THE MINISTRY CHANGE IMPERATIVE

Catholic Healthcare Providers Must Translate Their Assets into Action

BY KEVIN J. SEXTON

At this moment, leaders in Catholic healthcare face an urgent need to rally its significant strengths. Environmental forces are dramatically increasing the vulnerability of mission-driven hospitals that serve the poor and elderly. The budget cuts Congress makes to balance the federal budget will hit Medicare and Medicaid hard through the year 2002, drastically reducing these programs' capacity to support hospitals' frequent role as a safety net provider for people without insurance.

Managed care is sweeping the nation as employers respond more aggressively to the steep increases in healthcare costs they have seen throughout the last two decades.

These trends will pull significant dollars from acute hospital care, ultimately threatening the current strength and vibrancy of Catholic healthcare. A much different future is entirely possible, however. The Catholic healthcare ministry has a whole series of unique and significant strengths that could lead to expanded presence, enhanced mission influence, and improved access and service for the people you serve.

Mr. Sexton is senior vice president, Lewin-VHI, Inc., Fairfax, VA. This article is adapted from an address given October 30, 1995, at the National Convocation of Catholic healthcare leaders, a meeting that launched the New Covenant, *an ongoing process to promote collaborative strategies throughout the Catholic health ministry.*

For more information about the *New Covenant* process, order *A Report on the National Convocation of Catholic Healthcare Leaders* (call CHA at 314-253-3458). You may also contact Tim Eckels at CHA's Washington, DC, office: 1776 K Street, NW, Suite 204, Washington, DC, 20006 (202-296-3993). See also "*New Covenant* Process: Progress toward Collaboration," *Health Progress*, January-February 1996, p. 16.

Catholic Healthcare at Risk

We developed a model at Lewin-VHI to illustrate the impact of these major environmental changes on healthcare providers. The model demonstrates the potential for hospital closures by the year 2000 by projecting managed care penetration, program cutbacks, and shrinking inpatient utilization. Hospitals with untenable financing are assumed to close or consolidate, with residual patients then shifted to other facilities.

Now we all know that the actual numbers generated by this model are estimates. No prognosticator or algorithm can produce certainty. But I do feel confident about the direction and general magnitude of the results we have generated.

To explain why, let me give you the starting point for the model, which is *actual* inpatient days per 1,000 population for the most recent year available (see **Table 1**). The U.S. average is 744 days per 1,000; but note the wide variation among states, with a high of 1,171 days per 1,000 and a low of 385 days per 1,000. Obviously the U.S. average will be declining significantly as managed care moves from the West Coast to other regions of the country.

Our projections are based on three managed care scenarios reflecting a low, medium, and high rate of managed care penetration by the year 2000. Based on the middle (or number 2) scenario in **Table 1**, inpatient days will be 494 per 1,000 nationally, compared with the current 744.

Going one step further, the model projects that *almost one-third* of all Catholic hospitals could close in response to this change combined with financial cutbacks in Medicare and Medicaid. One can easily quarrel, of course, with the degree to which hospitals will actually close or consolidate in response to financial decline, but the *overall reduc-*

tion in hospital use and financing represented by these projected closures is both plausible and likely. If anything, the situation could be worse.

Eighteen-Month Window

Our model shows that your presence and influence will be *seriously diminished* in the coming years unless there are substantial anticipatory changes in how you carry out your mission. You who make providing a safety net part of your intrinsic mission have a window in which to take action to respond. The amount of time will depend on your market, but to count on more than 18 months for building an effective response would be unwise. Within 36 months, the window will close.

If you believe in your mission, you start with the notion that failure is not an option. You have the potential to exert a great deal of influence over what happens. Costs must be curtailed; savings must be achieved. But you possess the ability to influence where the dollars in the healthcare system go and to maintain your ability to help the 38 million people who do not have health insurance and others for whom a diminution of your special access would be harmful.

Control through Integration

The key to continued presence and strength during the coming years is *integrated delivery*. You may decide to remain primarily an acute care hospital, but if you do, you run a much greater risk of being much less vital and influential.

This is because, inevitably, healthcare dollars will be redistributed. Where those dollars go will depend on who the "integrator" is—that is, whether it is corporate HMOs and managed care companies that organize the continuum of care, or you and other not-for-profit providers.

