Can Mission-driven Organizations Provide Community Services?

BY JOHN J. BUCKLEY, JR.

With managed care sweeping the country, Catholic healthcare organizations are asking how they can remain faithful to their traditional mission and values in light of shrinking resources. A recent study[1] confirms that mission-driven providers face thorny challenges. Researchers examined private healthcare providers' role in public health and population-based services in their communities. They surveyed eight facilities (none of which were Catholic) in large urban areas. The research revealed that providers' ability to comprehensively serve their communities may be jeopardized by several factors, including the following:

- Community benefits activities are infrequently related to operational strategy.
- Projects are seldom done in collaboration with other organizations and are narrowly focused on a neighborhood or group.

Motivation for Community Benefits

The researchers used the Institute of Medicine's framework of three core private health functions—assessment, policy development, and assurance—to evaluate the organizations' community benefit programs. They discovered that the majority of these programs were motivated by mission and other altruistic purposes such as addressing root causes of health problems or reducing barriers to access (rather than by business concerns such as increasing revenue).

Where community health services are placed in the organization reflects these altruistic motivations. The responsibility for these services was usually vested in corporate offices or in departments on the periphery of the organization's business strategy, rather than in an operating unit.

The report points out that healthcare organizations—squeezed financially by declining admissions and lengths of stay, changing practice patterns, and new reimbursement structures—are scrutinizing all their activities to see how they contribute to the business strategy. Thus the report predicts that the placement of community benefit activities at the periphery of the organization, without established connections to operations, will be these activities' "undoing."

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As the study ironically indicates, managed care and capitated payment may decrease the emphasis on prevention and public health. Respondents said that many of their organizations had been preparing for capitation by becoming leaner and more cost conscious. When projects met opposition, financial officers and administrators were the persons most likely to provide it.

The report adds that the community activities most likely to be dismantled are those with the most potential to support the organization's changing operational strategy: "If indeed the market moves to full-risk capitation, and the organization's interest is in assuming responsibility for the health and health care of covered lives, then the visibility in the community, the network of alternative delivery sites close to the enrollee, and the emphasis on community-wide primary prevention efforts all support a successful strategy."[2]

Narrow Focus

The study indicates that needs assessments were frequently intense and comprehensive, but they were also often uncoordinated, duplicative, and disconnected from business strategy. Assessments were usually concentrated in one neighborhood, and policies were established for a neighborhood or addressed a specific issue of a particular group. Almost 40 percent of community efforts were undertaken by the organizations acting alone, rather than with other organizations.

Moreover, competition among healthcare facilities and systems impeded successful implementation of projects. A healthcare organization often offered a wide array of services to targeted populations but with little coordination or collaboration inside or outside the organization.

Continued on page 62