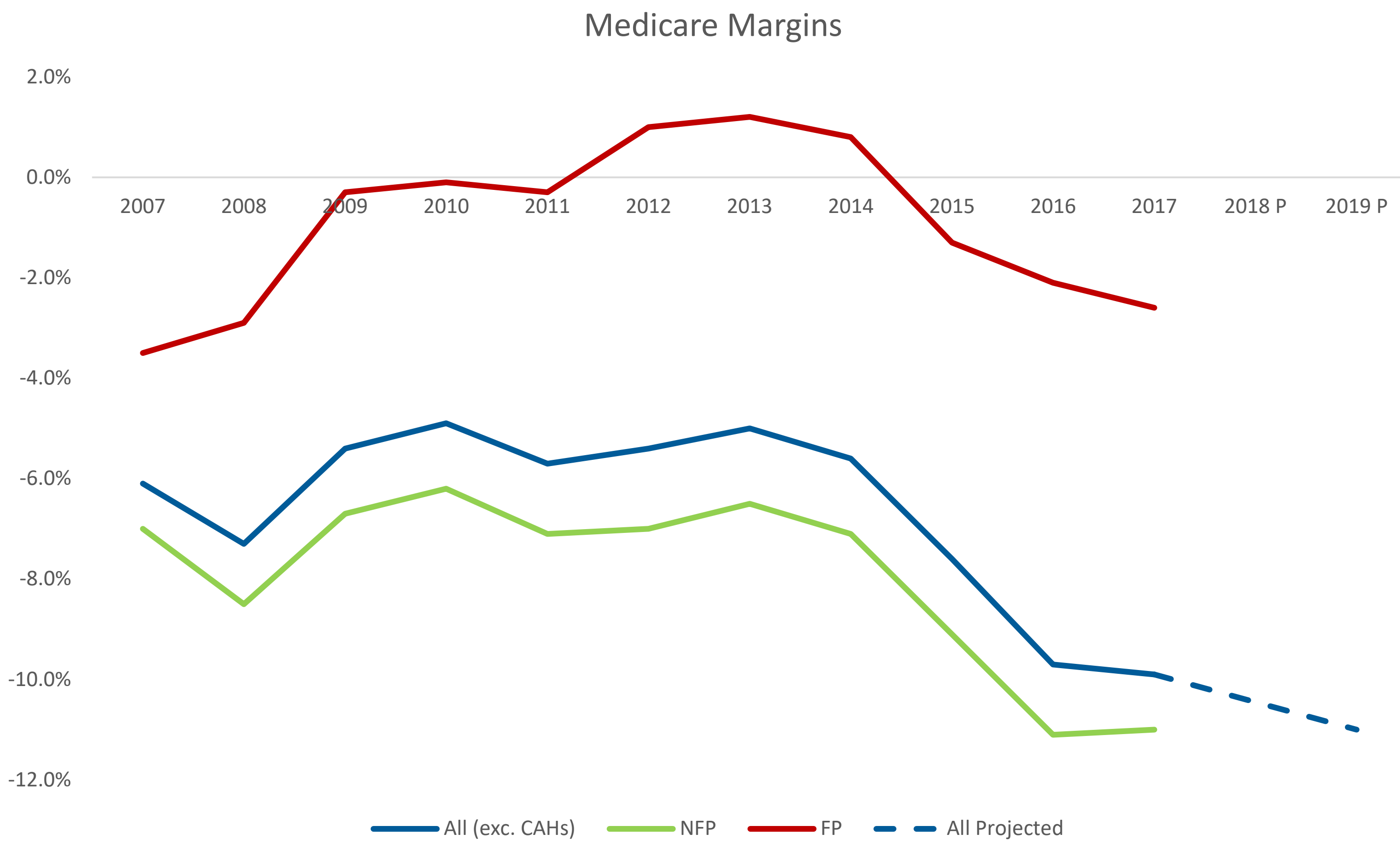
### Reduced Re-admissions
- Result of Value Based Payment program

### Accelerating shift to outpatient care
- Transition from traditional inpatient focused hospital care to outpatient care

### Market Consolidation and New Entrants
- Aetna/CVS
- Walmart/Humana
- Haven (Amazon/Berkshire/JP Morgan)

### Consumerism
- Retail mindset
- Convenience
- Transparent pricing

# Fee-For-Service Financial Model – Results




Medicare margins are expected to decline due to a tightening labor market and other sources of cost inflation projected to outpace growth in payment rates.

*Private commercial insurers are also applying pressure to control and limit growth in reimbursement.*

Source: MedPac Annual Report to Congress, March 2019

# Growth of High Deductible Plans

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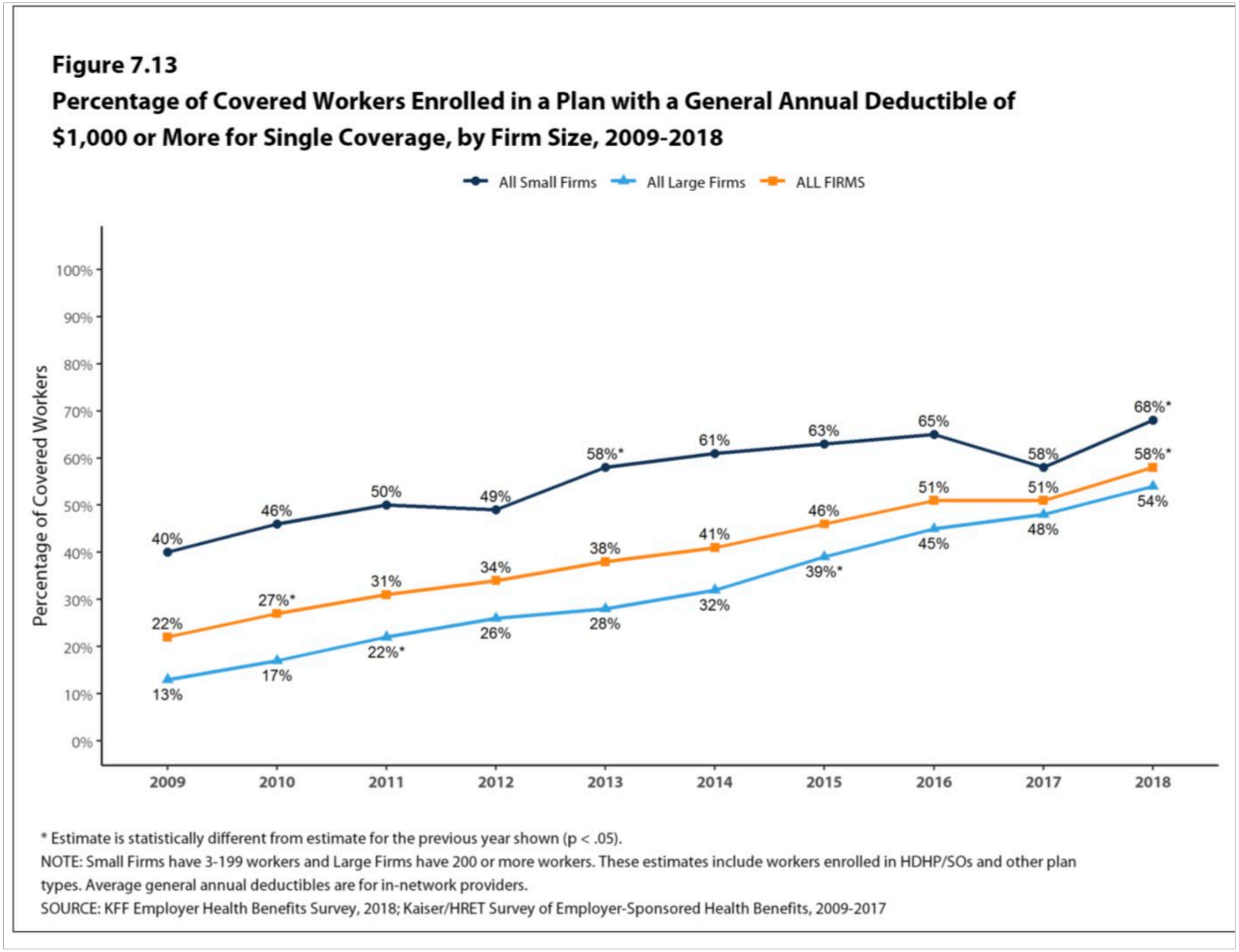


