A TIME TO LEAD:

Shaping Your Community's Healthcare Future

79th Annual Catholic Health Assembly
June 5-8, 1994, Philadelphia

Introduction

HEALTHCARE REFORM ON THE HORIZON

Healthcare reform is just around the corner, policymakers warned more than 1,200 Catholic Health Association members attending the 79th Annual Assembly. In the promise of reform lie threats, opportunities, and—most of all—challenges.

The challenges take many forms: increasing demands on leaders to shape their organizations' future and ensure continuation of the Catholic healing ministry; requirements for collaboration, often with organizations that differ in many respects, if not in the basic values held; and a growing call for attention to the health and well-being of communities.

Throughout the assembly, speakers highlighted the best and brightest ideas for making integrated delivery networks a success. And they spoke to the spirit as well, calling for renewed commitment to the ministry and its mission. As underlined by CHA's study on leadership competencies (p. 35), the key to leadership excellence in the current environment lies not just in business acumen (though that will be required), but also in a personal dedication to the ministry's goals, to its values, and to the people it serves.

Breakpoint Change Necessitates Partnerships

George Land

> **This period of discontinuous change calls for creativity and a recognition that everything is connected.**

"Paradigm shift"—one of today's most hackneyed phrases—is not radical enough to describe the challenges of our current environment. George Land, president of Leadership 2000, Inc., Phoenix, has coined a more accurate term—"breakpoint"—to describe a time of change in which old solutions no longer work because the rules have shifted 180 degrees from what we have always known.

This current period of discontinuous change is analogous to what happens in systems of nature, Land said in his keynote address. In organizations, as in nature, the first phase is formation, where the system is attempting to find a pattern. This is an unpredictable, creative stage, characterized in business by the entrepreneur.

Once the pattern has been established, then a breakpoint happens, Land said, and the rules guiding the system radically shift. In this second phase, organizations succeed by repeating, extending, and enhancing the pattern established in the first phase. The key player is the manager, who maintains order and limits creativity.

Eventually, however, "the system uses up its potential in the environment," Land explained, and so it hits another breakpoint, where again the rules change 180 degrees. The outcome is integrated partnerships—a hybridization whose outcomes are unpredictable yet far more successful than anything in the past.

"In the third phase, the system is constantly reinventing itself at higher levels of complexity," Land said. Success in this phase hinges on the synthesis of things that were not together before, the synergy that comes out of that, and the discontinuity of change, which enables a leap to another level of performance.

Land pointed to the examples in nature, where every cell in the body works together cooperatively because every cell shares the same vision of the whole. He said that it is essential within organizations that people know where they are and where they are going, and that they be able to course-correct by learning and creating on the way.

The learning organization, Land continued, is forced to look at reality in a new way, akin to the new view of nature that recognizes it is evolutionary and creative (as opposed to linear and logical). Land said that his company has tested people's creativity and found that although 98 percent of four- to five-year-olds are working at their highest creative potential, the same is true of only 2 percent of adults. "We teach children to set up an immune surveillance system to eliminate anything new or different," Land said. "Judging squelches creativity and our capacity to work with others."

Another new realization about nature, Land pointed out, is that everything is connected. Following this, "the most powerful business principle I know of is unconditional love," he said. He noted that integration, cross-functional teams, and other recent trends are all based on this principle.

Land's final piece of advice is that we "dare not work from the past—we have to look at future probabilities." He noted that learning organizations thrive on failure and mistakes, learning and creating along the way. "We are coming out of a great era of limitations," he said, "limitations that led us to this platform from which we can spring to a new future."

George Land
NEW FUTURE

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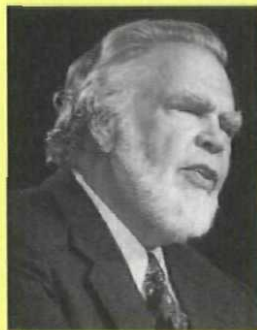# Prerequisites and Steps for Building a Regional System

David A. Anderson

> **Providers creating regional health systems must devote significant time and effort to getting the right elements in place.**

Providers should not assume that they can evolve naturally from their current role to the role of assuming clinical and financial risk for the health status of a defined population, David A. Anderson, a partner at KPMG-Peat Marwick, Chicago, cautioned in his keynote address. "This is not a natural evolution," Anderson stressed. "It is something that is going to take significant time and effort."

Providers committed to creating a system that truly serves its community must have the right elements in place before they can succeed,

Anderson said. Visionary, committed leaders are the first requirement, he pointed out. Without their influence, systems can never achieve the functional integration (e.g., of human resources, information systems, and planning) required to integrate clinical services so that they meet identified needs.

Physician-system integration is another prerequisite to meaningful progress on clinical integration, Anderson noted. "The further along organizations are in both forms of integration, the stronger they tend to be on most measures of financial performance," he said.

The top priority in developing a system, Anderson reminded the audience, is "to connect community needs to resource requirements." To achieve this, systems will need to establish mechanisms enabling them to "continually put in information on outcomes and effectivenss research and use that to build guidelines and protocols that drive their CQI and TQM processes."

David A. Anderson

Anderson suggested that organizations adopt a six-month game plan to prepare themselves to function effectively as regional health systems. The first step is to change attitudes that might block successful system implementation. "Leaders must begin by sending the message that there is no going back, that the past is gone," Anderson said. He also urged managers and adminstrators to give up the "own and control" mentality that has long characterized healthcare management.

Once on the road to regional integration, Anderson said, leaders should ask themselves what size their system should be given its mission and market and how to achieve that size. They should also investigate how to align management and governance structures to support clinical integration and whether to own hospitals or insurance companies.

A final challenge for system leaders is to evaluate the current corporate structure—along with the personnel who make up the managerial and adminstrative team—to determine whether the skills and positions currently in place are right for a regional healthcare system, Anderson said. Such skills include the ability to negotiate, manage conflict and change, and build teams, he noted.

But perhaps the most critical skill for system leaders is the ability to implement their goals, Anderson concluded. "Being a visionary is not enough," he said. "For system development to succeed, leaders themselves must be in the trenches."

Building a Regional System

STEPS TO INTEGRATION

David A. Anderson offered the following as further near-term steps organizations can take in preparing to become a regional system:

■ Think through the epidemiologically based needs of community health.

■ Restructure internal financial reporting to reflect the move from revenue centers to (partial) cost centers.

■ Put a doctor or nurse (or both) *in charge* of something meaningful.

■ Give all hospital (and other operating unit) leaders responsibilities (and rewards) for cross-continuum activities.

■ Send some of your brightest, most promising doctors to a "mini-business school."

■ Send some of your brightest, most promising executives to a "mini-medical school."

■ Put someone in charge of clinical integration for your system.

■ Build a long-term game plan to become a more integrated regional health system.

LEADERSHIP

CHA Introduces Competency Study

John B. Larrere; David C. McClelland, PhD; Rev. David J. Nygren, CM, PhD; Sr. Miriam D. Ukeritis, CSJ, PhD

A landmark study pinpoints competencies of outstanding leaders in Catholic healthcare.

Four persons involved in CHA's landmark study on leadership competencies addressed the study's rationale and implications in a panel discussion moderated by Philadelphia television personality Diane Allen.

The study found that outstanding executives in Catholic healthcare compare favorably with their counterparts in business and industry in conventional measures of competency. More striking, they demonstrate additional competencies that have not been found in similar studies of outstanding executives (see **Box**, p. 36; also see *Health Progress*, June 1994, pp. 28-36, for a full description of the study).

David C. McClelland, chairman of McBer & Company, Boston, and a long-time student of leadership competencies, noted that one distinctive strength of leaders in Catholic healthcare is a

combination of self-confidence and positive regard for others. He defined self-confidence as the ability to "stick to your guns—the feeling that you can still bring something off in spite of encountering difficulties."

In religious terms, such self-confidence can be defined as "being a friend of the truth"—a conviction that "what you are doing is God's will," McClelland said. Self-confidence of this kind can be dangerous, he acknowledged, unless it is balanced by a tendency to see the best in others. "The combination enables these leaders to act decisively but also to avoid arrogance," McClelland noted.

John B. Larrere—senior vice president, Hay McBer, Boston—acknowledged that he had not expected to find such a distinctive set of competencies among leaders in Catholic healthcare. "Compared to leaders in other areas, who are often motivated most by the desire to have an impact, leaders in Catholic healthcare have more of a need for personal relations," he said. Larrere added that this motivation showed most in the spirituality of leaders in Catholic healthcare—the way they expressed their faith in God and in a personal and direct commitment to serving the poor.

Rev. David J. Nygren, CM—director, Center for Applied Social Research, DePaul University, Chicago—remarked that many of the concrete accomplishments of leaders in Catholic healthcare

Insight-driven Strategic Action

Achievement Motivation

Change Leadership

Information Seeking

Integrity

Spirituality

Analytical Thinking

Caring

Shaping the Environment

Positive Regard Self-Confidence

Interpersonal Understanding

Organizational Awareness

Service to the Community

Leadership

KEY COMPETENCIES OF OUTSTANDING LEADERS

Spirituality Cluster
Positive Affiliation
Faith in God
Finding Meaning

Professional Expertise Cluster
Achievement Motivation
Information Seeking
Analytical Thinking
Shaping the Environment

Integration and Action Cluster
Organizational Awareness
Interpersonal Understanding
Insight-driven Strategic Action

Caring for People
Personal Traits Cluster
Positive Regard
Self-Confidence

Caring Cluster
Service to the Poor
Integration of Ministry Values
Firmness and Compassion in the Face of Failure

Integrity Cluster
Genuineness
Moral Wisdom

Change Leadership

COMPETENCY STUDY PANEL
Panel discussion participants (from left to right, Rev. David J. Nygren, CM; Sr. Miriam D. Ukeritis, CSJ; John B. Larrere, and David C. McClelland) discussed the rationale and implications of CHA's leadership competency study.

can be traced directly to their spirituality and need for affiliation. "They think through their business and ministerial objective very clearly," Fr. Nygren said, "but the analytic process is screened by a set of values that helps them identify the actions they should take."

Change leadership, another key competency, enables leaders in Catholic healthcare "to challenge the status quo where it needs to be challenged," observed Sr. Miriam D. Ukeritis, CSJ. A research associate at DePaul University's Center for Applied Social Research, Sr. Ukeritis said effective change leadership is rooted in the drive to serve people. She noted that the power of ministerial values gives leaders in Catholic healthcare the strength to take necessary action despite the resistance change such action often provokes.

Delving into Competencies

John B. Larrere; David C. McClelland, PhD

Motivation is a key to leadership effectiveness.

Studying competencies of outstanding leaders within a given field is critical because it helps organizations determine the best fit between "key situations" and leaders' disposition and talent, John B. Larrere said in a breakout session.

