STRATEGIC MERGER IN FAITH-BASED HEALTH CARE:
MEASURING SUCCESS OF COVENANT HEALTH AT YEAR ONE
THROUGH THE APPLICATION OF
SOCIAL RETURN ON INVESTMENT METHODOLOGY

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Abstract

Multiple mergers have occurred in the Canadian healthcare system over the last two decades with limited research regarding these consolidations, reasons for undertaking them or the successes realized post amalgamation. Many assumptions are made regarding cost savings that result from the unions as well as efficiencies gained but no specific studies have been undertaken to determine return on investment of such transformation. This paper offers a review of a significant consolidation of 12 Catholic healthcare organizations into one during late 2008 in Alberta, Canada, documenting a three-step process for analysis of success and the return on investment. The research validates preconsolidation goals as indicators of success, measures that success and then applies Social Return on Investment (SROI) methodology to determine the cost benefit ratio of the consolidation at the end of the first year. As a final point of review, leadership of the new organization reflects upon the benefits of using a Social Return on Investment model and the utility of using the model in this particular scenario.
Biography

Born in Moose Jaw, Saskatchewan, Rochelle (Sheli) Murphy moved to Edmonton, Alberta, Canada, during high school years and following graduation felt called to serve in healthcare. She completed training as a registered nurse at the Royal Alexandra Hospital, School of Nursing in 1976. From 1976 to 1992, Sheli practiced in different venues, emergency services, pediatrics and pediatric intensive care as well as doing research with a variety of principle investigators, covering multiple types of studies and conditions. Entering into leadership positions as an educator, she taught emergency nursing to student nurses as well as staff nurses, and taught Advanced Life Support courses to a multitude of care providers from paramedics to physicians in the early 1990s. Sheli received her Bachelor of Science in Nursing from the University of Alberta in 1995. During the mid 1990s, her leadership role shifted from education to management where she served at first as a frontline manager in a busy urban emergency department. Promoted to site administrator and then Vice president of the Misericordia Hospital, Edmonton, an acute care facility, she worked with Caritas Health Group where she led a strong management team in rebuilding and enhancing programs and services at the facility. She also served as the Chief Nursing Officer for the organization. During this time, she completed a Masters Degree in Business Administration focused on Health Care Management as well as a Masters in Nursing from the University of Phoenix in 2006.

Presently she continues to serve in Catholic healthcare as Vice President of Operations for Rural Health Services with executive lead for Professional Practice and Research for Covenant Health. Covenant Health is a faith based organization integrating 16 sites province wide in the Catholic tradition of caring for people with health care needs at all stages of life. Receiving her PhD in Business Administration, focused on Leadership and Administration, from the Greenleaf University in Jefferson City, Missouri, she focused on analysis of consolidation and the resulting Social Return on Investment. Sheli is married and a proud mom of two beautiful adult children.
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Chapter 1: Introduction

The healthcare system within Canada is a not for profit, publicly funded health care system. Healthcare mergers and consolidations in the Canadian health system have been the focus of significant change countrywide since the early 1990s. These mergers are directed at improving efficiencies within the system and are frequently undertaken with the hope that monies spent at consolidation are recovered. Because of this limited research on success or outcomes of such endeavors, there is a need to develop approaches to assess success and value of these transformations in a public system. The system is supported mostly through taxpayer dollars so consideration for reporting level of achievement to governments and the public should be undertaken with each major change. Reflecting upon the limited funding and the increases and enhancements that create a greater financial burden, many experts have concerns about the sustainability of our system. Consolidation of facilities was one potential solution to reducing some of those costs for the purpose of reallocation from administration to services.

Many consolidations in healthcare appear to occur without the clarity of neither costs to amalgamate nor expectations or identification of specific goals that will define the success of such a significant undertaking. Use of change management science, community engagement and tools to assist in ease of reporting at key milestones would provide both a road map for a methodological approach as well as help to define reviews and reporting mechanisms. Engaging in such formal processes would enhancing leaders’ capacity to identify success points, or in the event of failure or arising concerns, course correct or redefine alternative opportunities.
As a limited offering to the contribution of this body of knowledge, a study of a recent consolidation of 16 faith based facilities in Alberta, previously managed as 12 organizations, Covenant Health is studied at the end of the first year of becoming one integrated organization. The methodology of measuring success provides only one potential approach to such an undertaking. The review consisted of a three-step process to evaluate of success by (a) validation of reasons to amalgamate formed part of the measurable outcomes; (b) internally measuring perceived success of meeting those indicators; and (c) Social Return on Investment (SROI) measure to determine the financial burden or benefit to Albertans.

Determining the SROI contributes to an alternative emerging body of knowledge that considers the benefits to society beyond the financial investment and offers a greater system look at the change. Defining return on investment beyond the traditional dollar spent to dollar gained, SROI reflects upon the return gained by the system and community by considering cost benefit, cost avoidance and cost savings.

**Review of the First Year as Covenant Health**

Covenant Health is a not-for-profit, faith-based health care corporation that resulted from the October 7, 2008 merger of 16 multi-level-care Catholic facilities in Alberta, Canada. During very tumultuous times in health care in Alberta, as well as strained economic conditions worldwide, leaders from the 12 organizations involved agreed that merging was the best alternative given multiple emerging circumstances. Significant events created the impetus and the urgency for transformation of Catholic health care in Alberta. The underlying triggers for change included the risk of damage to faith-based health care and the threat of extinction of Catholic health care in Alberta. The
initial events included, but were not limited to, one facility’s inability to maintain standard infection control practices, another’s impending financial collapse, as well as other facilities’ facing management, financial, and governance challenges. Concurrently, a significant announcement from the Alberta Minister of Health revealed the assimilation of nine health regions into a single entity within the province. Based upon all of these conditions, the strategic alignment of the Catholic health care facilities provided opportunity to sustain this alternative system thus providing a diverse approach to health services in Alberta.

Any transition incurs costs; therefore, determining the benefit or risk of such an undertaking is an enlightening measure for any organization. Typically, when considering an amalgamation, institutions focus on cost benefit, the financial expenditure versus the financial gain, to provide a level of information necessary to make the best decision. The motivation for many mergers includes increasing profits and gaining greater market share as well as boosting growth opportunities; however, in public sector companies, these targets may not be directly transferable. In Canada, health care is a socialistic, not-for-profit service for which growth and profit are not the primary force, whereas efficiency and cost savings are. These measures alone are not the sole benefits of amalgamation, but under review, these tend to be the focus for determining success of past mergers. In fact, in the 1990s, government in Alberta directed multiple mergers of hospitals into regions to save on expenditures and gain efficiencies, anticipating a reduction of financial burden to taxpayers. Over the course of the past 2 decades, there has been further reduction in the number of health authority regions based upon similar reasoning: cost reduction and renewal of office efficiency. These goals carried forward
into 2008, when all of the regions were reduced to one, Alberta Health Services (AHS). Albertans remain skeptical of such cost reductions. After the 1st year, there was a projected deficit of 1.3 billion dollars for health care in Alberta, along with continued concerns regarding access and utilization (AHS, n.d., ¶ 2).

Simultaneously in Alberta, there is another stream of health care providers, the voluntaries. Not directly controlled or governed by the provincial health authority, but co-opted through agreements with AHS, these organizations provide health services in return for funding. This funding flows from government through AHS to voluntaries. A legislative mandate directed voluntaries and Health Authority Regions to determine which services to amalgamate into shared services in 1995 for further cost savings (Regional Health Authorities Act, 1994). The Regional Authorities control these shared services and provide services, as determined by the respective authorities, to the voluntaries. The voluntaries are faith based or privately owned ventures.

Covenant Health is the new organization formed from the amalgamation of 12 of these voluntaries. At the end of the first year, review was required to determine areas for celebration as well as opportunities for improvement. Through reflection upon the nature of health care and the tradition of Catholic service, this review needed to extend the analysis of the merger beyond the financial to the social benefits congruent with the mission of the organization. To provide a more comprehensive review, a multi-pronged approach was used (a) to measure the level of success achieved, considering the goals of the consolidation; and (b) to measure the new organization against available evidence of other successful mergers in Canadian health care as well as the greater social contribution of the organization at one year.
Prior to the incorporation of Covenant Health, key contributors, past CEOs, board chairs, and the Alberta Catholic Bishops agreed upon three areas for success, each with specific indicators that would mark success for the venture; goals for the transition were defined. In addition, review of the literature revealed that the Canadian Institute for Health Care Information determined six hallmarks of successful mergers through studies and think-tank opportunities with past executives and scholars. For the purposes of this study, both sets of indicators were used. In addition, using the Social Return on Investment (SROI) model of analysis, costs of the amalgamation, juxtaposed onto the socioeconomic benefits of the venture, provided a financial measure for consideration. Much of the study was subjective and qualitative, as individuals associated with the new organization or in the recent past with the multiple old facilities provided their perceptions. The research question includes the following:

1. Did the merger accomplish what was hoped for?
2. What lessons are there, and what recommendations emerge to offer further improvements to the merger?
3. Is there a positive Social Return on Investment evident at the end of year one?

A secondary query regarded the model of SROI analysis: Is this model applicable and beneficial when determining success of health care merger?

**Statement of the Problem**

Bringing together healthcare facilities has been occurring regularly in the last few decades throughout Canada. Most frequent reason cited is to improve efficiencies and save money that could be reallocated to improve program access or other health services enhancements with the ultimate goal of improving health for Canadians. These
amalgamations cost taxpayers considerable dollars and citizens should expect a positive change, but without study such information is not available to the public. In addition, these changes create major chaos throughout the greater system and should be followed or reviewed to identify success and benefits so health executives can learn and course correct but this does not occur routinely nor are reviews of any kind published for general public access. In fact very few formal studies occur following consolidations so identifying evidence of such efficiencies and benefits is minimal. This study seeks to contribute to both the evidence of success of one such amalgamation and use of

The problem for this specific study is multi-pronged and involves validating pre-merger goals, measuring the level of success achieved towards those goals and critical factors found in the literature, then an analysis of the cost benefit of the consolidation of the 16 Catholic facilities in Alberta. Use of a tool that is relevant for examining a system that impacts more than service and financials is a second inquiry within this research.

Following such a significant merger, unprecedented in Canadian faith-based health care, there was a need to review the success at the end of year one. Covenant Health, as well as the 12 previous Alberta Catholic health organizations, believed strongly in making a value-added contribution to the health care system as well as parts of the greater social system. Identifying value added through a tool that considers societal and environmental contributions, as well as the need for stewardship of all resources, aligns with Catholic values and ethical foundations. Recognizing areas for improvement can provide the organization with focus for future improvement
Purpose and Research Questions

The study served three purposes, first to provide a review of the merger and the social contribution of Covenant Health in the health care industry within Alberta. Second, the study provides other not-for-profit or faith-based health organizations with a road map of activities and avoidances should they have a future vision of merger. Finally, the study was designed to determine areas upon which Covenant Health should focus for the following year to improve the merger as well as the level of social contribution.

This study was conducted using a mixed method including (a) quantitative assessment, involving assignment of financial proxies and values to outcome measures; and (b) a qualitative component, mapping details of the merger to document the story of the merger as well as people’s perceptions. Storyboard development created opportunity for predicting problems, aligned with strategic directions for making inferences for future institutional work. The learning began with an awareness of what was hoped, what unfolded during and after the first year of consolidation, and where gaps occurred, thereby providing focus for course correction over the next few years.

Statement of Potential Significance

There had been limited study of the success of mergers in Canadian health care. Review of such a significant consolidation provides evidence for other providers, regardless of the basis of their foundation, faith based or secular. The process Covenant Health used to initiate the coming together of multiple facilities as well as the key reasons for that union provides the context within which other providers can learn.
Additionally, this study provided an opportunity for Covenant Health to examine the Social Return on Investment (SROI) model in defining success for internal audiences. This information may help to shape the organization by identifying areas of focus for improvement as well as alternative developments. Beyond the institutional significance for internal use of the SROI, there is also an external value. The SROI tool has received limited use in the health care sector, none within Canada in reviewing health care mergers to date; therefore, determining the use of SROI as an alternative cost-benefit model for other organizations delivering health care will be beneficial. More broadly, this study may offer some proof of the utility of the SROI process and analysis or, conversely, provide reasons not to use such analysis for similar assessments.

Regardless of determining the appropriateness of the SROI model, this study provided an opportunity for multiple internal stakeholders to define what success of the merger looked like to them, thereby increasing awareness and engagement across the internal spectrum and providing considerable value for individuals.

**Conceptual Framework**

There were two concepts at play within this review. First, the concept of success and the measurement of that success with the purpose to determine the organizations ability to meet the goals set immediately preceding the amalgamation. Considering that there is more than a 50% failure rate of change initiatives and transformation (Schroeder, 2009), determining the level of success of such a major undertaking in the healthcare system provides key information provide a sense of stability and opportunity for ongoing improvements. If goals are not met to some degree, this may be an early indicator that this transformation will not be successful. Measuring achievements of goals is at this
early stage provides opportunity to plan actions to rectify the situation focusing on areas of lesser achievement, and identify opportunity to be more successful in the years ahead.

The second concept is one of cost-benefit. If an organization is successful post merger at reaching predetermined goals for the amalgamation, they need also to have some level of financial stability to continue the work. Both concepts intersect to provide a positive outcome of consolidation. Cost-benefit framework is useful as a method for scrutiny of business decisions. Cost benefit is defined as follows:

The benefits of a given situation or business-related action are summed and then the costs associated with taking that action are subtracted. Some consultants or analysts also build the model to put a dollar value on intangible items, such as the benefits and costs associated with living in a certain town. Most analysts will also factor opportunity cost into such equations. (“Investment Dictionary,” n.d.)

A positive balance indicates success of the action. The cost to produce is less than that of the final product or action; hence, there is a benefit to the expenditure. This study considered systemic benefits beyond financial cost: the transaction costs combined with the full transitional benefit to society, social and economic, that is, the Social Return on Investment. Considering the societal benefit of health, this approach appears to be a better method than the traditional solely financial review.

**Summary of the Methodology**

Involvement of four groups of stakeholders occurred at different steps in the study. These four groups included (a) board members, past and present; (b) governing and community and senior leadership teams; (c) the greater leadership team; and (d) staff and physicians. There were three potential avenues for feedback: one-to-one interviews,
surveys, and focus groups. Information was provided through presentations or written venues. Surveys were manual, through paper and pen, or electronic, through real-time devices or Web-based applications.

A three-step process provided opportunity for different groups to provide input related to success points and achievement.

1. Phase one. Individual interviews of senior leaders, past board members, and past CEOs included open-ended questions to determine goals of the consolidation. The feedback was compared with predetermined goals to validate the goals as success indicators.

2. Phase two. Indicators were examined to determine the aforementioned groups’ perceptions of the level of success that had occurred by the end of year one and to develop recommendations for future improvements.

3. Phase three. A selected group of leadership representatives in a large focus group determined the SROI of the consolidation and the utility of the method. This activity was followed by small-group evaluation of specific goals and use of individual surveys to consider the process and future use of SROI.

Most leaders within faith-based health care systems believe there is a significant difference between the services they provide and services provided by their secular counterparts. Being called to serve, driven by traditions beyond those of health care alone, and rooted in faith and centuries of caring for others are intrinsic to faith-based health care. These organizations try to make humanistic, values-based decisions. Based upon these considerations, choosing a success measurement tool that fits with the
organizational type is fundamental to truly determining success, developing recommendations for future course correction, and ensuring congruency of analysis.

Limitations

Limitations of this study are three fold: the current environment, the application of the model, and the objectivity of the subjects.

The most influential limitation existed because of the economic times. During the year of the merger as well as the first year post merger, there was a significant worldwide recession. This situation created multiple complexities for ongoing provision of service because of the inevitable need to reduce services as the government system could not tolerate the ongoing deficit created by health care in Canada. In Alberta, economic instability continued as the dollar was increasing in strength and the price of oil, one of the major Alberta export businesses, was decreasing. This phenomenon resulted in both loss of exports and loss of income to government coffers. As government leaders demanded that health care officials reduce spending, there was considerable loss of jobs as well as potential loss of programs. Because of these circumstances, the perception might have been that Covenant Health was unsuccessful in mitigating risk to facilities and that, therefore, the merger was less successful than hoped.

In addition, many of the success factors are inherent in good working relationships with funders and the extent to which stakeholders connect at all levels across the two organizations. Based upon the transformational times in the greater health system as well as multiple levels of reorganization, many of those connections and processes were in chaos at the time of this study. This situation likely impacted evaluators’ perceptions of the success that Covenant Health had attained at year one.
Second, the SROI model was in early development stages and continuing to evolve. Although the model application was complex, the ability to standardize with similar organizations was extremely limited. Validated SROI indicators and standardized costing were not available because SROI had not been applied to another health care organization post merger in Canada (S. Robinson, personal communication, September 16, 2009). Consequently, there was a complete lack of hospital indicators to draw upon for comparison or to guide development of new ones. Application to hospitals outside Canada reflected project-specific scenarios, not entire organizations. Additionally, determining cost to society was less specific than desired. Ability to determine solid proxies for financial measures was not perfect and was based upon conjecture in the event that an intervention did not occur or occurred unsuccessfully. To keep the project manageable, the review of indicators focused on absence of the merger versus absence of a goal.

Finally, success was defined in a less than an ideal objective manner; based upon the perceptions of internal stakeholders one could argue this was a skewed review. Persons involved in the merger, as well as personnel with ongoing investment in the merger, provided considerable input in defining and validating indicators and measures of success, whereas external stakeholders, partners and recipients of health care in communities, were still in the process of learning who Covenant Health was. To involve consumers and individuals in partnership organizations in the review would have been premature. Involvement of the community boards should have provided some community perspective; however, they already had significant commitment to the organization and might not have provided a truly objective review. In addition, during
the first and last phases for this study, frontline staff and physicians did not have the opportunity to define indicators or identify financial implications and proxies. This exclusion was for the purpose of keeping the project from becoming unwieldy. As well, the ability to connect with frontline providers was limited according to access to computers and e-mail addresses. Consideration should be given to further involvement for the future, should continued SROI occur within this organization.

Because a senior leadership person was leading the review, an additional concern relates to the accuracy of responses; although some of the vehicles for information collection provided for anonymity, this factor may have affected how people answered.

**Definition of Key Terms**

**Canon Law**

The accountability roles document for board members explains that canon law “is the law of the Roman Catholic Church and governs entities that are considered works of the church. Although canon law does not directly refer to health care, many of the canons influence how health care structures can exist” (Brown, 2009, n.d.).

**Community Board**

Covenant Health defines a community board as an advisory, representative group that acts as a linkage between the community where the facility exists and the organization, leadership, and governing board. Mike Shea (2009), Vice President of Board Support, set the mandate as follows:

The community boards have a mandate to represent the Covenant Health Board in their communities and to ensure that there is effective communication between the local communities and the provincial Catholic organization. These boards
will be actively engaged in the planning processes for Catholic health in the province, both in identifying needs in the community and in determining the programs to be offered to best meet these needs. (n.d.)

**Governing Board**

Covenant Health (n.d.) defined the Governing Board accountability “to ensure that the accountability requirements of both canon law and civil law are being met [by the organization]” (p. 1). The accountability document developed early in the merger determined the Governance Board’s responsibilities to include the following duties: (a) formulate the organization’s mission, vision, and values; (b) establish strategy; (c) set and monitor goals (i.e., meet the vision); (d) ensure effective management; (e) fulfill fiduciary responsibilities (mission, quality, and financial); (f) act on behalf of the communities being served. These functions are reflective of the dual roles of the Board in providing strategic leadership and direction to the consolidated organization and being stewards of the assets available for providing health services in Alberta.

**Monetization**

Monetization may be defined as the rendering to a legal tender or, in this case, outcomes’ being assigned financial meaning to present a singular denominator for determining worth.

**Organizational Culture**

The culture of an organization has been defined as follows:

Pervasive, deep, largely subconscious, and tacit code that gives the “feel” of an organization and determines what is considered right or wrong, important or
unimportant, workable or unworkable in it, and how it responds to the unexpected crises, jolts, and sudden change (“Organizational Culture,” n.d., ¶ 1).

In light of a major transformation, consideration of the organizational cultures was imperative. One of the most difficult aspects of merging is blending cultures; yet cultural dimensions are frequently ignored (Canadian Health Services Research Foundation, 2000).

**Organizational Influence**

Organizations exist within a system, not alone and not without significant influence from multiple sources. Influence occurs at multiple levels internally and externally. Determining stakeholders, as well as understanding how they influence, provides a filter through which an organization can acquire greater knowledge about achievement. *The Eight Rings of Organizational Influence*, written by Rosenberg (2003), includes discussion of the spheres of influence. Anchoring the organization in a clear vision is crucial. Contacting this vision through development, communication, and demonstration of a strong mission and set of values connects people, providing them a sense of belonging when their work clearly links to the organizational direction (Rosenberg). Rosenberg also examined the external influences consistently affecting an organization. Patterns and cycles of the greater system produce context for an entity (Rosenberg). Covenant Health exists in a cycle of world, national, and provincial economics. Patterns of change in funders and access to money, patterns of increasing technology demands, patterns of illness and consumer demand on health resources compete for attention and resources. Internally a division of influencing factors occurs between people and processes. People’s level of passion, focus, and work-life balance
determine how they will do the work. During change, people need clear focus, passionate commitment to the vision, and a desire to be with the organization as the new journey begins. If people connect and sense a fit with the new entity, they tend to support the change (Rosenberg). (See Figure 1.)

![Eight Rings of Organizational Influence](image)

**Figure 1. Eight Rings of Organizational Influence**
Source: Rosenberg, 2003

Lewin, in his field theory, defined the interdependence of fate and task as group process or people processes that create a joint influence, recognizing that each individual brings his or her own level of persuasion to the change, negatively or positively affecting an organization’s ability to shift forward and achieve new goals (as cited in Smith, 2001).

The second division Rosenberg (2003) identified internally is that of process. Successful change requires concise, clear, and definitive action moving people forward through the change. People need goals, roadmaps, and clear expectations. Once
processes are set, education and support produce the necessary components to assure the environment provides the highest potential for success.

**Regional Health Authority**

During the mid-1990s, the Alberta government, under the Health and Wellness section, amalgamated singular health facilities and sectors into geographically defined authorities to promote financial savings, enhance integration, and build greater efficiencies within the system. These authorities, according to the Regional Health Authorities Act (1994), became accountable for population health within their boundaries. Voluntary organizations receive funding and service direction from these authorities.

**Social Return on Investment (SROI)**

Social return on investment represents an alternative measure to typical cost-benefit models. The Managing Director of Programs for Roberts Enterprise Development Fund (REDF) defined SROI as “the ‘return’ on investment in a social mission venture” (REDF, 2008, ¶ 11). Emerson, Wachowicz, and Chun (2001) of the Harvard Business School wrote, “This value creation process simultaneously occurs in three ways along a continuum, ranging from purely Economic, to Socio-Economic, to Social” (¶ 2).

**Value added**

In economic terms, value added is defined as “cost of materials and labor to produce a product, and the sale price of a product” (“Value Added,” n.d.). In social terms, this concept extends to social strain and creates a call to interested people to band
together and drive rapid change to improve the situation. There are six steps enabling movement toward a value-added evolution:

1. There is awareness of the issue, and the opportunity for action presents.
2. Authorities are stretched to the point of inability to deal with emerging issues.
3. People in the situation believe there is a crisis.
4. A trigger precipitates urgency.
5. People involved band together and seek a consolidated action for change.
6. Past social pressures and control are absent or fail, creating the ability for the transition (“Value Added”).

All of these steps were clearly present for the transition to Covenant Health. The SROI model provides an option for storyboarding Covenant Health’s journey thus far, determining if the merger produces value beyond this entity or adds value to the larger system.

**Value of One**

Value of one is the financial value resulting for a unit of one. Use is important when one is concerned with inability to target accurate total costs; this measure provides a reasonability check and a reference point for further valuation.

**Voluntaries**

“The voluntary sector (also non-profit sector) is the sphere of social activity undertaken by organizations that are for non-profit and non-governmental. This sector is also called the third sector, in reference to the public sector and the private sector” (“Voluntary Sector,” n.d., ¶ 1). The Office of the Third Sector of the UK Cabinet Office (n.d.) defined the third sector:
The third sector is a diverse, active and passionate sector. Organisations in the sector share common characteristics:

- non-governmental
- value-driven
- principally reinvest any financial surpluses to further social, environmental or cultural objectives.

The term encompasses voluntary and community organisations, charities, social enterprises, cooperatives and mutualls both large and small.
Chapter 2: Literature Review

This literature review considered both scholarly and organizational documentation. Review of internal documents was important to understand the environment and to uncover the reasons and urgency that created the need for a merger of the 12 organizations. Further, these internal documents supported the fit with the new organization and the model of choice for measuring cost benefit of the merger. The scholarly review converged on recent past study of Canadian health care mergers and values-driven, cost-benefit analysis.

Introduction: Topics, Purposes, and Methods of the Literature Review

Key foci for literature review included the following topics: preamalgamation of Catholic health facilities in the province of Alberta and papers prepared for Alberta Catholic Health Corporation (ACHC) (2008a), not-for-profit amalgamations and mergers, social return on investment (SROI) and other cost-benefit models, and benefit of using SROI tools. Most topics were searched by using ProQuest database, EBSCOhost, Canadian Health Services Research Foundation (CHSRF) database, and the Internet, with the exception of information regarding the Alberta Catholic Health facilities for which access to internal documents was attained through the Covenant Health corporate offices.

