Leaders' Perceived Value of Leadership Competencies in Healthcare Organizations Participating in Mergers and Acquisitions

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DEDICATION

I dedicate this work to those nearest to me who have sacrificed their time for over three years so that I might complete my goal. To Lee, Carter, and Bobby Moore who have given me time away to complete the degree requirements and have forgiven me for my absence from so many life events. This is dedicated to Heather Moore who has been an amazing proofreader and champion and Cami Moore for demonstrating grace and sharing your time so generously.

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LIST OF ABBREVIATIONS

ACHE	American College of Healthcare Executives
AONE	American Organization of Nurse Executives
CD-RISC	Connor-Davidson Resilience Scale
CMS	Centers for Medicare and Medicaid Services
COPE	Coping Orientation to Problems Experienced
CVF	Competing Values Framework
DOJ	Department of Justice
FTC	Federal Trade Commission
GCD	Global Competency Directory
HCO	Healthcare Organization
HFMA	Healthcare Financial Management Association
HHS	Health and Human Resources
HLA	Healthcare Leadership Alliance
M&A	Mergers and Acquisitions
MCAP	Management Competency Assessment Program
MGMA	Medical Group Management Association
PRISMA	Preferred reporting Items for Systematic Reviews and Meta-Analysis
REDCap	Research Electronic Data Capture

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ABSTRACT

Background: The increasing cost of care delivery creates financial challenges for healthcare organizations (HCOs). In response to these challenges, HCO leaders may use mergers and acquisitions (M&A) as one commercial method to help overcome the burden of economic downfalls. The complexities of leading an organization through M&A requires leaders to be competent across a broad range of clinical and administrative areas.

Objectives: This study aimed to explore perceptions from leaders who had lived experiences with M&A to understand how they value various leadership competencies.

***Methods*:** An explanatory sequential mixed methods study was conducted with HCO leaders who had lived experiences with M&A. Phase one surveyed perceptions from the members of four healthcare professional associations and independent HCO leaders. The survey was based on the five competency domains from the American College of Healthcare Executives (ACHE) Leader Competency Directory. Phase Two offered participants from Phase One the opportunity to discuss their lived experiences and perspectives from the Phase One findings during semi-structured interviews with the researcher.

***Results*:** Study results indicated that leader competencies are valued differently by clinical and administrative leaders and if their points of view were from the acquiring or acquired HCO. Participants mostly represented the administrative professionals, from the acquiring, employed by non-profits HCOs, and had successfully completed their most recent M&A. Communication and Relationship Management competencies were shown to be the most valued. Leaders competent in these skills may be better prepared to effectively influence their followers, possibly enhancing the likelihood their M&A will be completed as intended. Particularly, leaders using the local vernacular in communications with followers may further enhance their effectiveness for

organizational change. Administrative leaders perceived themselves as the most competent in the skills associated with the Business Acumen domain. Clinical leaders perceived themselves as the most competent in the skills related to the Knowledge of the Healthcare Industry domain. Further, participants with M&A experience experienced greater success in their most recent M&A.

Conclusion: The researcher has developed a guide for leaders facing M&A informed by the study's results. The guide is intended to provide HCO leaders who have not participated in M&A with guidance from HCO leaders with lived M&A experiences. Understanding which competencies are valued by leaders who have participated in M&A may enhance the likelihood of successful organizational change for those who are inexperienced.

INTRODUCTION

CHAPTER I

INTRODUCTION

The United States Congress mandated, through the Social Security Amendments [Act] of 1983, the Centers for Medicare and Medicaid Services (CMS) adopt the inpatient prospective payment system (PPS) reimbursement method (Federal Trade Commission [FTC], 2004; Office of the Inspector General, 2001; Social Security Amendments, 1983). The retrospective reimbursement system, in place prior to 1983, was more closely related with hospitals' actual expenses of providing patient care than the PPS (Fienberg et al., 2018; Mosley, 2008; Shin, 2018). Since implementing the PPS, the healthcare industry has become "volatile and hard to manage" (Shaygan, 2018, p. 213). Annual U.S. healthcare costs have risen above $4 trillion (Derlet et al., 2022; Li et al., 2023). Even considering the enormous expense, hospital profitability is declining (Chhabra et al., 2022; Pope & Yehia, 2023; Williams et al., 2020).

Healthcare leaders manage revenue losses associated with the increased cost of providing care, the changing needs of their communities, and increasing regulatory demands through strategic business ventures with other service providers (FTC, 2004; Department of Health and Human Services [HHS], 2021; Postma & Roos, 2016; Schmitt, 2017). Through strategic ventures such as mergers and acquisitions, healthcare organizations (HCOs) may strengthen their financial position by reducing operational costs (Barrette et al., 2022; Schmitt, 2017; Shaygan, 2018). The terms mergers and acquisitions may be used interchangeably or collectively and are often abbreviated in the literature as *M&A* (Cooper et al., 2019; Kaplan, 2020; Khuntia et al., 2022; Lajoux, 2006; Schmitt, 2017). For this study, the following defines M&A as ". . . a major organizational transaction in which two or more organizations combine most or all of the assets and competencies to create a third entity, the merged unit" (Solstad et al., 2021, p. 22).

Research shows pursuing M&A can be risky as integration failures in hospital M&A are common (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Gale, 2015; Stokes & Bruce, 2021). Research has also revealed that M&A integration activity to create a new single business entity from two formerly separate institutions contributes to operational instability and the need for intentional leadership (Appelbaum & Batt, 2021; Chesley, 2020; Heine et al., 2023). The integration process can be

complicated for healthcare leaders. Unlike leaders in other industries, they have the compounded responsibilities of managing business administration and clinical operations (Belkowitz et al., 2023; Sherman et al., 2007; Tasi et al., 2019). Administrative and clinical leaders who understand their leadership competencies in these areas may benefit when navigating the complexities of organizational change (Herd et al., 2019; Kakemam et al., 2020; Okonkwo et al., 2020).

This study investigates healthcare M&A, examining the motivations, outcomes, challenges, and leadership competencies needed to manage these complex organizational changes. It provides a detailed overview of the topic through a review of the literature and original research with HCO leaders who have lived M&A experience.

Background and Significance

Financial Imperatives Driving Healthcare Mergers and Acquisitions

Healthcare leaders are tasked with addressing diverse challenges inherent to care delivery. Studies indicate that a significant challenge in clinical service delivery arises from understaffing (American College of Healthcare Executives [ACHE], 2024a; Fagerdal et al., 2022; Foroughi et al., 2022; Forster et al., 2022; Kalaitzi et al., 2019; Pope & Yehia, 2023). Concurrently, external factors, such as the escalating prevalence of chronic illnesses, are likely to impose additional strains (Hunter & Murray, 2019; Li et al., 2023; Talbird et al., 2020). The COVID-19 pandemic strained the operations and finances of health systems worldwide (Jin & Wang, 2022; Loganadane et al., 2022; Rhodes et al., 2023). Furthermore, healthcare leaders are expected to identify and respond to dynamic market innovations spearheaded by competitors (Harju & Neufeld, 2022; Khuntia et al., 2022; Richards et al., 2022; Zhou et al., 2023). These challenges, universally associated with healthcare M&A, are a global phenomenon (Al-Fadhala & Elamir, 2021; Maile et al., 2022; Solstad et al., 2021). Collectively, these challenges may culminate in potential revenue losses. Additionally, HCOs can be subjected to pro-competitive regulations that may necessitate the organization’s participation in M&A to remain solvent (Mageroy et al., 2023; Postma & Roos, 2016; Solstad et al., 2021).

Despite ranking as the second highest concern in a 2023 survey, financial challenges had ranked as the most significant concern for U.S. community hospital leaders (non-federal, short-term, non-specialty) for 18 consecutive years (ACHE, 2024a).

Expansion through M&A may provide HCOs with additional revenue from enhanced service lines provided in new geographies (Burns & Pauly, 2023; Hayford, 2012; Postma & Roos, 2016; Shaygan, 2018). Expanding hospitals may also grow to capture a greater patient market share (Chhabra et al., 2022; Robinson & Knight, 2018; Wang et al., 2022). Private HCOs and academic medical centers (AMCs) may also participate in M&A (Appelbaum & Batt, 2021; Chhabra et al., 2022; Cutler & Morton, 2013). Benefits of AMCs and HCOs forming a newly combined entity through M&A may be found in the improved access to care and convenience afforded to patients (Corwin et al., 2003; Huntoon, 2023; Sun et al., 2021).

Kaufman-Hall (2019), healthcare consultants specializing in M&A, monitor and report on published healthcare-related M&A transactions. They identified a significant increase in M&A activity between 2015 and 2019. During the same period, the annual U.S. per capita healthcare cost (the cost of providing healthcare to one person) rose by 13.8% (CMS, 2022). Additionally, the first quarter of 2022 reflected M&A transactions of $19.2 billion for healthcare M&A, an increase of $10.4 billion during the same period in the previous year. Fueling the M&A activity are near-zero interest rates, low-yielding non-healthcare investments, and a capital surplus market (W. Glass, personal communications, October 2022). Historically, HCOs with M&A intentions have announced at an average annual rate of approximately 97 transactions since the 2010 passage of the Affordable Care Act (National Institute for Health Care Management, 2020; Owsley & Lindrooth, 2022; Schmitt, 2017). However, not all M&A is completed as intended (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Robinson & Knight, 2018).

Expanding HCOs have several other commercial methods available to join with other HCOs which can be less disruptive than M&A. HCOs may use affiliations with other HCOs to align their shared needs and circumvent the M&A regulatory process (Shaygan, 2018). Joint ventures (JVs), another commercially available process, may allow HCOs to expand service lines to complete specific short-term projects (Schmitt, 2017; Shi & Singh, 2010). Further, a less disruptive commercial process, partnerships between HCOs can mutually expand service lines into new locations, stopping short of a full merger (Horan, 2022). Mergers combine the strengths of two organizations,

expanding service lines and markets while creating new hospital networks. (Federal Trade Commission [FTC], 2004; Solstad et al., 2021). Acquisitions are characterized as an HCO incorporating another, often smaller, HCO into a larger, more comprehensive system (Damiani et al., 2021; Miller et al., 2017). Even though there are several alternatives, M&A has been shown to be the most financially rewarding commercially available method of integration (Cutler & Morton, 2013; Noether & May, 2017; Stankova et al., 2019). The financial benefits for HCOs participating in M&A can be significant (Barrette et al., 2022; Cooper et al., 2019; Schmitt, 2017).

Care Quality, Costs, and Organizational Implications in Healthcare M&A

Care Quality

Researchers have identified a link between healthcare sector M&A and negative health outcomes (Beaulieu et al., 2020; FTC, 2004; Khuntia et al., 2022; O'Hanlon et al., 2019). The literature shows the processes associated with M&A integration may result in decreased care quality (Folcarelli et al., 2022; Mariani et al., 2022; Rabbani, 2021). The organizational changes associated with M&A may impact patients' quantity of treatments and access to care (Hayford, 2012; Kam et al., 2020; Rabbani, 2021). Still, in some settings patients may receive improved care which may be attributed to M&A (Bruch et al., 2020; Jiang et al., 2021; Wang et al., 2022). In addition to clinical improvements in patient care, administrative aspects of the patient experience may also improve (Attebery et al., 2020; Wang et al., 2022).

Costs

Research indicates an association between M&A and increased patient cost (Bruch et al., 2020; Cooper et al., 2019; Dafny et al., 2019; Hayford, 2012). Further, studies show that when HCOs secure a larger share of the patient population, the patient's costs may rise (Barrette et al., 2022; Capps et al., 2018; Dauda, 2017). These M&A-associated concerns prompted a U.S. Presidential executive order instructing the FTC to investigate healthcare competition and consolidation (Executive Order No. 14036, 2021; Huntoon, 2023; Smith, 2021). As part of their 2021 investigation, the FTC ordered six private payors to submit subscriber premiums and activity data to measure the financial impacts of HCO mergers (FTC, 2021). The agency findings have yet to be released but

have spurred a forum for public comments on healthcare M&A co-sponsored by the FTC and DOJ (FTC, 2022).

Regulators and HCO leaders have different views on the effectiveness of M&A (Kaplan, 2020; Khuntia et al., 2022; O'Hanlon et al., 2019). Evidence has demonstrated that healthcare leaders often overstate the potential benefits of M&A to regulators (Greaney & Richman, 2018; Rabbani, 2021; Schmitt, 2017). While hospital leaders often support M&A, some regulators are skeptical about whether these mergers produce the claimed benefits (Noether & May, 2017; Rabbani, 2021; Schmitt, 2017).

Organizational Implications in Healthcare M&A

Employees can be skeptical of the benefits of M&A, too, when asked to create one culture from two previously independent HCOs (Appelbaum et al., 2021; Chesley, 2020; Cunha et al., 2019; Lucero et al., 2020; Martin, 2021). Evidence shows that when acquired and acquiring entities converge, leaders establishing trust and deliberately communicating with followers can be pivotal in overcoming the organizational disarray that can be associated with M&A-related organizational change (Aunger et al., 2021; Canady & Miller, 2023; House et al., 2022; Robinson & Knight, 2018). An M&A deployment strategy attuned to the employees' needs may help facilitate leaders' intended outcomes for M&A (Chesley, 2020; Miller & Millar, 2017). Research found that successful M&A implementation may be contingent upon pivotal factors associated with the prevailing economic circumstances before the M&A, the strategic objectives of the acquiring entity, and the motivations of the leadership driving M&A (Auschra, 2018; Galpin & Herndon, 2014; Maile et al., 2022). The literature indicates leadership as instrumental to the success of M&A activity (Chesley, 2020; Longenecker & Longenecker, 2014; Robbins, 2018). However, it does not comprehensively explain the leadership competencies essential for successful organizational transformation.

The complexity of leading through change may be attributed to the competing frameworks that guide leaders through organizational change (Errida & Lotfi, 2021; Kakemam et al., 2020; Nelson-Brantley & Ford, 2017). Employees at HCOs involved in M&A may be expected to adapt to significant organizational change. Leading organizational change may be more effective when leaders adapt their approach to consider the staff's needs (Al-Fadhala & Elamir, 2021; Easton & Steyn, 2022; Kaltiainen

et al., 2020). This involves a thorough understanding of the organizational needs at each stage of the process: before, during, and after the changes (Miller & Millar, 2017; Round et al., 2018; Solstad et al., 2021; Vaishnavi et al., 2019). Additionally, studies suggest leaders implementing broad organizational change should acknowledge the need for individual transformations which may be required to foster a new culture (Cerezo-Espinosa de los Monteros et al., 2021; Chesley, 2020; Kaplan, 2020; Robinson & Knight, 2018). Research indicates that granting employees creative flexibility enables them to independently arrive at solutions for challenges which may stem from organizational change (Fagerdal et al., 2022; Jonasson et al., 2018; Khan et al., 2018; Martin, 2021). When employees perceive threats due to organizational change, such as job insecurity, employee stress may increase (Greco et al., 2021; Gronstad et al., 2019; Kaltiainen et al., 2020). The stress brought on by organizational change can be mitigated through the use of resilience and adaptive coping mechanisms (Fagerdal et al., 2022; Forster et al., 2022; Russo et al., 2018).

Before executing organizational change, leaders should assess their readiness for change and contrast their organization's capacity for change with similar changes happening in the broader healthcare industry (Martin, 2021; Vaishnavi et al., 2019). Leaders that proactively assess employee emotions during periods of organizational change may help identify employee concerns early. Addressing these concerns may subsequently lead to employees who are more committed to the changes (Kaltiainen et al., 2020; Solstad et al., 2021; Vaishnavi et al., 2019). Similarly, leaders showing an intentional commitment to executing organizational change can have a cascading effect throughout the organization, positively influencing organizational behavior toward the change. (Aunger et al., 2021; Leiter & Harvie, 1997; Lohrke et al., 2016; Martinussen et al., 2020; Miller & Millar, 2017).

Advancing Leadership Competencies in Healthcare

The literature explores leader competencies within organizational hierarchies, highlighting how leaders require a diverse and adaptable skillset to address the changing needs of the organization (Hala et al., 2018; Harper & Maloney, 2022; Sherman et al., 2007). Numerous competency assessments are available with many sharing similar

characteristics (ACHE, 2023; Garman et al., 2020; Kakemam et al., 2020; Ylitalo et al.,2022).

Universities are responding to the practical demands of hospital leadership by ensuring their students graduate with the necessary skills to be effective leaders early in their careers. These competency based programs aim to prepare students to address the complexities when leading HCO change (Belkowitz et al., 2023; Cellucci et al., 2018; Hala et al., 2018; Harolds & Miller, 2022). Since 2013, the Association of University Programs in Health Administration (AUPHA), as a condition of certification, has required undergraduate programs to provide competency-based education; the Commission on Accreditation Healthcare Management Education (CAHME) did the same for graduate programs in 2008 (Cellucci et al., 2018). Competency-based curricula address areas of (a) leadership, (b) communication and relationship management, (c) professionalism, (d) healthcare knowledge, and (e) business skills (Stefl, 2008). Cellucci et al. (2018) add (f) teamwork to these key areas. Healthcare leaders have curated a wide range of self-scoring competency assessments to bridge classroom learning and leadership in situ (Bender et al., 2019; Hala et al., 2018; Kasaai et al., 2023; Sherman et al., 2007).

In other nations such as Norway, Canada, India, and Italy, international care delivery has experienced substantial transformations because of changes in national health policy (Gronstad et al., 2019; Gulati et al., 2021; Isonne et al., 2021; Martin, 2021). Studies highlight the universal nature of the competencies and needs of healthcare leaders. These studies underscore the need for competency assessments to reflect providers' cultural and geographic health delivery context (Hahn & Lapetra, 2019; Hernandez et al., 2018; Hosseini et al., 2023; Imanipour et al., 2021; Okonkwo et al., 2020; Schleiff et al., 2020).

ACHE Competency Domains

Leaders of HCOs guide their organizations in settings where their actions and decisions can lead to significant consequences for their patients (Beaulieu et al., 2020; Folcarelli et al., 2022; Kam et al., 2020). Leaders' actions also impact their employees' [physical and mental] health and well-being (Bureau of Labor Statistics, 2022; Harrison & Zavotsky, 2018; Martinussen et al., 2020; Robertson & Long, 2019). Consequently,

leaders may need specific competencies to navigate simultaneously through their routine daily operations and the major changes associated with M&A. Many leader self-assessments are available to inform leaders of their perceived mastery across leadership competency domains (ACHE, 2023; Bender et al., 2019; Harolds & Miller, 2022; Harrison & Zavotsky, 2018; Hernandez et al., 2018; Sherman et al., 2007).

A 2002 task force developed the ACHE leadership competencies assessment questionnaire with input from seven professional associations comprising the Healthcare Leadership Alliance (ACHE, 2023, Stefl, 2008). Given that the questionnaire was developed using a broad range of inputs, it may effectively provide insights into the competencies required for leaders during M&A. Several of the leadership competency domains found in other competency assessments overlap the ACHE leader competency domains: (a) leadership, (b) communications and relationship management, (c) professionalism, (d) knowledge of the healthcare environment, and (e) business skills and knowledge (ACHE, 2023; Harrison & Zavotsky, 2018; Kakemam et al., 2020; Sherman et al., 2007; Stefl, 2008). Studies providing insights into leader competency self-assessment responses show that leaders' perceptions of their competencies vary culturally and geographically (Gulati et al., 2021; Hosseini et al., 2023; Okonkwo et al., 2020). Self-assessments have been extensively modified to evaluate the specific needs of international health professionals (Hahn & Lapetra, 2019; Kasaai et al., 2023; Marchildon & Fletcher, 2016). These adaptations underscore the imperative for leader competencies to evolve with the needs of a global healthcare community.

Leaders showing strong interpersonal skills have been positively associated with transforming their workplace during organizational change (Aunger et al., 2021; Kakemam et al., 2020; Raeder, 2023). Further, competent leaders may promote improved care quality (Gulati et al., 2021; Harrison & Zavotsky, 2018; Hernandez et al., 2018; Okonkwo et al., 2020). This study employs the ACHE leadership competency directory as its framework to examine the leader competencies at work during M&A. The Directory’s five domains, covering 80 criteria, and its accompanying 300-item questionnaire provide leaders a means to track their progress from novice (leaders who may still need guidance in an area) to expert (leaders who may offer to guide those less

skilled). Leaders are encouraged to cyclically self-score how well they perceived they perform at a given competencies across the domains (ACHE, 2023).

Statement of the Problem

Literature addressing the role of M&A, its purpose, benefits, and challenges to healthcare organizations is abundant (Aunger et al., 2021; Beaulieu et al., 2020; Khuntia et al., 2022). Organizational change leadership research in the context of generalized leader and follower (subordinates) behaviors also exists (Berson et al., 2021; Jachimowicz & Weisman, 2022; Kakemam et al., 2020; Raeder, 2023). However, research regarding HCO leaders' perceived competencies during M&A activity is lacking. Further research is needed to identify the specific leadership competencies necessary to successfully manage organizational changes related to M&A using a well-defined framework.

Purpose of the Study

The purpose of this explanatory sequential mixed methods study was to investigate the success or failure of M&As and the role that ACHE healthcare leader competencies may have played during the M&A. The researcher also explored leader experiences related to the five ACHE competency domains during M&A. Participants were given the opportunity to share with the researcher their explanation of why they felt they did when scoring their perceptions.

Questions to be Answered

1. What do healthcare leaders report about the success or failure of M&As and the role that the ACHE leadership competencies played during the M&A?
2. What are healthcare leaders' experiences during M&A as related to the five ACHE leadership competencies?
3. How do the experiences of healthcare leaders during M&A relate to what leaders reported regarding the success or failure of their M&A in the context of the ACHE leader competencies?

Definitions of Key Terms

ACHE- American College of Healthcare Executives is a professional group supporting the needs of healthcare executives with education, training, and programming designed to support the changing needs of healthcare delivery (ACHE, 2024b).

Financial Health- a measure of a hospital's financial strength considering factors of profitability on income, cash liquidity, and percentage of debt to the value of assets (Apenteng et al., 2021).

Healthcare Industry- an ecosystem of healthcare consumers, clinical and administrative professionals supporting healthcare consumers, clinical organizations, healthcare delivery organizations, regulators, policy makers, and insurers (Hermes et al., 2020).

Healthcare Organization- a specifically conceived ecosystem delivering coordinated care through a healthcare-focused labor force (Electronic Clinical Quality Improvement, 2023).

Health System- an organization of one or more hospitals coordinating care with one or more physician groups providing care through central ownership or administration (Agency for Healthcare Research and Quality, 2023).

Leaders- individuals who foster a culture of growth and autonomy, enabling followers to function within an ecosystem of risk-taking, open communications, and hands-on governance to identify unforeseen opportunities and solutions (Hanson & Ford, 2013)

Leadership- *"*a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2013, p. 5).

Leader Competencies- competencies requisite for healthcare leaders, enumerating the skills, knowledge, and abilities essential for efficacy (Hahn & Lapetra, 2019).

Mergers and Acquisitions- "a major organizational transaction in which two or more organizations combine most or all of the assets and competencies to create a third entity, the merged unit" (Solstad et al., 2021, p. 22).

Organizational Change Management- the specific processes associated with executing organizational change (Errida & Lotfi, 2021).

Quality of Care- the extent to which healthcare services for individuals and communities enhance the probability of achieving desired health outcomes as guided by contemporary professional knowledge (FTC, 2004).

Reimbursement Schedules- a repository for the dollar value of reimbursable healthcare procedures considering the physician's costs of providing the procedure, operating expenses, and malpractice insurance premiums (Haglin et al., 2020).

Possible Application of Findings

Healthcare organizations have expanded their operations through M&A for over 40 years (Department of Justice [DOJ], 2010; FTC, 2004). This consolidation is likely to continue. Healthcare organization leaders may use the study's findings to help manage organizational change during M&A activity. The healthcare industry may use the results to understand the ideal leadership competencies necessary to better prepare their HCOs for M&A. The current study's findings may also be instrumental in recognizing the risks associated with M&A investments in the absence of certain leadership competencies. The results may also inform HCO leaders on which competencies are indicated when exploring M&A with target HCOs and how these competencies, when present, may promote a successful outcome before an acquiring HCO announces its intent to merge.

Summary

Hospitals will likely continue to engage in M&A as a strategy to remain financially solvent or increase revenue, as studies show that M&A has been a viable means to meet rising market competition (Appelbaum & Batt, 2021; FTC, 2004; Postma & Roos, 2016). While HCOs may have other commercial methods available, successfully completing a fully integrated M&A produces the most valuable results for the HCO. Successful organizational change depends on the employees accepting the new unified vision, mission, and values (Canady & Miller, 2023; Errida & Lotfi, 2021; King et al., 2020). Even so, when hospitals participate in M&A, the effects may negatively impact the quality of care and care delivery (Beaulieu et al., 2020; Kam et al., 2020; Rabbani, 2021). To better prepare future HCO leaders for broad organizational changes universities are using competency based education to help train future HCI leaders. Leaders may check their competencies using any of the many self-assessments available to HCO leaders.

Leadership plays a critical role in completing M&A as HCOs intend (Cerezo-Espinosa de los Monteros et al., 2021; Chesley, 2020; Longenecker & Longenecker, 2014). However, the specific leader competencies associated with successful M&A outcomes have not been thoroughly studied.

REVIEW OF THE LITERATURE

CHAPTER II

REVIEW OF THE LITERATURE

Healthcare organizations have experienced profound structural changes due to the changes in reimbursement schedules, as evidenced by the topic's numerous reports and analyses (Department of Health and Human Services, 2021; Federal Trade Commission [FTC], 2004; Social Security Amendments of 1983). The financial pressure is exacerbated by increased competition, which could further reduce reimbursement amounts (Erwin, 2015; Khuntia et al., 2022; Richards et al., 2022; Zhou et al., 2023). Additionally, there is a notable increase in bureaucratic oversight of healthcare delivery (Derlet et al., 2022; Shaygan, 2018). A comprehensive review of the literature examines the dynamics of healthcare organizations' (HCO) profitability, organizational change, leadership competencies, and the impact on the access to and cost of care. The studies reviewed span various research methodologies, geographical regions, and aspects of healthcare mergers and acquisitions (M&A) to provide an understanding of this complex phenomenon.

Financial Imperatives Driving Healthcare Mergers and Acquisitions

Leaders may struggle to anticipate their organization's operational budget requirements and face even greater challenges in predicting the demands triggered by external events like the COVID-19 pandemic. Pope and Yehia (2023) conducted a quantitative study of HCOs to understand the differences between their current and pre-COVID-19 (2019–2022) profitability. Survey participants (N = 915) were members of The New England Journal of Medicine Catalyst Insights Council. The council members are clinical and administrative executives who are surveyed monthly regarding current healthcare issues. They represent non-profit (75%) and for-profit (25%) organizations from the United States (n = 543) and the international community (n = 372). Pope and Yehia (2023) surveyed participants to understand the profitability of their HCO and identify areas of their business under consideration for cost reduction to enhance their "financial health" (p. 8). Respondents identified staffing costs, delaying the operational transition to an accountable care organization, postponing digital transformation, and concerns about mergers and acquisitions as strategic business considerations. The data analysis revealed, with a margin of error of ±3.2% at a 95% confidence interval, that

participants (*M* = 54%) showed their financial state was worse than before COVID-19. Hospitals (*M* = 35%) are improving their profitability through reductions in hospital staff. The need to address staffing was more concerning for non-profit hospitals (*M* = 85%) than for-profit hospitals (*M* = 72%). Participants (*M* = 30%) anticipated declining reimbursements would affect their plans to become an accountable care organization or undergo a digital transformation. Participants (*M* = 12%) also had concerns about M&A. Concerns about M&A are globally recognized, showing a minimal difference (M = 3%) between U.S. and international participants.

Even though the U.S. healthcare system's delivery of patient care is distinct from its international counterparts, M&A among HCOs is a global phenomenon with similar M&A-associated challenges (Al-Fadhala & Elamir, 2021; Kaltiainen et al., 2020; Maile et al., 2022). Demonstrating the universality of how changes in governmental healthcare policy may act as a driver for M&A, Postma and Roos (2016) sought empirical evidence to understand how health policy drives increasing M&A. A quantitative survey of 239 Dutch healthcare executives, each with firsthand M&A experience between 2005–2008 and 2009–2012, shared their motives for participating in M&A. These two M&A transaction periods are concurrent with The Netherlands' national health policy changes, which introduced "competition and financial risks" through hospital deregulation and new reimbursement methods (Postma & Roos, 2016, p. 122). Before 2005, the Dutch government regulated hospitals, and funding was provided through nationalized insurance. Survey participants represented the views from healthcare conglomerates, those providing more than one specialty of care (28%), nursing homes (19%), mental care (15%), hospitals (14%), and disability care (8%). Nearly half (43%) of survey respondents participated in more than one M&A during the period. Most survey respondents (73%) served in hospitals with 100 million euros or less in corporate earnings.

Postman and Roos (2016) conducted a chi-squared test of independent and pairwise comparisons for motivating factors, revealing no statistically significant differences between data collected during the two periods or sectors. Researchers found that, on aggregate, the two primary motivators for hospital M&A are enhancing care delivery and increasing market size for a strategic financial advantage. However, when

participants identified their HCOs' motivations for each of the transaction periods, researchers recorded a shift in purpose ($p < 0.05$) from providing care delivery (2005–2008) to increasing patient volume in new markets (2009–2012). The study's findings suggest that HCO motivations for M&A are connected to policy changes that encourage provider competition, potentially threatening hospital revenue. Additionally, it largely validates healthcare executives' M&A motivations from previous studies. This study confirms the linkage between the motivations to participate in M&A and national health policy changes encouraging provider competition and changing reimbursement models. Researchers did not control for other merger motivations or bias from participant perceptions of private industry M&A.

National health policy changes, specific to reimbursements, have also negatively impacted U.S. hospital revenue and have been responsible for declining profitability in clinical care (Pope & Yehia, 2023; Shaygan, 2018; Williams et al., 2020). This decline necessitates HCOs to embark on strategic business ventures (Appelbaum & Batt, 2021; FTC, 2004; O'Hanlon et al., 2019). In addition to public and private hospital entities, academic medical centers (AMCs) may also pursue market share expansion, achieving financial advantages (Ingwersen et al., 2023; Maile et al., 2022; Sun et al., 2021). Chhabra et al. (2022) conducted a qualitative study of surgical departments at expanding AMCs to scrutinize the influence of M&A on the academic mission. The researchers recruited 30 current ($n = 28$) and past ($n = 2$) U.S. department chairs, achieving a participation rate of 42%. The Society of Surgical Chairs assisted with this recruitment. The participants varied in their representation of AMCs, from large academic health systems to medical schools without an academic health system affiliation.

Chhabra et al. (2022) conducted 15–60-minute telephone interviews using a semi-structured interview guide between August and December 2019. The interviews examined six key topics related to the participant's role, cultural differences between facilities, care coordination, clinical strategy, and success determinants. Three researchers initially thematically analyzed the collected data by reviewing three random transcripts. Two additional researchers tested the resulting themes, and through group consensus, the researchers identified the themes to be used against the total population of interviews. Transcripts were also examined using the qualitative data analysis software MaxQDA.