"People are effective when they match the right behavior and motivation to the right situation," said Larrere, who is senior vice president, Hay McBer, Boston. For example, a physician who defines herself as someone who helps people help themselves is likely to achieve better results than one who defines herself as "smart." The former, Larrere pointed out, will "know more about the patient in fewer visits, and thus be more likely to get relevant information about the kind of treatment the patient needs."

Although everyone understands that leaders are important to an organization, few grasp how profound their impact is, Larrere said. "About 70 percent of observable differences between organizational cultures can be explained by differences in the leaders," he noted, adding that differences in culture account for about 28 percent of differences in bottom-line performance.

Few grasp how profound leaders' impact is on an organization.

According to David C. McClelland—chairman, McBer & Company, Boston—one of the most interesting findings of CHA's competency study was the strong correlation between spirituality, caring, and moral integrity. But McClelland cautioned the audience against assuming that caring and spirituality were essentially the same thing. "I have found that people quickly burn out when they want to care for people but lack a deep sense of the meaningfulness of their activity. Mother Teresa doesn't burn out."

One key to Hay McBer's approach in analyzing competencies is to observe actions that hint at "just-noticeable differences" in the way leaders embody certain competencies. For instance, the commitment of a leader who explicitly maintains direct services for the poor will be less than that of one who initiates new services. But the strongest evidence of this commitment would be when a leader displays or expresses strong delight in helping the poor. The advantage of developing such a graded series for a particular competency, Larrere noted, is that it allows an organization to recognize a desirable competency in a leader and at the same time identify a direction for strengthening that competency.

McClelland said that his experience in working with leaders to develop competencies has taught him three important lessons. First, the leader has to see how the competency meaningfully fits into her or his life. Second, although people can develop competencies on their own, they are much more likely to succeed if they have the help of a group—with peer support and someone who can lead them through exercises. Finally, the process must be specific, with clearly defined goals and concrete feedback.
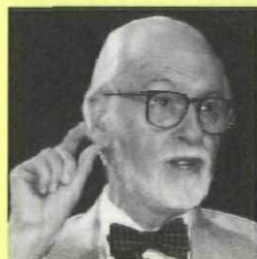
David C. McClelland
FINDING MEANING

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THE REFORM IMPERATIVE

To healthcare providers, the reasons for healthcare reform are more than just statistics; they're real people with real problems. But the often-heard statistics bear repeating:

■ Some 39 million Americans, including 10 million children, are without health insurance.

■ More than 85 percent of uninsured Americans work or are part of a family headed by a worker. In 1992, the number of uninsured in working families increased by 1.8 million persons.

■ More than 1 million persons in the United States are expected to

lose healthcare coverage this year when they become divorced, widowed, or too old to be covered by their parents' insurance policies.

■ Healthcare expenditures as a percentage of the gross national product (GNP) have more than doubled in the past three decades, from 7.2 percent in 1965 to an estimated 16 percent in 1995. By 2024, healthcare costs are projected to total 35 percent of the GNP.

■ Between 1980 and 1991, national per capita healthcare expenditures rose 9.3 percent annually, while employer premiums rose 14.4 percent annually as costs were shifted to employers to compensate for a growing uninsured population and payment shortfalls from public programs such as Medicare and Medicaid.

Nurturing the Drive Toward Healing

Rev. David J. Nygren, CM, PhD; Sr. Miriam D. Ukeritis, CSJ, PhD

> **The goal is to match the leader's values with the values of the institution and sponsor.**

Sponsors and others involved in the leadership selection and development process must respect the fact that potential leaders in Catholic healthcare usually come to the ministry with a strongly developed sense of purpose and meaning, Rev. David J. Nygren, CM, and Sr. Miriam D. Ukeritis, CSJ, emphasized in an assembly breakout session.

Persons seeking leadership positions are "looking to express their intrinsic drive toward healing," said Fr. Nygren, director of the Center for Applied Social Research at DePaul University, Chicago. For Catholic providers the question is whether this drive matches the organization's goals and purposes, he noted, adding that CHA's model of leadership competencies "will allow you to assess the possible marriage between this person's values and your institutional and sponsor values."

One of the key steps in implementing CHA's model is the behavioral event interview, said Sr. Ukeritis, research associate at the Center for Applied Social Research. "That's where you find out what's important to a person," she said, "what they speak about spontaneously." Those trained to perform the interview, which lasts about three hours, learn to look beyond "scripted" answers to plumb a person's fundamental values and concerns.

"There must be evidence from a person's past that he or she has demonstrated some of the competencies the model has identified," Fr. Nygren said. The behavioral event interview, he continued, "gets you beyond 'God talk,' anchoring your selection process in what people have actually done, as opposed to something they might merely espouse."

Rev. David J. Nygren, CM

Fr. Nygren said that the competency model can also be used to identify and assess potential leaders within an organization and provide them with formative experiences that help them along their career path. "You have to be able to identify baseline competencies—what someone needs to enter a position—as well as competencies that can be developed on the job," he noted.

Organizations also need to clearly define the paths aspiring leaders within their ranks must take to move up, Fr. Nygren said. "At any point along the line in the developmental process," he stressed, "a person should be able to say, 'I'm here, and I want to be there, and this is how I'm going to get there.'" In most systems, however, no clear idea exists of the skills and competencies expected of leaders. "Unless we concentrate on developing career paths and grooming people," he asked, "how can we expect our most competent people to stay with us?"
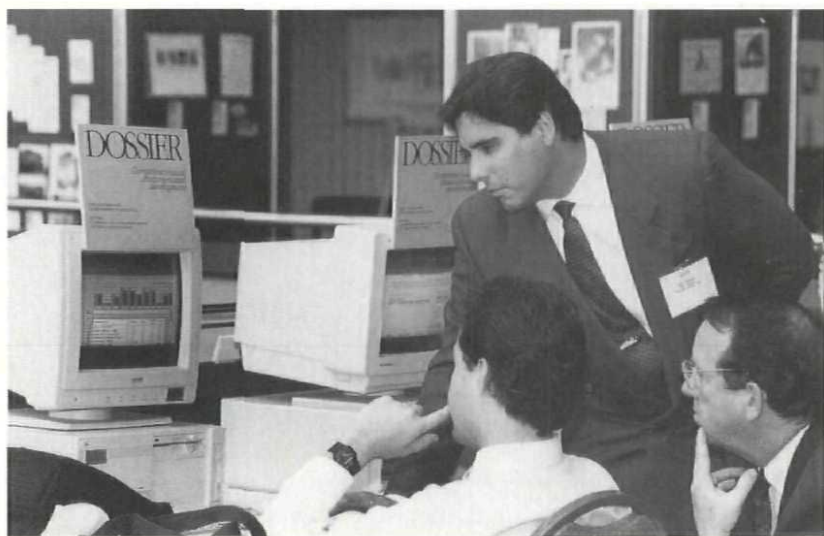

DOSSIER

CHA members preview Dossier, an assessment and development tool based on competencies identified in CHA's study of outstanding leaders. Using data collected from questionnaires completed by leaders and co-workers, Dossier identifies resources through which leaders can develop their competencies.

HEALTHCARE REFORM

Congress Grapples With Mandates, Cost Controls

Alice M. Rivlin, PhD

> **The Clinton plan gives consumers more choice among health plans.**

As Congress attempts to draft healthcare reform legislation that supports universal coverage, the two most pressing problems it faces are mandates and cost controls,

noted Alice M. Rivlin, director, Office of Management and Budget in the Executive Office of President Bill Clinton.

The Clinton administration views employer mandates as "the least destructive" course to ensuring affordable healthcare coverage to low-income persons and low-wage firms, said Rivlin. She pointed out that small companies' fear of an employer mandate is now dominating the debate in Congress, adding that subsidies will have to be provided for low-wage companies and low-income persons.

How to control costs is another issue plaguing Congress. Price controls are not attractive to Americans because of negative experiences in the past. The Clinton administration advocates "managed competition," in which consumers have more choice among healthcare plans and a financial stake in the outcome of that choice, explained Rivlin.

This combined emphasis on competition and choice, with local price restraints, will ensure that overall costs will not increase too rapidly,

Competition and choice will constrain healthcare cost increases.

she said. However, Rivlin acknowledged that some form of "premium caps" to control costs will be important when the reformed system is initiated. "We cannot expect managed competition to work instantly," she asserted. "Some form of cost control will be necessary."

Speaking for the Clinton administration, Rivlin thanked CHA for its "leadership and sound thinking throughout the healthcare reform debate." She emphasized that the administration drew on CHA's input as it put together its healthcare reform proposal. Rivlin touched on several principles CHA and the Clinton administration share such as universal healthcare coverage, benefits for the elderly, and

Alice M. Rivlin

physician choice.

Rivlin acknowledged CHA's opposition to coverage for abortion services, a position the association has repeatedly made clear to the White House, Congress, and the national press.

She emphasized that the Clinton administration "understands and respects your views and *expects* CHA to continue to make its views known."

Expect a Reform Bill

Sen. Jack Danforth, R-MO;
Sen. Tom Daschle, D-SD

Two senators predict compromise and caution but eventual passage of healthcare reform.

Congress will probably pass a healthcare reform bill this year, but not without caution and compromise, two members of the Senate Finance Committee told assembly-goers via satellite from Washington, DC.

Congress realizes that any reform legislation it passes will have an enormous impact on the nation, Sen. Jack Danforth said. He explained that legislators are worried they might "create something that maybe looks good on paper but that in practice turns out to be less than perfect."

The cost of reform, how quickly it will be implemented, and what it will mandate are the principal causes of concern in Congress, Danforth said. He pointed to recent projections that reform will create significant costs for the government.

Danforth noted that uncertainty about costs has led him to support a "pay as you go" approach to implementing universal coverage. "You have to make sure the savings are there first" before adding benefits, he said. Danforth also suggested that Congress take a cautious approach to mandates. He said an employer mandate to provide health coverage for their workers, in particular, would have "enormous consequences for the economy and employment." Mandated abortion coverage would also be unacceptable, Danforth noted, saying he would propose amendments to any bill that included it.

Sen. Tom Daschle predicted that no bill will pass in its current form but said "a great deal of agreement" exists on Capitol Hill regarding the fundamental principles of reform.

The most important goal is universal coverage, Daschle stated. But for such coverage to have a meaningful effect, the nation's healthcare system will also have to deliver higher-quality care, he said. Daschle suggested that achieving universal coverage and high quality depend on giving more
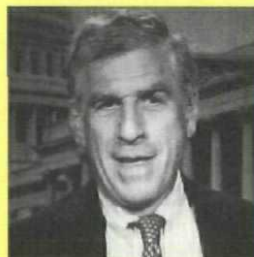
Jack Danforth
EMPLOYER
MANDATE

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important roles to alternative providers, such as nurse midwives, and changing people's perceptions of what a health system does. "I believe that we can change from an illness system to a wellness system," Daschle said. Such a transformation, he added, will not only make healthcare more effective; it will also reduce costs.