Although the review of key documents for the Catholic facilities did not represent scholarly documentation, this analysis was crucial for understanding the platforms and influences that drove the initial merger of 16 facilities. The purposes of the internal reviews included the following: (a) to understand the context and influences that stimulated the need and desire for merging the Catholic facilities governed by the sponsor organization, Alberta Catholic Health Corporation; (b) to determine what success was
expected and how it would be demonstrated through specific outcomes; (c) to provide storyboard documentation for future reference through historical accounting of the consolidation; and (d) to answer specific questions from previous assessments based upon the review of literature regarding other recent not-for-profit health organizational mergers. Finally, the literature review focused on cost-benefit models to understand potential measures for performance and desired outcomes of mergers.

**Analysis of Internal Organizational Documentation**

Documentation prior to the merger reflected alternative resolutions sought prior to determining amalgamation of all the Catholic health care facilities and explained the multiple risks and pressures at some facilities.

**Trigger One: Relationship Breakdown Between Voluntaries and One Regional Health Authority**

This trigger emerged as concerns regarding sterilization practices at St. Joseph’s General Hospital were noted in the media in the summer of 2007. The newspaper reported that procedures for cleaning and sterilization at the site were not at current standards, thereby resulting in tissue residue being left on instruments, and that less than standard site practices resulted in exposure to antibiotic-resistant strains. This report raised significant concerns within the entire system as reviews in other facilities, faith based and secular, demonstrated other points of standards breach. Upon investigation, relationship breakdown was cited as a major contributing factor to the inability for facilities to have their cases fairly heard or to receive adequate funding to resolve concerns.

Concurrently, the deficit at a second Catholic site within the province of Alberta, St. Mary’s Hospital, was increasing year over year. There was erosion of site autonomy
as the regional authority imposed their staff into positions within the facility rather than providing funding for St. Mary’s to hire personnel to resolve ongoing pressures. Relationship breakdown of boards and administration between these two facilities and the regional authority created severe tension and governmental concern for the provision of care to citizens of the area. Conflict occurring between voluntaries and the health authority led to counterproductive interactions, resulting in loss of healthy communication and lack of financial and operational support from the authority to the voluntaries. The perception of this experience was not unique to the Catholic facilities; other voluntaries and contracted providers also indicated a similar sense of being unsupported financially and operationally (H. James, personal communication, May 15, 2008). Prior to the St. Mary’s board’s dissolution, they struggled with options to resolve issues, including handing the operations over to the regional authority. ACHC intervened and subsequently provided alternatives and support to ensure that the operation remained a Catholic mission.

In the fall of 2007, the boards at the four Catholic facilities in east central of the province of Alberta were dissolved, as was the regional authority board. Termination of the administration team at St. Joseph’s as well as the CEO of the regional health authority occurred. An interim CEO appointment, from an alternative voluntary organization, and the hiring of a nurse leader happened in late 2007. Concurrently, the government appointed coadministrators to the regional health authority. These administrators became responsible for resolving critical issues, reviewing current operations and developing recommendations for resolution of ongoing relationship management issues as well as conflicts between the authority and Catholic providers within the region.
Early in 2008, the Catholic facilities’ sponsor, ACHC, directed to find a resolution related to the four sites within this region, approached the Board of Directors and the CEO for Caritas Health Group to provide a review for both Governance and Operations of the four east central facilities. CEO Patrick Dumelie brought together a team of external consultants and internal senior leadership personnel to review critical issues, examine current operations, and develop recommendations to respond to the issues at hand and enhance all four sites’ ability to function within the regional authority context. The initial recommendation was to merge the four facilities into one entity. One of the senior executives from Caritas Health Group was reallocated to bring the four organizations together, and Patrick Dumelie, CEO of Caritas Health Group, became the interim CEO for the new entity as of April 2008.

**Trigger Two: Youville Home - 140 Years of Mission and Ministry Threatened**

Youville Home, founded by the Sisters of Charity (Grey Nuns) of Montreal in the late 19th century, has continued to be shaped by their commitment to compassionate, holistic care; they responded to a regional request to increase the number of beds to support senior care for both long-term care and assisted living in the community of St. Albert, Alberta. In this pursuit, management at Youville developed a plan for a phased-in approach to the redevelopment of the campus. Unfortunately, misunderstandings of the funding model and coverage for mortgage created a funding and revenue mismatch for the actual costs of the redevelopment and ongoing operation of the facility. The regional authority asked the facility management to open the new beds while maintaining the current ones, without additional operational funding. Youville Home’s Board of Directors, following a mounting deficit, considered multiple options but, ultimately,
requested Caritas Health Group to consider assuming responsibility for the management
and operation of Youville Home in St. Albert. This request was not the only option with
which the board grappled. Consideration to transfer the operation to the regional health
authority was an alternative option; however, because both entities, Caritas and Youville,
were connected to the same originating religious organization and, therefore, shared a
congruent legacy, the board determined the most appropriate alternative was to ask
Caritas Health Group to assume responsibility.

The resulting action occurred February 6, 2008, as the Alberta Catholic Health
Corporation (ACHC) (2008b), Catholic sponsor for Youville Home, approved the
transfer of responsibility for Youville Home to Caritas Health Group, a tri-site
organization that included the Misericordia and Grey Nuns Community Hospitals and the
Edmonton General Continuing Care Centre. Caritas Health Group committed to manage
Youville Home, address challenges, find efficiencies, expand services by opening all
long-term care beds, and build on the strengths of both organizations (ACHC, 2008c).

**Trigger Three: A Question of Sustainability**

In light of the St. Joseph’s issue and the financial crises at Youville and St.
Mary’s, other Catholic facilities began to raise concerns about their sustainability and to
query alternative strategies to ensure maintenance of their operation within their current
communities. These queries resulted in two summits, one in the summer of 2007 and a
second one in May 2008, where CEOs and Board members considered current pressures
and alternatives for resolution. Simultaneous changes to the regional health authority
provided a sense of urgency to make a rapid decision and move forward to protect and
elevate faith-based health care in Alberta.
Concurrent Influencing Factor: Dissolution of Health Authorities and Emergence of a Single Entity for Alberta’s Health Care

In May 2008, Alberta Health and Wellness removed all CEOs and Boards from the nine regions; the Mental Health Board; the Alberta Cancer Board; and the Alberta Addiction, Drug, and Alcohol Commission in the province of Alberta. An interim CEO and Board Chair were appointed to manage a transitional entity of one Health Service authority throughout the province (AHS, 2009). This change created chaos in the system and delineated a need for a major transformation that continues to date. Structural changes broke apart several past relationships between Catholic providers and regional personnel, resulting in a sense of disconnection and inability to represent site needs to the funder.

These triggers and the simultaneous event became the impetus for a value-added proposition for faith-based health care delivery in the province. Congruent organizations, aware of their vulnerability, developed a solution and implemented the agreed upon resolution. The sense of vulnerability occurred as each facility was working to over capacity and could no longer deal with multiple demands and diminishing resources. Many stakeholders, internal and external, were aware of the multiple emerging issues and believed that many organizations sponsored by ACHC were in jeopardy. These stakeholders chose to come together, determine the best solution, and then act together to inform government officials of their decision. Because this occurred at the same time as the larger health system was in chaos, many people who would have opposed this transition no longer had the ability to obstruct; as new players tried to oppose, the strength of the Catholic providers relationship with government overruled the resistors and provided strong support for developing the parallel transition. All of these points
constituted the key components for the foundation of a value-added response at a vital point in the evolution of Catholic health care in Alberta.

Evaluating Covenant Health based upon predetermined targets for success at year one provided opportunity for further improvement of the consolidation, including an understanding of the value to the undertaking and the cost benefits to the greater system. Goals, that is, indicators for success, for Covenant Health identified by key contributors included the following three themes and breakdown objectives:

1. Revitalize the mission, pursue a renewed vision for Catholic health care
   a. Renew and continue a legacy of responding to unmet needs
   b. Expand our influence and be of greater service in communities throughout the province

2. Leverage the strength of our 16 sites
   a. Leverage the expertise and knowledge from all sites
   b. Enhance stewardship and accountability
   c. Facilitate effective governance and management

3. Simplify and streamline relationships
   a. Provide opportunity to be legitimate “Go to Provider” for Alberta Health Services
   b. Provide greater voice to shape and positively influence the health care system
Description and Critique of Scholarly Literature

Two areas of scholarly literature review were undertaken for this research. One centered on mergers and acquisitions, narrowed to Canadian health care mergers and acquisitions, to enable the reviewer to refine points of the study most appropriate to the population of study. Although there may be lessons to learn from other merger and acquisition research, that would be the focus of another study. Essential to the literature search were criteria for measuring health care merger success, recent case study of similar populations, and understanding of the impetus for similar mergers. The second area of review involved searching for a cost-benefit analysis model that included a values-based component.

Mergers and Acquisitions in Canadian Health Care

Review of an annotated bibliography sponsored by the Canadian Health Services Research Foundation identified 25 studies of mergers in health care completed in the late 1990s. This review identified six common themes and observations based upon the documents. These observations included study focuses and findings related to the following topics: (a) cost benefit or efficiency gains; (b) consequences of mergers; (c) lack of economic advancement, which was frequently referenced but not well studied; (d) other alternatives to mergers, some described anecdotally, which might produce greater opportunities for savings but require further study as well as determination of the appropriate relationship and environment for response to certain circumstances; (e) identification of two types of service integration—vertical and horizontal—both of which need further study to determine their effectiveness; and (f) the possibility that a merger may fail regardless of a positive financial environment for several possible reasons,
including internal strife, governance difficulties, and physician interference. Although proposals for success were abundant, there was little research to support these measures.

A second study commissioned by CHSRF represented responses from a think tank of Canadian health care executives who identified issues and concerns resulting from the mergers of the 1990s. These experts identified clear areas of consideration when initiating or reviewing a merger. The areas included four undertakings identified by Montreal researcher Jean-Louis Denis:

1. Attend to team building of the executive team to build a sense of collegiality and trust, resulting in improved cooperation during challenging points.
2. Consistently connect the leadership team with people throughout the entire organization to produce confidence, clarity of roles, and rules of engagement.
3. Through micromergers, develop clinical integration to unite departments across the organization. Success of these micromergers creates important symbols for the new organization.
4. Win community support through strong connections between the board and the area people; together build a strong vision and sense of engagement (as cited in CHSRF, 2000).

In addition, other executives offered the following critical considerations:

1. Get government support; mitigate as much as possible political undermining.
2. Create a simple board structure and ensure that trustees are supportive of the merger and the CEO leading the creation of the new organization.
3. Move quickly; the tendency of political bodies is to decide slowly, and this can undermine pressing forward with change.
4. Do not over plan; decisive action is as important as the process of planning.

5. Develop clear objectives for the organization, and reflect frequently on the drivers behind the merger.

6. Find funding to support the merger; mergers have costs attached, and change occurs better when funds are available to support the transition.

7. Communicate consistently, constantly, and clearly with the audience appropriate content in a timely manner.

8. Celebrate successes, new beginnings, and rededication of mission! If you give people a focus on the new, their preoccupation with the past is decreased (CHSRF).

The fact that most health care environments within Canada focus on financial savings, not spending, as well as current pressures to reduce spending, means that finding spare funds to support a merger from traditional streams is unlikely. Money, however, is an essential requirement for success; as one leader reflected, “you need to have a lot of wires that don’t completely touch to believe you can merge two institutions and not come up with start up costs” (Roberts, as cited in CHSRF, 2000). In actuality, most mergers occur with cost saving as one of the goals; to begin by spending more is perceived as being at cross-purpose to the vision of merger.

Culture and cultural transitions were a concern within this study, primarily because of the previous lack of attention to cultural concerns. The author noted that culture remains “one of the most neglected aspects of change” (CHSRF, 2000, p. 3). Culture is an intricate part of an organization and, therefore, a complex component of merger. Culture reflects institutional pride; connection to the internal culture results in
retention and a sense of belonging for many who choose to work within certain facilities. Allusive but critical to an organization, culture consideration as two organizations merged was not part of the final review for this document; culture was once again neglected. Further study regarding culture was recommended, but no culture-specific consideration for successful merger was suggested.

**Value-Added Cost Benefit Analysis**

Most of the literature attached value directly to a monetary concept, rather than a contributory sense of desired behavioral goals. Only one method continued to surface in the literature search that provided a social value-added perspective. The concept, founded by Roberts Enterprise Development Fund (REDF), was invented to discern the social value of investments ("Value-added," n.d.). Application of social value to a project or organization began in the late 1990s (Emerson et al., 2001), thereby shifting the traditional income and expenditure process for determining cost achievement in not-for-profit environments to one of social benefit. Unfortunately, because of the newness of this method of analysis, there was limited scholarly evidence in this regard. Review of the ProQuest database produced no scholarly articles, and the EBSCOhost database had catalogued only one.

Through the World Wide Web, two major sources of information were found regarding Social Return on Investment; both sites had been set up to support individuals and organizations in conducting the analysis. One was a worldwide network organization called New Economic Foundation (NEF), which “works on economic, social and environmental issues through a mixture of practical pilot projects and tools for change, in-depth research, campaigning, policy discussion, and raising awareness through the
media and publications. We also incubate new organisations and campaigns that can create long-term change in society” (NEF, n.d., p.1).

The second was a United Kingdom Network sponsored by government to provide groups support in using SROI for specific purposes. “The SROI Network is a network dedicated to the consistent and effective use of SROI. It is a membership organisation with members who are practitioners, academics, funders and investors with an interest in the use and development of social return on investment” (SROI Project, n.d., ¶ 1).

During the course of this study, a third provider emerged, which provided a Canadian context. The city of Calgary was embarking on use of the SROI method for evaluating cost savings in social program application. Although in the early stages of application, indicators still were being developed; therefore, they were of limited value to this research.

Table 1 presents information about SROI, including reasons to use the model. The table presents guidelines provided by a civil authority; although the guide indicated the usefulness of SROI, it included no referral to evidence of usefulness other than users’ feedback.
Table 1. Social Return on Investment Model

**SROI can help you improve services by:**
- facilitating strategic discussions and helping you understand and maximise the social value an activity creates;
- helping you target appropriate resources at managing unexpected outcomes, both positive and negative;
- demonstrating the importance of working with other organisations and people that have a contribution to make in creating change;
- identifying common ground between what an organisation wants to achieve and what its stakeholders want to achieve, helping to maximise social value;
- creating a formal dialogue with stakeholders that enables them to hold the service to account and involves them meaningfully in service design.

**SROI can help make your organisation more sustainable by:**
- raising your profile;
- improving your case for further funding;
- making your tenders more persuasive.

**SROI is less useful when:**
- a strategic planning process has already been undertaken and is already being implemented;
- stakeholders are not interested in the results;
- it is being undertaken only to prove the value of a service and there is no opportunity for changing the way things are done as a result of the analysis.


The database search during this review revealed no scholarly reviews of the model and only one health care project that used the model to advance a case for a specific patient population. This model, although logical and responsive to current trends in social responsibility, was just emerging; therefore, there was limited opportunity to
study the model in depth. Most of the supporting work was presented as case study, and because of the breadth of the organizations studied, there was limited transferability from one case to the next. Nonetheless, reading the case studies provided for thoughtful deliberation of possibilities.

Much of the financial value application in the case studies was representative of cost savings based upon spending forecasts, but financial proxies are much more subjective and there appeared to be no solid criteria for determining the societal financial implications. Open to interpretation of stakeholders, these numbers will not support benchmarking between like organizations without the development of an objective approach to determining the number.

The claim that SROI analysis benefits an organization has not been researched either; however, based on case studies, SROI provides a multidimensional look at values benefit of an entity. Therefore, the model provides an opportunity for persuasive argument to assist in support from others, financial or otherwise.

At the time of this study, the model was actively being used in the United Kingdom for the third party sector for the following reason:

The market place in which the third sector operates is becoming more sophisticated. With new social investment vehicles and increasing contestability for public services, customers are more interested than ever in getting the best value and securing positive change…. SROI is a framework to help understand the value of social change from the perspective of those changed. (Office of the Third Sector, 2008, ¶ 1)
Beyond traditional cost-benefit analysis, Social Return on Investment considers measuring the value of an investment further than dollars and cents. The New Economic Foundation (NEF) measures benefit to society by considering influence on people and the planet: “Value driven organizations are using new ways to understand, measure and foster awareness of their impacts” (Lawlor et al., 2008, p. 3). Another group of authors wrote,

The three types of value being created by the REDF Portfolio (Economic, Socio-Economic and Social) should be understood as being created over a specific investment period…. Furthermore, all three types of value should be understood to rest upon a fourth dimension of value creation—that of Transformative Value. The central purpose of the nonprofit sector is to create some type of change—to transform our society and world for the better. Transformative Value becomes the foundation upon which the other three types of value are based. (Emerson et al., 2001, ¶ 13)

(See Figure 2.)

Figure 2. Social Return on Investment Model
Source: Emerson et al., 2001
The ICTD organization, working with underprivileged world citizens, commented further: “Due to the absence of appropriate metrics to measure social value creation the work done by the non-profit sector is grossly undervalued and thus the (social) value created by the investment is not known” (April 2007, p. 31).

The SROI model is a methodical approach to identifying the scope of measure and stakeholder involvement to build an impact map. Analysis of the impact provides opportunities for assessing advancement and determining future opportunity, through monetization, and creates weighted value to social and environmental factors, providing comparability to financial costs.

Some sources asserted that reducing the importance of social value to a singular ratio demeans the significance of the contribution (S. Robertson, personal communication, February 21, 2010). Others considered the value to be in the total process: the stories that surround each point of measure and the final ratio that provides a standardized comparator to the more commonly used financial Return on Investment (ROI) ratio, producing a more understandable point for business professionals, who often make up boards of directors (Emerson et al., 2001). SROI demonstrates the benefit of change to people—families and groups, including communities—and expression of the change benefit or value in monastic terms based upon five social values or broad categories for adding value to the social system. Those categories include the following: (a) cost reallocation, by diverting need for public support or human services so that another can access that same support or service; (b) increases in household income; (c) increases in taxes paid to any level of government; (d) cost savings resulting from reduced public support or service provision; and (e) improvements in personal well-being
that are difficult to express in monetary terms, but equally as important (e.g., improved well-being, self-confidence, etc.) (City of Calgary, 2009).

A clear framework for organizing the SROI approach is presented in *A Guide to Social Return on Investment* (Nicholls et al., 2009). This framework includes six stages at which stakeholders provide feedback regarding points of measure as well as their opinions:

**Stage 1: Establishing scope and identifying stakeholders**
- Establishing scope
- Identifying stakeholders
- Deciding how to involve stakeholders

**Stage 2: Mapping outcomes**
- Starting on the Impact Map
- Identifying inputs
- Valuing inputs
- Clarifying outputs
- Describing outcomes

**Stage 3: Evidencing outcomes and giving them value**
- Developing outcomes
- Collecting outcomes data
- Establishing timeframe for outcomes
- Placing value on each outcome

**Stage 4: Establishing impact**
- Deadweight and displacement
- Attribution
- Drop-off
- Calculating your impact

Stage 5: Calculating the SROI
- Projection into the future
- Calculation of the net present value
- Calculation of the ratio
- Sensitivity analysis
- Payback period

Stage 6: Reporting, using, and embedding
- Reporting to stakeholders
- Using the results
- Assurance (Nicholls et al., pp. 4-5)

Inferences for Forthcoming Study

Cost-benefit analysis of the merger of 16 Catholic facilities, representing 12 organizations, into one organization, Covenant Health, required consideration of success beyond the financial. Using the SROI model, although the model was still emerging, provided a more complete review of year one post consolidation. Understanding the need to merge, the goals of the leaders creating the merger and mission of the organization provided an opportunity to identify successes beyond the organization alone. The process of stakeholder involvement also enhanced awareness and engagement of individuals, producing ongoing connectivity to the new organization, a culturally relevant benefit.
Secondarily, this review provides another case study in the body of knowledge and may produce additional areas on which to focus future work, not only for Covenant Health, but also for other health organizations and, potentially, for the SROI network.

**Conceptual Framework for Forthcoming Study**

The conceptual framework considers success by measuring two different perspectives of success, those being the level of achievement of preconsolidation goals and financial stability attained at the end of year one post amalgamation. One measure cannot be considered exclusive of the other. If Covenant Health is successful at meeting predetermined goals but in doing so also ends the first year in a large deficit position, this cannot be regarded as a true success. Alternatively, if they are unable to realize a reasonable level of success of goals but end the year in a balanced or positive financial position, then this scenario would also fall short of true measure of success. In order to understand both of these concepts internal stakeholder engagement will be imperative to confirm preamalgamation goals are accurate and to determine the level of achievement has occurred within the first year. Without reaching goals and maintaining financial stability, health systems will fail and in Canada that creates a taxpayer burden, so monitoring, measuring and trending both achievement and financial viability demonstrates accountability to those we serve.

The SROI provides structure for documentation of the story of the beginning of Covenant Health, including stakeholder involvement, and the opportunity to determine if this merger was successful and to what degree, not just for the new organization and previous organizations, but also for the society in which that organization exists, finally confirming or adjusting the course for Covenant Health. Important key concepts for
understanding this study include stakeholder engagement, healthcare sustainability and Social Return on Investment methodology. SROI has been defined and discussed in the previous chapter.

Stakeholder Engagement

SROI process hinges on involvement of stakeholders. Knowing best practices for that engagement, and adhering to them, creates a positive environment for study. One expert encouraged leaders to “get to know [their] stakeholders… engage as early as possible… listen with both ears open… communicate, communicate, communicate some more… use policy as a carrot not a stick… create communities” (Sharma, 2008).

The Directorate of Civic Engagement for National Health System in West Kent, England (2009) identified best practice guidelines as key to the engagement process:

1. Provide for broad consultation with adequate time, for example, 12 weeks for written responses.
2. Be clear about the proposal, who is involved, questions, and timeframe for development.
3. Provide for clear, concise, and readily accessible consultation.
4. Provide feedback to the stakeholders regarding findings and the ways in which individuals influenced the process.
5. Monitor effectiveness of consultation.

The New Economics Foundation (n.d.) follows the Assurance Standard developed by AccountAbility (2007), which sets forth the following guidelines:
1. Use sampling techniques that ensure adequate representation of the stakeholder groups.
2. Ensure that reviewers and researchers maintain objectivity in process application and analysis of results.
3. Involve stakeholders in determining the process and encourage their feedback early in the process.
4. Be aware of and recognize differences between stakeholders.
5. Assure confidentiality.
6. Document both rationale and processes of the engagement.

All of these guidelines are key considerations to ensure the best possible scenario as engagement with stakeholders occurs.

The International Financial Corporation (2007) offered eight key points for good stakeholder engagement. These include (a) stakeholder identification and analysis, (b) information disclosure, (c) stakeholder consultation, (d) negotiation and partnership, (e) management functions, (f) reporting for stakeholders, (g) stakeholder involvement throughout the process, and (g) grievance management. Understanding and using the recommended key components are important for mitigating influence of poorly applied process to study outcome.

**Sustainability of Health Care**

Longwood authors uncovered concerns with the longevity of health care in Canada: “If recent trends persist, provincial government spending on health care will consume more than half of total revenues from all sources in six of 10 provinces by the year 2020” (Skinner as cited in Stuart & Adams, 2007). The Stuart and Adams study
determined key causality of potential loss of sustainability to be a combination of multiple etiologies: (a) aging of the population, (b) new and more expensive treatments (particularly new drugs), (c) new diagnostic procedures, (d) more demanding consumers, (e) new diseases, (e) increasing prevalence of chronic diseases. With this rate of growth in costs, organizations need to reflect upon the long-term view and find potential solutions to slow increasing costs. Mergers may be one option, as some savings occur through economy of scales. Understanding the savings to the larger system, beyond financial, demonstrates contribution beyond health boundaries.
Chapter 3: Methodology

This mixed-method, combined qualitative and quantitative study, used a newly emerging model called Social Return on Investment. This model provides a platform for cost-benefit analysis beyond the customary financial measure. The in-depth study focused contributions of an organization on “people and the planet” (NEF, n.d.).

Overview of Methodology

One year prior to this study, 12 Catholic organizations representing 16 health care facilities across the spectrum of care, came together into one organization, representing a momentous undertaking in Canadian Catholic health care. Following such a sentinel event, the need to review the process and to conduct evaluation at year one was evident. Because Catholic Health providers believe strongly in service above self and making a value-added contribution, using an analysis tool that considers societal and environmental contributions along with financial stewardship was consistent with the ethical base and values inherent in Catholic health care.

The researcher used the SROI model as a framework to define scope and involve stakeholders (See Appendix B). Appendix B outlines information requirements for SROI and completes the SROI to the point where the study begins. Clarifying and confirming goals and matching goals to indicators of success and that success to financial proxies were determined through the study. Consideration of the social value categories and implications should the consolidation not have occurred were used to measure the savings because the consolidation did happen. When the potential savings were not quantifiable, the value of one was considered.
Research Questions and Hypotheses

Detailing the cost benefit of the merger of the 12 Catholic organizations, representing 16 facilities, the research questions were based upon a review of the extent of the success of the consolidation of the organizations into Covenant Health, including the cost benefit of this success to the citizens of Alberta. Questions included the following:

1. How successful has Covenant Health been at year one post consolidation?
2. What areas for improvement arose for enhancing greater success?
3. At year one post amalgamation, what is the cost benefit based upon Social Return of Investment (SROI)?
4. Does SROI adequately evaluate changes resulting from the merger of the Catholic health care organizations in Alberta?

Research Procedures

The population for the study included internal stakeholders for Covenant Health. These stakeholders represented four groupings: (a) governing board and community boards, (b) senior executives, (c) formal leadership team, and (d) staff and physicians. The researcher conducted a three-phase inquiry and engagement process. The participants were provided a consent and information sheet relaying necessary details to provide an informed consent compliant with International Research Standards (See Appendix A). The researcher will store all study information and subsequent data for 5 years post study. An ombudsperson’s contact information was provided for each phase of research should the participants have any concerns with proceedings.
Phase One

Goals and outcome measures were confirmed and clarified through consultation with stakeholders. Completion occurred through selection of five people from each stakeholder group, excluding staff and physicians, for a total of 15 individuals. One-to-one interviews were conducted to validate preconsolidation goals and suitability for use as indicators. An independent person called randomly selected individuals and arranged a time if the person agreed. Provision of a participant consent form and a one-page explanation of Social Return of Investment (SROI) were essential at the beginning of each one-to-one interview. If the interview occurred via the phone, the consent was read and verbal agreement obtained; the consent form and information sheet were provided later. Interviews addressed the following questions:

1. What were the top two goals for success expected from each individual interviewed and what indicator measured accomplishment?
2. What were their personal goals during this period and what indicator demonstrated a measure point for success?
3. What were the consequences of not achieving these goals?