Table 2 (p. 20) illustrates my point. The "scenario 2" version of our model will drive funds away from hospitals. But if you develop integrated systems of care, collaborating with providers of primary care, home care, and other health services, you can more effectively control your destiny and enhance your mission.

In 1993 the nation spent about $20 billion on home care, $70 billion on nursing home care, and $170 billion on physicians. Working with home and long-term care providers and doctors, not-for-profit hospitals can keep healthcare dollars in the healthcare system and do a better job of allocating resources and increasing people's access to care.

Integration Requirements

What will it take to achieve integrated delivery? Four ingredients are critical:

- Size
- Linkages with other healthcare services
- Strong associations with services and entities outside healthcare
- Insurance expertise

You have no reason to assume that the Catholic health ministry cannot succeed in something this important. The first three of the above ingredients, in fact, are natural advantages for Catholic healthcare.

Enormous Catholic Presence First, Catholic healthcare has an enormous presence: 622 hospitals in 48 states and 714 long-term care facilities in 47 states, representing significant market share in many areas (**Figure 1**, p. 21). Approximately 10 percent of the nation's hospitals are Catholic, and these hospitals provide 16 percent of all admissions and outpatient visits.

If you believe in your mission, you start with the notion that failure is not an option.

Second, you are involved in many health ministries beyond the hospital walls and have often been leaders in the movement toward integrated delivery systems (see *Profile of Catholic Healthcare 1995,* Catholic Health Association, 1995 [available on request]).

Linkage Opportunities Finally, the Catholic health ministry has unique opportunities to plug into an extraordinary range of social and personal services. Almost a fourth of the U.S. population is Catholic, and there are 19,700 Catholic parishes. Parishes mean people, employees, services, programs. They can be a source of critically important connections and service linkages.

Catholic hospitals have about 5 million admissions a year, but 325 Catholic healthcare centers take care of another 2 million people. Some 18 million people receive social services each year from 1,949 Catholic social service centers.

TABLE 1: PROJECTED UTILIZATION BY 2000

Payer	U.S. Average Utilization	Highest State Utilization	Scenario 2 Utilization	Lowest State Utilization
Medicare	2,515	3,883	**1,745**	1,121
Medicaid	897	2,054	**514**	426
Private	371	517	**251**	227
All	744	1,171	**494**	385

Projections based on inpatient days per 1,000 population, *U.S. Community Hospitals*, 1993.

Warning Signs

On the flip side, although the Catholic health ministry makes up the country's largest healthcare system, it lacks coordination among its 58 systems and many freestanding hospitals. In addition, the number of hospitals, while large, is declining. Some Catholic institutions are melding into non-

To succeed, Catholic organizations need critical mass, clarity of purpose, and a strategic plan.

Catholic systems and face a potential loss of identity and mission imperative. These developments all carry warning signs and a message: Maintaining the status quo—failing to consolidate your strengths and build a comprehensive, integrated response—is risky.

What It Takes to Succeed

Catholic healthcare organizations need three things to parlay their assets and desire to move ahead into mission success: critical mass, clarity of purpose, and a strategic plan. The figures illustrate that Catholic healthcare has critical mass, and in their mission to serve the poor and underserved, Catholic hospitals share a clear purpose. What they now require is a strategic plan and a sense of urgency in taking specific action.

Comparing For-Profit and Catholic Healthcare

A comparison of Columbia/HCA and Catholic healthcare is instructive. First, the overall status of Columbia/HCA compared with that of Catholic healthcare (**Table 3**, p. 22) may come as a surprise to healthcare executives who read *Modern Healthcare* but otherwise know little about the Catholic health ministry. How many know that Catholic hospitals account for more than 20 percent of admissions in 19 states, compared with only 3 states for Columbia/HCA?

Second is the issue of goals. Columbia/HCA is trying to build critical mass by market. It is absolutely clear about its goals, and it is focused on a strategy. The goals of Columbia/HCA are growth and increased shareholder value, as well as demonstrating the value of for-profit healthcare to the public.