Findings revealed a stronger correlation between expansion and business incentives than expansion and academic considerations. Institutional priorities included financial performance, including sharing back office administrative functions post-merger. These factors led to the institutional challenges of conflict over goals, governance, compensation, and cultural assimilation. Furthermore, the outcomes highlighted the advantageous impacts of expansion for the acquired and acquiring organizations, such as enhanced brand visibility when merging with larger systems, increased clinical income to cross-subsidize research, and augmented staffing for under-resourced hospitals. Despite the richness of the collected data, researchers cautioned about the generalizability of the study conducted with a small population sample of those in expanding AMCs with strong views on M&A. For the sake of transparency, the researchers acknowledged that their greater experience in academic medicine might have introduced bias into the study.

The economic advantages of healthcare M&A are extensively recorded (Chhabra et al., 2022; Jiang et al., 2021; Sun et al., 2021; Wang et al., 2022). They may, however, come with risks (Beaulieu et al., 2020; Folcarelli et al., 2022; Hayford, 2012; Rabbani, 2021). The FTC, policymakers, and healthcare leaders alike have expressed concerns regarding the risks of healthcare M&A (FTC, 2021; Kam et al., 2020; Rabbani, 2021). Noether and May (2017) investigated if the benefits of M&A, cost reduction, and additional efficiencies could be achieved through less disruptive or less formal affiliations. Joint ventures, where two independently licensed HCOs share resources but do not create a third entity, may convey the same results with less consternation. The mixed methods exploratory study began with structured interviews with U.S. hospital leaders (N = 20). Leaders were asked five questions to understand their motivations for participating in M&A, whether they had engaged in less formal affiliations, and whether they believed the goals of the HCO could have been met without M&A. An econometric analysis compared industry data from 2009–2014 to the researchers' collected data regarding treatment cost and revenue sourced from the Healthcare Cost Report Information System (HCRIS), a public database of healthcare costs submitted by providers accepting reimbursements from Medicare. Researchers sourced the names of the HCOs to be studied from data collected by the American Hospital Association's (AHA) annual survey and the Irving Levin Associates database of hospital ownership

changes. To be included in the study's test group, HCOs must have appeared in the change of ownership dataset. Quality data on patient care was obtained from the Centers for Medicare and Medicaid Services (CMS) Hospital Compare database. An analysis of the researcher's qualitative data indicated that leaders perceived M&A as a method to maintain solvency during declining patient visits and changing payment methods. Leaders have also linked the financial advantages of standardizing clinical procedures with a decrease in negative patient safety incidents, resulting in operational cost savings. Further, participants indicated hospitals may experience operating cost savings (5%–10 %) when participating in M&A but not through less formal affiliations. A portion of the operating cost savings (2.5%) was attributed to employee reductions. The quantitative data underwent analysis through a difference-in-difference approach and a logarithmic calculation of both the collected and industry data sets to account for variations in hospital geography, payor mix, hospital size, and service lines. The results for approximately 14,000 records show M&A contributed to a decline (2.5%) in operating expenses per patient admission ($p < 0.05$), a decrease (4.2%) in 30-day readmissions ($p < 0.1$), and a decrease (.07%) in the mortality rate. Additionally, hospitals expanding into new markets through M&A may have experienced a corresponding increase in patient volume. Researchers concluded that U.S. healthcare providers and regulators disagree that increasing revenue and decreasing costs are exclusive to M&A. Utilizing comprehensive U.S. healthcare data from multiple sources broadens the study's generalizability to all U.S. hospitals.

The economic benefits of consolidation are well-documented for hospitals (Dafny et al., 2019; Hayford, 2012; Owsley & Lindrooth, 2022; Rabbani, 2021). Hospitals might see reduced operational expenses related to care provision, but these cost savings are not consistently demonstrated across acquiring and target institutions. Schmitt (2017) investigated the legitimacy of cost reduction claims made by hospital leaders to gain regulatory approval to participate in M&A. In a quantitative study of 337 changes in ownership records of U.S. general acute care hospitals between 2000 and 2010, the researcher evaluated hospitals with a single ownership change. The researcher matched change of ownership records with hospital cost data from the HCRIS and the AHA database. Transactions were categorized based on whether hospitals purchased others

inside or outside their local patient-serving areas, with the distinction made by acquirers crossing state lines, hospital service areas, or hospital referral regions. An econometric analysis compared real-world data to the researchers' collected data from the HCRIS and AHA archived data to show if the M&A activity produced cost reductions. The cost to treat one patient was trended using a difference-in-difference model between hospitals participating in M&A (test group) and those not participating in M&A (control group). The results indicated that the cost differences are negligible in the year the M&A is completed. However, difference-in-difference results using ten years of data showed an average annual cost savings of 4%–7% when the acquiring hospital is out-of-market. Further, savings from M&A between smaller hospitals in the same market are insignificant. The findings also suggest that M&A does not achieve immediate cost reductions, and when cost reductions materialize, they do so asymmetrically. The researcher could not discern whether the changes in treatment costs were due to changes in patient service lines or new treatment protocols. It is also unclear if the cost changes were due to the acquiring hospital having greater buying power than the purchased hospital. These are among the limitations noted.

Care Quality, Costs, and Organizational Implications in Healthcare M&A

Care Quality

The promise that M&A will deliver improved care may not always materialize (Beaulieu et al., 2020; Kam et al., 2020; Mariani et al., 2022). Beaulieu et al. (2020) studied Medicare data from U.S. hospitals participating in M&A to determine if the M&A activity had affected care quality. In a quantitative study of U.S. hospital data recorded between 2007 and 2016, researchers using a difference-in-difference analysis found a negative association between hospitals participating in M&A and care quality. The researcher's test group (n = 246) consisted of short-term acute care hospitals with at least 25 beds and 100 fee-for-service annual Medicare admissions. The control group (n = 1,986) consisted of hospitals not participating in M&A during the period. Researchers compared test group data from 2009 to 2013 with control data from the two years before and three years after the M&A activity to analyze changes in clinical care, patient experience, mortality, and readmissions. The metrics for the patient experience (SD = -.17, p = 0.002, 95% CI [-0.26, -0.07]) declined within three years following M&A. This

decline indicated a nine-point change "from the 50th to the 41st percentile in the performance distribution of the control hospitals" (Beaulieu et al., 2020, p. 57). The 30-day readmission rates for the same period (10%, p = 0.72, 95% CI [-0.53, 0.34]) showed improvements before retreating to the same levels as before the M&A. The 30-day mortality rate declined slightly (3%, p = 0.72, 95% CI [-0.20, 0.14]). The study did not control for a patient's use of another hospital during the study period, which may have influenced the findings. Researchers concluded that M&A does not improve hospital care quality.

Consequently, while clinical quality has been shown to decline after M&A, improvements in the patient's perceived inpatient experience have been mixed. Some studies assert an improvement (Jiang et al., 2021; O'Hanlon et al., 2019; Wang et al., 2022). Other studies, however, disagree on the universal quality improvements associated with M&A (Beaulieu et al., 2020; Folcarelli et al., 2022). Attebery et al. (2020) conducted a study to determine if the patient experience improves in U.S. hospitals that previously participated in a merger. Using a retrospective quasi-experimental design, researchers compared 2009 – 2013 data from the AHA Annual Survey, Irving-Levin Associates (a healthcare consulting firm tracking M&A), and the CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures. The study period coincided with years during increased M&A activity. Researchers compared 198 hospitals (99 in each, hospitals merging and not merging) to the study criteria. The hospitals were matched using a hierarchical propensity score matching technique, a statistical technique to reduce bias from study subjects with confounding variables. The HCAHPS data were used to profile hospitals participating in mergers (test group) against those that had not merged (control group). The researchers Attebery et al. (2020) used a subset of HCAHPS' 10 core measures to define the dependent variables. The subset variables were (a) overall patient experience (a composite of all measures), (b) communications with nurses, (c) communications with doctors, and (d) staff responsiveness. Performance data for both test and control groups were measured at six equal intervals over 36 months for each pre- and post-merger period. The data from the test and control groups were subjected to a paired *t*-test analysis of the descriptive statistics, and a difference-in-difference calculation was employed to compare HCAHPS

measures over the 72-month study period. The results show that the control group had higher HCAHPS measures for the overall patient experience 24 months post-merger ($p < .10$). The measure of communications with nurses was higher for the control group 36 months post-merger ($p < .10$); otherwise, there were no material differences between the remaining measures. Trending data 36 months post-merger indicates the test group improved their overall patient experience HCAHPS measures year over year, albeit at a rate slower than the control group. Statistically significant differences began in year two, where the test group underperformed the control group, 1.30% to 2.60%, respectively ($p < .10$). In year three, the test group improved in their performance but again behind the control group, 1.75% to 2.83% respectively. Findings indicate that patient communications with nurses at the test group hospitals do not improve as quickly compared to the control group of hospitals that had not merged. Researchers speculate that frontline nurses bear the brunt of the organizational disruption associated with M&A. This impact is more evident in the communications with nurses' measure than in other measures. Limitations of the study were central to the data available, the small sample size of the test and control groups, and the impact of merger hospitals not consistently reporting HCAHPS measures.

Patients' care delivery for some treated in rural markets may improve after M&A despite declining care quality and mixed results elsewhere. Jiang et al. (2021) showed the potential benefits patients at rural hospitals may expect after M&A. The researchers conducted a quantitative case-controlled study seeking to measure changes in care quality for inpatient visits at rural hospitals participating in M&A. Data from 1.3 million discharges from the rural community and rehabilitation hospitals ($N = 438$) measured between 2009–2016 were sourced from the Healthcare Cost and Utilization Project and the Agency for Healthcare Research and Quality (2023) to define the study population and improve the dataset to investigate long-term trends. The test and control groups from the study's total population ($N = 438$) included rural hospitals participating in M&A ($n = 172$) and rural hospitals not participating in M&A ($n = 266$), respectively. Researchers used a difference-in-difference analysis of patient quality and safety data across hospitals in the test and control groups. Researchers employed logistic regression models to gauge how the results matched expectations. Further, researchers aligned the comparison

merger dates using a coarsened exact matching method. The researchers measured the rural hospital mortality rate data annually for four years after M&A, finding the rate fluctuated but did not return to pre-M&A levels. Using descriptive analyses and difference-in-difference measures comparing discharges from control and test groups, rural hospitals participating in M&A improved their mortality rates for all conditions from -0.443 (95%, p = .02, CI [-0.813, 0.073]) in year one post-merger to -0.757 (95%, p = .01, CI [-1.348, -0.166]) in year five. Hospital records from ten years before and after the merger were used for trending the descriptive statistics. Although sample sizes varied based on data availability, researchers found that (a) the mortality rate measuring heart attacks improved (4.4%) at the test group hospitals but less (1.6%) at the control group hospitals. Likewise, the test group hospital data showed that mortality rates declined across morbidities: heart failure (0.8%), acute stroke (1.7%), and pneumonia (1.2%). The researcher suggests that the decline in mortality rates might be connected to the increased clinical resources available to rural hospitals following M&A. Further, rural hospitals may "share staff and expertise. . . to alleviate workforce shortages" (Jiang et al., 2021, p. 8) after M&A by rotating staff from the acquiring hospital into the acquired rural hospitals. These findings contradict other literature, indicating that hospital mergers' benefits are not extended past hospital operational savings and care quality. The study was unable to control for patients who received services away from the merged hospital or died during transfer. These factors could have contributed to the observed improvement in mortality rates.

Urban safety-net hospitals may benefit from M&A similarity to rural hospitals. Wang et al. (2022) studied a safety net hospital acquired by an urban AMC, aiming to evaluate shifts in quality and safety metrics. The study conducted at New York University's Langone Health system examined patient discharge records (N = 181,252) from 2010 - 2019. Discharge records were sourced from the hospitals' electronic health records and divided into two groups: pre-merger (n = 122,348) from September 2010 to August 2016 and post-merger (n = 58,904) from September 2016 to August 2019. Sources also included the CMS Hospital Compare data and reports for nursing quality. The study focused on various outcome measures of all-cause mortality rates, readmissions, hospital-acquired infections (central line-associated bloodstream

infections- [CLABSI] and catheter-associated urinary tract infections- [CAUTI]), and patient experience scores. Researchers used a limited dataset removing patient identifiers, consistent with the Standard for Quality Improvement Reporting Excellence (SQUIRE) reporting guidelines. Preliminary analyses involved descriptive statistics of patient demographics to determine pre and post-patient groups. Subsequent analyses using chi-squared tests examined the differences between the groups.

Wang et al. (2022) used statistical process control and an interrupted time series to measure intervention effectiveness for mortality and readmission rates. Results indicated a positive change in all measures at the previously independent safety net hospital. Unadjusted mortality rates improved by 27%, outperforming pre-merger trends. Unadjusted readmission rates improved 24%. Hospital-acquired infections were mixed with each CLABSI and CAUTI (per 1,000 discharges), showing an initial rise following the acquisition. Only one CLABSI measure, patient discharges from medical and surgical floors, showed an immediate reduction post-merger and remained improved through the third year. Patient experience scores in the overall hospital experience improved every year through the first year, as did the patient's willingness to recommend the hospital improvements in clinician communications. Conversely, initial declines were noted in perceptions of clean and quiet patient rooms. These declines, however, recovered significantly by year three post-merger. The study's limitations were identified with the narrow scope of a single hospital acquisition, pre-merger below-average scores, and the multiple interventions after the acquisition, any of which may have been responsible for the changes. Despite its limitations, the study's findings may be generalizable due to the complete integration of hospital service lines and technology, which could enhance care quality.

Costs

While the effects of M&A on care quality can vary, there is a tendency for patient costs to be negatively affected by M&A activities. Hayford (2012) studied inpatient treatment intensity at hospitals participating in M&A to determine if treatment intensified and if treatment charges increased due to M&A. The researcher examined inpatient data from 40 California hospitals associated with M&A between 1990 – 2006. Data from the California Office of Statewide Planning and Development provided the discharge records

from general acute hospitals indicating demographics, payments, diagnoses, and procedures performed. The collected data were limited to patients with ischemic heart disease from 697 zip codes, covering 98% of the zip codes affected by hospital M&A during the study period. The primary treatment intensity measures were identified as the number of patients receiving bypass surgery and angioplasty, as well as the number of procedures performed on a patient. Five dependent variables, including descriptive treatment characteristics and mortality rate, were matched with patient treatment data, and compared using ordinary least squares and instrumental variable regression analyses. This approach provided a comparative assessment to evaluate changes in treatment intensity related to the M&A activity. The study's findings were notable, revealing a 34% surge in procedures performed. Patient charges also increased over the study period by 281%. The researcher hypothesized the reasons for the increases but acknowledged that no statistical measures were applied to establish a cause-and-effect relationship. The study's implications suggest a nuanced relationship between hospital M&A activities, treatment intensity, and resulting increases in treatment charges. These characteristics may warrant further study into the dynamics of M&A as an influencer in treatments administered and their associated costs.

Escalations in treatment costs transferred to patients after M&A may validate patient concerns. Rabbani (2021) conducted a case study into the effect of non-profit hospital M&A on patient treatment pricing for childbirth services. The M&A activity studied occurred across three hospitals in the Toledo, Ohio, market. In examining the FTC documents, the researcher modeled the pricing impacts on patients in the Toledo healthcare market from the studied M&A, 2010 – 2011 Truven MarketScan patient discharge data, and U.S. Census data. MarketScan data provided the researcher with a total of 3,504 childbirth pricing observations from 335,723 individuals across 146 metropolitan statistical areas (MSA); 145 of these comprised the control group, with the Toledo MSA as the test group. A synthetic control method used weighted averages of control group data to produce a synthetic control group. Synthetic control group data were subsequently used to project future trends based on the historical weighed averages simulating the expected market pricing behavior acting as if the M&A had not occurred. A traditional difference-in-difference technique was used to compare the forecasted

trends with actual post-M&A Toledo market data. The results indicated that the M&A increased patient out-of-pocket pricing after M&A. The actual trend, as recorded by MarketScan, indicates OOP increased above the synthetic trend (the expected price) by $201 until it dropped to $90 above the synthetic trend after an FTC challenge to the M&A. The difference-indifference comparisons of the actual cost to the synthetic model confirm OOP increases of $129 post-merger and $102 after the FTC challenge. The study acknowledges several limitations due to being conducted in a highly concentrated market, raising questions about the generalizability of the results in less dense markets. Additionally, the 145 MSA control group markets were not checked for simultaneous M&A activity, nor were comparisons made between for-profit and non-profit hospitals.

Evidence demonstrating the negative effects of healthcare M&A on health consumers has been presented (Cutler & Morton, 2013; Hayford, 2012; Huntoon, 2023; Rabbani, 2021). Similar impacts on health consumers' access to and costs for care have been shown to occur when hospitals and physician groups participate in M&A (Greaney & Richman, 2018; Koch et al., 2017; Richards et al., 2022). Capps et al. (2018) studied physician practices acquired and subsequently integrated into hospitals (vertical integration) to determine the financial impact on health insurers and subscribers. The study utilized data from 2007 to 2013, encompassing a variety of payors and a broadly distributed group of U.S. patients, accounting for 12% of the U.S. population. The data use agreement between the researchers and the payors prevents disclosure of the payors' names, details of the patient demographics, and service charges. A weighted average of inpatient and outpatient charges represented the pricing. Researchers identified physicians vertically integrated as the test group, using provider tax identification numbers and the AHA database of system ownership. The control group (physicians not associated with vertical integration) was identified using the same method. Researchers used a difference-in-difference method to estimate the impact vertically integrated physicians may have on subscribers' healthcare spending. Results indicated the test group spending increased by 14%, and enrollees treated by the test group increased spending by 5%. Additionally, researchers examined other factors influencing price hikes besides vertical integration, including hospital mergers, physician billing for costlier outpatient procedures, and market share. Findings revealed that an absence of in-market competition

was responsible for a 35% increase in physician prices. Hospital service charges contributed 45% to the surge due to unique facility reimbursements only afforded to the hospitals. Physicians with a higher market share charged 14% more than their counterparts with lower market share. The 2015 Bipartisan Budget Act, which limited future hospital service charges, may limit the study's generalizability to M&A activities before 2015.

When HCOs undergo consolidation, the emergent entity may possess enhanced leverage to negotiate with payors (Appelbaum & Batt, 2021; Barrette et al., 2022; DOJ, 2010; Postma & Roos, 2016). Seidu Dauda (2017) investigated the connection between hospital and insurer concentrations on patient pricing to identify the dynamics between concentration and patient pricing. The study used multiple databases addressing patient pricing, building projects, and provider/insurer markets. The analysis integrated data from the Truven Health MarketScan database (spanning 2005 – 2008, inclusive of 4.8 million records corresponding to 3.5 million unique U.S. patient transactions), AHA Annual Survey, Health Leaders-InterStudy, Bureau of Health Professions, Area Resource File and County Business Patterns, and Health Planning Association. Distance and travel time defined the hospital service market boundaries. The results were further segmented by travel time between competing hospitals in intervals between 10 and 80 minutes. The study controlled for covariates, costs, and variable service demands using an instrumental variable technique and ordinary least square estimates. Further, the researcher modeled the data against additional econometrics tools- the Under and the Weak identification Kleibergen-Papp tests, tests of reliability, and the Over Identification Hansen J statical test, a validity test, to add rigor to the findings. The researchers concluded that the greater hospital market concentration (fewer independently owned hospitals) is responsible for higher prices (3-9%, $p < .001$), whereas insurer concentration may lower prices (11-15%, $p < .001$). Overall, patient prices increase when a patient's time to travel to a competing hospital exceeds 40 minutes. Further, insurer concentration may depress prices when market concentration is outside the 60-minute time-to-travel boundary. The results suggest an area's concentration of hospital ownership may increase provider market power, resulting in increased pricing power to obtain higher prices from insurers. Conversely, insurer concentration may serve as a countervailing power to influence

providers to lower prices. The observed patient records were collected from commercially insured patients, which may limit the study's generalizability to commercially insured patient populations.

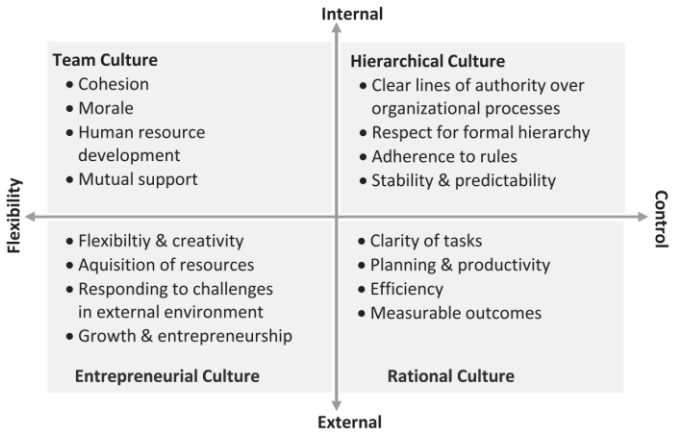
Organizational Implications Before, During, and After Healthcare M&A

The organizational disorder associated with integrating HCOs during M&A has been shown to be disruptive to patients (Folcarelli et al., 2022; Kam et al., 2020; Rabbani, 2021). Similarly, the integration process of uniting two previously independent cultures can concern staff (Kaplan, 2020; Martin, 2021; Robinson & Knight, 2018; Solstad et al., 2021).

In an exploration of healthcare leader/ follower dynamics, Chesley (2020) examined how leaders need to remain connected with their teams as cultures can change after M&A. A quantitative longitudinal case study of M&A at two hospitals in Appalachia evaluated staff's ideal workplace cultures before and after M&A. The investigation occurred at two intervals over three years. A 42-question survey was sent to all 15,662 employees, representing the total population of employees at both hospitals. The researchers designed the survey using the four quadrants and two poles of the competing values framework (CVF). The CVF defined team culture ideals across four quadrants: team culture, entrepreneurial culture, hierarchical culture, and rational culture, and four poles: demands from within or external to the organization (the vertical axis) and flexibility or control from management (the horizontal axis). The researchers included the characteristics of the descriptions used in each quadrant, shown in Figure 1.

Figure 1

Competing Values Framework



Note: Each quadrant contains organizational characteristics related to culture. The characteristics were used to map the desires of staff pre and post-merger.

Chesley (2020) plotted participants' responses against the CVF to reveal the ideal work culture employees would assign themselves to before and after the M&A. The researchers evaluated the mean scores of the employees using *t*-tests with a 95% confidence interval. Before the M&A transaction, study results indicated employees shared a "minimal level of cultural overlap" according to Chesley (2020, p. 144). Further, they preferred a hierarchical culture with a strict chain of command, $t(2,971) = 42.7$, $p < .001$) and entrepreneurial (greater autonomy), $t(2,970) = 5.12$, $p < .001$). There was minimal overlap found, with both groups marginally favoring the entrepreneurial culture. A measure of preferred culture after the M&A transaction revealed an alignment of both teams' desire for a more hierarchical team culture ($M = 1.63$, $SD = 0.55$). Participants indicated they sought to clarify "who is in charge. . ." (Chesley, 2020, p. 147). The study's generalizability lies in the universal requirement for leaders to understand team cultures before and after M&A activities, suggesting leaders remain nimble.

Health systems participating in M&A often expand beyond their local market geography to out-of-market or out-of-state locales (Owsley & Lindrooth, 2022; Rabbani, 2021; Schmitt, 2017). Therefore, the absence of a shared physical workspace forces executives to administer leadership remotely. Although their governance may differ, international HCOs also participate in M&A, which may require remote leadership (Cunha et al., 2019; Gronstad et al., 2019; Jonasson et al., 2018; Martinussen et al., 2020; Postma & Roos, 2016). Solstad et al. (2021) investigated hospital staff's perceived availability of their leaders during M&A integration when considering their physical and cognitive (perceived) distance from the leader. The study aimed to understand if leaders distant from their clinical staff (nurses and doctors) were perceived as less involved in M&A integration. Researchers conducted a longitudinal mixed methods case study at three Norwegian hospitals during two rounds of M&A activity in 2005 and 2014. The study participants included only experienced clinical professionals. Researchers collected qualitative data from individuals with seniority who were expected to interact directly with senior leaders. Low response rates to the two identical instruments issued to hospital staff in 2005 (38%) and 2014 (16%) were acknowledged as a possible confounder

contributing to bias. To mitigate the bias, researchers used descriptive statistics for the primary analysis. Participant surveys indicated that for both data collection years (2005 and 2014), hospital communications regarding the M&A integration were shared hierarchically from leaders at the top down to the staff. This consistency in communication hierarchically limited the variability in communication methods. Leaders and staff were co-located during the 2005 M&A activity. Conversely, leaders were remote from staff during the 2014 M&A activity. The findings show that distance was a factor in staff's perceptions of leaders' participation in organizational change. Participants' perceptions of the integration challenges increased when physical distance separated leaders and staff, as measured in 2005 (58%) and 2014 (70%). Employee perceptions of their influence on leaders regarding operations, planning, and budgeting weakened from 2005 (50%) to 2014 (80%) in response to leaders being physically distanced from staff. In comparison, researchers indicated that enhanced leader-staff communication and coordination in integration efforts during M&A activities between 2005 and 2014 were responsible for a reduction (42%) in staff feeling disconnected from their leaders during M&A despite the increased physical distance. Interview quotes showed that matching the leader's professional background with that of the staff improved perceptions of leader effectiveness, even across greater physical and cognitive distances. Researchers recommend leaders participating in M&A implement new collaborative methods to close any perceived gap.

The reliance on leader communications and collaboration during healthcare M&A integration is positively associated with followers' acceptance of organizational change (Cerezo-Espinosa de los Monteros et al., 2021; Chesley, 2020; Harrison & Zavotsky, 2018; Longenecker & Longenecker, 2014). In this context, Robinson and Knight (2018) conducted a qualitative study of chief nursing executives (CNEs) involved in hospital acquisitions. Researchers sought to understand the executives' perspectives of the events and, using these perspectives, determine the processes that should be present to help the transition. The U.S. study was conducted with CNEs (N = 16) from rural and urban hospitals that had been part of acquiring (n = 5) and acquired (n = 11) hospitals. The American Organization of Nurse Executives (AONE) recruited participants for the study through their electronic newsletter. The researchers used an 11-item interview guide

addressing the topics of communications, challenges encountered, leadership dynamics, and organizational culture. An analysis of the data yielded four themes. The most common perception was the lack of executive communications provided to the CNEs; staff from the acquiring and acquired organizations shared this perspective universally. Other common perspectives were respect, rapid changes without notice, and a lack of a unifying shared vision to create a common culture. Most CNEs agreed that the acquisition process presented opportunities to expand one's professional network and enhance learning.

Transparent communications contribute to creating effective work environments, which is essential for cultivating a new culture and enhancing management's understanding of the unique stressors encountered by staff (Greco et al., 2021; Harrison & Zavotsky, 2018; Sherman et al., 2007). To understand how stress impacted staff during M&A, Russo et al. (2018) conducted a quantitative exploration of the stress coping mechanisms, defined as personal responses to perceived threats, used by bedside nurses when their hospital participated in M&A. Researchers recruited a total participant pool of 2500 nurses through email and electronic postings. The researchers sought to understand what actions the nurses may have taken to deemphasize stress. Researchers conducted the study across the three campuses of a recently merged U.S. hospital system. Notably, two of the three locations are American Nursing Credentialing Center (ANCC) Magnet locations. Hospitals earn Magnet credentials by demonstrating a commitment to operate as a transformative and empowering workplace for nurses (ANCC, 2024). Location one (H1) was a Magnet-credentialed AMC hosting a level-one trauma unit in a metro setting. Hospitals two (H2), also Magnet certified, and three (H3), lacking Magnet certification, were each categorized as community hospitals. The researchers' method used a single survey incorporating items from three instruments:

- a demographic questionnaire addressing participant's sex, education, ethnicity, vocation, and marital status,
- the Coping Orientation to Problems Experienced (COPE) inventory assessment, which employs a four-point Likert scale to gauge participants' emotionally focused coping actions (Carver et al., 1989),

- the Connor-Davidson Resilience Scale (CD-RISC), measuring participants' reactions to stressful events through 25 items using a five-point scale of rarely true (0) . . . true nearly all of the time (4) (Connor & Davidson, 2003).

Russo et al. (2018) found 14% or 353 nurses from H1, H2, and H3 responded to the survey, and more than half (52%) were from H1. From the demographics, researchers, using descriptive statics, calculated a composite resiliency score for nurses at all three campuses of 81.53. Data indicated nurses at H1 were marginally less resilient in coping with organizational changes than at H2 and H3, with a resiliency score of 80.8, 83.66, and 81.3, respectively. The data were analyzed using a Pearson product-moment correlation (PPMC). The PPMC measures the strength of correlation between two variables and may be helpful when decerning the difference between two groups and is measured by a coefficient, *r* (Prion & Haerling, 2014).

Russo et al. (2018) found that nurses at H1 (r = 0.56) and H2 (r = 0.57) perceived the changes as opportunities for personal growth more than the nurses at H3 (r = 0.33). Further, measures of nurses actively coping were associated with H1 (r = 0.47) and H2 (r = 0.37) more so than with H3 (r = 0.30). Similarly, the use of deliberate response control to the stress of the organizational change was nearly uniform at H1 (r= 0.23), H2 (r = 0.22), and H3 (r = 0.21). The researchers highlighted that H1, with the greatest number of resources available to staff, had the lowest resilience score to cope with the organizational changes. They suggested future research evaluate what resources and coping mechanisms may be available to staff during organizational change. Researchers acknowledged the study's limitations, such as the overall low response rate and the various channels where nurses may have received the recruiting notice. The study's value lies in its novel exploration of nurse coping strategies at multiple sites following M&A activity.

Advancing Leadership Competencies in Healthcare

Changes in healthcare organizations, such as those seen in M&A, can negatively affect employees (Greco et al., 2021; Jonasson et al., 2018; Kaltiainen et al., 2020). Research indicates that leaders who evaluate the organization's readiness for change before initiating it tend to positively impact employees' commitment to the change process (Nelson-Brantley & Ford, 2017; Vaishnavi et al., 2019). Assimilating two

formerly independent HCOs during M&A can be a drain on people and processes and lead to an unrealized venture (Kam et al., 2020; Longenecker & Longenecker, 2014; Robbins, 2018). Therefore, it is essential that leader competencies be maintained and emphasized throughout the merger and acquisition process.

Custom-developing assessments can evaluate leader competencies using standardized or varied measures and domains (Bender et al., 2019; Hernandez et al., 2018; Kasaai et al., 2023). Just as HCO challenges are a universally addressed global phenomenon, the study of leaders' competencies also resonates with an international audience (Gulati et al., 2021; Hosseini et al., 2023; Okonkwo et al., 2020). In their systematic literature review, international researchers Kakemam et al. (2020) identified the key competencies for effective management among global hospital leaders. The study was informed by leadership, management, and competency assessment literature published between 2000 and 2020. The guidelines and checklist from the preferred reporting items for systematic reviews and meta-analysis (PRISMA) standards helped researchers select relevant peer-reviewed publications. In the final analysis, researchers selected international (n = 10) and U.S. (n = 2) studies that employed mixed methods, quantitative, or qualitative designs. Subsequently, the researchers used a best-fit synthesis methodology to map themes from the literature selected into one of six competency domains supported by the management competency assessment program (MCAP) found in Table 1. The researchers could not synthesize all the themes identified with the MCAP competencies.