(See Appendix C for an example of the collection sheet.)

Phase Two

1. Following validation and refinement of the goals set forward in the original documents, stakeholder groups were surveyed. The survey combined consolidation goals as nine indicators and an additional six developed from the literature (See Appendix E). A five-point Likert response scale was provided for individuals to indicate their perceptions regarding whether or not Covenant Health
had achieved success per indicator; the response choices were the following: 1 =

*do not know*, 2 = *strongly disagree*, 3 = *disagree*, 4 = *agree*, 5 = *strongly agree*.

Groupings in the urban sites included senior leadership, next-level leadership, governing
and community board members, rural site staff, and next organizational level. Most
groups received a presentation of the study, then were asked to identify the level to which
these goals had been achieved at year one. These groups were surveyed through the
following methods: (a) senior executives – real-time electronics; (b) greater leadership
team, executive directors, directors, and managers – real-time electronics; (c) five
randomly selected sites’ community board members, staff, and physicians – manual
surveys; and (d) governing board and next organizational staff and physician leaders from
urban sites – electronic Zommerang Web-based survey. Results were compiled and
shared with senior leadership. Senior leadership assisted in the determination of level of
perceived success as well as areas for improvement based on indicators that did not meet
success targets. Results and areas for improvement were shared with the greater
leadership team; results, with improvement strategies, were shared with the Governing
Board of Directors. Appendix D includes a copy of the survey.

**Phase Three**

An internal stakeholder consultation group was developed, based on areas of
expertise and interest, to determine SROI measures; these measures were determined
with a large focus group, followed by the involvement of small working groups. The
group gathered and was provided a short presentation on Social Return on Investment.
Following the presentation, the group as a whole considered three questions:
1. If Covenant Health had not come together, what would have been the likely outcomes?

2. What are the specific implications for individuals and sites?

3. What are the costs associated with those implications?

In a smaller group format, three groups each considered one of the themes for the goals for success; objectives of those themes identified further SROI implications. Then, as individuals, the participants answered two questions regarding the utility of the SROI model:

1. How does this exercise of applying costs and benefits feel? And why?

2. Do you believe we have been able to identify financial measures or proxies that create a realistic picture?

SROI was then developed and shared with the executive team, along with the phase three team’s perception regarding the applicability of SROI for ongoing evaluation of continued success and accomplishments.

**Human Participants and Ethics Precautions**

The Medical Council of Canada mandates policy for research involving human beings and follows Tri-council standards for research. This group defines common policies for ethical conduct involving human beings during research. The Human Research Ethics Board (HREB), a tribunal between Edmonton Zone health facilities, University of Alberta, and Covenant Health approved the study. Covenant Health Research Center also reviewed the proposed study for congruency with the Canadian Catholic Bishops’ Health Ethics guide and corporate regulations for Covenant Health.

The guiding ethical principles for studying humans include the following:
1. Respect for human dignity is the moral imperative for all research involving human beings. A person’s body, mind, and culture are interrelated; therefore, research requires attention to the whole person. Based upon this principle, other principles emerge.

2. Respect for free and informed consent requires that researchers clearly articulate what the study is about, how the research subject will participate, what the risks are to the subject, and the fact that the subject may opt out at any time. Coercion of subjects is unacceptable; the decision to participate is the subject’s alone to make once he or she is fully informed.

3. Respect for vulnerable persons, being mindful of the special needs of those that do not have the capacity to understand and truly consent to being participants, often requires special procedures to ensure protection of their needs.

4. Respect for privacy and confidentiality, or protecting the identity of results so that no one can connect outcomes with a specific individual, is required. Typically, legislation of the governing authority needs to be respected; in Alberta, that is the Freedom of Information and Privacy Act.

5. Respect for justice and inclusiveness connotes that the ethics review will proceed in a fair and equitable manner, with standard procedure duplicated for similar research projects. This principle also considers that populations will not be disadvantaged by either having or not having the advances occurring from specific research.
6. Balancing harm and benefits, or making sure that any foreseeable harm will not be greater than the benefits of the research, is necessary.

7. Minimizing harms or nonmaleficence asks researchers to do no harm or to mitigate potential harm through the procedures used to conduct the study.

8. Maximizing benefits, beneficence, or the duty one has to create the greatest benefits through the research completion is important (Medical Research Council of Canada, 2003).

Each participant in this research received a letter explaining the study, the process, the confidentiality of responses, and the ability for any individual to withdraw at any time.

Ethical cautions for this research included concerns about harming current relationships that were particularly vulnerable during times of rapid and significant change. Maintaining anonymity during data gathering is very important to guarantee participants the reduction of any personal exposure as well as accurate representation of their views. Lack of personal exposure could not be provided in phase three when respondents were involved in a focus group. As well, caution was extended to the greater population who were recipients of care. Compromising confidence in Covenant Health and the health care system serving more than 3 million citizens would be significantly harmful and was measured against the benefits to the organizations of understanding the 1st-year successes and failures prior to releasing results to the greater population.
Chapter 4: The Results

Research Questions

The results are grouped and presented in accordance with the research questions set forth in Chapter 1. The preliminary question was the following: How valid are the indicators and organizational goals developed by the board and CEO preconsolidation? The subsequent four research questions were the following:

1. How successful has Covenant Health been at year one post consolidation?
2. What areas for improvement arose for enhancing greater success?
3. At year one post amalgamation, what is the cost benefit based upon Social Return of Investment (SROI)?
4. Does SROI adequately evaluate changes resulting from the merger of the Catholic health care organizations in Alberta?

Validation of Organizational Goals

Phase one of the study investigated the soundness of the organizational goals that were agreed upon by the new governing board and CEO as demonstrating the reason for the amalgamation of the 12 Catholic health care organizations in Alberta. Five potential contributors from three different groups—past CEOs, current senior leadership, and past board chairs—randomly selected, shared their thoughts on the need for Catholic facilities’ coming together, as well as the key areas for success, by exploring three questions (See Appendix C). These objectives, compared to the goals set by the new board and CEO, validated the goals and the measure of strength of the connection for each goal with those identified by participants.
Of the 15 candidates randomly selected from a pool of 36, nine (60%) validated all nine goals for the consolidation of Covenant Health. The strength of each indicator was noted as a correlation coefficient (-1.0 to +1.0) based upon the number of participants that related to the goal as they viewed the needs of the new organization.

Compiled results are presented in Table 2; Appendix G includes complete data.

Table 2. *Strength of Indicators of Success*

<table>
<thead>
<tr>
<th>Indicator or measure of success</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Revitalize the mission, pursue and renewed vision for Catholic health care</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Since the formation of Covenant Health, the mission for Catholic health care has been renewed.</td>
<td>0.11</td>
</tr>
<tr>
<td>1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs.</td>
<td>0.44</td>
</tr>
<tr>
<td>1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province.</td>
<td>0.44</td>
</tr>
<tr>
<td><strong>2. Leveraging the strength of all 16 facilities</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Covenant Health is leveraging the expertise and knowledge from all sites.</td>
<td>1.00</td>
</tr>
<tr>
<td>2.2 During this 1st year as Covenant Health, enhanced stewardship and accountability is occurring.</td>
<td>0.44</td>
</tr>
<tr>
<td>2.3 Because of coming together as Covenant Health, effective governance and management are facilitated.</td>
<td>0.11</td>
</tr>
<tr>
<td><strong>3. Simplify and streamline relationships</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Coming together as Covenant Health, and through this 1st-year’s work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services.</td>
<td>0.11</td>
</tr>
<tr>
<td>3.2 Being together as Covenant Health, we provide a greater voice to shape and positively influence the health care system.</td>
<td>1.00</td>
</tr>
<tr>
<td>3.3 Creating Covenant Health provides a single point of accountability for quality and health service delivery</td>
<td>0.22</td>
</tr>
</tbody>
</table>
In addition, participants identified further expectations of the amalgamation that reinforced the 2000 Canadian Health Services Research Foundation (CHSRF) literature regarding the success points for health care facility mergers. These points included the following: (a) community engagement; (b) stakeholder engagement; (c) leadership connections; (d) clinical integration; (e) strong, visible leadership team; and (f) cultural concerns.

**Level of Success of the Consolidation to Covenant Health**

Seven different groups, through three different venues, answered 15 consistent questions that mirrored the goals of success and the evidence offered through the CHSRF (2000) literature. The measure was the participants’ perceptions of the success achieved to date for each of the nine goals identified by the Governing Board and CEO, as well as an additional six metrics of success. The participation uptake varied among the groups for an overall rate of 65%. The participant selection was group dependent; participants, according to either convenience sampling or self-selection, completed the survey. The seven groups represented (a) the governing board; (b) senior leadership; (c) larger leadership or management group for all 16 sites; (d) staff and physicians from a random selection of five of eight rural sites; (e) community board members from a random selection of five of eight rural facilities; (f) next-level staff, educators and practitioners, and physicians at Acute Urban facilities; and (g) next-level staff at Urban Continuing Care and Rehabilitation Services. The venues used to gather the data were selected from the following: (a) Sierra system “real time” answers; (b) manual recording; and (c) Zoomerang, an online survey tool.
The response choices consisted of a modified Likert scale, a one-dimensional scale ranging from 1 to 5, providing participants with the following options: 1 = *do not know*, 2 = *strongly disagree*, 3 = *disagree*, 4 = *agree*, 5 = *strongly agree*. There was also a comment box to provide candidates with the opportunity to write comments, provide examples, or identify support for response choices.

Assuming that all goals were equally significant, the average, overall success rate was 75% for achieving predetermined goals and 63% for additional indicators of success. Removing the ‘do not know’ category from the results provides a slightly different perspective. As one considers only those participants that registered their perspective upon the indicators, the results show a higher level of agreement of achieving success of the goals; predetermined goals average at 87%, while the additional indicators from the literature indicate an 86% agreement rate. Consistency of comments from those that ‘did not know’ cite communication or understanding as reasons for not knowing. Table 3 and depicts the combined group responses indicating level of agreement with regard to the success of each Covenant Health goal and Table 4 shows the results with the ‘do not know’ category removed. Appendix H includes group-specific results.
Table 3. Measure of Success by Indicator Inclusive of all Participants

<table>
<thead>
<tr>
<th>Level one: Identified goals at consolidation</th>
<th>Do Not Know</th>
<th>Disagree or Strongly Disagree</th>
<th>Agree or Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Revitalize the mission, pursue a renewed vision for Catholic health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed.</td>
<td>11%</td>
<td>4%</td>
<td>85%</td>
</tr>
<tr>
<td>b. Renew and continue a legacy of responding to unmet needs</td>
<td>11%</td>
<td>4%</td>
<td>85%</td>
</tr>
<tr>
<td>c. Expand our influence and be of greater service in communities throughout the province</td>
<td>11%</td>
<td>8%</td>
<td>81%</td>
</tr>
<tr>
<td>2. Leverage the strength of our 16 sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Leverage the expertise and knowledge from all sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Enhance stewardship and accountability</td>
<td>20%</td>
<td>12%</td>
<td>68%</td>
</tr>
<tr>
<td>c. Facilitate effective governance and management</td>
<td>20%</td>
<td>17%</td>
<td>63%</td>
</tr>
<tr>
<td>3. Simplify and streamline relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Coming together as Covenant Health, and through this 1st year's work, we are positioned to be a legitimate &quot;Go to Provider&quot; for Alberta Health Services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Provide greater voice to shape and positively influence the health care system</td>
<td>5%</td>
<td>8%</td>
<td>87%</td>
</tr>
<tr>
<td>c. Develop single point of accountability for quality and health service delivery</td>
<td>15%</td>
<td>19%</td>
<td>66%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>14%</strong></td>
<td><strong>11%</strong></td>
<td><strong>75%</strong></td>
</tr>
</tbody>
</table>

**Level two: Goals for successful mergers**

1. Covenant Health Executive has developed a strong and positive team. | 13% | 6% | 81% |
2. The Covenant Health leadership team connects with people throughout the entire organization routinely. | 16% | 25% | 59% |
3. Covenant Health is beginning to develop clinical integration across sites and sectors. | 36% | 19% | 45% |
4. Covenant Health is building strong connections between the boards and the communities where facilities are located. | 48% | 11% | 41% |
5. Covenant Health has built a strong vision. | 4% | 6% | 90% |
6. Covenant Health is building a sense of engagement with stakeholders and communities. | 30% | 10% | 60% |
| **Average** | **25%** | **13%** | **63%** |
Table 4. *Measure of Success by Indicator Excluding ‘Do Not Know’ category*

<table>
<thead>
<tr>
<th>Measure by group of stakeholder perception of level of success in achieving the goals – SLT</th>
<th>Do Not Know Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree or Strongly Disagree</td>
</tr>
<tr>
<td>Level one: IDENTIFIED GOALS AT CONSOLIDATION</td>
<td></td>
</tr>
<tr>
<td>1. Revitalize the mission, pursue a renewed vision for Catholic health care</td>
<td></td>
</tr>
<tr>
<td>a. Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed</td>
<td>5% 95%</td>
</tr>
<tr>
<td>b. Renew and continue a legacy of responding to unmet needs</td>
<td>6% 94%</td>
</tr>
<tr>
<td>c. Expand our influence and be of greater service in communities throughout the province</td>
<td>8% 92%</td>
</tr>
<tr>
<td>2. Leverage the strength of our 16 sites</td>
<td></td>
</tr>
<tr>
<td>a. Leverage the expertise and knowledge from all sites</td>
<td>24% 76%</td>
</tr>
<tr>
<td>b. Enhance stewardship and accountability</td>
<td>15% 85%</td>
</tr>
<tr>
<td>c. Facilitates effective Governance and management</td>
<td>22% 78%</td>
</tr>
<tr>
<td>3. Simplify and streamline relationships</td>
<td></td>
</tr>
<tr>
<td>a. Coming together as Covenant Health and through this first year's work, we are positioned to be a legitimate &quot;Go to Provider&quot; for Alberta Health Services.</td>
<td>9% 91%</td>
</tr>
<tr>
<td>b. Greater voice to shape and positively influence the health care system</td>
<td>8% 92%</td>
</tr>
<tr>
<td>c. Single point of accountability for quality and health service delivery</td>
<td>21% 79%</td>
</tr>
<tr>
<td><strong>Averages</strong></td>
<td>13% 87%</td>
</tr>
</tbody>
</table>

Level Two: GOALS FOR SUCCESSFUL MERGERS

1. Covenant Health Executive has developed a strong and positive team. 6% 94%
2. The Covenant Health leadership team connect with people through out the entire organization routinely 30% 70%
3. Covenant Health is beginning to develop clinical integration across sites and sectors 10% 90%
4. Covenant Health is building strong connections between the Boards and the communities where facilities are located. 21% 79%
5. Covenant Health has built a strong vision. 6% 94%
6. Covenant Health is building a sense of engagement with stakeholders and communities. 13% 87%

**Averages** 14% 86%
Determining Social Return on Investment (SROI)

The qualitative data of the leadership opinions obtained from open participants’ discussion of potential SROI measure points were applied to calculate the cost benefit of the merger. The participants in this phase consisted of a convenience selection from leadership at the executive and director levels to ensure adequate representation of finance, operations, and human resources for the best potential consideration of implications. Of the 32 participants selected and invited to attend a 3-hour focus group, nine did attend, representing a participation rate of 28%.

During the focus group, an explanation of SROI was provided, after which a three-step approach for information gathering occurred. The first step consisted of general discussion with the full group to identify what the results for the 16 facilities might have been if the consolidation of the Catholic health care facilities had not occurred. Second, the focus group was divided into three groups to consider one category of success indicators, should Covenant Health not have realized such success within the first year. The third step consisted of determining the usefulness of this method. Results are reported in the next section.

SROI measures for the Covenant Health amalgamation occurred through a large focus group discussion, as well as discussion with organizational leaders. Prefaced upon consideration of the costs should the intervention not have occurred, the participants attempted to determine what the cost to society would have been; they then applied finances to the loss, thereby creating the benefit of the investment. Recognizing that retrospective study does not provide specific details of the potential numbers, there needed to be a reasonability test applied. The outcome of not consolidating considered
the value of one. That is, what cost would have been incurred for one person, or one facility, if the consolidation had not happened? This value of one consideration provides a reasonability check through which the audience can extrapolate how great the consequences might have been and mitigates exaggeration of the projection.

SROI equals the benefit of the merger (saving of the cost of not intervening) minus the actual cost of merger. The final SROI represented a ratio of one dollar’s being invested to result in a social savings of seven dollars, thereby indicating a positive SROI; the success of Covenant Health has had a greater SROI benefit than cost.

Total costs for the expenditure were gathered from the CEO of the previous Alberta Catholic Health Corporation, the overarching organization for the 16 Catholic facilities preconsolidation, and the CFO of the largest organization, through which the majority of the work of the consolidation was directed. As has long been the case with faith-based entities, the transformation was accomplished in a very frugal manner. Those currently serving within the 12 institutions, minimizing additional costs paid out, performed a great deal of the work of consolidation. Total costs were reported as $1,090,000. Actual costs were likely much higher but impossible to quantify, as the work became part of the daily routine for many of the past CEOs and senior team members at the largest organization, and, subsequently, the work of the new executive team. These costs represented one-time expenditures and operational expenditures, those that produced ongoing annual savings to one of the previous organizations. Additional costs resulted from development of new positions and operational requirements for the larger organization. Table 5 displays a compilation of those costs.
Table 5. *Costs Associated With Covenant Health Consolidation*

<table>
<thead>
<tr>
<th>General ledger assignment</th>
<th>Resulting source of expenditure</th>
<th>Actual cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-time costs</td>
<td>Legal, severance, summits</td>
<td>($435,000)</td>
</tr>
<tr>
<td>Operational–Annual costs</td>
<td>Annual savings for salaries and benefits of 2 FTEs</td>
<td>$300,000</td>
</tr>
<tr>
<td>or savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New costs</td>
<td>New positions (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Travel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retreats including leadership and board development</td>
<td>($995,000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total savings (costs)</td>
<td></td>
<td>($1,090,000)</td>
</tr>
</tbody>
</table>

Through open discussion with group leaders, the social return on the costs discussion considered the likeliest outcomes that would have happened without the amalgamation of these 12 Catholic entities one year prior, that is, the Social Return on Investment. This qualitative exercise resulted in the monetization of the qualitative data, thereby producing a quantitative cost benefit of the intervention. The social values ascribed to were those values depicted by social value theory, categorizing those values into five points. Five broad categories of social benefits of change were considered with regard to implications for the following: (a) cost reallocation, (b) increases in household income, (c) increases in taxes paid, (d) cost savings, and (e) improvements in personal well-being (City of Calgary, 2009).

The potential inferences were considered only once and, although there was a high likelihood that more than one incident of some of the outcomes might have occurred, the potential future with only one such occurrence was assessed; a reasonability check was used to ensure that costs were not overstated. Table 6 depicts the probable
results and the monetization of those consequences. Appendix I provides the detailed
discussion points from the leadership focus group.

Table 6. Impact Analysis Costs Without Consolidation or Costs of an Unsuccessful
Consolidation

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Resulting source of expenditure</th>
<th>Actual cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of CEO</td>
<td>Recruitment of new CEO</td>
<td>$150,000</td>
</tr>
<tr>
<td>Loss of one manager or director</td>
<td>Recruitment for leadership level – manager or director</td>
<td>$10,000</td>
</tr>
<tr>
<td>Hiring of new individuals to positions due to people leaving (based on average salary cost for director-pay band level)</td>
<td>Capacity to work @ 50% x first 3 months, 75% next three, leveling out at 6 months (pay x performance, % x months annualized) @ $200,000 annually</td>
<td>$37,500</td>
</tr>
<tr>
<td>Hiring of new individuals to positions due to people leaving (based on average salary cost for manager-pay band level)</td>
<td>Capacity to work @ 50% x first 3 months, 75% next three, leveling out at 6 months (pay x performance, % x months annualized) at $150,000 annually</td>
<td>$28,125</td>
</tr>
<tr>
<td>Hiring of new individuals to positions due to people leaving (based on average salary cost for frontline nurse pay).</td>
<td>Capacity to work @ 50% x first 3 months, 75% next three, leveling out at 6 months (pay x performance, % x months annualized) $90,000 annually</td>
<td>$17,875</td>
</tr>
<tr>
<td>Shutting of one of the smaller facilities</td>
<td>Severance costs for closed site (annual compensation) 2008/2009 year and severance 2 weeks per year of service, most rural facilities. LOS &gt; 20 years = 40 weeks: 40/52 = 76% of total annual compensation</td>
<td>$2,000,000</td>
</tr>
<tr>
<td></td>
<td>Annualized savings of closing facility – transfer of budget to funder resulting in no savings to Covenant Health</td>
<td>$0</td>
</tr>
<tr>
<td>One major litigation due to compromised quality</td>
<td>Average cost of paid settlements during fiscal year 2008/2009</td>
<td>$27,250</td>
</tr>
</tbody>
</table>

(continued)
Table 5 (continued)

| Community costs | Travel to next community with MD. Community specific, assuming everyone in the community saw the MD at least once a year and considering a smaller community where this realistically could happen, 1000 people would be traveling two ways at a cost of 0.435 per km to see an MD, between 20 and 70 kms, dependent upon the community. Therefore, 1000 x 50km x 0.435 | $21,750 |
| One household’s moving to another town or province or country | Loss of economic expenditure of one household (average household expenditure in Alberta) | $68,279 |
| Closure of emergency department | Loss of service, necessitating travel for urgent or emergency care (next facility > 70 kms x 2 ways x $0.435 x # ED/OPD visits (4500) Cost of ambulance transfer for the highest acuity patients to nearest facility. Cost per ambulance call (City of Calgary, 2009) $468.43 X 100 transfers. | $274,050 |
| Individual costs | Loss income and social status (determinant of health) | Difficult to monetize |
| Loss of well-being | Unemployment compensation for one person for one year at top level $457/week X 52 weeks | $31,990 |
| Other systems costs | Loss of tax payment to government impacting social programs = 25% of total compensation costs @ smallest facility. Average cost of Unemployment compensation per person X FTEs at smallest site | Difficult to monetize considering rehire potential |
| | | $687,500 |

Total

Identification of categories to organize the SROI Value map emerged as references were made to what likely would have happened had the merger not occurred. These results did not readily fit into the social value categories. Interestingly, there was a
strong correspondence of themes with the strategic directions of Covenant Health, which provided integration of the information into topics readily transferable to other reports previously developed. Table 7 depicts the SROI value map.

Table 7. SROI Value Map (October 2008 to October 2009)

<table>
<thead>
<tr>
<th>SROI indicators used</th>
<th>Total value year one</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   Human resource retention</td>
<td>$243,500</td>
<td>Cost for recruitment of CEO, director, manager, staff person Loss of productivity, one individual @ 4 organizational levels, orientation and build up of productivity over time</td>
</tr>
<tr>
<td>2   Service Provision</td>
<td>$3,130,412</td>
<td>Cost of loss of smallest facility Severance cost of total FTEs Travel costs for services previously provided on site. Loss of average household spending in one community Loss of taxation income to province</td>
</tr>
<tr>
<td>3   Quality</td>
<td>$27,250</td>
<td>Average cost of one litigation</td>
</tr>
<tr>
<td>4   Mission Fidelity</td>
<td>$4,000,000</td>
<td>Loss of grants to provide service to population with unmet needs (Seniors + Mental Health)</td>
</tr>
<tr>
<td>5   Community Engagement</td>
<td>$100,000</td>
<td>Loss of fund-raising prospect in one community</td>
</tr>
<tr>
<td>a. Annual social value created by CH</td>
<td>$7,501,172</td>
<td></td>
</tr>
<tr>
<td>b. Total investment year one</td>
<td>$1,090,000</td>
<td></td>
</tr>
<tr>
<td>Number of facilities</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Total investment per facility</td>
<td>$68,125</td>
<td></td>
</tr>
<tr>
<td>SROI at year one (b:a)</td>
<td>1:7</td>
<td></td>
</tr>
</tbody>
</table>
The SROI value, the Social Return on Investment ratio, is 1:7, demonstrating a positive return on the investment at the end of year one: a social gain of 7 dollars for every dollar spent.

**Relevance of SROI to Measure the Success of Consolidating Health Care Facilities**

Following the presentation explaining SROI and the initial two steps for SROI proxies, the participants provided their sense of the applicability of the SROI model and the functionality for the future use of this model. Most of the participants were positive about the application of SROI to measuring values added of the organization within a greater system (See Table 8). Appendix I includes a complete set of results.

**Table 8. Utility of SROI Method for Reviewing Covenant Health Consolidation**

<table>
<thead>
<tr>
<th>Question</th>
<th>Agreement x/n</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does this exercise of applying costs and benefits feel? Why?</td>
<td>Not quantifiable</td>
</tr>
<tr>
<td>Do you believe we have been able to identify financial measures or proxies that create a realistic picture?</td>
<td>8/9</td>
</tr>
<tr>
<td>Based upon these exercises, do you see any potential to plan for the future based upon information gathered today…? Does the exercise add value?</td>
<td>8/9</td>
</tr>
</tbody>
</table>

Qualitative data reveal the following common themes from participant responses regarding the applicability:

1. SROI was a many-layered process that raised some good questions and interesting issues.

2. More categorization might have helped to provide some structure to help with sorting.
3. Value-added exercise – the process provided a platform for looking at benefits of organizational structure; it was helpful to pause and identify trends and critical junctures in the consolidation.