Real reform will require that people take greater responsibility for their health and for how they use the healthcare system, Daschle said. "Patients want everything," he noted, "but too often they do not appreciate what things cost." He said that practices which hide healthcare costs, such as cost shifting, must be eliminated as far as possible.

Broad-based support for achieving meaningful cost containment will be crucial to the success of reform, Daschle added. He said that proposals for malpractice reform, fraud reduction, and lower premium costs are among initiatives on the table to reduce costs.

Daschle does not believe that reform will involve a challenge to the tax-exempt status of not-for-profit healthcare systems. He did suggest, however, that the tax-exemption of benefits for individuals might be challenged under some reform scenarios.

THE FAITH TO CONFRONT CHALLENGES

Acknowledging that Catholic healthcare providers "may be tempted to turn away from the Lord, lose heart, become disillusioned, and retreat into the past," Rev. Gerald A. Arbuckle, SM, PhD, urged assembly-goers to confront the challenges with which they are faced by putting aside "self-interests, little kingdoms, narrow visions, and irrelevant strategies." At the opening liturgy, Fr. Arbuckle told participants that they could not ensure a strong Catholic presence in healthcare unless they developed "a faith atmosphere, fueled by commitment to the Eucharistic Lord."

Pointing to "the contemporary urgency for a Catholic healthcare system to witness to the dignity of human life," at the second liturgy Fr. Arbuckle, director of the Refounding and Pastoral Development Unit, Catholic Theological Union, Sydney, Australia, asserted that the United States does indeed need the Catholic healthcare ministry to speak against "situations in which human dignity is being threatened or crushed" through abortion and euthanasia.

Fr. Arbuckle focused on leadership at the third liturgy. In addition to "creative imagination and drive," Fr. Arbuckle suggested that Catholic healthcare leaders must have "a faith-based sense of humor that encourages them to laugh at them-

Rev. Gerald A. Arbuckle, SM

selves and to be open to the humanly impossible through the power of God in their lives." Without these qualities, "leaders will become closed to new ideas, arrogant, and even dictatorial."

Catholic healthcare providers risk losing security and that which is familiar as they face reform, Fr. Arbuckle noted at the Assembly's closing liturgy. He said, "Either we escape from reality or we face the challenges, moving forward with hope." Catholic healthcare providers cannot move forward, cannot change unless they are "prepared for daily conversion in faith to the person of the Lord. Change is all too threatening without him."

Physician Support For Reform

Robert Graham, MD

> **Despite fears of governmental control, most physicians favor healthcare reform.**

Although physicians as a group support healthcare reform, "more than anything else, they fear governmental control of medicine," according to Robert Graham, executive vice president of the American Academy of Family Physicians, Kansas City, MO. "This has been a mantra in physician organizations for more than 20 years and will continue to be so," he noted.

Despite these fears, most physician groups have come out with healthcare reform proposals, he said. "Generally, the last 10 years have been a frustrating and irritating decade for physicians," said Graham, pointing to constraints placed on their practices by third-party payers, Medicare, and the changing nature of the marketplace.

Still, individual physicians' desire for change is highly variable, Graham added, and generalists and specialists have divergent opinions. Generalist physicians—those on the front lines—are more focused on the need for comprehensive coverage and a broader scope of benefits, Graham said. "They have a good feel for the deterioration of benefits and financial barriers to medical care," he said.

Subspecialists—though also aware of inequities in the present system—are "less sanguine about whether to make the transition" to a reformed system, Graham said. He noted that specialists are more concerned about competition. Our education system has produced a huge number of well-trained subspecialists, not all of whom are needed, he said. These physicians see a direct and immediate threat in potential changes to a system where care managers of one type or another make more decisions about how many specialists of a certain type are need-

ed and whether patients should have direct access to subspecialists.

Graham laid out three potential outcomes and future scenarios growing out of the present reform debate:

1. Congress could pass meaningful, significant reform, assuring all people that their healthcare needs will be met. The system would still be decentralized and pluralistic, but with universal coverage, adequate benefits, and competition at the micromarket level for cost containment. In addition, individuals, rather than payers, would select their provider or provider group, thus ensuring competition on the basis of quality and eliminating an unhealthy relationship between providers and payers.

2. Concerned about elections, Congress could pass a bad bill that would put those without insurance into the Medicaid program without increasing the dollars available. This would entail the total corporatization of healthcare, with purchasers driven to find lower-cost alternatives and physicians and hospitals becoming units of production with little or no say in decisions.

3. Gridlocked by political considerations, Congress could fail to pass any bill and the issue would not be taken up again in the near future. If reform does not occur now, the likely ensuing healthcare crisis would prompt Congress to pass a single-payer system within five to six years, Graham said, as the number of uninsured doubles, insurance companies go insolvent, and hospitals find themselves unable to pay their bills. Although a single-payer system has been anathema to medical professionals, Graham noted that providers might be more comfortable with such a system where there is a degree of accountability not present in the alternatives.

SPIRIT AWARDS

Assembly-goers review the 1994 winners of CHA's Spirit Awards for communication achievement. Forty-four winners were chosen from almost 400 entries in 20 categories.

Answering the Call in a Pluralistic World

Rev. Martin E. Marty, PhD

> **Ten elements integral to the Catholic tradition are also transmittable to others.**

The call that gives coherence and mission to the Catholic healthcare ministry is still being answered by those in the ministry, Rev. Martin E. Marty said. But in our increasingly pluralistic society, selective elements integral to the Catholic tradition must be transferable to non-Catholics for there to be a distinctive identity, character, and ethos.

"You believe you have the true call, but not that you're the only ones who can respond to it or the only ones who can be served by it," he told the audience in his Flanagan Lecture address.

Marty, who is Fairfax M. Cone Distinguished Service Professor of the History of Modern Christianity at the University of Chicago, pointed out that several factors complicate the Catholic response to the ministry's call (or vocation): bureaucratization of the world, acceptance of a liberal (i.e., open) society, pluralism, and government involvement. However, these must not stifle the response, particularly during a time when the public is hungering for spiritual fulfillment.

Marty pointed to 10 elements in the Catholic call that Catholics can respond to but that "are also graspable and transmittable by non-Catholics in merged, governmentally related institutions and associations." Being Catholic, he said, means:

■ Being "pioneers and custodians of all those who like to speak of the 'holistic.' In the Greek sense of *katholikos*, "Catholic" means that "the principle of totality,. . .the good of a person's being as a whole," is central.

■ Having concern for the soul. Like individuals, institutions have souls—an integrated vital power. "You have to ask how they can manifest and put to work 'soul' in a time when there is patient hunger for its expression and system
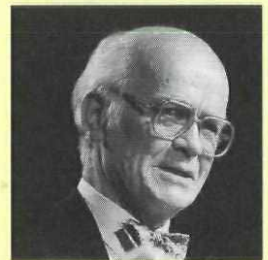
Rev. Martin E. Marty
INSTITUTIONS

Institutions, Marty said, have souls. "You have to ask how they can manifest and put to work 'soul' in a time when there is patient hunger for its expression and system unconcern for it."

unconcern for it," Marty noted.

■ Having a sacramental view of the world. Not only Catholics stand in awe of creation and nature, but they do take that awe, translate it to human life, and see what touches that life (including research, discovery, and care) as sacred. "Their response of praise is to be expansive, not limiting, as they work to enhance the sense of the sacred among others," he said.

■ Being attentive to human dignity. Marty pointed to the danger of reducing a patient to "the cardiac case in bed 3." "There is no question that the medical and healthcare delivery fields are not innately and not assuredly concerned with human dignity," he said.

■ Being "alert to the quest for human meaning." To efficient, bureaucratic, complex healthcare systems, this quest may look like a luxury, Marty noted. "Yet whoever has been a patient, whoever is a good listener and is empathic, knows that the search is primal."

■ Knowing the "value of ritualization of passages and experience of crisis." He pointed to Catholics' use of rituals, symbols, and myths to help people deal with pain and joy alike.

■ Knowing the importance of "human exemplarity in healthcare." Though not alone in this, the Catholic tradition is known for developing motivated personalities, for stressing "the Christian concept of the professional as minister and servant in a time when such defining exemplars are too rare."

■ Being responsible to community. The example of Catholics (whether in religious orders or lay voluntary associations) can serve as a model "in a time when hyperindividualism can be detrimental to well-being," Marty said.

■ Being moved by the call of justice. Again, this is not an exclusively Catholic trait but one essential to "put the response [to the call] to work in company with others who may hear the call in other terms."

Achievement Citations

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CHA HONORS INNOVATIVE PROGRAMS

The Catholic healthcare ministry has a long history of reaching out to populations with special healthcare and social service needs. Three hospitals with noteworthy programs were awarded CHA Achievement Citations at a special assembly ceremony.

The **Comprehensive AIDS Resource Education (C.A.R.E.) Program**, based at St. Mary Medical Center, Long Beach, CA, is a network of community-based HIV services and case management projects. The C.A.R.E. Program serves HIV clients in Long Beach, South Bay, and surrounding communities regardless of where they receive medical care.

The only project of its kind in California (and possibly in the nation), the C.A.R.E. program combines the accessibility and personalized service of a community-based program with

the resources and economies of scale provided by a large acute care medical facility. For more information on C.A.R.E., contact Carolyn Carter, manager of public relations (310-491-9885).

Another innovative service improving access to care for an at-risk population is offered by The Mercy Hospital of Pittsburgh. The goal of **Operation Safety Net (OSN)** is to reconnect the unsheltered homeless to the rest of the Pittsburgh community.

Initiated in 1992, the program operates through six teams of medical volunteers and formerly homeless who visit the unsheltered homeless at night in four Pittsburgh areas. The teams have made contact with more than 800 individuals, helping to remove many of the barriers (including hopelessness and mistrust) that prevented them from seeking necessary health and

human services. Through its coordinated citywide "safety net," OSN responds to a wide variety of needs, including housing, clothing, food, and transportation. For more information on the program, call OSN at 412-232-5737.

