FEET ON THE STREET

How Collaboration and Strategy Saved Two Outreach Programs

BY TERRY WEINBURGER, M.S.

In early 2009, a new for-profit specialty surgical center, Ohio Valley Medical Center, opened in Springfield, Ohio. As a result, Community Mercy Health Partners anticipated a $5 million loss in revenue for inpatient services at nearby Springfield Regional Medical Center, one of its two acute-care hospitals, and set about recalibrating the annual budget. My assignment was to review the community benefits package and cut $1 million in annual operating expenses within the nine remaining months of the fiscal year.

Two of Springfield Regional Medical Center's five community outreach programs were earmarked for elimination. Ohio's tax revenue shortfall put them in particular jeopardy when a source of their operating revenue, a grant-funded program called "Help Me Grow," lost a significant amount of state financial support, and funding from the local school district through an alternative education grant faced being cut nearly in half.

Despite this hovering financial storm, we were able to save the two outreach programs thanks to diligence, creative collaboration with a local federally qualified health center and careful attention to values inherent in Community Mercy Health Partners' mission. Here's how we did it:

PROGRAMS UNDER THREAT

Keifer-Mercy Health Center, a primary care clinic established in 1997 and located inside an alternative school, served more than 200 students and their families. Open year-round, the clinic provided convenient access to health care and social services. Its focus on primary and preventive health aligned with the school's philosophy of removing barriers that hinder students from learning, graduating and achieving self-sufficiency. In 2008, the Ohio Department of Education named the clinic a "best practice" model for school-based health clinics.

Social work services such as classroom interventions, support groups, a smoking cessation program and other therapy groups played a vital role, and the clinic provided home visits and coordinated services for families.

Students using the clinic came from families with serious issues including domestic violence, mental illness, substance abuse, child abuse and neglect. Social work services such as classroom interventions, support groups, a smoking cessation program and other therapy groups played a vital role, and the clinic provided home visits and coordinated services for families, as well. The clinic's expense budget for fiscal year 2009 was $410,000 with a staff complement of five full-time equivalencies.

The other program facing elimination was Mercy Parent-Infant Center, a 35-year-old program whose team of nurses, social workers, educators, support staff and volunteers offered childbirth classes, parenting classes, support groups for parents of young children, pregnancy tests and counseling, home visits by nurses and social workers, material assistance such as food, baby formula, diapers, clothing and car seats, referrals and coordination with other social service programs.

Located in downtown Springfield, across the street from the main bus ter-

minal, the center was open every afternoon during the week and it scheduled classes — open to all ages, races and socio-economic groups — during evening hours. Clients served were initially uninsured or Medicaid-eligible families with infants and children under 3 years of age, as well as pregnant women. Many were single women in their late teens to early 20s. Many were in crisis — unemployed and homeless was a common profile — and in need of pregnancy testing and counseling.

Often, these young parents were at-risk victims of neglect or abuse and had low educational levels. Some clients were referred or mandated by the Department of Human Services and juvenile court for education and counseling.

In 2009, with support from two dozen human service and community organizations, churches and service clubs and with the help of numerous volunteers, the clinic distributed more than 6,000 pieces of clothing, approximately 8,600 units of formula and provided meals, baby food, car seats, baby accessories and equipment. The clinic's total annual expense for fiscal year 2009 was approximately $522,000, with a staff complement of 2.5 full-time equivalencies.

THE OPERATIONAL PLAN

With the clock ticking, I mobilized the director of community outreach and the programs' manager to quickly put our "feet on the street," seeking options for trying to save the programs. Collaboration was our mantra, and a community clinic known as Rocking Horse Center turned out to be a viable partner. The center, located in the city of Springfield, was established in 1999 with significant financial support from Community Mercy Health Partners and the community. In 2008, the Mercy group assisted Rocking Horse Center in securing status as a federally qualified health center, a designation that allowed it to realize a higher level of reimbursement for services provided to Medicare and Medicaid recipients.

With endorsement from our chief executive and the board of Community Mercy Health Partners, I contacted the chief executive of Rocking Horse. Our organizations had similar missions and a longstanding collaborative relationship, and we agreed to explore possibilities for Rocking Horse to take over the two threatened outreach programs.

Our transition of ownership for the two community outreach programs resulted in an improved service delivery model and in enhanced services to the at-risk populations.

WE MADE IT HAPPEN

Our director for community outreach completed a values alignment assessment and determined that the two threatened programs ranked high in alignment with Community Mercy Health Partners' mission and core values. We told the local media that the programs were in jeopardy and that an exploratory project to save them was underway with Rocking Horse Center.

Both organizations presented their business cases to designated board committees and boards. We involved the outreach programs' community-based advisory committees, and the programs' leadership gave regular informational updates to their staffs. Meanwhile, local community publicity was favorable, with headlines commending both organizations.

