

Editor's Note: "Perspective" is an occasional column that features updates, points of view and brief discussions of issues by guest authors and CHA staff.

A CAUTIONARY TALE REVISITED

Nearly 20 years ago, Fr. Richard McCormick, SJ, PhD, asked if Catholic health care could live out its mission in the current health care environment, which, at the time, he described as having the following characteristics: medicine as business, depersonalized care, cuts in Medicare and Medicaid, impoverished public hospitals, rampant mergers and competition, obsolescence of the hospital and threatened pastoral care.¹ I wrote an article reflecting on McCormick's question and ended it, unlike McCormick himself, by expressing hope that mission was still possible for us within Catholic health care despite the various challenges.² Looking back on that article with the wisdom of hindsight, I am, paradoxically, more and less hopeful today than I was at the time. Let me explain and attempt to offer some constructive comments as well.



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McCormick's pessimism was grounded largely in a variety of external factors impinging on Catholic health care and forcing it to choose between business ends and ministerial commitments. To be sure, most of these are still present today.

Yet, ironically, I am more hopeful than I was 15 years ago precisely because certain external factors are coalescing to force dramatic change in the way U.S. health care is structured, paid for and delivered. These include: macro-economic factors (e.g., unsustainable cost of health care per capita at about \$10,000 and about 18 percent of gross domestic product; health policy factors (e.g., Medicare payment and delivery reforms emphasizing value over volume, such as Medicare Advantage, accountable care organizations and bundled payment initiatives); technology factors (e.g., expanded use of electronic health records, application of Big Data insights to clinical decision-making, and virtual/telehealth innovations); demographic factors (e.g., a sicker, aging U.S. population in need of increasingly more care); and consumer factors (e.g., mounting out-of-pocket health costs for individuals/families and bottom-line pres-

ures for employers making them more cost- and quality-conscious).

All of these factors are moving us inexorably toward a value-based health care delivery system that: **a)** rewards providers for improving health outcomes and reducing costs through the provision of safe, evidence-based, effective care in appropriate settings; and **b)** more closely aligns with the Catholic health care mission, which is to transform the health of our communities, especially those that are economically, physically and socially marginalized, so that every person encounters the healing presence of God and is given the opportunity to flourish.

However, I am less hopeful that we can live out the mission because, like the vast majority of

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health systems, Catholic health care systems are mired in a vicious cycle of trying to sustain an outdated, capital-intensive acute/specialty care infrastructure that perpetuates the access, cost and quality problems plaguing the U.S. health care system. Sustaining this inherently flawed infrastructure that provides questionable value beyond rescue medicine is the lens through which all major decisions are made, from strategic plans, capital allocation and operating budgets to revenue cycle management, physician recruitment and service-line offerings.

It also is often why health systems, despite being well-intentioned, tend to be perplexingly monolithic in their strategic thinking and so eager to enter into mergers and acquisitions. These purportedly are undertaken to improve the health of communities, but they typically only decrease competition within local markets and enhance the negotiating leverage of hospitals and medical groups, thereby further driving up health care costs and exacerbating the plight of poor and low-income people.

The hard truth is that Catholic health care cannot continue to operate primarily or exclusively within an acute/specialty care framework and still insist we are living our mission. There is a better way to care for people, to improve the health of communities, and it isn't by overinvesting in hospitals and high-margin specialty care, waiting for people to get sick, and competing with other systems to "put heads in beds," as traditional hospital operators, borrowing a concept from the hotel industry, are accustomed to saying. We have known this within Catholic health care, indeed the entire health care industry, for years. And that's not all:

- We have known that we can better manage the health of populations by placing primary care at the center of the delivery system and improve community health by going outside hospital walls into communities providing basic care when and where it is needed, especially to the poor and vulnerable.

- We have known that we can reduce unnecessary hospitalizations by creating convenient, affordable outpatient access points and limit hospital readmissions through simple means like better discharge planning, follow-up phone calls and

post-discharge clinician visits.

- We have known that we can lower the cost of care by moving non-emergent diagnostic procedures and certain surgeries out of the hospital to lower cost settings and not converting physician practices to hospital-based providers to increase reimbursement.

- We have known that we can more justly distribute health care resources throughout communities by putting care sites and offering services in areas with the greatest need, as opposed to areas with the best payer mix.

- We have known that we can better allocate capital by investing in structures and services that

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communities actually need versus expensive hospital towers in over-bedded markets and the latest technologies just to keep up with competitors.