4. Values-based decision-making and social return on investment will always be difficult to define and adequately represent as a concept.

5. Congruent with Covenant Health values, this method provided consideration beyond hard financials to include the soft dollar costs as well.

6. The process stretches one’s perspective more broadly.

7. It was not the traditional approach, but it did seem to represent good possibilities with regard to the organization.

8. More may be able to be extracted with further thought and assessment.

9. Direct financial impact can be quantified, but indirect impacts may be harder to ascertain. It is difficult to put a dollar value on benefits and difficult to allocate certain costs with regard to staffing, facility, boards, and committees to determine benefit cost.

10. It was somewhat subjective versus objective; therefore, ability to prove some of this is questionable; it represents only a best guess of what would happen, yet it is important to ponder.

Overall, the sentiment was that the exercise was useful and adaptable. Additional insights considered the opportunity to apply this method when considering a specific procedure or more readily quantifiable intervention within the health sector.
Chapter 5: Interpretations, Conclusions, and Recommendations

At the end of year one Covenant Health had attained a solid level of success, an overall 75% perceived success rate from internal stakeholders, based upon the preconsolidation goals and indicators acquired from the literature. Analysis of the level of success for each organizational goal provides information for future enhancement of success. Key areas of success, those indicators perceived as more than 80% successful, or as set by the executive team, the As of the report card, should be celebrated, and approaches designed to enable the success of these indicators should continue. These top marks were assigned to the following goals of consolidation:

1. Regarding the full category of revitalizing the mission and renewing the vision for Catholic health care, responses were highly favorable (85%):
   a. Renewing and continuing a legacy of responding to unmet needs (85%)
   b. Expanding the organization’s influence and being of greater service in communities throughout Alberta (81%)

2. In the third category of simplifying and streamlining relationships, participants perceived strong success for two of the three indicators:
   a. After coming together as Covenant Health and completing the first year’s work, being positioned to be a legitimate “Go to Provider” for Alberta Health Services (83%)
   b. Having a greater voice to shape and positively influence the health care system (87%)

3. For the measures identified as points of success for Canadian health care mergers there were some additional successes:
a. Covenant Health Executive has developed a strong and positive team (80%).

b. Covenant Health has built a strong vision (90%).

If the results are adjusted to measure only those with perspective on the success level by removing those that do not know, there is a slightly different picture; a much more favorable result. This would presume the same pattern would emerge should these participants know and respond in a similar break down. This would not be the case if all those who indicated they did not know actually had a higher percentage of disagreement than the group who indicated they were aware and either disagreed or agreed to some level. Regardless, by both measures, success at year one for Covenant Health has been realized from an internal stakeholder perspective.

These beginning strengths create a strong foundation for a solid vision and organizational direction. This research demonstrates success, as internal stakeholders perceive the reach for predetermined goals. The results do not reflect nor can they represent a population beyond the population involved in this study; however, recognizing that the research was internally focused, a possible future study to determine how the external stakeholders and communities perceive the success of the new organization could create new perspectives for Covenant Health. A study focusing upon feedback from the Alberta Health Services, the Alberta government and associated ministries’ perspective of accomplishments would assist the executive in understanding where they could further develop in the future.

The areas for recommended focus during year two include those observed to have less than 60% of participants identifying success, or those observed to have 20% or
greater disagreement that Covenant Health (CH) succeeded in meeting the predetermined goals. These areas include the following:

1. Leveraging the strengths of all facilities. There was only 57% agreement in this regard.

2. Leaders’ connecting routinely throughout the whole organization. A fourth (25%) of all participants disagreed that CH was having success in doing so, whereas only 59% agreed.

3. Success at beginning clinical integration throughout the organization. Agreement was measured at only 45%.

4. Building strong connections between boards and communities. There was 41% agreement from participants regarding success in this category.

When adjusted to remove the do not now response category, these indicators also improve dramatically but they continue to represent the lowest agreement responses and so produce the greatest area for course correction. Attention to developing action plans to address these concerns is fundamental for the continued success of this consolidation.

The third area that provided concern relates to the percentages of participants that indicated they did not know. When over one quarter of the people providing feedback do not know and are unable to measure success, one must wonder why they do not know: Were they disengaged with the organization or did they simply not have enough information to make a choice regarding how successful CH had been in specific areas? The fact that these individuals were participating in the research indicates that they were engaged. This leads one to believe that communication of key information was less than optimal. Multiple comments provided by participants indicated communication was an
elemental need that was currently not occurring to the degree warranted for the changes. Specific areas of concern in this category included the following:

1. With regard to whether or not Covenant Health was building strong connections between the boards and the communities where facilities were located, 49% did not know.

2. With regard to whether or not Covenant Health was beginning to develop clinical integration across sites and sectors, 36% of participants did not know.

3. With regard to the success of Covenant Health in building a sense of engagement with stakeholders and communities, 30% were unaware of the level of success.

An interesting observation is that the overall success noted by the participants was much higher in those goals predetermined by the Governing Board than those identified in the literature as consistent factors for successful mergers: 75% compared to 63%, respectively. One might conclude this phenomenon occurred because these were the areas of focus for the leadership team, and therefore prioritized at the expense of potential for considering others; in fact, the leadership team did not explore the literature to determine what specifics could have been attended to during the coming together of 12 organizations. Regardless of that gap, CH appeared to have enjoyed a very positive first year.

Reflecting upon the Jean-Louis Denis (as cited in CHSRF, 2000) recommendations of areas for newly merged organization, Covenant Health (CH) had attained some success in each of the areas he predicted as needed for successful consolidation. Unfortunately, CH attained an A grade with only one of these hallmarks at
year one. Top marks were given for CH with regard to “attend[ing] to team building of the executive team to build a sense of collegiality and trust, resulting in improved cooperation during challenging points” (CHSRF). As noted earlier, attention is required to improve success in the other three crucial requirements:

1. Consistently connect the leadership team with people throughout the entire organization to produce confidence, clarity of roles, and rules of engagement.

2. Through micromergers, develop clinical integration to unite departments across the organization. Success of these micromergers creates important symbols for the new organization.

3. Win community support through strong connections between the board and the area people; together build a strong vision and sense of engagement (CHSRF, 2000).

Finally, recognizing the need to attend to cultural components during amalgamations was also touted as critical to ongoing success of mergers (CHSRF, 2000); in this research, the respondents noted that culture reflects organizational pride and that individual connection to the internal culture results in improved retention and sense of belonging. Although this survey did not measure culture, several comments emerged from the participant responses indicating concerns about maintaining previous identity and degree of independence from Corporate. There was also a mention of “us versus them” or the site versus Covenant Health, which speaks to a lack of a sense of belonging to the greater organization.

Analyzing the findings, recognizing the implications, then determining key recommendations provides a road map for year two for Covenant Health. Based upon the
internal perception of meeting the objectives of the consolidation there are specific areas for concrete actions. Three recommendations for future work include the following:

1. Concentrate on those areas considered weak with the intent to improve both communication of strategies and knowledge as well as to create higher levels of success for targeted goals.

2. Discern present or emerging cultural components and attend to developing a cultural shift that will result in a strong sense of pride and a desire to be attached to the organization.

3. Determine the perceptions of external stakeholders regarding success of indicators.

In addition, meeting a level of success for the predetermined goals was a significant accomplishment but the achievement must also consider the cost of that success. If the goal accomplishment puts the organization at risk financially, the future of the organization will be in jeopardy. Success measures that consider financial return on investment provide another lens through which to define success of the amalgamation to better define the cost benefit of consolidating the 16 facilities to one. The next portion of this chapter presents discussion of the financial state of the union at year one.

**The Cost Benefit of Consolidation - Social Return on Investment**

Neil Roberts, a health care merger expert, stated, “You need to have a lot of wires that don’t completely touch to believe you can merge two institutions and not come up with start up costs” (CHSRF, 2000). Covenant Health, however, works within a not-for-profit, public system that creates limited ability to free up funding to ensure the availability of adequate finances for the transformation of 12 organizations into a
singularity, across a large geographical distance. Because of the pressure to keep costs minimized, those within the organization often take on the additional work without additional resources, thereby generating concern about burnout and potential loss of key leaders from the organization early in the redevelopment.

Considering how to represent the return on investment is a complex decision. Finding an adequate tool to consider more than just financial investment and dollar benefit, but inclusive of these relevant measures, is important for understanding, reporting, and future planning. To this end, developing an SROI ratio provides a numerical understanding of the cost benefit of the consolidation beyond the traditional ROI or cost or the investment against the financial gain of the change. This ratio compares cost to change to the social value gained through an intervention. The social value is defined as that which would be lost if that intervention did not occur. Although this ratio represents an objective measure—one readily understood by board members, investors, and funders—the distillation of those values to a financial exercise diminishes the poignant and expressive values that convey the true depth and breadth of the implications of the transformation. The human side of the value added to the system, which produces the abiding understanding of the absolute benefits, is revealed through both the process of mapping the value as well as in the categorization of each benefit. In reducing these benefits to a numerical factor, the reader may not have a clear sense of the full impact—the human elements that provide an emotional connection to the outcome; however, the representation provides an initial step to open the discussion of greater social value.
Social value defined in five spheres—cost reallocation, cost saving, tax producing, individual gain, and improved household income—focus the leadership discussion to determine value added (City of Calgary, 2009). One specific area of social value that is inferred but not actually captured in these five spheres is cost avoidance. This particular study demonstrated people’s perspective that a cost benefit was realized by avoiding actual cost spending, for example, keeping an intact senior team for the entire first year prevented an additional cost of recruitment and loss of productivity. From an organizational perspective, this is better represented as cost avoidance because the dollars to recruit and the impact of loss of productivity to the organization were never in the budget. In fact, if this had become reality, funds from other areas may have been required to be reallocated to develop a recruitment and orientation support. Consideration of cost avoidance in a public system produces alternative usage for tax dollars, so from a total system perspective, one could dispute that this is cost savings at a higher level.

In this study, key discoveries are both positive, what was accomplished through the consolidation, and negative, the impact should this amalgamation not have occurred. Interestingly, surfacing themes have some affinity to the strategic direction of Covenant Health (CH). The SROI demonstrates that Covenant Health was very efficacious with resources to provide necessary support for the amalgamation. The cost-benefit analysis shows a strong positive ratio of 1:7, indicating a positive variance of return on investment. Considering that many organizations require time to develop a positive ratio, this was a terrific first year financial endpoint. Schroeder (2009) cited a survey of senior business executives from the Economist Intelligence Unit, which indicated that over 50%
of change initiatives and transformations fail; consequently, to have such a major transformation realize a positive SROI at the end of year one is remarkable. Covenant Health has been successful in both the realization of goal attainment, perceived by internal stakeholders at an overall 75% rate of success, and a positive SROI.

The discussion with the focus group to determine the metrics for social values and the financial proxy was quite arduous and complex, circular at times, repetitive and time consuming. Upon completion, the individuals were reasonably positive about use of the model; however, some were not sure if they had captured all the potential social value. Therefore, a sense of uncertainty prevailed about the completeness of the representation of the final ratio.

Furthermore, there was no precise financial application, but rather estimates and assumptions, which introduced a level of subjectivity. Developing consistent objective, standardized, and widely accepted measures would assist in improving the credibility of the applications in similar situations. In addition, keeping a centralized log of projects and implications would assist in developing consistency and objective indicators and measures as a referral base for others. While this has begun in the Calgary application, the financial measures are related largely to social system application rather than healthcare and are limited in numbers. Some could be transferable but there are also health specific societal measures that need consideration. Creating a similar repository for health would provide consistency as individuals apply SROI on a variety of projects that would also help decision makers gain a greater understanding of the system implications for determining dollars to be allocated.
An additional finding was the congruency between the impact themes of the leadership focus groups and the strategic directions for the new organization. The five strategic directions included (a) live the organization’s mission and values in all that is done, (b) build and engage the organizational team, (c) continuously improve quality and safety, (d) respond to those in need, and (e) engage and work with community (Covenant Health, 2009). Categorizing the value added, or potential value lost, into these groupings also promotes an organizational fit for future SROI framing.

Although this singular numerical representation demonstrates an objective measure regarding cost benefit, the ratio falls short of telling the entire story and actually diminishes the full implication and impact of the consolidation; however, the calculation provides instant clarity regarding the significance of the social impact of the mission. The calculation quickly captures the attention of the audience and creates the desire to learn more, thereby providing a bold and potentially controversial vantage point for introduction to the greater discussion. The intrinsic value of considering SROI lies in the discussion; therefore, arousing the curiosity of an individual is essential to the process.

SROI method may be considered soft or vague and over time and as external environmental change modifies social requirements, the initial results may be less relevant year over year. We live in an extremely dynamic system with multiple intersecting influences and those effects change over time dependant upon multiple factors. While SROI provides a more complex cost benefit analysis considering the greater social benefit of a specific change, the evolution of the system continues to affect the return over time. For example, if the value-add of the SROI is reduced because of other options or if public pressure demands a different approach, then the change will
become irrelevant or less useful. Proactively, if there was regular review to monitor both external influences and the routine appraisal of the ongoing return, the evaluation provides leaders with the ability to also shift and change in response to external effect.

Some additional challenges with this particular application of SROI are related to the ability to determine what financial success should be included in the review; some initiatives were well underway by the end of the first year but did not actualize until after the recognized date of October 7, 2009. Multiple dates could have been perceived as marking the anniversary. Three dates provided milestones in the consolidation process: (a) the announcement date, October 7, 2008, when the 16 facilities came together to form one organization, with the initial legal steps in place to provide governance of one single board; (b) the missioning date, February 9, 2009, when the board and CEO were blessed and vowed to do this work of the Catholic Church; and (c) the legislative date, April 1, 2009, which provided legal recognition of Covenant Health as a lawful entity under the provincial authority. The determination of defining the year was less important than providing consistency of the mark throughout the organization. From a fiscal aspect, further measuring complexities arose, as fiscal year definition was April 1 to March 31; therefore, measurement of SROI at the anniversary date of October 7, represented half of the previous year and half of the current year, resulting in potential confusion with year-end statements. If reviewers were aware of this aberrancy, the actual measure was still usable. As CH continues to integrate successfully, there may be future alternatives to line up SROI measurement with other major financial annual milestones.

Some emerging thinking as the material was presented in different venues considered the multiple applications within healthcare. Some queried the ability to
formalize the cost savings so there was specific opportunity to reduce spending or clearly demonstrate reallocation of the money to alternative services. A repetitive theme in healthcare relates to implementing change with a goal to produce a savings without deliberately recapturing those savings and therefore not being able to provide evidence of the saving, nor ability to reallocate funds. The belief in healthcare is many times achieving savings occurs slowly and incremental over prolonged periods and therefore difficult to recapture. A process that planned to deliberately capturing savings post change could provide solid evidence of the gain from investment as well as provide opportunity for intentional reallocation of the savings to another area that would once again produce savings becoming perpetual funding for new initiatives. This method of paying forward savings could serve to demonstrate an even greater social return. If the trend is for higher social accountability, SROI provides one technique to express benefit beyond traditional methods. The method provides a total picture approach to evaluate and demonstrate a more significant contribution of a specific change producing greater understanding of both the project and the outcomes.

Utility of SROI and Covenant Health

Most of the focus group agreed that going through the process of considering the consequences of not being united into one organization was both useful and enlightening. Taking the opportunity to reflect upon the history and anticipated events that were avoided was beneficial and enlightening to the group. While identifying a complete list of cost savings, avoidance or reallocation was arduous and likely felt to be totally complete at some points, however, participants felt considering the journey and discussing the perceived positive outcomes was very valuable.
Recommendations for future use of SROI within Covenant Health are as follows:

1. Determine if the measure is useful to the board and leadership for future application and define specifics of expectations, for example, frequency and drill-down levels.

2. If recommendation one is affirmed, establish who will coordinate this work and develop consistent approaches for SROI procedures, as well as begin to develop and list standardized monetized indicators with consideration for inflation factor.

3. Establish proficiency within or contract out to experts in the field, as projects or year-end measures require.

The Covenant Health team should be quite pleased with the level of success at year one for both consolidation goals as well as the demonstrated financial affirmation of investment. Future work focused upon areas of less success and attention to the cultural dynamics will provide clear direction to continue building on the current success rate. Further demonstration through application of SROI offers a consistent reporting method to the board and organization; thereby developing greater understanding of implications of dollars spent and returned social value.
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Appendix A: Participants Consent Letters for Three Phases of Study

Covenant Health – One Year in Review
Information Sheet – Phase One

Background:

One year ago, Covenant Health emerged as a new health care entity in Alberta following the consolidation of 16 Catholic health care facilities in October 2008, Missioning in February 2009, Legislative recognition in April 2009, and Royal Assent in June 2009. Reflecting on this developmental year provides opportunity for determining success of the amalgamation and prospective growth and improvement for the following year.

Project: “Consolidation of Covenant Health: One Year in Review”

Principal Investigator: R. Sheli Murphy.

Purpose:
This study will provide a review of the merger and the social contribution Covenant Health is making in the health care industry within Alberta to determine what areas Covenant Health should focus on for the following year to improve the merger as well as level of social contribution through application of the Social Return on Investment Model.

Procedures:

This study has three phases to completion; you have been asked to participate in Phase one:

Phase 1: Confirming and Defining the Indicators to Measure Success

Conducted through one-on-one interviews either by phone or through face-to-face meetings of approximately 15 to 30 minutes in duration.

The benefit of this information will be in validating the preconsolidation goals. There are no personal benefits or identified risks.

Your responses are kept confidential and anonymous; however, respondents are grouped according to three groups: Past CEOs, Past Board Chairs and Senior Leadership. All personal identifiers will be removed from the documents prior to storage and within the report. Any quotes used will be referenced as to study phase and group you are in. The report will be public, and details could be shared widely within Covenant Health.

The results will be stored in a locked case in room IW141 Covenant Health corporate offices and accessible by R. Sheli Murphy, for 5 years (May 2015). If at any time you are uncomfortable with the process or the information you have shared, you may withdraw your consent and participation. If you have any questions as to your participation or the process, please do not hesitate to contact me – R. Sheli Murphy at 780-498-1454.
If you have any concerns about any aspect of this study, you may contact Covenant Health at 780-735-7494 or HREB at 780-492-0302. These offices have no direct affiliation with the study investigators.

**Phase one: Covenant Health – One Year in Review**

**CONSENT FORM**

<table>
<thead>
<tr>
<th>Part 1 (to be completed by the Principal Investigator):</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Title of Project: Covenant Health – One Year in Review</td>
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<tr>
<td>Principal Investigator: R. Sheli Murphy</td>
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<tr>
<td>Phone Number: (780) 498-1454</td>
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<tr>
<th>Part 2 (to be completed by the research subject):</th>
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<tr>
<td>Do you understand that you have been asked to be in a research study?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>Have you read and received a copy of the attached Information Sheet?</td>
<td>☐ ☐</td>
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<tr>
<td>Do you understand the benefits and risks involved in taking part in this research study?</td>
<td>☐ ☐</td>
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<tr>
<td>Have you had an opportunity to ask questions and discuss this study?</td>
<td>☐ ☐</td>
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<tr>
<td>Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your future?</td>
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<tr>
<td>Has the issue of confidentiality been explained to you?</td>
<td>☐ ☐</td>
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<td>Who explained this study to you?</td>
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</table>

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject: ___________________________ / ___________________________ (Print Name)

Date: ___________________________

Signature of Witness ___________________________
Background:  
One year ago, Covenant Health emerged as a new health care entity in Alberta following the consolidation of 16 Catholic health care facilities in October 2008, Missioning in February 2009, Legislative recognition in April 2009, and Royal Assent in June 2009. Reflecting on this developmental year provides opportunity for determining success of the amalgamation and prospective growth and improvement for the following year.

Project: “Consolidation of Covenant Health: One Year in Review”

Principal Investigator: R. Sheli Murphy.

Purpose:  
This study will provide a review of the merger and the social contribution Covenant Health is making in the health care industry within Alberta to determine what areas Covenant Health should focus on for the following year to improve the merger as well as level of social contribution through application of the Social Return on Investment Model.

Procedures:

This study has three phases to completion; you are being asked to participate in phase two.

Phase 2: Internal Stakeholders Define Level of Success

Conducted through surveys, multiple choice with opportunity to provide comments either electronically or on paper, taking approximately 30 minutes.

The benefit will be organizational, and your responses will help identify areas for improvement in Covenant Health over the next few years. There are no direct benefits or risks to you as participant.

Participating and returning the survey will indicate your consent to use the information you have provided; this demonstrates “implied consent.” Your responses are kept confidential and anonymous; however, respondents are grouped according to groups, Urban Acute, Urban Rural, Senior Leadership, Rural Staff and Physicians, Rural Board Members and Governing Board as well as Formal Leadership. All identifiers will be removed from the documents prior to storage and within the report. Any quotes used will be referenced as to study phase and group you are in. The report will be public, and details could be shared widely within Covenant Health.

The results will be stored in a locked case in room IW141 Covenant Health corporate offices and accessible by R. Sheli Murphy, for 5 years (May 2015). If you have any questions as to your participation or the process, please do not hesitate to contact me – R. Sheli Murphy at 780-498-1454. If you have any concerns about any aspect of this study, you may contact Covenant Health at 780-735-7494 or HREB at 780-492-0302. These offices have no direct affiliation with the study investigators.
Background:
One year ago, Covenant Health emerged as a new health care entity in Alberta following the consolidation of 16 Catholic health care facilities in October 2008, Missioning in February 2009, Legislative recognition in April 2009, and Royal Assent in June 2009. Reflecting on this developmental year provides opportunity for determining success of the amalgamation and prospective growth and improvement for the following year.

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Principal Investigator: R. Sheli Murphy.

Purpose:
This study will provide a review of the merger and the social contribution Covenant Health is making in the health care industry within Alberta to determine what areas Covenant Health should focus on for the following year to improve the merger as well as level of social contribution through application of the Social Return on Investment Model.

Procedures:
This study has three phases to completion; you have been asked to participate in Phase Three

Phase 3: Determine SROI of the Merger

Conducted through a focus group setting for approximately 180 minutes.

There are no direct benefits or no direct risks to you as a participant.

Your responses are kept confidential and anonymous by the researcher; however, I cannot guarantee other participants in the focus group will do so. All identifiers will be removed from the documents prior to storage and within the report. Any quotes used will be referenced as to study phase and group you are in. The report will be public, and details could be shared widely within Covenant Health.

The results will be stored in a locked case in room IW141 Covenant Health corporate offices and accessible by R. Sheli Murphy, for 5 years (May 2015). If at any time you are uncomfortable with the process or the information you have shared, you may withdraw your consent and participation at that time without any concern of reprisal. If you have any questions as to your participation or the process, please do not hesitate to contact me – R. Sheli Murphy at 780-498-1454. If you have any concerns about any aspect of this study, you may contact Covenant Health at 780-735-7494. This office has no affiliation with the study investigators.
Covenant Health – One Year in Review

CONSENT FORM

Part 1 (to be completed by the Principal Investigator):

Title of Project: Covenant Health – One Year in Review

Principal Investigator: R. Sheli Murphy

Phone Number: (780) 498-1454

Part 2 (to be completed by the research subject):

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Do you understand that you have been asked to be in a research study?</td>
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<tr>
<td>Have you read and received a copy of the attached Information Sheet?</td>
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<td>Has the issue of confidentiality been explained to you?</td>
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Who explained this study to you?

_____________________________________________________

I agree to take part in this study: YES ☐ NO ☐

Signature of Research Subject: _______________________ / ____________________

(Printed Name)

Date: ______________________________

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT.
## Appendix B: SROI Template

<table>
<thead>
<tr>
<th>Covenant Health</th>
<th>SROI Evaluation</th>
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<tbody>
<tr>
<td>Stage One</td>
<td>Establishing Scope and Identifying Stakeholders</td>
</tr>
<tr>
<td>Establishing Scope</td>
<td>1.1 Initial Scoping</td>
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<tr>
<td></td>
<td>What do you want to measure?</td>
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<tr>
<td></td>
<td>Are you an independent researcher or do you work within the project area or organization you wish to study?</td>
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<tr>
<td></td>
<td>Why do you want to begin this project now?</td>
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<td>For whom is the analysis?</td>
</tr>
<tr>
<td></td>
<td>1. Revitalize the mission, pursue a renewed vision for Catholic health care</td>
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<tr>
<td></td>
<td>1.1 Since the formation of Covenant Health, the mission for Catholic health care has been renewed.</td>
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<tr>
<td></td>
<td>1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs.</td>
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<tr>
<td></td>
<td>1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province.</td>
</tr>
<tr>
<td></td>
<td>2. Leveraging the strength of all 16 facilities</td>
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<tr>
<td></td>
<td>2.1 Covenant Health is leveraging the expertise and knowledge from all sites.</td>
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<td>2.2 During this 1st year as Covenant Health, enhanced stewardship and accountability is occurring.</td>
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<td>2.3 Because of coming together as Covenant Health, effective governance and management is facilitated.</td>
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<td></td>
<td>3. Simplify and streamline relationships</td>
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<tr>
<td></td>
<td>3.1 Coming together as Covenant Health, and through this 1st year’s work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services</td>
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<tr>
<td></td>
<td>3.2 Being together as Covenant Health, we provide a greater voice to shape and positively influence the health care system.</td>
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</tbody>
</table>
3.3 Creating Covenant Health provides a single point of accountability for quality and health service delivery

Greenleaf University dissertation committee

What is the timeframe for the analysis?
Three months: at anniversary and during first quarter of Year 2

What resources will be required and are these available?
Access to participants; SROI consultation group to determine cost implications of indicators

1.2 **What will you measure?**

What are the activities for which you want to determine an impact?