In Everett, WA, the **Providence Hospital Sexual Assault Center** provides education, support, and advocacy services for victims of sexual abuse and nonoffending family members. With 7 staff members and 45 community volunteers, the center has become a community leader in promoting and providing coordinated victim services. Since 1979, it has served more than 19,500 victims of sexual abuse and their families. Approximately 85 percent of the center's clients are under 18 years of age. For more information on the Sexual Assault Center, call Medrice Coluccio (206-258-7561).
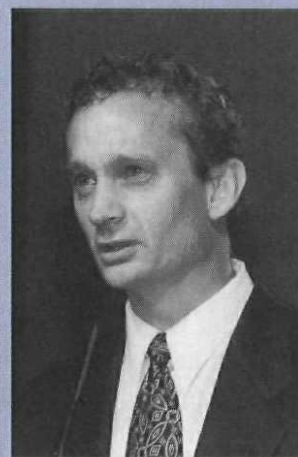
HONORING
FLEXIBILITY

Accepting the Achievement Citation for Operation Safety Net, Jim Withers, MD, who coordinates the program, thanked CHA for honoring the poor, those who have no voice. The award, he said, demonstrates the transformative power of the Catholic health system. "You're honoring flexibility and the willingness to see things in a new way. Let's not fool ourselves. Our salvation is linked to the salvation and health of those we reach out to touch." Look for Dr. Withers's "Human Element" article in the September issue of Health Progress.

■ "Knowing that a special ethos and ethic informs the different communities and persons" in our society. Marty asserted that Catholicism's special ethos is a transcendent call, but it is heard by many persons, whose needs are best served by considering their particular life stories and situations.

The Value of Managed Care

Molly Coye, MD

> **Through managed care, Catholic providers have the opportunity to offer high-quality services at a lower cost.**

As the U.S. healthcare system leans toward a managed care agenda, will Catholic hospitals choose to claim "spotted owl" status, maintaining they are uniquely valuable and should not be allowed to become extinct, or will they demonstrate value, showing they can improve their communities' health? The Catholic healthcare ministry must take the latter path, asserted Molly Coye.

Many communities are in the process of reforming their healthcare systems; however, they will be forced to rely on the national political process for two key elements: financing access to care for the uninsured and establishing a framework for accountability, stated Coye. To accomplish these, providers are focusing on managed care but question whether such a system is "friend or foe, obstacle or opportunity." Despite the challenges, managed

Molly Coye

care presents healthcare providers an opportunity to offer high-quality services at a lower cost, she said.

Coye, who is senior vice president, Health System Development, Health Dimensions, Inc., San Jose, CA, described California as a "laboratory for managed care." Providers there have found that managed care offers quality assurance and 24-hour access to care, reduces hospitalization, and reallocates money recouped on care for preventable illnesses to where it is needed—prevention.

To make a successful transition to managed care, California providers have done the following:

■ Increased access to needed services
■ Shifted resources to preventive services
■ Lowered costs
■ Educated families and individuals on home healthcare and self-care
■ Fostered cultural competence (e.g., by hiring employees who speak the "languages of the community")
■ Continually improved clinical quality
■ Built information systems for accountability

Managed care, Coye asserted, is about more than just lowering costs, it is about value as well. She pointed out that U.S. providers have increased costs beyond the point at which quality is improved, and lowering costs will not necessarily hurt quality. The challenge is to get quality to drive what providers do.

If those in the Catholic healthcare ministry can keep its vision alive, she said, the ministry will bring value to the reformed healthcare system because it delivers more than just healthcare, such as education and social services.

Access to services alone will not have a substantive impact on health, asserted Coye. Prevention will be important as well. Americans' health problems—because of tobacco use, poor diet, and alcohol abuse—can be met head-on at the community level, noted Coye. She described California's campaign in which television advertising (in English, Spanish, and Japanese), with the support of more than 200 community advocacy groups, led to a 17 percent decrease in tobacco use in three years.

ASSEMBLY SURVEY

Each day, almost 350 assembly-goers registered their opinions at computer terminals located near the registration area. Participants indicated that during the next several years, Catholic identity will be the most pressing issue facing the Catholic healthcare ministry in the United States.

A few of the many issues participants said they are addressing are immunization (44 percent), cultural barriers (41 percent), violence (29 percent), and transportation (26 percent).

Fifty-three percent believe competition among healthcare providers is good for communities, with 59 percent citing an impetus to maintain quality, pressure to cut costs, and a wider array of services as primary reasons why. Duplication of technology was often chosen (67 percent) as the reason why competition can negatively affect a community.

Almost 70 percent of respondents believe their leadership teams are equipped to manage change; however, when asked if they were looking forward to capitation, 53 percent indicated they were not or were undecided. Potential for undertreatment was respondents' greatest concern about capitation.

"Ultimately, healthcare providers are accountable for the health of their communities," asserted Coye. They must meet objectives such as preventing premature deaths and increasing years of productive life and access to care. If healthcare providers can accomplish these goals, through an increase in accountability and quality, they will "create a revolution," asserted Coye. "I believe that the Catholic healthcare ministry can lead this revolution in, for, and with their communities."
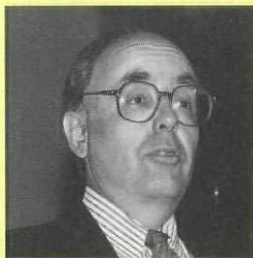
James D. Beyers
CONSOLIDATION

The consolidation of St. Clare Hospital and Monroe Clinic has enabled the organizations to provide higher-quality services while consuming fewer resources, reported Beyers.

Sr. Jane Frances Brady, SC
THE UNINSURED

"If comprehensive deregulation came down," urban teaching hospitals "would be left with the cities' many uninsured, while suburban hospitals would draw off the paying patients."

Organizations Evolve To Meet the Mission

James D. Beyers; Sr. Jane Frances Brady, SC; Kay McLeod

Local collaboration, state-level advocacy, and a continuum of care enable three providers to meet their communities' needs.

The route to becoming a cost-effective, high-quality, mission-driven provider differs according to the situation. Three healthcare administrators described the paths their organizations have taken to ensure access to high-quality care for the populations they serve.

In Monroe, WI, changes in reimbursement during the 1980s and a trend toward managed care began to hinder the growth of both St. Clare Hospital and the Monroe Clinic, a physician-owned entity, former St. Clare President James D. Beyers reported. In 1992 they merged as the Monroe Clinic, a Catholic organization headed by Beyers. The consolidation has enabled the organizations to provide higher-quality service while consuming fewer resources.

The clinic and hospital had to overcome several significant obstacles before they could come together, Beyers reported. "While St. Clare had developed a growth plan," he said, "many of the physicians were satisfied with the status quo." Moreover, as a for-profit entity, the clinic was at first reluctant to commit to a preferential option for the poor. Competition between the two facilities for shrinking reimbursement dollars was another point of difference.

However, the election of a new board of trustees for the clinic in early 1991 paved the way for more productive talks between the hospital and the clinic, beginning with an agreement that any new entity would be Catholic. A merger agreement was reached late in 1991, winning approval from all but two of the physicians who owned the clinic.

In New Jersey continued state-level advocacy has been necessary to guarantee care for inner-city residents. In the late 1950s the board of trustees at St. Joseph's Hospital, Paterson, NJ, decided that the hospital's continued survival as a source of care for the area's indigent population required that it become a major medical center. Sr. Jane Frances Brady, SC, St. Joseph's president and CEO, said that paying business generated by the hospital's tertiary services helped keep the facility afloat.

A key factor in the hospital's continued viability was the passage of legislation in 1972 that provided coverage for indigent care. St. Joseph's had led a group of hospitals, called "The Urban Coalition," whose work helped secure the indigent care provision. However, in 1992 a New Jersey court ruled that an add-on tax for funding indigent care was illegal. The ruling, Sr. Brady said, threatened the survival of about 20 New Jersey hospitals that were the main source of healthcare for the state's indigent population.

The hospitals appealed for help from the New Jersey Hospital Association, but found that the association, under pressure from suburban hospitals, was supporting legislation that would deregulate a system that designated regional centers of excellence.

"If comprehensive deregulation came down," Sr. Brady said, urban teaching hospitals like St. Joseph's "would be 'cherry-picked' and left with the cities' many uninsured, while suburban hospitals—long anxious to have things like neonatal care and cardiac surgery—would draw off the paying patients."

With support from the New Jersey Hospital Association, the legislation passed in 1992. In 1993 St. Joseph's and 21 other affected hospitals formed a new association to advocate for support of the state's indigent population and the facilities that serve them. One of its first accomplishments was legislation creating a special Hospital Relief Fund, which provided $162 million to New Jersey hospitals that serve a disproportionate share of Medicaid patients.

Mercy Medical's program works, Kay McLeod suggested, because it provides services that reduce intensity and level of care.

Another imperative for mission-driven providers is the need to evolve in response to clients' changing needs. Established as a traditional nursing home in 1949, Mercy Medical, Daphne, AL, now offers a comprehensive continuum of care for elderly residents of three Alabama counties. Services include hospice, inpatient care, assisted living, home healthcare, and rehabilitation. A 32-unit independent living retirement community will open in fall 1994.

Kay McLeod, Mercy Medical's administrator, said that the impetus for creating the continuum came 15 years ago, when Mercy administrators recognized that the traditional healthcare models were not effectively addressing the elderly's

needs. Despite varying reasons for being admitted, persons placed in nursing homes tended to be "institutionalized for the remainder of their lives in a facility that fostered and perpetuated dependency," McLeod noted. The situation pointed to a need for more aggressive therapy and rehabilitation programs for those who could benefit from them and greater attention to the comfort and dignity of those who cannot.

Mercy Medical's program works, McLeod suggested, because it provides services that reduce intensity and level of care. In addition, by providing a continuum of services, the program can be flexible in utilizing reimbursement sources. The program's diversity also creates options for the patient, McLeod noted, and it has enabled Mercy Medical to branch into needed services not being offered by other providers.

INTEGRATED DELIVERY

Catholic Identity an Asset in IDN Arrangements

Wilfred F. Loebig, Jr.

> **An inclusive mission to build relationships fosters the creation of varied delivery networks.**

"A clear focus on our Catholic identity, fully integrated with our management philosophy, has helped us attract the right partners for the right reasons," said Wilfred F. Loebig, Jr., president and CEO, Wheaton Franciscan Services, Inc. (WFS), Wheaton, IL. His system, he said, is currently building five integrated delivery networks (IDNs).

Because WFS does not define an IDN as an entity it must own or control, the system participates in many different types of arrangements (see **Box**). "The heart of our mission statement is building relationships," Loebig said. The statement—"The Wheaton Franciscan System is committed to human and community development in ourselves and in health and shelter"— refers to helping people develop their potential and developing meaningful relationships at all levels, Loebig explained.

In the past, he said, non-Catholic organizations have seen mission as a barrier to building delivery networks with Catholic hospitals. But

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the mission statement prompts the exploration of profound issues, he said. Once other organizations understand the mission, "they can find a place in it for themselves," Loebig said. "The inclusive nature of our mission helps us build IDNs with hospitals that aren't Catholic, healthcare providers that are secular, and even corporations that operate for profit," he said.

