Grow, Partner or Exit

A Mission Discernment Framework

MICHAEL A. SLUBOWSKI, FACHE, FACMPE

Because of changes occurring in the health care world, as well as in our social, political and economic environments, the Catholic health care ministry faces challenging decisions regarding ministry repositioning, cost management, customer focus, competitive niches and the size of commitment that can be made to those who are poor and underserved.

Care is rapidly shifting from acute settings to home and outpatient settings. Many Catholic health providers still rely too heavily on high-tech inpatient services as part of the service mix.

In many markets, demand is dwindling for traditional inpatient and hospital-based outpatient services, which has resulted in growing competition among multiple providers for the remaining business.

The cost of care is escalating rapidly — much more quickly than the consumer price index — and employers and government payers are shifting more of the cost burden to consumers, who cannot afford it.

Efficiencies must be achieved to offset the difference between dwindling payer reimbursement and the growing cost of delivering care.

Catholic providers tend to serve markets with high percentages of populations covered by governmental payers who don't cover the cost of care delivered.

Consumers are demanding convenient, accessible services and digital, low-cost solutions to access care and information. Niche providers and other companies that are new to health care but more adept at rapidly responding to customer demands are providing solutions faster than those with a hospital-centric legacy.

These kinds of issues must be addressed individually and uniquely in each circumstance that a Catholic provider encounters. But to prepare the ministry for discernment calls for facing present realities and, perhaps more importantly, raising questions to which there are no immediate and easy answers.

DISRUPTERS AND DIFFICULT DECISIONS

Consolidation and partnerships are forming among all kinds of providers — Catholic, other faith-based, secular not-for-profit, investor-owned and private equity. In addition, other kinds of companies are consolidating to be disrupters in the health care industry by creating niche services and products targeted at customers who have generous commercial insurance or the ability to pay out of pocket. Disrupters include retailers, pharmaceuticals, health plans, large employers, information technology companies, etc.

Whenever the subject of growth comes up, questions of "To what end?" and "Is bigger better?" always come to mind. Such questions arise in all businesses and in all sectors of the economy, but they seem to be particularly present for Catholic providers. As part of an overall growth strategy, some Catholic health providers must make difficult decisions to divest hospitals and other health care services in communities where they lack sufficient presence to be viable as a comprehensive network provider for payers or employers.

It's a challenging issue when Catholic provid-

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ers decide to exit a community that they have served for many years. As a ministry, we believe that being a compassionate and transforming healing presence in our communities is our mission; in essence, it is our reason for being, and we place a special emphasis on serving those who are poor and vulnerable. At the same time, merger, divestiture and acquisition activities are occurring industrywide.

'ACID TEST' QUESTIONS

Despite Catholic health care's stated mission, is choosing to grow organically, or acquire strong partners, or divest challenged ministries, simply a financial decision?

As a Catholic health provider, do we provide something distinctive?

Will decisions for the ministry's future — whether they involve entering a new community or leaving one — mean the community will be better off?

If we leave a community, what do we leave behind?

What happens if our ministry in a community is unsustainable financially, but a community need is still present?

CATHOLIC IDENTITY IS ADDED VALUE

Catholic health care believes the ultimate measure of good performance, or "adding value," is how we demonstrate Catholic identity, defined broadly as:

> "In communities across the country, Catholic hospitals, clinics, long-term care and other facilities are caring for people of all ages, from conception to natural death. These Catholic health care organizations are motivated by faith in the healing mission begun by Jesus. This mission reveals a vision of healing that goes beyond medical care to meet the holistic needs of people, families and communities, always respecting the dignity of each human person. As a ministry of the Roman Catholic Church, Catholic health organizations commit to: promote and defend human dignity; attend to the whole person; care for poor and vulnerable persons; promote the common good; act on behalf of justice; steward resources; and act in communion with the church."[1]

Given this definition of mission, a Catholic health ministry should be measuring its effectiveness at:

Promoting and defending human dignity: This includes advocacy efforts and public policy positions, for example.

Attending to the whole person: This includes person-centered care, services that go beyond clinical care and include social needs and social determinants of health, psychological needs and spiritual needs.

Caring for poor and vulnerable persons: This includes access to care, especially primary care and preventive care, regardless of ability to pay; charity care, full participation in Medicaid, Medicare and other programs that do not fully cover the cost of care.

Promoting the common good: For example, are the populations served, including employees and their families, healthier as a result of the ministry's programs and interventions? They are harder to measure, but public health initiatives, reduction of violence, engagement in civic affairs, etc., could be other examples.

Acting on behalf of justice: This includes supporting fair/just wages, advocacy for access to a basic level of health coverage for all, among other examples.

Stewarding resources: That is, affordability of care — how we use our resources to provide value-based outcomes at the lowest cost; how we leverage skill, scale and learning to benefit our communities.

Acting in communion with the church: For example, opposing assisted suicide and, instead, promoting robust palliative care programs and hospice programs to respect life from conception to natural death.

