A Starting Point For Delivery Reform

Catholic Healthcare Providers Can Receive Guidance From A Time to Be Old, a Time to Flourish

This article explains the philosophy shaping the healthcare reform proposal of the CHA Leadership Task Force on National Health Policy Reform.

Our nation's current healthcare delivery system focuses on providers' financial well-being rather than on the holistic health of individuals and families. The Catholic Health Association (CHA) has therefore prepared a plan for healthcare reform that is client centered and promotes a continuum of care (see "CHA Seeks Input on Systemic Reform Proposal," December 1991, pp. 12-16).

In its report, *A Time to Be Old, a Time to Flourish: The Special Needs of the Elderly-at-Risk* (1988), the CHA Task Force on Long Term Care Policy offered a useful template for healthcare delivery reform. The task force called for a client-centered approach characterized by a coordinated continuum of care designed to meet the varying needs of the elderly. Although the proposal focused on the elderly, the underlying concepts and principles apply equally well to the general population. This article draws substantially on the text of *A Time to Be Old* to make a similar case for broader healthcare delivery reform.

Current State of Healthcare Delivery

Today's U.S. healthcare delivery system can best be described as a "nonsystem"—a set of expensive and uncoordinated programs and services that have evolved in an irregular and often patchwork manner. The sheer number of federal, state, and local programs, many of which have their own eligibility and funding arrangements, suggests the degree of complexity and confusion that exists. In long-term care alone, for example, more than 80 federal programs offer some kind of assistance to the elderly and disabled. Many more programs emanate from state and local governments. A wide range of private-sector initiatives for the elderly also supplement these efforts.

The ideal healthcare system offers client-focused services. The client, healthcare professionals, community agencies, and the client's family plan the services together. The discontinu-

Summary The ideal healthcare delivery system is client focused and ensures that the individual and the family receive the appropriate mix of services to meet their needs. Healthcare delivery should be presented as a coordinated continuum of care.

Key integrating elements are essential to provide healthcare services on a day-by-day basis as a continuum of care. Integrating elements that form the bridge between clients and services include planning, care management, a management information system, financing, and an appropriate administrative structure.

Many Catholic healthcare providers are expanding by acquiring a variety of services. However, many of these acquisitions are in response to today's competitive environment, whereas a true continuum of care must focus on the client's range of functional needs. Catholic providers must keep in mind that not all services they provide will be profitable.

Although Catholic healthcare providers will be pressured to focus on fiscal strength and market position, they must put the client's holistic needs first. By doing so, they can help create a client-centered healthcare system in their communities.

ities in our present healthcare system, however, often do not allow this. The system has many large gaps: between primary and acute care, between institutional and community-based care, between acute care and long-term care, and between health and social services.

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Toward More Humane, Effective Care

How can we create policies to provide more humane and effective healthcare? The starting point is the individual and his or her family. The system's primary objective should be to ensure that the individual and family receive the appropriate mix of formal and informal services to meet their needs. From this client-focused perspective, healthcare delivery can be viewed as an extended transition from one functional state to another.

Healthcare delivery should be presented as a coordinated continuum of care. A successful continuum of care has three features:

- *Client focus.* It is "user friendly" (i.e., its primary focus is on the needs and preferences of those being served). Clients are its reason for being. In a true continuum of care the system is responsible for actively anticipating and assessing individuals' and families' needs and seeing them through each site of care, level of care, and level of support.
- *Services.* The continuum is more than a collection of services located in the same community or related to the same organization. The range of services is comprehensive and covers social-intensive, community-based, outpatient care, as well as health-intensive, institution-based, inpatient care. In a continuum, each type of care provider has a significant role in providing services. By providing continuity of care, the delivery system focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change.
- *Integrating elements.* To operate these services on a day-by-day basis as a continuum of care, the system must have key integrating elements. The integrating elements ensure that the delivery system remains focused on the client and avoids competing and conflicting programs, communication gaps, budget conflicts, autonomously functioning programs, and multiproduct marketing. The integrating elements also help maximize the efficient use of scarce resources, both human and financial.