For example, Ameritech, Milwaukee, selected WFS as its partner in developing an information system for IDNs that it could market across the nation. Loebig said Ameritech chose his system because it had the clearest vision of the future of healthcare and had demonstrated its ability to implement its vision.

Building on a common vision and trust, the two organizations signed a seven-year contract. Loebig said neither organization wanted to commit substantial resources to the project without trust that both would stay with it. Nor did they want to delay the project with months of legal negotiations. As a result, Loebig said, the contract is only 14 pages—a major paradigm shift for the system made possible by its focus on mission.

He cited other instances in which the system's mission has helped it establish cooperative arrangements: an affiliation with another religious congregation that has grown beyond its original scope; a partnership with a 150-member physician group; and a holding company established with a nonreligious community hospital in the Chicago area. The latter equal partnership taught the system that it could relinquish control and still retain influence. "I anticipate more of these types of arrangements in the future,"
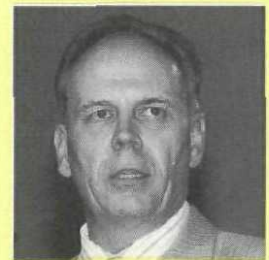
Wilfred F. Loebig, Jr.
INCLUSION

"Our Catholic Identity holds out an invitation of inclusion to everyone, patients and partners alike. There is absolutely no doubt in my mind that our Catholic identity is an asset in developing IDNs. Catholic identity is our past and it is also our future."

Loebig told assembly-goers.

Loebig is convinced that the mission and values inherent in Catholic identity "can set our systems apart from the others." Catholic healthcare providers must make a "significant investment" in careful planning and dialogue with potential network collaborators to articulate the organization's mission, vision, and management philosophy, Loebig said. "Our Catholic identity holds out an invitation of inclusion to everyone, patients and partners alike," he continued. "There is absolutely no doubt in my mind that our Catholic identity is an asset in developing IDNs. Catholic identity is our past and it is also our future."

Shared Values Crucial

Charles J. Dougherty, PhD; Sr. Norita Cooney, RSM

> Catholic organizations need to partner with those which serve the common good by assessing the community's needs.

When choosing partners for integrated delivery networks (IDNs), Catholic healthcare providers must consider values, material cooperation, and the obligation to seek Catholic partners first, asserted Charles J. Dougherty, director, Center for Health Policy and Ethics, Creighton University, Omaha.

Values play an important role in determining whether a Catholic provider becomes involved in an IDN. "Catholic providers must articulate these values to potential partners and reinforce that the IDN is not a financial arrangement," said Dougherty. They must find partners who:

■ View healthcare as a service, not a business.
■ Respect human dignity. Potential partners who do not share this belief may offer abortion or sterilization services, deny services to those who cannot pay, and have a poor record as an employer.

■ Serve the common good by assessing the community's needs.
■ Are committed to stewardship, especially to decreasing duplication of services.
■ Have a preferential option for the poor—including persons who are uninsured, are enrolled in Medicaid, and have preexisting conditions.
■ Promote the appropriate level of responsibility and authority for care, especially government's responsibility for healthcare.

Catholic providers must also consider material cooperation when identifying potential IDN partners. "Evil cannot be formally intended, but indirect and unintended [material] cooperation with the evil can be justified under some circumstances," said Dougherty. A Catholic healthcare organization can be involved with one that creates an evil if:

■ The cooperation is not formal.
■ The evil is not direct (i.e., the Catholic facility does not commit the evil).
■ The evil takes place away from the Catholic facility.
■ The evil the partner creates is not new or increased.
■ The value of the partnership "outweighs" the contribution made to the evil.
■ The potential for scandal is minimal. Scandal occurs, Dougherty explained, when the partnership "literally shakes the faith of the believers in the community."

Catholic healthcare providers have a "prima facie ethical obligation to seek Catholic partners unless the obligation is overridden by another stronger obligation," said Dougherty. He noted that Catholic partners have a common mission to advance the same values. In addition, Catholic partnerships will help maximize the survival of Catholic hospitals and impede the creation of scandal. The "overriding factors" to which Dougherty referred come into play when the potential Catholic partner is not actively pursuing its mission, is moribund, adds little to the IDN because of location or array of services, or declines.

Partnering is inevitable in Omaha, where its 11 hospitals currently have 2,500 beds, with a projection of 800 in 1999, said Sr. Norita Cooney, RSM, president and CEO of Mercy Midlands, Omaha.

In choosing a partner, Sr. Cooney said, Mercy Midlands evaluated criteria such as area hospitals' costs and lengths of stay. Mercy chose to partner with Immanuel Medical Center to form Community Health Vision. Together, they have reduced the duplication of services in the Omaha area, opened neighborhood healthcare centers, and initiated case management programs.

Charles J. Dougherty
COOPERATION

Catholic providers must consider material cooperation where identifying potential IDN partners. "Evil cannot be formally intended, but indirect and unintended [material] cooperation with the evil can be justified under some circumstances."

Assessing Community's Readiness for Integrated Delivery

Carolyn L. Drummond

> **Providers must look at community needs, market evolution, and provider relationships.**

Before forming an integrated delivery network (IDN), the players must decide what community they are planning for by looking at service and target market areas and counties and asking whether the population base in the area is sufficient to support an IDN, said Carolyn L. Drummond.

One of the major challenges for a provider becoming involved in an IDN is deciding what its functional role will be. "Your organization needs a vision of what role it will occupy and to decide who it will partner with," said Drummond, who is director of strategic planning, Daughters of Charity National Health System, St. Louis. One role is to encompass the entire IDN; but she warned that few providers could pull this off because it means being provider and insurer. Becoming the service provider is probably a healthcare organization's best choice of roles, Drummond said.

Once a provider decides on its role, it needs to assess its community's needs and health status, complete a demographic profile, and do a provider profile. In addition, Drummond advised providers to look at their community's stage in market evolution to learn whether it is in the:

- Unstructured stage, where there are independent hospitals, physicians, employers, and health maintenance organizations (HMOs)
- Loose framework stage, where HMOs and preferred provider organizations (PPOs) are beginning to penetrate
- Consolidation stage, where HMOs and PPOs are starting to consolidate and hospital systems are beginning to form
- Managed competition stage, where purchasers contract with integrated hospital-physician systems and the financial risk shifts to primary medical groups

Critical areas to look at when assessing the market, Drummond said, include whether it is fragmented or dominated by one provider, the percentage of the market that is managed care, the use rates (actual and projected trends), and the payment approach accepted.

To understand the players, providers must look at relationships—among and between physicians, hospitals, and community providers, she said. For example, providers must assess things such as hospitals' shared services, clinical linkages, alliances, networks, and systems. This "relationship mapping" is a good exercise for top managers, said Drummond, because it can improve their internal communication skills and help them become more familiar with one another's areas of expertise.

A major player for Catholic healthcare providers is their local bishop. Drummond stressed that providers must communicate with their bishops, setting up a schedule for communication. Providers must know bishops' plans, priorities, and perceptions regarding healthcare.

Drummond said additional questions to ask when forming an IDN are:

- What are the critical success factors of the network?
- What are the participation parameters?
- What are the provider's core competencies?

Carolyn L. Drummond
TALK WITH BISHOPS

A major player for Catholic healthcare providers is their local bishop. Drummond stressed that providers must know bishops' plans, priorities, and perceptions regarding healthcare.

Capitation Can Be Positive

David N. Schopp

> **Capitation helps lower volume and intensity of care—in line with national reform goals.**

Interest in capitation was "jump-started" by President Bill Clinton's healthcare reform proposal, which will place constraints on health maintenance organizations' (HMOs') annual premium increases, said David N. Schopp, director, Managed Care Services, Daughters of

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MANAGED CARE GROWING

The managed care industry has expanded rapidly in recent years, and the trend is only likely to escalate. According to the Group Health Association of America, the number of health maintenance organization (HMO) members increased 9.2 percent in 1993, for a total membership of 45.2 million. The number of HMO members will grow another 11 percent to reach 50 million by the end of 1994. California and Massachusetts continue to be the top HMO states, with more than one-third of the population enrolled.

As managed care organizations have grown, so has physician participation. In 1989, 59 percent of physicians participated in such organizations; by 1993, the figure had grown to 75 percent.

Charity National Health System, St. Louis. HMOs realized they would have to move quickly to pass on risk to physicians and hospitals through capitation, he pointed out. (See report of capitation seminar, pp. 18-20.)

Business Meeting

CHA FLEXIBLE IN SERVING MEMBERS

In his remarks as incoming chairperson of CHA's Board of Trustees, Daniel F. Russell promised that CHA will continue to be "visible and assertive in its leadership role" during his tenure. "Your expectations and needs from CHA may change," he said. "Just as you will be flexible in dealing with reform, CHA will be flexible in serving you." (Also see Russell's article on p. 12.)

Citing activities in advocacy, sponsorship, and leadership development, among others, outgoing Chairperson Sr. Maryanna Coyle, SC, stated, "We have lived the words we have spoken. We are anticipating the reality of change and are serving the needs of members as they continue Jesus' healing ministry."

CHA President and CEO John E. Curley, Jr., pointed to the recent reconfiguration of the National Coalition on Catholic Health Care Ministry as a critical development for the ministry. He predicted that the coalition—which includes representatives from CHA, the Leadership Conference of Women Religious, the National Conference of Catholic Bishops, and the Conference of Major Superiors of Men—will become a model of how Catholic leaders can work together. The coalition, he said, creates an unprecedented opportunity "to constructively and effectively address—at the policy level and national level—such issues as Catholic identity, Church relatedness, and leadership development."

The assembly's business included unanimous adoption of a resolution that will limit CHA dues by indexing them to the Consumer Price Index (CPI). The resolution also changes long-term care facilities' dues. They

Sr. Maryanna Coyle, SC, welcomes CHA's incoming chairperson of the Board of Trustees, Daniel F. Russell.

previously paid $1 per bed but will now pay 33 cents per $1,000 of expenses, as acute care facilities do. (The effect of the change is moderated by the CPI limitation, which will apply to their $1 per bed rate.)

In presenting the dues resolution, Secretary-Treasurer Judy Pelham said that the intent was to have a consistent formula for all dues-paying members and to have CHA share the financial pressures that the members are facing.

In other business, the assembly elected Sr. Ruth Marie Nickerson, CSC, to chairperson-elect and elected six new board members. (For a complete list of the 1994-95 board, see pp. 58-59.)

Newly elected to the CHA Nominating Committee were Sr. Karin Dufault, SP, chairperson of the board, Sisters of Providence Health Care System, Seattle; C. Kregg Hanson, president, Northern Division, Catholic Health Corporation, Bloomington, MN; and James E. Small, regional executive, Daughters of Charity National Health System–East Region, Linthicum, MD.