Table 1

MCAP Competencies and Sub-Themes

MCAP Competencies	Sub-Themes
Evidence	1-Evidence appraisal 2-Evidence application and decision making 3-Evaluation of decision
Resources	1-Staff management 2-Financial management 3-Organisation management
Knowledge	1-Knowledge of healthcare environment 2-Knowledge of organisation 3-Application of knowledge in legal and quality practices
Communications	1-Relationship management and teamwork 2-Communication 3-Personal quality
Leadership	1-Leading people and teams 2-Leading organisation 3-Leader quality
Change	1-Change preparation 2-Change implementation and evaluation 3-Leader quality in change

Note: Each of the six competencies have three subthemes influencing leader actions.

Themes promoting the alignment of personal and organizational ethics, along with those advocating for continuing education and training, were not assignable to a specific MCAP domain. The researchers suggested expanding the MCAP to include a domain for professionalism to accommodate these themes. Leader competencies are contextualized within the hierarchy of the HCO, among leaders or managers, and across different geographical locations. The study findings did not distinguish between leader or manager competencies, assuming all roles had equal needs. The study may be generalized to aid in developing a competent healthcare labor force.

A number of national and international associations have developed competency assessments for use in educational or professional settings (Cellucci et al., 2018; Hala et al., 2018; Sherman et al., 2007). Garman et al. (2020) studied the National Center for Healthcare Leadership's (NCHL) competency model version 2.1. The researchers sought to enhance the model's applicability to measure competencies across a broader spectrum of health professions in preparation for the forthcoming NCHL version 3.0. Researchers addressed the lack of global interprofessional standardized healthcare leadership competency models by conducting a literature review to identify emergent trends in a four-phased mixed-methods approach for empirical validation. Study participants were recruited with the assistance of the NCHL and purposive sampling throughout the four phases. Researchers initially reviewed prospective healthcare literature from organizations such as the Organization for Economic Cooperation and Development (OEDC), the Institute for Alternative Futures, and others. Emergent healthcare trends were sorted into themes and validated by a focus group of U.S. healthcare executives. Using the validated themes, the researchers implemented the Behavioral Event Interviewing (BEI) method, facilitating a measure of how individuals behave in specific situations.

Garman et al. (2020) interviewed four pairs of early and mid-level careerists and three chief executives. The BEI output produced 825 leader behaviors spanning seven domains, further refined in the third validation phase. Results from two focus groups attending two NCHL meetings in 2017 validated the researchers' general behavior descriptors. These were coded into an electronic survey and distributed to a diverse group of healthcare leaders. Researchers determined the agreement level among raters regarding

each competency using Content Validity Ratios. The researchers' final validation phase analyzed the output of the three phases against the content of leadership competency models from various health professions using natural language processing, a computer software tool designed to interpret human language (Baclic et al., 2020). The findings indicate that a single model comprising 28 competency measures across seven domains can represent 85% of the interprofessional competency measures tested. Within this model, three domains identified competencies leaders need to complete tasks, while four domains identified competencies leaders need to continue their growth. Six domains are expansions from the NCHL version 2.1 competency model. The researchers added a Values domain, encompassing a single competency measure aimed at capturing a leader's professional and social responsibility. Generalizability may be limited due to the intrinsic bias from a small sample of interviewees, participants' possible pre-existing familiarity with the NCHL, which may have influenced their perspectives toward version 2.1, and the narrow focus on healthcare systems rather than the healthcare sector.

In another study of competencies applied in the professional setting, Harper and Maloney (2022) studied the leader competencies essential for Nursing Professional Development (NPD) leaders, specifically those conducting professional development over multiple sites. Researchers posit a growing need for clinicians to understand their leader competencies as M&A creates the need for nurses to take on new leadership roles. The study was conducted among NPD leaders (N = 30) from U.S. states (n = 19), identified through purposive sampling from Association for Nursing Professional Development members. Most represented leaders in acute care settings (90%); more than half of these leaders also provided NPD for staff in ambulatory care (63%). The researchers' novel study instrument merged the American Organization of Nursing Leadership and NPD competency measures. The resulting 134-item survey mapped these competencies into five domains: (a) executive nursing leadership, (b) NPD, (c) business acumen, (d) organizational alignment, and (e) communications and relationship building. Participants scored their perceived importance of each of the 134 items using a nine-point Likert scale. Using an eDelphi method, the researchers issued the survey over three rounds, seeking consensus on the importance of the 134 items. The eDelphi method collects data over several iterations, with respondents receiving feedback regarding how

their responses compared to the consensus before each iteration. The eDelphi method keeps participants anonymous from one another while allowing them to modify their responses in successive iterations of the survey. Researchers determined that 10 of the 134 competency measures did not gain consensus from the participants as important for multi-site NPD leaders. These measures focused on the business aspects of grant writing, collective bargaining, succession planning, partnering with policymakers, and the personal aspects of remaining jovial and clinically competent. Researchers cite limitations of the study as the time frame conducted, which coincided with the end of the initial wave of COVID-19 infections, and the study method's lack of standards.

Professional competencies may be traced back to the foundational principles of competency-based education programs. Such competencies frequently span multiple domains of leadership, as explained by Cellucci et al. (2018). The researchers studied the growth and adoption of competency-based education programs in the United States. The researchers aimed to understand how higher education programs enhanced their competency-based education proficiencies. The Association of University Programs in Health Administration (AUPHA) manages the competency-based education criteria. Researchers performed a content analysis on AUPHA university applications (N = 42) filed between 2011 and 2016 requesting certification. This period provided study data from before (2011–2013) and after (2015–2016) the AUPHA 2013 mandate requiring universities to adopt a competency-based curriculum. The researchers conducted a content analysis of the university AUPHA applications, searching for key terms, regarding competencies, reflecting the applicants' adoption or growth in competency-based curricula (Cellucci et al., 2018). Researchers measured universities' use of terms from seven competency domains. They found an increase in the competency language supporting all competencies from the curriculum: business skills (29%), communications (22%), professionalism (102%), knowledge of the healthcare environment (66%), relationship management (142%), leadership (11%), and teamwork (170%). Further, universities are placing an increasing weight (102%) on internship preceptor evaluations to assess student's command of the competencies.

Master's educated Clinical Nurse Leaders (CNLs) distinguish themselves from managerial nursing roles by concentrating on the provision of care aligned with the most

current, evidence-based practices (American Association of Colleges of Nursing, 2013). Bender et al. (2019) conducted a comprehensive analysis of the successive versions of policy documents pertaining to masters-educated Clinical Nurse Leader (CNL) competencies to assess whether the modifications correspond adequately with the contemporary needs of the nursing profession. Researchers evaluated the three CNL publications addressing the competency requirements- (a) the 2007 seminal research report by the American Association of Colleges of Nursing (AACN), (b) its update from 2013 and the (c) 2016 supplement which added a job analysis. Additionally, a literature search for scholarly articles on CNL topics in PubMed and CINAHL yielded 166 unique works. Researchers created a framework for synthesizing the three publications and the scholarly articles. Three broad themes consistent with clinical leadership competencies provided the evaluation benchmark- clinical leadership, clinical outcomes, and clinical environmental management. Researchers' synthesis identified an emergent trend regarding the CNL's competency advancement. The expectations that CNLs would need time to advance from novice to expert did not align with the followers' presumptions of trained CNLs. Bridging CNLs from novice to expert requires nursing leaders to be integrated within a microsystem (focusing on care delivery processes instead of treatment protocols) to make sense of the barriers to reaching their improved clinical goals. Researchers cite the utility of the study as its ability to assist educators when communicating the merits of a nursing leader's career track and providing students with clarity regarding the competencies required of a CNL. While the work was a collaborative effort among nursing experts, it may be limited by the researchers' experiences.

In a practical application to measure the impact of competency-based medical education, Hala et al. (2018) formulated and validated a tool to determine progressive enhancements in leadership competencies between first-, second-, and third-year U.S. medical residents. The University of Utah faculty designed the novel Foundational Healthcare Leadership Self-assessment (FHLS), drawing on multiple sources in generalized and healthcare leadership literature. In phase one of the study, two one-hour focus groups comprising the Utah family medicine residency program faculty and eight medical residents evaluated the initial 33-item self-assessment draft (later refined to 21

items) to identify the critical competencies that should be included. The assessment used a five-point Likert scale, ranging from beginner (1) to expert (5), enabling participants to self-score their competencies. For phase two, researchers recruited participants through a purposive sampling of 30 medical residency program directors, with 22 responding. Sampling criteria were based on geography and the type of medical education program offered; 163 medical student residents from 12 states participated by answering the self-assessment. The FHLS focuses on five competency domains: (a) accountability, (b) collaboration, (c) communication, (d) team management, and (e) self-management. Using a chi-squared analysis and the Fisher exact test, researchers compared the demographics of the 163 phase two participants against those of the U.S. family medicine residency Accreditation Council for Graduate Medical Education. The survey results show that, although there was little difference in average competency scores between sexes, more advanced residents had higher competency scores ($p < 0.01$). Further, non-white residents scored themselves as more competent in the leadership domain ($p = 0.055$). Researchers cite the limitations of the FHLS study as being developed by faculty and students from a single location, aimed specifically at family medicine practice, and using loosely defined criteria for the beginner-to-expert self-assessment rankings.

In further exploring the practical application of competency evaluations of clinicians, Sherman et al. (2007) directed their research toward understanding the competencies inherent to nursing leadership. The researchers aimed to identify the competencies required by nursing managers. In a qualitative study of U.S. nursing leaders ($N = 120$) in Florida, researchers invited 40 chief nursing officers to nominate nursing managers from their organization to participate in the study. The study participants were divided between nursing managers with more than ($n = 98$) and less than ($n = 22$) two years of professional nursing experience. Researchers conducted face-to-face interviews using a structured interview guide comprising 26 open-ended questions. The researchers used a grounded theory method to code and validate the interview data. The researchers used field notes and participant quotes to validate emerging themes. In the final analysis, researchers determined that any nursing competency model should include the attributes collected during the interviews. Each of the attributes may fall into one of six categories: (a) personal mastery- an understanding of oneself; (b) financial management- the cost of

talent; (c) human resource management- talent retention; (d) interpersonal effectiveness- being present for your team, (e) caring- connecting with your team, and (f) systems thinking- multidepartment interconnected care. Researchers noted two major themes throughout the interviews: the nurse manager role as a career choice and the stressors and challenges of the role. The study's generalizability is directed at higher education competency-based education development for nursing administration.

ACHE Competency Domains

Stefl (2008) explored the history of healthcare leader competency development to understand its importance to the global healthcare community. The researcher examined the 300 self-assessment questions from the Healthcare Leadership Alliance (HLA) competency domains of (a) leadership, (b) communications and relationship management, (c) professionalism, (d) knowledge of the healthcare environment, and (e) business skills. Hospital leaders scaled the HLA 300 self-assessment questions using the Dreyfus five-point scale (1 = *novice* to 5 = *expert*). The HLA is comprised of the professional associations: American College of Healthcare Executives (ACHE), American College of Physician Executives (ACPE), AONE, Healthcare Financial Management Association (HFMA), Healthcare Information and Management Systems Society (HIMSS), Medical Group Management Associates (MGMA), and the American College of Medical Practice Executives (ACMPE). The 2002 HLA task force identified that the knowledge, skills, and abilities needed by competent leaders were common in five of the seven existing professional organizations' self-assessments. The task force streamlined multiple assessments into one by formally evaluating members' certification and credentialing domains, categorizing them into five common competencies, selecting relevant performance metrics, and developing the assessment questionnaire. The task force further determined an interdependency across the domains, with leadership central to all. A psychometric firm reviewed the initial competency directory to remove duplicates and logically reorganize it. When the HLA task force surveyed the perceptions of individuals involved in competency-based education (N = 340) from four universities, participants unanimously agreed that all competencies were necessary. Findings also show the professional associations AONE and ACHE have modified the HLA self-assessment to include professional association-specific information. Further, the task

force successfully mapped 77.3% (*n* = 232) of the total 300 HLA questions to all competencies needed across many health management professions. This wide applicability contributes to the generalizability of the HLA competency leader competency domains.

Standardized and custom-tailored competency assessments for healthcare leadership are being implemented globally (Hosseini et al., 2023; Okonkwo et al., 2020; Sawleshwarkar & Negin, 2017; Ylitalo et al., 2022). In a practical application of the ACHE leadership competency assessment, Gulati et al. (2021) studied the leader competency gap in India's clinical workforce. In a recent quantitative study of senior leaders and physicians (*N* = 416), researchers aimed to show how the lack of clinical leader training may hinder the country's long-term goals for improved health outcomes. Researchers issued the ACHE leader competency assessment questionnaire to survey participants during nine clinical management training events between 2012 and 2020. Participants held postgraduate clinical and administrative degrees (78%); however, most (85%) had no formal management training. Immediately after completing the survey, participants were prompted to identify two leadership challenges seen as obstacles to enhancing care delivery. The researchers received 767 challenges and sorted each into one of the five ACHE competency domains: (a) leadership, (b) communication and relationship management, (c) professionalism, (d) knowledge of the healthcare environment, and (e) business skills. The findings indicate the respondents' top challenge was motivating their workforce (54%), followed by communications with patients (52%), commercial contracting (48%), general leadership skills (47%), and retaining staff (45%). The respondents' lowest concerns were implementing national health policy (3%) and risk assessment (2%). Researchers observed that government-funded health reforms addressing healthcare inequities rely on competent leadership for successful implementation. Researchers expressed concern about the limited number of healthcare professionals who had taken leadership training, especially considering the National Health Policy mandates for healthcare leaders' professional development. The study's generalizability provides policymakers with data about the current state of clinical leadership and provides input for future training.

Building on the need for locale specific competencies, Hahn and Lapetra (2019) reviewed the Global Competency Directory (GCD), contrasting the leadership competency assessments developed for an international audience and the HLA 2004 assessment developed in the United States. The GCD competency assessment design was patterned after the U.S. HLA assessment but modified for a global audience. Six organizations with limited awareness of the needs of the U.S. healthcare system developed the HLA assessment. The GCD expanded its use beyond the U.S. healthcare system by seeking input from low and middle-income countries with unique healthcare leadership needs. The GCD assessment was reviewed by 96 healthcare professionals in 14 countries. Unlike the HLA assessment, the GCD formalized its strategy to include a leader competency framework addressing policy development and higher education, professional development, and a formal credentialing system for merit-based career advancement. The GCD is available online, at no cost, and translated into six languages. The HLA offers leaders 300 competency measures in a single questionnaire; the GCD requires users to duplicate their self-assessments over 80 competency measures in two questionnaires. The first questionnaire is used to check for job relevancy and the second to measure perceived competency. The researchers acknowledge both self-assessment programs promote continuous improvement.

Summary

Healthcare leaders routinely face unique challenges (Fagerdal et al., 2022; Solstad et al., 2021; Talbird et al., 2020; Zhou et al., 2023). These challenges can intensify during the organizational upheaval associated with M&A (Folcarelli et al., 2022; Kam et al., 2020). Leaders frequently face the challenge of simultaneously managing the standard administrative demands of the organization and maintaining high standards of clinical care and patient safety during the M&A processes (Beaulieu et al., 2020; Noether & May, 2017; Schmitt, 2017). Balancing these administrative duties is crucial, yet M&A processes have been shown to upset the operational and care delivery balance. Leaders should periodically review and evaluate their competencies to strengthen their proficiencies (Gulati et al., 2021; Sherman et al., 2007). Competency assessment tools have been developed for a global healthcare leader audience, often custom-crafted using a regionally specific vernacular (Hahn & Lapetra, 2019; Sawleshwarkar & Negin, 2017).

The ACHE Leader Competency Assessment, tailored for hospital executives, examines five key domains across 80 leadership topics (ACHE, 2023). By identifying and addressing perceived gaps in skills through competency assessments, leaders can better prepare themselves for the demanding process of steering an organization through organizational change (Cellucci et al., 2018; Gulati et al., 2021; Stefl, 2008). The current research continues the extensive studies that focus on measuring healthcare leader competencies but with a focus on leaders' perceived competencies present during M&A.

INVESTIGATION

CHAPTER III
INVESTIGATION

Healthcare organizations (HCOs) use strategic ventures to gain market share; mergers and acquisitions (M&A) have been associated with HCOs gaining market share (Cutler & Morton, 2013; Noether & May, 2017; Stankova et al., 2019). Strategic outcomes of M&A may largely depend on the unifying actions of HCO leaders to unite staff during M&A-associated organizational change (Canady & Miller, 2023; Cerezo-Espinosa de los Monteros, 2021; Chesley, 2020; Martinussen et al., 2020). Effective leader communication is an antecedent to successful organizational change (Longenecker & Longenecker, 2014; Nelson-Brantley & Ford, 2017; Raeder, 2023; Vaishnavi et al., 2019; Ylitalo et al., 2022). Leaders may use a number of self-assessments to collect feedback regarding their competencies, and several allow a leader to reflect on their competencies regarding communication skills (Herd et al., 2019; Kakemam et al., 2020; Sherman et al., 2007). The American College of Healthcare Executives (ACHE) offers a publicly accessible self-scoring competency assessment encompassing communications and four additional competency domains. Through this assessment, leaders can gauge their competencies within each domain, measuring their perceived proficiencies from novice to expert (ACHE, 2023).

Organizational change leadership research in the context of generalized leader and follower behaviors exists (Berson et al., 2021; Errida & Lotfi, 2021; Jachimowicz & Weisman, 2022). However, research into the leadership competencies present during M&A activities within HCOs is lacking.

Purpose of the Study

The purpose of this explanatory sequential mixed methods study was to investigate the success or failure of M&As and the role that ACHE healthcare leader competencies played during the M&A. The researcher also explored leader experiences related to the five ACHE competency domains during M&A. Participants were given the opportunity to share with the researcher their explanation of why they felt they did when scoring their perceptions.

Questions to be Answered

1. What do healthcare leaders report about the success or failure of M&As and the role that the ACHE leadership competencies played during the M&A?
2. What are healthcare leaders' experiences during M&A as related to the five ACHE leadership competencies?
3. How do the experiences of healthcare leaders during M&A relate to what leaders reported regarding the success or failure of their M&A in the context of the ACHE leader competencies?

Research Design

The researcher sought to understand the perceptions of leadership competencies from those with lived M&A experiences. This study was conducted using an explanatory sequential mixed methods design conducted in two phases. An explanatory sequential mixed methods design was used to elucidate the quantitative findings further through qualitative interviews (Creswell & Creswell, 2018). A mixed methods sequential study combines the strengths of both qualitative and quantitative research methods, allowing for a more comprehensive understanding of the phenomenon (Creswell & Creswell, 2018). These interviews were intended to explore the leaders' perceptions of the success or failure of their most recent M&A and how their leadership competencies may have influenced their actions in the context of the five ACHE domains. Quantitative data were captured in phase one, analyzed, and shared with participants as part of the phase two interview guide. Sharing the quantitative data during the interview provided a foundation for participants in phase two to share their reactions to the data. Participants were offered the phase one findings to help them reflect and offer more detailed explanations of the collected data, enhancing clarity and understanding.

The researcher applied a grounded theory approach to the qualitative component of the study. Charmaz (2006) suggests that grounded theory may help the researcher develop theories from data for three pivotal reasons:

1. Studies leveraging data collected economically are valued.
2. The circular output of findings between the phases allows for coded results to drive additional inquiry for greater understanding.
3. Grounded theory retains pragmatic underpinnings.

Setting

Participants for the study were selected from businesses and clinical leaders who currently serve or have served in leadership roles at HCOs participating in M&A. Participants were recruited through three healthcare professional associations and two LinkedIn social media groups. This study invited participants from the Medical Group Management Association (MGMA) membership, which offers advisory and research services to its 60,000 members (MGMA, 2023). Similarly, study participants were recruited from the Healthcare Financial Management Association (HFMA), guiding 96,000 healthcare financial professionals in education, certification, and regulatory analysis. Members of HFMA are regularly surveyed on their perceptions of hospital management risks (HFMA, 2023). Professionals were also recruited from the Healthcare Executives Network (HExN), a LinkedIn group founded in 2007 with 398,000 members. This group, consisting of hospital leaders, focuses on biotechnology research, healthcare, and pharmaceuticals (Foley, 2023). Also, recruiting from social media, the Mississippi Hospital Association (MHA) posted a notice of the study to their LinkedIn followers. These associations and the LinkedIn group have approximately 600,000 members in aggregate (Foley, 2023; HFMA, 2023; MGMA, 2023).

Participants

Business and clinical leaders from U.S. hospitals were recruited from the professional associations of MGMA, HFMA, MHA, and two LinkedIn online communities. The researcher followed the associations' prescriptive steps to recruit study participants from these four organizations accordingly:

- HFMA- Chief Partnership Executive posted to their online community,
- HExN- Group Administrator posted to their LinkedIn online community page,
- MGMA- the researcher posted to the online MGMA communities using the MGMA member electronic application,
- MHA- Vice President of Communication & Member Engagement posted to their LinkedIn online community page,
- The researcher posted the announcement to their professional LinkedIn page.

The same announcement was posted to all communities. Multiple recruitment requests were sent to all communities except HFMA. The recruiting message included a link to

the phase one questionnaire (Appendix I). Participants clicking on the link were redirected to the REDCap online data collection platform, where the informed consent cover letter was presented. Participants consented to participate by moving forward in the REDCap questionnaire. The HFMA, HExN, and MHA administrators initiated contact with each member using the societies' standard means of communication- email, listserv for HFMA, or posting for LinkedIn online communities for MGMA, HExN, and MHA. Agreements from these administrators granting the researcher access to the groups' membership were formalized (see Appendices A–D).

Participant continuity between phases one and two is essential to derive additional meaning from the initial quantitative data (Creswell & Creswell, 2018). In phase one of the study, participants were asked about their leadership roles as a prerequisite to proceed with the leader competency questionnaire. Participants needed to acknowledge certain criteria in the Research Electronic Data Capture (REDCap) system based on their roles and the institutions' involvement in M&A to proceed with the questionnaire. Those not meeting the study's inclusion criteria received an automated message that the questionnaire had ended and were not invited to participate in phase two.

The study's inclusion criteria for participation were that individuals currently hold or previously held a leadership role during the M&A activity and were not employed as individual contributors. Cerezo-Espinosa de los Monteros et al. (2021) consider those with firsthand knowledge to be expert when sharing their opinions on HCO organizational change. Participants did not need to presently hold the roles they had during the M&A activity, nor required to be employed by the same organization.

The study excluded participants who may have been part of the HCO before or after the M&A but were not affiliated with the organization during the M&A process. Systems integrators, which hospitals often retain to execute the M&A, were also excluded. Although leaders may consult systems integrators during the M&A process, it is not assumed the SI would have HCO staff reporting directly to them.

Instruments

The researcher utilized three questionnaires, two hosted by the REDCap platform in phase one and one maintained by the researcher in phase two. The first questionnaire was used to determine whether the participants met the threshold for the inclusion group.

If the participants met the study's inclusion criteria, they proceeded with the first questionnaire. Otherwise, they received a disqualification message, and the questionnaire ended.

The participants reported their demographic information through a series of quantitative questions concerning their number of M&A activities, leadership role, M&A completion status, if employed by the acquiring or acquired HCO, role as a clinical or administrative leader, and the organization's tax status before the M&A activity. Understanding the organization's tax status allows the researcher to qualify the leaders' perceptions from those employed by non-profit, for-profit hospital leaders, charities, governmental hospitals, or others. Further, in addition to the demographic information, participants were asked specific questions intended to measure their perceptions of their leader competencies across the five ACHE leader competency domains. The ACHE self-assessment is an unrestricted, publicly available, self-scoring leadership tool measuring a leader's perceived competency across five leadership domains- (a) leadership, (b) communications and relationship management, (c) professional and social responsibility, (d) knowledge of the healthcare environment, and (e) business skills and knowledge (ACHE, 2023). All participants were offered the same ACHE domains-based questionnaire and asked to gauge their perceived management competencies using a five-point Likert scale (1 = *novice* to 5 = *expert*) (see Appendix E).

Five items on the questionnaire paralleled the five ACHE (2023) competency domains. The sixth item on the questionnaire was arranged in two parts. For this question only, participants were asked to rank, by domain, their perceived importance of the leader competencies during the M&A organizational change ranging from 1 (*least valuable*) to 5 (*most valuable*). In the second part of question number six, participants were asked to again rank their perceptions of which domains should have been most important during their M&A activity had the event happened in a perfect world. Their observations were expected to help identify differences in perceptions between the leader competencies applied and those perceived that could have contributed to greater M&A success had they been applied.

Participants completing the first questionnaire were automatically transitioned to a second REDCap questionnaire and asked if they would share additional thoughts during

a phase two semi-structured interview. They were also asked if they would like to participate in a random drawing for a $50 Amazon gift card. Participants' contact information was required to move forward with the phase two interviews or the drawing. Participants opting into the interview or gift card drawing were offered a second REDCap questionnaire where they could submit their contact information. The first and second questionnaires were not linked. The use of two separate questionnaires prevented any direct correlation between the participants' quantitative responses and their personal contact information.

A third questionnaire was utilized to conduct the phase two qualitative semi-structured interviews. Data from phase one was analyzed and the findings, in part, informed the semi-structured interview guide. Participants electing to be interviewed in phase two were contacted via phone or email to schedule interviews. During the interviews, participants were asked questions encouraging them to recall and elaborate on their perceptions of the necessary leader competencies during the M&A process (see Appendix F). These interviews aimed to enhance the researcher's understanding of the quantitative data collected in phase one and to identify any gaps or limitations in leader competencies observed during the M&A process.

No data were collected until the participant acknowledged the informed consent cover letter presented at the beginning of the REDCap questionnaire (see Appendix G). Participants' election to proceed served as their informed consent and willingness to participate. The first questionnaire was piloted to two executives (one each clinical and administrative) who had lived M&A experiences and who were known to the researcher. The participant remarks from the pilot did not materially influence the production questionnaire's final design. Phase two qualitative data collected also followed the context of the ACHE leader competencies. The consistent design between the phase one and two instruments offers insights and explanations into phase one findings.

Phase One

Data Collection

After the University of Mississippi Medical Center's (UMMC) IRB approval of the study (see Appendix H), the researcher received assistance from the administrators of the professional associations in recruiting participants. As previously agreed with the

professional associations, the recruiting ran concurrently across HFMA, MGMA, MHA, HExN, and the researcher's LinkedIn online communities. The same announcement was posted to all communities. The recruiting message included a link to the phase one questionnaire. Participants clicking on the link were directed to the REDCap online data collection platform, where the informed consent cover letter was presented. Participants consented to participate by moving forward in the REDCap questionnaire.

Participants completed the first questionnaire by answering seven demographic items and six items regarding their perceived leader competencies. Participants were asked specific questions to measure their perceptions of their leader competencies across the five ACHE leader competency domains. They were also asked to rank the importance of how each domain influenced their M&A lived experiences. Five items on the questionnaire paralleled the five ACHE (2023) competency domains. These were originally defined by the Healthcare Leadership Alliance, of which ACHE was a member (Stefl, 2008). The sixth item on the questionnaire was arranged in two parts. For this question only, participants were asked to rank, by domain, their perceived importance of the leader competencies during the M&A organizational change from *least valuable,* ranked as a one (1), to *most valuable,* ranked as a five (5). In the second part of question number six, participants were asked to again rank their perceptions of which domains should have been most important during their M&A activity had the event happened in a perfect world. Their observations were expected to help identify differences in perceptions between the leader competencies applied and those that were perceived to have contributed to greater M&A success had they been applied.

After participants submitted their responses to the second part of the sixth question, they were asked if they would like to participate in the qualitative phase two portion of the study or in a random drawing for a $50 Amazon gift card. Participants were automatically redirected to the second and separate questionnaire if they opted to participate in phase two or to enter the drawing. They were prompted to share their personal contact information in this separate REDCap questionnaire, which was not linked to the participants' phase one responses. The gift card winner was chosen using the Microsoft XL random number generator and a participant ID from the second questionnaire. The drawing was conducted after the phase two interviews.

Data Analysis

In the initial data analysis stage, quantitative data were examined for descriptive statistical measures and to identify patterns or variances in the participants' responses. The researcher collaborated with the UMMC statistician in data analysis and preparing the findings for visual representation. Visualizing the findings may help the researcher determine patterns and identify gaps in potentially missing data, which may have been overlooked when viewing the numerical data alone. Data analysis focused on descriptive statistics, including counts and percentages, due to the purely categorical nature of the data. Fisher's exact tests were used for inferential analysis. The quantitative data were downloaded from the REDCap platform and analyzed using the UMMC quantitative analytics platform- Stata v18.0. These findings partly informed the content for the phase two qualitative interview guide. Phase two participants were informed of the outcomes from phase one and asked to comment on the findings. These findings helped the researcher understand why participants in phase one answered the questionnaire as they did and sparked additional remarks prompted by the findings.

Phase Two

Data Collection

Phase one participants indicating their desire to participate in phase two interviews were contacted directly by the researcher using the contact information from the second REDCap questionnaire. Each participant in phase two was presented with the informed consent cover letter documentation in the phase two coordination email before scheduling their interview (see Appendix J). Their scheduling of the interviews was the acknowledgment of informed consent. Interviews were recorded using the UMMC-provided Microsoft Teams collaboration software and the researcher's hand-held Olympus digital voice recorder as a backup device. Digital media was secured on the One Drive at UMMC, which is password-protected and encrypted. Recordings were transcribed by Microsoft speech-to-text software, and the subsequent transcripts were secured, and audio files deleted. No recordings have been kept locally with the researcher. Printed transcripts have been reviewed for coding, the documents subsequently destroyed, and only electronic copies have been maintained at the UMMC One Drive. Ten interviews were conducted, and data saturation achieved, a milestone at

which the interviews ceased to reveal new themes. A summary of findings, as a function of member checking, was sent to the interviewees as a check for accuracy. Members did not wish to augment the findings as presented.

Data Analysis

The interview data were coded to identify similar themes, revealing general concepts and allowing common themes to emerge. Similar concepts emerged to create shared categories for the remainder of the interview content. A peer coder was not associated with the data collection. To prevent bias, the researcher and the peer coder determined the emergent themes independently.

The researcher employed the Corbin and Strauss (2015) Corbin method of manual coding in three steps:

- Open, a process whereby the researcher became intimately familiar with the responses by studying the interview transcripts and through memoing.
- Axial, a process whereby the researcher assembled the data with the new connections identified in the interview transcripts.
- Selective, a process whereby interview data become linked to central themes. The interview transcripts were categorized into smaller segments where consistent statements emerged across smaller data portions.

Furthermore, the study included (1) member checking, wherein the subjects reviewed the researcher’s findings (Creswell & Creswell, 2018); (2) researcher and peer coding aimed at eliminating qualitative research errors by having two researchers independently examine the transcripts, segment the information gathered, and group the information into themes (Creswell & Creswell, 2018), and (3) journaling, a method for mitigating researcher personal bias by taking notes on the reactions to statements made by subjects and to serve as record of the researcher's evolving understanding by (Corbin & Strauss, 2015).

