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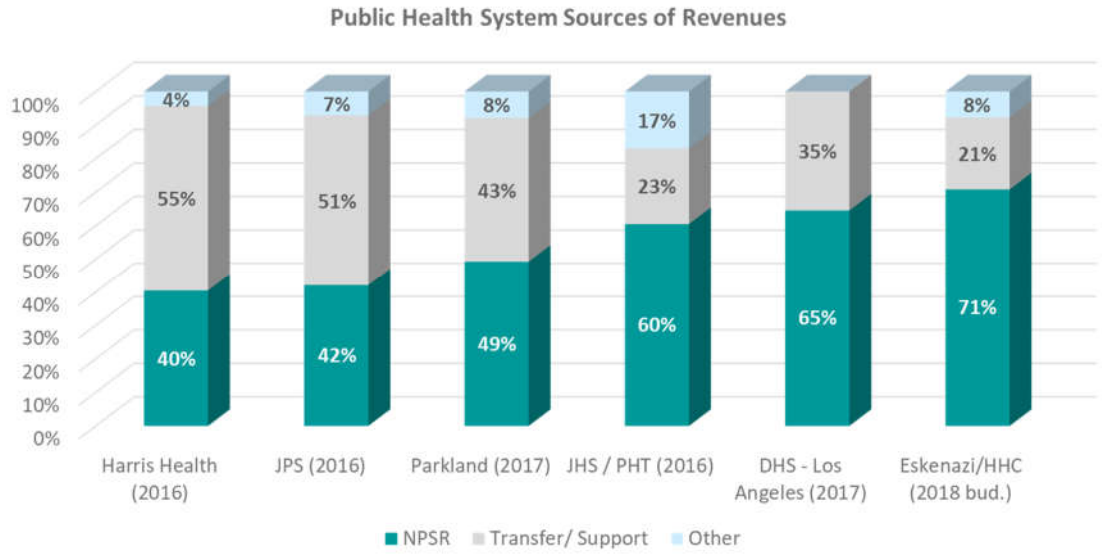
PUBLIC HEALTH SYSTEMS – STRATEGIC PATHS

In America, like most other nations, there is a need to provide healthcare services to a substantial indigent/poor population that cannot afford adequate healthcare coverage. As a result, States and Counties across the country established public hospitals whose core mission is to both provide care to this demographic and train the next generation of providers. Typically, these services are mostly subsidized by federal, state, and local governments in the form of various governmental transfers as a public service to their communities. In a small sampling of stand-alone public health systems across the country, Net Patient Service Revenues typically only make up 45%-65%[1] of the revenue base compared to other not-for-profit systems where this number is usually over 90%.



Increasingly, as the cost for healthcare has continued to rise exponentially, these transfers of funds have become ever more at risk. The ACA, in theory was supposed to shift these payments from lump sum transfers to the State Medicaid programs where States could better manage care through this payment mechanism. However, as it has been well documented, Medicaid expansion has been highly variable across the country and has not yet eliminated lump sum transfers or significantly reduced utilization of services. Fundamentally, Public Health Systems' funding is being squeezed, putting public systems at financial risk. As a result, the largest public health systems in the country have had to continually revisit their long-term strategy in context of the realities of their funding streams. This financial pressure will continue to mount given the current trajectory and proposed regulations, and as a result we will see these stand-alone public health entities move down a continuum towards one of two different strategic paths.

[1] Publicly available annual reports from Harris Health (Houston), JPS (Fort Worth), Parkland (Dallas), Jackson Health – Public Health and Trust (Miami), Department of Health Services (Los Angeles), Health and Hospital Corporation (Indianapolis)

Path 1: Contract and Focus

To counter those outside forces, and remain viable, Public Health systems can truly declare that they are going to make the most of their subsidized budget and not attempt to compete with traditional health systems. Essentially this path forces leadership teams to identify the servcies that are most needed in the community and support those services within the funding streams provided to them from the public. This means divesting or partnering for services that are traditionally offered by the hospital because the operating budget cannot continue to support those efforts. Health system leadership should view this strategy as if they were in a total capitated environment and focus their investments on those that are most needed by the community and constituents involved. The driver in this strategy is trying to do more with less. To do so, leadership should:

1. Assess "their" patient population by defining who it is that they serve, where they live, and how much it is expected to grow over the planning horizon
2. Look at the current care continuum and understand where there are the biggest gaps in service (i.e., preventative care, primary care, acute care, post-acute care) for the targeted population that the health system serves
3. Estimate how much it will cost to fill the necessary gaps, and devise a plan to fill those needs
4. Apply the budgeted dollars to the programs in most need and try to maximize the resources in place

A "contract and focus" strategy may lead system leadership to allocate strategic dollars to social determinants of health, telemedicine, or behavioral health access while downsizing their acute care bed chassis. The obvious benefit to this approach is that it allows leadership to truly focus on fulfilling the mission of the organization. However, there are some significant drawbacks, including:

1. Primary reliance on governmental transfers and capitation as a funding mechanism puts the system at risk to politics, budget cuts, and other outside influencers
2. Minimizing traditionally core services may impact the systems ability to maintain certain training programs
3. Access to services that are not as highly prioritized as others, but still in demand may be reduced or eliminated

Path 2: Grow and Diversify

As traditional FFS streams are squeezed, health systems are reacting by expanding and consolidating markets while fighting for scale and improved payor mix. Likewise, Public Health Systems can play the same game. Continuing down this path for public health systems that have limited access to capital, and a mission to serve the neediest populations can be difficult.

However, leadership may determine that governmental subsidy will continue to decline at a substantial rate and they must expand and diversify its revenue base to remain viable long term. In this case, leadership should move down a traditional strategic planning path by:

1. Defining their market and understanding all the demographic and competitive dynamics
2. Identify specialty services where they can compete long-term with a differentiated service from other market competitors

3. Deploy strategic capital to build programs around those services including recruitment of physicians and required capital assets to ensure appropriate access
4. Focus on improving operational efficiencies and throughputs across the care platform
5. Identify strategic partnerships to grow out the network and fill care continuum gaps

This strategic path, if successful, allows health systems to diversify their revenue base and limit risk to outside influence. Like Path 1, there are some substantial drawbacks that must also be considered:

1. Prioritizing investment in profitable services vs. investment in the public need can be in conflict and may minimize the mission
2. This strategy will put public health systems in direct competition with other market providers
3. Access to capital is essential to execute on changing market dynamics and competitive influences
4. Public entities that are county-funded often cannot expand outside county boarders potentially limiting their ability to grow into targeted services or favorable geographies

As we have seen in recent years, the public has continually given its resounding support to have public health systems in their communities. Just in the last 5 years, three large public systems in the country (Maricopa, Jackson Health, and JPS) have all been awarded major bond approvals to invest in infrastructure and programs by public votes in the amounts of hundreds of millions of dollars. With these dollars come significant opportunity, but also a burning platform to establish a successful long-term strategy to ensure the capital dollars are well spent. There are many variants of the proposed paths, and there is a continuum of options along those paths for leadership teams to consider. With the

pressures mounting on available healthcare dollars, public health leaders will need to make a choice as to which general path they want to move to remain viable long-term and best meet the needs of their constituents.