Schopp defined capitation as "prepayment for services on a per member per month basis." He explained that a provider—physician or hospital—is paid the same amount of money each month for a member even if the member does not receive services, or regardless of the cost of services. To calculate the monthly capitation rate, providers should multiply annual utilization rate by unit cost and divide by 12.

Although the thought of moving to a capitated environment may overwhelm providers, Schopp pointed out that such an environment:

■ Allows physicians and hospitals to receive payment whether or not care is provided, making cash flow constant.

■ Lowers volume and intensity of care—in line with national reform goals.

■ Frees providers from having to defend inpatient census. Getting the go-ahead from insurers to provide certain services would no longer be necessary.

■ Shifts capital to outpatient and home care services.

■ Focuses on health and prevention.

■ Aligns hospital and physician economic interests concerning utilization management, appropriateness standards, and use of lower-cost modalities.

When establishing a capitation contract, each provider needs to clearly identify which services will be capitated and the parties that will be financially responsible for those services, asserted Schopp. Physicians and hospitals must then determine how the funds will flow (e.g., percentage of premium dollars that will be allocated to primary care services, referral services, facility services, other services, and the HMO's administrative expenses).

In the capitation environment, Schopp said, primary care physicians will become gatekeepers of care, and specialists will increasingly rely on them for referrals. Physicians will evaluate hospitals on the basis of price, efficiency, and quality, asking, "Is this hospital my best choice as partner?" Hospitals will shift from revenue centers to cost centers and will focus on keeping members healthy.

In addition, capitation will redirect capital investment from new beds, expensive renovations, and high-technology equipment to physician organizations, information systems, vertically integrated investments (e.g., home health and subacute services), and medical office buildings for primary care physicians.

Experienced managed care leaders and support staff are critical to the success of capitation, said Schopp. He recommended hiring "outstanding performers with a strong business orientation and entrepreneurial spirit."

Finally, Schopp emphasized that an adequate information system is critical for success, noting that hospital software programs are not capable of handling the complex calculations of a capitated system.

Integrating Strategic And Financial Planning

Ellen Barron; Donald A. Westermann

Achieving long-term goals depends on making strategic goals an integral part of the organization's financial plan.

In proactively planning for reform, the Franciscan Health System, Aston, PA, asked itself some difficult questions: Were the system's strategic and financial plans in sync? Was the system making strategic and financial decisions effectively? Were short-term trade-offs in the financial plan still supportive of long-term strategic directions? Ellen Barron, senior vice president of corporate development, and Donald A. Westermann, senior vice president, corporate services and finance, described the process the system developed so it could answer affirmatively.

An important lesson they learned is to expand the definition of "capital" beyond fixed assets (bricks and mortar). The system defines "capital" as including what the organization puts on the table to expand its mission, such as investments in managed care companies, Barron and Westermann said. Another step is to check the alignment of strategies and resource allocation, they said.

To coordinate the two plans, the system made several "key assumptions" that form the rationale—the "why"—for the integrated model, Barron and Westermann explained:

■ Large population groups will be aggregated for the purpose of purchasing comprehensive healthcare.

■ Each population group will be represented by a large purchaser.

■ Regional delivery systems will be organized to provide this care. The delivery model will be based on managed care and paid for predominantly by capitation.

■ Regional integrated delivery systems (IDSs) will provide comprehensive care.

■ Primary care physicians will provide the basis of care.

■ The IDSs will be capable of bidding for large contracts and assuming risk.

■ Service will be characterized by convenience, quality, and value and will be customized to meet the needs of the local market.

■ The IDSs will partner with other IDSs to cover large geographic areas.

On the basis of these assumptions, four goals, with performance measures for each, were incorporated in the plan. For example, the goal of developing an affordable IDS that provides a continuum of care includes developing information systems, reorganizing delivery of care, and aligning primary and specialty care networks. Thus, when the system had to reduce requested capital budgets from $136 million to $100 million, it was able to ensure that strategic initiatives were kept in the plan.

Westermann and Barron advised communicating with all parties—CEOs, CFOs, and planners—when integrating the plans. "You need to be future oriented," they added, to create plans that support the most likely future scenarios. They concluded with a provocative prediction: The next generation of planning will go beyond the healthcare system itself to integrate strategic and financial planning with other entities in networks.

Profiling to Manage Better

Deborah Arbitman

Networks can use provider profiling to manage patient care, manage costs, and demonstrate value.

Managing better and creating the best networks are the new keys to success for providers, claimed Deborah Arbitman at a session on integrated delivery outcomes. In the last 12 months providers have begun to focus on tools to manage networks, with the ultimate goal of demonstrating value, said Arbitman, vice president, Value Health Sciences, Inc., Santa Monica, CA.

DEBORAH ARBITMAN
Providers have begun to focus on tools to manage networks, with the ultimate goal of demonstrating value, said Arbitman.

Provider profiling—of physicians, hospitals, and other providers—is such a tool, she said. Using commonly available data, providers can use profiling to manage patient care, manage costs, and achieve and demonstrate value, according to Arbitman.

The "number one foundation" for any system of profiling is that it have clinical integrity, Arbitman insisted. To do a clinical analysis of a physician's practice, for example, a provider would develop a framework that includes defining the patient's condition, an episode of illness, and appropriate levels of services for various conditions. Within the framework, available data such as diagnostic codes and records of comorbid conditions can be used to adjust for patient complexity. A patient's condition can be assessed throughout the network, not just in the hospital.
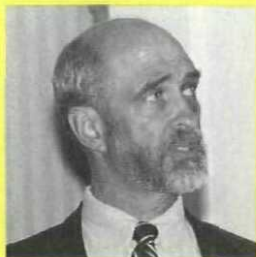
Arbitman advised providers to use profiling to classify physicians by specialty according to the types of services and condition mix they serve. This classification is more accurate than simply using the specialty stated by the physician, she said.

Analyzing data can help providers look at questionable billing practices, examine questionable practices and outcomes, and ultimately establish clinical rules. Arbitman stressed that data should not be used as a "report card" or "policing mechanism," but analyzing procedures that seem to violate the norm can provide information to improve quality of care. For example, studies of psychiatric care showed that certain patients returned to work faster when they saw a psychiatrist without first seeing a lower-cost provider such as a social worker. In another instance, a Tennessee hospital that kept cardiac surgery patients in the recovery room much longer than all other hospitals in the state demonstrated better patient outcomes.

Analyzing procedures that seem to violate the norm can provide information to improve quality of care.

Besides uncovering information that can improve outcomes, profiling's uses include selecting providers, measuring cost and quality, optimizing specialty balance, setting standards of care, and providing continuing physician education. Physicians, Arbitman said, are scientists and will change their practice patterns if they are shown credible, scientific data.

Demonstrating value is the ultimate purpose of profiling, Arbitman pointed out. She said 20 percent of healthcare costs are related to 2 percent of patients—people who are very sick. Managing the costs of care for these very ill people is the only way to progress in managing healthcare costs, she said. "This has big implications for profiles," she said. "They provide the tools to get the best doctors and the best care in our networks."

Philip M. Lohman
INFORMATION

To develop an effective information system, Lohman said, integrated delivery systems first can create an efficient, representative information technology committee with a strong clinician presence and a managed care outlook.

Integrating Information

Philip M. Lohman, PhD

The imperative to be nimble and flexible makes information the key strategic asset of an integrated delivery system.

An effective integrated delivery system (IDS) must meet a number of strategic goals, each of which requires comprehensive and coordinated information systems support, Philip M. Lohman noted.

Lohman, who is research director, First Consulting Group, Long Beach, CA, identified six "strategic success factors" in a delivery system's integration process: continually improved clinical and service quality, responsiveness to the market, low-cost operation, regional presence, multiple access points, and the ability to operate as a system.

"At each stage of integration," Lohman noted, "the delivery system will confront an entirely new set of issues and will have to make decisions under conditions of risk and uncertainty." He added that systems will be able to reduce their risk to the extent that they can quickly collect and analyze strategic information, apply that information to decision making, and implement decisions by transmitting information quickly throughout the enterprise.

The imperative to be nimble and flexible makes information the IDS's key strategic asset, noted Lohman. Information, he said, can act as a "solvent" to dissolve complex, outmoded structures; break down organizational barriers; bridge process gaps; and lower the "wall" between providers and other healthcare participants. It can also be a "catalyst" that fosters new organizational designs; empowers employees; supports reengineering efforts; communicates goals, policies, and directives organization-wide; and provides feedback enabling "midcourse" corrections.

A typical IDS information network will be high speed and high resolution, with the ability to carry voice, data, image, and video throughout the system, Lohman said. Although the information system may consist of several networks (e.g., within a building, across a campus, between cities or states), he emphasized that it must be approached as "*one* organization's network." It should allow users to access any network resource from any location on the network, he pointed out, and it thus depends on the ability of networked systems to work with each other.

The computer-based patient record (CPR) is one of the most promising network technologies under development, Lohman said. He noted that a good CPR can overcome many problems asso-

ciated with the paper chart, including illegible, missing, incomplete, or inaccurate data. The CPR also provides a basic tool for clinical integration, making patient data accessible to all clinicians and allowing data to be collected for clinical repository and external use.

Although the CPR is a single system, Lohman noted that its data originate in several other systems, including clinics, physician offices, and various departments within hospitals.

To develop an effective information system, Lohman concluded, IDSs first can create an efficient, representative information technology committee with a strong clinician presence and a managed care outlook. With such leadership in place, systems can develop a flexible information technology infrastructure that includes open systems, a robust network, and network compatibility standards for new applications. Throughout this process, system managers and administrators should identify high-priority needs, continually reevaluate the existing infrastructure, selectively upgrade current systems, and develop plans to migrate from the hospital information system to an IDS network.

Continuum-of-Care Approach

Charles E. Hawley

Healthcare reform requires a radically different approach, emphasizing care coordination and case management.

With the dominance of chronic disease and greater use of healthcare services by the functionally impaired, the need for long-term care is already significant and continually increasing. As vice president of long-term care and housing at the Sisters of Providence Health System, Seattle, Charles E. Hawley sees a crying need for long-term care to be included in healthcare reform. "If we can't afford it now, it's never going to be affordable in the future," Hawley said.

In restructuring the healthcare delivery system, Hawley recommends a radically different approach, an integrated, client-oriented system that guides and tracks patients across all settings. In such a system, with integrated administrative structures, capitated financing, and integrated management information systems, "care coordination and case management services are the glue that binds everything together," Hawley said.

Case management can be extremely cost-effective.