There are other measures of how effectively we demonstrate Catholic identity — through excellence across a balanced scorecard of measures, or demonstrating superior performance through rapid movement to top scores in:

- Achieving zero harm for patients, residents and employees
- Quality and care outcome measures
- The patient care experience (for example, "Would Recommend" scores on the Centers for Medicare and Medicaid Services' CAHPS hospital and CG-CAHPS clinician and group surveys)
- Highest levels of employee engagement
- Provision of care at the lowest possible cost

- Financial stewardship and ability to generate sufficient capital for reinvestment
- Provider engagement and alignment

Finally, and perhaps most important, Catholic health care needs to answer threshold questions regarding community need:

- Are we a "relevant" provider in a community? Will adding to, or subtracting from, our presence in a community better meet community needs and enable us to improve access and quality at a lower cost to those we serve?
- Does the community have sufficient health care capacity, or a surplus of capacity? Are we exacerbating excess capacity and excess cost by duplicating existing services in the community?
- Are we providing unique services or a unique level of access, quality and service at low cost that would result in an unmet need if we leave the community?
- Would those who are most vulnerable have access to basic health services if we left the community or turned over operations to a secular and/or for-profit provider? Are there alternative services that we could provide to the community besides acute care that would meet a need?
- Are there unmet needs that we are not providing if we are in a community?
- If we enter or partner with another provider in a community, do we have the expertise and bandwidth to help a provider rapidly improve its balanced scorecard performance? Are there others that could do a better job of helping the provider improve performance?
- If we partner with an other-than-Catholic provider, do we have a common mission and shared values? Do we have alignment on measures that define success? In what time frame? Can we successfully partner and maintain our Catholic identity?
- If we leave a community, are there needed services that we should continue to provide, such as safety-net clinics, etc.?

Measuring some of these elements of Catholic identity can be elusive, but they must be considered and further developed in order to assess the ministry's role in communities we currently serve or hope to serve.

'ACID TEST' QUESTIONS

If a community would be negatively impacted should a Catholic health care provider cease to provide inpatient care, the discernment process examines other alternatives, notwithstanding difficulty perceived in accomplishing such transformation.

Can the Catholic provider align with other community providers to share the burden presented by uncompensated care or services whose costs are covered by public programs?

Can the Catholic provider's service in other markets generate sufficient income for the system to cross-subsidize a challenged market?

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Can the Catholic provider narrow its scope of inpatient services or observation care to one that is more targeted to community need?

Is it possible to develop a more rapid shift to community-based ambulatory care and home care in order to provide care to more people at a lower cost per capita?

Can the Catholic provider obtain subsidies or incentives from fundraising, community agencies, local governments or employers who wish to maintain the presence of the provider and its economic and employment base?

MEASURING THE VALUE OF SCALE

Bigger is not always better, and economies of scale can be overshadowed quickly if organizations do not effectively manage people, process, technology and culture as they grow. Here are some thoughts on how scale can potentially add value for a provider so it can better serve its communities.

Admittedly these are more traditional measures of adding value, and they do not necessarily include added dimensions of Catholic identity, but they can be a means to achieve greater success as a Catholic health ministry. Some of these scale economies can be achieved through partnerships or contractual relationships — not necessarily through merger with or sale to a larger provider.

Scale economies can be realized with purchasing and supply chain programs. Large health systems (those with revenue over $5 billion), have

a distinctive advantage in lowering these costs. One can argue that joining a big group purchasing organization (GPO) associated with large systems can accomplish the same objective, but many of the largest systems have gone well beyond leveraging the procurement function and have developed full supply chain capabilities for warehousing, distribution and even manufacturing.

Scale can lead to more effectiveness at getting attention from legislators, deploying advocacy initiatives and cascading advocacy initiatives down to the market level. Because of their national relevance, larger health systems tend to get invited to major meetings with legislators in Washington D.C.; they have an effective cascading program and mobilization programs to get "grassroots" support within each of their communities to contact legislators.

In contrast, smaller organizations tend to have limited resources to support mobilization, and they may be heavily dependent on national and state associations to advocate on their behalf. Many national and state membership associations have a more diluted message, since they are representing a much broader and diverse constituency and cannot necessarily support initiatives that Catholic health systems might emphasize.

Organizations with scale tend to make more investment in research, development and innovation efforts. Many larger health systems are piloting innovations on their own or that originate from start-up companies in which they have an equity interest in through innovation funds.

Scale can provide the potential to extract more value from information system platforms than small systems can. The cost of licensing, implementing and maintaining clinical electronic medical record systems and enterprise resource management systems are enormous. Furthermore, the cost of information security and running backup data centers with fail-over capability (automatic transfer to the backup data center if the primary center fails) can be spread over a much larger number of users. Finally, most organizations are moving from data to advanced analytics, and there is value in pooling efforts to develop platforms for deep analytics and performance improvement.

