

Radical Changes Demand New Skills

By MICHAEL ROWAN, M.H.S.A., FACHE

Sweeping changes over the last two years have transformed core concepts of our health care system — concepts such as standard organizational structures, the traditional responsibilities of executives and the roles of board members in strategic decision-making. The changes in all of these areas over the next several years will be dramatic and far-reaching.

The broad range of challenges surrounding how America provides health care and how we pay for it will require an entirely new generation of leaders and a transformed governance model featuring board members who do far more than perform standard fiduciary functions.

Leaders of the future need to be able to adapt to a revolution in health care that will continue to emphasize “systemness” — that is, ever-increasing standardization, specialization and centralization.

But it all comes back to our mission — and why we exist as Catholic health care ministries. Our founding sisters went where the needs were. Now,

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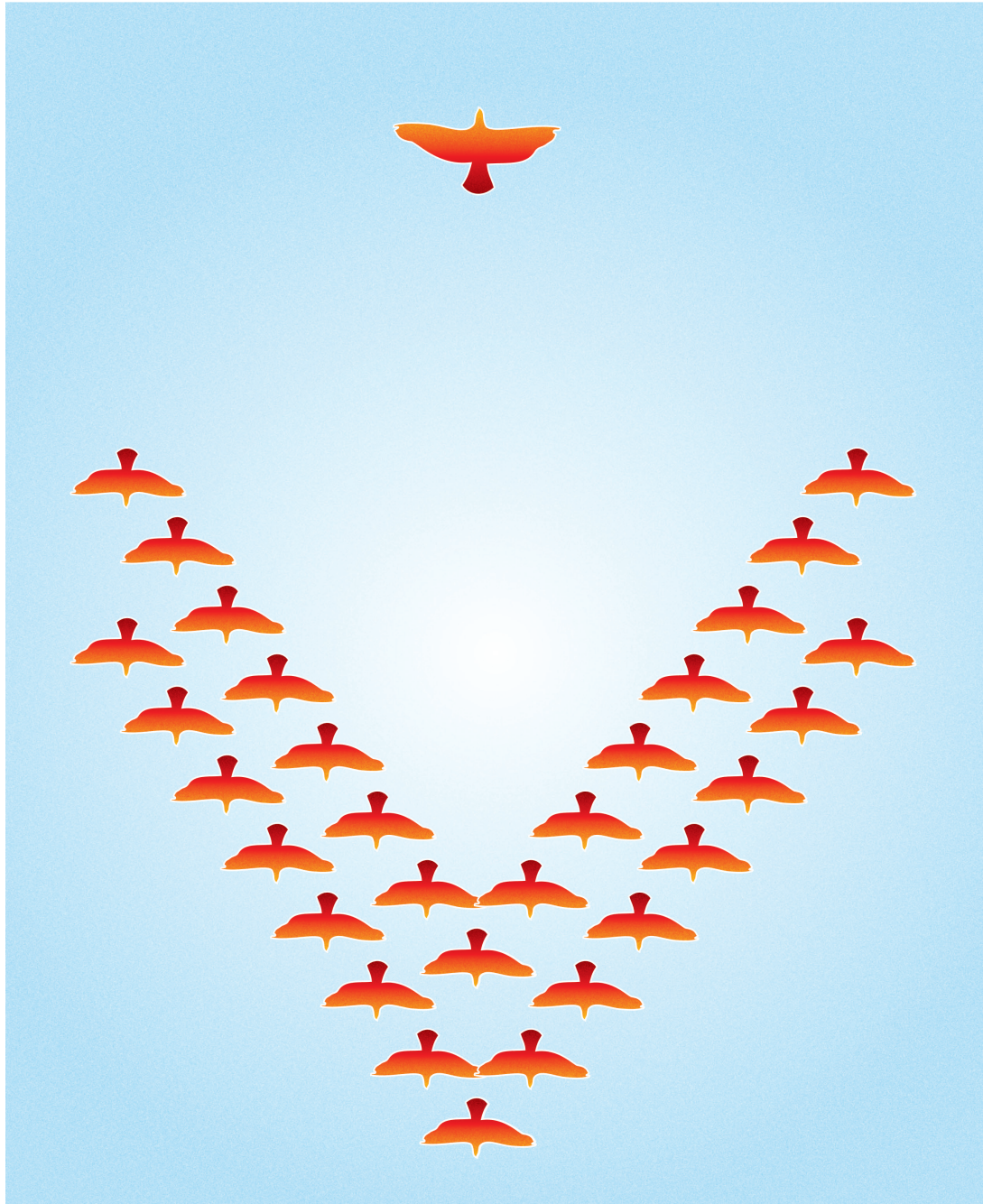
the survival of Catholic health care depends on our ability to read “the signs of the times” and to react accordingly, improving and expanding our mission and our ministry by creating and sustaining new ways to care for the poor and the underserved and to improve the health status of the communities we serve.