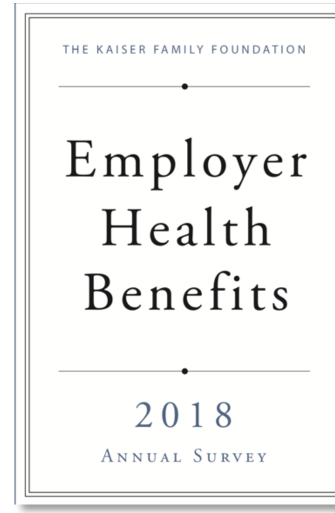


*Growth in high deductible health plans places increased pressure on patients / consumers and requires providers to start competing on cost and enhancing business operations to reduce financial exposure.*

# Market Overview – Results



## United States & New York Admissions per 1000


**Utilization Metric**
- Admissions per 1000
- ER Visits per 1000
- IP Days per 1000
- OP Visits per 1000

**State**
Multiple values

*Reduced demand for inpatient services leaves hospitals with large, fixed assets that must be reconfigured to provide outpatient care.*

**Source:KFF.org**
**Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.**

**axis not at zero**

# Moody’s Issues Negative Outlook for Nonprofit Hospitals in 2019

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- Moody's Investors Service has issued a negative outlook on the nonprofit healthcare and hospital sector for 2019, reflecting Moody's expectation that **operating cash flow in the sector will be flat or decline and bad debt will rise**
- Moody’s predicts **operating cash flow will either remain flat or decline by up to 1 percent in 2019**, depending how well hospitals manage expense growth
  - The agency expects cost-cutting measures and lower increases in drug prices to cause expense growth to slow, but said **expenses will still outpace revenues** due to several factors, including the ongoing need for temporary nurses and continued recruitment of employed physicians
- Hospital **bad debt is expected to grow 8 to 9 percent in 2019** as health plans place greater financial burden on patients

MOODY’S INVESTORS SERVICE

Source: Becker’s Hospital Review, *Outlook is negative for nonprofit hospital sector, Moody's says,* Ayla Ellison, 12/5/18
https://www.beckershospitalreview.com/finance/outlook-is-negative-for-nonprofit-hospital-sector-moody-s-says.html

# The Risks Are Real: Hospital Closures

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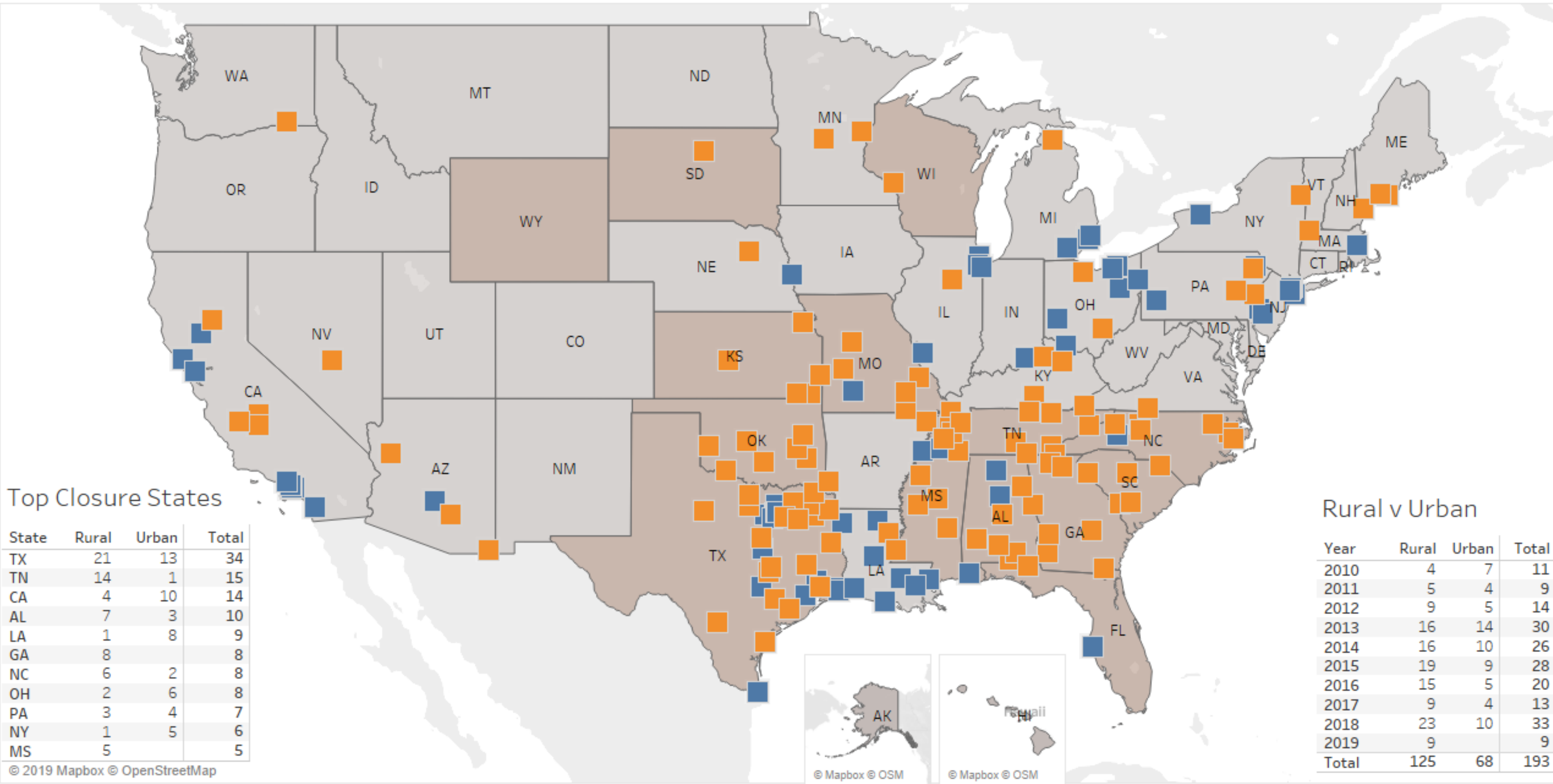
Rural and Urban Hospital Closures since 2010




Top Closure States

| State | Rural | Urban | Total |
|---|---|---|---|
| TX | 21 | 13 | 34 |
| TN | 14 | 1 | 15 |
| CA | 4 | 10 | 14 |
| AL | 7 | 3 | 10 |
| LA | 1 | 8 | 9 |
| GA | 8 | | 8 |
| NC | 6 | 2 | 8 |
| OH | 2 | 6 | 8 |
| PA | 3 | 4 | 7 |
| NY | 1 | 5 | 6 |
| MS | 5 | | 5 |

Rural v Urban

| Year | Rural | Urban | Total |
|---|---|---|---|
| 2010 | 4 | 7 | 11 |
| 2011 | 5 | 4 | 9 |
| 2012 | 9 | 5 | 14 |
| 2013 | 16 | 14 | 30 |
| 2014 | 16 | 10 | 26 |
| 2015 | 19 | 9 | 28 |
| 2016 | 15 | 5 | 20 |
| 2017 | 9 | 4 | 13 |
| 2018 | 23 | 10 | 33 |
| 2019 | 9 | | 9 |
| Total | 125 | 68 | 193 |