<table>
<thead>
<tr>
<th>Year One Measures</th>
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</thead>
<tbody>
<tr>
<td>Determine/validate pre-consolidation goals</td>
</tr>
<tr>
<td>Measure success of meeting predetermined goals</td>
</tr>
<tr>
<td>Define additional measure points based upon literature from Canadian health care mergers</td>
</tr>
<tr>
<td>Recognition of the opportunity through consolidation to establish a bold and innovative direction for Catholic health care in Alberta</td>
</tr>
</tbody>
</table>

Likert Scale 1 = *do not know*, 2 = *strongly disagree*, 3 = *disagree*, 4 = *agree*, 5 = *strongly agree*

1. Covenant Health Executive has developed a strong and positive team.
2. The Covenant Health leadership team connect routinely with people throughout the entire organization.
3. Covenant Health is beginning to develop clinical integration across sites and sectors.
4. Covenant Health is building strong connections between the boards and the communities where facilities are located.
5. Covenant Health has built a strong vision.
6. Covenant Health is building a sense of engagement with stakeholders and communities.

Determine what the implications are for facilities and province if no consolidation occurred OR if consolidation unsuccessful

Working with invited leadership group, present SROI method and then through discussion determine the “costs” if Covenant Health did not occur, or if it was unsuccessful.

Analyze utility of using SROI methodology for ongoing cost/benefit analysis of new organization and/or other applications.

At the leadership invitee meeting (phase three), determine if the method (SROI) is helpful and useful for future considerations.
1.2.2 Describe intended participants

Governing Board Members
Senior Executive Team
Leadership Team
Rural Community/Foundation Board Members
Rural Staff and MDs
Urban Staff and Physicians

1.2.3 Over what time period will the social returns be measured?

First year of Covenant Health operations.

1.3 Checklist

Do the Board and Senior Management Team support the SROI analysis? Yes

Is their agreement that internal or external resources will be made available? Internal stakeholders identified above. External SROI expert (Stephanie Robertson)

Have you obtained agreement about which areas of work the analysis should cover? Yes

Has background information been collected on the organization (or project), including how it operates and who the key participants are? Yes

1.4 Identifying Stakeholders

Construct a comprehensive list of stakeholders Define and list names
Define and list names of indirect beneficiaries
Who contributed to the coming together of Covenant Health?
Identify who else is effected by the merger

Determine who is included and who is excluded from the stakeholder list Internal stakeholders with whom researcher has access to face-to-face or through e-mail included
Excluded are external stakeholders (at this time).

Choose which of these stakeholders are key to the SROI analysis Prioritize and randomize who will be consulted for the initial exercise.
One-on-one interviews to learn of key stakeholders’ goals and objectives

Validate questions that reflect pre-consolidation goals for Covenant Health and any additional goals beyond Covenant Health; based upon these, what is important to measure in the SROI analysis?

Collect information about the goals and objectives.

Group and prioritize goals based upon frequency of repetition. Develop survey and presentation. Approval from CEO and VP Planning

Develop Stakeholder Engagement Plan.

At Senior Leadership Team meeting, have executives provide direction to engagement groups.

Electronic real time instrument for instant feedback

Greater leadership team at Retreat

Manual completion of survey

Rural board members at sites

Manual completion of survey

Rural staff and MDs at sites

Zoomerang Web survey, via e-mail

Governing Board

Zoomerang Web survey, via e-mail

Urban Acute/CC Staff & MDs

SROI indicator measure SROI utility of application

Leadership invitees Leadership invitees

<table>
<thead>
<tr>
<th>Stage 2</th>
<th>Mapping Outcomes</th>
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<tbody>
<tr>
<td>2.1</td>
<td>Start impact map</td>
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<tr>
<td>2.1.1</td>
<td>Identify corporation and objective of that corporation</td>
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<td></td>
<td>Review documents proceeding amalgamation, distill goals of consolidation. Interviewing key stakeholders to validate foci</td>
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<tr>
<td>2.2</td>
<td>Identifying inputs</td>
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<td>Determine what stakeholders are contributing to make a specific activity happen.</td>
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<td>Work with finance to determine costs invested in specific activities.</td>
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<td>2.3</td>
<td>Valuing inputs</td>
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<td>Implications if Covenant Health would not have come into existence</td>
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<td>Social values</td>
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<td>Facility implications</td>
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<td>Greater Catholic health care provision implications</td>
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<td>2.4</td>
<td>Clarifying outputs</td>
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<td>Determine consequences</td>
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<td>Group discussion of themes with considerations aligned with themes and determine financial measurables.</td>
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<td>2.5</td>
<td>Describing outcomes</td>
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<td></td>
<td>Determine utility of SROI in this set of circumstances</td>
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<td>Group discussion and survey completion</td>
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<tr>
<th>Stage 3</th>
<th>Evidence outcomes and giving them value</th>
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<tr>
<td>3.1</td>
<td>Developing outcome indicators</td>
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<td>Based upon value map and clarified outputs and outcomes.</td>
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<tr>
<td>3.2</td>
<td>Collecting outcomes data</td>
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<td></td>
<td>Use value of one as quantifying potential</td>
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<td>3.3</td>
<td>Establishing how long outcomes last</td>
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<td></td>
<td>Outcome measure to be one time and annual based</td>
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### Stage 4  Establishing Impact

| 4.1 | Deadweight and displacement |
| 4.2 | Attribution |
| 4.3 | Drop-off | See Phase three results |
| 4.4 | Calculating your impact |

### Stage 5  Calculating SROI

| 5.1 | Projecting into the future |
| 5.2 | Calculating net present value |
| 5.3 | Calculating the ratio | See Value Map and SROI ratio |
| 5.4 | Sensitivity analysis |
| 5.5 | Payback period |

### Stage 6  Reporting, embedding, and assurance

| 6.1 | Reporting to stakeholders |
| 6.2 | Using the results | TBD with Executive team |
| 6.3 | Assurance |

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**Source Documents:**

2. Enhancing the Roles of ACHC & Member Organizations in a Regional Health: Introducing a Single Governance Model for Catholic Health Service Providers in Alberta. (2007, July).
5. Transition to Covenant Health Debrief. (n.d.).
Appendix C: Procedure and Questions Form for Phase One

Gretel Pepper to call and ask randomly selected individuals if they wish to participate in Phase One of Sheli’s PhD Research project. This initial phase is to validate success indicators. These indicators were adopted early in the consolidation of the 16 facilities. If they agree to discuss, set up appointments for discussion regarding “Hopes of Consolidation” by phone or face-to-face.

At meeting –
1. Sheli Murphy to explain project
2. Face-to-face, provide project information and ask for consent to be signed.
3. If done over the phone follow up to get a signed consent and provide information sheets.
4. Three questions will be asked and responses recorded by Sheli.
5. Sheli will read back responses captured and confirm they are correct, clear and represent the participant’s point of view.
6. Additional comments will be elicited.

Questions for reflection:

1. Reflecting back upon the consolidation of the Catholic Facilities in Alberta, I am asking you to identify the top two goals or benefits of coming together.

2. What was your personal goal of this union?

3. Considering the benefits you have identified, can you identify the consequence if the consolidation would have failed?

Additional Comments:
Appendix D: Power Point Presentation and Participant Survey for Phase Two
This morning I would like to take a bit of a journey backward in time with you, visit some key goals, and evaluate how well we have done.
End Goals of this Study

• Measuring success of the Covenant Health coming together at ‘Year One’…celebrate our success!
• To determine areas for improvement for the next year.
• Determine the value of the consolidation to the people of Alberta.

The total research project involves multiple layers of work. Measuring success of the Covenant Health coming together at ‘Year One’ is one portion and I so much appreciate your input…..we will use this information to determine areas for improvement for the next year to further enhance our success. The final portion will be to attempt to determine the value of the consolidation to the people of Alberta.
The journey backwards starts over two years ago as specific events that called us to action and provided opportunity for change. There were concurrent events that provided context. Patrick provided key milestones of this first year yesterday. And, I will be reviewing some detail pieces today...

As well I would like to review the proposed benefits and goals for our coming together as key players anticipated a year ago and to share with you evidence of what some research shows key points of what good mergers need to be successful.
One Year Ago

“Covenant Health will positively influence the health of Albertans and be of greater service to those in need by working together with compassion, quality and innovation”

One year ago and two days, the organization emerged with a clear vision soon after our consolidation.
Precipitating Events

1. Quality and financial issues

2. Maintenance of Governance and Management expertise

3. Relationship breakdown with regional partner and Bill 48

The journey begins in March of 2007 when St. Joseph’s hospital was reported to have exposed patients to potential infection risks because of improperly sterilize equipment, as well there was an increase in MRSA cases in the facility and the community.

Secondly, there were challenges with financial support/management at some other facilities, Youville worked to open new beds in a new facility, and then were asked to keep the old beds open, without adequate resources to carry out both. The Youville Board, in January 2008, under the leadership of Mr. Dale Rokosh, explored a few alternatives. Believing in the benefits of remaining connected Catholic roots, the board chose to build a solution with Caritas Health Group, a sister facility.

St. Mary’s Camrose, experienced a major deficit some of which was driven by misunderstanding of what the region agreed to fund through out the year. Some believed the facility would do better, would have a greater opportunity to serve the community, if the region took over operation of the facility….continuing to run as a Catholic facility was in jeopardy.
The relationship breakdown with ECH region and the voluntaries generated government intervention and the board of the region was dissolved and two administrators were appointed to manage the region. Working closely with ACHC, the voluntary boards were released and a consolidated interim board and interim leadership team for the four catholic facilities of east central was brought together and work began on strengthening the four facilities by bringing them together, and working to resolve issues between the region and the sites.

In Nov. 2007, the Minister of Health, Dave Hancock, introduced Bill 48. This bill at introduction virtually cancelled the Master Agreement previously signed in 1994 which provided health regions and faith-based facilities with means and direction to negotiate service agreements in good faith.

Bill 48 as proposed, removed negotiation mechanisms and replaced them with a unilateral process of Ministerial discretion and the ability to assume the operations and assets of a faith based organization based on an opinion rather than fact and due process.

As well the Bill allowed the minister to interfere in determining governance of voluntaries and appointment of medical staff.

This Bill permitted, RHAs to direct Faith based service providers with no consideration for ethical or mission fidelity concerns, or with any responsibility to provide adequate resources. Of course this raised concerns around potential loss of ability for voluntaries to provide quality care or reasonable work environments. In short….this bill, as it was introduced, threatened the very existence of faith-based health care in Alberta.

All of these events, created the need and the urgency for change.
In June 2007 during the turmoil within some Catholic facilities, CEOs and Board Chairs met. Initially they met to open discussions about the issues that beset many of the sites:

1. Not clear about the value added - real difference
2. System Integration = assimilation
3. Executive churn resulted in underachieving
4. Underdeveloped strategic partnerships.

In June 2007 during the turmoil within some Catholic facilities, CEOs and Board Chairs met. Initially they met to open discussions about the issues that beset many of the sites:

There was a sense of not being confident or clear in what value they added to the system. Increasing integration with the region raised concerns of assimilation...resistance is futile!!! Some sites suffered from churn at the senior levels resulting in a failed expectations of leadership at sites. Because leaders were always turning over, strategic partners were not nurtured or developed.
Many sites did not feel they had the capacity/resources to do the work and do it to the level the leaders wanted to. The Alberta government announced May 15, 2008, they will consolidate the province's nine regional health agencies into one. The new body also integrates the Alberta Cancer Board, the Alberta Mental Health Board and the Alberta Alcohol and Drug Abuse Commission. The hoped for benefit from the move of streamlining the administration of health care to redirect the savings to front-line services (CBC, May 29, 2008).
In May of 2008, the ACHC sponsored facilities came together to build a solution. Those in crisis during the previous year, had already sought alternative courses, but in light of Bill 48, and ongoing difficult discussions with the minister and ADM of Health, others became aware of their susceptibility and were seeking alternatives. The end result was an agreement to consolidate as one organization to mitigate risk, leverage strengths and provide and ability to establish a renewed unified vision.
So our life together really began in August 2008, post summits. Bishops Decision to support the consolidation of all the Catholic Health Facilities in Alberta previously sponsored by ACHA occurred in August 2008. Appointment of CEO, Patrick Dumelie also in August 2008. Formal announcement to key stakeholders and public October 2009 and the new organization was launched. Announcement of the Leadership Team October 2009.
Key Milestones

Development of vision, mission and values for the new entity Nov 2008
Board Orientation and clarification of Governing Board/Community Board roles and responsibilities Dec 2008
Missioning and formal commitment to the Church by the leaders (Board and CEO) to carry on the healing ministry of Jesus Christ Feb 2009
Formal confirmation of the next level of structure Feb 2009
Strategic directions approved April 2009

Development of vision for the new entity by the Sponsors and Board Nov 2008
Missioning and formal commitment to the Church by the leaders (Board and CEO) to carry on the healing ministry of Jesus Christ February 2009
Formal confirmation of the next level of structure Feb 2009
Board Orientation and clarification of Governing Board/Community Board roles and responsibilities Feb 2009
Strategic directions planning begins Feb 2009
Key Milestones

Leadership Retreat May 2009
Private Members Act passed in June 2009 (retro to April 2009)
Readjustment of Senior Leadership Team roles (June 2009)
Strategic Framework roll out (June 2009)
Site Celebrations and Missionings of sites from May to September 2009

Private Members Act passed in June 2009 (retro to April 2009)
Leadership Retreat May 2009
Readjustment of Senior Leadership Team roles (June 2009)
Strategic Framework roll out (June 2009)
Site Celebrations and Missionings of sites
Goals of Consolidation

I. Revitalize the mission, pursue a renewed vision for Catholic health care
   i. Renew and continue a legacy of responding to unmet needs
   ii. Expand our influence and be of greater service in communities throughout the province

Three major goals emerged and specific objectives were developed to define expectations for this new organization....
First to Revitalize the mission, pursue a renewed vision for Catholic health care, how:
Renew and continue a legacy of responding to unmet needs
Expand our influence and be of greater service in communities throughout the province
Goals of Consolidation

II. Leverage the strength of our 16 sites
   i. Leverage the expertise and knowledge from all sites
   ii. Enhance stewardship and accountability
   iii. Facilitates effective governance and management

Secondly to Leverage the strength of our 16 sites by
Leveraging the expertise and knowledge from all sites,
Enhancing stewardship and accountability, and
Facilitating effective governance and management.
Goals of Consolidation

III. Simplify and streamline relationships
   i. Provides opportunity to be legitimate “Go to Provider” for Alberta Health Services
   ii. Greater voice to shape and positively influence the health care system
   iii. Single point of accountability for quality and health service delivery

Finally to Simplify and streamline relationships in order to
Provide opportunity to be legitimate “Go to Provider” for Alberta Health Services,
Be a Greater voice to shape and positively influence the health care system
And provide Single point of accountability for quality and health service delivery
In addition to these key measures specifically identified for Covenant Health’s consolidation, the evidence defines some specific indicators of successful mergers of Canadian healthcare facilities during the 1990s, according to a think tank of Canadian Health Care Executive experts brought together by Canadian Health Services Research Foundation to determine the imperatives for success of mergers in the past decade: One well known researcher took the feedback and distilled into specific areas:

- Attend to team building of the executive team to build a sense of collegiality and trust, resulting in improved cooperation during challenging situations.
- Consistently connect the leadership team with people throughout the entire organization to produce confidence, clarity of roles and demonstrates, through their behavior, expected behaviors and rules of engagement. Through program/sector clinical integration, consistency is built and cross site departments are united across the organization, building a strong intrafacility network – communities of practice….micro-mergers. Success of these integrations creates important symbols for the new organization.
- Win community support through strong connections between the board and the communities; together build a strong vision and sense of engagement (CHSRF, 2000).
Questions

So that ends the reflective portion….any questions?
Participation

• For those of you who have signed the consent, this exercise is to measure how successful you believe we have been as a leadership team, an entity in achieving these goals.

• The following statements are a compilation of goals and benefits expected at the time of consolidation and a fourth section measuring against success point identified in the literature.
The next portion of this presentation is the interactive part. The exercise is for you to measure how successful you believe we have been as a leadership team, an entity in achieving our goals. To measure success of each indicator:

- 0 don’t know.
- 1 disagree
- 2 slightly disagree
- 3 agree
- 4 strongly agree
Participation

• For preservation and safety of data collection, please proceed to use the survey located @ your table and manually mark your choice as well.

• Examples of why you agreed or disagreed would be appreciated

For preservation and safety of data collection, please proceed to use the survey located @ your table and manually mark your choice as well. Examples of why you agreed or disagreed would be appreciated…but I will give you a few minutes at the end of the exercise to write them down, so you may just want to write a key word as a reminder for later.
Today you will see the results as they are electronically applied. Based upon your feedback, we will determine areas of weakness that will help determine work in the future.
You are asked to respond in the role as a leader within Covenant Health, please reflect on where we were one year ago and what the experience has been over the year…

please register your level of agreement with each statement by pressing the number on the key pad that reflects your choice.

So just pause for one moment …. You are asked to respond in the role as a leader within Covenant Health, please reflect on where we were one year ago and what the experience has been over the year… how correct are the following statements?
1.1 Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
Revitalize the Mission, Renew the Vision

1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
Revitalize the Mission, Renew the Vision

1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province:

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
Leverage the strength of our 16 sites

2.1 Covenant Health is leveraging the expertise and knowledge from all sites

- 1 don’t know
- 2 strongly disagree
- 3 disagree
- 4 agree
- 5 strongly agree
Leverage the strength of our 16 sites

2.3 Because of coming together as Covenant Health effective governance and management is facilitated.

- 1 don’t know
- 2 strongly disagree
- 3 disagree
- 4 agree
- 5 strongly agree
Simplify and streamline relationships

3.1 Coming together as Covenant Health and through this first year’s work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services

- 1 don’t know
- 2 strongly disagree
- 3 disagree
- 4 agree
- 5 strongly agree
Simplify and streamline relationships

3.2 Being together as Covenant Health we provide a greater voice to shape and positively influence the health care system.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
Simplify and streamline relationships

3.3 Creating Covenant Health provides a single point of accountability for quality and health service delivery.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
Secondary Research

4.1 Covenant Health Executive have developed a strong and positive team.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
4.2 The Covenant Health leadership team connect with people through out the entire organization routinely.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
4.3 Covenant Health is beginning to develop clinical integration across sites and sectors.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
4.4 Covenant Health is building strong connections between the board and the communities where facilities are located:

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
4.5 Covenant Health has built a strong vision.

– 1 don’t know
– 2 strongly disagree
– 3 disagree
– 4 agree
– 5 strongly agree
4.6 Covenant Health is building a sense of engagement with stakeholders and communities.

- 1 don’t know
- 2 strongly disagree
- 3 disagree
- 4 agree
- 5 strongly agree
If you can take a few minutes and write down any examples/reasons why you might have responded in a certain way. As well, there is a small area at the bottom of the last sheet……If you have a comment to share please take the opportunity to write it down….take about five minutes and then Patrick is going to review the results with you.
One Year in Review of Covenant Health

The following questions represent the indicators for success hoped for as the 16 Catholic health facilities came together to form one organization in Alberta. The first set of indicators is taken from premerger documents and confirmed through one-to-one interviews of internal stakeholders. The second set is from literature that defines key components of successful mergers. The internal indicators are arranged in three themes, which represent the core goals for the merger. Please assign the level of your agreement by circling the number that most closely represents your perception using the following scale:

1 do not know.
2 strongly disagree
3 disagree
4 agree
5 strongly agree

Please provide any examples that come to mind as you make your choice in the box below the comment and responses. Thank you in advance for your participation.

1. Revitalize the mission, pursue a renewed vision for Catholic health care

1.1 Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed.

1 2 3 4 5

1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs

1 2 3 4 5
1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province.

2. Leveraging the Strength of all 16 facilities

2.1 Covenant Health is leveraging the expertise and knowledge from all sites

2.2 During this first year as Covenant Health, enhanced stewardship and accountability is occurring.

2.3 Because of coming together as Covenant Health, effective governance and management is facilitated.
3. **Simplify and streamline relationships**

3.1 Coming together as Covenant Health, and through this first year’s work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services.

3.2 Being together as Covenant Health, we provide a greater voice to shape and positively influence the health care system.

3.3 Creating Covenant Health provides a single point of accountability for quality and health service delivery.
4. **Successful merger research questions from the literature:**

4.1 Covenant Health Executive has developed a strong and positive team.

1 2 3 4 5

4.2 The Covenant Health leadership team routinely connect with people throughout the entire organization.

1 2 3 4 5

4.3 Covenant Health is beginning to develop clinical integration across sites and sectors.

1 2 3 4 5
4.4 Covenant Health is building strong connections between the boards and the communities where facilities are located.

1 2 3 4 5

4.5 Covenant Health has built a strong vision.

1 2 3 4 5

4.6 Covenant Health is building a sense of engagement with stakeholders and communities.

1 2 3 4 5

Thank you so much!

Additional Comments
Appendix E: SROI Power Point Presentation and Participant Survey for Phase Three
Thank you so much for joining me today....
I plan to give you a VERY brief overview of SROI and then ask you to work with me and others on three separate exercises.
These represent Phase three of my research for Covenant Health – One year in Review post consolidation.
Please read the information sheet and check lists, fill out the necessary information and then sign the consent.
If you chose to not participate after reading, I completely understand.
Please proceed to review and respond to the sheets in front of you...I will give you a few minutes to do so
(PAUSE)
Any questions or concerns so far?
Great let's proceed........
Why bother measuring Social Return on investment?

Because there is so much more than just dollars and cents to describe that which we do in not for profits. We do not work towards increasing profit margins and gaining more of the market share…in fact our focus tends to be on decreasing use of our services and creating efficiencies within our organizations.

Even so often traditional measures were applied to not for profit public sectors in order for stakeholders to have a sense of accomplishment of the organization.

Traditional measures were defined as:
ROI or Return on Investment is a cost – benefit measure.
The benefits of a given situation or business-related action are summed and then the costs associated with taking that action are subtracted.
The ROI is the difference…and hopefully produces a positive variance or profit.
On the other hand SROI is different.

One definition is from the Harvard Business School: The authors stated Social Return on Investment is
“This value creation process simultaneously occurs in three ways along a continuum, ranging from purely Economic, to Socio-Economic, to Social” (Emerson, Wachowicz & Chun, 2001).
Defining SROI

Enterprise Development Fund’s (REDF) Managing Director of Programs defines SROI as:

“the ‘return’ on investment in a social mission venture” (REDF, 1996 -2008).

Social Return on Investment: A Cost-benefit Analysis

Social return on investment is analysis that provides an alternative measure to typical cost-benefit models. Roberts The Guide to SROI application defines improvement potential through:

- Facilitating dialogue, assisting in enhanced understanding of social value of an activity.
- Enables groups to target appropriate resources for managing.
- Demonstrates importance of other organizations working to contribute to positive change
- Identify ‘common ground’ between two interdependent organizations
- Provide stakeholder opportunity for holding people accountable for performance, and involves them in a meaningful manner (2009).

This model demonstrates advantages for organizations by:

- Raising the entity’s profile.
- Demonstrates value add beyond financial leveraging stronger arguments for increased funding, influencing the sustainability factor.
- Adds a persuasion element to project requests.
- While still useful, the full impact of SROI may not be as compelling when a strategic plan is in play.
- There is no interest by the organization or stakeholders for the results of the review.
- When there is no opportunity for change or to undertake consideration for new ways to move forward (SROI Guide, 2009).
In February this year I had a chance to sit down with one of two SROI experts in Canada. Stephanie Robertson is located in Calgary and has been working closely with multiple organization to determine the Social Return on Investment new programming and interventions create. She defines SROI as:

“the social value gained from a specific intervention, focused at improving society” (2010)
SROI is a framework to help understand the value of social change from the perspective of those changed (UK Third Sector, 2008). These values are considered from the 5 social value spheres. These were identified on the City of Calgary website and include:

1. cost reallocation by diverting need for public support or human services so another Calgarian can access that same support or service;
2. increases in household income;
3. increases in taxes paid to any level of government;
4. cost savings resulting from reduced public support or service provision;
5. improvements in personal well-being that are difficult to express in monetary terms, but equally as important (e.g. improved well-being, self-confidence etc) (2009).
Most of the literature attached ‘value’ directly to a monetary concept, rather than a contributory or sense of desired behavioral goals. Only one method continued to surface in the literature search that provides a value-add perspective. The concept, founded by Roberts Enterprise Development Fund (REDF), invented to discern the social value of investments (Wikipedia, 2009). Stretching this thinking to apply social value of a project or organization started in the late 1990’s (Emerson, Wachowicz & Chun, 2001), and moves the traditional income and expenditure process for determining cost achievement in not for profit environments. Unfortunately, because of this newness, there is limited scholarly evidence to achievements, so through this project I hope to add to that body of knowledge, while creating some potential benefit to Covenant Health.
The understanding of the greater social good a project/transition creates provides a more complete story of the change.

Enhancing outcome measures to include monastic value of greater social gain.

Governors and authorities look for a numerical, usually money based, analysis for objective decision making.
As with any model, there are limitations. SROI is a very new approach, emerging in 1990s, and there are very limited applications in Canada….in fact the City of Calgary is just embarking upon using this model for some of the social programs supported by local tax dollars.

There is only one example I could find in health, and it was procedure specific, at a practice level versus an organizational level.

The other concern articulated in the literature is that of the minimalizing of significance a purely numerical representation provides. The real value is in the process and understanding the application of costs to what has been achieved through a specific intervention.

As well, it is often difficult to determine the volume of identified social implications. Because of this it is important to not exaggerate the results and therefore, undermine reasonability of what the specifics are when volumes are not available. An important principle to apply in such cases is the value of one. That is what is the cost or cost savings of the intervention for one…that is one person or one unit of measure.
On the intranet, two major sources of information were found regarding Social Return on Investment, but both sites are set up to support individuals and organizations in conducting the analysis. One is a worldwide network organization called New Economic Foundation (nef), “works on economic, social and environmental issues through a mixture of practical pilot projects and tools for change, in-depth research, campaigning, policy discussion, and raising awareness through the media and publications. We also incubate new organisations and campaigns that can create long-term change in society” (nef, n.d.).