Ethical Considerations

The researcher completed the UMMC IRB self-certification assessment and determined that the proposed study is research involving human subjects (see Appendix K). The researcher also completed the Collaborative Institutional Training Initiative (CITI) training developed by the National Institutes of Health (NIH). Once UMMC IRB

approved the study, the researcher began phase one according to the process defined by the professional association's administrators.

The HFMA, HExN, and MHA administrators (not the researcher) initially contacted their membership on the researcher's behalf with an invitation to participate in the study. Further, the researcher shared an invitation to participate in the MGMA communities and their own LinkedIn professional page. The informed consent cover letter was shared with the participants in REDCap at the beginning of phase one. At the end of phase one, participants electing to move forward with phase two or participate in the gift card drawing were requested to share their contact information. If opting into the interview or gift card drawing, the second questionnaire offered participants a response area within the REDCap questionnaire to submit their contact information. The first and second questionnaires were not linked. The study preserved participant anonymity by using two separate questionnaires to ensure participants' responses could not be linked to their personal contact information. Participants were also presented with the informed consent cover letter in the interview coordination email at the beginning of phase two. Scheduling the interview served as informed consent and their willingness to participate.

To preserve respondents' anonymity, the statistician evaluating phase one data only knew the participants by their participant ID, as recorded by REDCap. This method ensured participant anonymity by recording responses in questionnaires that were not linked to their personal contact information. Contact information shared during phase one was not linked to the quantitative questionnaire. This information was limited to name, email, and telephone number. Phase two participant identities were masked in printed transcripts or shared electronic documents with pseudonyms such as *AA, BB*, etc., reflecting the order in which they were interviewed. Any participant-identifying data is maintained in a password-protected and encrypted file on the UMMC One Drive, which will be maintained for six years per UMMC's data retention policy.

Questionnaire data will be maintained in REDCap, and interview data (transcripts and audio/video files) will remain in a password-protected UMMC One Drive. Any printed materials were shredded after review and kept only as electronic copies in the UMMC One Drive. Transcript data were coded from printed or electronic copies. The

digital audio files used for backup were deleted, and the transcripts will be stored for six years per UMMC's data retention policy.

Timeline

After UMMC IRB approval, the researcher began phase one of data collection. Subsequently, the HFMA, HExN, and MHA administrators (not the researcher) initially contacted their membership on the researcher's behalf with a general overview of the study and the questionnaire link. The researcher posted notice of the study to the MGMA communities and their professional LinkedIn page. The study's chronology may be found in Table 2. The final project defense was presented on April 29, 2024.

Table 2

Timeline

Actions	**Milestone Completion Dates**
Approval from UMMC committee	January 5, 2024
Enter questionnaire in REDCap	January 8, 2024
IRB submission	January 19, 2024
IRB approval	February 16, 2024
Participant recruitment began	February 20, 2024
Schedule phase two interviews	February 20- March 27, 2024
Analyze quantitative data	March 18, 2024
Finalize interview guide from phase one findings	March 19, 2024
Begin interviews	March 20, 2024
Member checking	April 3- April 4, 2024
Analyze qualitative data	March 20- April 3
Associate findings to QTBA	April 3- April 4, 2024
Develop the solution—Chapter 4	April 4, 2024
Develop the implementation—Chapter 5	April 6-7, 2024
Send to Committee Chair for final review	April 12, 2024
Send Chapters 4 & 5 to Committee	April 15, 2024
Final defense	April 29, 2024

Resources

Resources used during the study were:

- recruitment of participants: email listserv and LinkedIn,
- data collection: REDCap, Microsoft Teams collaboration software, Microsoft Office Suite, and Olympus digital voice recorder,
- data analysis: Stata, UMMC statistician, peer coder, and Microsoft Office Suite,
- data storage: UMMC One Drive.

Summary

The two phases of an explanatory sequential mixed methods study promote generalization and universal findings (Creswell & Creswell, 2018). This study addressed leaders' perceptions of their leadership competencies during lived M&A experiences, as guided by the five ACHE leader competency domains. The quantitative questionnaire grounded the qualitative interview guide, and together, the two phases offered findings for the researcher to answer the study questions regarding what leaders report about their perceived leadership competencies and values during M&A.

The study may have limited geographic generalizability due to the survey questions aligning with the traits of leader competency measures derived from assessments developed for HCO leaders in the United States. Data were collected from a limited number of professionals recruited through four clinical and administrative professional associations and the researcher's professional network. The quantitative portion of the study identified results by respondent demographics. The data were limited to HCO clinical and administrative leaders. Quantitative data collection may reveal generalizability across HCO leaders' roles, workplace IRS classification, or if they were part of the acquired or acquiring HCO. Results from the qualitative data were associated with the ACHE leader competency directory and not applicable to other competency measures not using the ACHE five domains.

Although this study is centered on leadership competencies in healthcare M&A, which may limit its wider applicability, its value is expected to increase as more HCOs engage in M&A activities (National Institute for Health Care Management, 2020). Exploring study participants' perceptions from lived M&A experiences may help HCO leaders support future M&A. Establishing a baseline of leader competencies perceived as

most productive in managing the complex processes of M&A-associated activities may lead to more successful M&A experiences.

SOLUTION

CHAPTER IV
SOLUTION

Healthcare organizations (HCOs) may address the business challenges associated with the provision of care through mergers and acquisitions (M&A) of other healthcare HCOs (Hayford, 2012; Postma & Roos, 2016; Shaygan, 2018). The M&A process requires that leaders balance the clinical and administrative requirements of providing care amidst the distractions of unifying two disparate cultures. Despite leader intentions to complete the M&A process, many fail to achieve their HCO's objectives (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Gale, 2015; Stokes & Bruce, 2021). Additional research is needed to understand the leadership dynamics at work during M&A. This study aimed to identify those dynamics through the following questions:

1. What do healthcare leaders report about the success or failure of M&As and the role that the ACHE leadership competencies played during the M&A?
2. What are healthcare leaders' experiences during M&A as related to the five ACHE leadership competencies?
3. How do the experiences of healthcare leaders during M&A relate to what leaders reported regarding the success or failure of their M&A in the context of the ACHE leader competencies?

Description of Participants

Phase one of this explanatory sequential mixed methods study employed an electronic questionnaire distributed to clinical and administrative professionals. The researcher recruited participants from the memberships of the Medical Group Management Association (MGMA), the Healthcare Financial Management Association (HFMA), the LinkedIn online communities of the Mississippi Hospital Association (MHA), the Hospital Executive Network (HExN), and the researcher's professional page. Study participants were recruited for three weeks, resulting in 86 valid questionnaire responses. Although a total of 595 responses were captured in the Research Electronic Data Capture (REDCap) system, data integrity issues were identified that subsequently disqualified 509 responses. The differences are addressed in the Limitations section of this study. Accordingly, 26% of the respondents identified as clinical and 74% identified

as administrative professionals. Participants from the professional associations were weighed equally and not required to provide answers to all questions. Partial responses were accounted for as incomplete in the results.

Participants were presented with seven qualifying and demographic questions prior to completing the six-item perceived leadership competencies survey. Among these were demographic questions regarding their role (clinical or administrative). To be included in the study participants were required to have held a leadership role during their M&A activity. Additionally they were asked about their number of years in leadership, organizational business classification (for-profit, non-profit), point of view before the M&A (acquiring or acquired), if the M&A was completed as intended, and the competencies they may have wished present.

The literature offers, leaders who understand their organization's capacity for change may improve their chances to complete organizational change as intended (Martin, 2021; Vaishnavi et al., 2019). Leaders with greater tenure before their M&A activity may have a deeper understanding of the organization's readiness for change than those who are newer to the organization. The questionnaire provided participants with response options to measure their years in leadership roles as 0-5, 6-11, 12-17, and 18 or greater (see Appendix L, Table L3). The data show that 96% of respondents had been in leadership roles between 0 and 17 years, and 40% of these respondents had significant longevity between 12 and 17 years.

Most (79.4%) participants reporting a profession indicated they served as administrative leaders during their most recent M&A activity (see Appendix L, Table L4). Clinical and administrative professionals are employed across institutions with various business classifications, which may include for-profit, non-profit, charitable, and governmental entities, each having unique business requirements. Using the U.S. Internal Revenue Service (IRS) Business Classification, this demographic question was intended to measure how each classification may influence leader perceptions or impact the M&A process or outcomes. Most participants identified with the IRS' non-profit classification (51%). Others identified as for-profit (30%), charity (7%), government (1%) other (see Appendix L, Table L5). Participants were asked to quantify the number of M&A activities in which they have participated. The questionnaire offered response options as

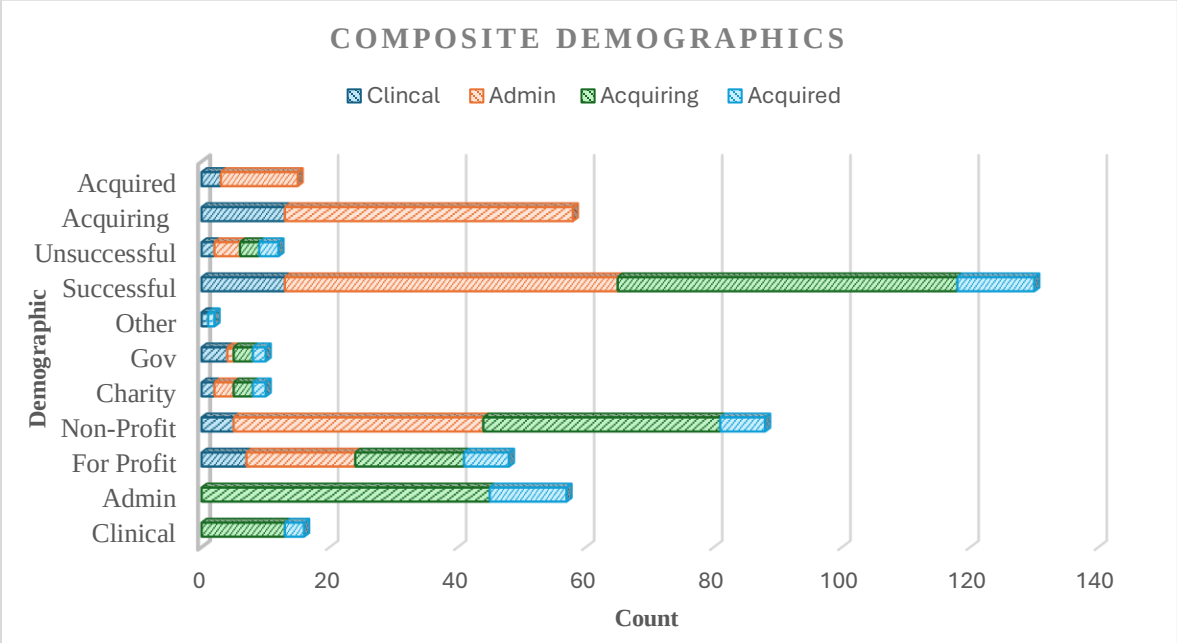
1, 2, 3, or more than 3. Most participants (66%) indicated they had participated in more than one M&A activity (see Appendix L, Table L6).

Participants were asked if their most recent M&A was completed as intended. Surprisingly, 77% report successful M&A ventures. This success rate is contrary to the literature, which often cites that M&A activities frequently do not achieve their intended outcomes (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Gale, 2015; Stokes & Bruce, 2021). By examining the M&A success rates in conjunction with the perceived leadership competencies present during the M&A process, the researcher aimed to shed light on the effectiveness of certain competencies when addressing the complexities of M&A activity (see Appendix L, Table L7).

Participants were asked about their point of view within the organization. This question was intended to establish if competency perspectives were different from leaders in the acquiring and acquired organizations. The data show a more than three-to-one (66%) response rate from participants from acquiring HCOs (see Appendix L, Table L8). Collectively, the data indicate a high response rate from administrative professionals (79%) employed by an acquiring (78%) non-profit HCO (65%) with M&As completed as intended (92%). These data are graphically represented in Figure two.

Figure 2

Composite Demographic Data at a Glance



Note: Graphic representation of composite data is based on descriptive statistics.

Additionally, these data have been correlated with the participant's leadership tenure. The results indicate greater time in a role is positively associated with successful M&A. Further, the demographic data show a correlation between leaders' tenure and the number of M&A activities in which they have been involved. Results show most (40%) leaders had 12-17 years of experience at the time of their most recent M&A activity, and most had participated in at least two M&A activities. Administrative professionals serving in the acquiring organizations indicated the greatest number of successful M&A activities. (see Appendix L, Figure L3).

In phase two of the study, participants were invited to share their opinions and provide insights to help explain the quantitative results. Twelve participants offered to be interviewed. Ten of these participated in an interview with the researcher using UMMC's Microsoft Teams video conferencing system, which recorded and transcribed the interactions. All participant interviews, scheduled for 35 minutes, lasted between 19 and 46 minutes each. Notably, only 10% of the phase two participants held clinical roles, reflecting a similar trend observed in the respondents' professions from phase one.

Research Findings

Collectively, the data from phases one and two offered clarity on what leaders perceive as the leadership competencies present during their most recent M&A activity and the desired competencies they wish had been present. The data provided insight into leader competencies during successful and unsuccessful M&A activities. The survey data were generally analyzed using participant scores above the midpoint. The researcher often used scores exceeding the midpoint to accentuate the differences between the various domains and demographic information frequently separated by marginal differences. This approach can help identify trends or patterns among those who responded more positively or agreed more strongly with the survey items.

The qualitative data were provided by participants with experiences in successful and unsuccessful M&A. Analysis of the qualitative data revealed six subthemes, four primary themes, and one predominant theme that help explain participant perspectives on leader perceived competencies across the five domains.

Phase One Quantitative Findings

Subsequent to the participant qualifying and demographic questions, a six-item questionnaire collected data regarding the participant's perception of their leadership competencies during their most recent M&A activity. Five items on the questionnaire paralleled the five ACHE (2023) competency domains. The ACHE domains are measures of "expertise in critical areas of healthcare management" (ACHE, 2023, p.1). The associated domains are (a) leadership, (b) communication and relationship management, (c) professionalism, (d) knowledge of the healthcare environment, and (e) business skills (acumen). For context, each question also briefly defined the associated competency domain using terminology from the ACHE Leadership Competency Assessment.

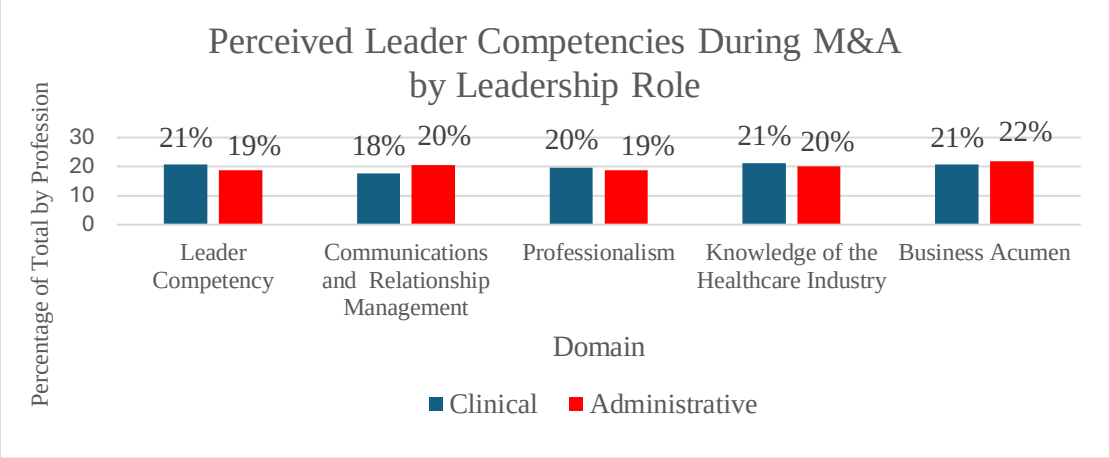
The sixth item on the questionnaire was arranged in two parts. For this question, participants were asked to rank the competencies they perceived as most valuable to the HCO during their lived M&A experiences from the least valuable (1) to the most valuable (5). In the second part of question number six, participants were asked to consider again their most recent M&A but this time as if it occurred in a perfect world. They were again asked to rank the competencies they now perceived would have been most valuable to the HCO during the M&A.

The quantitative data analysis from the first five survey items indicated that participants across all demographics perceived their most apt competency during their most recent M&A activity to be in the Business Acumen domain. Responses were 2% higher for the Business Acumen domain than the average of the four others. The total population of participants ranked the remaining domains from least valuable to most valuable (see Appendix L, Figure L4).

Additional analysis of the responses using the total population of data by domain revealed that clinical leaders had a slightly lower perception of their Communications and Relationship Management and Business Acumen competencies than did administrative leaders. Figure 5 compares perceived leader competencies during M&A between clinical and administrative participants. Figure 5 is important as HCO leadership is often led by a duality of clinical and administrative professions (Saxena, 2021).

Figure 5

Leader Perceived Competencies by Role



Note. Percentage of participants by perceived leader competencies by domain by comparison of the leader roles.

When analyzing the responses from all participants across the five domains from the first part of question six, Business Acumen was identified as the domain most highly demonstrated by leaders. The researcher used the total population of data for all values from the five-point Likert scale and, for contrast, values above the mid-point (4) and (5) (see Appendix L, Table L9). Leaders rating themselves above the midpoint, excluding the lower scores of 1 (*novice*) to 3 (*competent*), may suggest leaders perceived a greater confidence in their abilities.

In the second part of question number six, participants were asked to rank again their perceptions of which domains should have been most important during their M&A activity had the event happened in a perfect world for contrast to the first part of question six. Again, both tables indicate values from the total population and those above the mid-point (see Appendix L, Table L10). The difference in these data represent the participants' wishes and what they likely needed during the M&A if executing it in a perfect world (see Appendix L, Table L11).

The contrasting data above the midpoint, between what the participants witnessed versus what they wished for or needed, is shown in Table 12. Participants indicated a need for stronger competencies in the Communications and Relationship Management domain by 7.20% and in the Leadership domain by .08%. In contrast, participants

indicated they could have witnessed less in the Professionalism (-21.50%) and Knowledge of the Healthcare Industry (-12.10%) and marginally less in the Business Acumen (-.52%).

Table 12

Witnessed v Wished Perceived Importance by Domain

	Leadership	Communications and Relationship Mgt.	Professionalism	Knowledge of the Healthcare Industry	Business Acumen
Witnessed records above the mid-point	60.78%	55.76%	41.50%	34.32%	34.84%
Wished records above the mid-point	60.86%	62.96%	20.00%	22.22%	34.32%
Percent change	+0.08%	+7.20%	-21.50%	-12.10%	-0.52%

Note. A negative percentage change between witnessed and wished data indicates the participants valued the domain less than when witnessed. A positive percentage change indicates the participants valued the domain higher than when witnessed.

Further analysis of the 7.20% delta between what was witnessed and wished in the Communications and Relationship Management domain was nearly uniform, with only a small delta (2.5%) across clinical and administrative participants (see Appendix L, Figure L6).

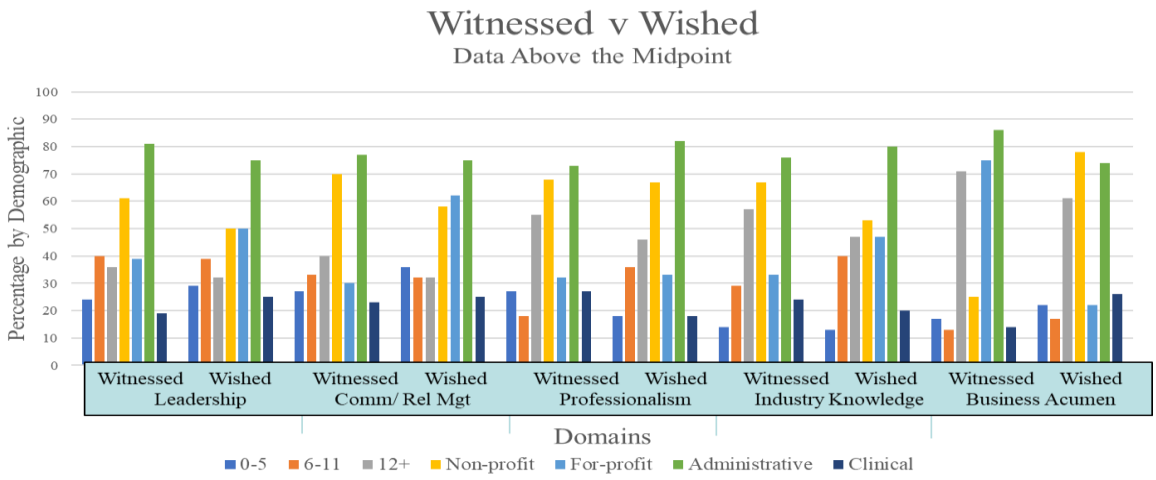
An exploration of the data from the two-part question, using Fisher exact tests, contrasted what was witnessed and wished for by dependent and independent variables, considering years in leadership, role, and their employer's IRS classification. The independent variables measured the participants' perceived values of each ACHE competency domain, both witnessed during the event and wished for retrospectively.

A measure of the leaders' perceptions of their competencies, witnessed versus wished, for the three independent variables are indicated in Figure 7. The data may describe the greatest changes between the independent variables as follows:

- Clinical professionals with the least years in leadership employed by a for-profit organization wished for a higher degree of competency in the Leadership and Communications and Relationship Management domains during the transition.
- Administrative professionals with the most years in leadership, employed by a for-profit organization wished for a higher degree of competency in the Professionalism domain during the transition.
- Administrative professionals with at least six years but no more than 11 years in leadership employed by a for-profit organization wished for a higher degree of competency in the Knowledge of the Healthcare System domain during the transition.
- Clinical professionals with not more than 11 years in leadership employed by a for-profit organization wished for a higher degree of competency in the Business Acumen domain during the transition.

Figure 7

Leader Competencies Witnessed v Wished



Note. Data above the midpoint have been selected to identify the most strongly desired perceptions.

Considering all responses from novice to expert, the data for both witnessed and wished; many outcomes had p-values below the acceptable threshold of 0.1. Additionally, one measure was statistically significant with a p-value of less than 0.05. The domains below the 0.1 p-value threshold were Communications and Relationship Management (0.083) and Professionalism (0.012) when viewed by Clinical or Administrative

responses. Otherwise, p-values for all demographics ranged between 0.012 and 1.0, with an average of 0.62. Further examination of the data in context with the literature provides a comprehensive view of the perceived competencies essential for leaders expected to execute M&A.

ACHE Domain, Leadership

To what degree do participants attribute elements from the five competency domains to successful organizational change? The literature emphasizes overt displays of leadership as an antecedent to success (Aunger et al., 2021; Leiter & Harvie, 1997; Lohrke et al., 2016; Martinussen et al., 2020; Miller & Millar, 2017).

This study data affirmed the literature in that leaders who have participated in M&A value the competencies of the Leadership domain. Participants with the highest incidence of M&A failures ranked their perceived competencies lowest in the Leadership domain. Less than one percent of those reporting their Leadership domain competency above the midpoint were unsuccessful. In contrast, 43% of respondents self-assessed their leadership competencies as above competent (4) to expert (5). Competencies from the Leadership domain were perceived to be demonstrated significantly more by administrative professionals (84%) than their clinical counterparts (16%). Further, contrasting the data between the administrative peer group, leaders from the acquiring organizations perceived their Leadership domain competencies to be higher (39%) than leaders in the acquired. The data indicated that the administrative respondents' scores above the midpoint were divided equally between the acquiring and acquired organizations. Also, Leadership was the only domain that did not receive an expert ranking from the clinical professionals in the acquired organizations.

Addressing the quantitative findings for question six, a contrast of witnessed and wished for the Leadership domain, the literature indicates leadership skills are needed to help employees adapt and assimilate into a new culture (Canady & Miller, 2023; Chesley, 2020; Robbins, 2018). Respondents perceived they witnessed Leadership domain characteristics marginally less than they perceived as necessary when considering data above the midpoint.

While there was only a marginal increase of 0.08% across all respondents between witness and wished, these differences were not uniformly distributed; clinical professionals desired more leadership competencies to be demonstrated by 3%.

ACHE Domain, Communications and Relationship Management

Interpersonal skills are competencies identified within the Communications and Relationship Management domain. These skills have been positively associated with organizational change (Aunger et al., 2021; Kakemam et al., 2020; Raeder, 2023). Although research shows that leader-follower dialogue can be more time-consuming, it is also more efficacious (Emond et al., 2021; Martin, 2021; Round et al., 2018). Leaders who approach organizational change by first aiming to rebuild trust with followers may retain well-adjusted staff who modify their behavior to accommodate organizational changes (Chhabra et al., 2022; Khan et al, 2018; Martinussen., 2020).

Again, the study supported the findings from the literature regarding the importance of communication. Half (50%) of all clinical and administrative respondents perceived their competencies as above competent (4) to expert (5) in the domain. Administrators from the acquiring organization reported higher (67%) Communications and Relationship Management competencies than leaders in the acquired organization. Only one respondent identifying as clinical from the acquired organization perceived their competency above the midpoint. Otherwise, the acquiring organization's clinical responses were low (5%). Eight percent of the respondents, self-scoring their perceived competencies above the midpoint in the domain, were unsuccessful in their M&A activity.

Intentional leader communications with staff have been positively associated with M&A integration (Aunger et al., 2021; Canady & Miller, 2023; House et al., 2022; Robinson & Knight, 2018). Focusing on the data from question six, the Communications and Relationship Management domain registered the most substantial percentage increase in desired competencies among all domains examined. Data analysis revealed respondents aspired to higher proficiency levels within this domain when measuring responses above the midpoint. This trend was consistent across all demographics, with an increase of 7.20%. Notably, the desire for improved skills in this competency was more pronounced among clinical professionals than their administrative counterparts.

ACHE Domain, Professionalism

A leader may demonstrate professionalism by aligning their personal ethics and development with the organization's requirements and needs (Harolds & Miller, 2022; Kakemam et al., 2020). In response to HCO demands for specific competencies, competency-based higher education programs have increasingly emphasized the qualities associated with the Professionalism domain to better prepare students for future employment (Cellucci et al., 2018; Hernandez et al., 2018). Leaders exhibiting Professionalism may encourage unification through joint personal development sessions with their old and new staff after M&A (Canady & Miller, 2023).

The study data reflected that leaders perceived they demonstrated professionalism least when compared to three domains, albeit by less than 1%, and for comparison, at the same level as the Leadership domain when focused on data above the midpoint. Less than half (43%) of all clinical and administrative respondents perceived their competencies as above competent (4) to expert (5) in the domain. The administrative leaders from the acquiring organization perceived demonstrating Professionalism competencies higher (60%) than leaders in the acquired. Clinical leaders from the acquiring organizations perceived their Professionalism competencies to be nearly one-third (30%) more than their peers in the acquired organization. Clinical and administrative leaders indicating their M&A was unsuccessful produced the lowest scores in the Professionalism domain.

The literature offers that leaders may employ skills from the Professionalism domain to help staff adjust to the new normal (Canady & Miller, 2023; Cerezo-Espinosa de los Monteros, 2021; Kakemam et al., 2020). The Professionalism domain had the largest drop (21.50%) across all domains for what was witnessed versus wished when considering the data above the midpoint. In the respondents' ranking of domains by perceived importance, the respondents placed the Professionalism domain as the lowest priority. A notable shift was observed in the comparative analysis of desires between clinical and administrative professionals: administrative staff strongly preferred traits within the Professionalism domain, diverging from the trends seen in other domains. This indicates a distinct difference in priorities between the two groups of professionals.

ACHE Domain, Knowledge of the Healthcare System

The literature indicates HCO leaders' knowledge of their environment, and the broader healthcare industry may help overcome the consternation associated with organizational change (Jones & Fulop, 2021; Vaishnavi et al., 2018). Also, followers identifying professionally with their leaders may experience higher productivity (Leach et al., 2021; Nelson-Brantley & Ford, 2017). Knowledge of the healthcare system includes the patient's point of view, which is important as patient care quality may decline after M&A (Beaulieu et al., 2020; Kam et al., 2020; Mariani et al., 2022). Likewise, patient costs can increase (Cutler & Morton, 2013; Hayford, 2012; Huntoon, 2023; Rabbani, 2021).

More than half (53%) of all clinical and administrative respondents reported perceiving their knowledge of the healthcare system competencies as above competent (4) to expert (5), indicating respondents' confidence in their perceptions of how they demonstrated knowledge of the healthcare system. Few (15%) perceived their competencies below the midpoint. Further, this domain ranked second highest (28%) in expert responses. The administrators from the acquiring organization perceived demonstrating their knowledge of the healthcare system higher (61%) than administrative leaders from the acquired. The administrative leaders from the acquiring organization perceived their competencies as higher (64%) than their clinical counterparts from the acquiring organization. Interestingly, the clinical and administrative professionals in the acquired organizations perceived their competencies with a marginally higher (10%) difference. Four percent of the respondents, self-scoring their perceived competencies above the midpoint in the domain, were unsuccessful in their M&A activity.

Leaders with insight into their HCO and the broader healthcare industry may better understand the organization's readiness for change before attempting it (Martin, 2021; Vaishnavi et al., 2019). An analysis of the leader responses regarding the Knowledge of the Healthcare System domain showed it had the second largest drop (12.10%) following the Professionalism domain from what leaders witnessed and wished. The data indicated that administrative professional respondents with at least six years in leadership but not more than 11 years employed by non-profits sought more knowledge of the System. In the comparative analysis of the perceptions held by clinical versus

administrative professionals, the data indicated administrative professionals place a higher priority on elements within the domain than clinical professionals. This divergence suggests that administrative professionals exhibited a greater propensity for having more knowledge of the System during the transition.

ACHE Domain, Business Acumen

The Business Acumen domain addresses the strategic and managerial skills needed to execute the business of leading an HCO. Leaders of HCOs, unlike leaders in other industries, are responsible for patient care quality and operational excellence (Belkowitz et al., 2023; Sherman et al., 2007; Tasi et al., 2019). A productive level of clinical staffing (a domain characteristic) may be incumbent on HCO leaders (ACHE, 2024a; Martinussen et al., 2020; Harrison & Zavotsky, 2018). As fiscal management is a critical component of Business Acumen, leaders may use novel methods to raise non-clinical revenue (Erwin, 2015; Mahajan et al., 2022). Research indicates that participating in M&A can have a positive financial effect on HCOs (Barrette et al., 2022; Cooper et al., 2019; Schmitt, 2017).

Leader perceptions related to the Business Acumen domain were the most positive among all domains recorded during the first phase of data collection. Clinical and administrative leaders (58%) perceived their competencies above the midpoint, above competent (4) to expert (5). Respondents were confident in their perceptions of how they demonstrated the characteristics of the Business Acumen domain. This domain ranked highest (26%) in recording leaders' perceptions as experts (5). The administrators from the acquiring organization perceived their domain competencies as higher (62%) as compared to leaders in the acquired. Administrators in the acquired organization were more confident (50%) in their business acumen than their clinical leaders in the acquired organization. Five percent of the respondents, self-scoring their perceived competencies above the midpoint in the domain, were unsuccessful in their M&A activity. Notably, all responses from the clinical professionals below the midpoint were unsuccessful.