**Current Status of Medicaid Expansion Decision**

- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

**Rural v Urban**

- Rural
- Urban

Rural v Urban based on cost report designation

Sources: Cost Report data, The Cecil G. Sheps Center for Health Services Research, KFF.org (Updated 6/4/2019)

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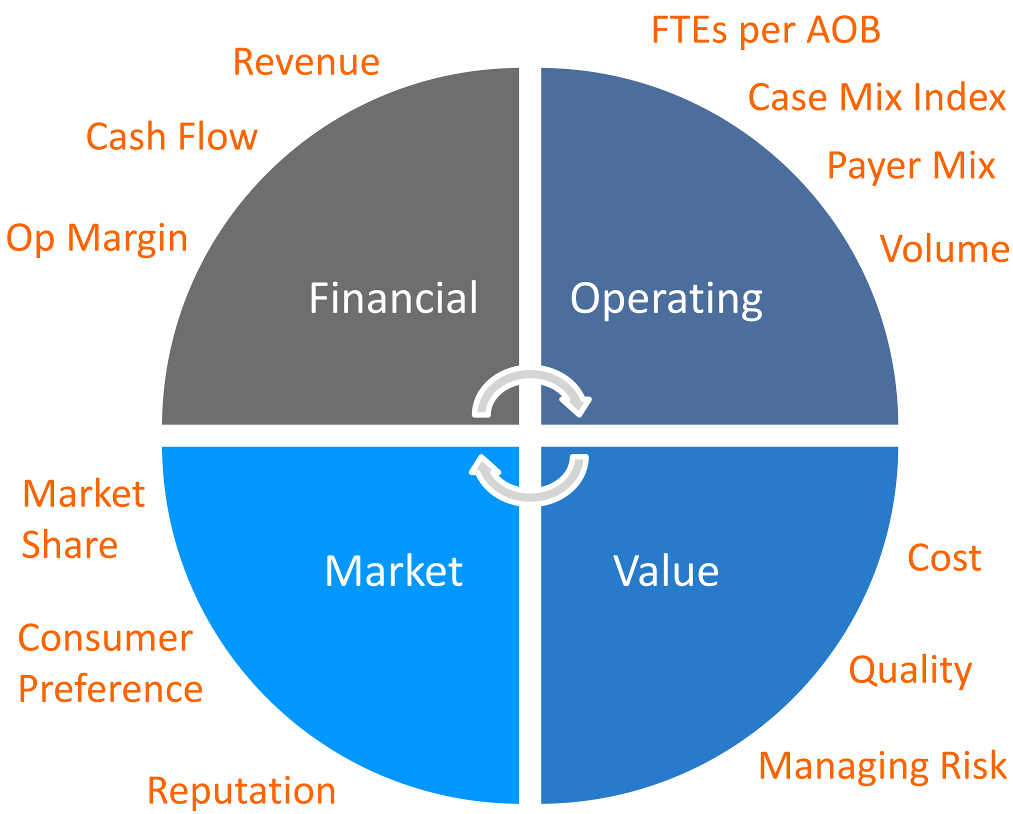
The map above shows closures – it does not show those hospitals that have had to curtail operations or mission driven activities or been forced into bankruptcy.

# RISK INDICATORS

# Evaluating & Mitigating Strategic Risk

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# Financial Risk:
# Operating EBIDA in a Strategic Context

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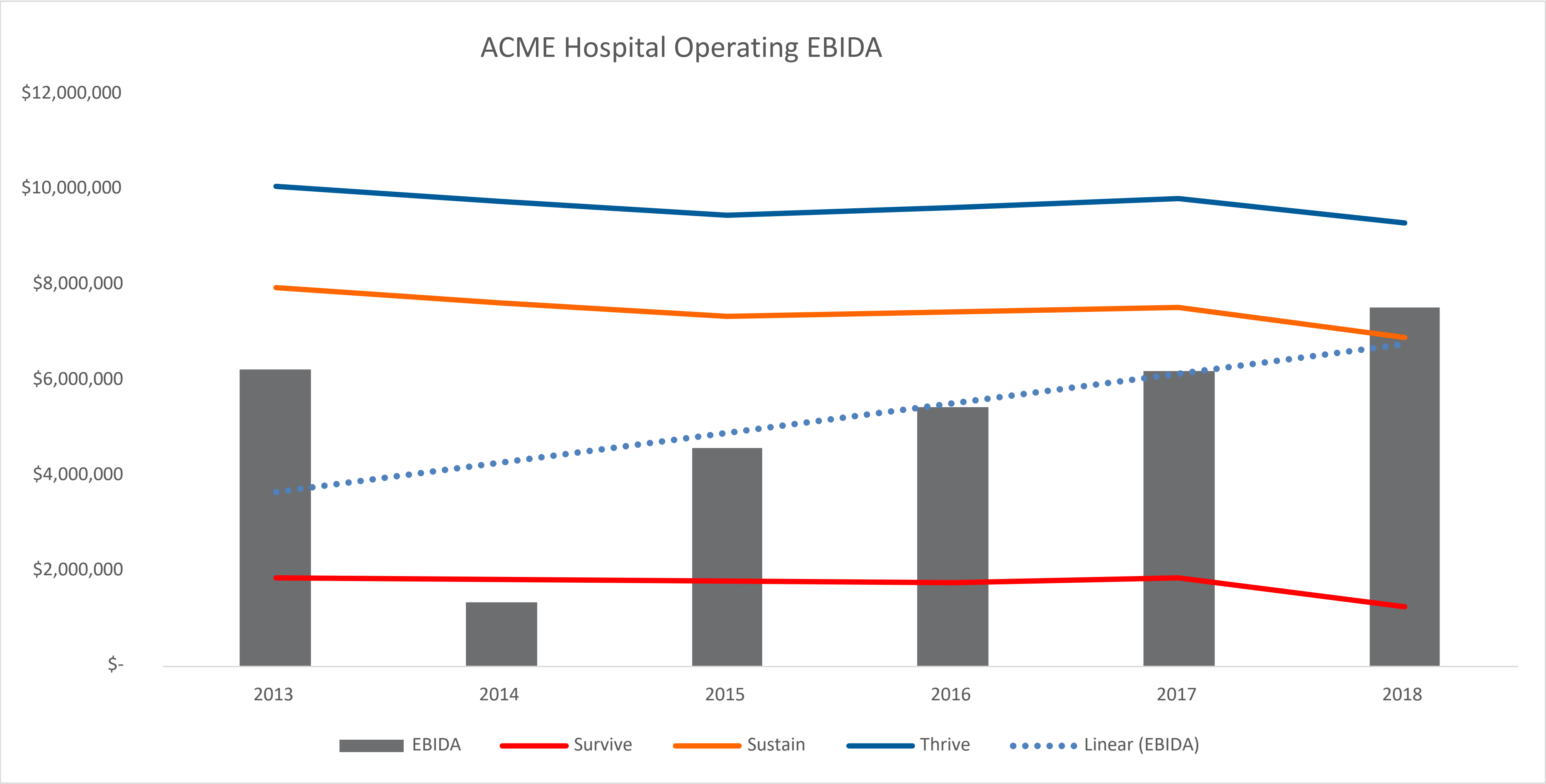


EBIDA = Thrive: 4.0% of operating expenses + 120% of depreciation expense + debt service

EBIDA = Sustain: 120% of depreciation expense + debt service

EBIDA = Survive: debt service

# Value Risk: HCAHPS Results

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Compared to its regional competitors, ACME Hospital has the highest quality scores in 5 out of 10 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) categories, and scores above the national average in all 10.
***ACME Hospital is the leading hospital in the region in terms of quality and patient experience.**

Data from March 2019

Highest
>= National
< National
Lowest

Colors are compared to selected peers for Highest and Lowest, then compared to the National % benchmark. It is possible to be the lowest among peers, but above the selected benchmark.