He defines care coordination as "assuring that a person receives the right care, from the right provider, at the right place, and at the right time." Care coordination affects everyone, he said, while case management is targeted to high-risk persons more likely to need intensive, costly, and dependent levels of care. In case management, generally a nurse or social worker follows a systematic process to plan care, procure services, monitor, evaluate, and reassess patients.

"Properly structured case management can be extremely cost-effective," Hawley noted. He added that current models have shown that case management needs to be closely aligned with primary care physicians; it must go beyond institutional walls, across settings, and into the community; and it can enhance both patient and provider satisfaction.

Hawley also recommended the development of extended care pathways—"policies and procedures for addressing health conditions across all settings," including the community. Such pathways would be interdisciplinary and focus on prevention of further disability, rather than treatment of acute disease, he said.

Currently, Hawley said, the Sisters of Providence Health System is working on developing a pilot extended care pathway for one of the nine chronic conditions recommended by the National Chronic Care Consortium (which include Alzheimer's disease, arthritis, cerebrovascular disease, and depression). The system also has plans to establish a formal case management program within each of its service areas. As part of this program, Hawley explained, case management will review a screening questionnaire for all new enrollees in the health plan, and a multi-disciplinary team will assist the primary care manager.

Charles E. Hawley
BEYOND WALLS

Case management needs to be closely aligned with primary care physicians; it must go beyond institutional walls, across settings, and into the community; and it can enhance both patient and provider satisfaction, said Hawley.

HEALTHCARE COMPUTING

Requests for comparative outcome data and the movement to managed care are driving increasing healthcare computerization, according to half of more than 1,000 respondents to a recent survey conducted by HIMSS and Hewlett-Packard. An equal number of respondents predicted that more streamlined healthcare encounters would be the biggest development affecting consumers in the next three years.

Nearly a third of respondents said integration across facilities is their top information system priority for the next two years; implementing a computer-based patient record was next (19 percent).

Healthcare institutions' investments in information systems will increase somewhat or substantially over the next two years, according to 85 percent of respondents. The greatest challenges cited will be upgrading networks (24 percent) and incorporating multimedia technologies (24 percent).
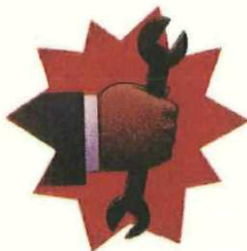
Include Physicians In Integration Planning

Connie R. Curran, EdD; Wende L. Fox; Kenneth E. Cummings, MD

> **The quality of relationships with physicians will determine the success of integrated delivery arrangements.**

CONNIE R. CURRAN;
WENDE L. FOX

One essential for building successful integrated delivery networks is to integrate physicians, said Connie R. Curran (right). Wende L. Fox advised creating procedures whereby physicians are unaware of a patient's insurance coverage and establishing practice protocols that are used for all patients, regardless of how their care is financed.

Building successful integrated delivery networks (IDNs) comes down to two essentials: being the low-cost, high-quality provider and accomplishing physician integration, according to Connie R. Curran, national director of patient care services, APM, Inc., Chicago. Reengineering all levels of the organization to be more efficient is key to providing cost-efficient care, improving clinical efficiency, and reaching service excellence as IDNs are developed, she said.

Wende L. Fox, principal with APM, outlined 10 caveats for providers as they develop programs that integrate physicians (see **Box**). She referred the audience to CHA's *Workbook for Building Relationships with Physicians* for more details on the points. (The workbook will be sent to members later this summer.)

During the healthcare system's transition to managed care from fee-for-service, organizations will have to deal with conflicting financial incentives for different patients, a questioner noted. Fox advised creating procedures whereby physicians are unaware of a patient's insurance coverage and establishing practice protocols that are used for all patients, regardless of how their care is financed.

Kenneth E. Cummings

The quality of relationships with physicians will be the determinant of hospitals' success in integrated delivery arrangements, asserted Kenneth E. Cummings, vice president for medical affairs, St. Joseph Health System, Kansas City, MO. The system's medical staff development plan includes a primary care network of four satellite clinics, a physician services organization, and a family practice residency developed with the University of Kansas. The system is also building a medical mall that will contain offices for primary care and specialty physicians, as well as urgent care and ambulatory surgery centers.

The system's physician integration actions have been shaped by the realizations that physicians must be central in planning, development, and operations; primary care physicians are a high priority; equity opportunities are important to physicians; and professional physician management should be encouraged, he said.

Physician Integration

TEN CAVEATS FOR PROVIDERS

Wende L. Fox offered the following suggestions for providers working on physician integration:

■ Look for models that align physicians' incentives with those of the hospital and each other. Multispecialty group practices represent the greatest degree of physician-physician integration, and professional services agreements provide the highest degree of physician-hospital integration, she said. But the function is more important than the model. "We've seen successful IDNs in every category," she noted.

■ Develop shared values and a common vision with physicians.

■ Include physicians in producing a detailed integration plan.

■ Collaborate on important decisions regardless of the structure.

■ In recruiting primary care physicians, analyze their needs and provide support to meet them.

■ Design multiple physician panels, with different selection requirements for different managed care contracts.

■ Encourage patients to become involved in their care to minimize physicians' fears that patients will overutilize the system or that they may be encouraged to underserve patients in a capitated system.

■ Be cautious about postponing action to achieve a "perfect" contract.

■ Continuously improve the delivery organization on the basis of performance measures that assess response to community needs.

■ "Overcommunicate" to all constituents needed to support physician-hospital integration, including physician office staffs, hospital staff, and the community.

St. Joseph Health System has included physicians on boards and committees, expanded administrative positions for physicians (e.g., in quality assurance and utilization review), and created position descriptions and provided management training for board members to help physicians know what is expected of them, Cummings explained. The system also devotes a four-person staff to physician relations.

Physicians' attitudes will change when they are presented with facts, understand that it is in their best interest to change, and are dealt with honestly and consistently, Cummings said. St. Joseph works toward providing the "ideal" practice opportunity for primary care physicians, which includes practice management help and clinical independence (the system has made a major effort to have medical directors, not administrators, set practice parameters).

Managing the Human Dimension Of Change

Thomas A. Atchison, EdD; Philip J. Karst, PhD

> **The organization's culture must be considered in forming collaborative relationships.**

The business aspects of assembling an integrated delivery network are only half the battle; the other half, just as important, involves the human dimension.

"It takes two wings to fly," according to Thomas A. Atchison, president of the Atchison Consulting Group, Oak Park, IL. The "wings" for reengineering a corporation, he pointed out, include tangible items such as cash, strategies, and communications, as well as the intangibles, such as mission, values, leadership style, and motivations. Unfortunately, in transforming their healthcare organizations, leaders may be ignoring the intangibles, taking the joy out of work and breeding hatred among employees.

"It's easier to explain radical change if we say we're not changing our mission and our values," he stressed. He reminded the audience that form must follow function, and that "your mission is not to protect the bricks and mortars of your hospitals." He advised leaders to stress that changes are consistent with their organization's mission and values, and then to set a clear vision—"where you're going and how you'll know when you've gotten there." Fear, uncertainty, and doubt arise, he added, if people do not understand the reasons for change and what their role is.

The organization's context and values—its culture—cannot be ignored in forming collaborative relationships. Atchison noted that he disagrees "with the conventional wisdom of 'No margin, no mission.' The truth is, it's, 'No mission, no margin.' The corporate culture can have a significant impact on a firm's long-term economic performance." He added that corporate culture will be an even more important success factor in the next decade.

Philip J. Karst, associate vice president, the Catholic Health Association, pointed out that the association has put out a lot of information on how to build integrated relationships, focusing on clinical and financial integration. "You may think you can do all this without touching people," he said, but the cross-cultural groups involved in integrated delivery networks—hospitals, long-term care, community-based providers, and the insurance industry—must all learn how to work together.

"You can have multiple correct points of view," Atchison added, "but they need to be working in one direction on one thing." To successfully manage change, Atchison said, leaders first must establish the vision—what they want to change to. Next, they should "think small"— "break it up into small bits and pieces to show people they can manage change." The final three steps are to "move fast, evaluate, and celebrate," he said.

He cautioned listeners not to cling to outmoded strategies and ossified practices, a tendency he diagnoses as "cognitive arthritis." Because we're at breakpoint, he said, we need to be creative, to try new things.

HEALTH AND WELL-BEING

Promoting Community Health

Sr. Helen Owens, OSF; Sr. Marianne Hieb, RSM

> **Social forces and Gospel values shape the Catholic commitment to reform.**

Two critical factors combine to make healthcare reform an imperative for Catholic providers, according to Sr. Helen Owens, OSF, and Sr. Marianne Hieb, RSM. One is societal forces, including increases in healthcare spending and in the number of uninsured. The other is the Gospel value that commits Catholic facilities to providing healthcare for all.

Create A Healthy World

Sr. Helen Owens, OSF
WELLNESS

"We have a unique opportunity today to work with people to help them live their lives to the fullest. To achieve this, we need a new delivery system that is person centered and wellness and community focused, with emphasis on primary and preventive care."

ASSEMBLY ACTIVITIES EMPHASIZE WELLNESS

As healthcare providers are shifting their mind-sets to focus on wellness and prevention, rather than illness and cure, this year's Catholic Health Assembly echoed that theme. For the first time, CHA incorporated wellness activities into the assembly program, enabling members to learn about personal health issues, as well as how they can help their employees and communities.

At a Roundtable Luncheon on Health and Well-Being, 21 presenters from CHA-member institutions led discussions on various topics. More than 300 assembly-goers attended the luncheon to learn and share information about programs such as meditation, life-style changes, parish nursing, senior wellness, spirituality, T'ai Chi, stress management, therapeutic massage, violence prevention, wellness

architecture, and workplace wellness.

In addition to educating participants, the luncheon was a first step in building a network of information on health and well-being among those in the Catholic healing ministry. Particpants received a booklet of abstracts from the program presenters to aid in their dialogue and collaborative efforts.

Other wellness activities centered around the Oasis, staffed by Our Lady of Lourdes Wellness Center, Camden, NJ. At the Oasis, assembly-goers could receive head and neck massages, health screenings, nutritional counseling, and literature on holistic health topics.

Other activities interspersed throughout the assembly included a two-mile walk and classes in T'ai Chi, yoga, and meditation.

Finally, a "Health and Well-Being Leadership Think Tank" of members who are expert in wellness issues gathered to brainstorm about CHA's role in helping members foster health and well-being in their communities. Participants also contributed ideas for a conference CHA will hold in October, where national experts from areas such as public health, government, and research will give CHA input on where to direct its activities and how it can collaborate with other organizations interested in wellness.

