One Impact

Coming together, one community at a time.

March 2025

One Impact: Maximizing Community Investment

Governance Institute faculty member Kevin Barnett, Dr.P.H., M.P.H., M.C.P., of the Center to Advance Community Health and Equity at the Public Health Institute, recently spoke with Michael A. Slubowski, FACHE, FACMPE, President & CEO of Trinity Health, as part of our ongoing One Impact campaign to improve the financial health of patients and communities. The following article features highlights from their conversation.

This article is part of a series of interviews we have conducted with executive leaders from hospitals and health systems who have demonstrated both courage and a commitment to better serve our communities and our nation. In this troubling time for the healthcare sector, there are a growing number of observers who have concluded that there is a lack of internal will to make necessary changes to proactively address improving the health of our communities. We're looking to leaders such as Mr. Slubowski to help us chart a path forward.

Kevin Barnett (KB): *Can you share with us what factors have contributed to Trinity Health's longstanding commitment to partner with others to address the social determinants of health?*

Michael A. Slubowski (MS): There has always a sense of responsibility for community health and well-being and leveraging some investment capability to support addressing the social determinants of health. In recent years, the potential to advance population health and assume responsibility for total cost of care and outcomes for people seemed like a natural progression. The focus has also been not only to identify communities

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with the biggest challenges in terms of poverty, housing, health status, etc., but to be in a position to have some way to identify a numerator and a denominator and document impacts.

Recently, I've been talking to other Catholic system leaders to touch base and find out what they're doing. Most have noted that when they came on board five to 10 years ago, they were all focused on population health. The problem is that the payers didn't go that way, and the policymakers did not follow through with their promises to move in this direction. So, we as a sector have abandoned all that, and we're back to optimal efficiency in a predominantly fee-for-service environment.

We're trying to get more voice with the government folks, and among other input, we share that they're going to get whipsawed if they keep turning risk-based payment to profit commercial payers, because every time you try to hold the line on rates or coding they're going to take it out on the subscriber or on the member.

Mike Slubowski, President and CEO of Trinity Health, provides executive leadership to a Catholic health system that serves 26 states with 93 hospitals, 10,000 medical group providers, 107 continuing care locations, 26 PACE programs, 127,000 employees, and $24 billion in annual revenue. He serves on the Trinity Health Board of Directors, and has accountability for the overall strategies, achievement, advancement, and success of the system.

Slubowski serves on committees and advisory groups with the American Hospital Association and the Catholic Health Association. He also serves on the Board of Universal Technical Institute, a trade and technical college for skilled trades and healthcare careers.

Slubowski's service as a healthcare executive includes tenures as President and CEO of Sisters of Charity of Leavenworth Health System in Colorado; President, Health Networks for Trinity Health before its 2013 merger with Catholic Health East; and in executive leadership positions at health systems including Henry Ford Health System in Detroit, Michigan; Samaritan Health Services in Phoenix, Arizona; and Providence Hospital in Southfield, Michigan.

KB: *I'm having these conversations with other executive leaders who are grappling with the state of affairs in regional markets. The federal government appears to be under the delusion that we have—and they need to protect—dynamic competitive regional markets.*

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What would you propose that the federal government begin doing that it's not currently doing?

MS: My firm belief is that the health of populations and the common good are core functions of government. As such, the government needs to create an environment where if they're collecting revenue, they must preserve a commitment to address public needs like Medicare, Medicaid, safe drinking water, affordable housing, and it all needs to be effectively coordinated. It also needs to provide incentives that that line up with a not-for-profit community.

What the government has done is driven by the idea that healthcare and the health of communities can thrive in a free market environment. In their vision, for-profit companies are the solution because they know how to be efficient, and they know how to run things better than organizations that are community-based, not-for-profit. It is a delusion. The public discussion is about healthcare approaching 17 to 18 percent of GNP; I think it's closer to 30 percent. When you look at everything that is now part of the sector, such as private equity, the numbers increase significantly. Wealth is drained out of the pockets of the public, and into the pockets of those demanding 15 percent annual return on investment—instead of providing more resources directly to communities that need it.