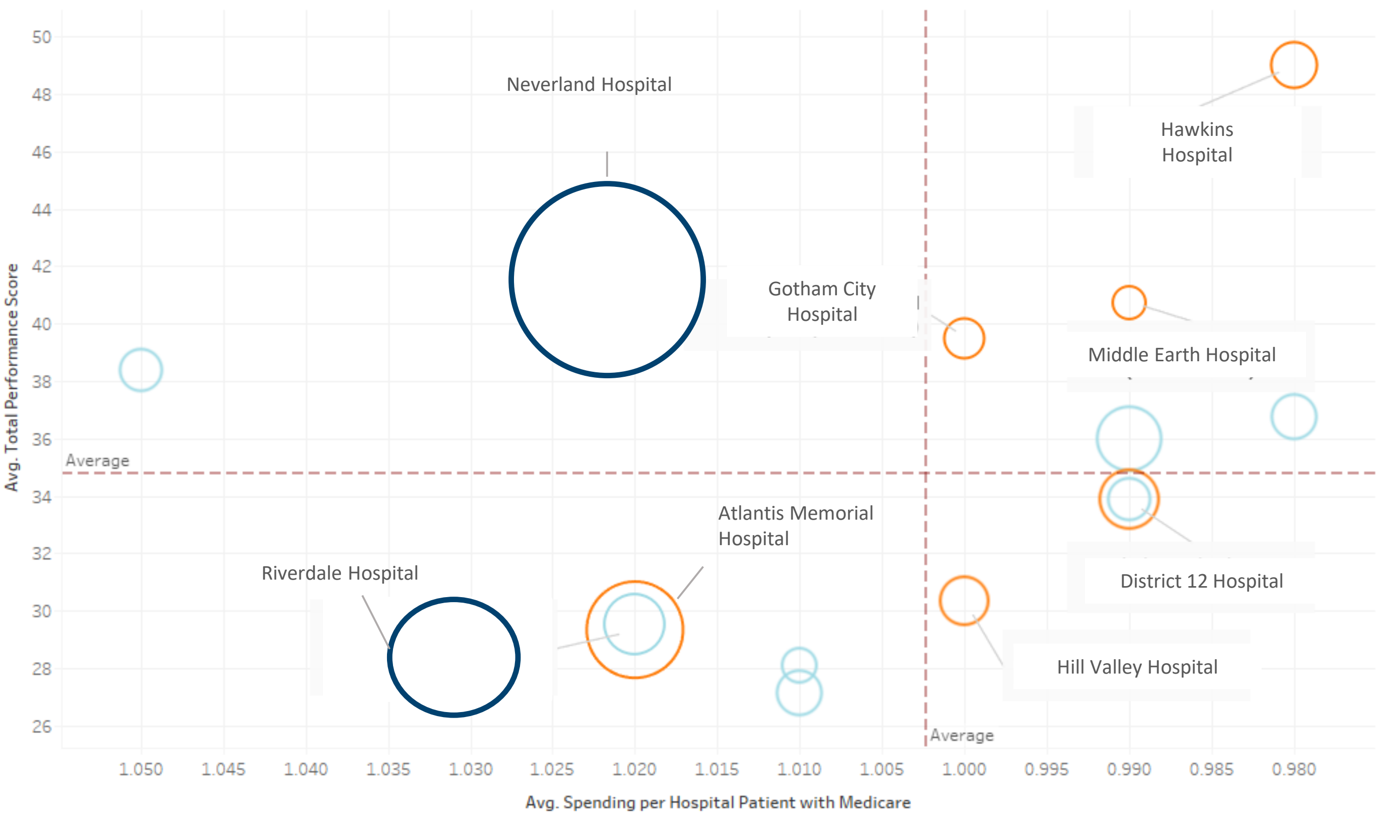
| HCAHPS Question | National% | NH | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Summary Star Rating | | | ★★★ | ★★★★ | ★★★★ | ★★★ | ★★★★ | ★★★ | ★★★★ |
| Patients who reported that their nurses "Always" communicated well | 80% | 81% | 80% | 84% | 85% | 79% | 81% | 76% | 86% |
| Patients who reported that their doctors "Always" communicated well | 81% | 82% | 80% | 85% | 89% | 80% | 80% | 76% | 83% |
| Patients who reported that they "Always" received help as soon as they wanted | 70% | 70% | 60% | 75% | 76% | 63% | 72% | 62% | 67% |
| Patients who reported that staff "Always" explained about medicines before giving it to them | 66% | 66% | 61% | 63% | 71% | 61% | 65% | 63% | 70% |
| Patients who reported that their room and bathroom were "Always" clean | 75% | 77% | 67% | 83% | 78% | 71% | 67% | 72% | 84% |
| Patients who reported that the area around their room was "Always" quiet at night | 62% | 55% | 44% | 64% | 67% | 57% | 40% | 55% | 60% |
| Patients who reported that YES, they were given information about what to do during their recovery at home | 87% | 89% | 88% | 92% | 89% | 89% | 90% | 88% | 93% |
| Patients who "Strongly Agree" they understood their care when they left the hospital | 53% | 55% | 54% | 58% | 59% | 51% | 54% | 54% | 59% |
| Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) | 73% | 73% | 72% | 79% | 81% | 65% | 75% | 68% | 83% |
| Patients who reported YES, they would definitely recommend the hospital | 72% | 73% | 76% | 75% | 78% | 63% | 81% | 71% | 83% |

Source: http://data.medicare.gov/OData.svc/dgck-syfz

# Value: Cost-Quality Matrix

## Cost-Quality Comparison

StateQvC: NH




KEY

| | |
|---|---|
| High Quality/ High Cost | High Quality/ Low Cost |
| Low Quality/ High Cost | Low Quality/ Low Cost |

The value comparison of hospitals is based on CMS Total Performance Score (TPS) and the ratio of Medicare Spending Per Patient for each facility.

The TPS scores are based on the most recent data available from CMS.

The Medicare Spending Per Patient "Efficiency Index" ratio shows whether Medicare spends more, less or about the same per Medicare patient treated in a specific hospital, compared to how much Medicare spends per patient nationally.

The source of these data is CMS.

Note: Only hospitals with both measures are included in the comparison. The size of the mark is relative to the net patient revenue at each hospital, based on the most recent cost report filing.