Participants at the assembly think tank asserted that providers need to ask what is important to the community when developing health and well-being programs. "We tend to provide a medical model rather than asking community members what they need," said Carolyn Drummond, director of strategic planning, Daughters of Charity National Health System, St. Louis. Participants agreed that the Catholic healing ministry should lead in creating programs that meet spiritual and emotional needs, not just focus on physical disease. As part of this holistic approach, the ministry can "get political" and advocate for measures that address societal problems affecting health, added Judy Fulop, well-life consultant, St. Joseph Health Center, Kansas City, MO.

Participants worried about financing for health and well-being programs in a time when programs that do not demonstrate immediate positive affects on the bottom line are vulnerable to cutbacks. "It's a very scary time about who will pay," said Barbara Burke, director of business health, St. Vincent's Hospital and Health Services, Carmel, IN, noting that

OVER LUNCH
Roundtable participants discussed programs for promoting health and well-being, including life-style changes, spirituality, and stress management.

Catholic providers' decision to promote community health and well-being flows naturally from their understanding of the reform imperative, Sr. Owens said. "We have a unique opportunity today to work with people to help them live their lives to the fullest," she told the audience. "To achieve this, we need a new delivery system that is person centered and wellness and community focused, with emphasis on primary and preventive care."

Sr. Owens is vice president of mission and

Sr. Hieb is director, Wellness Spirituality Programs, Our Lady of Lourdes Medical Center, Camden, NJ. The origins of the facility's wellness center can be traced to the creation, in 1979, of a Community Health Education Department that emphasized wellness and holistic care. The center now offers a wide variety of services, including stress management and relaxation training, Christian yoga, infant massage, and an introduction to meditation.

T'AI CHI
The controlled meditative movements of T'ai Chi form a discipline that is both physically and spiritually stimulating.

insurance carriers are not willing to pay for substantive health assessments.

Financing questions pose ethical challenges for providers, added Michael J. Nanko, vice president, Mercy Healthcare Arizona, Phoenix. In a time of limited resources, he said, providers will be forced to set priorities as they decide who they will serve and what activities they will undertake. Wellness programs have often focused on marketing rather than improving community health, he noted, and now providers must decide whether to concentrate on the root causes of health problems (e.g., violence, teen pregnancy) or to continue a variety of disparate activities.

Demonstrating results and cost savings will become increasingly important, participants said when asked to cite the major problems for which they are seeking solutions. Several expressed deep concern about how prevention activities will be funded under capitation. Motivating clients to use wellness programs so they can achieve the program's potential benefits is another concern for all participants, as is protecting the confidentiality of health assessment data so that information cannot be used to financially penalize employees.

For more information on CHA's health and well-being activities, contact Debi Sampsel at 314-253-3515.

YOGA
Simple yoga exercises can relieve stress and muscle tension.

The need for reform comprises a number of specific imperatives, Sr. Owens told assembly-goers. To effectively promote community health, she noted, Catholic providers must continue to care for the individual while responding to the needs of the community. In addition, learning how to empower others will help maximize their impact on community well-being. Sr. Owens added that Catholic healthcare providers must enthusiastically claim their Catholic identity, not being afraid to use language and values that challenge typical "business" language and values.

The reform imperative for Catholic healthcare providers, Sr. Hieb asserted, "comes down to the fact that we are still about the mission of people. What we must continue to hold out is our purpose: service to God's people; keeping alive a Christian vision of dignity and care for individuals, respect for human institutions and systems, and care for the environment, which is the expression of the creative act of God."

Assessing Community Needs

Alan M. Zuckerman; John F. DiCola

> **Community needs assessments help providers fulfill their mission.**

Assessing the health status and needs of the community is a means to fulfill mission; preserve tax-exempt status; and develop responsive, integrated delivery systems, according to Alan M. Zuckerman.

"The community health assessment is driven by a genuine desire in the nineties to fulfill the mission," said Zuckerman, executive vice president of Chi Systems, Inc., Philadelphia.

"In the current era of healthcare reform, the interest in community health status is really driven by an interest in integrated delivery and a better alignment between healthcare organizations and the needs of the population," he added.

Zuckerman described a community assessment conducted by a system in Delaware County, PA. The system found that many sources of information were already available, including inpatient data from the regional hospital council and mortality and morbidity data from the state.

It also conducted a qualitative assessment, convening 12 focus groups with various area providers (e.g., pediatricians, psychiatrists, personal home care operators) and consumer groups (e.g., mothers of young children, African Americans, healthy elderly). The 14-month assessment yielded 12 major recommendations that are now in various stages of implementation.

Zuckerman outlined a methodology for identifying and responding to community needs:

1. Enlist partners.
2. Define the community.
3. Develop a community health profile.
4. Conduct a community needs assessment.
5. Mobilize the community for action.

John F. DiCola, director of corporate planning and marketing for the Sisters of Charity Health Care Systems (SCHCS), Cincinnati, said SCHCS renewed its commitment to community benefits reporting this year by adopting CHA's standards for community benefit. He also described the health status and needs assessment currently being implemented by SCHCS Nebraska, a five-hospital system in the central part of the state.

The objectives for the Nebraska system's assessment include developing a health status baseline for future action, catalyzing responses to community need, building linkages with the communities served, and broadening the system's focus from delivering acute care to assuming responsibility for the overall health status of defined populations.

The SCHCS Nebraska process is expected to be completed in six months.

Alan M. Zuckerman
COMMUNITY HEALTH

"In the current era of healthcare reform, the interest in community health status is really driven by an interest in integrated delivery and a better alignment between healthcare organizations and the needs of the population."

NETWORKING
Assembly-goers take a break between sessions to share impressions about the latest presentation.

63 HOSPITALS CELEBRATE 75 OR 50 YEARS OF CHA MEMBERSHIP

Sixty-three hospitals celebrating 75 or 50 years of membership in CHA were honored at a pre-assembly reception.

The 54 hospitals observing 75 years' membership were: **St. Vincent's Hospital**, Birmingham, AL; **St. Joseph's Hospital and Medical Center**, Phoenix; **St. Vincent Infirmary Medical Center**, Little Rock, AR; **Seton Medical Center**, Daly City, CA; **O'Connor Hospital**, San Jose, CA; **St. Francis Medical Center of Santa Barbara**, Santa Barbara, CA; **St. Mary's Hospital & Medical Center**, Grand Junction, CO; **St. Vincent's Medical Center**, Jacksonville, FL; **Saint Joseph Hospital**, Belvidere, IL; **St. Mary's Hospital**, Centralia, IL; **St. James Hospital and Health Centers**, Chicago Heights, IL; **St. Mary's Hospital of East St. Louis, Inc.**, East St. Louis, IL; **St. Mary Medical Center**, Galesburg, IL; **Saint James Hospital**, Pontiac, IL; **St. Francis Hospital & Health Centers**, Beech Grove, IN; **St. Joseph Medical Center**, Fort Wayne, IN; **Saint Margaret Mercy Healthcare Centers**, Hammond, IN; **Covenant Medical Center**, Waterloo, IA; **St. John's Regional Health Center**, Salina, KS; **St. Mary's Regional Medical Center**, Lewiston, ME; **Carney Hospital**, Boston; **Saints Memorial Medical Center, Inc.**, Lowell, MA; **Lee Memorial Hospital**, Dowagiac, MI; **St. Francis Hospital**, Escanaba, MI; **Providence Hospital and Medical Centers**, Southfield, MI; **St. Marys Health Center**, Jefferson City, MO; **St. John's Regional Health Center**, Springfield, MO; **Columbus Hospital**, Great Falls, MT; **St. Joseph Hospital**, Polson, MT; **Saint Francis Medical Center**, Grand Island, NE; **Saint Elizabeth Community Health Center**, Lincoln, NE; **St. Joseph Hospital**, Nashua, NH; **St. Joseph Medical Center**, Albuquerque; **Sisters of Charity Hospital**, Buffalo, NY; **St. John's Queens Hospital**, Elmhurst, NY; **St. Joseph's Hospital**, Elmira, NY; **St. James Mercy Hospital**, Hornell, NY; **Mary Immaculate Hospital**, Jamaica, NY; **Mount St. Mary's Hospital of Niagara Falls**, Lewiston, NY; **Cabrini Medical Center**, New York City; **St. Francis Hospital**, Poughkeepsie, NY; **St. Joseph's Hospital**, Asheville, NC; **Mercy Hospital**, Devils Lake, ND; **St. Ann's Hospital of Columbus, Inc.**, Westerville, OH; **Providence Hospital & Medical Center**, Medford, OR; **Sacred Heart Hospital**, Allentown, PA; **St. Joseph Hospital**, Lancaster, PA; **St. Mary's Healthcare Center**, Pierre, SD; **Seton Medical Center**, Austin, TX; **Mercy Regional Medical Center**, Laredo, TX; **Providence Health Center**, Waco, TX; **St. Peter Hospital**, Olympia, WA; **Providence Medical Center**, Seattle; **St. Mary Medical Center**, Walla Walla, WA.

Nine hospitals celebrated 50 years as CHA members: **St. Vincent's Medical Center**, Bridgeport, CT; **Providence Hospital**, Washington, DC; **Good Samaritan Regional Health Center**, Mount Vernon, IL; **Holy Family Hospital**, Estherville, IA; **Sacred Heart Hospital**, Cumberland, MD; **St. Mary's Medical Center of Saginaw**, Saginaw, MI; **St. Mary's Hospital of Troy**, Troy, NY; **Mercy Hospital Anderson**, Cincinnati; **Hazleton–Saint Joseph Medical Center**, Hazleton, PA.

HUMAN COST METER

During CHA's assembly, 11,020 Americans died as a result of inadequate preventive care and unhealthy life-styles, according to the Human Cost Meter, a digital counter that ticked off three lives every minute. The Human Cost Meter reminded participants of the number of lives that could be saved if health education and preventive medicine were integral parts of the U.S. healthcare system.

Each year the 10 leading medical causes of death—including heart disease, cancer, cerebrovascular disease, chronic pulmonary disease, accidents, and pneumonia—take the lives of more than 1.7 million Americans. In addition, life-style factors such as tobacco use, poor diet, and little exercise claim another million American lives. Loneliness, depression, low self-esteem, and other spiritual crises also increase the number of deaths that could be prevented.

Prevention magazine's recently released annual Prevention Index shows that 68 percent of Americans aged 25 or older are overweight. In 1983, the first year the index was published, the figure was only 58 percent.

The Prevention Index tracks 21 different factors affecting adults' health. In 1994 the index fell for the first time since 1988, the only other year it showed a decline. Of the six dietary factors tracked, five showed declines, including limiting fat, limiting sugar, and eating fiber.

On the other hand, the six behaviors most important for promoting health—including not smoking, wearing seat belts, not driving after drinking, and socializing regularly—all showed gains.