- We have known that we can enhance patient choice by making health care prices transparent and publicizing more meaningful clinical outcome data.

We have known all this and more, yet mission is not driving strategy and, for the most part, we haven't changed our acute and specialty care mindset or business model. In fact, we continue to cling to it because we have huge debt obligations and capital commitments tied to acute and specialty care and have to chase the money stream while contenting ourselves with providing charity care and engaging in activities that count as community benefit under the IRS definition. These contributions make us feel good and even make a difference in the lives of some people episodically, but it is hardly transformative or distinctive of Catholic health care — virtually all health systems do these very same things.

What would be different, if not distinctive, and more closely align with mission is if we were to organize our efforts around the most urgent community health needs, partner with diverse organi-

zations to address social determinants of health and strategically shift our focus and investments to more accessible, convenient and low-cost structures and services centered around preventive and primary care, behavioral health, chronic disease management and palliative and end-of-life care. This would truly create value and lead Catholic health care down a much different path, resulting in a radically different-looking delivery system that would have a far greater impact on the health status of communities, especially poor, low-income and vulnerable members for whom health care would become more accessible and affordable. Acute and specialty care would still have a place in such a system but it would be secondary to and complementary of these other services that could be provided in a variety of settings and through technological means at a fraction of the cost of hospitals.

This is the type of system that Catholic health care should aspire to develop and the types of services and modes of delivery to which we should direct our sizable investments, which currently get absorbed almost entirely by the acute and specialty care infrastructure. However, devising

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a system of this nature necessitates a new way of thinking that has not been evidenced in a systematic way in the majority of health systems in the U.S.

To be fair, some Catholic health systems are doing some innovative things to transform the health of communities and reinvent themselves for value-based care. For instance, Providence St. Joseph Health, with system offices in Renton, Wash., and Irvine, Calif., has invested \$100 million to improve awareness, diagnosis and treatment of mental illness, which affects approximately 20 percent of all U.S. children and adults, causing untold suffering and contributing substantially to the nation's unsustainable health costs.

Providence St. Joseph Health also has contracted directly with The Boeing Company in a landmark value-based care deal, assuming financial risk to manage the health of a significant portion of Boeing's Puget Sound employees, dependents and retirees.

St. Louis-based Mercy health system has entered into a similar value-based care contract

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with The Boeing Company, and, even more significantly, has invested over \$50 million in creating the Mercy Virtual Care Center through which hundreds of clinicians work round-the-clock in providing high-quality, cost-effective care virtually to critically ill patients in hospitals and chronically ill patients at home. These are not the only examples. Other Catholic health care systems are planning for and developing new competencies to improve clinical outcomes, better manage the health of populations and reduce costs through the provision of safe, evidence-based, effective care in appropriate settings. For most systems, though, these tend to be, at least at this time, tangential to the core business and implemented mainly to funnel paying customers into the acute and specialty care side of the system.

We have a real opportunity within Catholic health care to reclaim the essence of our mission, but to do so, we must redesign our health systems around community health needs and invest in structures and services that truly promote health and make health care more accessible and affordable, especially for those on the margins. To accomplish this, we need to stop being and acting like hospital-centric systems more concerned about preserving the status quo and maximizing revenue than we are about transforming the health of communities and caring for the poor and vulnerable.

Change of this magnitude admittedly will be difficult and could fundamentally alter the short-term financial outlook of Catholic health care sys-

tems as reimbursement catches up with the new delivery model. However, the mission demands no less, and we will have to guard against the tendency to fall back on the seductively expedient “no margin, no mission” principle.

The good news is that if mission isn’t enough reason, there is a growing business case to transition to a value-based health care delivery system. The government, employers, and individuals are demanding more accountability from providers and increasingly tying reimbursement to value over volume. Moreover, innovative health systems and medical groups, along with disruptive new entrants, already are moving in this direction and building early leads over incumbents that continue to resist or are slow to change.

By embracing the transition to value, Catholic health care can gain a competitive advantage, ensure our long-term sustainability and, most importantly, align our work with our mission. The only question is, will we do what we have known we should be doing for years, or will we let this opportunity pass? The choice is ours.

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NOTES

1. Richard McCormick, “The End of Catholic Hospitals?” *America* (July 4, 1998).

2. Michael R. Panicola, “A Cautionary Tale,” *America* (April 29, 2002). www.americamagazine.org/issue/370/article/cautionary-tale.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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HEALTH PROGRESS®

Reprinted from *Health Progress*, March - April 2017
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