Competencies, particularly in the domains of Communications, Relationship Management, and Business Acumen, were valued by leaders in acquiring organizations who generally rated their competencies higher than those in acquired ones.

Professionalism and Knowledge of the Healthcare System were also highly valued, with over half of the respondents perceiving their competencies above the mid-point.

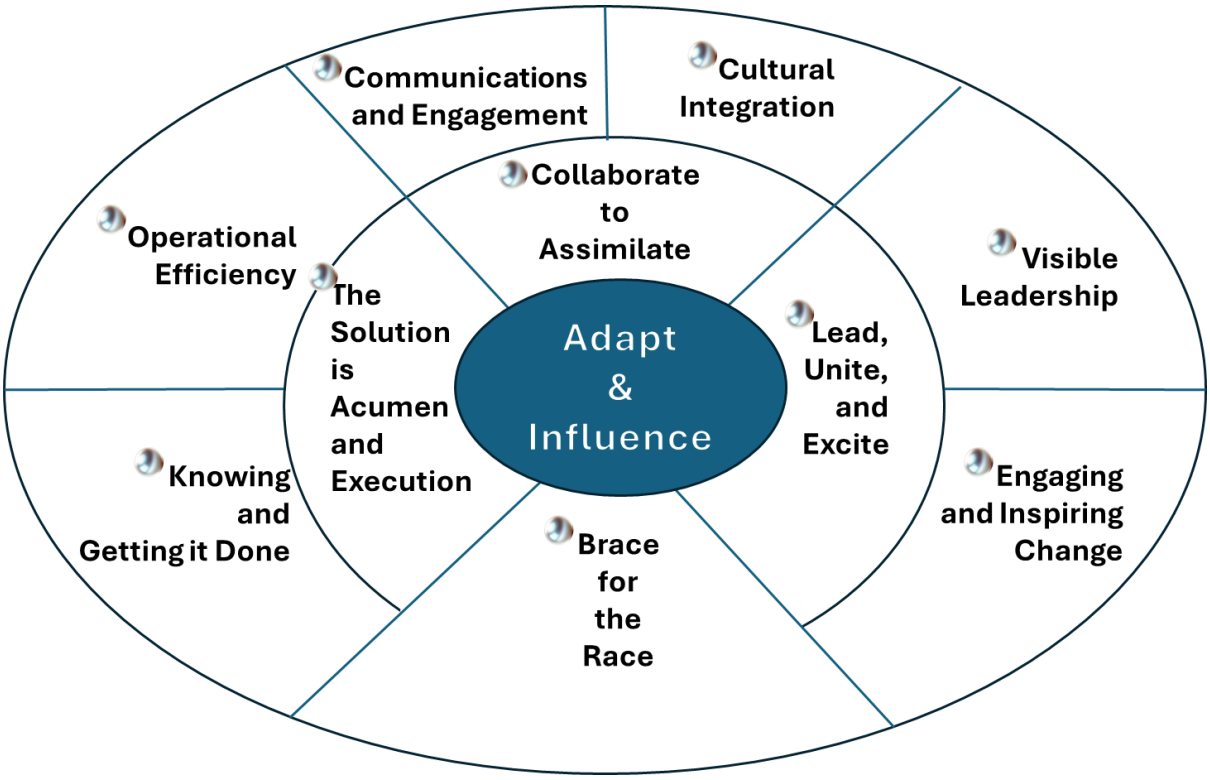
According to the literature, these broad competencies are crucial for navigating the complexities of M&A-associated organizational change. A leader's use of the elements found in the Business Acumen domain may help address the new organizational dynamics inherent after organizational change (Chesley, 2020; Robinson & Knight, 2018; Sherman et al., 2007). Recall participants perceived their delivery of the characteristics from the Business Acumen domain as being the most competent across all domains. When analyzing the data above the midpoint, leader-perceived confidence may explain the smallest drop (0.50%) found in all domains between what was witnessed and the wished outcomes. Additionally, the composite margin indicated a preference for less business acumen, suggesting participants may feel there was little room for improvement. This perception may have been accurate, as evidenced by the data, which indicated a low rate of failures (5%) among participants who rated their perceived competencies above the midpoint. In assessing the variance between clinical and administrative professionals, the witnessed and wished data suggest that clinical professionals strongly desired (18%) greater business acumen domain elements during future M&A organizational change.

Phase Two Qualitative Findings

The researcher applied the Corbin and Strauss (2015) method of coding, a technique frequently associated with grounded theory research. The method incorporates three phases of coding qualitative data: open, axial, and selective coding. Each phase is intended to abstract the data and refine possible connections. This method of analysis may identify common themes in qualitative research. The qualitative data were collected across ten interviews lasting just over six hours total. Participants shared their perceptions of leader competencies during synchronous video or telephone interviews. Participant names have been replaced by identifiers AA-JJ as part of the researcher's ethical responsibilities. The researcher employed a semi-structured interview guide to prompt the participants' responses, partially developed from an analysis of data from the first phase of the research. The phase two coding of the data yielded six subthemes, four primary, and one predominant theme. The outcome of coding is represented in Figure 8.

Figure 8

Emergent Themes



Note. Summary of themes from qualitative data. These "Pearls of Wisdom" are also the basis for the study's product.

Theme One: Collaborate to Assimilate

Leaders insisted that frequent communications between leaders and staff were an important part of the M&A organizational change process. Leaders remaining engaged with staff while they face the challenges of implementing organizational change may provide opportunities to build leader/ follower trust. Participants discussed leader strategies for developing a single culture from two previous and sometimes rivalrous cultures. Aligning teams at the onset of the integration process may lead to less long-term conflict. Leaders should not wait for peers from the new organization to be assigned by their executive administrators to begin the process of assimilation. Likewise, staff should seek out their peers and begin learning from one another proactively. These actions may help individuals understand the new norms and adapt to their unfamiliar environment. Below are participant quotes supporting these findings.

> "So really [it] took some good communication and working side by side with these people to get to where you need it to be" (Participant JJ).

> "Especially if you're dealing with a competitor in the market that has. . . always had this adversarial relationship...it's tough to get people on board" (Participant CC).

> "[Leaders should] promote assimilation. It will not happen without you" (Participant HH).

Subtheme 1.1: Communications and Engagement. Participants advocated that improved communication between leaders and followers could lead to greater success. Communications should be bidirectional between leaders and staff as well as among small groups. Listening can be a nuanced part of communication, which may require further professional development for some leaders.

> "People are not very good at listening. You know, it's hard to do, but I think like just listening more [could make you a better communicator] (Participant GG).

> "So, I will say that as a rule, administrators always have an opportunity to do better in communications" (Participant BB).

> ". . . people that tend to end up in these executive leadership roles they're good, they got there by rocking the boat. [It's] just that sort of person, that personality, relationship management can be nuanced and difficult" (Participant GG).

Because peers may positively influence one another through small groups with critical knowledge of their functional areas, leaders should provide staff with a forum to share their knowledge and encourage peer engagement. The business of care may be similar across many healthcare organizations, but departmental leaders understand the nuances of their department which must be adapted to the new collective organization.

> "I am the gate. I have the [local] knowledge of my business where the...other side of the table knows nothing about my organization" (Participant AA).

> "[It's important that] all key stakeholders from every relevant team or department has representation throughout the process. Pairing those like the clinical leadership together and you know they're having their own discussions and meetings and then perhaps you know all joining this part of a larger group as well" (Participant DD).

> "I think we have really good people in our organization and some of them came from other industries and had that really strong business acumen. It definitely wasn't assigned, but I think as a team we just relied on a couple of those people really heavily and one of them was someone who had been involved in a couple of transactions [we] learned from like what they did wrong. It's like, oh, we didn't do that well last time" (Participant EE).

Leaders may consider using the consultant or corporate-developed change messaging as a guide, but a local leader using the local vernacular should convey it to followers. Local leaders using familiar language may build trust more effectively than those using unfamiliar messaging, which may be useful for leaders looking to influence staff during the integration. Participants shared the necessity for communications to be fully transparent and inclusive. Leaders should also recognize and address when they do not have the answers to staff questions. They should investigate the unknown and communicate their findings. Participants indicated leadership is entwined with communications, not a choice of one or the other.

> "I want to know the key talking points on the [consultants' template] and then communicate that in my own style to the team" (Participant DD).

> "You know, and the leaders need to deliver the message. Maybe the consultants can help wordsmith, but the leaders need to deliver that message" (Participant FF).

> "[If there are] 25 different hospitals across the country and say there's going to be like an announcement and you're going to get an internal email at 10:00 AM on Monday, at 9:00 AM across all these sites, the leaders of those sites should come and just give an in person [localized communications], a townhall" (Participant GG).

> "I would say that transparency with your communications, whether it's creating a great marketing strategy to keep everybody informed about the movement in M&A is really, really important and to have them be part of the process as much as possible" (Participant II).

> "It's like communication, [is] the why, the where, the how and that kind of leads to leadership, but it's not leadership versus communication" (Participant JJ).

Subtheme 1.2: Cultural Integration. Participants indicated that aligning their areas of responsibility with counterparts in the new organization can increase the pace of assimilation. Alignment is likely to be more effective when it occurs among individuals within the same professional field.

> ". . . it's always nice to have a physician champion, right, because colleague to colleague is much more relevant than an admin person trying to tell a physician. . . . having that physician champion usually gets you further faster" (Participant JJ).

> "When we start to share that with my peers like oh hey, [I] met with the ortho guys. They're great. They do some things that we don't do. And so you know that sort of [cultural integration is] what we call [the] tone of the process [which]

begins to change through that peer network" (Participant EE).

Additionally, each exchange between the acquiring and acquired organizations is an opportunity to learn from/ about one another. Proactive communications regarding the changes require that leaders share the background and the "why" behind the necessary changes. Concurrent with the literature, participants felt strongly that teams could learn from one another during M&A integration.

> "I mixed the two groups staff's together. They assumed the staff would just talk and bridge the cultures. I found in the last two mergers, that if I put some from the main group into the new group and vice versa, they would learn their culture" (Participant HH).

> "Relationships are established in not one or two meetings but established over a period of time whether in person or over zoom" (Participant DD).

> "[We] must communicate, iteratively so the team knows how we arrived at the destination not just that we arrived" (Participant CC).

> "People hear system and then they think systemness. That means everything has to be done exactly the same way. And it doesn't to be successful. And in fact, if everything's done the same way it. I think there's a risk in it. You're going backwards" (Participant FF).

> "Sometimes there's sensitivities around that. . .where like for example, if you're selling off of business, . . .[people] tend to be like a little more tight. I think you should just sort of try to tell people in person first before they get. . . an email that doesn't really speak to them" (Participant GG).

Theme Two: Lead, Unite, and Excite

Participants indicated leaders are valued by staff and their actions are observed for their commitment to execute the organizational change management plan. Participants pinpointed key aspects within the processes of planning, leading, and executing, where the contributions of leaders positively influenced the outcomes of the M&A.

> "You gotta sell it. . . no matter how you're working on anything, you know, to get to the hearts and minds of people, that's where these come in. They have to trust you. Professionalism is about trusting, and leadership is about inspiring and enabling people to succeed (Participant BB).

> "I think the nuances are really, really hard. Strong leaders can walk you through the strategy of why coming together is important" (Participant EE).

> "People have to be cognizant of where they're going, what they're doing, what the community is, what the culture is" (Participant JJ).

> "What I mean what they need to know is how is my workflow going to change with this merger happening? And, am I going to be able to do my same job, right" (Participant II).

Subtheme 2.1: Visible Leadership. The participants highlighted the significance of leaders' actions being visible while establishing the direction and pace for organizational transformation. While leaders can delegate change-related tasks, participants indicated they must remain engaged with the workforce, avoiding physical or cognitive detachment. During the integration process, participants noted that executives will step away once the process is underway leaving the integration chore to subordinates. This absence could clarify why early in career clinical professionals sought more leadership than they observed.

> "Leadership has led the charge...when it comes to, you know, the nuts and bolts of making it work again, you know your leadership has made the [charge], and there have been enough high-level discussions at 100,000 feet that. . . this is why we like each other. We've decided we're [going to] go down this path of getting married. It's the [rest] of us who have to figure out how to make it work" (Participant AA).

> "So, if I look at, you know, even the differences between the two I was involved in, the ones that are more successful are when Leadership stays very involved" (Participant EE).

> "I can say without hesitation that any successful medical group has got to have a strong, wonderful leader, that has a vision" (Participant HH).

Furthermore, their staff can perceive leaders who exhibit vulnerability and self-sacrifice as valuable. Participants indicated they did not expect leader involvement at the low levels during integration, however, staff will be observing their leaders for competencies in organizational change management.

> "I just don't think it's a good leadership quality to...close off from...lower levels of an entity. [Leaders] need to show that [they] don't always know the answer to things and that's okay. [Show] you're trying to work through them and solve them. I think like a little bit of vulnerability [can be] can be a valuable quality" Participant GG).

> "[So the] president of this huge hospital is just walking into the office just to have meetings so that he knew that people realized what was happening and how [the M&A] was going to happen and, well, [the staff knew] that was going to happen. He was an excellent speaker and he also was committed to what he said. . . so great stuff" (Participant JJ).

> "We know that we have the right people in the room that understand the process and then we're making the best decision we can. I have a tendency to explain more [and get a wider view of input during changes]" (Participant EE).

Subtheme 2.2: Engaging and Inspiring Change. It is essential for leaders to convey information in a context-specific manner to prevent staff from being overwhelmed with details unrelated to their position. Look beyond the organizational chart to understand the people within the teams impacted when communicating. As part of influencing organizational change, leaders may need to overcome the staff's natural resistance to adapt to new organizational norms.

> "I think that it's critical to really understand [when] pursuing M&A activity, it's imperative that [you] really have a great understanding of the culture of the organization that you are either merging with or trying to acquire and how that's going to fit with the culture of my [current] organization" (Participant DD).

> ". . .my more recent experience is that corporate is looking at an org chart and numbers and data, and there's a whole bunch of assumptions beneath that. . . Knowing the audience. . . even within an entity, [communicating to] a board of directors is different than nurses on the floor. . ." (Participant FF).

> "I think you have to constantly be evaluating yourself to make sure that your message is getting where it needs to go and the method in which you want it to, and you can tell by responses. Is my message getting across to our people, [are they] in agreement or at least understanding the message so that if there are conflicting opinions, we [can] discuss them. Brainstorm. Maybe things need to change" (Participant JJ).

> "I think what you always have to do is [focus the messaging back] to, it's about the patients. It's about what we can do together for the patients. It's about, what we're going to offer as a unified entity and not necessarily...one...versus the other. I think if you always redirect to [benefits to patients] you can bring people along" (Participant CC).

> "But the...decision process [spent more time] to perhaps get these people to vocalize what their concerns were. To the extent that it was nothing other than just a hard no, an opposition to any affiliation" (Participant BB).

Theme Three: Brace for the Race

Participants noted that the process of M&A led to exhaustion among those involved. This fatigue may result in leaders reacting to problems rather than addressing them by prioritizing, collaborating, and considering the larger staff dynamics when making decisions. The participants emphasized the importance of leaders recognizing the long-term considerations that must be addressed during the initial planning stages. They

noted that strains in relationships early on can affect the success of M&A. If leaders are unable to influence staff to change with the organization they may embrace a concept of failing quickly or make the necessary adjustments to their approach early in the process.

> "I think [M&A] is so long and I think it's like a marathon. I think people get tired, right? It's like I'm tapping out, [you] tap in. Healthcare is a busy place, right? We had full time jobs before we did [an M&A] and so it piles on additional things. . . I feel like we do the wedding part of the transaction and not the marriage part of the transaction, which is really the hard work" (Participant EE).

> "Let's get this thing signed and closed and we'll figure out some of these other softer things, other things later that come down the road" (Participant GG).

> "Or you find out the deal is not a cultural fit and move on early on" (Participant DD).

> "The thing that that marked the end for us was a few of our board members and selected members of our medical staff went to visit one of the hospitals of this of this larger affiliation partner and the idea, the intent was that they would go there and it would be just this affirming experience. They came away with the opposite. I can't say for sure, but I think there was also some innate resistance and reasons to act on the resistance [were] found in this visit" (Participant BB).

Theme Four: The Solution is Acumen and Execution

Participants expressed that qualities from the five ACHE Leadership Domains are fundamental for leaders who participate in M&A. They indicated that lacking these essential qualities may undermine an individual's ability to influence staff to adopt change. Leaders should recognize their limits but exercise their full capacity for bringing about organizational change. Participants indicated that the characteristics associated with the Professionalism and Leadership domains were "table stakes." The term, derived from the poker card game, is found in the U.S. business lexicon, paralleling the uncertainties in business to poker's risk and reward concept. Table stakes are the minimum monetary investment necessary to participate in a poker game, which, in a business context, translates to the fundamental skills and resources needed for a competitive advantage (Almquist & Sherer, 2018).

> "Like [Professionalism and Leadership] they were to me, like table stakes. It's like if you don't have this, you probably shouldn't be on the team" (Participant EE).

> "[Knowledge and Business Acumen] are table stakes, [leaders] lack credibility if they don't have these and so, you know, any institution's [leaders] that's worth anything is going to have these" (Participant BB).

Participants indicated that administrative leaders were selected based on their business expertise and, therefore, should bear the responsibility of navigating the business through the M&A process.

> "Because you're mashing together two organizations and having a sense of how. to best capitalize on the strengths" (Participant FF).

> "I think you start a little bit by not trying to be the expert in all things for all people and being a little humble in the process. . . wishing cannot check a box, action checks boxes" (Participant EE).

> "I think so much of the M&A process is a transactional process about money and making sure that patient lives and all the assets that are being converted are maintained" (Participant II).

Subtheme 4.1: Operational Efficiency. The participants stressed the necessity of influencing staff to adapt to the anticipated organizational changes early. Given the general reluctance of staff to accept organizational change, leaders must present their understanding of the inevitable changes in the most positive way by highlighting the benefits, sharing a new vision, and acknowledging concerns regarding the new collective organization.

> "M&A is operational change management and changing operations is going to affect everything. A comprehensive view is needed" (Participant AA)

> "There were some people who were so anxious by the M&A that they just split. They just jumped ship and they went on their way. The people who hung on, which I found very interesting in a behavioral standpoint, were the dead wood, the people who like didn't want to do anything better, didn't want to grow, had spent a lot of time there and was not going to leave until somebody forced them to quit. They weren't eager for the change" (Participant II).

Leaders and staff should understand the organizational success metrics may change during the process. Leaders should be prepared to adapt to changes with full transparency to followers. Similarly, leadership succession may also undergo changes.

> "I mean, you're managing risk. . .you have a legal team and they're going to tell you no, 10 different ways. . . they're going to outline these risks. You have to really just sort of navigate through all of the information and be able to make a decision, is this a go or no go at the end of the day" (Participant GG).

> "So in order to keep the staff that you have or the group that you have happy at the end of the day, you have to keep, you have to be very transparent as much as you can about what's going on...so they understand the changes that have transpired across the continuum of the negotiations. Things change from beginning to end" (Participant CC).

> “The [leader] heir apparent may not become the heir in the end” (Participant HH).

Because organizational success metrics may be fluid, one participant offered that assigning broad operational goals rather than specific success metrics may be more productive at the outset of the M&A integration process.

> “Work to achieve whatever financial quality targets, you know, that's what the system should be saying. . .[or] if you can't get it done, we'll help you or will replace you. I want a 5% margin. I want these quality indicators. We need to be hitting those” (Participant FF).

Subtheme 4.2: Knowing and Getting it Done. Organizational change is a change at the organizational level, not the department level. Using communications to encourage inclusivity across many departments may be a fundamental principle of the organizational change strategy. Developing the change management strategy may be more effective when informed by peers which have lived experiences in M&A. Data based decision making may help leaders make informed decisions, but action must be taken on the data.

> “Healthcare is very complex and M&A is sort of industry agnostic, but the combined business acumen, the chops or prowess, that's sort of your ability to know how to execute a deal. And then if you layer that on top of actually knowing the intricacies of healthcare, that [helps you] make decisions. Those sort of go hand in hand like if you have both business acumen and knowledge of healthcare, I think that seems like that's really important” (Participant GG).

> “And so, I do feel that Healthcare is still not necessarily learning from the mistakes that lots of other companies have made. . .I feel like healthcare, I always think that healthcare should be wiser and more knowledgeable because the data is out there. You don't have to do it yourself” (Participant II).

> “For the last 20 years, bigger isn't better. Better is better, you know, look at the data and [bigger HCOs] don't have the data to support their results. I just went through and looked at outcomes for the system hospitals that were within 100 miles of these two [smaller] hospitals, their results smoked everybody, but you wouldn't know that from a billboard or something” (Participant FF).

> “Addressing legal ramifications, [if you’re] going through...an evaluation process of [M&A] you have to understand from a legal perspective what you can and can't say, what you can and can't share, if you're doing site visits or if you're speaking to individuals, whether in the public or if you're speaking to board members or if you're speaking to other people within the other organization” (Participant CC).

Discussion of Findings

The findings placed in the context of the literature may help give meaning to their significance. The researcher explored perceived leadership competencies of HCO leaders with lived M&A experiences to fill a literature gap. Many leadership self-assessments exist to help leaders understand their competency gaps by measuring their perceived competencies between novice and expert (ACHE, 2023; Bender et al., 2019; Harolds & Miller, 2022; Harrison & Zavotsky, 2018; Hernandez et al., 2018; Sherman et al., 2007). The researcher chose the five domains from the ACHE (2023) competency directory as the measure of competencies for this study. The literature touts the value of competency measures for effective HCO leadership (Hala et al., 2018; Harper & Maloney, 2022; Sherman et al., 2007). The purpose of the study was to add to the literature by exploring how perceived leader competencies may have influenced the outcome of M&A activity in healthcare organizations. These findings may contribute to a broader understanding of competencies needed by HCO leaders executing M&A.

Study Question One:

1. What do healthcare leaders report about the success or failure of M&As and the role that the ACHE leadership competencies played during the M&A?

Solstad offers the definition of success for the study; ". . . a major organizational transaction in which two or more organizations combine most or all of the assets and competencies to create a third entity, the merged unit" (Solstad et al., 2021, p. 22). The study data indicated most leaders (92%) were successful in their M&A activity. Broad success, however, may be contrary to the literature. While it fails to define a win/ loss ratio for completing successful M&A, it is clear that most M&A activity is met with challenges (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Robinson & Knight, 2018). Further, the literature indicates successful organizational change is predicated on strong leadership (Aunger et al., 2021; Leiter & Harvie, 1997; Lohrke et al., 2016; Martinussen et al., 2020; Miller & Millar, 2017). The data supported the literature. Leaders perceiving their leadership competencies below the Likert scale's midpoint in the Leadership domain were unsuccessful. The aggregate data across all domains indicated that leaders ranking their competencies below the midpoint were largely unsuccessful. The study data indicated that participants desired more (7.20%)

Communications and Relationship Management competencies than they witnessed during their most recent M&A.

Study Question Two

2. What are healthcare leaders' experiences during M&A as related to the five ACHE leadership competencies?

According to Participant EE, cultural integration through effective communications, or "tone," is critical to successful M&A. Chesley (2020) indicates that cultures may change from before M&A integration from entrepreneurial and one of independent thinkers to one which is desirous of a more hierarchical one. The domains of Knowledge of the Healthcare Environment, Professionalism, and Business Acumen were offered as "table stakes" by Participants BB and EE. These are fundamental competencies leaders are expected to demonstrate. Paradoxically, leaders may be empowered by showing vulnerability to their staff, provided it is used judiciously.

Staff may expect that leaders cannot know all the answers to all questions. Leaders, however, exceeding their staff's perceived boundaries may be counterproductive. According to Participants AA, DD, and EE, leaders should remain open and inclusive, considering all staff comments in decision-making. The literature agrees. Leaders should communicate iteratively through the organizational change process (Emond et al., 2021; Longenecker & Longenecker, 2014; Solstad et al., 2021).

Study Question Three

3. How do the experiences of healthcare leaders during M&A relate to what leaders reported regarding the success or failure of their M&A in the context of the ACHE leader competencies?

Leaders reported that successful M&A may be significantly influenced by the competencies associated with the Communications and Relationship Management domain. While leaders perceived other domains as valuable and well executed, leaders building strong relationships through effective communications may determine the HCO's successful outcome. Further, participants offered insights into the low success rate associated with lower self-assessments in the Leadership and Professionalism domains. Participants had minimum expectations of their leaders in these two areas and assumed leaders were equipped with these competencies. Responses also indicated M&A

failures could be due to poor communication between leaders and staff or cultural alignment, thus a desire for stronger Communications and Relationship Management competencies. The findings highlighted that while most leaders report success in their M&A activity, the quantitative and qualitative data highlighted the complexities associated with M&A. While most questionnaire respondents indicated success, interviewees indicated they had been both successful and unsuccessful, which may not have been reflected in the quantitative responses. The study data highlighted what may constitute successful leadership competencies during these disruptive events. Particularly, competencies in Leadership and Communications and Relationship Management domains emerge as decisive factors in addressing the challenges of M&A. Leaders who excel in these areas may foster successful integration and contribute to the long-term success of their newly combined organizations post-merger. This research contributes valuable insights into the leadership competencies of M&A and emphasizes developing key competencies to manage the M&A outcomes in healthcare organizations better.

Utilization of Findings

The literature suggests M&A will continue as a commercial method to confront HCO care delivery costs and grow market share (Hayford, 2012; Postma & Roos, 2016; Shaygan, 2018). The researcher collected data from HCO leaders participating in M&A activity and offers the original research to inform strategic planning and leadership development within the healthcare delivery and healthcare investment sectors. The study provides a nuanced perspective of HCO leaders' perceived competencies, representing valuable human capital insights, which may help develop a profile of the skills perceived to be necessary for successfully completing M&A. Although M&A is a daunting task, this study may assist HCO leaders attempting M&A navigate its' complexities.

The findings can serve as educational content at HCO continuing education workshops, professional healthcare M&A conferences, and competency-based training programs. Additionally, the study findings could be useful for investors (venture capitalists, private equity firms, and investment bankers) involved in M&A to preliminarily assess leadership competencies in the institutions they are considering for acquisition or investment.

The researcher applied the findings to develop the executive summary, “Pearls of Wisdom for the HCO Leader Facing M&A,” (Pearls). Pearls is designed to offer insights and best practices from experienced peers (see Appendix M). Pearls synthesizes findings from the literature and this original research, reflecting the experiences and needs of peer HCO leaders during their most recent M&A activities. Furthermore, an academic poster summarizing the study’s findings has been prepared as a visual aid for presentation at professional conferences (see Appendix N).

Summary

The aim of this explanatory sequential mixed methods study, conducted in two phases, was to capture the perceptions of leadership competencies among leaders who have participated in M&A. Participants in the study were assessed using the leader competencies scale associated with the five domains outlined in the ACHE Competency Directory (ACHE, 2023). The skills from the five domains of the ACHE self-assessment tool were developed with broad input from seven professional healthcare organizations (Stefl, 2008). The researcher employed the five ACHE domains to measure perceived leadership competencies, specifically within the context of healthcare M&A, representing a potentially novel application.

The findings from phase one data indicated that participants ranked their perception of competencies from the Business Acumen domain the highest. Additional findings indicate a positive association between successful M&A completion, a participant's years of leadership experience, and exposure to at least two previous rounds of M&A activity. The most successful leaders were administrative professionals in the acquiring organization, employed by non-profit, charity, or government HCOs. When investigating the difference between what leaders witnessed during their most recent M&A and what they needed during their M&A, retrospectively, most leaders would have preferred a higher measure of competencies from the Communication and Relationship Management domain.

The findings from phase two data collected from those participating in phase one offered perceptions regarding the quantitative findings. Using open, axial, and selective coding of the qualitative data, four primary themes and six subthemes emerged to support one predominant theme. The predominate theme, adapt and influence, indicates a strategy

where local leadership may help followers more readily adapt to the organizational changes. Local leaders may influence follower change more effectively because they understand the local HCO dynamics. This generalized theme provides insights from the qualitative data regarding how peer leaders addressed the unique organizational changes during their M&As. Leaders should anticipate that organizational changes during M&As will produce unexpected challenges. These challenges are often best addressed at the local level by leaders who understand the context of the challenges and can effectively relate to and influence those implementing the M&A.

The findings indicate the most successful M&As are associated with those leaders who have had M&A experience. The researcher curated an executive summary using the original research to share the experiences of leaders participating in M&A, aiming to educate leaders facing similar M&A challenges. The executive summary, The Pearls of Wisdom for Leaders Facing M&A incorporates the study's relevant literature on achieving the intended outcomes during M&A-associated organizational change. Further, Pearls includes the findings from phase one and phase two, which document the experiences of HCO leaders during M&A. The construct and implementation of the executive summary is detailed in the following chapter.

IMPLEMENTATION

CHAPTER V

IMPLEMENTATION

The annual costs of U.S. healthcare consumption are estimated at more than $4 trillion (Derlet et al., 2022; Li et al., 2023). Despite this enormous outflow, some hospitals experience low or negative profit margins to maintain care delivery (Appelbaum & Batt, 2021; Noether & May, 2017; O'Hanlon et al., 2019). These burdens may influence a healthcare organization (HCO) to participate in a merger and acquisition (M&A) to overcome revenue gaps (Burns & Pauly, 2023; Hayford, 2012; Postma & Roos, 2016; Shaygan, 2018). Healthcare organizations attempting M&A risk a range of care delivery problems. Patient care quality during M&A integration can be negatively impacted (Beaulieu et al., 2020; FTC, 2004; Khuntia et al., 2022; O'Hanlon et al., 2019). Further, the organizational changes brought on by unifying two previously independent HCOs can jeopardize staffing (Appelbaum et al., 2021; Chesley, 2020; Cunha et al., 2019; Lucero et al., 2020; Martin, 2021).

Leader competencies, such as those given in the Leader Competency Directory from the American College of Healthcare Executives ([ACHE], 2023), can be pivotal to completing M&A as intended (Aunger et al., 2021; Canady & Miller, 2023; House et al., 2022; Robinson & Knight, 2018). The Directory and other leader competency assessments are plentiful in the literature (ACHE, 2023; Garman et al., 2020; Kakemam et al., 2020; Ylitalo et al.,2022). The literature, however, is incomplete when acknowledging which competencies are needed during M&A. Studies from the Department of Justice (2010) and the Federal Trade Commission (2004) suggest HCOs will likely continue to leverage M&A. The industry may benefit from understanding the leadership competencies at work during M&A and what impact these competencies have in a range of settings.

This explanatory sequential mixed methods study aimed to examine M&A outcomes and the influence the ACHE leader competencies may have had on the M&A processes. The study's quantitative results varied across the five ACHE domains when leader self-assessments were analyzed by demographic, leader role, or business classification. The competency self-assessment domains included (a) leadership, (b) communications and relationship management, (c) professionalism, (d) knowledge of the

healthcare environment, and (e) business skills and knowledge (acumen) (ACHE, 2023). Clinicians and administrative leaders view their competencies slightly differently, with the former perceiving they are more competent than their administrative counterparts in Leadership, Professionalism, and Knowledge of the Healthcare Industry domains. The latter perceive they excel above their clinical leader peers in Business Acumen and Communications and Relationship Management domains.