Integrating Elements Integrating elements provide the coordination among services and distinguish a true continuum from other sets of services that simply have information and referral systems. Without the coordination, there is no continuum. The integrating elements require each service provider to network or collaborate with many other community and healthcare agencies.

The following integrating elements form the bridge between clients and services:

- *Planning.* A commitment to coordinated, community-wide planning is required for any successful continuum of care. The governing boards and top managers of each service in the continuum and appropriate medical staffs should be involved.
- *Care management.* Care management refers to a process for assessing both the short- and the long-term healthcare and social services necessary to meet the needs of families and individuals. Care management involves development of a support system that selects from an array of services within the continuum. It consists of several basic components: screening, functional assessment, family and care-giver needs assessment, care planning, team conferences, program eligibility determination, service, referral, monitoring and tracking, and reassessment.
- *Management information system.* A management information system (usually a computerized communication system) should be able to access and integrate data from all the services in the continuum. The result increases accuracy in both historical data and scrutiny of clients' functional levels and integrates health and social service data with financial data.
- *Financing.* For continuum budgeting to be effective and efficient, all providers must participate in the budgeting process. This facilitates planning and enables revenue-generating programs to supplement necessary but financially

weaker ones such as care management. Pooling program funds will also make savings possible due to economies of scale and operational efficiencies. In this regard, capitated financing theoretically offers incentives to develop a continuum: flexibility in choosing the most appropriate service, minimal billing and collection efforts, and means to limit total expenditures for healthcare.

- *Administrative structure.* Organizational leaders are key to connecting all the elements to achieve a successful continuum. Appropriate leadership enables the providers of separate services to feel they belong to one integrated organization. The leaders are also able to convey a clear vision of the continuum. Through joint planning, identifying problems, and sharing information, administrators are able to coordinate the numerous services and support systems within the con-

INNOVATIVE RESPONSES TO CHANGE

Reform of the nation's healthcare system would surely involve profound changes for all players, including Catholic healthcare providers. The following case studies include examples of Catholic healthcare facilities and systems that are already responding to today's changing healthcare environment and to the challenges in their own communities. They demonstrate the capacity of the Catholic healthcare ministry to adapt its institutional presence and sustain the healthcare mission in new and sometimes unexpected ways.

Mercy Center for Health Services

After 97 years of providing acute care services in Watertown, NY, in 1989 Mercy Hospital faced declining admissions, an increasingly weaker financial base, loss of physician support, and strong competition with a newer hospital. Realizing the town could not sustain two hospitals, Mercy Hospital's board of trustees and staff went through a wrenching decision-making process. Ultimately, Mercy decided to use its existing foundation of non-acute care services to maintain a Catholic presence in the city but to cease providing acute care. It also filed for Chapter 11 bankruptcy.

The hospital already was a center for elderly care services. It expanded its renal dialysis stations from 6 to 10 and converted 2 medical-surgical units to obtain 80 more skilled nursing beds, for a total of 284. The hospital, renamed Mercy Center for Health Services, also provides an after-care outpatient program, diagnostic radiology services, home care, and a walk-in clinic that is drawing 18,000 visits a year.

Mercy is still in Chapter 11 but is now operating at a break-even level, compared with an annual $3 million loss over the past 4 years. Even more important, the management team believes Mercy is now better serving the needs of the community rather than fighting over the declining acute care patient base.

San Vincente Family Health Center

With a Medicare/Medicaid census hovering around 53 percent, in 1987 it became obvious that Hotel Dieu Hospital in El Paso, TX, could no longer sustain continued losses under prospective payment and inadequate state funding. The Daughters of Charity closed the hospital but were not willing to abandon their service to the poor in El Paso. In 1988 they opened San Vincente Family Health Center.