The second is a United Kingdom Network sponsored by government to provide specific groups support in using SROI for specific purposes. The SROI network is “The SROI Network is a network dedicated to the consistent and effective use of SROI. It is a membership organisation with members who are practitioners, academics, funders and investors with an interest in the use and development of social return on investment” (SROI Network, ¶ 1).

The market place in which the third sector operates is becoming more sophisticated. With new social investment vehicles and increasing contestability for public services, customers are more interested than ever in getting the best value and securing positive change . . . SROI is a framework to help understand the value of social change from the perspective of those changed. (Office of the Third Sector, 2008).
Exercise One

Consider our change, coming together of Covenant Health, at the highest level, simplest level.

What would the cost have been if the intervention had not occurred?

Larger Group Exercise

- Cost to the people
- Cost to the sites
- Cost to the communities
- Cost to the Church
- Cost to the health system
Smaller Group Exercise
2-3

Based upon the goals of coming together, can you consider three questions for each of the 9 goals.

1. Cost to accomplish?
2. Benefit of accomplishing
3. Cost if we are not successful
Exercise Three

Reflect upon the work today and answer these questions.....

✔ How does this exercise of applying costs and benefits feel? Why?
✔ Do you believe we have been able to identify financial measures or proxies that create a realistic picture?
✔ Based upon these exercises, do you see any potential to plan for the future based upon information gathered today...? Does the exercise add value?

Thank you all for working with me today....would like to ask you to take a few moments to reflect upon the actually exercise today and answer the individual questionnaire.
Participant Questions and Survey Phase Three

Large Focus Group Questions:

Consider our change, coming together of Covenant Health, at the highest level, simplest level. What would the cost have been if the intervention had not occurred?

Small Group Work Questions:

SROI – Covenant Health

The following nine goals were defined as achievement objectives for aligning the 16 Catholic Facilities in Alberta in October 2008, formed from consultation with all facilities and leaders as well as past site board members. These identified the reasons to come together and defined the hope of what could be accomplished.

Please consider the costs to achieve these goals, the benefits created by realizing success (in part or wholly), and the cost or consequences should Covenant Health not be successful in attaining the goal. Costs do not necessarily mean dollar-specific values. Some “costs” may be the same for different goals, but will only be counted once within the SROI. Sometimes we cannot accurately predict the cost or benefit, so we will apply the “value of one” as the least amount to provide a defendable projection.

Revitalize the mission, pursue a renewed vision for Catholic health care

1.1 Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed.

What were the costs?

* e.g., cost for summits

What are the benefits of accomplishing this goal?

* e.g., sense of solidarity leading to improved retention of staff at all facilities during major transition. Previous leadership remains intact because of ongoing fit with the new organization

What is the cost or potential outcome if we are not successful?

* e.g., loss of one health care provider (value of one)

1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs.

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?
1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province.

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?

2. Leveraging the strength of all 16 facilities

2.1 Covenant Health is leveraging the expertise and knowledge from all sites.

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?

2.2 During this first year as Covenant Health, enhanced stewardship and accountability is occurring.

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?

2.3 Because of coming together as Covenant Health, effective governance and management is facilitated.

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?
3. **Simplify and streamline relationships**

3.1 **Coming together as Covenant Health, and through this first year's work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services.**

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?

3.2 **Being together as Covenant Health, we provide a greater voice to shape and positively influence the health care system.**

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?

3.3 **Creating Covenant Health provides a single point of accountability for quality and health service delivery.**

What were the costs?

What are the benefits of accomplishing this goal?

What is the cost or potential outcome if we are not successful?

*Can you think of any other benefits or cost savings accomplished, not identified pre “Covenant Health” since the amalgamation?*
Individual Questions to Survey Relevance of SROI Application

SROI – Covenant Health

Reflecting upon the process of determining cost and benefit beyond traditional financial application (ROI), the following survey questions seek to determine how useful this exercise is in creating additional value to organizational assessment for measuring success and planning for the future. Please answer the following three questions to assist in this evaluation.

How does this exercise of applying costs and benefits feel?
Why?

Do you believe we have been able to identify financial measures or proxies that create a realistic picture?

Based upon these exercises, do you see any potential to plan for the future based upon information gathered today…does the exercise itself add value?

Thank you so much!
Appendix F: HREB (Ethics) Approval and Covenant Health Confirmation Letter
Approval Form

Date: April 27, 2010
Principal Investigator: R. Shell Murphy
Study ID: Pro00010146
Study Title: Consolidation of Covenant Health: One Year in Review Measuring Success.
Approval Expiry Date: April 26, 2011

Thank you for submitting the above study to the Health Research Ethics Board - Health Panel. Your application, along with revisions received March 30, April 7, and April 27, 2010, has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Alberta Health Services or other local health care institutions for the purposes of the research. Enquiries regarding Alberta Health Services administrative approval, and operational approval for areas impacted by the research, should be directed to the Alberta Health Services Regional Research Administration office, #1800 College Plaza, phone (780) 407-6041.

Sincerely,

Glenn Griener, Ph.D.
Chair, Health Research Ethics Board - Health Panel

Note: This correspondence includes an electronic signature (validation and approval via an online system).

https://hero.ualberta.ca/HERO/Doc/0/7169V6TKP524T53741LD3TA3DF/fromString.html
April 27th, 2010

Shel Murphy;
email: shel.murphy@covenanthealth.ca

RE: Study #1136, Pro00010146, “Strategic Merger in Faith-based Health Care: Review of the First Year with Covenant Health”

Dear Shel Murphy,

Thank you for submitting information on your research study to the Covenant Health Research Centre. I am pleased to inform you that your study has received Covenant Health Operational/Administrative Approval for all Covenant Health sites.

We have a copy of the current Health Research Ethics Board (HREB) approval letter on file. We do not require that you submit protocol amendments as these will be reported to HREB; however, it is important that we receive updated copies of:

- HREB approval letters;
- consent forms;
- study information sheets; and,
- reports of serious adverse events if applicable.

We would also appreciate a copy of your final research report upon completion of the study. You are eligible to submit a paper, article or abstract for inclusion in the “Covenant Health Research” publication. The Covenant Health Research Centre may reference your name, study name, and location of study in various Covenant Health research publications, reports, sessions or internal websites, unless you advise us to the contrary.

All documents can be faxed to (780) 735-2674, emailed to research@covenanthealth.ca or mailed to the Covenant Health Research Centre, Misericordia Community Hospital, Cabriini Centre R07-3, 16940-87 Avenue, Edmonton, Alberta, T6E 4H5.

On behalf of the Covenant Health Research Centre and the Covenant Health Research Steering Committee, we wish you every success with this project. If you have any questions, please do not hesitate to contact the Covenant Health Research Centre at (780) 735-2274.

COVENANT HEALTH RESEARCH CENTRE

Mary-Anne Clarke
Administrator
Appendix G : Phase One Compiled Results of Survey
<table>
<thead>
<tr>
<th>ID</th>
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<tbody>
<tr>
<td>A-1</td>
<td>Strengthen the individual facilities within the new corporation in view of the regional context/shift to a one service system. Strengthen our position within that new system.</td>
</tr>
<tr>
<td>1</td>
<td>1. Strengthen the individual facilities within the new corporation in view of the regional context/shift to a one service system. Strengthen our position within that new system.</td>
</tr>
<tr>
<td>2</td>
<td>Enable Catholic faith based to survive. There were huge risks staying separated</td>
</tr>
<tr>
<td>3</td>
<td>To capitalize on the resources that were not available within the old world. Strength of the collective and individually….eg called upon to do everything independently such as strategic planning, recruitment, more resources to be available…..one individual wearing may hats</td>
</tr>
<tr>
<td>A-2</td>
<td>Strengthening of the Catholic organization within Alberta….as individual organizations were at risk. That risk rolled out to others. The stronger or larger ones ‘prop’ up the smaller weaker ones.</td>
</tr>
<tr>
<td>1</td>
<td>1. Strengthening of the Catholic organization within Alberta….as individual organizations were at risk. That risk rolled out to others. The stronger or larger ones ‘prop’ up the smaller weaker ones.</td>
</tr>
<tr>
<td>2</td>
<td>Longer term stability with a stronger ability to support one another better than the previous organization…benefit gain was not equivalent.</td>
</tr>
<tr>
<td>A-3</td>
<td>Have one consistent organization with common vision goals and strategy that would be recognized provincially. Coming together provincially and nationally, we have a greater presence.</td>
</tr>
<tr>
<td>1</td>
<td>1. Have one consistent organization with common vision goals and strategy that would be recognized provincially. Coming together provincially and nationally, we have a greater presence.</td>
</tr>
<tr>
<td>2</td>
<td>Consistent management and vision of the work, as manager there is clear expectation that will be consistent between the sites. Barriers removed to information and funding</td>
</tr>
</tbody>
</table>
1. To have one voice for Catholic Health care within Alberta - Single point of access.

2. Build our collective strengths as we come together...share in expertise between all facilities, eg. financial, quality, etc

C- 1. People are proud to work within Covenant Health and there is a new sense that they belong to the organization...key is the culture of belonging.

2. Covenant Health is a known entity and has a positive influence in the health system and beyond

C- 1. Cultural alignment not necessarily throughout the whole having one culture, but seeing the culture as unique and part of the greater organization. Recognize and celebrate the strong emotional attachments. Slow integration of culture...like marriage, making the marriage work. Imperative in the leadership messaging that goes out. Not assimilating but rather celebrating strengths and differences.

2. Visibility of leaders...true engagement of leadership team into each facility/team as evidenced by helpfulness, being present on the sites, lots of two way communication, listening, need to learn from the sites language rather than be the suits from the city, sense the difference because of leadership being there, genuine, can't get coddled by 'pulling the bandaid off quickly' people are encouraged with the leadership team, feel genuine support, have a sense of ownership. We need to understand this will take time.

1 matches with
3.3 Creating Covenant Health provides a single point of accountability for quality and health service delivery
2 matches with
2.1 Covenant Health is leveraging the expertise and knowledge from all sites

1 has no match, but does address cultural dynamics of 'belonging' and 'pride'2 matches with 3.2 Being together as Covenant Health we provide a greater voice to shape and positively influence the health care system.

1 again speaks to cultural dynamics of the merger and has a remote match to
2.1 Covenant Health is leveraging the expertise and knowledge from all sites

2 also no specific match but speaks to "leadership visibility", organizational support to make the changes and internal "stakeholder engagement".
1. Influence the healthcare system
Greater role in the service delivery of health care — doing more of the work than we currently are within Alberta. That influencing looks like - new ways of doing things - new standards - how decisions are made. People want to see the difference we make and would become the goal other organizations would reach for, leading by example. We are able to make influences at tables where policy is made. We develop new models of holistic approaches…influenced by the models in place (work a few SLT are already working on)...approach change by involving key stakeholders. e.g. pandemic Framework at the provincial level.

2. Growth
A greater geographical reach of services. We are of greater service – we fill in the gaps. We have a greater role in more programs and services. New facilities/programs in new communities. Others recognize the tremendous value we bring to the system. Be recognized for bringing new or unusual things to the table, not being afraid of asking the tough questions.

1 matches with

2.1 Covenant Health is leveraging the expertise and knowledge from all sites

3.3 Creating Covenant Health provides a single point of accountability for quality and health service delivery

2 matches with

1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province.

3.1 Coming together as Covenant Health and through this first year’s work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services

3.2 Being together as Covenant Health we provide a greater voice to shape and positively influence the health care system.

1 matches with

2.1 Covenant Health is leveraging the expertise and knowledge from all sites

1 matches with

2 matches with

3.2 Being together as Covenant Health we provide a greater voice to shape and positively influence the health care system.
Initially involved 2008 May, in response to what was unfolding with AHS. With the withdrawal of ‘regional support’. There was unchecked expansion in the ‘old’ region and not specifically fairly distributed. 1. Merger would then be a way of addressing inefficiencies. 2. In the past there was a decrease connection between ACHC and the site, giving a sense of isolation to board and site leadership. The merger was to improve connections. Intuitively, participant thought the merger would drive a better use of funding and resources.

2. What was your personal goal of this union?

A- Advantage to develop networks and to grow.
1
A- Provincial voice, synergy.
2 It is not always the benefits to be gained, but rather the benefit to be given.
Local needs may not be as well represented because the larger organization slows down our ability to move quickly.

A- Goal ability to link with others corporately to provide direction and support for areas such as accreditation and ICP, to deance gaps as we do ethical reflection and consultation….gain broader support to managers and frontline staff.
3

C- Wanted to have a greater voice within the system. So coming from a larger organization could participate and better realize those things that would make happen. Passion for the work spread to a provincial level
1

C- Integration of sites successfully to produce cross site efficiencies and develop more cohesive approaches.
2

C- To have a job at the end of the org structure shift but more so to have a sense of purpose, to contribute or add value. “Does s/he care for anybody” to take that servant role, to be seen as serving, making a difference, being useful.
3

C- In entering this “Brave New World” we make a greater difference because of the traditions – the healing of Christ.
4
Hope that we would be supported….we would be valued more than when it was on its own……to be able to serve with confidence that we will continue. To recognize there is a need to determine what services the community needs and then adjust to meet those needs, be responsive as the sisters would have, open minded, open hearted. Worried that we would be ignored, that the site and people would be seen as a small part and not attention given them rather than valued as a contributor to the organization.

Did not want site left to be influenced by those that did not understand our specific needs. Decrease with human contact of concerns with the changes. Wanted to ensure the site would be heard.

To make a difference (personally) within the facilities.

Wanted to ensure the site was “backed up” with IT, support with other parts of a greater organization.

Maintain influence through work with the Board.

To use skill level and to learn and to make a contribution…to consider the quality and service delivery connections.

To feel useful – contribute in some way. There is a different sense of how and who now.

2.1 Covenant Health is leveraging the expertise and knowledge from all sites 1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province 1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs

1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs

3.2 Being together as Covenant Health we provide a greater voice to shape and positively influence the health care system

### SROI Implications

**3. Considering the benefits you have identified, can you identify the consequence if the consolidation would have failed.**

Reputation risks and we would not have the autonomy and level of independence to be at the mercy at AHS’ direction. Being doing only what was prescribed rather than being able to shape our future…..greater risk than where we are positioned to day. Embarrassing…seeing our difference no longer existing, seeing that difference grow…confidently hang our hat on those values…we are not only articulating and but expecting behavior to follow.
Reputation risks and we would not have the autonomy and level of independence to be at the mercy at AHS’ direction. Being doing only what was prescribed rather than being able to shape our future…..greater risk than where we are positioned to day. Embarrassing…seeing our difference no longer existing. seeing that difference grow…confidently hang our hat on those values…we are not only articulating and but expecting behavior to follow

Loss of autonomy traded off for ensuring we were collectively at risk, so we may have lost Catholic

The outcome people would have seen the administrative burden of the process for naught….generated a lot of heat but no light. Struggle would demonstrate ‘circling the wagons’ an act of desperation….leading to undermining of confidence which directly would call into question quality and care ability further implicating our ability to recruit….total loss of confidence….mission demise, distancing of the Catholic

Disenfranchise staff resulting in an inability to retain and recruit to the organization.

Be seen as a duplicate system with no value added.

Multiple and serious in nature. We will see distrust, relationships breakdown, lost opportunities, escalating costs, people set at cross purposes, resentment, underground mentality, loose effectiveness as a leader, a new norm is developed so current and important attitudes and processes become stone-walled and there is a loss of collaboration, or even a sense of the need for collaboration.

Greatest concerns for the organization are marginalization to the work and ability contribute. Stagnation, we become irrelevant. We go to a mentality of “circle the wagons”. The greater system loses because we have not made that contribution. Utilitarian versus the common good message will be lost.
We would be lost, the facility would no longer exist….What did the sisters come for….to fulfill those needs in the community. If we meet those needs we will be succeeding so conversely if we do not meet those needs, then we would not have succeeded. Continues to fear that without retaining MDs and staff that we will sink out of existence….but with the grouping together and the competence less likely to lose or not recruit….to maintain staff and services is key to survival.

Huge problem d/t fracture of the old board. If Covenant Health did not succeed in a positive merger, this could have led to reputation damage. The dollars wasted in coming together. This can be a difficult community, they tend to decrease change and are stubborn…prefer the old way of doing things. The cost of not succeeding would lead to a situation that would detract from X (the major economic generator) which would have implications for the town and its success.

The most difficult thing is to articulate that difference, that hope clearly articulate that difference with confidence….determining the value add….

Being one larger organization slows down some Thoroughly impressed by how we have been able to come together, responded and connected at every site and level within the organization.

Learning the new connections is challenging The pace is so very fast
C-1 Been a challenging year…bigger regionalization coming but major change was not anticipated. Formation of the new world sees emergence of two major care providers, with financial burdens with new and unknown leaders. The pace of change was reasonable…the connecting factors become the next greatest challenge. The complexity both internally, integrated and then to find the right Don’t lose sight of the choices we need to make to confirm our future. Defining the value adds post consolidation……..the benefit/burden measure

C-2 Need to continue to integrate services.

C-3 We need to have humility, show our true values in how we respond…this is God’s work, we have and are called to a higher purpose. We need to ensure we walk our values especially in times of crisis – keep ourselves grounded

C-4 Nothing more to add.

E-1 The most difficult thing is to articulate that difference, that hope clearly articulate that difference with confidence….determining the value add from one of the competence and concern of the people have shown to each individual sites…..Kevin…Patrick…how quickly and competently corporate has responded and continues to do so to work with the site to achieve the mission, the work

E-2 Maximizing the Interdisciplinary Problem Solving (IPS) process. Within this model there is a most important factor - the “Commonwealth of Dignity” and this is so clearly identified in Covenant Health – demonstrated. Living the values is so obviously demonstrated and this overflows to patients and residents…this is good. Covenant Health needs to continue with the understanding
Appendix H: Phase Two Compiled Results of Survey
Measure by group of stakeholder perception of level of success in achieving the goals – SLT

<table>
<thead>
<tr>
<th>G. Board</th>
<th>SLT</th>
<th>Leadership</th>
<th>Rural - B Members</th>
<th>Rural - Staff</th>
<th>Urban CC</th>
<th>Urban - Acute</th>
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<tr>
<td>Invited Participants</td>
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<td>11</td>
<td>124</td>
<td>20</td>
<td>65</td>
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<tr>
<td>Responding Participants</td>
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<td>100</td>
<td>8</td>
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<td>36</td>
<td>52</td>
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<tr>
<td>% Response Rate</td>
<td>60</td>
<td>77</td>
<td>80</td>
<td>40</td>
<td>57</td>
<td>51</td>
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Level one: IDENTIFIED GOALS AT CONSOLIDATION

1. Revitalize the mission, pursue a renewed vision for Catholic health care
   a. Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed
      Do not know
      | 1 | 0 | 3 | 10 | 5 | 8 | 26 |
      Strongly Disagree 2 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
      Disagree 3 | 0 | 1 | 0 | 1 | 4 | 4 | 10 |
      Agree 4 | 1 | 4 | 59 | 4 | 20 | 22 | 25 | 135 |
      Strongly Agree 5 | 5 | 4 | 36 | 4 | 6 | 5 | 12 | 72 |
      Respondents 6 | 8 | 99 | 8 | 37 | 36 | 51 | 245 |
   b. Renew and continue a legacy of responding to unmet needs
      Do not know
      | 1 | 2 | 0 | 9 | 2 | 7 | 21 |
      Strongly Disagree 2 | 0 | 0 | 0 | 2 | 0 | 2 | 4 |
      Disagree 3 | 0 | 2 | 0 | 1 | 3 | 5 | 11 |
      Agree 4 | 5 | 3 | 55 | 7 | 22 | 25 | 25 | 142 |
      Strongly Agree 5 | 1 | 4 | 41 | 1 | 3 | 6 | 13 | 69 |
      Respondents 6 | 8 | 100 | 8 | 37 | 36 | 52 | 247 |

While a few participants did not know if revitalization of mission and renewing of vision had a measure of success at year one, the majority, 84% of participants, agree Covenant Health has had success at year one for revitalizing the mission and renewing the vision.

The majority of participants, 84%, agree Covenant Health has had success at year one for renewing and continuing the legacy of responding to unmet needs.
c. Expand our influence and be of greater service in communities throughout the province.

<table>
<thead>
<tr>
<th>Do not know</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
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Do not know | Strongly Disagree | Disagree | Agree | Strongly Agree |
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</table>

Respondents 6 8 100 8 37 36 52 247

2. Leverage the strength of our 16 sites

a. Leverage the expertise and knowledge from all sites.

<table>
<thead>
<tr>
<th>Do not know</th>
<th>Strongly Disagree</th>
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Do not know | Strongly Disagree | Disagree | Agree | Strongly Agree |
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Respondents 6 8 100 8 36 36 52 246

b. Enhance stewardship and accountability.

<table>
<thead>
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<th>Do not know</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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Do not know | Strongly Disagree | Disagree | Agree | Strongly Agree |
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</table>

Respondents 6 8 100 8 36 36 52 246

The majority of participants, 81%, agree Covenant Health has had success at year one in expanding our influence and being of greater service within the healthcare system.

Almost one quarter, 24% of respondents, do not know if Covenant Health has been successful at leveraging the strengths of all sites. 19% disagree and 59% agree Covenant Health has had success at leveraging the strengths of all sites.

69% of all respondents believe Covenant Health has enhanced accountability and stewardship during this first year, 20% do not know and 11% disagree.
c. Facilitates effective Governance and management

<table>
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3. Simplify and streamline relationships

a. Coming together as Covenant Health and through this first year's work, we are positioned to be a legitimate "Go to Provider" for Alberta Health Services.

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<tr>
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64% of respondents believe Covenant Health has been successful in building effective governance and facilitating management. 17% disagree and 19% do not know.

16 facilities coming together into one organization to be a legitimate "go to provider" for AHS has been perceived as successful by 83% of the respondents. 7% would disagree, and 10% do not know.
b. Greater voice to shape and positively influence the health care system

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</table>

87%, a strong majority of participants, believe Covenant Health has been successful through being together to provide a greater voice that will shape and influence the health care system. 8% would disagree, and 5% do not know.

c. Single point of accountability for quality and health service delivery

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<th>Response</th>
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<th>SLT</th>
<th>Leadership</th>
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Creating Covenant Health has created a single point of accountability for quality and health services delivery within the Catholic system is believed to be 68% successful, while 18% would disagree and 14% do not know.
**Level Two: GOALS FOR SUCCESSFUL MERGERS**

1. Covenant Health Executive has developed a strong and positive team.

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</table>

80% of the participants believe the Senior Executive team has been successful in developing a strong and positive team. 7% would disagree and 13% do not know.

2. The Covenant Health leadership team connect with people throughout the entire organization routinely.

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Only 59% believe Covenant Health has successfully connected leaders with people throughout the entire organization. 25%, one quarter would disagree and 16% do not know.
3. Covenant Health is beginning to develop clinical integration across sites and sectors.

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Over one-third, 36%, of the research participants do not know if Covenant Health has been successful at year one of developing clinical integration across sites and sectors. 46% agree this is occurring, but comments were often made that this is in the early stages. 18% disagree.

4. Covenant Health is building strong connections between the Board and the communities where facilities are located.

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</table>

Almost one half of respondents do not know if Boards are making strong connection with communities, 43% would agree Covenant Health has had success in making connections, while 10% would disagree.
5. Covenant Health has built a strong vision.

<table>
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90% of participants believe Covenant Health has been successful at developing a strong vision. 6% disagree, and 4% do not know.

6. Covenant Health is building a sense of engagement with stakeholders and communities.

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61% of respondents believe Covenant Health is building a sense of engagement with stakeholders and communities, 10% disagree and 31% do not know.
Areas to Consider Opportunity or Improvement Potential

Agree scores below 60%
1. Board connection to communities, only 43% agree this is occurring.
2. 46% Covenant Health is beginning to clinically integrate.
3. Only 59% agree we are leveraging the strengths of all the sites.
4. Only 59% feel Covenant Health leaders are connecting throughout the organization on a regular basis.

Already Underway
1. Rural Health Strategy and community consultation.
2. Accreditation and integration teams (Rural and Urban)
3. Accreditation, ICP, OH&S, DAL development and Seniors' strategy, Mental Health strategy, Palliative strategy.
4. Internal Communication planning.

Disagree scores above 20%
1. Leaders connecting routinely throughout the organization, 25%

(Repeat)
1. noted above.
2. noted above.

3 Highest do not know scores
1. Board connection to community 47% do not know
2. Clinical integration is unknown by 36% of respondents
3. 31% do not know if Covenant Health is engaging stakeholders and communities.