NEW LEADERS

As the operating model for health care undergoes a system-wide face-lift, so, too, will the basic job description of the high-level health care executive. To be successful in the future, senior health care executives must shift their attention from acute care services and adapt to a reimbursement system that rewards value over volume.

Value-based purchasing by the federal government means health systems will need to improve the quality of care while focusing on prevention and wellness. A growing focus on population health will mean managing utilization and reducing the cost of each episode of care. That’s a new way of life, especially for an organization as big and diverse as Catholic Health Initiatives (CHI), headquartered in Englewood, Colo. For a system like CHI, which operates 76 hospitals and other facilities in 19 states, entirely new care systems must be developed to eliminate hundreds of millions of dollars of cost — which means that it is essential to hire and retain executives with the skills needed to lead and oversee such monumental changes.

Who will they be or where will they come from? Search firms certainly will zero in on a successful executive who works for a large corporation with multiple divisions in several states, because he or she understands large, complex organizations. A mix of experience in health care delivery, long-term care and employee management are all sig-



nificant assets for our leaders of the future.

Another potential recruiting avenue: academia, including health care management schools or nationally recognized business schools.

Also, more health care systems are moving to “shared risk,” partnering with insurers, physician groups and others in the belief that together they can provide better services at lower costs — and reap the financial benefits when they do so. For that reason, executives who combine a strong insurance background with health care delivery

will be in great demand.

Radical change demands a new outlook and perspective. For many long-established health care leaders accustomed to tradition and the status quo, it may not be possible to evolve and acquire the kinds of skill sets necessary for this level of change. Through inertia or other factors, they may not accept the need for change and innovation, refusing to budge from a rigid position that amounts to a formula for failure.

As it moves toward integrated care, CHI is

no longer seeking “hospital administrators” in local markets, as in the past. Instead, the organization is looking for far-sighted executives who understand the continuum of care. The successful health care executive of the future must be able to see this broad spectrum and understand how the different components align. At CHI and other organizations, this requirement will have tremendous impact, not only on leadership, but also on the development of partnerships with other organizations and providers.

In Roseburg, Ore., for instance, where CHI operates 174-bed Mercy Medical Center, Kelly Morgan, the president and chief executive officer, is in the process of partnering with DCIPA, an independent practice association in Douglas County with more than 200 physicians — every physician in the community. As the only hospital in Roseburg, Mercy will have an equity stake in the independent practice association, a significant development that closely aligns financial incentives for both the hospital and the physician network.

Meantime, physicians with executive skills and experience play a vital role in this transition. Increasingly, complex health systems that span the continuum of care will need to partner with doctors who, in the past, often competed for patients and procedures. In the new model, they

will be integrated into the health system in both a clinical and an administrative sense. CHI is concentrating on training chief medical officers in leadership and executive skills. Their partnership and support will be crucial to success as CHI and other organizations expand the number of employed physicians to help prepare for the changes ahead.

For instance, at Mercy Medical Center-Des Moines, a ministry of CHI in Iowa, seven physician leaders were selected earlier this year to partner with an administrative colleague as a major step in aligning operational functions more effectively at the 802-bed acute care hospital with three campuses. Each two-member team, or dyad, will be accountable for the performance of their service lines, creating a heightened sense of teamwork among physicians and other providers who have long been independent in both training and traditions.