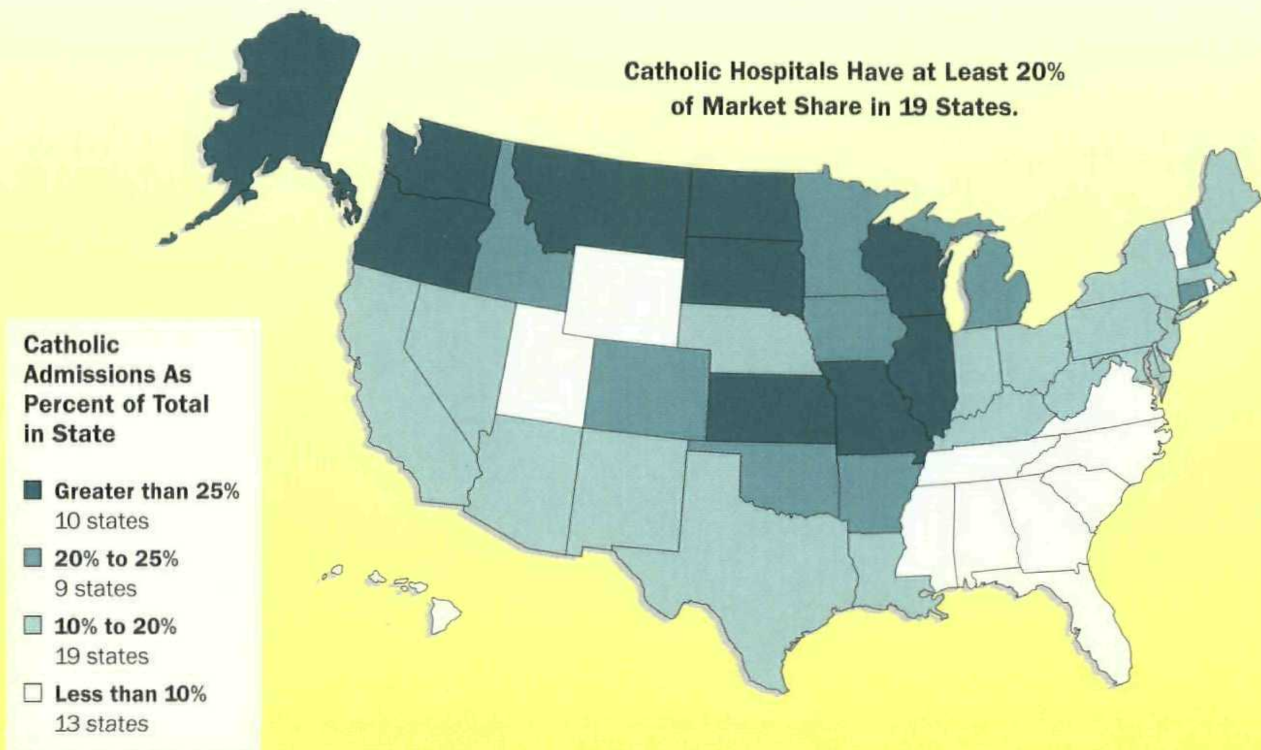
Catholic healthcare's overall goals are equally clear: compassionate care, service to the poor, care coordination, improved community health, quality, and stewardship. But these goals must be translated into action through specific strategies. You need to ask yourselves, "Five years from now, will Catholic healthcare have a local market strategy? A regional strategy? A national strategy? Or just a collection of Catholic hospital and system strategies?" The answers will determine where you go from here.

Local Strategy Local control of quality and cost is part of the Columbia/HCA strategy. As it consolidates its delivery capacity within markets, it works hard at forming partnerships with physi-

TABLE 2: INTEGRATION WILL BE THE KEY TO MANAGING MORE HEALTHCARE DOLLARS

	Under "status quo," hospitals would expect to manage about one-third of healthcare dollars in 2000.	***Scenario 2 reconfiguration will drive funds away from the hospital sector.***	***Expanding focus beyond hospital care presents opportunities to control your own destiny.***
Personal health expenditures	$1,300 billion	$1,300 billion	$1,300 billion
Upside potential from nonhospital revenue			>$600 billion
Current hospital share	**$422 billion**	**$422 billion**	**$422 billion**
System reconfiguration scenarios		$340 billion	

FIGURE 1: PERCENTAGE OF ADMISSIONS IN CATHOLIC HOSPITALS



SOURCE: *Profile of Catholic Healthcare 1995*, Catholic Health Association, St. Louis

cians. Together, these provide local market leverage. Columbia/HCA supports its local market presence with regional and national support strategies. Catholic healthcare clearly emphasizes local presence, but what about regional support?