KB: *If the government were to act, for example, as it relates to the promise of well over a decade to move to risk-based payment, what would be some important steps that they could take?*

MS: A lot of the CMMI Innovation Center projects around population health have created limited risk corridors and I think what they could have done [instead] is issue block grants to help not-for-profit providers jointly develop health plans. Working together, they would have network sufficiency and the infrastructure to manage the health of the populations they serve. One example here at Trinity Health is our PACE[1] program. We have to connect clinical and social services and proactively address the needs of people within a budget, and it's being done in a not-for-profit environment. Our outcomes are very good and we're able to manage within that budget and make a very modest margin. Perhaps most importantly, it's a much less costly alternative to people being institutionalized.

Most countries that have a public healthcare system have decided there's going to be a level of benefits provided to everyone…. They allow for people who have means or companies that want to provide an incremental benefit to buy an add-on policy for people who want faster access or enhanced benefits. The bottom line is that everybody ends up with some kind of coverage that meets a minimum standard. It's hard to justify the approach we're taking right now…all the funding is now on the backs of employers, and they can't sustain it.

1 Program of All-inclusive Care for the Elderly (CMS).

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KB: *I'm going to pivot now to a question around leadership. Please give us a reality check on the charges and challenges faced by CEOs in these turbulent times. What are the kinds of balancing acts you have as it relates to engaging your senior executive team on the role of healthcare in addressing the drivers of poor health?*

MS: I know many of our team members have unspoken thoughts and feelings of why, given limited progress in the policy arena, are we still insistent that total cost of care and outcomes are important priorities for our organization? It's especially hard when they see so many of their colleagues in other systems moving away from it. Everybody points to HCA and other big systems that are not pursuing population health at all. When I was on the board of a Florida health system, they were committed to the health plan they started. They were subsidizing it, and board members were asking, "Why are we still doing this?" With 1,000 people a day moving into Florida, the point of view was, "Let's just go for fee-for-service."

People see that investing in addressing the drivers of poor health in the current policy environment is more of an investment than a return on investment. At the same time, there are other priorities including economic self-sufficiency. We regularly face the reality that payers are reluctant to enter into meaningful partnerships. You have to live in that shared-risk environment to appreciate that there is another way. My first healthcare job was with the Henry Ford Health System when we purchased Health Alliance Plan, and our medical group was fully capitated. We did well and we were able to serve populations. There was high satisfaction and we were able to be economically self-sufficient. We could connect clinical care to social needs and we could make decisions that were flexible even in how we provided care and access to care.

So I grew up in that environment; I saw how it worked and then I went to the dark side when I left there, to organizations that are fee-for-service focused and more facility focused. The fee-for-service world is a "build it and they will come" environment. It's hard to make that shift.

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KB: *There have been a growing number of media reports documenting "bad actors" in the non-profit healthcare arena; stories of closures of safety net hospitals in inner cities, expansion of hospitals in more affluent communities, and aggressive collection practices, among others. What is missing from the public dialogue?*

MS: From a visual standpoint, people see cranes going up on healthcare campuses, and then they get their bills; they see the dollar amounts in those bills and rightly ask, "Are these organizations committed to supporting the community?" Twenty years ago, Sister Carol Keehan at the Catholic Health Association lobbied hard with the IRS to better define community benefit with a more detailed 990 reporting process, but there are limitations to what it captures.

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Because the focus is only on the numbers, we're left with situations during the pandemic where offsets from the federal government suggest that our commitments to communities have declined. For Trinity Health, in 2024 our community benefit reporting dropped from $1.6 to $1.3 billion, and the primary reason for the drop was that two states paid provider taxes. For Iowa, one of those two states, they had not increased their Medicaid rates for 15 years. But nobody sees that.

A lot of the work that we're doing now is to better define community impact and to better capture resource allocations that address the drivers of poor health; and by the way, we lose money on Medicare, too. When we ran the numbers, it would have pushed our total allocations from $1.3 to $2.2 billion for fiscal 2024. We must somehow get that into the public spotlight and encourage more accurate documentation by federal organizations like the IRS. I don't feel the same resolve from trade association leadership to fight for needed changes as they would have 20 years ago. We must do a better job of telling our story and showing it in numbers. A lot of people say there's a lot more than just financial tallies, but that's how we're being measured.

KB: *We must find a legitimate way to better distinguish the organizational behavior of non-profit and investor-owned hospitals and health systems. We are challenged in part because, for example, the IRS requires hospitals to back out the cost of community health workers for any reduction in utilization that might be associated with better coordination of prevention services. Do you have any observations or thoughts about that issue in particular?*

MS: There are indirect costs to support a program like that, regardless of what we end up [receiving] in the way of funding. In a fee-for-service system, we take it in the chin when we're trying to keep people out of the hospital and out of the emergency room. It is a challenging dilemma.