The qualitative data collection revealed:

- the critical need for corporate communications to be delivered by local leaders,
- the importance of a transparent dialogue between leaders and staff,
- every exchange is an opportunity to educate,
- planning requires representation from every department,
- leaders need to be visibly in charge and transparent,
- stay nimble during integration to adapt to corporate and staff needs,
- leaders have a foundation in soft skills and knowledge of their business,
- staff will watch the leader to see if they change first.

Solution/ Product

The 18-month academic study explored leadership competencies critical to healthcare organizations participating in M&A. By examining leaders' perceived competencies quantitatively and the qualitative reasons for the leaders' responses, the research highlighted the necessity for adaptability amidst M&A-associated organizational change. The findings revealed a gap between current leadership competencies and those leaders wished they possessed, underscoring the importance of developing these skills to enhance success probabilities. The study confirms that M&A organizational change may best be orchestrated by leaders influencing staff to adapt to new norms.

To advance this project, the researcher has developed an executive summary to share the collected study data, logically organizing the study's findings from phase one and the literature with the phase two themes. The summary, "Pearls of Wisdom for the HCO Leader Facing M&A," (Pearls) is designed to serve as a silent mentor for leaders preparing for M&A. When used in facilitated group discussions, an executive summary outlining leaders' highly perceived competencies may help inform leaders approaching

M&A with advice from their peers who have lived experiences. According to Jolly et al. (2019), sharing common experiences helps others better understand the world. The executive summary synthesizes the study findings from both study phases and the literature, yielding novel research with new insights. The product considers the essential competencies for successful M&A in the context of ACHE Leadership Competency domains. This approach ensures that the wisdom gained from the study will be methodically shared and utilized by leaders participating in M&A (see Appendix M).

Developing Pearls based on the literature and the empirical findings of the study ensures that it is grounded in academic rigor, remains highly relevant, and may provide pragmatic solutions to challenges encountered during M&A. Designed to enhance continuing education or workshop programs; Pearls is intended to stimulate critical thinking among its users. Leaders may use Pearls to prepare themselves for M&A. During a preparatory workshop, Pearls may help leaders may develop responses to hypothetical case-based scenarios offered by peer experiences. Pearls also includes advice from peers through the study's qualitative data collection to provide insights into best practices for managing demanding situations, particularly with staff. The executive summary is a practical resource that aligns with the ACHE's leadership competency framework and reinforces its relevance and applicability to industry challenges during M&A.

The first Pearl, *listen, empower, and learn,* is connected to the study's literature review and both phases of data collection. The related ACHE domains associated with the literature and findings are Communication and Relationship Management and Professionalism. Communication and Relationship Management encourages leaders to evaluate their collaboration and labor relations skills. Professionalism emphasizes the importance of ethics and accountability within the leadership framework. The literature widely discusses how leader and follower collaboration can improve staff's acceptance of organizational change (Cerezo-Espinosa de los Monteros et al., 2021; Chesley, 2020; Harrison & Zavotsky, 2018; Longenecker & Longenecker, 2014). The study's quantitative findings indicated participants desired an increase (7.20%) in the Communication and Relationship Management competencies during their most recent M&A. Further, the findings indicated that participants who reported they were novices in

the Professionalism domain experienced less organizational change success than those reporting their competencies above the midpoint. During the qualitative data collection, interviewees expressed the needs associated with these two domains. Leaders indicated that collaborating in small groups and nuanced communications by leaders could help assimilate staff during M&A associated organizational change. Additionally, integrating culture may set the tone for the success of the M&A activity however, followers need to be accountable to the new organizational norms and be careful not to act contrary to the new organizational dictates.

The second Pearl, *maximize strengths, and enhance organizational value,* is closely related to the ACHE Leadership and Communications and Relationship Management domain competencies. The literature indicates strong leaders are needed during the M&A integration process to unite staff from two previously independent cultures (Kaplan, 2020; Martin, 2021; Robinson & Knight, 2018; Solstad et al., 2021). Quantitatively, the data show leaders who perceived themselves as highly competent were successful in their M&A activity. More than their administrative leadership peers, clinical leaders desired to see more (3%) from the competencies in the Leadership domain in their next M&A. Qualitatively, interviewees shared the need for leaders to use their strengths but not overstep and diminish staff contributions. Leaders need to share the vision of the newly combined organization. Leaders may determine the M&A success metrics but will need to be a unifier to disparate teams to deliver on the promise of the new organization.

The third Pearl, *endure the risk, commit completely,* is associated with the three ACHE domains of Business Acumen, Leadership, and Professionalism. Competencies identified within these domains focus on human resources and risk management, managing change, and time and stress management, respectively. Literature correlated to this Pearl suggests leaders should help followers reduce stress as they proceed with the M&A integration. Staff may negatively perceive a range of threats related to the disruption of organizational change (Greco et al., 2021; Gronstad et al., 2019; Kaltiainen et al., 2020). The study's quantitative findings indicate a minor gap (0.52%) between what leaders offered and what they expected was necessary for competencies in the Business Acumen domain. The confidence displayed by leaders in the Business Acumen

domain was opposite from what was wished by leaders relative to the Professionalism domain, where the gap (21.50%) suggests that greater competencies in the domain were unnecessary. The qualitative findings may explain the gap. Interviewees shared how they assumed executive leaders participating in M&A would come to the events with the competencies found in the Professionalism domain. Leader fatigue was also mentioned as a concern relative to leaders showing commitment to what can be an extended and exhaustive process.

The fourth Pearl, *lead with informed action* is associated with the ACHE domain competencies from the Knowledge of the Healthcare Industry and Business Acumen domains are critical to M&A success. The literature offers that understanding the changes to be made and the organization's readiness for those changes may contribute to leaders' success during organizational change (Martin, 2021; Vaishnavi et al., 2019). The literature also indicates understanding the chronology and what is expected during each phase of organizational change may also increase the success that organizational change will complete as intended (Miller & Millar, 2017; Round et al., 2018; Solstad et al., 2021). During the quantitative phase study participants ranked their perceived competencies in these two domains highest, having more expert ranking than the other three domains. The volume of expert rankings indicates there was little room for leaders to improve their competencies in these domains. Qualitatively, interviewees attributed leaders' credibility, organizational planning, and plan execution to guiding their M&A to a successful conclusion. Many participants indicated they were involved in successful and unsuccessful M&A organizational change.

Pearls presents the study data as a practical tool to prepare HCO leaders who are facing M&A. The summary highlights essential leadership competencies within the literature, the ACHE framework, and the original collected data. This novel use of the findings may better prepare leaders attempting M&A.

Dissemination Strategy

The Pearls of Wisdom for the HCO Leader Facing M&A will be electronically distributed to the ten participants from the phase two qualitative data collection who asked to receive the study and its findings, participant recruiters from the Medical Group Management Association (MGMA), the Healthcare Financial Management Association

(HFMA), the LinkedIn online communities of the Mississippi Hospital Association (MHA), the Hospital Executive Network (HExN), and the researcher's mentors Dr. Marc Mobley, Dr. Mark Montoney, and Mr. Brian Scheri. The professional organizations MGMA, HFMA, and the ACHE will receive a writer's inquiry to publish the findings. The researcher will generate an interest in the study results by notifying his professional network of the study's findings. The researcher will call his contacts within the consulting industry at Kaufman Hall and Accenture, investment bankers at JP Morgan, and solution integrators at KPMG will be informed of the study's availability and transformative potential. An electronic copy of Pearls and an offer to review the study will be available on the public website below. Further contacts at HLTH, VIVE, and iiBIG will be solicited for speaking engagements at conferences and trade shows. The study is publicly available to anyone with an interest in the topic of M&A or ACHE Leadership Competencies at: http://www.mnahospitalleadership.com.

Interprofessionalism

The benefits of M&A are not limited to one demographic as evidenced by the participant responses. The dependent variables of the participant's job function (Clinical or Administrative) and IRS classification (Non-profit, For-Profit, Charity, or Government) reflect the interprofessional value of the study. The Pearls guide may be shared among clinical and administrative professionals in various HCO classifications. Further, the study results suggested leaders collaborate across traditional clinical and administrative boundaries to address the integration complexities during M&A. The study's qualitative data indicated leaders should recognize representatives from every clinical and administrative department during the organizational change process.

Limitations

Recruiting issues were central to this study's constraints. Using social media to recruit participants helped capture a significant number of responses; however, many (509 of the total) proved fraudulent. It is undetermined which social media posting invited the fraud. While fraud in academic research is uncommon, it is a growing problem (Pozzar et al., 2020). The University of Mississippi Medical Center's Research Electronic Data Capture (REDCap) resources qualified all responses. Although a formal forensic analysis could not be conducted because IP addresses were not collected to

ensure anonymity, the REDCap administrator disqualified suspicious responses due to time of day, frequency, and response patterns. Although unrelated to the REDCap fraud, corporate cybercrime issues also impacted participant recruiting. The Change Health medical claims clearing house cyber event, which "forced the company to disconnect more than 100 systems on February 21", delayed recruiting a day after the process began (Rundle & Stupp, 2024, para. 4). The Healthcare Financial Management Association (HFMA) prioritized helping its members return to stable operations above soliciting their membership for the study. They issued the request for participation to their membership approximately 12 days after the researcher's initial request, possibly reducing its availability to their 96,000 members by seven days.

The phase one questionnaire limited responses to participants most recent M&A rather than collecting data from all M&A experiences. Participants were asked to report how many M&As they had been involved in, but to recall only their most recent M&A activity when weighing their competencies (novice to expert) across the leadership domains. Although most reported their participation in multiple M&As, the questionnaire was structured for a yes or no response when asked if the most recent M&A had been completed successfully. This potential limitation was identified during the phase two interviews when several participants indicated their experiences across multiple M&As with varying outcomes. Responses from those participating in multiple M&As may have had greater success and overstated their competencies because of their lessons learned from unsuccessful transactions. This may also help explain the mismatch between the 77% success rate reported by participants and the literature which indicates a significant number of M&As are not successful. The study data may have been enhanced if it more accurately considered the broader experiences from those with multiple successful and unsuccessful M&As.

Participant bias may also be a limitation. Participants were mostly (74%) associated with the administrative profession. Additionally, this lack of clinical participation may have biased the results toward leader competencies associated with a more administrative culture. The lack of clinical responses and interviews may limit the generalizability of the research.

Recommendations for Future Research

Subsequent research should aim to enhance participant diversity, as the current study's cohort predominantly consisted of administrative professionals. Future findings may vary if investigators included a more balanced sample between clinical and administrative professionals. Moreover, recruiting participants from a clinically oriented demographic could yield valuable insights, especially if researchers employed self-assessment tools designed for clinical leaders rather than the ACHE tool used in this research. A global perspective may also be welcomed. Healthcare organization M&A is a global phenomenon with self-assessments developed for regional healthcare leaders in multiple languages. Finally, a more detailed exploration of the competencies solely reflecting on the ACHE Leadership domain competencies may help clarify the discrepancy observed in this study. Interviews with participants indicated they valued the importance of the Leadership domain competencies; however, they self-assessed their abilities as below the intermediate level more than in any other domain.

Conclusion

The present investigation sought to explore leaders' perceptions of their competencies at work during M&A activity across various demographics. Participants were recruited from professional associations and social media communities. The publicly available ACHE Leader Competency Directory self-assessment was used to scale leader perceptions of their competencies across five domains. The explanatory two-phase sequential mixed methods study surveyed leaders in phase one regarding their perceived competencies during their most recent M&A activity. Subsequently, in phase two, volunteers who had completed phase one were interviewed and asked to explain the reasons behind their perspectives. The findings indicated that leader perceived competencies vary between clinical and administrative staff. Clinical leaders perceived their competencies as higher in the domains of Professionalism, Leadership, and Knowledge of the Industry. Administrative leaders perceived their competencies as higher in the Communications and Relationship Management and Business Acumen domains. Leaders shared their perceptions between what was witnessed in their most recent M&A and what they perceived may have been more beneficial to the outcomes if

conducted in a perfect world. Clinical and administrative leaders acknowledged they would like to have experienced greater competency measures from the Communications and Relationship Management domain in a perfect world. Leaders have acknowledged their M&A best practices in the qualitative phase by explaining their reasonings for their answers in phase one. These have been collected, analyzed, and organized into the Pearls of Wisdom for HCO Leaders Facing M&A. Pearls may offer leaders peer advice when they are challenged during the process of M&A.

Pearls will be offered as a resource to prepare leaders to address the unexpected disruptive events of M&A and produce a smoother transition. It offers leaders guidance based on the data collected from this study and the relevant literature. Pearls could serve as a mentoring tool, offering leaders informed guidance through scenarios intending to help them navigate M&A challenges on the advice of experienced peers. The guide may serve as a critical resource, empowering leaders with peer advice and strategies for navigating the complexities of M&A.

APPENDICES

APPENDIX A

Medical Group Management Association (MGMA)

RE: [EXTERNAL]RE: MGMA Data Inquiry

AH Allison Hammer, MA, FMC, CAE <ahammer@mgma.com>
To Allen O. Moore

Reply | Reply All | Forward

Thu 1/11/2024 5:05 PM

Start your reply all with: Thank you, I will do that. | That would be great, thank you! | Thank you! | Feedback

Hi Allen,

You were next on my list to respond to today! Yes, your survey has been approved. I would suggest posting 3-5 sentences about your survey including the open and close dates as well as your background and the reason for the survey. Please only post in 2-3 communities. Do you need directions on how to post?

ALLISON HAMMER, MA, FMC, CAE
MEMBER ENGAGEMENT SPECIALIST

TEL 877.275.6462 x1572
EMAIL **ahammer@mgma.com**

From: Allen O. Moore <aomoore@umc.edu>
Sent: Thursday, January 11, 2024 4:01 PM
To: Allison Hammer, MA, FMC, CAE <ahammer@mgma.com>
Subject: RE: [EXTERNAL]RE: MGMA Data Inquiry

Allison, greetings from UMC. I wanted to check in to see if there are any questions I could answer for you regarding the logic behind the survey. Once the survey is approved on your end the University may approve by months' end. We would like the survey to be open for two weeks after it posts but cannot see it being open past February 16 +/-. Since we last chatted the REDCap survey has been built and you are welcome to give it a look. Link: https://redcap.umc.edu/surveys/?s=4MERTYYMWC8AWEWY

Glad to talk it through if you like.

Allen
256-415-1234

From: Allison Hammer, MA, FMC, CAE <ahammer@mgma.com>
Sent: Wednesday, January 3, 2024 5:13 PM
To: Allen O. Moore <aomoore@umc.edu>
Subject: RE: [EXTERNAL]RE: MGMA Data Inquiry

Hi Allen,

Thank you for the follow-up. Happy New Year!

The questions are being reviewed this week and I should have an answer for you soon. Do you have a date that it must be posted by and when you need results by?

Thank you,
Allison

APPENDIX B

Healthcare Financial Management Association (HFMA)

RE: [EXTERNAL]RE: UMMC Doctoral Research

TN Todd Nelson <tnelson@HFMA.ORG>
To Allen O. Moore

Reply | Reply All | Forward

Sat 1/13/2024 4:40 PM

You replied to this message on 1/13/2024 5:17 PM.

Hi Allen,
Thank you for reaching out. I just went through the survey and it looks good to me. Let me know once approved and we will share with our communities.
Sincerely,
Todd

Todd Nelson FHFMA, MBA
Healthcare Financial Management Association
Director, Professional Practice & Partner Relationships, Chief Partnership Executive
708.492.3353 (Direct) | tnelson@hfma.org

From: Allen O. Moore <aomoore@umc.edu>
Sent: Friday, January 12, 2024 12:22 PM
To: Todd Nelson <tnelson@HFMA.ORG>
Subject: RE: [EXTERNAL]RE: UMMC Doctoral Research

Todd, I wanted to bring this back around from last week. I am getting close to an approval with the University's institutional review board and wanted to share with you the questions I would like to ask the HFMA membership. The REDCap hosted survey is completely confidential and intended to take less than 5 minutes. A link to the survey is provided below. Can you take a look and confirm these are fit for use. The survey may be found at the link: https://redcap.umc.edu/surveys/?s=4MERTYYMWC8AWEWY

Your thoughts please,

Allen
256-415-1234

APPENDIX C

Hospital Executive Network (HExN)

[EXTERNAL]Re: UMC Doctoral Project- survey to be posted to HExN

TF Tim Foley <tfoley@msgconsultinggroup.com>
To Allen O. Moore

Reply | Reply All | Forward

Wed 1/17/2024 1:29 PM

Looks good, Allen.

let me know when you want to go live.

Tim Foley
518-256-9195

On 2024-01-11 17:53, Allen O. Moore wrote:

> Tim, thank you again for offering to post a call to the HExN membership with my study. I wanted to share the 12 questions from the study's quantitative phase with you only at this time. The survey is intended to measure leader perceived competencies (as defined by ACHE) present during hospital M&A and intended to be completed in less than 5 minutes. Will you please take a look and at the survey (link below) and confirm it is acceptable to post as soon as the University approves. Once they approve, we will be able to go live.
>
> https://redcap.umc.edu/surveys/?s=4MERTYYMWC8AWEWY
>
> Many thanks,
>
> Allen Moore
> 256-415-1234

APPENDIX D

Mississippi Hospital Association

Re: [EXTERNAL]Pending Quantitative Survey

SR Shawn Rossi <srossi@mhanet.org>
To Allen O. Moore

Reply | Reply All | Forward

Tue 1/16/2024 8:37 AM

You replied to this message on 1/16/2024 10:31 AM.

Thanks, Allen.

I will be glad to share it on LinkedIn once you have approval. Just let me know! Also, send me a little blurb about what you would want people to know before clicking the link!

From: Allen O. Moore <aomoore@umc.edu>
Sent: Monday, January 15, 2024 10:31 AM
To: Shawn Rossi <srossi@mhanet.org>
Subject: [EXTERNAL]Pending Quantitative Survey

Shawn, as I formalize my IRB request, I wanted to share with you the forthcoming REDCap survey link: https://redcap.umc.edu/surveys/?s=4MERTYYMWC8AWEWY . Can you please have a look at it and confirm the survey would be suitable for the membership.

Many thanks. See you on the 26th.

Allen

256-415-1234

APPENDIX E

Phase One Questionnaires

Phase One- questionnaire one

Leaders' Perceived Value of Leadership Competencies at Healthcare Organizations Participating in Mergers and Acquisitions

I am a graduate student under the direction of Professor Dr. Vickie Skinner in the School of Health Related Professions at the University of Mississippi Medical Center. I am conducting a research study to explore

Leaders' Perceived Value of Leadership Competencies at Hospitals Participating in Mergers and Acquisitions.

You are invited to participate in this study because you may have lived experiences leading teams involved in the integration process during mergers and acquisitions. If you agree to participate, you will be asked to respond to a six-item questionnaire, which may take less than 10 minutes to complete. Subsequently, you will be given the opportunity to participate in an interview to discuss your lived experiences. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The questionnaire is anonymous. The results of the study may be published, but your name will not be known.

If you have any questions concerning the research study, please call me, Dr. Skinner, using the contact information below.

Participants will be given the opportunity to be entered into a random drawing for a $50 Amazon gift card.

Participation in the questionnaire will be considered your consent to participate. Thank you.

Sincerely,

Allen Moore, student researcher
email: aomoore@umc.edu
phone: 256-415-1234

Dr. Vickie Skinner, primary investigator
email: vskinner@umc.edu
phone: 601-815-5141

Are you willing to participate in the study?

◯ Yes
◯ No

Thank you for your time you may now close your browser.

Have you participated in a Healthcare Organization (HCO) merger and acquisition (M&A) while serving in supervisory capacity in the United States?

◯ Yes
◯ No

Considering your most recent M&A activity, how many years did you serve in a supervisory capacity prior to the M&A activity?

◯ 0-5
◯ 6-11
◯ 12-17
◯ 18+

Considering your most recent M&A, in what leadership capacity did you serve?

◯ Clinical
◯ Administrative

Considering your most recent M&A, how was your HCO classified by the IRS?

☐ For-profit
☐ Non-profit
☐ Charity
☐ U.S. Government
☐ Other

Including your most recent M&A activity, in how many M&As have you participated?

◯ 1
◯ 2
◯ 3
◯ Greater than 3

Considering your most recent M&A, did the HCOs complete the M&A activity? This study defines a completed M&A as a major organizational transaction in which two or more organizations combine most or all of the assets and competencies to create a third entity [regardless of the HCO name or license retained or replaced].

◯ Yes
◯ No

Considering your most recent M&A, did you participate as the acquiring or acquired HCO?

◯ Acquiring
◯ Acquired

Questionnaire Instructions

Instructions to Participants

The questionnaire instructions below are provided in REDCap immediately following the demographic questions.

This questionnaire consists of six items regarding your perceived competencies present during your lived experiences with M&A. The questionnaire uses competency definitions as outlined by the Healthcare Leadership Alliance and it is intended to be brief.

If you have been involved in more than one M&A activity please reflect on your most recent experience. There are no correct answers, and this questionnaire is not being timed.

Please respond to items one through five by self-scoring your perceived competencies as demonstrated during your M&A activity. Your responses will be recorded on a five-point Likert scale ranging from Novice (1) to Competent (3) to Expert (5).

Question six has two parts.

Your responses will again be recorded on a five-point Likert scale ranging from Novice (1) to Competent (3) to Expert (5).

Part one asks you to rank the competencies you perceived as most valuable to the organization during your lived experiences with M&A.

Part two considers the lessons learned during M&A activity. It asks you to rank, speculatively, which competencies you now perceive would have been most valuable to the organization during your lived experiences with M&A.

At the end of the questionnaire, you will be given the opportunity to enter a random drawing for a $50 Amazon gift card.

Q1. Considering your most recent M&A, your Leadership competency (negotiating with employees to act on a new shared vision, creating a single hospital culture, developing relationships internally and externally, fostering mutual trust with employees, and developing solutions to manage change) demonstrated during the M&A was:

1 Novice	2	3 Competent	4	5 Expert
◯	◯	◯	◯	◯

Q2. Considering your most recent M&A, your Communications and Relationship Management competency (addressing stakeholder needs, maintaining relationships based on professional ethics, understanding the needs of labor, and alternative dispute resolutions) demonstrated during the M&A activity was:

1 Novice	2	3 Competent	4	5 Expert
◯	◯	◯	◯	◯

Q3. Considering your most recent M&A, your Professionalism competency (upholding patient safety, acknowledging cultural and spiritual diversity, practicing stress management techniques, networking, mentoring or advising, and participating in community service) demonstrated during the M&A activity was:

1	Novice	2	3 Competent	4	5	Expert
○		○	○	○		○

Q4. Considering your most recent M&A, your Knowledge of the Healthcare Industry competency (understanding managed care models, applying healthcare regulations, staffing-clinical and non-clinical, professions associated with the delivery of care, and healthcare technology) demonstrated during the M&A activity was:

1	Novice	2	3 Competent	4	5	Expert
○		○	○	○		○

Q5. Considering your most recent M&A, your Business Acumen competency (analyzing data and drawing inferences, operationalizing systems, reimbursement principles, financial planning and stewardship, human resources, strategic planning, applying information technology, mitigating risks, improving quality, providing a healthy work environment, and establishing a patient safety culture) demonstrated during the M&A activity was:

Novice 1	2	Competent 3	4	Expert 5
○	○	○	○	○

6.1 Considering your most recent M&A, rank the competencies you perceive as most valuable to the HCO during your lived M&A experiences from least valuable (1) to most valuable (5).

	Least Valuable 1	2	3	4	Most Valuable 5
Leader Competency	○	○	○	○	○
Communications and Relationship Management	○	○	○	○	○
Professionalism	○	○	○	○	○
Knowledge of the Healthcare Industry	○	○	○	○	○
Business Acumen	○	○	○	○	○

6.2 Considering your most recent M&A, in a perfect world, rank the competencies you now perceive would have been most valuable to the HCO during the M&A from least valuable (1) to most valuable (5).

	Least Valuable 1	2	3	4	Most Valuable 5
Leadership	○	○	○	○	○
Communications and Relationship Management	○	○	○	○	○
Professionalism	○	○	○	○	○
Knowledge of the Healthcare Industry	○	○	○	○	○
Business Acumen	○	○	○	○	○

Questionnaire one automatically proceeded to questionnaire two without retaining the participant ID.

Phase One- questionnaire two

Interview & Amazon Gift Card Drawing

All responses will remain confidential

Would you be willing to expand on your responses in a brief interview?

◯ Yes
◯ No

Name:

_____

Email:

_____

Phone:

_____

Would you like to be included in the Amazon $50 gift card drawing?

◯ Yes
◯ No

APPENDIX F

Interview Guide

Interview Guide

The following are questions leading phase two's qualitative data gathering:

1. During the phase one quantitative questionnaire you were asked about the leader competencies at work during your most recent M&A. With regards to the overall leader competencies- leadership, professionalism, and knowledge of the industry, clinical participants indicated they perceived their performance as marginally above their administrative counterparts. Administrators perceived they ranked higher in communications and business acumen. Why do you feel participants perceive their competencies in these areas differently?

2. The quantitative data revealed Business Acumen and Knowledge of the Healthcare Industry were the two most highly perceived competencies present during M&A.
Recall, Business Acumen addresses- analyzing data and drawing inferences, operationalizing systems, reimbursement principles, financial planning and stewardship, human resources, strategic planning, applying information technology, mitigating risks, improving quality, providing a healthy work environment, and establishing a patient safety culture. Knowledge of the Healthcare Industry addresses, understanding managed care models, applying healthcare regulations, staffing clinical and non-clinical, professions associated with the delivery of care, and healthcare technology.
Why do you feel these were highly valued?

3. The quantitative data revealed Leadership and Professionalism were the two lowest perceived competencies during M&A.
Recall Leadership addresses negotiating with employees to act on a new shared vision, creating a single hospital culture, developing relationships internally and externally, fostering mutual trust with employees, and developing solutions to manage change. Professionalism addresses upholding patient safety, acknowledging cultural and spiritual diversity, practicing stress management techniques, networking, mentoring or advising, and participating in community service.
Why do you feel these were less than highly valued?

4. Communications and Networking, the second of the competencies you were asked to consider, was ranked in the middle of the five competencies. It has in its domain the concept of trust between leaders and followers. Most perceived their Communications and Networking competency as middle of the road. Can you help explain how one might become an expert in the domain when building follower trust can be difficult in a fluid M&A environment?

5. Thinking about the two-part question, number six, in the first part, you were first asked to rank the five competencies as they were perceived during your most recent M&A activity, and in the second part asked to rank the same competencies but, as you wish they had been demonstrated during M&A in a perfect world. The quantitative data show the greatest divergence between the domains of Professionalism and Communications Relationship Management. Why do you think most leaders wished they had demonstrated greater Professionalism and Communicated or built better Relationships?

6. What else should I know about your experience?

APPENDIX G

Informed Consent Cover Letter

Informed Consent Cover Letter

Dear _____:

I am a graduate student under the direction of Professor Dr. Vickie Skinner in the School of Health Related Professions at the University of Mississippi Medical Center. I am conducting a research study to explore

Leaders' Perceived Value of Leadership Competencies in Hospitals Participating in Mergers and Acquisitions.

You are invited to participate in this study because you may have lived experiences leading teams involved in the integration process during mergers and acquisitions. If you agree to participate, you will be asked to respond to a six-item questionnaire, which may take less than 10 minutes to complete. Subsequently, you will be given the opportunity to participate in an interview to discuss your lived experiences. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The questionnaire is anonymous. The results of the study may be published, but your name will not be known.

If you have any questions concerning the research study, please call me, Dr. Skinner, using the contact information below.

Participants will be given the opportunity to be entered into a random drawing for a $50 Amazon gift card.

Participation in the questionnaire will be considered your consent to participate. Thank you.

Survey Link: https://redcap.link/rta406zi

Sincerely,

Allen Moore, student researcher
email: aomoore@umc.edu
phone: 256-415-1234

Dr. Vickie Skinner, primary investigator
email: vskinner@umc.edu
phone: 601-815-5141

APPENDIX H

IRB Approval

Initial Approval Letter

Waiver of Documentation of Informed Consent Approval Letter

Investigator Name: Vickie Skinner
UMMC IRB Tracking Number: UMMC-IRB-2023-445
Review Classification: Expedited

IRB Telephone: (601) 815-5016
IRB E-mail: UMCIRB@umc.edu

Board Action Date: February 16, 2024
Approval Expires: February 14, 2025
Submission Type: Initial Application w/ Waiver of Documentation of Informed Consent

DHHS FWA: 00003630 **IORG:** 0000043
IRB 1 Registration: 00000061
IRB 2 Registration: 00005033
IRB 3 Registration: 00013555

Protocol Title: Leaders' Perceived Value of Leadership Competencies at Healthcare Organizations Participating in Mergers and Acquisitions

THE FOLLOWING ITEMS ARE APPROVED:

- IRB-protocol-template_move to Cayuse
- IRB-Attachment_b_Communities' Agreement
- IRB-Attachment_b_Investigator's plans to present and conduct the interview
- IRB-Attachment_b_Study Participant Email_with Link and Notice
- IRB-Attachment_c_Recruiting Coordination Email for Phase Two
- IRB-Attachment_b_REDCap_Contact Information for Interview and Amazon Gift Card Drawing
- IRB-Attachment_b_Semi Structured Interview Question Guide
- IRB-Attachment_b_REDCap_Primary Survey_LeadersPerceivedValueOfLeaders
- IRB-Attachment_b_Participant Instructions from REDCap
- IRB-Attachment_b_Phase One Cover Letter

APPENDIX I

Study Participant Email / LinkedIn Posting for Phase One Invitation

Recruiting Announcement

Study Participant Email / LinkedIn Posting for Phase One Invitation

Dear _____:

I am a graduate student under the direction of Professor Dr. Vickie Skinner in the School of Health Related Professions at the University of Mississippi Medical Center. I am conducting a research study to explore,

Leaders' Perceived Value of Leadership Competencies in Healthcare Organizations Participating in Mergers and Acquisitions

You are invited to participate in this study because you may have lived experiences leading teams during hospital mergers and acquisitions. The researcher needs your input to explore the five leadership competencies from the ACHE competency directory and how they may be present during healthcare M&A. You will be asked to respond to a six-item questionnaire, which may take less than 10 minutes to complete. Subsequently, you will be invited to participate in an interview to discuss your lived experiences. The study is confidential. The study's results may be published, but your name will not be known.

Participants will be given the opportunity to be entered into a random drawing for a $50 Amazon gift card.

Survey Link: https://redcap.link/rta406zi

If you have any questions concerning the research study, please call me or Dr. Skinner using the contact information below.

Sincerely,

Allen Moore, student researcher
email: aomoore@umc.edu
phone: 256-415-1234

Dr. Vickie Skinner, primary investigator
email: vskinner@umc.edu
phone: 601-815-5141

APPENDIX J

Phase Two Email Coordination

Recruiting Coordination Email for Phase Two

Study Participant Email for Phase Two Coordination

To: Named Participant

From: Allen Moore, Doctor of Health Administration candidate

RE: Study opportunity -- Share your Lived Experiences During Hospital Mergers and Acquisitions (M&A)

Thank you for your interest in participating in phase two of the study. You have indicated your willingness to be interviewed about your lived experiences regarding M&A. Your participation in this study is voluntary. The results of the study may be published, but your name will not be known. Scheduling your interview is considered your willingness to participate.