Due diligence included a review of assets, equipment, furnishings, job descriptions, salaries, benefits, contracts and vendor/supplier agreements, organizational charts, leases, pending litigation or claims, volume information for the past three years, a summary of income and expense statements for the past three years and payer mix information.

In recommending a change of ownership and transfer of operations, we also developed a detailed plan for transfer of staff. Leadership and human resource representatives from both organizations hosted a group meeting and one-on-one sessions with the staff. We developed a communication plan for 24 supporting organizations, agencies, service clubs, area churches and constituent groups in the service area.

A legal agreement was drawn up. Community Mercy Health Partners hosted a recognition and celebration for staff and advisory board members. Effective January 2010, Rocking Horse Center assumed day-to-day business operations of the two community outreach programs with some service enhancements, thanks to the higher level of reimbursement provided to Rocking Horse as a federally qualified health center.

LESSONS, OBSERVATIONS AND REFLECTIONS

In her article titled "Evidence-Based Public Health Benefits Communities," Kathleen Gillespie offers us a challenge to modify our services when necessary to improve the health of the residents in the communities we serve.[1]

Sometimes that may mean giving up operational control and administration if we can enhance and better serve our community residents, especially those individuals who may lack financial resources or insurance coverage. Indeed, our transition of ownership for the two community outreach programs resulted in an improved service delivery model and in enhanced services to the at-risk populations.

Paying attention to community health status and needs requires special leadership competencies. In reference to the 2005 National Center

for Healthcare Leadership research-based model, CHA's Brian Yanofchick, senior director, mission and leadership development, mentions the key competencies and qualities needed for successful health care leaders of the future.[2] Of the three domains for a leader (people, execution and transformation), community orientation falls in the transformation domain. Behaviors for this competency include responding appropriately to community needs, taking personal responsibility for collaborative planning, anticipating and understanding the community and advocating for the broader health environment.

These competencies and behaviors were certainly evident among all participants who collaborated and forged an alternative that sustained both programs and positioned Rocking Horse Center to enhance services going forward. As a *post factum* reflection, Community Mercy Health Partners leadership and board used a mission-based, decision-making model developed by Catholic Health Partners. (See box below.)

NOTES

1. Kathleen N. Gillespie, "Evidence-Based Public Health Benefits Communities," *Health Progress* 89, no. 2 (March-April 2008): 6-7.
2. Brian Yanofchick, "Note for Tough Times: Don't Rob St. Paul to Pay St. Peter," *Health Progress* 90, no. 1 (January-February 2009): 4-5.
3. Julie Trocchio, "A Wondrous History of Community Benefit," *Health Progress* 87, no. 6 (November-December 2006): 11-12.

TERRY WEINBURGER is vice president, mission services for Community Mercy Health Partners, Springfield, Ohio, a regional health care system serving south central Ohio. The system is a member of Catholic Health Partners of Cincinnati.

ASSESSING THE PROCESS

Community Mercy Health Partners used these questions based on a Catholic Health Partners model as a *post factum* reflection:

Were any of our core values of compassion, excellence, human dignity, justice, service or sacredness of life explicitly invoked or implicitly understood during the process?
Yes, both compassion and service were two core values discussed with stakeholders and referenced in printed material. Our value of stewardship also was referenced throughout the entire nine months.

Did any principles of Catholic social teaching come into play, such as common good or a preferential option for the poor?
A focus on the common good and continuing support by Mercy Health Partners to Rocking Horse Center were key drivers in the dialogue among the various stakeholders. Concern for the welfare of the clients and students was an ever-present concern, and storytelling gave a voice and face to the at-risk populations served.

Who were the significant stakeholders in the outcome? How will they be affected?
Students and clients continue to be served. Other stakeholders, including staff, board members, community advisory committee members, area service clubs, churches, foundations and family members, were all supportive and pleased with the outcome.

Did we have sufficient information, clearly presented, to make an informed decision?
Yes, the due diligence process included data for three years of operations for both outreach programs. Also, scheduled face-to-face presentations among leaders of the organizations involved provided them sufficient information and data to make informed decisions.

Did we give sufficient time to differing viewpoints? On what basis were the differences resolved?
Yes, this was a nine-month transition. Initially the senior leadership at Community Mercy Health Partners focused on implementing a quick transition. Meanwhile, the board members focused on community input, requesting that collaborative alternatives be explored before accepting a recommendation from leadership.

Were there any implications related to the *Ethical and Religious Directives for Catholic Health Care Services?*
None.

Was the outcome clear, and can everyone involved defend it?
The outcome was clear to the organizations involved and to the public. The media was briefed at the beginning of the collaboration process and again at a press conference when a workable alternative had been secured. In summary, the process involved the right participants, was based on assembling the right facts, clarified the right values and led to consensus among the various stakeholders.

In short, the legacy of community benefit programs in Catholic health care — a tradition that dates in the United States to the 18th century in New Orleans — remains alive and well today in downtown Springfield, Ohio.[3]

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2010