Two examples of these crucial service lines are oncology and orthopedics. In each of these areas — among many others — long-term success will be based on having a medical director and an administrative officer working hand-in-hand, blending both the business and the medical side to emphasize value, quality and efficiency, the watchwords of health reform.

As David H. Vellinga, Mercy’s president and CEO, said at the time, “Mercy has always had great physician leaders, but now we’re formalizing their leadership roles by clearly defining them and engaging physicians to lead clinical changes and operational improvements.”

For Mercy, the definition of a clinically integrated organization is aligning physicians, hospitals and other providers to improve quality, safety and efficiency, and to contract effectively in order to compensate providers for value. Clinical integration is not an end in and of itself. Its purpose is to position Mercy for success in the management of population health and to sustain the viability of our mission.

That same situation — an emphasis on alignment — is also firmly in place in Nebraska, where CHI and St. Elizabeth Regional Medical Center in Lincoln last summer purchased the 63-bed Nebraska Heart Hospital and the Nebraska Heart Institute, a group practice with about 30 physicians. As a result of that affiliation, the existing cardiovascular surgery services at St. Elizabeth were consolidated with the Nebraska Heart Hospital. St. Elizabeth and CHI’s other hospitals in Nebraska — Good Samaritan, Kearney; Saint

NEW SKILLS FOR EXECUTIVES

To sustain the Catholic health care mission, the evolution of administrative skills will require top executives to:

- Assess new local markets and partnering strategies — even with former competitors, including doctors — in order to gain size, scale and coverage
- Develop insurance and risk products
- Analyze the local market shifts in health insurance product offerings and focus resources to create new business models that are financially viable. For instance, how do we go about developing a Medicare Advantage program — and then go out and market it to the community?
- Work with physicians to design organizational models that align facility and physician financial incentives. Those common incentives are especially important in a post-fee-for-service era
- Work with medical, nursing and other health professionals to develop models of care that deliver value
- Create structure out of ambiguity in an ever-evolving landscape



Francis Medical Center, Grand Island; and St. Mary's Community Hospital, Nebraska City — are now also aligned with The Physician Network, a CHI subsidiary that has more than 50 primary, specialty and urgent-care practice sites across the state.

Moving forward, the entire Catholic health care ministry is developing a sense of shared mission, vision and values with our physician partners, focusing on physician leadership and clinical integration as foundational concepts for developing a highly effective, clinically integrated health care network. With primary care and population health underpinning this strategy, we hope to achieve three goals that dovetail with the objectives of health reform: high quality, improved patient satisfaction, and effective, efficient care at the lowest cost.

NEW STRUCTURES

For its part, CHI, the nation's second-largest faith-based health system, is far different from the structure it formed upon its creation 16 years ago. It has transformed itself from a holding company to an operating system. Now, it is rapidly transitioning from a hospital company to a highly sophisticated, integrated delivery system working across the entire continuum of care to provide wellness services in local markets.

Like other forward-looking organizations, CHI and its top leaders recognize the need to not only provide high-quality, cost-effective care but also to develop and manage a new-era business model that accepts risk by "insuring" the health of the populations it serves. The concept for the future represents the internal merger of health care provider and insurer.

Somewhere in the future, CHI — and other Catholic systems — will be in a position to go to a large employer in the community and say, "You have this population of about 5,000 employees. We have looked at their utilization patterns, their epidemiology and demographics, and we believe we could provide care to that entire group for 10 percent to 15 percent below what it now costs. We can do that by being more engaged in health promotion and prevention and by getting patients the right care at the right time in the right place — whether it's the hospital, an ambulatory care center or at home."

That's what population health is all about. Integrated, well-coordinated health care systems will be able to reduce the cost of care to employers,

governmental entities, individual patients and society as a whole, while at the same time improve efficiency and quality.

CHI already has taken a major step toward the management of population health with its own employees through a program called Healthy Spirit, a wellness initiative and preventive care plan that encourages individuals to take a more

The concept for the future represents the internal merger of health care provider and insurer.

active role in their lifestyles, nutrition, fitness and chronic-disease management, among other areas. The program includes individual assessments of health status, educational programs and a newsletter to highlight the keys to healthier living and healthier communities — the mission of CHI. The health assessments include financial incentives, including when employees use the information from their personal assessments on interventions that improve their health.