Source: CMS
Net Patient Revenue as of FY 2017

# Market Risk: Market Share in Primary Service Area

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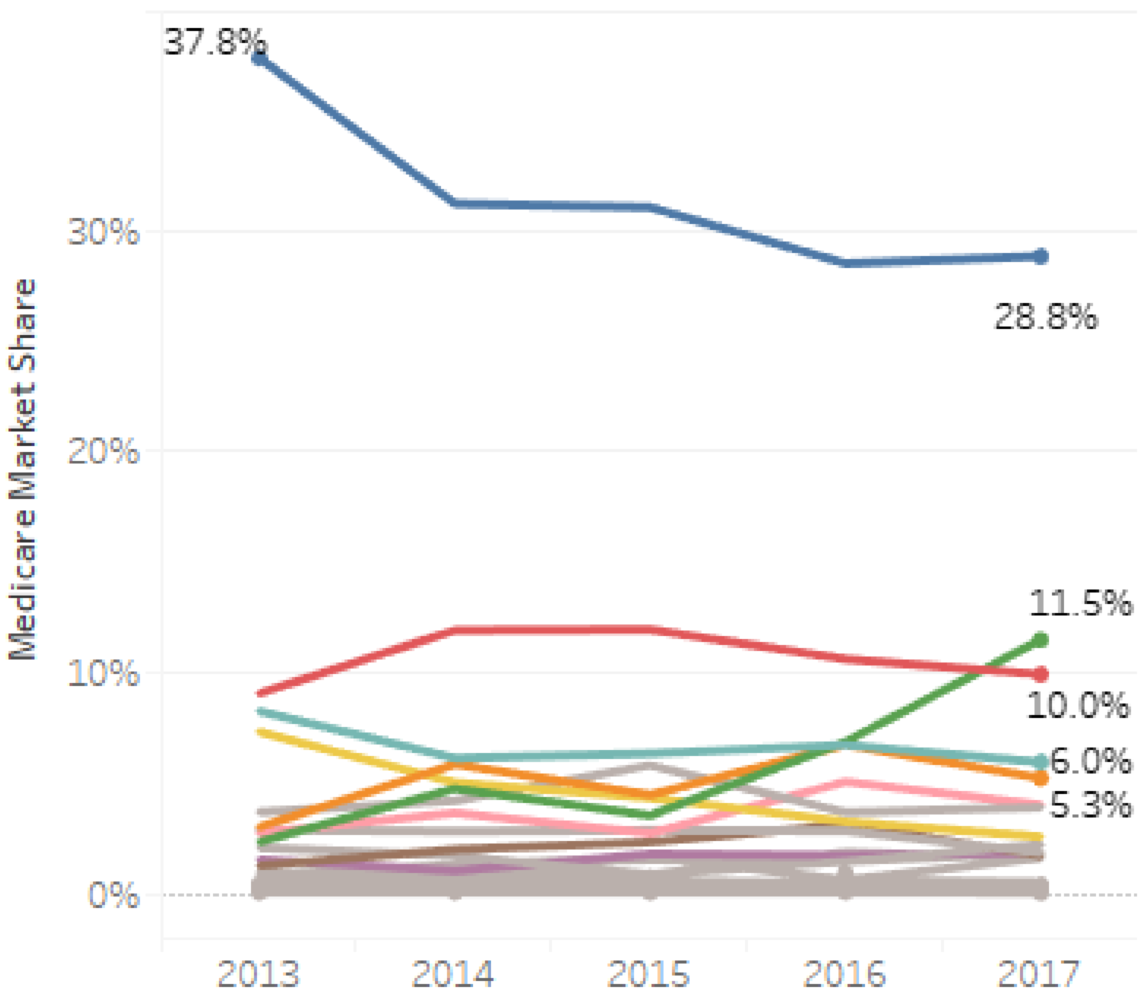


ACME Hospital has experienced a decrease in Inpatient Medicare market share since 2013 with a recent reverse of the downward trend.

Competitor A has capitalized with significant market share gains in ACME's service area.

With the Competitor A is purchasing another area hospital, the risks posed by the Competitor A's market share trend increase for ACME Hospital.

Source: Truven Health Analytics

# Risk: Signs of Distress

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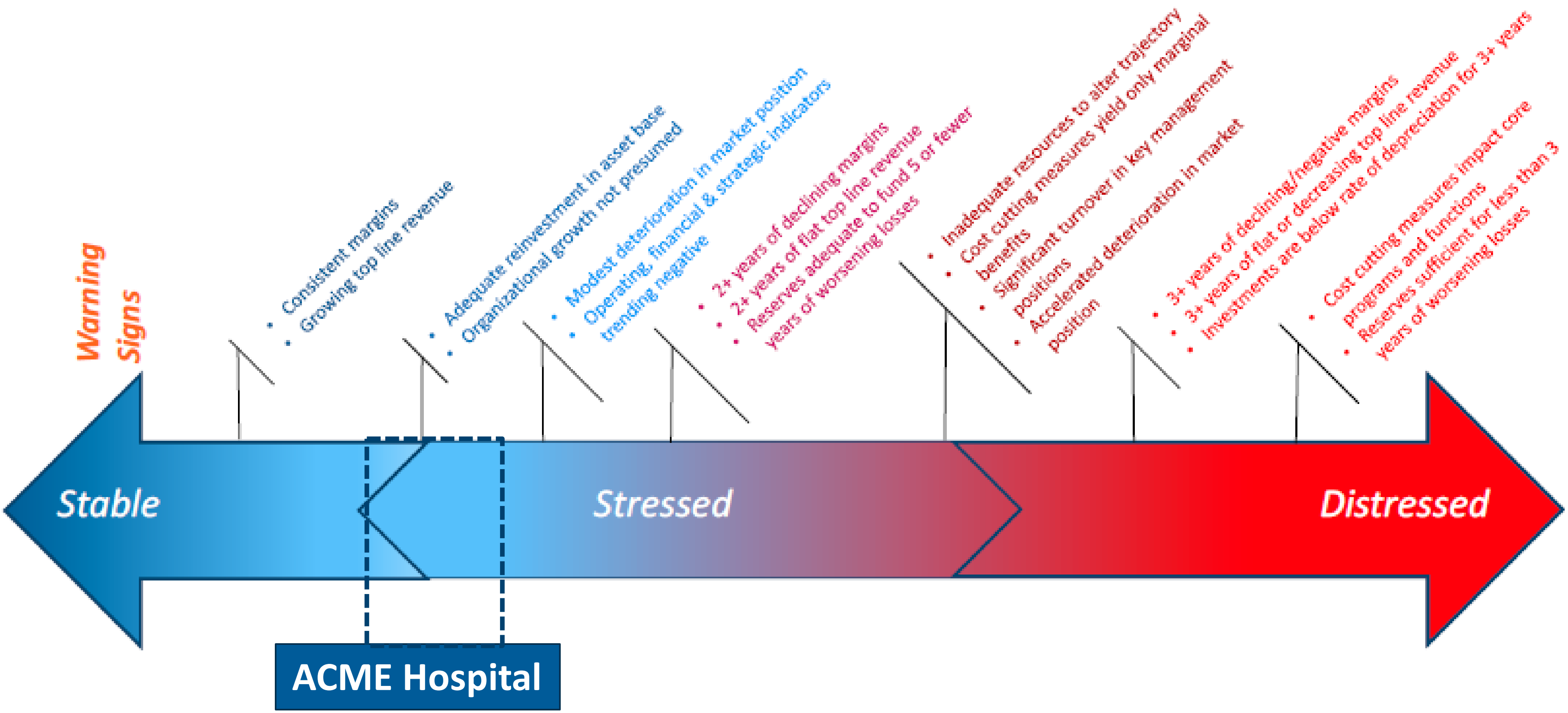


*"Sometimes circumstances overwhelm you. You can do all the planning you want."*

Steven Werse, Ship Captain & Secretary-Treasurer of the Master Mates and Pilots Union

# Stable to Stressed to Distressed

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| Status | ACME | +/- | Indicator |
|---|---|---|---|
| Stable | No | + | Consistent Positive Margins |
| | Yes | + | Growing Top Line Revenue |
| | Yes | + | Adequate Reinvestment in Asset Base |
| Stressed | Yes | - | Organizational Growth Not Presumed |
| | Yes | - | Modest Deterioration in Market Position |
| | No | - | Operating, Financial and Strategic Indicators Trend Negative |
| | No | - | 2+ Years of Declining Margins |
| | No | - | 2+ Years of Flat Top Line Revenue |
| Distressed | No | - | Reserves Adequate to Fund 5 or Fewer Years of Worsening Losses |
| | No | - | Inadequate Resources to Alter Trajectory |
| | No | - | Cost Cutting Measures Yield Only Marginal Benefits |
| | No | - | Significant Turnover in Key Management Positions |
| | No | - | Accelerated Deterioration in Market Position |
| Very Distressed | No | - | 3+ years of Declining/Negative Margins |
| | No | - | 3+ years of Flat or Decreasing Top Line Revenue |
| | No | - | Investments are Below the Rate of Deprecation for 3+ Years |
| | No | - | Cost Cutting Measures Impact Core Programs and Functions |
| | No | - | Reserves Sufficient for Less than 3 Years of Worsening Losses |

Using the framework presented in Stroudwater's 2017 AHLA article, we find ACME to be "stable" but with several warning signs regarding "stress".