KB: *In my work in different communities we're getting better at drilling down with GIS data that illuminates an array of health inequities at the zip code and census tract levels. At the census tract level, we see rates of preventable emergency room use and admissions as high as 10 times the county average. It suggests that in a regional market we should be looking at ways to strategically align our charitable resources in these neighborhoods. At the same time, this runs us into the "wrong pocket" issue. Have you had any success in coordinating with competitors in a regional market to align and focus community health resources?*

MS: We have a few markets where we are doing food access and health screening programs with competitors. Here in southeastern Michigan, we have pooled resources

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with other health systems to support some of those activities. I may be dating myself now, but wasn't it a couple decades [ago] that we started all these community health resources, working with the public health department and other providers? I think a lot of that slipped away over time. There were times during the pandemic where we worked with others on vaccination clinics and related activities where it made sense to come together. There's more opportunity there, but you also have the challenge of working with people who don't want to worsen their payer mix.

KB: *If your competitor is in a better part of town, it's hard for them to justify spending their charitable resources on prevention services for people that don't come into their emergency departments.*

MS: All this is happening while there is significant growth of physician-owned facilities that are taking commercially insured people out of our doors, and they aren't contributing anything from a charity care standpoint. They'll do their Medicaid, Medicare, and charity business at our hospital.

KB: *I was struck by a recent report that highlighted the dramatic growth in private equity ownership, not just of physician practices, but a broad spectrum of functions in healthcare and beyond. Of course in each case, the core expectation was a minimum 15 percent annual return on investment. Where are we on this issue?*

MS: I've shared our many experiences at Trinity Health with you. Perhaps the most recent is that we were recently approached by a private equity company who wanted to partner with us on our PACE program, as they see it as an area of potential expansion. When we met, I shared that we do a really good job of running the program, and we make a 5 to 6 percent margin, and that doesn't come close to the returns that private equity requires. They looked at me and they said, "Mike, you don't understand. We're not focused on the bottom line. We're focused on the top line, because five years from now, we sell at a multiple of the top line." We had another group in here about three weeks ago, and they're doing outpatient infusion centers and a couple of our CEOs were excited about a partnership. We met with them, and they picked locations they thought would be most convenient. My first question was, "Do you take Medicaid?" The answer was "no." My second question was, "Do you take Medicare?" The response was "selectively." So, we can go set up a place that only takes commercially insured patients…. We won't.

KB: *Let's shift to board composition and process. The Governance Institute conducted a recent survey and observed that at the board level, conversations and goal setting about social determinants and the role of hospitals have declined. With current financial challenges, hospitals are giving less attention to these issues. Can you share your thinking about what we need to do to ensure that we don't lose that important part of our identity?*

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MS: I'm proud of Trinity Health at the system level and the work we're doing in the communities. We are working to ensure that we have balanced and diverse boards in terms of gender, race, ethnicity, and religious preference, as well as the skills and experience they bring to the board. We're not just focused on finance and lawyers; we have people with serious community health experience. We have clinicians. In the new world of technology we're trying to make sure that we bring different skills and competencies to the table as well.

At the system level, we are blessed to have four religious women on our board, but these numbers are dwindling everywhere. We're still working hard to put a religious woman on each of our community boards. You know their commitments to their communities; they really make a difference. We're not perfect, but when I look at the composition of other health system leadership teams and boards, they are not diverse. Unless you have diversity, you're not going to get the kinds of discussions around purpose, common good; what does it mean to build a healthy community, and what is our role?

For many other hospitals and health systems, they believe their role is to provide healthcare services. They have lots of new buildings and clinical programs; they do not believe they have a role in building healthy communities.

KB: *One of the many notable practices at Trinity Health is the culture of engagement on the board. You have an 80–20 rule, where presentation time is limited to 20 percent of proceedings, and 80 percent of time is preserved for dialogue. Over the years of presenting at The Governance Institute, many board members have shared with me that there is often little time for questions. Why do you think dialogue with board members is important?*

MS: It is essential to have people at the table with common goals around the higher purpose, but who also bring diverse perspectives, expertise, and experience. You aren't recruiting people to be wallflowers or mushrooms that you water in the dark. We are committed to robust board engagement. We've redesigned our agendas around initiatives to run, evolve, and transform the ministry. We provide short reports on strategy and operations. The board does its homework and reads the material in advance of meetings so that we don't have to give long presentations. We tee up questions for board discussion and deep inquiry and dialogue. If there are moments of silence then we dig deeper, seeking even more insight from board members. We value generative discussion, which leads to insight and, if we're lucky, some breakthrough thinking and ideas. True north is our mission, vision, and values.