The interview will be conducted via the Microsoft Teams collaboration and communications platform and recorded on the platform and locally using an Olympus handheld voice recorder. The digital copies will be secured, transcribed, and summaries will be made available to you. No printed copies are maintained. The interview will last no longer than 30 minutes and will be scheduled between March 20th and March 27th.

Please forward two days/ times that work well for you, and I will send a calendar invitation to hold our time together.

If you have any questions concerning the research study, please call me or Dr. Skinner using the contact information below.

Sincerely,

Allen Moore, student researcher
email: aomoore@umc.edu
phone: 256-415-1234

Dr. Vickie Skinner, primary investigator
email: vskinner@umc.edu
phone: 601-815-5141

APPENDIX K

UMMC IRB Self-Certification

Self-Certification Form for Determining Whether a Proposed Activity is Research Involving Human Subjects

When to Use this Form:

1. If you need documentation for funding agencies, administrators, or collaborators
2. If you are unsure whether or not you need to submit your project to the IRB
3. If you are unsure if your project is research
4. If you are unsure if your research involves human subjects

This form is not an Exempt Certification or IRB review
Exemptions are a type of IRB review. If your project meets the definition of human subjects research you must submit the project to the IRB for review.

Administrative Information

Your Name	Allen Moore	Degree(s) + Department	DHA School of Health Professions
Mailing Address	1648 Hermitage Drive Florence, Alabama, 35630	Phone	256-415-1234
		Email	aomoore@umc.edu
Project/Study/Grant Title/Award#	N/A		

1) Is your project "research"?

"Research" is defined under 45 CFR 46.102(d) as a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities, which meet this definition, constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes.

Is your project a "systematic investigation"?	☐ No ☒ Yes *"**Systematic investigation**" is an activity that involves a prospective research plan that incorporates data collection, either quantitative or qualitative, and data analysis to answer a research question.* *Systematic investigation involves a predetermined method for studying a specific topic, answering a specific question, testing a specific hypothesis, or developing theory.* ***Examples of systematic investigations include, but are not limited to**, observational studies, interview (including those that are open-ended) or survey studies, group comparison studies, test development, program evaluation and interventional research.*
Is the primary intent of the project to develop or contribute to generalizable knowledge?	☐ No ☒ Yes *Investigations designed to develop or contribute to **generalizable knowledge** are those designed to draw general conclusions (i.e., knowledge gained from a study which may be applied to populations outside of the specific study population), inform policy, or generalize findings.* *To develop or contribute to generalizable knowledge requires that the results (or conclusions) of the activity are intended to be extended beyond a single individual or an internal program.* *Intent to publish results/conclusions in a peer-reviewed journal or to present at a regional or national meeting does not determine this response. Thesis or dissertation projects conducted to meet the requirements of a graduate degree are usually considered generalizable.*

Examples of activities that are not considered research under the above definition:

- **Quality Assurance/Improvement:** Activities whose purposes are limited to: (a) implementing a practice to improve the quality of patient care and then (b) collecting patient or provider data regarding the implementation of the practice for clinical, practical, or administrative purposes. Planning to publish an account of a quality improvement or quality assurance project does not necessarily mean that the project fits the definition of research
- **Case Reports:** The external reporting (e.g., publication, poster or oral presentation) of an interesting clinical situation or medical condition of up to three patients. The patient information used in the report must have been originally collected solely for non-research purposes as the result of a clinical experience.
- **Public Health Surveillance:** A series of ongoing systematic activities, including collection, analysis, and interpretation of health-related data essential to planning, implementing, and evaluating public health practice closely integrated to the dissemination of data to those who need to know and linked to prevention and control.

If you answered **No** to one or both questions, you may stop here. You are not conducting research that needs to be reviewed by the IRB. A copy of this completed form should be maintained in your project file. Do not submit a copy of this form to the IRB.

If you answered **Yes** to both questions above, continue below.

2) Does your project involve "Human Subjects"?

Human Subject is defined under 45 CFR 46.102(f) as a living individual about whom an investigator conducting research obtains:

1. data through intervention or interaction with the individual, or
2. identifiable private information.

Does the project involve "intervention" or interaction with a human subject?	☐ No ☒ Yes *"**Intervention**" includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject.*
Does the project involve access, by PI or project personnel, to identifiable private information?	☐ No ☒ Yes ***Private information** includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).* *Private information must be individually identifiable (i.e., the identity of the subject is or may be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.*
Does the project involve receipt of data/specimens that were collected by another with identifiable private information?	☒ No ☐ Yes (and answer two questions below)

Are the data/specimens coded such that they could be re-identified?	☐ No ☐ Yes
Is there a written agreement that prohibits you and your staff access to the link?	☐ No ☐ Yes

If you answered **No** to all 3 questions in section 2, or **No** to the first two questions and **Yes** to the third question and both sub-parts you are not conducting research that needs to be reviewed by the IRB... A copy of this completed form should be maintained in your project file. Do not submit a copy of this form to the IRB.

Any other combination of answers means that the proposed activity may be research that involves human subjects. You must submit an application to the IRB before starting your project. Visit the IRB's website, umc.edu/irb or call the Human Research Office, 601 984-2815 for more information.

Your Signature

Date	April 23, 2023
Print Name	Allen Moore
Signature	Allen Moore

I certify that the information above is true and accurate.

Note. Self-certification form for determining whether a proposed activity is research involving human subjects. From The University of Mississippi Medical Center, 2015. https://www.umc.edu%2FResearch%2FResearch-Offices%2FHuman-Research-Office%2Ffiles%2520-%2520irb%2Firb-not.human.subjects.research.self.certification.v3.5.docx&psig=AOvVaw1YE5kyVAcHIlJC1H4xdtAg&ust=1682361793742178

APPENDIX L

Figures and Tables

Figures and Tables

Table L3

Participant Time in a Leadership Capacity

	Years in Leadership	Frequency	Percent	Cumulative Percent
Complete records	0-5	19	25%	25%
	6-11	20	27%	51%
	12-17	34	44%	95%
	18+	3	4%	99%
Incomplete records		1	.01%	100%
Total		77	100%	100%

Note. This table represents the questionnaire participants' time in leadership.

Table L4

Number of Clinical and Administrative Participants

	Role	Frequency	Percent of Total	Cumulative Percent
Complete records	Clinical	15	20%	20%
	Administrative	58	79%	99%
Incomplete records		1	.01%	100%
Total		73	100%	100%

Note. This table represents the role of the professionals who identified as clinical or administrative during their most recent M&A activity.

Table L5

Participants' Business Classification

	Business Classification	Frequency	Percent	Cumulative Percent
Complete records	For-profit	24	30%	30%
	Non-profit	44	55%	85%
	Charity	6	7%	93%
	U.S. Government	5	6%	99%
	Other	1	1%	100%
Incomplete records		0	0%	
Total		80	100%	100%

Note: This table represents the business classifications of each participant's HCO. The single Other from the table identified their organization as privately held. There were four overlapping qualifications.

Table L6

Number of M&A Activities

	Past M&A Activity	Frequency	Percent	Cumulative Percent
Complete records	1	17	23%	23%
	2	22	30%	53%
	3	15	20%	73%
	Greater than 3	20	27%	100%
Incomplete records		0	0%	0%
Total		74	100%	100%

Note. This table represents the number of career M&A activities per participant.

Table L7

Participants' HCO Success with M&A

	M&A Success	Frequency	Percent	Cumulative Percent
Complete records	Yes	66	89%	89%
	No	6	8%	97%
Incomplete records		2	3%	100%
Total		74	100%	100%

Note. This table represents M&A successes in participants' most recent M&A activity.

Table L8

Participant Viewpoint

	Viewpoint	Frequency	Percent	Cumulative Percent
Complete records	Acquiring	57	77%	77%
	Acquired	16	22%	99%
Incomplete records		1	1%	100%
Total		74	100%	100%

Note. This table represents participants employed by acquiring or acquired organization.

Note. Percentage of participants' perceived leader competencies by domain, all data.

Table L9

Individual Ranked Likert Scale Responses- Questions 1-5

	Leadership	Communications and Relationship Mgt.	Professionalism	Knowledge of the Healthcare Industry	Business Acumen
All records	19.17%	20.05%	18.85%	20.21%	21.73%
Frequency above the mid-point	32	37	32	39	43
Records above the mid-point as part of the total	17.25%	20.00%	17.25%	21.50%	24.00%
Percent change	-1.92%	0.05%	-1.6%	-1.29%	+2.27%
Incomplete records	1	2	3	3	2

Note: This table represents the collective quantitative responses by the ACHE Leadership Domain. All records represent the total population of the data. Total occurrence above the mid-point indicates participants scoring themselves as 4 or 5 on the Likert scale.

Table L10

Witnessed Perceived Importance by Domain

	Leadership	Communications and Relationship Mgt.	Professionalism	Knowledge of the Healthcare Industry	Business Acumen
All records	20.24%	20.47%	18.77%	18.89%	21.60%
Frequency above the mid-point	31	29	21	19	22
Records above the mid-point as part of the total	60.78%	55.76%	41.50%	34.32%	34.84%
Percent change	40.54%	35.29%	22.73 %	15.53%	13.24%
Incomplete records	25	24	22	14	9

Note: This table represents participants' observations as they witnessed the five domains during their most recent M&A activity. All records represent the total population of the data. The total occurrence above the mid-point indicates the number of times participants scored themselves on the Likert scale as a 4 or 5.

Table L11

Wished Perceived Importance by Domain

	Leadership	Communications and Relationship Mgt.	Professionalism	Knowledge of the Healthcare Industry	Business Acumen
All records	19.50%	23.18%	17.71%	18.66%	20.92%
Frequency above the mid-point	28	34	11	14	23
Records above the mid-point as part of the total	60.86%	62.96%	20.00%	22.22%	34.32%
Percent change	41.36%	39.78%	2.29%	3.56	13.39
Incomplete records	30	22	21	12	9

Note: This data ranks participants' desires of Domain importance in a perfect world.

Figure L3

A Measure of Leadership and M&A Activity Experience

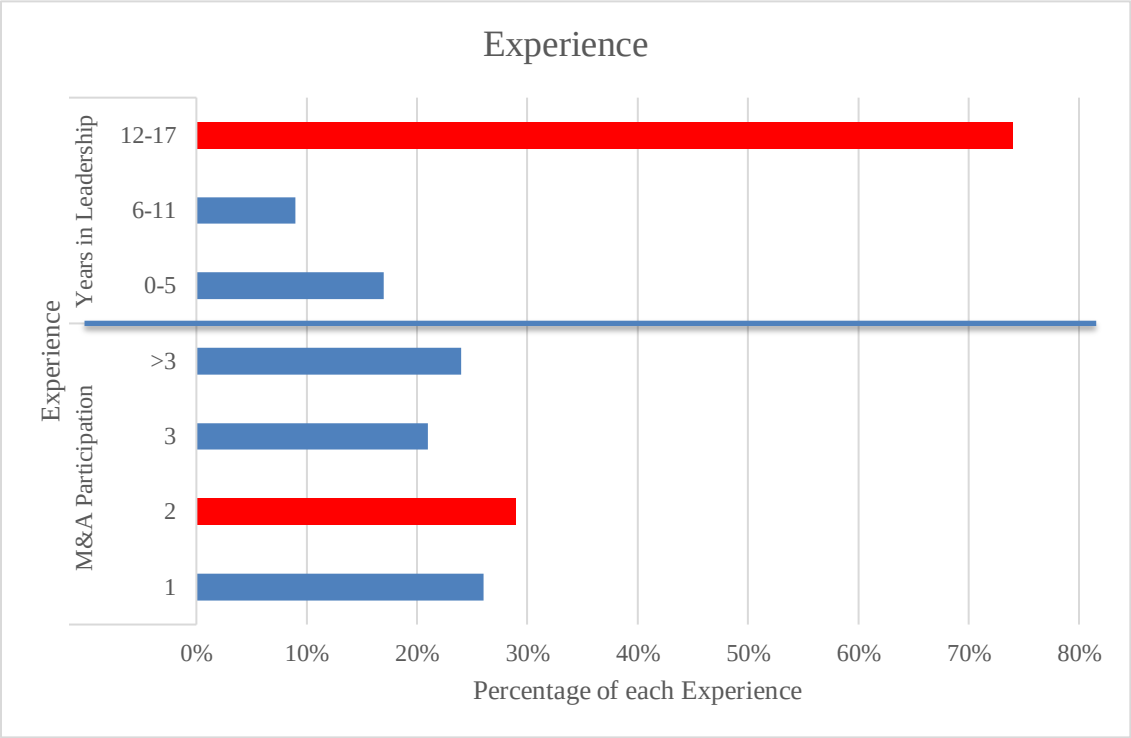


Figure L4

Participants' Perceived Leader Competencies During M&A

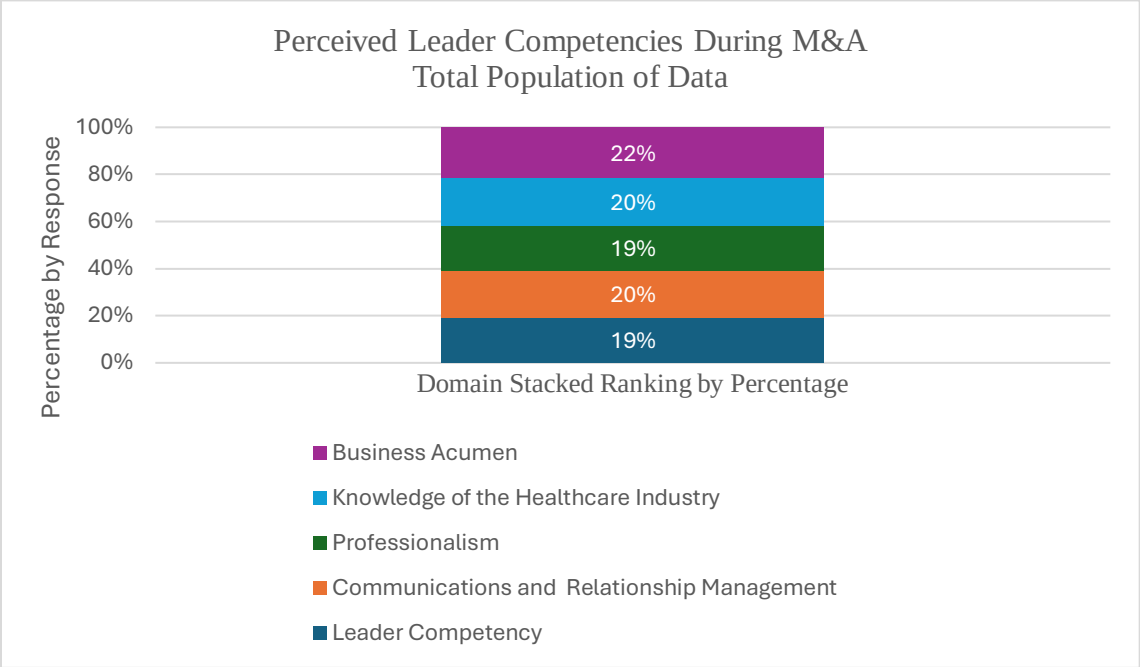
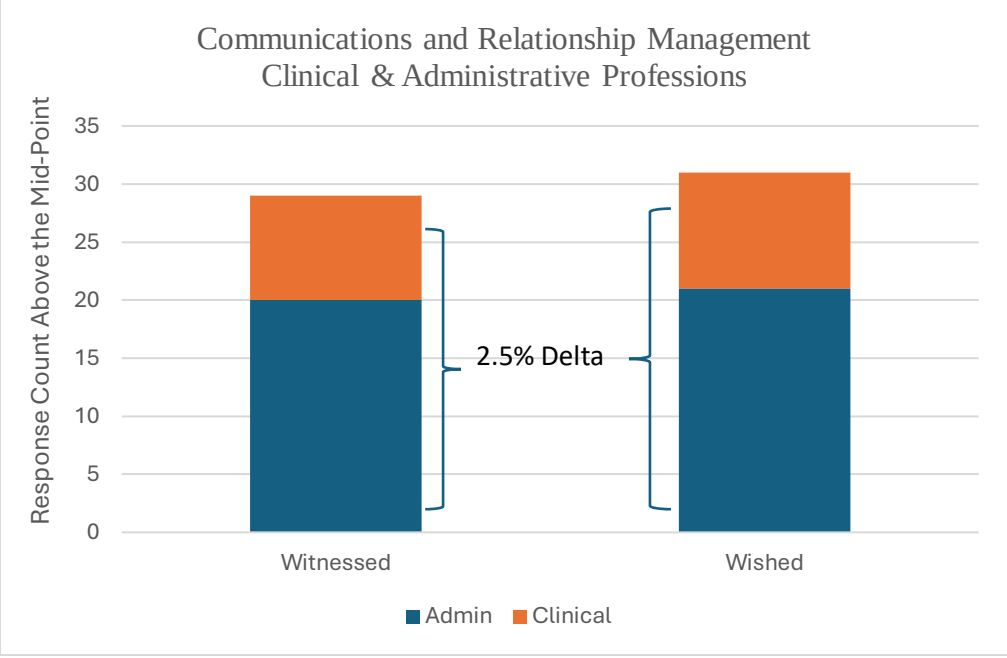


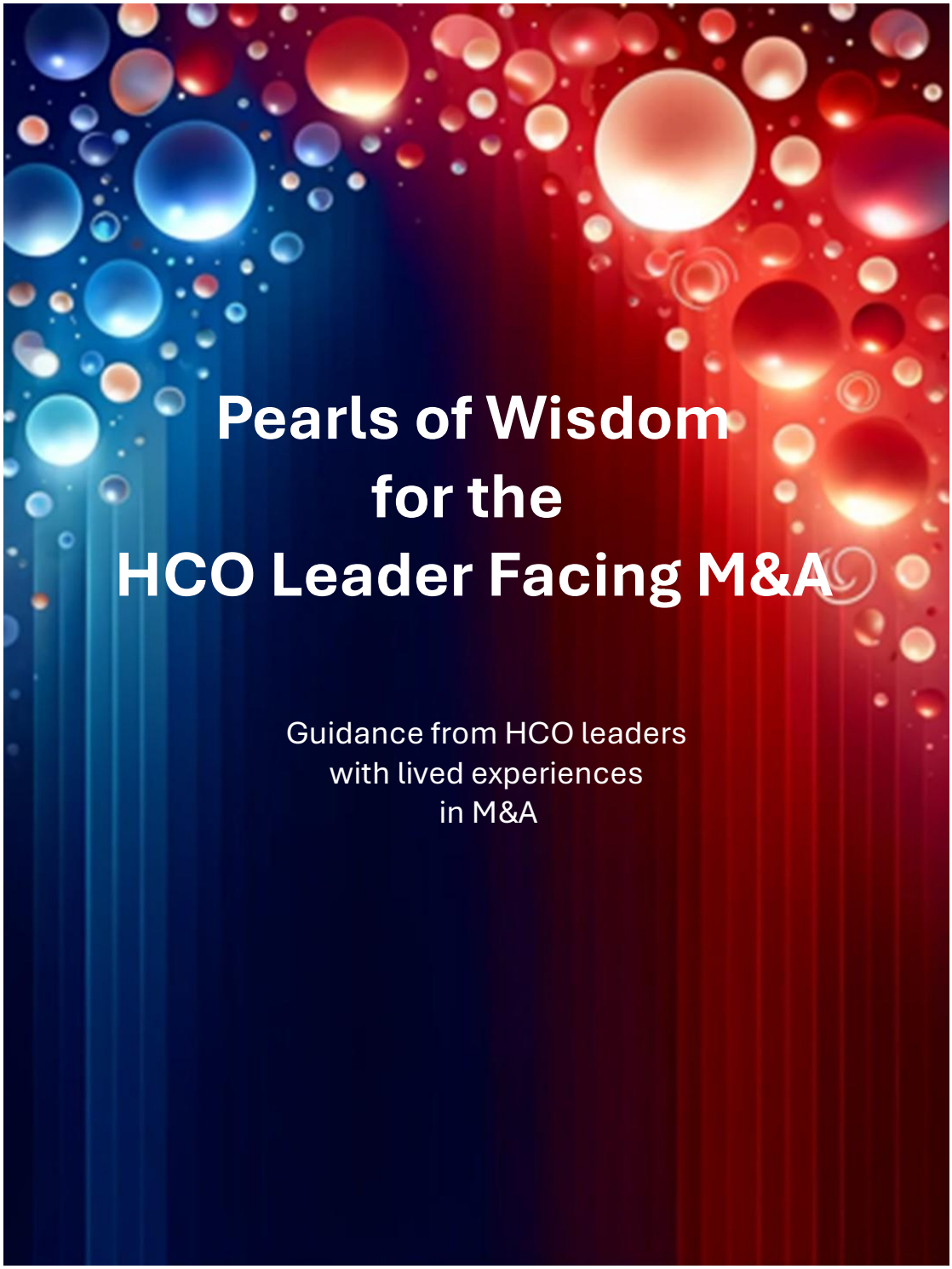
Figure L6

Professions Delta in Communications and Relationship Management



APPENDIX M

Pearls of Wisdom for the HCO Leader Facing M&A


Pearls of Wisdom
for the
HCO Leader Facing M&A
Guidance from HCO leaders
with lived experiences
in M&A

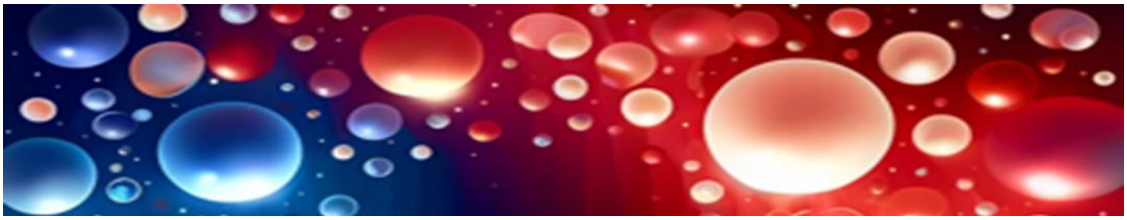
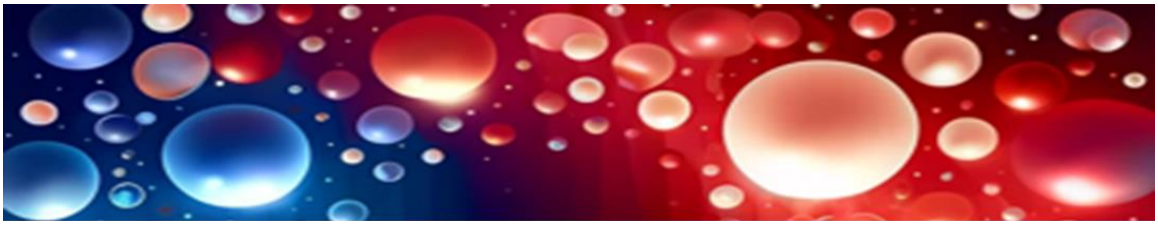


Table of Contents



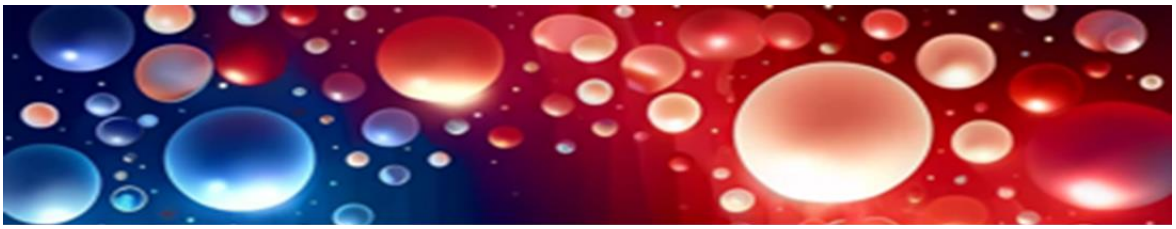
Introduction

The Pearls of Wisdom (Pearls) is a brief executive summary outlining the findings of an 18-month academic research study investigating leadership competencies at work during healthcare mergers and acquisitions (M&A). Although the literature associated with organizational change management is widely available, literature addressing healthcare leader competencies during organizational change associated with M&A is sparse. The study producing the data for Pearls called on research from over 200 international and U.S. scholarly and topical articles as well as original research. The study aimed to understand the leader competencies at work during the disruptive events of M&A.

This study answered the following questions:

1. What do healthcare leaders report about the success or failure of M&As and the role that the ACHE leadership competencies played during the M&A?
2. What are healthcare leaders' experiences during M&A as related to the five ACHE leadership competencies?
3. How do the experiences of healthcare leaders during M&A relate to what leaders reported regarding the success or failure of their M&A in the context of the ACHE leader competencies?

The American College of Healthcare Executives (ACHE) Leadership Competency domains defined the leader competencies for the study and are outlined on page four (ACHE, 2023).

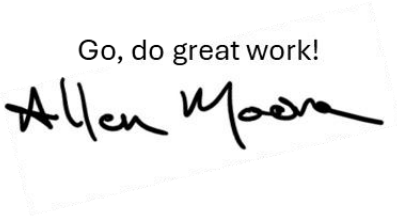


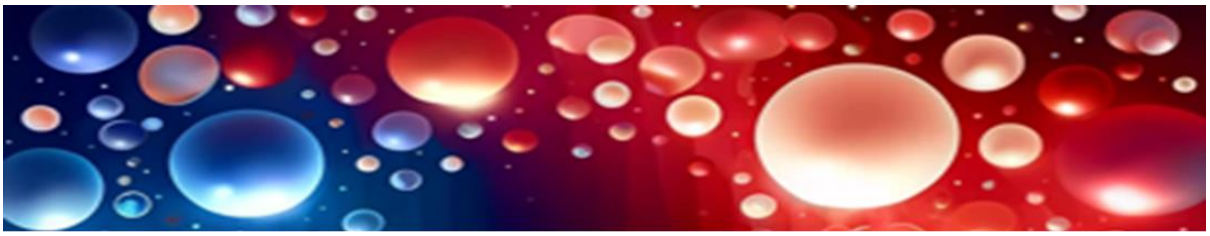
Use of the Pearls

The Pearls is an executive summary of the study's findings, intended to give insight into healthcare leaders' experiences during M&A and to prompt your critical thinking as you prepare for M&A. Reflecting on peer data may offer insights as to what can be expected during M&A and best practices to resolve difficult situations with staff. Use the pages on the left in the guide to examine the study's findings. Then, think about how you may apply these Pearls to your own circumstances. Develop YOUR action plans and record them on the pages on the right in the guide. Role play your planned actions with a peer, testing how well your proposed responses to the events may be received. Practicing your leadership competencies can enhance your ability to remember and effectively convey your messages as intended. Social learning theory suggests, you may become an apprentice to those you have never met when using their feedback (Bandura, 1969).

The complete doctoral research study, M&A integration workshop materials, and audio link may be found at the QR Code:

Go, do great work!

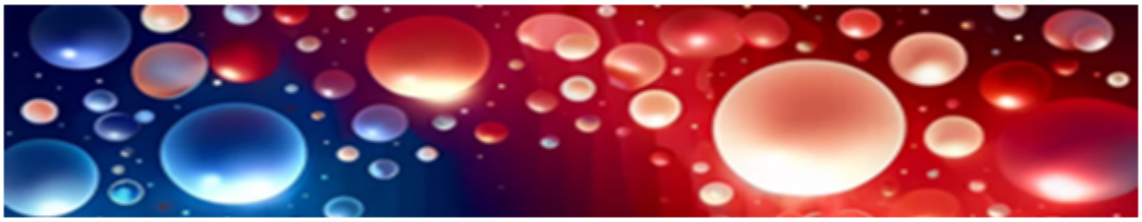




Competency Domains

The ACHE, as part of a larger effort lead by the Health Leadership Alliance (HLA), developed the Leadership Competency Directory in 2004 (Stefl, 2008). The five domain Directory is a publicly accessible, free, self-assessment consisting of 300 questions. It has been found to address 77% of all competencies common to the HLA health professions. Participants score their perceived competencies using a five-point Likert scale from Novice (1) to Competent (3) to Expert (5). The competencies found in each domain are:

- Leadership- negotiating with employees to act on a new shared vision, creating a single culture, developing relationships internally and externally, fostering mutual trust with employees, and developing solutions to manage change.
- Communications and Relationship Management- addressing stakeholder needs, maintaining relationships, understanding the needs of labor, dispute resolutions.
- Professionalism- upholding patient safety, acknowledging cultural and spiritual diversity, practicing stress management, networking, mentoring or advising, community service.
- Knowledge of the Healthcare Industry- understanding managed care models, regulations, staffing, and technology.
- Business Acumen- analyzing data, operationalizing systems, stewardship, human resources, mitigating risk.

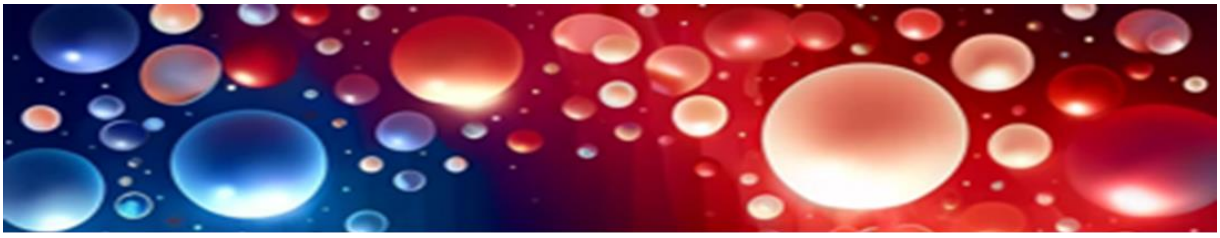


Study Question 1: What do healthcare leaders report about the success or failure of M&As and the role that the ACHE leadership competencies played during the M&A?

The quantitative data analysis from the study indicate that competencies required for successful M&A can be contextual. Clinical and administrative leaders have unique perceptions about their competencies which identify focus areas for leader training. Further contextual considerations, beyond their leadership viewpoint of clinical or administrative, are their employer's business classification, how many years of service they have as a leader, and how many M&A activities they have completed.