Key risks are the deterioration in market position and sustaining the margins seen in 2017 and 2018.

# Evaluating & Mitigating Strategic Risk

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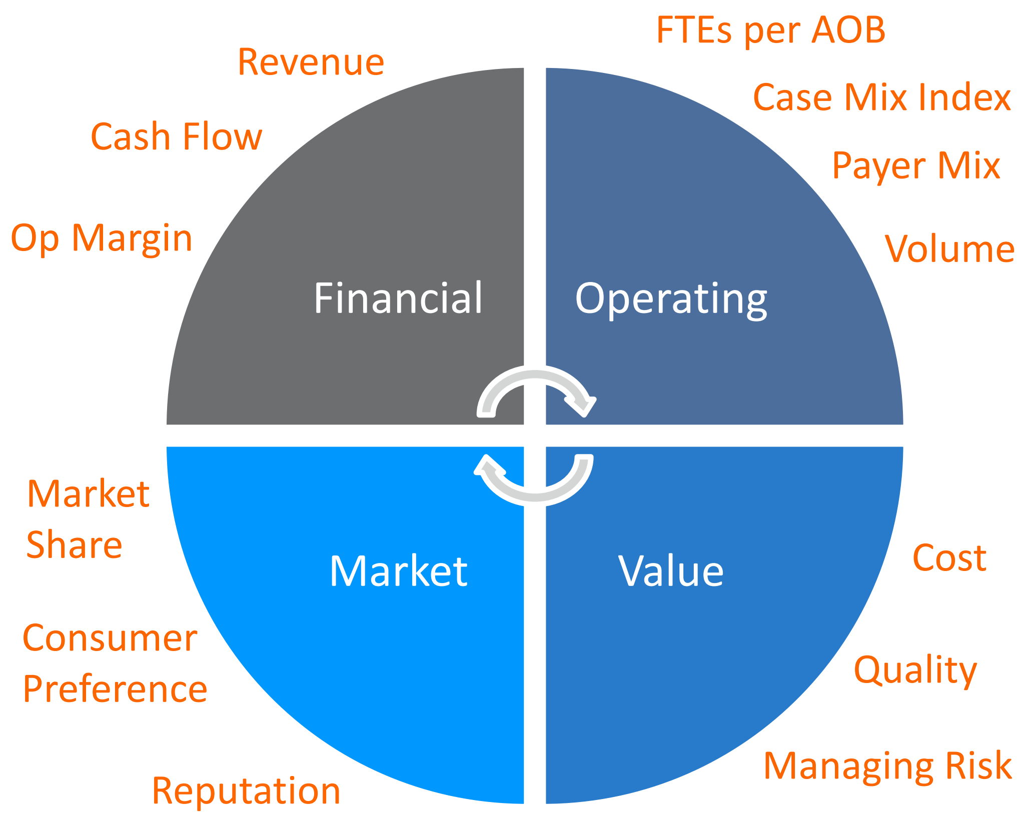


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# ACME Strategic Risk Score: 0.65

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| Category | Indicators | Risk | Comments |
|---|---|---|---|
| Financial Risk Indicators | • Operating Revenue Trend<br>• Operating Cash Flow & Cash Flow Margin<br>• Debt Service Coverage<br>• Operating Margin<br>• Days Cash on Hand<br>• Days in A/R<br>• Scale | +<br>+<br>+<br>+<br>+<br>+<br>- | • **Score: 0.87 out of 1.0 – Stable/Modest Risk**<br>• Top line revenue growth is vital to long term health of organization<br>• Operating Cash Flow & Cash Flow Margin are critical for DSCR covenant and investment |
| Operating Risk Indicators | • FTEs per AOB<br>• Case Mix Index<br>• Payer Mix<br>• Key Volume Trends (O/P and I/P)<br>• Practice Operations, Production and Losses<br>• Revenue and Cost per Adjusted Patient Day<br>• Scale | -<br>+<br>+<br>+/-<br>+/-<br>+/-<br>- | • **Score: 0.54 / 1.0 – Stressed/Elevated Risk**<br>• FTEs per AOB key efficiency metrics<br>• Payer mix and CMI indicate how well the organization is competing for sought after patient populations |
| Value Risk Indicators | • Cost Position<br>• Aligned Primary Care Base & Patient Panels<br>• Quality Scores<br>• Performance at Managing Risk for ERISA, ACO and other Population Health Vehicles<br>• Retail Pricing and Charge Variability | +/-<br>+<br>+<br>+/-<br>- | • **Score: 0.64 out of 1.0 – Stressed/Elevated Risk**<br>• Covered lives reflect key population health metric and move from fee for service<br>• What is the organization’s ability to manage the health status of populations |
| Market Risk Indicators | • Market Share Trends<br>• Provider Alignment, Recruitment and Retention (vs. documented need; turnover, productivity)<br>• Consumer Preference Research | -<br>+/-<br>+ | • **Score: 0.53 out of 1.0 – Stressed/Elevated Risk**<br>• Market share indicates how well the hospital is competing for patients and covered lives<br>• Provider alignment is essential for attribution of covered lives |

# Strategic Risk Monitor: Results

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**Hospital/Health System Strategic Risk Bands:**

- 0.80-1.0 – **Stable/Modest Risk**
- 0.65-0.79 – **Stressed/Moderate Risk**
- 0.50-0.64 – **Stressed/Elevated Risk**
- 0.30-0.49 – **Distressed/High Risk**
- 0.00-0.29 – **Very Distressed/Extreme Risk**

- ACME Hospital has a Stable/Modest Risk profile in one of the four risk quadrants: financial. ACME's lack of scale is the primary source of risk in the financial quadrant.
- ACME Hospital has a Stressed/Elevated Risk profile in the remaining three quadrants due to mixed results on key performance metrics.
- Overall, ACME hospital received a Stressed/Moderate Risk score of 0.65 due to greater risk on operating, market and value-based risk factors. ACME is at the low end of the Moderate Risk band and needs to be vigilant for erosion of its current risk profile.