Located in a part of the city where primary healthcare was vitally needed, San Vincente provides not only medical care but also health promotion and education, help finding housing, English classes, and other social services. U.S. citizenship is not a requirement to receive care, and brochures in English and Spanish emphasize that the center provides services "especially to those who are uninsured and cannot afford private medical care."

Southwest Catholic Health Network

In 1985 two Catholic healthcare systems in Arizona joined their four hospitals in a collaborative venture to provide healthcare services to the state's poor in an innovative, capitated Medicaid program—the Mercy Care Plan. The systems' leaders saw many poor people falling through the cracks, unable to receive healthcare. The systems joined forces in an effort to provide high-quality, Catholic healthcare to Arizona's poor, many of whom have crossed the border from Mexico.

The organizational structure of the new Catholic network provided for a 50-50 ownership between the sponsoring congregations. It also established a joint board of directors, a chief executive officer position, staff, and a central office.

This collaborative venture involved Carondelet St. Joseph's Hospital and Health Center, St. Mary's Hospital and Health Center in Tucson, and Holy Cross Hospital and Health Center, Nogales, affiliated with the Health Care Corporation of Sisters of St. Joseph of Carondelet, and St. Joseph's Hospital and Medical Center in Phoenix, affiliated with Catholic Healthcare West. They adopted the name Southwest Catholic Health Network.

The network, headquartered in Phoenix, has a contract with the Arizona Health Care Cost Containment System (or AHCCCS), a Medicaid system composed of prepaid, capitated healthcare organizations that provide a uniform benefit package to the indigent. Persons enrolled in the Mercy Care Plan who live outside the four Catholic hospitals' service areas receive care at hospitals the network has contracted with.

tinuum. Communication should flow in all directions: The boards of directors, staffs, physicians, and community must understand the direction and progress of the continuum through channels such as task forces, committees, management meetings, and newsletters.

Team Approach The success of a continuum of care depends on the willingness of providers, volunteer and community organizations, and administrators to collaborate and create an integrated network. Individuals and families are thus enabled to move within the continuum as their needs change, and the continuum responds quickly to these changes.

The continuum of care requires healthcare providers to plan and work with other service providers in the community. The continuum also requires a team approach to care that can identify and address a wider range of problems than can a single practitioner. Healthcare providers espouse the team approach within their facilities; however, the continuum of care requires that providers extend the team approach to the community when planning and delivering services to meet increasing needs of individuals and families. Representatives from the various providers in the continuum can and should jointly assess the healthcare needs of the community and jointly determine how the continuum can best meet those needs.

Implications for Catholic Healthcare Facilities

Many Catholic healthcare organizations and systems have recently been expanding their services by acquiring outpatient facilities, nursing care facilities, adult day care programs, home health services, retirement housing, and a variety of other services.

Although many of these services were started in response to perceived community needs, others are a response to today's intensely competitive market environments. Because of price competition, government cutbacks, and commercialization, even not-for-profit institutions are increasingly preoccupied with the business environment, market plans, market penetration, and outreach programs that attract patients who pay well.

For instance, some Catholic and non-Catholic healthcare organizations have developed vertically integrated models of service acquisition to improve their hospitals' market positions by providing a variety of services that will attract paying patients. Although many of these arrangements provide an array of integrated services, the integration is limited and is primarily from an acute care facility's fiscal and management perspective, rather than from a clients' needs perspective. Individuals and families might view a set of services as separate and distinct while the hospital sees them as integrated. Nevertheless, some healthcare organizations refer to a vertically integrated system or similar arrangement as a "continuum."

An explicit market focus may financially strengthen the healthcare organization and make an array of services available to the community. The result, however, is not likely to be a continuum of care, since a true continuum is more than a collection of services related to the same institution. A true continuum requires several other features, the most important of which is an explicit focus on the client's range of functional needs, as opposed to a primarily market-driven orientation.