Regional Strategy Columbia/HCA often combines a number of local markets to obtain regional leverage. It consolidates support and high-end clinical services where it makes sense. Then it builds an image, recognition, and a brand name.

Catholic healthcare must tap its power to build its image and centralize functions as appropriate. No other healthcare provider in this country has a market share of 30 percent in one state. Yet in one four-state region (Iowa, Wisconsin, Illinois, Missouri), Catholic healthcare has a 31 percent share. However, that market share is spread among 25 systems and 38 sponsors (see **Figure 2**, p. 22).

National Strategy Columbia/HCA buys and sells nationally where that provides leverage and then delivers care locally. One element of that approach is group purchasing. And Columbia/HCA has a template for governance models, business development, and physician equity models so that it does not replicate work scores of times. On a national level, Columbia/HCA helps local hospitals with surveys of the JCAHO (Joint Commission on Accreditation of Healthcare Organizations).

Catholic healthcare is buttressed by few of these national supports. Yet, think of the potential if you pooled some of your significant resources to invest in research and development of physician partnership models, governance models, or other common business strategies.

Three Practical Scenarios

The following possible scenarios offer you food for thought about how Catholic healthcare organizations might respond to the integration imperatives described above.

Regions with Large Catholic Market Share In this scenario, hospitals in states with a high percentage of Catholic hospitals (e.g., Illinois, Wisconsin, Missouri, and Iowa) link together and become an extraordinary force for integrating services, improving efficiency, and ensuring that the benefits of good healthcare are broadly available, especially to vulnerable populations. To accomplish this, they take the following actions on a regional basis:

• Unify governance structures and link with common management

TABLE 3: COMPARISON OF STATUS

Columbia/HCA	Catholic Health Ministry
• > 300 hospitals	• > 600 hospitals
• ~ 60,000 beds	• ~ 140,000 beds
• 3 states with >20% share	• 19 states with >20% share
• Revenues $14.5 billion	• Revenues > $40 billion
• Assets $16 billion	• Assets > $44 billion

• Integrate care to reduce costs and become attractive to payers
• Create an organizational image
• Link with physicians and insurers
• Form a managed care business arm

Integrating with other organizations is the only way to avoid foreclosure of options and influence.

These strategies can be supported nationally as well, potentially through a business development consortium that:

• Creates "best models" of workable systems for governance and managed care operations

• Develops group purchasing arrangements

• Develops comparative data bases on improving care and efficiency

Regions with Substantial Catholic Presence In large states or regions where there are many Catholic hospitals, but they have less than 25 percent market share (e.g., New Jersey, Pennsylvania, New York, California, Texas), Catholic hospitals can leverage their presence in several ways:

• Link with other providers, both Catholic and non-Catholic, and with schools, churches, and other agencies

• Unify governance where possible

• Create a managed care business arm

These efforts can also be buttressed with national support, including:

• Best-practice models for joining with physicians and with non-Catholic providers

• Managed care negotiation strategies

Regions with Few Catholic Hospitals But Large Market Share Catholic hospitals have very high market shares in many rural states (e.g., Alaska, Montana, Oregon). They have the opportunity to pioneer in making managed care work in rural areas. They need an overall regional strategy that includes:

• Unifying governance and management

• Finding ways to manage care and take risks in less populated areas

• Linking with physicians and insurers

A national business consortium could support these efforts by:

• Developing innovative communications vehicles among providers across long distances

• Creating best-practice models for delivering care in small markets

Why Act Now?

This is a moment of opportunity for Catholic hospitals. Integrating with other hospitals and with non-hospital Catholic organizations—not because you want to be big and tough but because you want to continue your mission—is the only way to avoid foreclosure of your options and influence in the face of relentless economic pressures to reduce healthcare costs.

The road ahead is steep and hard, but the Catholic health ministry has reason for optimism and confidence. You bring powerful assets to the table—presence, dollars, and especially a sense of mission. Now you must translate those assets' potential into specific actions. □

FIGURE 2: CATHOLIC HOSPITALS IN A 4-STATE REGION

• Market share—31%
• Represents 25 systems and 38 sponsors