As a clinically integrated delivery system, CHI is engaged in some basic restructuring and realignment of both processes and priorities. It used to be that the hospitals were the key element of a "health system." The other components of the continuum — everything from home health to ambulatory care — were considered to be secondary. Now, these no longer are simply subsidiaries of the hospital.

The new normal for health care also involves rapid growth and the consolidation of markets, leading to a wave of mergers, acquisitions and partnerships as organizations scramble for the size and scale groups of facilities and groups of providers need in order to bear risk.

Of course, health reform, now just past its two-year anniversary, is the driving force behind these monumental changes.

The Patient Protection and Affordable Care Act, which is designed to provide health insurance for more than 30 million additional Americans, was crafted to address a flawed and dysfunctional payment system that rewards doctors — and hospitals — for treating illness. In the future, providers will be rewarded for maintaining wellness.

The health care reform debate has placed a spotlight on the shortcomings of the current system. It has created an environment where col-

laboration, preventive health, value-based purchasing and accountable care are the watchwords. We're no longer focused predominantly on acute care services; instead, we are managing the wellness of entire populations, which simply underscores the historic mission of Catholic health care.

Are we prepared for the future? How do we change the traditional structure to integrate models like the accountable care organization, the medical home and bundled payments? These are the questions and issues the Catholic health care ministry must successfully address, because the whole notion and definition of quality care is changing.

NEW GOVERNANCE

The current structure of governance cannot be sustained. That is especially true in the case of local boards, which must be engaged in a different conversation about how to govern under constantly shifting conditions and still hold

true to the mission of the organization.

In this time of change, the goals of the organization must be clearly linked to Catholic identity, underscoring and fostering the essential definition of what it means to be a Catholic health care ministry. At the board level, mission and strategy are a common, constant theme through all committees. It is not isolated work. It is how we move forward.

Development programs are and will be essential to ramping up the skills and capabilities of the individuals who make key decisions on the future direction of their hospitals and health systems. For example, at CHI, we provide board development opportunities four times a year as a way to help board members understand the evolution of the health care industry, how it is changing and what we must

do to adapt and plan for that seismic change.

Every other year, CHI also hosts a three-day leadership summit, bring-

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ing in executives and health care leaders from across the nation to speak on topics such as generative governance and the importance of focusing on a philosophy of public health as we emphasize the treatment of entire populations rather than episodic care for individuals.

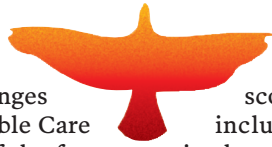
Catholic health care ministries will be challenged in the future to join with other than Catholic providers and other organizations to meet the needs of their communities. For size and scale and market coverage, it will be necessary to work outside the ministry in areas such as health plans, employee benefits and employed physician practices.

In Kentucky, for instance, CHI created KentuckyOne Health earlier this year as a partnership between Saint Joseph Health System, which operates eight hospitals in and around Lexington, and Jewish Hospital and St. Mary's HealthCare in Louisville, which operates five facilities. This was an example of building size and scale to meet the needs of local communities — in this case, of course, it involved an entire state. It was also an example of partnering with an other than Catholic organization, which will become an increasingly common occurrence across the industry. The vision for KentuckyOne Health, now the state's largest health care system, is to reshape the health care landscape in Kentucky to efficiently provide the highest quality care and services, reduce the incidence of disease and eliminate inequities in access to care in the communities it serves.