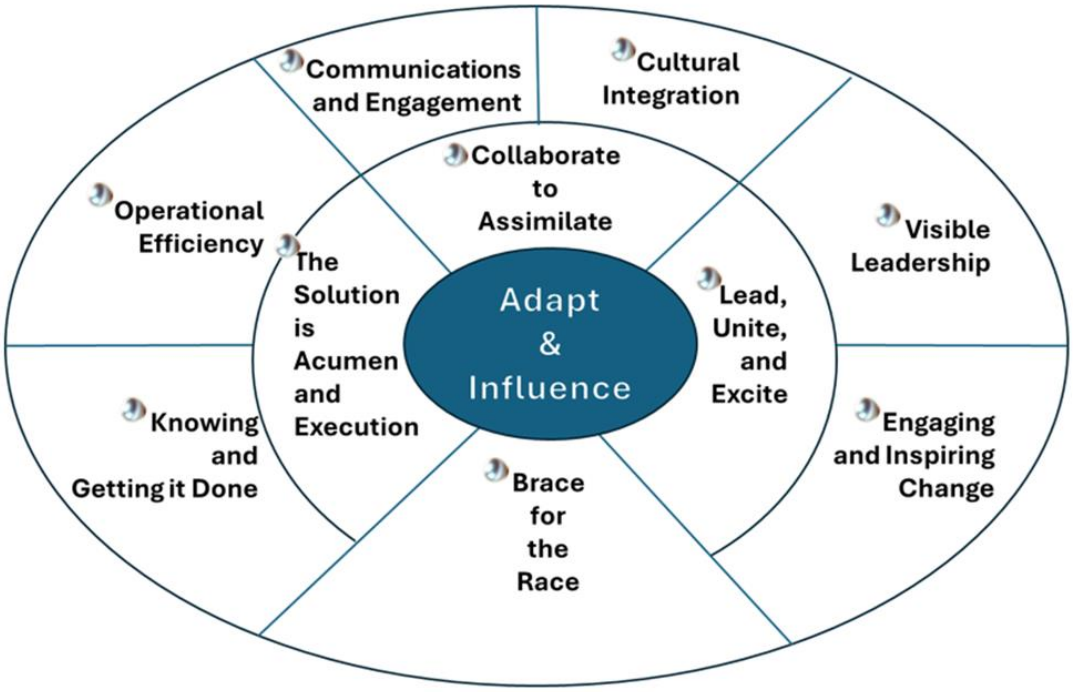
The findings indicate that participants across all demographics perceived their most apt competency during their most recent M&A activity to be in the Business Acumen domain. Overall, Business Acumen was rated 2% higher than the average of the four domains, and it had the highest number of participants self-identifying as experts in this competency. Participants indicated they wished for additional competencies in the Communications and Relationship Management domain by 7.20% in their next M&A activity.

Healthcare Organizations participating in M&A may be more successful if leaders are more intentional in their use of Communication and Relationship Management competencies. Staff consider leaders will approach M&A with above average competencies in Professionalism. Investing in communication and relationship management training may positively influence their professional conduct.

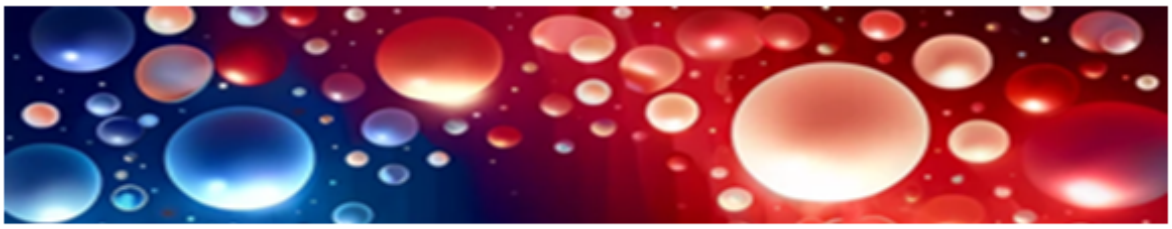


Study Question 2: What are healthcare leaders' experiences during M&A as related to the five ACHE leadership competencies?

Emergent Themes



Note. Summary of themes from qualitative data. These "Pearls of Wisdom" are also the basis for the study's product.



Study Question 3: How do the experiences of healthcare leaders during M&A relate to what leaders reported regarding the success or failure of their M&A in the context of the ACHE leader competencies?

The qualitative study data indicate competencies in Leadership and Communications and Relationship Management emerged as decisive factors in navigating the challenges of M&A. Leaders who excel in these areas may foster successful integration and promote the overall success of their organizations post-merger. Participant GG shared the following quote during data collection.

> "I just don't think it's a good leadership quality to...close off from...lower levels of an entity. [Leaders] need to show that [they] don't always know the answer to things and that's okay. [Show] you're trying to work through them and solve them. I think like a little bit of vulnerability [can be] can be a valuable quality."

Participants indicated leadership is entwined with communications, not a choice of one or the other as demonstrated by participant JJ quote.

> "It's like communication, [is] the why, the where, the how and that kind of leads to leadership, but it's not leadership versus communication."

These insights suggest that effective leadership during M&A isn't just about executing a plan. They are also about open and effective communication, which is foundational to guiding teams through the uncertainty of M&A associated changes. This openness may help answer the why, where, and how of the organizational changes making for a more motivated and unified team.

Pearl 1: Listen, empower, and learn

ACHE Domain Relationships:

- Communications and Relationship Management
  - build collaborative relationships
  - labor relation strategies
- Professionalism
  - consequences of unethical actions
  - accountability

Related Literature:

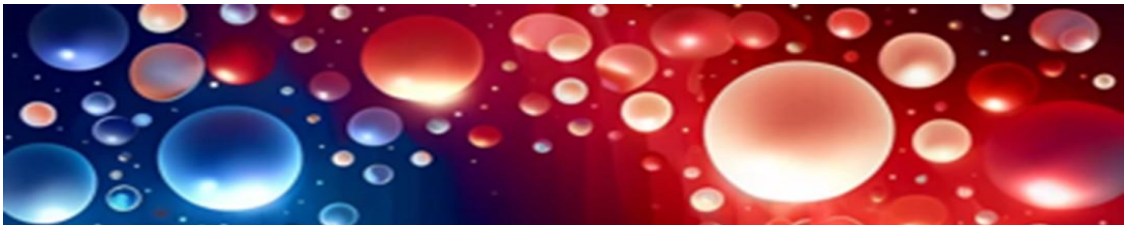
- Leader follower communications and collaboration during healthcare M&A integration is positively associated with followers' acceptance of organizational change (Cerezo-Espinosa de los Monteros et al., 2021; Chesley, 2020; Harrison & Zavotsky, 2018; Longenecker & Longenecker, 2014).

Quantitative Findings:

- An increase of (7.20%) in Communications and Relationship Management competencies during leaders most recent M&A
- Largest perceived need in all of the ACHE domains
- Clinical leaders desired higher competencies in the Communication and Relationship Management domain more than their administrative counterparts who also desired higher competencies
- Lower reported competencies in Professionalism correlated with lower successful M&A

Qualitative Theme #1: Collaborate to Assimilate

- Activate small groups
  - collaborate, investigate, relate findings
- Remain visible
  - active check-ins, be a better listener, look for nuances
- Be transparent
  - leader vulnerability can be endearing to staff
  - not having an immediate answer to every subject does not impede your leadership
- Culture is critical
  - sets the tone for the M&A process
  - local cultures may persist and resist full integration



Pearl 2: Maximize strengths, Enhance organizational value

ACHE Domain Relationships:

- Leadership
  - knowledge of own and other's cultural norms
  - establish a compelling organizational vision
- Communications and Relationship Management
  - organizational structure and relationships
  - team building techniques

Related Literature:

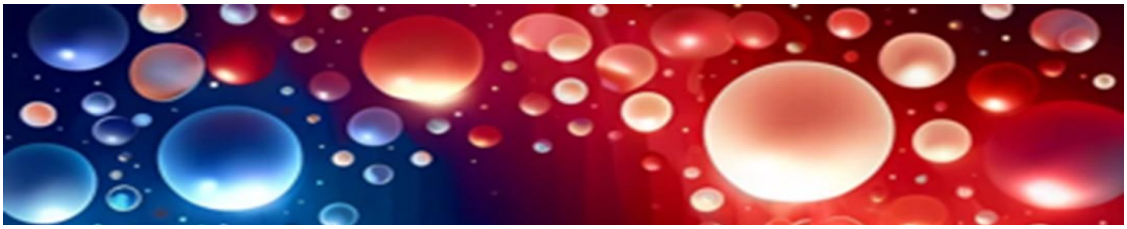
- The integration process of uniting two previously independent cultures can concern staff (Kaplan, 2020; Martin, 2021; Robinson & Knight, 2018; Solstad et al., 2021).
- Strategic outcomes of M&A may largely depend on the unifying actions of HCO leaders to unite staff during M&A-associated organizational change (Canady & Miller, 2023; Cerezo-Espinosa de los Monteros, 2021; Chesley, 2020; Martinussen et al., 2020).

Quantitative Findings:

- Higher ACHE Leadership domain scores correlate with fewer M&A failures
- Less than 1% self-scoring themselves above the ACHE Leadership domain mid-point were unsuccessful
- Less than half (43%) self-scored themselves higher than competent in the Leadership domain
- Clinical leaders desired 3% more of the ACHE Leadership domain competencies than administrative leaders during their most recent M&A
- Administrative leaders score themselves higher than clinical leaders on the ACHE Communications and Relationship Management competencies

Qualitative Themes:

1. Collaborate to Assimilate
   - Be relatable
     - relationships help execute change
     - speak at the receivers' level
   - Be the unifier
     - intentionally look for the good and bad in the incoming teams
     - more effort will be required to integrate former competitors
     - provide clinical staff a platform to engage with their new peers

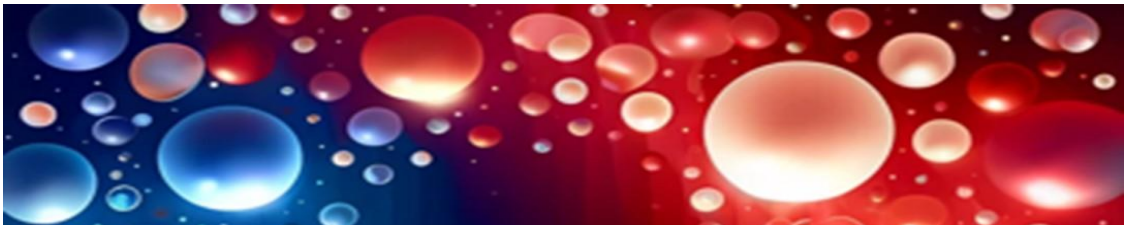


Pearl 2: Maximize strengths, Enhance organizational value

Qualitative Themes continued

2. Lead, Unite, and Excite

- Define
  - personal strengths and execute with them
  - primary resources and honor their functional responsibilities
  - roles and contributions of individuals, look beyond the organizational charts
  - initial and subsequent success metrics
- Reinforce
  - the new combined value of the organization
  - “bigger isn’t better, better is better”



Pearl 3: Endure the risk, Commit completely

ACHE Domain Relationships:

- Business Acumen
  - human resource management
  - risk management
- Leadership
  - managing change
  - organizational climate and culture
- Professionalism
  - professional norms and behaviors
  - time and stress management techniques

Related Literature:

- When employees perceive threats due to organizational change, such as job insecurity, employee stress may increase (Greco et al., 2021; Gronstad et al., 2019; Kaltiainen et al., 2020).
- Stress brought on by disruptive change can be mitigated through the use of adaptive coping mechanisms (Fagerdal et al., 2022; Forster et al., 2022; Russo et al., 2018).

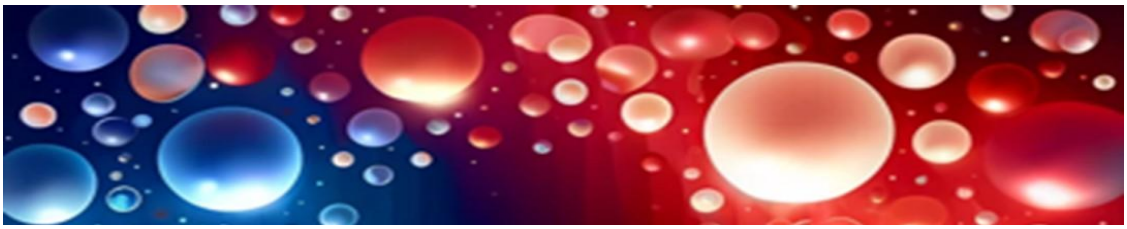
Quantitative Findings:

- Across the five ACHE domains
  - Business Acumen was demonstrated highest among all leaders
    - clinical leaders feel skilled in professionalism, leadership
    - administrative leaders confident in business acumen
    - leaders perceive a minor gap (-0.52%) in their performance
  - most significant gap (21.50%) in the Professionalism domain
- Early-career clinical leaders at for profit HCOs wished for greater ACHE Leadership competencies

Qualitative Themes

1. Lead, Unite, and Excite

- Execute the integration strategy
  - understand how the new entity will deliver care in the local market
  - collect data from many sources to navigate decisions
  - make thoughtful decisions even when the workloads increase
- Retain followers
  - communicate the shared vision
  - localize the corporate messaging
  - highlight the care quality value of the new organization



Pearl 3: Endure the risk, Commit completely

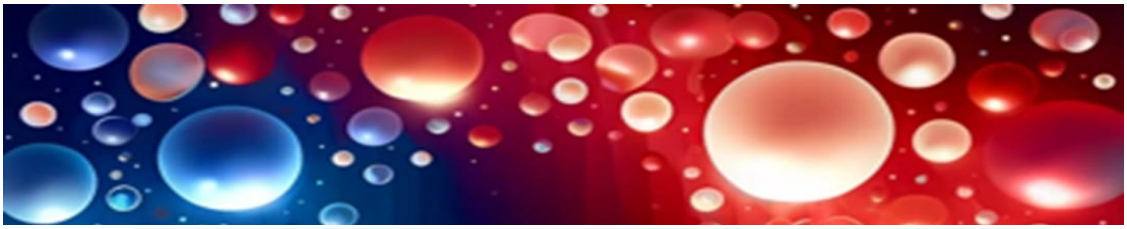
Qualitative Themes continued

2. Brace for the Race

- Process fatigue can trigger reactions, not solutions
- Show leader commitment
  - do not “tap out”
  - the process of M&A integration is a “marathon”
  - “we do the wedding part of the transaction and not the marriage part, which is really the hard work”
  - address tough questions to avoid staff misconceptions
- Look for ways to reduce stress
  - top performing staff may exit for less stressful settings
  - the stress of M&A integration may affect patient safety

3. The Solution is Business Acumen

- Change management is greater than change in a single department
  - M&A change is detailed and prescriptive
  - clinical practice is the organization’s product and needs intentional integration
  - unifying old and new processes may promote “systemness” but may overlook the contributions of skilled individuals
  - research which staff should stay and which should go
- Dynamics of change
  - organizational change should yield a competitive advantage
  - refine ill- defined requirements throughout the process
  - change is received differently across staff- be sensitive
  - perceptions of leaders being guarded when communicating can create barriers



Pearl 4: Lead with informed action

ACHE Domain Relationships:

- Knowledge of the Healthcare Industry
  - organization and delivery of healthcare/ compliance
  - staff perspectives within the organization
- Business Acumen
  - make recommendations from analyzing data
  - demonstrate critical thinking

Related Literature:

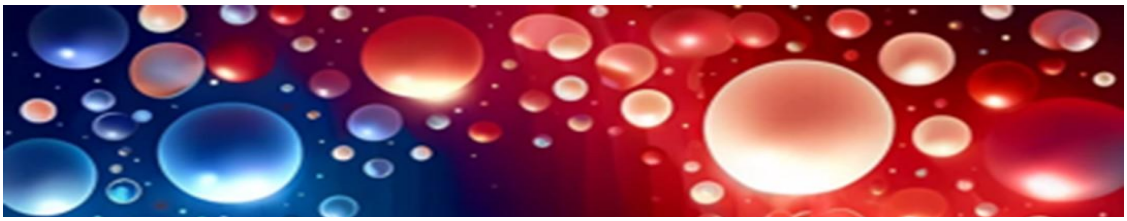
- Before executing organizational change, leaders should leverage their knowledge of the broader healthcare industry to assess their readiness for change (Martin, 2021; Vaishnavi et al., 2019).
- This involves a thorough understanding of what is required at each stage of the process: before, during, and after the changes (Miller & Millar, 2017; Round et al., 2018; Solstad et al., 2021; Vaishnavi et al., 2019).

Quantitative Findings:

- Over half of clinical and administrative leaders rated their ACHE Knowledge of the Healthcare Industry competencies as above the mid-point
- Second highest in leaders self-assessing their ACHE Knowledge of the Healthcare Industry domain at an expert-level
- Over half (58%) of clinical and administrative leaders perceived their ACHE Business Acumen competences above the mid-point
- The ACHE Business Acumen domain had the most expert rankings from all domains
- Leaders perceived little room for improvement in their ACHE Business Acumen competencies

Qualitative Theme 4: The Solution is Acumen & Execution

- Operationally
  - “[Knowledge and business] are table stakes, you lack credibility if you don't have these”
  - set / reset success metrics during the process- explain each
  - staff want to know they will have a job and how it may change
- Taking action
  - “wishing cannot check a box, action checks boxes”
  - M&A integration is all about “managing risk”



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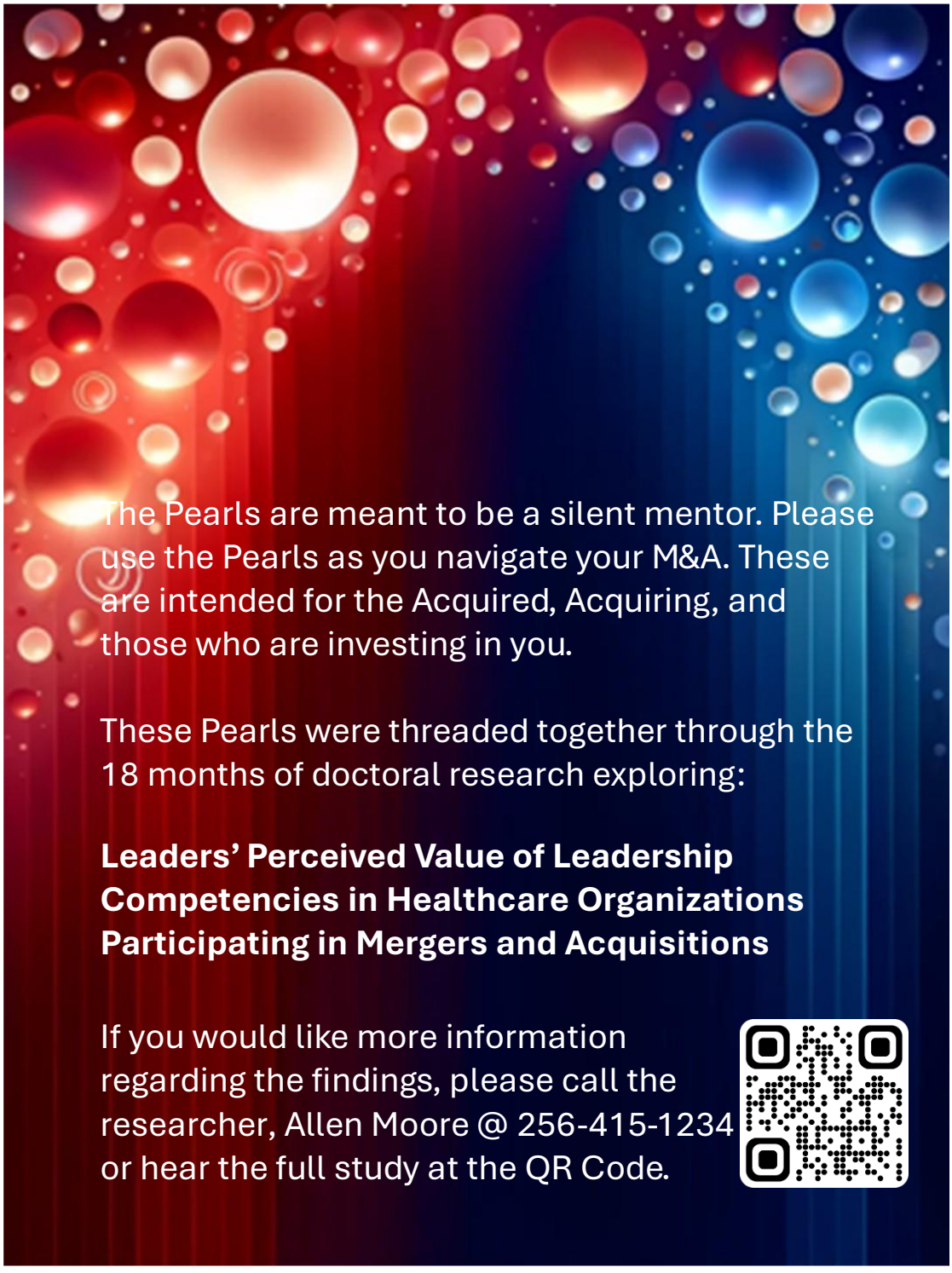

The Pearls are meant to be a silent mentor. Please use the Pearls as you navigate your M&A. These are intended for the Acquired, Acquiring, and those who are investing in you.
These Pearls were threaded together through the 18 months of doctoral research exploring:
Leaders' Perceived Value of Leadership Competencies in Healthcare Organizations Participating in Mergers and Acquisitions
If you would like more information regarding the findings, please call the researcher, Allen Moore @ 256-415-1234 or hear the full study at the QR Code.

APPENDIX N

Academic Poster

Leaders' Perceived Value of Leadership Competencies in Healthcare Organizations Participating in Mergers and Acquisitions

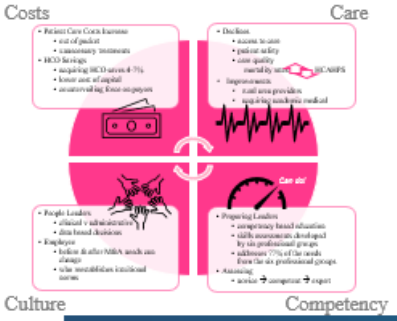
Allen Moore, MSHI, Vickie Skinner, DHA, Amber Arnold, DNP, Angela Burrell, PhD, Elizabeth Franklin, PhD, Kenneth Heard, JD, Seth Lirette, PhD, Marella Yates, DHA
University of Mississippi Medical Center

Abstract

The increasing cost of care delivery creates financial challenges for healthcare organizations (HCOs). Annual U.S. healthcare costs have risen above $4 trillion (Dieler et al., 2022; Li et al., 2023). Even considering the enormous expense, hospital profitability is declining (Chhabra et al., 2022; Pope & Yelin, 2023; Williams et al., 2020). In response to these challenges, HCO leaders may use mergers and acquisitions (M&A) as one commercial method available to help overcome the burden of economic downfalls. Research shows pursuing M&A can be risky for merging hospitals as integration failures in hospital M&A are common (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Cole, 2015; Stokes & Bruce, 2021). Research has also revealed that hospital M&A can create operational instability and the need for transitional leadership (Appelbaum & Bartz, 2021; Chesley, 2020; Heiler et al., 2023). This study aimed to explore perceptions from leaders who had lived experiences with M&A to understand how they valued various leadership competencies through a two-phase exploratory sequential mixed methods study with these leaders. Phase one surveyed leaders recruited from five healthcare professional associations and HCO affiliated leaders (N = 86). The survey was based on the five competency domains from the American College of Healthcare Executives (2023) Leader Competency Directory. Phase two of lived participants from Phase One (n = 10) the opportunity to discuss their experiences during interviews in context with the survey results. Phase one quantitative results indicated that leader competencies are valued differently by clinical and administrative leaders. Communications and Relationship Management competencies were shown to be the most valued (7.76%) above the other four competencies. Further, leaders felt most strongly about their competencies found in the Business Acumen domain. Qualitative results produced nine broad themes, three subthemes, and one predominate theme – adapt and influence. The results suggest that leaders tailoring their communications to their followers can improve their chances of success when implementing an M&A strategy.

Background and Significance

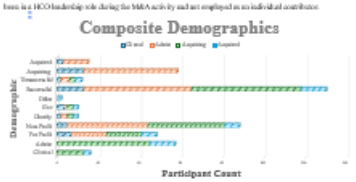
Contributing factors to HCO financial challenges are an aging population, increasing prevalence of chronic illnesses, the COVID-19 pandemic, and an unfavorable regulatory climate which may promote competition. These challenges can culminate in potential revenue losses. Expansion through M&A may provide HCOs with additional revenue from enhanced service lines in new geographies (Burns & Pauly, 2023; Shepherd, 2012; Postma & Ross, 2016; Slavgyna, 2018). Historically, these HCOs with M&A intentions have been measured at a average annual rate of approximately 97 hospitals since the 2010 passage of the Affordable Care Act (National Institute for Health Care Management, 2020; Ownby & Leadreth, 2022; Schmitt, 2017). However, not all M&A is completed as envisioned (Cerezo-Espinosa de los Monteros et al., 2021; Chhabra et al., 2022; Robinson & Knight, 2018).



Participants

Participants were recruited from the memberships of the Medical Group Management Association (MGMA), the Healthcare Financial Management Association (HFMA), the LinkedIn online communities of the Mississippi Hospital Association (MHA), the Hospital Executive Network (HExN), and the researcher's professional page. The three-week recruiting process resulted in 86 participants for phase one and ten for phase two. Participants served in various organizations, roles, at the acquiring and acquired organizations, and with differing lengths of experience in leadership positions.

The study's inclusion criteria for participation were that individuals currently or previously needed to have been in a HCO leadership role during the M&A activity and not employed as an individual contributor.



Design & Investigation

The purpose of this study was to explore healthcare leaders' estimation of the success or failure of their M&A and the role that ACHE healthcare leader competencies may have played during their lived M&A experience. The research sought to address these three questions.

1. What do healthcare leaders report about the success of their hospitals' M&A and their leadership competencies during M&A in the context of the five ACHE competency domains?
2. What are healthcare leaders' perceptions of real experiences with hospital M&A and the role of ACHE leadership competencies during the transition?
3. How do the experiences and perceptions of healthcare leaders regarding hospital M&A in the context of the ACHE leader competencies help explain what leaders reported regarding the success of their hospitals' M&A activity?

The researcher designed the study using an explanatory sequential mixed-methods approach, divided into two distinct phases. A six-item questionnaire collected data regarding the participant's perception of their leadership competencies during their most recent M&A activity. Five items on the questionnaire paralleled the five ACHE (2023) competency domains. The ACHE domains are measures of "expertise in critical areas of healthcare management" (p. 1) using a five-point Likert scale from novice (1) to expert (5). The associated domains are (a) leadership, (b) communication and relationship management, (c) professionalism, (d) knowledge of the healthcare environment, and (e) business knowledge and skills (not used). The sixth item on the questionnaire was arranged in two parts. Participants were asked to rank the competencies they perceived as most valuable to the HCO during their lived M&A experiences from the least valuable (1) to the most valuable (5). In the second part of the question, they were asked again to consider their most recent M&A, as if it occurred in a perfect world, and rank their competencies they now perceived would have been most valuable to the HCO during the M&A. The Phase One findings guided the Phase Two semi-structured interview guide. The guide prompted participants to discuss their interpretations of the survey results.

Quantitative data analysis focused on descriptive statistics, including counts and percentages, due to the purely categorical nature of the data. Fisher's exact tests were used for inferential analysis. Qualitative analysis of the data was performed using grounded theory, beneficial to the study for several reasons due to support of incremental data collection, the cyclical review of findings that spurred further investigation and deeper insights, and its support for a pragmatic approach to the research (Charmaz, 2006).

Research Findings

Data from the two phases identified leaders' actual and ideal leadership competencies in their most recent M&A. Using the grounded theory analysis the researcher identified 'Adapt and Influence' as the predominate theme.

HCOs are typically run by a duality of administrative and clinical leaders (Sinsom, 2021). The study data suggest leader consensus on strong Business Acumen competencies in their most recent M&A. Clinicians felt proficient in Healthcare Knowledge, Professionalism, and Leadership, while administrators saw their struggles in Business Acumen and Relationship Management.

Leader Perceived Competencies by Role

Through open analysis, the data yielded nine subthemes. Subsequently, through axial coding, three primary themes emerged. Refining the open and axial coding led to the identification of overarching narratives, or selective codes, indicating that leaders play a pivotal role in adapting and influencing their organizations during M&A transformations.

When participants rank-ordered the competencies they witnessed versus what they wished had been present, the consensus was a desire for greater competencies in the Communications and Relationship Management domain, 9.26% higher than the next highest domain – Business Acumen. Two measures were statistically significant at a p-value of <0.05. The domains below the 0.1 p-value threshold were Communications and Relationship Management (0.083) and Professionalism (0.012).

Leader Competencies Witnessed Versus Wished

Note. Data above the midpoint line been selected to identify the most strongly desired perceptions.

Solution & Implementation

Data collected from the two phases revealed leaders' perception of their competencies and their desired competencies, underscores the need for adaptability during M&A-associated organizational transformations. The study suggests that leaders must recognize and resolve competency gaps between their current skill sets and those they wished had been present during their most recent M&A. The findings also revealed relevant and timely wisdom that leaders may adapt to improve their chances of success.

The researcher has developed and will deliver to the healthcare and investment industries a bespoke reference entitled "Pearls of Wisdom for the HCO Leader Facing M&A". Pearls will incorporate the study's findings to aid leaders on their M&A journey by offering a series of **when and then** steps derived from the study's common themes. The Pearls will be electronically distributed to healthcare leaders who are involved in M&A. Pearls may also be used as an early planning tool by accountants Kaufman Hall, Accenture, KPMG, and investment bankers at JP Morgan. Further, contacts at HLTH, VIVE, and HIMSS will be solicited for speaking engagements. It may also be found on the researcher's corporate website https://www.MWAhospitalleadership.com.

Limitations

Recruiting issues were central to this study's constraints. Many of the participants recruited from social media (n = 580) proved fraudulent. It is underscored which social media posting invited the fraud. While fraud in academic research is commonplace, it is a growing problem (Pozzar et al., 2020). Although unrelated, the Change Health's medical claims clearing house cyber event, which "forced the company to disconnect more than 100 systems on February 21st, impacted recruiting a day after the process began (Handle & Stupp, 2024, para. 4). The cyber event forced one professional organizations to raise the request for participation to their membership approximately 12 days after the researcher's initial request.

Participant bias may also be a limitation. Most interviewees indicated their participation in a successful and unsuccessful M&A activity. This pairing may indicate a bias by participants to be included in the M&A success demographic rather than only being associated with failed M&A activities. A further bias may be found in the demographics where most participants (74%) were identified as part of the administrative profession. This lack of clinical participation may have biased the results toward a more the actions from those from an administrative culture. The generalizability of the research may be hindered by the lack of clinical responses and interviews.

Conclusion

The findings indicated that leader perceived competencies vary between administrative and clinical staff. During M&A, administrative leaders perceived their competencies as higher in the Communications and Relationship Management and Business Acumen domains. Likewise, clinical leaders perceived their competencies as higher in the domains of Professionalism, Leadership, and Knowledge of the Industry. During future transitions, administrative and clinical leaders acknowledged they would like to experience greater competency measures from the Communications and Relationship Management domains. The researcher's novel M&A guide, Pearls of Wisdom for HCO Leaders Facing M&A may be used to close the gap between the unexpected disruptive events of M&A. This collection of wisdom from experienced peers offers leaders a series of **when and then** scenarios to help form forward responses to unforeseen problems.

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The complete list of literature may be found at the QR Code.

For more information contact: Allen Moore @ 256-415-1234

APPENDIX O

Fair Use Statement

Fair Use Statement

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Doctor of Health Administration
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