The healthcare organization's strategic focus largely determines the kinds of services it develops, the degree of internal service integration it implements, and the role it plays in the larger community to ensure that its services are complemented by and integrated with other necessary services. If the healthcare organization is market focused, it will acquire services based primarily on what they can do to strengthen the organization. In a market-driven model, the organization may cancel services that are financial losers. A client-focused healthcare organization, on the other hand, first determines what services it must provide (or arrange to be provided by others) to ensure that individuals and families receive an appropriate mix of formal and informal services as they move from one functional state to another.

Not all the services provided by the healthcare organization or by other providers in the larger continuum will be profitable. In fact, many providers are currently struggling to continue to provide some services to vulnerable populations. All the providers together will have to determine how to support the unprofitable-but-necessary services.

The client-focused healthcare organization will make certain that its own departments are well integrated from the clients' perspective (e.g., Do the hospital outpatient services departments know about and work with the hospital-sponsored hospice program?). It will also help provide the necessary community leadership to guarantee that the essential integrating elements (described above) are developed and maintained. These elements will ensure that the continuum of care remains focused on the client and avoids competing and duplicative programs, communication gaps, and budget conflicts.

Catholic healthcare organizations are places of enormous competence and commitment. As

such, they are a moral force in the communities they serve and can be agents for improving the common good. A continuum of care offers Catholic healthcare organizations a way to ameliorate the harsher aspects of the current healthcare delivery system by making it work better for individuals and their families. Properly implemented, a continuum of care will better identify clients' needs and make available a wider spectrum of services than would otherwise be available. Together, these elements challenge Catholic healthcare facilities in several important ways.

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Assets and Challenges

Catholic healthcare organizations will find it difficult to convert to a client-focused continuum of care. Private and public program cost controls, coupled with intensive price competition, place today's healthcare organizations under enormous pressure. In such an environment it is a difficult and delicate task to balance a voluntary institution's responsibility to serve its community with its concomitant duty to preserve its assets so that it will survive to meet future community needs. In fact, today's free-market, procompetition policy orientation too often disrupts this balance by pressuring some voluntary healthcare facilities to focus on institutional fiscal strength and market position to the diminishment of their primary, noneconomic objectives.

Some institutions justify their emphasis on business by stating, "No margin, no mission." But this approach is inappropriate in the not-for-profit sector because it makes an institution's mission the handmaiden of its business imperatives. A more appropriate, though more challenging, practice that many voluntary healthcare facilities follow is to identify the mission and then determine how to assemble the public, private, and charitable resources necessary to implement that mission and maintain it over time.

This method recognizes the primacy of mission without disparaging the legitimate role of sound business practices in the operation of a voluntary healthcare facility. It also accords favorably with the religious origins of Catholic healthcare institutions, most of which were started in response to community need and sustained in faith under difficult circumstances and at considerable personal, material, and financial sacrifice.

The vision of putting the client's holistic needs first represents a fundamental challenge to today's overreliance on price competition in the delivery of healthcare and the commercialized message it elicits about arranging services under a "hospital flagship." It also challenges Catholic healthcare leaders, in a spirit of solidarity, to identify with their clients, who may be even more adversely affected by the problems associated with our fragmented healthcare system.

Catholic healthcare organizations should also consider that a mission statement that clearly focuses on client need may help the institution's survival in these difficult times. A clarification of institutional values creates criteria that can free healthcare organization managers to make critical choices about the institution's operational direction and help them resist questionable actions for a quick fix.

A healthcare facility that emphasizes client-focused care and community service can build valuable community and political support in an era of budget-driven public program cost reductions. The facility will also reinforce and legitimize its community service role at a time when many local, state, and federal, policymakers are questioning whether not-for-profit healthcare organizations should retain their tax-exempt status.

Finally, the inclusion of a client-focused continuum of care in a healthcare organization's strategic plan and operations may position the organization to become the "provider of choice" for private and public insurers. These insurers are and increasingly will be seeking to contract with providers who can offer their beneficiaries a wide range of appropriate, integrated, and cost-effective services.

By changing from a product-line orientation to one based on clients' total needs, Catholic healthcare providers can have an influence on creating a client-focused healthcare system within their communities. □