1. noted above.
2. noted above.
3. Communication strategy and Employee Engagement with HR.
### Level one: IDENTIFIED GOALS AT CONSOLIDATION

**1.a Revitalize the mission, pursue a renewed vision for Catholic health care**

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<tr>
<td>Leadership</td>
<td>It has been renewed but not advertised widely as it should be - I believe that more advertising re: Covenant Health more and more via media, paper, etc. Yes in the eyes of the politicians &amp; hopefully the public. Frontline gaps -not yet a full understanding there. (In the past) the mission had been put on the back burner because of workload, also relied on the Sisters. I believe that within the organization this is strong. I think that we can improve how the public perceives/acknowledges our unique contribution. Clearly stated &amp; bears the name of Jesus - both weighty and powerful. Restoring of pastoral care and ministerial presence for patients and staff. Following the presentation (re: history of consolidation) I have a greater appreciation. Work continues to be required at the local community level. A new life has been reinjected/new ownership. And strengthened. I believe that since the establishment of Covenant Health, the communities have become much more aware of Catholic-based healthcare and people's interests are again renewed (Much more attention to us). We now now have a strong voice (strength in numbers). Missioning.</td>
</tr>
<tr>
<td>Rural Boards</td>
<td>A renewal has begun (B) Very clear mission (B) We dare to speak openly about what Catholic health care can and does add to the system (B) New mission statement developed, widely circulated (B)</td>
</tr>
<tr>
<td>Rural Staff</td>
<td>Health care is healthcare who cares if it is Catholic or not? Previously the Catholic Health care presence was very subtle and grey. Covenant Health has been very effective in presenting in a comfortable manner the revitalized mission. Site participated in defining mission &amp; values - resulted in renewed mission for Catholic healthcare in depts and hospital. Patrick met with Premier - support from Premier re: mission for Catholic Health. Through meetings, functions &amp; publications the mission appears stronger at our worksite. More public visibility through media. I don't know that the mission for healthcare is different than that of other providers. Not employed until Covenant Health became an entity. I don't see any difference...What is Catholic healthcare - is it any different than AHS? A renewed focus on previous mission.</td>
</tr>
</tbody>
</table>
Strength of unified Catholic hospitals allows us to advocate for patient care in our respective communities. Coming together as one voice displaying Catholic values while re-inforcing our renewed vision - much more effective. Meeting and functions has put our worksite in great shape. The renewal of the Chapel - for worship for staff and patients and the morning prayers, Bible teaching are a welcome change - to better reflect our mission. Renewal and recognizable presence of Catholic values. It appears there is more respect at the provincial level. Although our hospital has always tried to live the mission!

Urban CC
Bringing the Catholic sites into one should strengthen the mission.

Urban Acute
Prefer the Caritas one.
Unable to determine any change at this time.
I have no actual change to the daily operation of the site that I am at.

b. Renew and continue a legacy of responding to unmet needs

Governing Board
No Comments

SLT
No Comments

Leadership
Again I believe more widespread advertising of Covenant Health - TV time, a few advertisements, would help. Yes - in the traditions of our founding communities. We need more focus on all or our founding communities. More now than the last 10 years - VERY EXCITING RENEWAL - MENTAL HEALTH EXAMPLE.
Mental Health - AHE 90 beds
Overall - Villa Caritas
Will require the release of God's creativity & provision of resources.
Seniors, others in need, homeless.
Stronger language re: healing ministry of Jesus Christ ties us closer to the original foundresses
Beginning - still work ahead
Need to be supported with resources to be able to achieve it.
(seen) particularly mental health and seniors.
(Example) Mental health - Villa Caritas

Rural Boards
Vision indicates that a focus is addressing unmet needs -don't agree that it is the vision that enables this goal (B)
Covenant Health is looking at establishing more services such as DALs and mental health (B)
We will eventually capture more indications of unmet needs as we reach out to our communities. Everyone has been so busy attempting to meet day to day needs there has been little time to see what is being missed (B).

Rural Staff
Everyone is working together to overcome deficiencies.
This is a work in progress.
Are able to justify costly programs directed at those most in need because the program falls within the mission.
Our side is working together in responding to unmet needs. This is great.
Responding to unmet needs, one example is when Covenant Health offered to help placement of any AHE patients who were being removed to be placed in a different environment - which was gratefully accepted to my knowledge. (in Caritas Villa I believe is the name).

Rural Catholic hospitals provide valuable resources that may not be available if our sites were closed.

Sure!!

I believe the legacy is, at this point, unrealized. It is only through persistent commitment that we can achieve our potential.

Our mission focus provides a unique guideline for healthcare.

We have enhanced and provide services now, which have not been available to us for quite some time. Able to help in the provision of services to some patients that would normally have been in AHE but need to relocate to better meet needs and due to future AHE bed closures.

Due to cutbacks by Alberta Services, I believe Covenant Health will be unable to provide essential services to patients and care will be effected as a result.

Needs are still not being met related to Alberta Health cutbacks of programs, staffing which remain to affect the care of the clients.

In what way???

Needs are still not being met. Need to coordinate more work the gov't who hold the purse strings.

I think we are doing a fairly good job of meeting the needs of our Community through out our years here. Ours is a unique environment which might require some carefully treading as “changes” are made.

What are the unmet needs?

Opportunity for utilizing a variety of sites to deliver care to the specific need population.

My perception is that AHS dictates our work.

Excellent intentional leadership in looking for populations experiencing gaps in service and stepping up to propose and act on means of filling those gaps.

But only as far as funding allows.

I think it was a waste of money and that we are continuing to meet the needs of patients regardless.

Covenant Health appears to be interfering with accepted health care practices with respect to XXXXXXXXXXXXXX individuals, a practice I have been conducting since 1996.

c. **Expand our influence and be of greater service in communities throughout the province**

**Governing Board**

No Comments

**SLT**

We hope it will, but as yet untested…we’re new

**Leadership**

We don’t see that influence at the site level, we’ve heard about it but hasn’t filtered down.

Connection to Stephen Duckett, added to strong local relationships = strength.

Very good work here.

Great work done in this area.

I don't know, too early to tell - the next year will help to bear evidence of this.

Being part of a group, enables us to have more of a voice.
DAL’s helping Fr. Lacombe Board from a cross-section.

Stronger voice.
Combined voice = strength.
Only beginning but we have excellent potential.
I think there has been a good start but more needs to be done - we are getting there.

We have a voice where we didn't have one at all with Capital Health.
Absolutely we get to also learn from others, e.g. - strength of DAL in Lethbridge.

AHS influences may be a barrier.
Has expanded influence but not sure if this will be congruent with being of greater services as there are other variables.
We are stronger together rather than going it alone.

Rural Boards
We represent communities all over the province and Alberta Health is listening (B).
Not coming together would have led to collapse in the smaller centers (B).
This was strongly indicated at the annual meeting in Edmonton by the representatives from AHS (B).
Agree somewhat, too early to tell if this merger will be of greater service to community. It has expanded Catholic health influence with Alberta Health (B).
Yes, I believe there is strength in numbers and we don't feel so isolated. Help is a phone call away now (B).

Rural Staff
I hope so but truly don't know.
Half the time nobody knows what is going on. Communication is not good at all.
I haven't seen any change. In places where it really counts i.e., the money - making machine, its still called Caritas Lottery ...somewhat two-faced I think.
I can not see this as yet in the facility I'm involved in.
Foundation of a strong institution was very needed and will be extremely beneficial.
By consolidated workforce rural Covenant Health sites have more expertise to assist in programs. Example IPC, OHS.
We have strength in numbers.
It gave us the opportunity to be a bigger voice.
By coming together, sharing ideas and services, we can influence health care, e.g. one facility accepting ALC patients to free up surgical bed in a larger facility.
Are seen as a voice within AHS and are being consulted with & kept informed of AHS decisions.
I don't see how this is going to change what we are doing - however I am happy Covenant Health has remained!
Higher people with Patrick's influence.

Needs are still not being met related to Alberta Health cutbacks of programs, staffing which remain to affect the care of the clients.
In what way???
Needs are still not being met. Need to coordinate more work the gov't who hold the purse strings.
I think we are doing a fairly good job of meeting the needs of our Community through out our years here. Ours is a unique environment which might require some carefully treading as "changes" are made.
What are the unmet needs?

Urban CC
again strength in numbers.
there has been no effort for team building or liaising initiatives
I agree that as a larger group, we will have expanded influence - but now we have to make the effort to put that into actions.

Urban Acute
We lack integration (IT, Communication, branding).
Still a lot of work to be done there.
The influence of a larger group is far more valuable than small independent areas.
What is the point of greater service when it is controlled by the Catholic Church that appears to override accepted medical practice.

2. **Leverage the strength of our 16 sites**
   a. **Leverage the expertise and knowledge from all sites**

   Governing Board
   This is a work in progress.
   Not from all sites - but certainly from Caritas and St. Michael's
   SLT
   No Comments
   Leadership
   Still work to be done.
   Rural sites have some knowledge and expertise that is not necessarily being used. Sometimes it seems the only expertise used is from Edmonton.
   Sharing expertise & knowledge is the best part of the strength of becoming together.
   In formative stages.
   Need for common idea sharing.
   Moving in the right direction but still needs work.
   Lethbridge and DAL a great example.
   I believe this has been done well - keep up the momentum.
   We are very ‘Caritas’ focused.
   So far at high levels only. Gaps at support levels, at least as seen by me, so much has yet to be accomplished.
   (As exampled by) The sharing & support from all sites. Sites merging under 1 ED.
   Allows for sharing of knowledge.
   An open-mindedness to various programs seems to indicate a willingness to embrace all.
   IT currently not throughout all organizations therefore not able to utilize all resources.
   More required, particularly in connecting program leaders/coordinators.
   Mission discernment tool will bring this together - still need more.
   In progress, will continue to improve.
   We (our department) has visited 2 other facilities to review their processes and give advice & assistance to them.
   (Acute sites giving rural sites advice).
   How are we tracking skill sets to know what we are missing?
   But we still have much to do on this point.
Rural Boards  
This is a work in progress - up until now we were unaware of how and where to obtain advice from the experts (B). Although this is just starting to take place, I see more acceptance of doing so among the facilities. Great potential (B). There have been many examples of this initiative, esp., in continuing education for our staff (B).

Rural Staff  
I believe this is being done, albeit a slow process which is understandable.

So is everybody else.

More cooperation is evident.

Expertise from other areas has been very forthcoming and helpful as we hope our expertise and experience can help others.

Still a work in process but it seems the facilities are working well together.

I hope so but I don't know this for sure.

We believe that we are definitely stronger - one voice representing 16 rather than 16 smaller voices. Leveraging this to become an impact that is recognized and acknowledged. Potential to do so not realize yet.

Lack of communication. AHS & Covenant Health.

Covenant Health does not recognize that issues in rural health differ from those in urban centers. CH still runs rural sites as if they are urban and have designated personnel to run programs and perform quality assurance. Rural workers have to wear many hats and perform daily workloads.

Again, I hope that we are able to better share our knowledge: experience.

There doesn't seem to be enough understanding of rural site issues/multitasking requirements and that expertise and knowledge may not be taken into consideration as much as it could/should.

I can only assume this to be true.

Urban CC  
Sites work independently of each other, and do not share information readily

I see this as being in its infancy stage.

trying to do this---but is still a work in progress.....a bit disjointed and communication is vague and inconsistent

Urban Acute  
operate in silos

it is only what we have been told is happening...I have not seen it in action.

I would agree, however, I also believe that the current managers are exhausted with the additional workload.

b. **Enhance stewardship and accountability**

**Governing Board**  
No Comments

**SLT**  
No Comments

**Leadership**  
We have filled out many, many reports but I don't know if it has enhanced our accountability yet.

Will continue to improve as we further define objectives & cascade to depts.

Very good focus here.

We are responsible to clear our deficit, not AHS or the government.

As we continue to join this increases.

I admire the humility demonstrated, e.g., honest that we have challenges and asking for suggestions.

In finance definitely, don't know about other areas.
Occurring - still some to go (Process is not smooth).
We were always stewardship focused and accountability focused.
Again, I believe we are getting there but I do not believe we are there yet - still work to be done & a few "clean ups to
be done".
Each of us is responsible for maintaining positive variances.
?hmm...I agree but not strongly.
It's an expectation - but is it occurring?
We are beginning.

Rural Boards

Again a work in progress - we can perhaps learn from one another as to ways of being more accountable and to be
better stewards (B).
Rural Staff
I hope so!
We still need more influence from above to keep our physicians and nurses accountable for their own practice.
The hospital clinical care is still functioning the still.
We have no choice with AHS mandate - it is a good thing; we all need to be more accountable to sustain our
healthcare system.
I agree because of what is expected of us through our mission, vision and values. Greater measurement of this
needs to occur.
This is a work in progress.
Yes...due to very tight controls with regards to our budget.
We are ahead of the AHS in making sure we meet their targeted budgeting reductions. Most AHS sites still don't
have their plans made yet. Ours is made and approved by Covenant and in the AHS's hands.
Yes in my area.
Increased with onsite pastoral care - better for patients and staff.

Urban CC
We have been responding to the concerns of the province
Not quite there yet, but will have to be for accreditation purposes in the fall.
Due to government financial cutbacks initially.
It is occurring very slowly - I would like to see a leaner operation.
Nothing has changed as far as I can tell...lots of wasted money.

Urban Acute

c. Facilitates effective Governance and management

Governing Board
Very impressed with the effectiveness of the Board and the Management team

SLT
Don't understand question
Yes for many, not sure for governance yet, community boards specifically

Leadership
Yes, but sometimes ability & autonomy taken away, when managers are able to make decisions.
The governance part is very strong as one.
Its coming - really see transparency and it appreciated.
Not without challenges.
I believe this is a work in progress - not there yet.
We are more consolidated but as individual facilities we always had effective governance & management. Better use of resources, more expertise. I have a renewed sense of hope! Pros/cons - larger bureaucratic culture compared to smaller/previous structures. Needs to continue.

This assumes sites did not have effective governance and management before the merger. However perhaps this is better than it could have been (B).

This principle should be the case but due to slow progress in Alberta Health Services answers to urgent needs are not happening (B).

Leadership with one voice for all sites is most beneficial and a welcomed change & improvement. Leads to better site direction.

In most areas not all. Still in early stages. Looks good so far. Still unclear of roles Covenant Health and Alberta Health Services play and their differences. Some is still unknown.

We are a stronger voice as a group than as individual facilities. I believe that wherever and if there is a lack - an uncertainty to direction, etc. this is clarified with Covenant, and supported through our VPs.

It may be happening for nursing but I see our department not having direction as to who we follow as no direction from Covenant Health. We rely on AHS members. Lack of communication @ site.

Management has been very difficult to deal with. They hear what they want to hear. again----communication and teamwork could be improved

THIS QUESTION IS UNCLEAR TO ME

What gains in economies of scale or capabilities have we really achieved? Can't have the same management presence across the whole province because people can only do so much. Too big of an area and not enough manpower.

How about the patient care?? has anyone asked frontline staff how that is affected? Management is spread too thin. Front-line management is struggling to meet organization's objectives. There is still a lot of mistrust.

We also had effective governance & management before Covenant Health came together. Probably, but don't know.

I am really not sure.
3. **Simplify and streamline relationships**
   a. **Coming together as Covenant Health and through this first year's work, we are positioned to be a legitimate "Go to Provider" for Alberta Health Services.**

<table>
<thead>
<tr>
<th>Governing Board</th>
<th>We can only be effective if AHS is effective.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLT</td>
<td>Don't know yet...AHS seem to have a reluctance about us @ times. Villa Caritas 1st example of being &quot;go to&quot;</td>
</tr>
<tr>
<td>Leadership</td>
<td>I think we need to better develop and articulate our niche in AB healthcare. Mental Health. At the top - Duckett/Hughes for sure. I believe that we are not yet firmly established as such - more work to be done. I don't believe this happening ever before. Really see that...especially last month. We have had to build the partnership but now after proving ourselves we are the one AHS comes to. Still some AHS leadership reluctance to accept this. Have had an opportunity to move forward because our organizations remain intact. Lots of opportunity for growth &amp; development here. in urban centers need to expand in rural areas As on provincial healthcare provider to another AHS allows us to respond across the same geographical boundaries. Yes, but some areas have been given increased responsibility without increased resources to do so. Villa Caritas. recent conversations with AHS Edmonton. Villa Caritas.</td>
</tr>
<tr>
<td>Rural Boards</td>
<td>Hopefully optimistic (B). Yes we can be counted on to provide the necessary services and are doing it. AHS has to realize that we are ready and willing to be accountable to Albertans (B). Perhaps too early to make this statement as a lot of organization at the AHS level needs to be done - Covenant Health, I think, is poised to accept the position if indicated (B)</td>
</tr>
<tr>
<td>Rural Staff</td>
<td>Not without adequate nursing staff. The freeze on hiring needs to be lifted before we wear everyone out. What does &quot;Go to provider&quot; mean exactly? our service has been the same, providing the same care. So is the non-Catholic system. It appears to be quite promising. As previously mentioned; offering services to cover a lack or a need in our province has been demonstrated - great working relationship with AHS. Stepping-stone. This has been an effective change. I feel our sites are good providers of healthcare. AHS should welcome our expertise. It appears to me that Covenant Health has been working hard to become an excellent provider for AHS. There are many well informed &quot;highly trained&quot; staff in multidisciplines that could offer help to AHS especially in the Diagnostic Services area. I believe it takes time but can slowly see a change with the AHS mentality and positioning. But we always have been.</td>
</tr>
</tbody>
</table>
I've always felt we were.
Yes, we are definitely doing this.
Patrick good relations with Dr. Duckett; positioning us well
has competition no doubt, but we are in the running
We are second movers
Now who is going to tell AHS that.
I thought Caritas was too.
Still feel we are back benchers with AHS.
Recognition limited.
We are still strongly governed by AHS and what is financed by the government, we seem to be the poor brother-in-law.
In the eyes of AHS, Covenant Health does not seem to have the same acceptance/respect as Caritas. They appear to have divorced themselves as a team player with us, going completely independent.
We are not as well known as Alberta Health Services. I feel like we get "lost" and are the unknown relative.
Definitely a larger voice to be heard province wide.
Please see my previous comments.

b. Greater voice to shape and positively influence the health care system

Governing Board No Comments
SLT No Comments
Leadership Lethbridge is leading the province in DAL.
Strength in #s.
As a group we have a much stronger voice which will hopefully allow the other organizations/AHS/etc. to take us more seriously.
With the political backing & that of the Catholic church we have a stronger voice.
- on our own, we would be "lost in the shuffle".
Absolutely yes, without a doubt.
Yes, I agree but again Covenant Health has to be more advertised to the people - you may know, lots of others don't.
Yes, there is strength in a larger organization.
In the old environment Caritas may have been heard. Rural sites would have been left out.
Patrick and the Board are doing an excellent job.
Rural Boards Alberta Health Services is listening to us and genuinely is interested in our input in a number of instances. AHS is also looking to us for assistance (B).
Cohesive collaboration is most effective to influence policy (B).
Definitely we can as a group influence the system. Alone we would have been lost in the shuffle (B).
I hope so.
Would hope that this happens, but do not get this feeling at meetings with AHS employees..
As staff, we still feel management doesn't really listen to staff's concerns. We feel micro-managed.
No, you need to have communication. This facility lacks communication.  
AHS seems to have a much stronger pull at present.  
We all endeavor to ensure that our facilities provide to our communities that we serve. I feel with Covenant Health this is being achieved with much thought and discussion.  
Strength in numbers.  
Our combined strength should help on a provincial level to give us a greater voice.  
We have a greater resource pool to compare and create the best possible service to the health care system.  
There is always strength in numbers...especially if we are all on the same page.  
As a small rural facility - we feel we now have a voice.  
Could not have had as positive an influence on our own.  

Urban CC  
If our focus is solely long term care, we are losing strength and credibility from acute care.  
I hope so but do not see evidence  

Urban Acute  
I saw Caritas as a strong voice.  
Sometimes bigger is not always better. If it creates more executive jobs, that takes dollars away from the patients.  
not convinced.  
I believe that the rural sites have absolutely benefited with the merger.  
We could if the blinders of the church were removed.

c.  **Single point of accountability for quality and health service delivery**

<table>
<thead>
<tr>
<th>Group</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Governing Board</td>
<td>No Comments</td>
</tr>
<tr>
<td>SLT Leadership</td>
<td>Not yet. I think there is great opportunity with this but we are not there</td>
</tr>
</tbody>
</table>
| Leadership     | Moving forward. Yes, for sure - processes still need to be established for outcome measurements.  
                  Getting there.                                                                  |
| AHS zones       | AHS zones still requesting information as well as Covenant Health - double requests. We should just have to report to Covenant.  
                  End result - Are we there yet?                                                   |
| Processes need  | Processes need to be developed.                                                            |
| to be developed | It will take time to have "all on board".                                                 |
| Still in process|                                                                                           |
| Rural Boards    | Yes, there is a much better line of authority and responsibility in our system (B). This must not assume that the sites were not providing accountable quality and service delivery before the merger (B). |
| Rural Staff     | ? There is a public & the Catholic. This is not a single point.  
                  Accountability for all health care at all levels is an issue.  
                  We are accountable for our own actions as professionals.  
                  Governed by AHS. Covenant Health then facility communication is very lacking. |
Still a lot of uncertainty and confusion re: when we do what our zone is doing n& when we wait to hear what Covenant Health wants us to do. Not sure of dotted lines of accountability to various areas of service delivery & how Covenant Health (or if...) is providing input to AHS provincial initiatives.

one Voice.

At this point the overall accountability of the organizations has not been realized.

Accountability confusing due to AHS business alignment on a day to day basis.

It provides a 2nd point of accountability. Single point would be if there was only AHS.

I would expect this to be a significant improvement over the unwieldy Alberta Health system.

We report to one body ensuring quality and accountability for our services.

By having the same standards between each site the best quality and service can be delivered.

By combining manpower expertise reference for rural site we will be improved.

Continue to improve

Urban CC

Covenant Health is not the single point of accountability - as we partner with Alberta Health Services for quality and health services delivery.

The name change was an unproductive expense

Urban Acute

To who, Health Care or patients? I think patients simply see as as healthcare.

But only for those institutions under our governance.

To an extent, There are too many facilities/surface area to really ensure the quality on a daily basis.

Not sure what this is trying to get at.

not sure what this is asking I think Covenant Health demonstrates accountability and quality...within participant facilities/services.

Only within Covenant Health and not the provincial structure.

Level Two: GOALS FOR SUCCESSFUL MERGERS

1. Covenant Health Executive has developed a strong and positive team.

   Governing Board  No Comments
   SLT               No Comments
   Leadership        They seem very cohesive & seem to enjoy each other.
                      Depends on their area.
                      Strong yes - positive for the most part.
                      Overall...some hold was @ some sites.
                      Absolutely. I feel blessed to be here and appreciate the transparency in difficult times.
                      They have always had a strong team but it has become even stronger.
                      I always feel rejuvenated after being together, strong and positive to take back to my team.
                      Yes and still working at getting stronger.
                      Regular meetings/sessions such as today.
I find it quite remarkable that such a highly skilled, positive and cohesive team has come together in such a short period of time (B).

Hard working, effective team (B).

Our CEO holds general staff meetings periodically to inform staff, to re-inforce our values and stewardship efforts - where we stand - how we can help each other & operate in a spirit of cooperation - or one team contributing to the whole of Covenant.

 Seems to be that way.
What limited exposure I have seen seems to be working well together. A god mix of resources.
Seem to be good people in top leadership all with great commitment.
Don't see a lot of this.
Mostly negative team.
Who are you?

Do not have the opportunity to work with Covenant Health Executive team on a close basis
the team still is coming together from all sites....depends what you mean as 'team'...which level of management?
CONTINUES TO BE A WORK IN PROGRESS

The teams I work in are strong but are hospital based.

2. The Covenant Health leadership team connect with people through out the entire organization routinely

Another work in progress.

We need more opportunities to do this.

SLT members rarely seen in the Edmonton sites, except running to meetings.
Patrick - yes. Rest of the leadership team not so good.

Until we are all on the same IT system, this is unlikely to happen in a meaningful way. Our site is routinely missed when announcements are made.

Excessive reliance on email = less "good conversations". Lots of asking for information, somewhat redundant, not enough coordination "from the top".

The President forums are priceless - never waiver on this venue!
The President forum is very positive - the executive team is visible to all.
and with the community boards.
Not regularly but there is effort.
Good work here - please continue the openness and availability.
Immediate is okay, don't know about non-direct reports.
Should improve over time.
I do not believe the proper relationship of senior executive does this at all - it is not apparent at all.
Not often with the frontline

Yes this is happening (B).

We need more regular communication about the Covenant Health Board meetings (B).
Site visits & emails reinforce this.
Yes we have had Patrick come and periodically on site & through teleconference to inform us, answer questions & to make sure we are included in the sharing of information.

I have seen Covenant Health leadership in meetings and in staff in-services, seem accessible.
Some baby steps but lower level ideas are not always acknowledged.
True: but the connection was frequently negative.
Individual reposts will be contacted but not the entire team.
Connection by the leadership team could be enhanced - there is president's forum regularly, but no regular contact with some of the other leadership team

**THIS IS IMPROVING AND NEEDS TO CONTINUE TO IMPROVE**

**Urban CC**

**Urban Acute**

Connect leaders more than teams.
Via electronics only?
Between MCH and GNH
the attempt is there, but many do not buy into it or want to extend themselves to get to interact…it is just a job.
I've never seen one come to our office.
Majority of staff have no idea who Patrick is or our site VP.

3. **Covenant Health is beginning to develop clinical integration across sites and sectors**

**Governing Board**
No Comments

**SLT**
I don't think we have really begun this work. Although I do believe (1 VP) is further along.

**Leadership**
Some discussions regarding pulling together. Establishment in the org structure re: Director of Medicine support this.
Remote areas make this more difficult.
In my own area I so not see this at all which is most unfortunate.
Beginning… needs lots of work only some sites are affected.
Yes, surely can not be done over night.
Still early.
A lot of work to be done.

When new facilities were added the materials m management should go to the sites & help integrate into the existing service. This should also include policies and procedures.
Yes - great to see- we need to stop wasting time reinventing the wheel.

Ground work to allow this to happen has been done well - it will just take more time to integrate more fully.

**Rural Boards**
I think so (B).

Yes the initial steps have been taken (B).
Rural Health Strategy initiative (B).

**Rural Staff**
I don't see this yet but perhaps I lack the knowledge.
I have not had much experience with this.

? I don't see this yet.
Have not seen this development yet.
Not there yet.  
I think this is happening.  
This is improving.  
Starting the process, more work is needed.  
We are beginning to "gel" as different sites are sharing & contributing - making sure we develop the clinical integration of all of our policies - making sure we are aligned with AHS.  
Agree, however slow progression at the department levels. Looking forward to this enhancement.