# RISK MITIGATION

# Time Is Never a Neutral Factor

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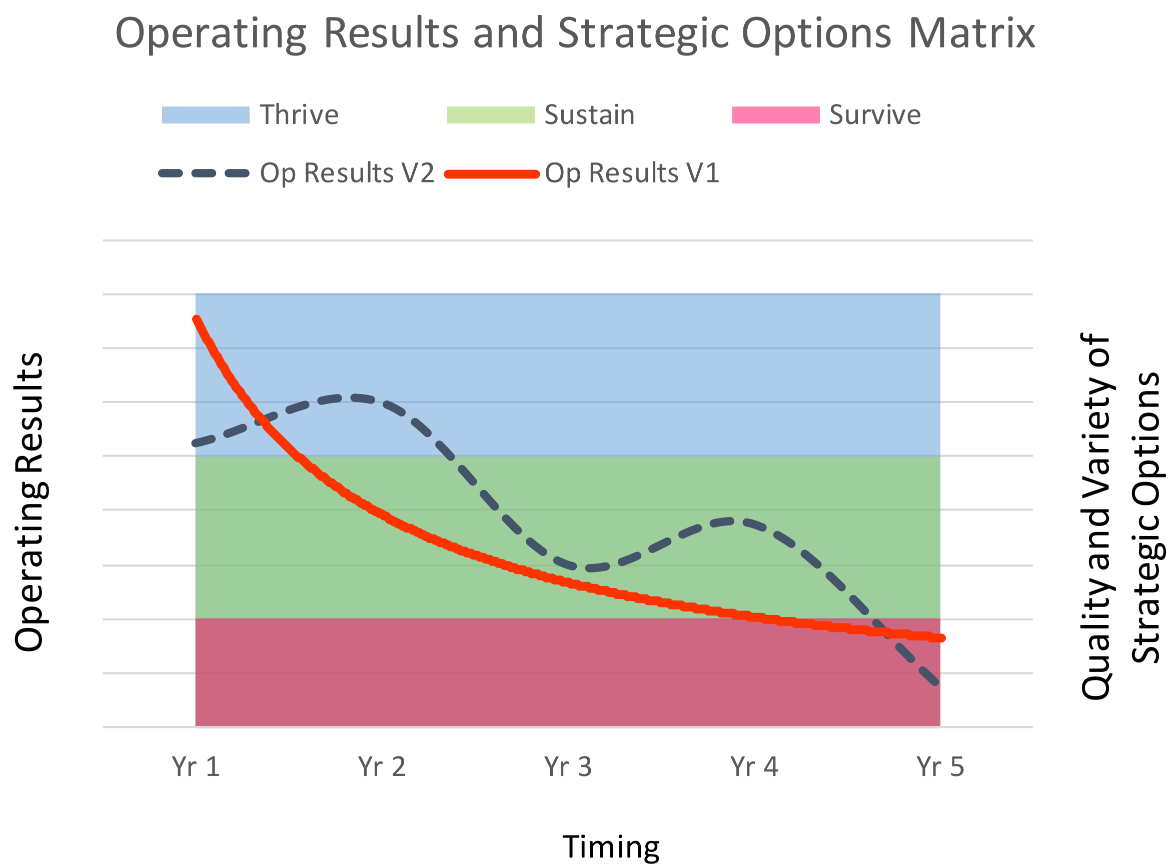


The Effects of Timing

- Variability in operating results
- Market specific developments (market position, competitor moves)
- Industry-wide developments (federal budget and reform initiatives)

# Every Strategic Option Has Inherent Risk

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"What is the best strategy to achieve our mission and vision?"

Independence vs. Affiliation/Partnership


**How do you minimize Operating Risk?**

- **Accountability** around strategic objectives between the board, the management team and the medical staff
- Maintain annual **operating cash flows** at least equal to debt service plus 120% of depreciation expense
- Invest in a **robust primary care / aligned provider base**
- Achieve required **value** metrics re: quality and cost and selectively assume risk
- Invest in a distributed and efficient **ambulatory network**

**How do you minimize Partner Risk?**

- Design a well-structured affiliation process with **clear objectives**
- Select a **strategically aligned partner**
- Vet alternative **affiliation structures** for fit with our strategic objectives
- Negotiate **Contractually enforceable key terms**
- Involve key stakeholders from the beginning and emphasize communication
- **Make candidates earn the right to be your partner**

# Evaluating & Mitigating Strategic Risk

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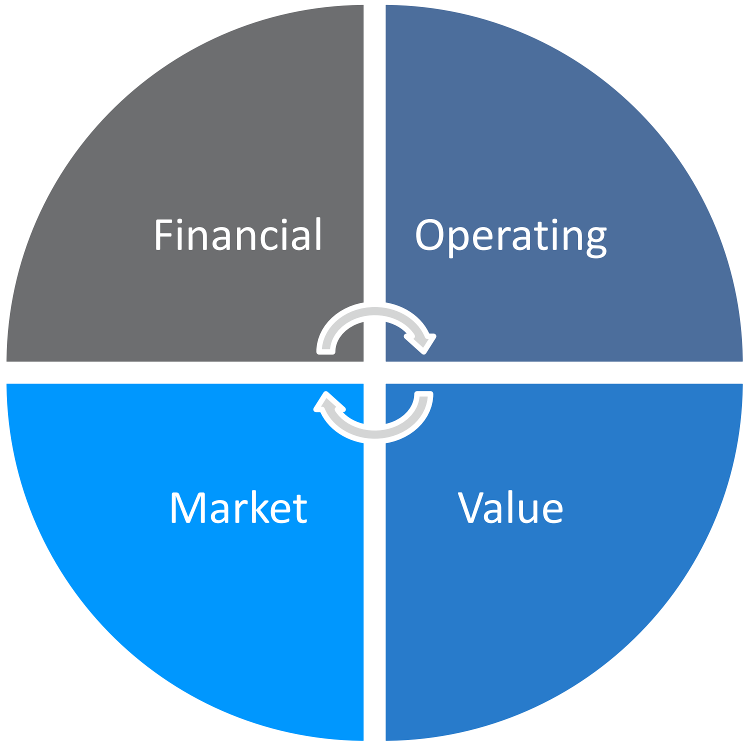
- Define “gaps” in performance
- Develop budget consistent with “sustain” threshold
- Quantify cash “run rate”
- Examine five-year trends at least annually




- Demand-Based Staffing tools
- Provider practice operations improvement
- Revenue cycle and coding
- Cost report reviews (CAHs)
- Practice / clinic designations
- Process redesign
- Supply chain & purchasing

- Identify growth opportunities
- Invest in aligned provider base
- Develop ambulatory network
- Address industry disruptors
- Implement retail pricing, access strategy
- Direct contracting

- Annual payor contract reviews
- Contracting strategy re: payor products and value-based models
- Value-based payment strategy
- Self-Insured population tools
- Medicare Advantage products
- Define need for payor and provider partners
- Manage total cost of care
- Address industry disruptors

Boards may not appreciate the cumulative effects of changes in risk factors that can take place over several years.

# Monitoring & Mitigating Organizational Risk

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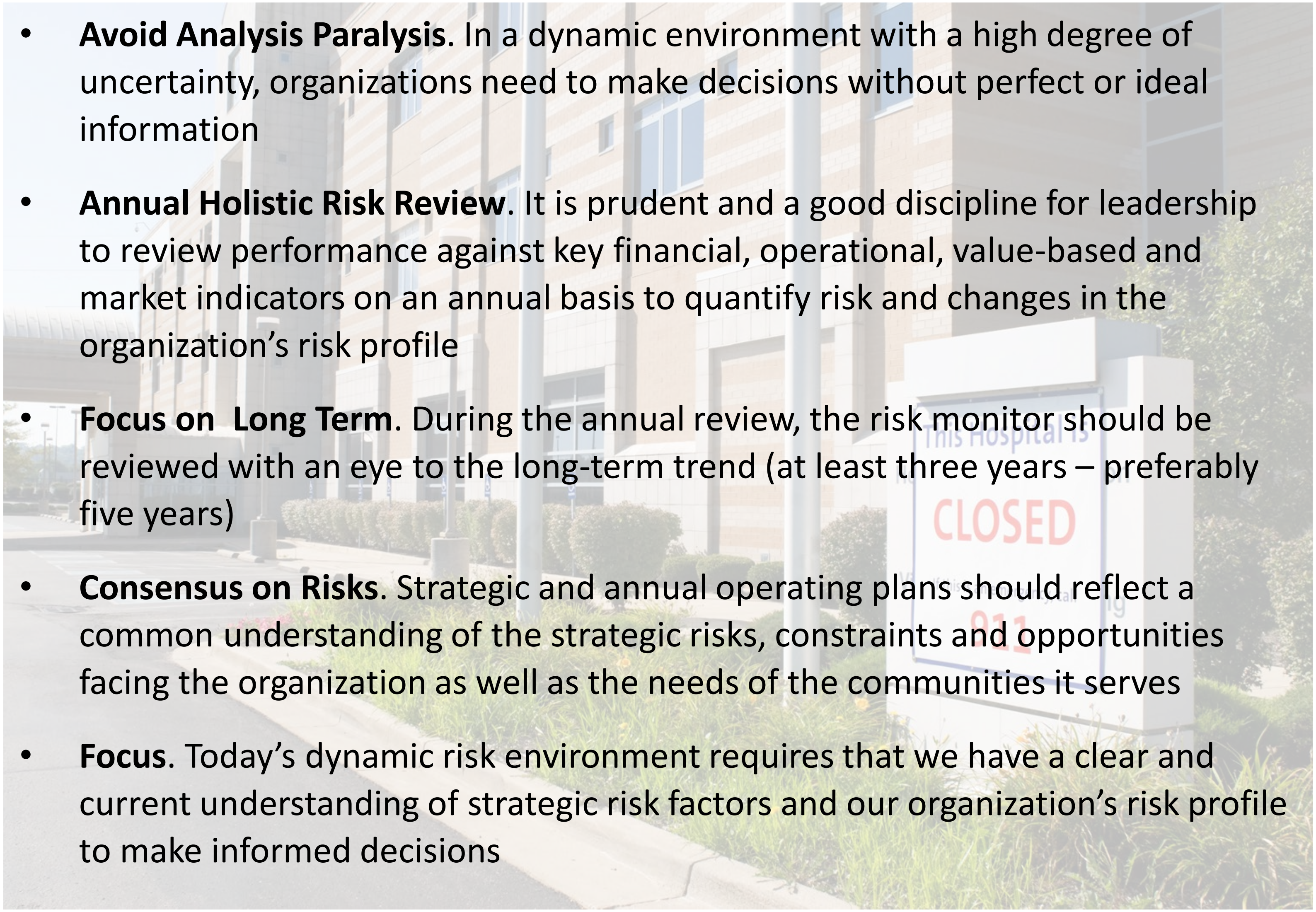