CHALLENGES AHEAD FOR LEADERS

Here are some of the challenges ahead for governance leaders. They must be willing to:

- Radically restructure comfortable and familiar organizations — in other words, alter the status quo
- Objectively assess leadership's ability to navigate toward the future and be successful with these dramatic changes
- Dispassionately assess their own skills, abilities and willingness to lead the organization into population health, insurance and the assumption of risk
- "Bet the farm" — and their legacy — on an investment in new care systems and new funding and reimbursement models
- Fundamentally redesign the organization by eliminating tens of millions of dollars in expenses in order to have a positive margin on shrinking payment rates
- Confront the puzzle of how to partner with other than Catholic organizations to provide a comprehensive array of services and still hold true to the mission, vision and values of Catholic health care
- Confront the reality that a merger, alliance or consolidation in which they are the minority partner may be necessary to survive in this rapidly changing world

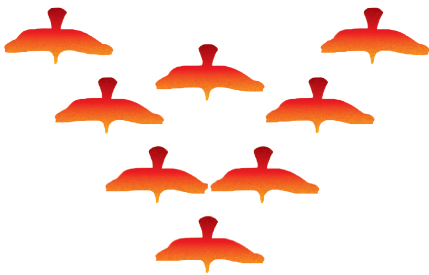


All of the many changes wrought by the Affordable Care Act highlight several of the fundamental, generative questions faced by health care leaders today: “Why are we doing what we’re doing?” And “How best do we serve a particular population?”

Board members must ask questions such as, “What is *not* being discussed? What are we *not* addressing?” And “Does this information challenge our long-held assumptions?”

Those questions — and the many implications of the answers — underscore the need for an entirely new governance system that is resolutely focused on mission. This means, for instance, that ingrained assumptions about margins will need to be changed forever.

We must be more intentional in actualizing our mission and in engaging board members in more meaningful work tied to the practical application of our mission and guiding principles. That involves far more than just discernment. Are mission leaders sorting through the philosophical and ethical questions posed by our day-to-day operations in crucial areas such as finance and strategic planning?



At CHI, the discernment process represents a comprehensive effort to ensure that all parties examine the moral and ethical implications of all of our decisions. For instance, in North Dakota, where CHI is expanding its

scope across the continuum to include physician offices, nursing homes and home health agencies, leaders went through a lengthy discernment process involving salaries of nurses and nurses’ aides. Ultimately, the organization concluded that nurses who work in long-term care facilities would not be paid at the same rate as nurses in acute care facilities, a decision based on a comparison of overall job duties and responsibilities. On the other hand, the organization decided that nurses’ aides working in those same long-term care facilities would be paid at a higher rate than their counterparts in hospitals — a determination, after discernment, that again was based on the nature, level and sophistication of the work and patient care duties performed by these employees.

MISSION AS DRIVER

As we move forward, mission must drive strategic direction, and not the other way around. As mission’s role becomes more integrative and strategic, as we focus on our mission as our guidepost and true north, those leaders will be much more effective in informing the decision-making process.

Currently, economic incentives — fee-for-service, patient census, volume — dictate the structure and activities of health care organizations. Governance leaders, thinking critically and strategically, must ensure that the structure of their systems is based on important values such as a focus on wellness and population health, not on traditional, bottom-line mind-sets that, for instance, tend to value expensive diagnostic and therapeutic procedures.

As one example, health system board meetings will become less about the overall operations of the hospital — the daily census, volumes, building plans or fundraising efforts — and more about such areas as actuarial

analysis, new insurance products and quality markers such as the percentage of children above age 5 who have been immunized.

In fact, once-cherished metrics like hospital admissions and the daily census will now serve to indicate the organization’s inability to provide effective preventive care or to manage chronic conditions. Those organizations will be left behind.

For governing boards, this means shifting the focus from the finance committee, where the income statement and balance sheet are paramount, to a value equation that includes improved quality, heightened efficiency and lower costs. These leaders must possess the business acumen to understand the financial and quality calculations that will lead to value and cost-effectiveness in the clinical process.

What’s more, governance members need the kinds of skills and competencies that are sometimes lacking on local boards, including: business experience in a large, complex corporate organization; risk and insurance experience; marketing; information technology; and health care management. Will legacy board members bring true value in this new model of health care? Simply being a civic leader may not be enough to succeed.

Most importantly, board members and health care executives, working together, will need to be able to tackle one of the most important and pressing generative questions of all: “What do we need to know *more* about as we look to the uncertainties of the future?” That’s the revolutionary question we all need to ponder.

MICHAEL ROWAN is executive vice president and chief operating officer, Catholic Health Initiatives, Englewood, Colo.

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