We're doing a lot of work right now with our executive leaders who sit on our community boards because we hear from our non-fiduciary community boards that since they don't

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approve budgets, they don't feel like they make meaningful contributions. We're working hard to emphasize that given our authority matrix and bylaws, they have full responsibility for community health and well-being; for quality, safety, and the care experience; and for advocacy. And by the way, they do review budgets and make recommendations to the system board; they just don't approve them. We're working to help people refocus on what they can and do contribute versus what they can't.

KB: *I'm interested in whether and how Trinity Health is engaging local or regional elected officials. We talked before about this interplay between government and hospitals advocating for more strategic investment by local governments in things like affordable housing. Do you see that as a role for your regional leadership?*

MS: Yes, we do. I think advocacy and engagement with community is an essential role for our regional CEOs and hospital presidents. I try to be with them when it comes to local, state, or federal representatives. We need to get them in our facilities and know what is happening and what some of the things we're experiencing that are a function of links between clinical and social care. Those experiences are impactful, but you have to work at it. One of my board chairs, a very wise man, said to me, "Mike, you've got to stay in the traffic. If you're not in the traffic, you're not going to know what's going on. You won't know who to connect to when you need to connect." Relationships are critical and we ensure that our CEOs and hospital presidents understand it is a priority.

There could also be a lot more integration of efforts between public health services and our health systems. I think in many ways they still operate as separate entities. The disconnect is particularly challenging given the long-term dearth of resources for mental health. There are solutions, but it can't be a revolving door to the emergency room or jail. Some communities have come up with creative ways to provide shelters, support systems, and remediation.

We're holding quarterly town halls on mental health and well-being for our own colleagues. In fact, we had one on Tuesday and it was post-election, but we weren't just focusing on the election because, you know, we have to realize that our people are representative of the population. We couldn't assume that everybody is feeling depressed over the [election] outcome. But I did notice there were a lot of comments and questions from many of the [hundreds of] people who participated in this town hall. There is much uncertainty as to the impact of the elections on not-for-profit healthcare providers like us. But we need to keep focused on our mission and support for the common good and look long term.

KB: *What are among the most important lessons that have emerged from the COVID pandemic?*

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MS: You must be connected to your community. When disasters like that occur, people need to come together to work on it. That said, I think that there was much more potential for people to work together. I think we were still fairly disjointed. Between public health, the federal government, the state governments, the local governments, and the provider systems—in terms of everything from supplies to medications to communication to the public to setting up vaccination centers—there was a lot of misinformation. Much of that was propagated by some elected leaders at the time. It is my belief that there were at least half a million needless deaths during the pandemic because of the misinformation propagated by some of our national and local leaders. If they had been straight with the public [regarding the efficacy of vaccines and masks] I believe we would have seen much less suffering and death.

My wife and I worked in the ICU at Ann Arbor during the pandemic in 2022, and I listened to nurses begging patients to allow them to vaccinate them and [patients] refused. Other patients, having previously refused vaccination would be brought in with end stage COVID, and with tearful frustration, nurses would have to inform them that it was too late.

When you have a disaster, you have to take away the necessary lessons and build them into your preparation for the future. At the national level, I just don't feel our sector learned the lessons necessary to change our processes, and I don't think the government has put us in a better position for the next time around.

KB: *Are there emerging models in Trinity Health's engagement of communities that you'd like to share?*

MS: We would like to proliferate more of the "Healthy Village"[2] concept. Our best current example is in Wilmington, Delaware. It is a way for non-profit organizations across sectors and the government to come together to create centers that provide social services and limited medical services, including programs like job training. We could scale these kinds of innovations and have a big impact. Another key partner in these efforts is the faith community. They can make immense contributions, ranging from the donation of land for housing to partnering in the engagement of community health workers. There is so much more we can do with the right support from government and a shared commitment to the common good.

2 A Healthy Village® by Dynamis Advisors is the purposeful design, development, financing, and management of real estate projects composed of partners, which, in their aggregate, improve individual health, achieve better outcomes, and reduce costs for the populations served.

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