Urban CC  
Urban Acute  
It's a starting point.  
Perhaps it is happening in some programs, but I have not seen evidence of it yet.

4. Covenant Health is building strong connections between the Boards and the communities where facilities are located.

<table>
<thead>
<tr>
<th>Group</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Board</td>
<td>No Comments</td>
</tr>
<tr>
<td>SLT Leadership</td>
<td>(One community) Board I don't feel is engaged, although I believe the other boards sound like they are connected.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Not in smaller communities.</td>
</tr>
<tr>
<td></td>
<td>As evidenced in retreat reporting.</td>
</tr>
<tr>
<td></td>
<td>Just beginning.</td>
</tr>
<tr>
<td></td>
<td>Our local board has struggled a little with the new role that up until recently was not clearly defined.</td>
</tr>
<tr>
<td></td>
<td>Not really sure - it does sound like it is starting?</td>
</tr>
<tr>
<td></td>
<td>Appears to…</td>
</tr>
<tr>
<td></td>
<td>-you're getting there.</td>
</tr>
<tr>
<td></td>
<td>Community Board &amp; Governance Board needs further enhancement.</td>
</tr>
<tr>
<td></td>
<td>Not so sure the communities understand Covenant Health.</td>
</tr>
<tr>
<td></td>
<td>MS &amp; SM participating in the mtg give guidance &amp; provides connection.</td>
</tr>
<tr>
<td></td>
<td>Meeting the board was a great experience - I would like to see more examples of such interactions (Staff recognition events) - greater visible leadership.</td>
</tr>
<tr>
<td>Rural Boards</td>
<td>Good start (B).</td>
</tr>
<tr>
<td></td>
<td>Work in progress (B).</td>
</tr>
<tr>
<td></td>
<td>It's beginning to do so (B).</td>
</tr>
<tr>
<td></td>
<td>Nothing further than what the existing (past) boards have done (B).</td>
</tr>
<tr>
<td></td>
<td>That may be too early to judge but I am confident that this goal will be achieved (B).</td>
</tr>
<tr>
<td>Rural Staff</td>
<td>i.e. H1N1 - pandemic need forms - AHS has Covenant Health has forms: then site has to make own. Only one person knew Rhonda McCarty!? No information passed on. Rhonda reports to higher ups - not correct information given.</td>
</tr>
<tr>
<td></td>
<td>There is still considerable confusion.</td>
</tr>
<tr>
<td></td>
<td>I haven't as yet observed this.</td>
</tr>
<tr>
<td></td>
<td>Our VP is a regular visitor to our site, to community boards, e.g. our community members on the Foundation Board.</td>
</tr>
<tr>
<td></td>
<td>The formation of the Community Board is a strong voice for our community and surrounding communities.</td>
</tr>
<tr>
<td></td>
<td>Site ED meets with Community Board.</td>
</tr>
</tbody>
</table>
At least I hope so. I can’t really comment on the experience of communities that I know little about.

5. **Covenant Health has built a strong vision.**

- **Governing Board**
  - No Comments

- **SLT**
  - No Comments

- **Leadership**
  - It seems to change. Now the mental health news of the community are more NB than the elderly. What about acute care?
  - We have a much clearer idea of where we are going. It is good to see what is expected of us - allows us to shape our goals & provides us with tools to use.
  - & powerful.
  - Amongst leaders yes. To the frontline, not certain.
  - I agree but only the people within Covenant health know this - I would spread the word.
  - Yes - absolutely.
  - Nice work done in this area.

- **Rural Boards**
  - Yes this is a reality (B).

- **Rural Staff**
  - Yes - strategic planning.
  - Covenant Health is always giving us direction as to our vision & goals, to be of service to the needy; to provide healthcare services to our communities, etc.
  - Mission/Vision/Values statement - to staff.
  - Compassionate health care is what we are striving for.
  - I agree and it is represented well on paper as well as with staff expectation.

- **Urban CC**
  - Our vision is very clearly identified and emphasized with new and existing staff.
  - don't think there was anything wrong with the old one.
  - I have yet to see it.
  - Just need to get it out to the frontline staff.
  - Covenant Health does not seem to follow the vision, mission and values they print.

- **Urban Acute**
  - I don't see it or am aware of it.

6. **Covenant Health is building a sense of engagement with stakeholders and communities.**

- **Governing Board**
  - More work needs to be done within the Edmonton Community. This is a factor of both scope and size.

- **SLT**
  - This work is just beginning

- **Leadership**
  - Getting stronger as Covenant gets "known" by the public and what Covenant stands for/represents.
  - Growing.
  - Agree - it's starting did you see the Sun article?
  - Again we are getting there but do not think we are there yet.
I have heard of some evidence of that but have-not been directly involved which at a managerial level is an underutilization of using our leaders & staff positions & contacts in the community. Just beginning - lots of work needs to be done.

Building.

Unsure about what is happening in non-Edmonton areas. In Edmonton, frontline staff still not feeling particularly engaged. Unsure of the progress in Rural Alberta.

### Rural Boards
This is an area that needs further work (B).

There is much work being done but it will take time to get everyone interested and on board (B).

Engagement and collaboration can't be overemphasized (B).

Haven't seen this happening yet (B).

### Rural Staff
I believe that they are but how, I am unaware.

Site ED meets with Community Board and stakeholders.

It is building it, It is not there yet.

I do know that our administration is involved with our communities to determine the needs of the community so we can best serve those - communication with local-municipal levels of community.

Return of Community Boards is a good start. I have not had much experience with this.

Not aware of this.

I assume this to be true. Unless you are in management I'm not sure we see it.

### Urban CC
Employee engagement survey and work in ongoing, but not certain about community engagement starting to do more of this.

need more feedback from stakeholders and communities

### Urban Acute
Lack of branding does not set us apart from AHS and does CH a disservice.

CH is working on building a sense of engagement.

Yes, a sense.

### ADDITIONAL COMMENTS

#### Governing Board
No Comments

#### SLT
As questions are all illusive it is difficult to answer for the whole organization. Could answer for own areas & portfolios.

#### Leadership
Does the frontline realize that Covenant Health just celebrated its first birthday? I think not - there should be some acknowledgment across the board.

With the addition of the small sites help should come from existing central sites. Often the smaller sites do not have resources (human & equipment) to do the job - utilizing best practice. Not enough benchmarking or utilization results.

Coming together has strengthened our position & enabled us to shape the provision of healthcare in our province. Lots moving in the right direction but still a lot of work needs to continue - but overall, great progress.

#### Rural Boards
There has been an enormous amount of work done and hopefully it will all pay off. Another year will provide more proof.

I have been very impressed with the progress to date.

#### Rural Staff
Site Administration appears to have so much to handle that there is not time to handle more minor areas.
I am proud to be part of Covenant Health and look forward to work and follow mission values for the years to come!
Very happy and appreciative of all efforts made by Covenant Health to enhance and retain services required in communities as well as a "big picture version".
I feel staff still feel disconnected with management and upper executive.
I find there is still confusion as to who governs us - Covenant Health or Alberta Health.
I have limited exposure between our site & other Covenant Health sites, therefore my insights are also limited.
I am very proud to be part of the Covenant Health group. Mission, vision & value is well being used and will be in the years to come.
I do not find the "openness" that is described as a priority that needs to be worked on
We serve the people of this province while being accountable for the resources we utilize. We need to speak with a collective wisdom to ensure this happens.
thanks for the opportunity!
Covenant Health has done an amazing job of "talking the talk and walking the walk". There is a palpable commitment to the Mission Statement which is demonstrated and supported by senior leadership. Well done!
This was a hard survey to answer. If my answers seem negative, it is not because I am down on my facility, but because there has not been any noticeable change to how things are done.
I don't think this survey was sell suited for employees in similar positions as mine.
I am new to Covenant Health but from day one I have been impressed with the welcoming atmosphere and dedication to patient care. Grey Nuns in particular has a friendly, supportive staff who truly work collaboratively. I'm impressed with the role of unit managers. They are knowledgeable and while have administrative tasks, they remain grounded in patient care and patient details. We all can be challenged with days that are busy and overwhelming. Yet the nurses at the Grey Nuns continue to practice with empathy, sensitivity and ensure patient needs are met. I'm glad to be part of such a successful team.

Why, given the words of the 'values we hold' (check them out) can the GNH go ahead and try to restrict the practice of XXXXXXXXXX individuals being seen on site, since this has been happening since 1996. In my opinion the Board has a lot of explaining to do
### Measure by group of stakeholder perception of level of success in achieving the goals

<table>
<thead>
<tr>
<th>Level one: IDENTIFIED GOALS AT CONSOLIDATION</th>
<th>Do Not Know</th>
<th>Disagree or Strongly Disagree</th>
<th>Agree or Strongly Agree</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Revitalize the mission, pursue a renewed vision for Catholic health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Since the formation of Covenant Health, the mission for Catholic health care in the province of Alberta has been renewed</td>
<td>11%</td>
<td>5%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>b. Renew and continue a legacy of responding to unmet needs</td>
<td>11%</td>
<td>5%</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>c. Expand our influence and be of greater service in communities throughout the province</td>
<td>10%</td>
<td>9%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>2. Leverage the strength of our 16 sites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Leverage the expertise and knowledge from all sites</td>
<td>24%</td>
<td>17%</td>
<td>59%</td>
<td>3</td>
</tr>
<tr>
<td>b. Enhance stewardship and accountability</td>
<td>20%</td>
<td>11%</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>c. Facilitates effective Governance and management</td>
<td>19%</td>
<td>17%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>3. Simplify and streamline relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Coming together as Covenant Health and through this first year's work, we are positioned to be a legitimate &quot;Go to Provider&quot; for Alberta Health Services.</td>
<td>10%</td>
<td>7%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>b. Greater voice to shape and positively influence the health care system</td>
<td>5%</td>
<td>8%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>c. Single point of accountability for quality and health service delivery</td>
<td>14%</td>
<td>19%</td>
<td>68%</td>
<td></td>
</tr>
</tbody>
</table>

**Averages**  
14%  11%  75%
**Level Two: GOALS FOR SUCCESSFUL MERGERS**

1. Covenant Health Executive has developed a strong and positive team.  
   - 13% 7% 80%

2. The Covenant Health leadership team connect with people throughout the entire organization routinely  
   - 16% 25% 59% 4

3. Covenant Health is beginning to develop clinical integration across sites and sectors  
   - 36% 18% 46% 2

4. Covenant Health is building strong connections between the Boards and the communities where facilities are located.  
   - 47% 10% 43% 1

5. Covenant Health has built a strong vision.  
   - 4% 6% 90%

6. Covenant Health is building a sense of engagement with stakeholders and communities.  
   - 31% 10% 61%

**Averages**  
- 25% 13% 63%

| Action plan to improve reds | >25% | >19% | <60% |
| Work on yellows            | >19% | >15% | <79% |
| Celebrate greens           | <5%  | <6%  | >79% |
Appendix I: Phase Three Actual Costs and Compiled Results of Questions and Survey
Compiled Costs of Amalgamation

<table>
<thead>
<tr>
<th>AHC costing</th>
<th>2007/08</th>
<th>2008/09</th>
<th>Totals</th>
</tr>
</thead>
</table>

**One Time Consultations:**
- Consultants Fees
- Summits
- Reports
- Legal
  - Severance  -85,000  -350,000  -435,000

**Operational annual savings**
- Decrease in positions (2)
- Benefit cost reductions
  120,000  120,000

**Total Costs**
-315,000

### Covenant Health Initial Costs

<table>
<thead>
<tr>
<th>Infrastructure Redesign</th>
<th>New Funding Required</th>
<th>Reallocation From</th>
<th>Cost Estimates provided by CH CFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>No</td>
<td>CHG - CEO</td>
<td>0</td>
</tr>
<tr>
<td>Senior VP Urban Acute</td>
<td>Yes</td>
<td>No</td>
<td>-200,000</td>
</tr>
<tr>
<td>SOO MCH</td>
<td>No</td>
<td>CHG - MCH VP</td>
<td>0</td>
</tr>
<tr>
<td>SOO GNH</td>
<td>No</td>
<td>CHG - GNH VP</td>
<td>0</td>
</tr>
<tr>
<td>VP Quality</td>
<td>No</td>
<td>CHG - VP</td>
<td>0</td>
</tr>
<tr>
<td>VP &amp; SOO Urban CC &amp; Rehab</td>
<td>No</td>
<td>Continuing Care</td>
<td>0</td>
</tr>
<tr>
<td>VP &amp; SOO Rural Health</td>
<td>No</td>
<td>St. Mary's - CEO</td>
<td>0</td>
</tr>
<tr>
<td>VP Communications</td>
<td>No</td>
<td>CHG - Same</td>
<td>0</td>
</tr>
<tr>
<td>VP Human Resources</td>
<td>No</td>
<td>CHG - Same</td>
<td>0</td>
</tr>
<tr>
<td>VP Finance and CFO</td>
<td>No</td>
<td>CHG - Same</td>
<td>0</td>
</tr>
<tr>
<td>VP Medicine and Chief of Staff</td>
<td>No</td>
<td>CHG - Same</td>
<td>0</td>
</tr>
<tr>
<td>VP Mission, Ethics and Spirituality</td>
<td>No</td>
<td>CHG - Same</td>
<td>0</td>
</tr>
<tr>
<td>VP Planning</td>
<td>Yes</td>
<td>-200,000</td>
<td></td>
</tr>
<tr>
<td>VP Board Support</td>
<td>No</td>
<td>ACHC - CEO</td>
<td>0</td>
</tr>
</tbody>
</table>

**Increased Travel**
-100,000

**Consultants**
-200,000

**Retreats**
- Leadership May 2009  -35,000
- Board and Leadership Oct. 2010  -40,000
  -775000

| Total Cost | -1,090,000 |
Phase 3 – Exercise One – Large Focus Group Results

Absence of the Intervention: The participants sense of the impact or projected outcomes if Covenant Health consolidation had not occurred.

*Negative or outcomes that would likely have occurred if Covenant Health had not been realized or had the consolidation not been successful:*

1. Loss of human capacity or expertise
   a. relationship loss = increased time spent redeveloping alternative relationships
   b. loss of productivity
   c. loss of the value of a human investment = loss of experience and expertise developed over time
   d. orientation costs
   e. severance costs
   f. recruitment costs

2. Individual loss
   a. Use of Employee Family Assistance Program (EFAP)
   b. relocation costs
   c. marriage counseling

3. Administrative loss
   a. relationship loss = loss in productivity
   b. loss of time to develop projects
   c. projects put on pause, information lost
   d. loss of efficiencies, as people try to determine new efficiencies.

4. Loss of staff due to decreased desire to work for the "public" system
   a. severance costs
   b. re-education costs
   c. cost of time to recruit
   d. loss of positive union relationship, increased grievances

5. Time loss due to fighting for existence
   a. loss of productivity
   b. time focused on something rather than the work
   c. loss of reputation costs
   d. sense of hopelessness decreases efficiencies and efforts

6. Loss of personnel to the province of Alberta
   a. loss of professionals, loss of expertise, loss of corporate knowledge
   b. relocation costs (individual’s)
   c. cost to recruit, foreign in some cases

7. Involved in the chaos of the current system with loss of productivity
   a. loss of alternative solutions
   b. increase in further diseconomy of scale
   c. increase in monopoly of a single system = decrease of critical second sight.

8. Loss of buildings or services
   a. citizens now traveling to receive services = travel costs
b. loss of economic input for a community

c. loss of wages = unemployment costs, welfare recipients

d. some individuals unwillingness to travel to seek services initially may = loss of health status.

e. possibility of those no longer employed moving to an alternative community = decreased population in already sparsely populated areas

9. Loss of boards and community connections

a. loss of foundations = loss of fundraising opportunities

b. decrease of understanding of the system = confusion and loss of personal “way-finding”

c. marriage counseling

Positive implications realized through consolidation:

1. Opportunity to be explicit about our values and implications of who we are.
   a. increase in staff satisfaction = improved care, productivity
   b. increased staff engagement = retention and longevity of service
   c. secrets of the office kept
   d. maintain expertise

2. Coming together – sense of belonging, solidarity in our focus
   a. ease and commitment seen with the need to reduce the budget by 3%
   b. decrease in duplication of effort = time saved.

3. Clarity of role, engagement, and trust
   a. no blame = decrease in time loss, more positive and time efficient decisions
   b. increased time to focus on the work
   c. ability to work at a more strategic level, leveraging positive relationships to increase service and funding

4. Confidence of people in the organization
   a. shared information, increased safety, decreased litigation,
   b. open and honest communications
Phase 3: Small Group Questions: Cost Implications associated with Predetermined Goals of Consolidation
## Strategic Merger

### IMPACT ANALYSIS

<table>
<thead>
<tr>
<th>Benefits of Accomplishing Goal</th>
<th>Cost details if not successful</th>
<th>Benefit - Gain &quot;Financial Proxies&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revitalize the mission, pursue a renewed vision for Catholic health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 Since the formation of Covenant Health the mission for Catholic health care in the province of Alberta has been renewed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solidarity</td>
<td>Loss of unique contribution = loss of value to be different</td>
<td>Holistic approach inclusive of health and wellness promotion and early diagnosis/intervention models, decreasing demand on expensive acute care services</td>
</tr>
<tr>
<td>Sense of Purpose</td>
<td>Confusion between public system and Covenant Health</td>
<td>Strategic Direction costs for development and communication tools following development.</td>
</tr>
<tr>
<td>Unique contribution to the system</td>
<td>Disengagement of those who have a sense of pride working for a faith-based organization. People will leave.</td>
<td></td>
</tr>
</tbody>
</table>

### 1.2 Covenant Health’s renewed vision for Catholic health enables us to continue a legacy of responding to unmet needs

<table>
<thead>
<tr>
<th>Legacy of the sisters congruency</th>
<th>Loss of services</th>
<th>Strategic Direction Implementation: Rural Health Strategy Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building on Strengths</td>
<td>Impact on Communities</td>
<td>Mental Health services expand provided close to home decreasing travel for patients and closer monitoring decreasing acute events, improving quality of life for those with mental health illness. Investment in Seniors care provides close to home care improving satisfaction with care. Investment in Seniors care housing increases jobs in communities.</td>
</tr>
</tbody>
</table>
### 1.3 Coming together as Covenant Health has expanded our influence and enables us to be of greater service in communities throughout the province.

- Having spiritual care in the facilities and communities
- Greater access to services in the communities
- People know who Covenant Health is.
- Covenant Health has better access to the people.
- Learn from each other
- More expertise readily available
- Sharing of services

- Risk of losing a diversity and approach to services
- Loss of available services
- Loss of a facility

- Establishment of community Boards
- Education of the boards
- Governance and community board meetings

- Increased access locally, decreasing the need for people to travel to the city to have a common intervention.
- Loss of local autonomy

### 2. Leveraging the Strength of all 16 facilities

#### 2.1 Covenant Health is leveraging the expertise and knowledge from all sites

- Expertise translates to provincial direction, e.g. DALs e.g. Killam - cost to get this off the ground
- Strength in numbers
- Learning from each other
- Better support

- No growth, organization becomes stagnant
- Possibility of getting smaller
- Loss of flexibility
- Loss of sites
- Loss of identity
- Frustration
- Loss of engagement

- Meetings, telehealth, travel, accommodations. Amount of effort - organizational and personal costs.
- Travel
- Relationship building
- Communication

#### 2.2 During this first year as Covenant Health enhanced stewardship and accountability is occurring.
| More stable fiscally, e.g. we have avoided overtime costs | Deficits, lay offs service reductions, loss of reputation. | Consolidating financial statements and process. Cost of the time to figure it out. |
| Coming together did not cause major disruption or dislocation, etc. | Economies of Scale - shared resources and processes for increased productivity. | Loss of facility |
| Sustainable | Loss of a service Catholic Health care @ risk |
| Political tie ins. | Lack of direction. Loss of facility - public system takeover. | Establishment of corporate office |
| Balancing budgets | Potential for confusion Potential for disengagement Loss of productivity |
| Stability of local governance Reduced transition costs No loss of corporate memory | | Infrastructure to communicate. |
| Stronger corporate support for governance and management | | Debts and deficit. |
| Single point of accountability and voice = greater opportunities Increased flexibility | Accrued debt from Youville Liability from Vegreville Developing new structure and evaluating positions |
| | Cost of Bert Boyd and consultants |
| | Hay review Loss of ED |

2.3 Because of coming together as Covenant Health effective governance and management is facilitated
### 3. Simplify and streamline relationships

<table>
<thead>
<tr>
<th>3.1 Coming together as Covenant Health and through this first year’s work, we are positioned to be a legitimate “Go to Provider” for Alberta Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Media = money and positive reputation.</td>
</tr>
<tr>
<td>Improved reputation equates to better fundraising; money attracts money.</td>
</tr>
<tr>
<td>Confidence attracts staff and resources.</td>
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</tbody>
</table>

### 3.2 Being together as Covenant Health we provide a greater voice to shape and positively influence the health care system.

<table>
<thead>
<tr>
<th>Repeat info in 3.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival of Catholic healthcare</td>
</tr>
<tr>
<td>Clear on mission, vision and values</td>
</tr>
<tr>
<td>Clear direction</td>
</tr>
<tr>
<td>Same as 3.1</td>
</tr>
<tr>
<td>Swallowed by AHS</td>
</tr>
<tr>
<td>Redirection of services</td>
</tr>
<tr>
<td>Loss of community</td>
</tr>
<tr>
<td>Same as above 3.1</td>
</tr>
<tr>
<td>Loss of local autonomy</td>
</tr>
<tr>
<td>Loss of local board responsibility as defined in the past.</td>
</tr>
<tr>
<td>Loss of fund raising opportunity</td>
</tr>
</tbody>
</table>
### 3. Creating Covenant Health provides a single point of accountability for quality and health service delivery

| Focus on service | Loss of personnel | Loss of efficiency - things take longer going through corporate. |
| Protect; not trying to be all things to all people | Loss of local relationship. |

More support, infrastructure  
Stronger Voice  
More resources to call upon.  
Autonomy to make our own decisions  
Standardization no longer one facility bringing all the Catholic system down

Loss of services  
Loss of reputation  
More critical incidents, more fatalities  
Negative media and reputation.  
Loss of Catholic healthcare leading to impact on the church and social impact to other catholic systems such as CSS and Catholic schools

Consistency across programs  
shared learning improves services  
Inability to recruit.

Lack of local autonomy  
Increase in time requirements for reporting  
More accountability  
Accreditation Canada (year two)  
Loss of original quality supports with the pulling of AHS staff from rural sites.

### 4. Can you think of any other benefits/cost savings accomplished, not identified pre “Covenant Health” since the amalgamation?

Individual sites were able to maintain their identity - treated with respect.
Phase Three: Individuals Sense of Applicability of SROI
## SROI Application Comments

### How does this exercise of applying costs and benefits feel? Why?

Intriguing - Many layered. It gets at some good questions and raises some interesting issues/ Takes a lot of sifting and sorting though. Would have liked to see some categories for consideration - some structure to help sort through the many, many thoughts and ideas.

Very interesting way of looking at benefits of organizational structure.

It's somewhat difficult - values based decision making and social return on investment will always be a concept difficult to defined and adequately represent when trying to define it.

In keeping with Covenant Health values - it is not just about hard financials need to translate the soft dollar costs as well.

Unfamiliar however does help to stretch one's perspective more broadly.

Not the traditional approach taken, but does seem like there are good possibilities in looking at our organization.

Interesting yes to some degree

More may be able to be extracted with further thought and assessment.

May be some areas that have a financial impact which is direct - harder to ascertain the more indirect impacts.

It was helpful to pause and identify trends and critical junctures in our consolidation. As we prepare to take on new sites it is essential we learn from our experience - to report successful steps and to avoid same pitfalls.

Stressful exercise. Hard to put a dollar value on benefits and hard to allocate certain costs re: staffing, facility, boards, committees to determine what a benefit costs.

Was interesting and relevant, was made practical not theoretical.

It helps you reflect on why we came together and the value add we have as an organization. Assists with our focus as an organization

A little to subjective for my objective brain. I am not sure we can prove some of the answers we gave. It was based upon qualitative observations - or our best guess of what would happen. But a very important thing to measure

### Do you believe we have been able to identify financial measures/proxies that create a realistic picture?

Perhaps themes but not sure these will be quantifiable?

Measurable? However, it is an important start. I think the idea of “one” is important and a useful approach.

Yes I so believe we just touched the tip of the iceberg. There is many soft cost benefits that were barely touched.

Yes, however it is difficult to think in isolation. The bigger picture (AHS) may have caused some answers to be swayed one way or another. It sort of feels like a subjective picture more than realistic.

Yes - good start brainstorming was helpful to see different perspectives - corp., rural, acute.
Yes, it helps to reflect back on the past year and assess the cost and benefits.
Yes - it is amazing how many SROIs there are and that these need to be factored into new strategies/consolidations going forward. I strongly recommend you capture SROI in the rural health strategy, for example.
Yes - but looking at the cost of losing services - how it affects people, businesses and communities.
Yes, although more time for the exercise would have been beneficial
Yes. We make decisions that have purpose and are grounded in our values. This has financial measures
Not sure - yes is some cases

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Based upon these exercises do you see any potential to plan for the future based upon information gathered today...does the exercise add value?

Taking stock is a very important and useful exercise and today's discussion suggests future areas for inquiry and investigation.

Very much - have to see the increase value in relation to a longer period of time.
I think it is important to follow up on this info.
It will always be valuable to have this type of feedback.
I don't honestly know - exercise added value - would like to reassess with the organization in a couple of years.
Yes, as mentioned above.
Yes it will help towards building Covenant Health reputation - increased services, improved morale, better relationships.
Yes, probably good to distil the info for broader distribution so that others can learn.
Yes, info sharing and relationship building. This would be interesting to see 5-10 years out.
Would like to see it repeated at 3-5 years post merger.

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