- **Avoid Analysis Paralysis**. In a dynamic environment with a high degree of uncertainty, organizations need to make decisions without perfect or ideal information
- **Annual Holistic Risk Review**. It is prudent and a good discipline for leadership to review performance against key financial, operational, value-based and market indicators on an annual basis to quantify risk and changes in the organization’s risk profile
- **Focus on Long Term**. During the annual review, the risk monitor should be reviewed with an eye to the long-term trend (at least three years – preferably five years)
- **Consensus on Risks**. Strategic and annual operating plans should reflect a common understanding of the strategic risks, constraints and opportunities facing the organization as well as the needs of the communities it serves
- **Focus**. Today’s dynamic risk environment requires that we have a clear and current understanding of strategic risk factors and our organization’s risk profile to make informed decisions

# Questions & Thank You



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# APPENDIX:
# THE *EL FARO* DISASTER

# El Faro Disaster: October 1, 2015

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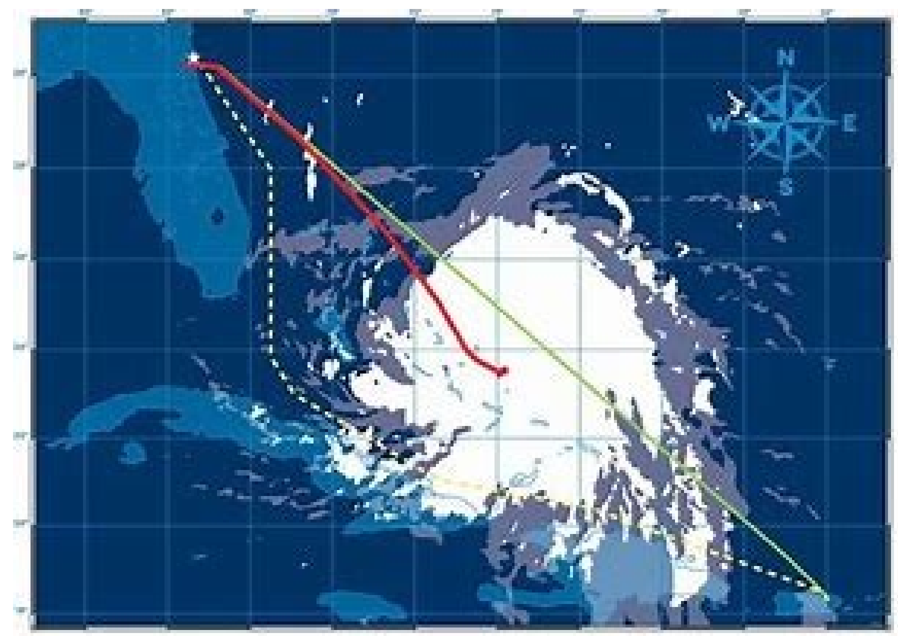
Around 7:30 a.m. on October 1, the ship had taken on water and was listing 15 degrees. Shortly thereafter, *El Faro* ceased all communications with shore.

USCG investigators placed nearly all of the responsibility on *El Faro*'s captain for underestimated the strength of the storm and not taking enough measures to avoid the storm. NTSB criticized the Coast Guard's practices of grandfathering in vessels, exempting them from using closed lifeboats. El Faro's owner also failed to maintain a superannuated and deteriorating vessel.

*El Faro* departed Jacksonville, Florida, bound for Puerto Rico at 8:10 pm EST on September 29, 2015, when then-Tropical Storm Joaquin was several hundred miles to the east. Two days later, after Joaquin had become a Category 3 hurricane, the vessel likely encountered swells of 20 to 40 ft and winds over 80 kn (92 mph) as it sailed near the storm's eye.



# October 1: The Situation Deteriorates Quickly

STROUDWATER

0:00 • At 5:43 am, the captain takes a phone call indicating suspected flooding in the no. 3 cargo hold and sends the chief mate to investigate.

0:30 • At 6:13 am, the ship loses its steam propulsion plant.

1:23 • At 7:06 am, the captain makes a phone call: "I have a marine emergency. We have water down in three hold. We have a heavy list. We've lost the main propulsion unit. The engineers can not get it goin'… The crew is safe. Right now we're trying to save the ship …"

1:32 • At 7:15 am, the chief mate returns to the bridge: Chief mate: "I think that the water level's rising, Captain."

1:41 • At 7:24 am, the captain, speaking with a crew member on the phone, says, "We still got reserve buoyancy and stability."

1:46 • At 7:29 am, the captain gives the order to abandon ship, and about a minute later can be heard on the bridge calling out, "Bow is down, bow is down."

1:48 • At 7:31 am, the captain yells over the UHF radio for the chief mate to "Get into your rafts! Throw all your rafts into the water! Everybody get off! Get off the ship! Stay together!"

1:56 • At 7:39 am, the recording ends with the captain and a crew member on the bridge.

# Maritime Disasters and Compromised Hospitals

STROUDWATER

***The probable causes of the sinking of El Faro and the subsequent loss of life were:***

- *The captain's insufficient action to avoid Hurricane Joaquin, his failure to use the most current weather information, and his late decision to muster the crew*
- *Ineffective bridge resource management on board El Faro, which included the captain's failure to adequately consider officers' suggestions*
- *The inadequacy of the owner's oversight and its safety management system*
- *Contributing factors: flooding in a cargo hold from an undetected open watertight scuttle and damaged seawater piping; loss of propulsion due to low lube oil pressure to the main engine resulting from a sustained list*
- *Contributing factors: lack of appropriate survival craft for the conditions*

***Leading risk factors for compromised hospital mission or closure are:***

- Insufficient cash flow / stagnant top line revenue
- Deferred investment, inadequate access to capital, poor systems
- Inefficient operations and processes
- Poorly performing aligned medical practices
- Non-competitive cost position and quality scores
- Aging medical staff, inability to recruit needed providers
- Contributing factors: Inadequate, untimely or incomplete analysis of key financial, operating, market and value trends over several years
- Contributing factors: inadequate oversight by the BOD and failure to understand changes in the organization's risk profile