Organizations with scale have the potential to share other system resources, many of which have fixed costs that can be spread over a broader number of care sites, such as compliance, safety, audit, human resources, finance, clinical improvement, marketing, advocacy, supply chain, revenue cycle, physician practice management, etc.

Organizations with scale have payer contracting expertise in a variety of markets with a variety of payers that can be leveraged to support smaller providers. And to the extent that there are national payers in multiple markets, there are opportunities to discuss and develop payer contracting and partnership strategies at a national level. These are just beginning to be more effectively deployed by larger systems.

Bond rating agencies favor health systems with wide and diverse geographic and service portfolios in terms of credit worthiness because their risk is spread across multiple markets with different payers, economic climates, etc. Of course, large systems must also manage their portfolio and must be successful in the majority of markets they serve. Geographically diverse systems are able to support unique communities where mission effectiveness is high but financial performance is compromised due to market conditions, such as higher charity care, no Medicaid expansion, etc.

Finally, there are some unique value proposition opportunities that are associated with some health systems that may uniquely add value, such as advanced population health capabilities, care continuum capabilities, etc.

Achieving scale through strategies of contracting, partnering, joint venturing, merging, etc., is not a panacea. It is a means, not an end, in providing sustainability for a health ministry to meet the needs of a community it serves. Achieving true value through scale requires clarity of purpose, simplicity in execution and a win-win relationship among parties to achieve mutual benefit.

'ACID TEST' QUESTIONS

With insight from objective benchmarking against others, does the Catholic provider have sufficient scale on its own to provide the highest quality care and service at the lowest possible cost to the communities it serves?

Does the Catholic provider have sufficient access to capital to reinvest for its future?

Is the Catholic provider being proactive in seeking opportunities to leverage scale while it is healthy so that it can remain strong and sustain the ministry, or is it experiencing rapidly declining performance and moving too far up the "desperation curve?"

Can Catholic health care and Catholic identity be preserved or strengthened in a community or communities as a result of partnering or merging with others to achieve scale economies?

If the Catholic provider seeks partners to achieve scale economies, are the organizations compatible from a mission, values and vision perspective? Is there a commitment to serve those who are poor and vulnerable? Is the partner in it for the long haul?

Is the Catholic provider focused solely on scale to be relevant in its present local or regional service area, or is it also considering the benefits of scale that can be achieved through alignment with a Catholic partner that isn't present in the communities it serves but can bring needed skill and scale economies?

Can Catholic identity be preserved by partnering with an other-than-Catholic provider?

Does the potential partner truly bring skill and scale economies to the partnership, or is it so big that it is experiencing "diseconomies of complexity?"

SUMMARY THOUGHTS

The subject of growth, partnerships and divestitures is challenging Catholic providers across the country, and there are no easy answers. Careful discernment of our value to communities is paramount if we are to effectively carry out our mission.

For Catholic health systems, the ultimate measure of value to a community is how we respond to community need and demonstrate our Catholic identity. Catholic health systems can extract value from integration with regional systems that are in the same geography, as well as with larger health systems, by effectively leveraging skill and scale opportunities.

However, partnerships with other-than-Catholic providers can be challenging due to differing objectives, disagreements on time frames and measures of success, and difficulty remaining in fidelity with church teachings. Careful consideration of partnerships to ensure alignment of values and long-term sustainability, in conjunction with dialogue with diocesan bishops when appropriate, is recommended to ensure that mission and community benefit remain paramount.

Finally, the value proposition of scale must be mined — it does not come without a common mission, shared vision, great servant leadership, cultural alignment, tremendous effort, outstanding project management, capital resources and a relentless pursuit of value.

MICHAEL A. SLUBOWSKI is president and chief operating officer of Trinity Health in Livonia, Michigan. He is chair of the Catholic Health Association board of trustees.

NOTE

1. The Catholic Health Association of the United States, "Catholic Identity Overview," *Catholic Identity* website. www.chausa.org/catholicidentity/overview.

QUESTIONS FOR DISCUSSION

Michael A. Slubowski, president and COO of Trinity Health, describes the options of growth, partnership and divestiture amid the changing world of Catholic health care. He proposes a decision-making process that incorporates serving to scale, committing to community and demonstrating Catholic identity.

1. What are some of the benefits of growing, partnering or exiting health care markets for patients, employees and communities? What are the drawbacks?

2. Slubowski provides three sets of "Acid Test Questions" for hospitals or health systems approaching decisions about mergers, acquisitions and divestitures. Are there any questions on the list that made you think about your own ministry and how it operates? Are there any questions you think should be added to the list?

3. How can Catholic health care systems and their providers show their values in a new or existing market? How can they reflect Catholic values even when exiting a market?

4. Does your organization incorporate discernment in its senior leadership formation program? If it doesn't, what do you suggest? If it does, how does the organization prepare senior leaders to spiritually discern the types of issues raised by Slubowski?

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