

Two Collaborative Organizations Improve Care Delivery

Healthcare leaders, discouraged by the failure of competition to control costs and improve care outcomes, are turning to collaborative models to enable them to serve their communities. At the heart of the healthcare reform proposals of the Catholic Health Association and other organizations are networks of providers that provide a continuum of services (see p. 24). Two successful models of collaboration—one that improves the efficiency of the delivery of cardiology services and one that integrates chronic care services—were explored at a forum sponsored by St. Paul-based InterHealth last fall.

CARDIOLOGY CONSORTIUM

The Rocky Mountain Heart Consortium, Denver, comprises 14 hospitals that offer open heart surgery services (see **Box**, below), as well as physicians and community leaders. It was organized by the Rocky Mountain Heart Research Institute, Denver (which recently merged with the consor-

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tium), to design a regional cardiac care delivery system through collaborative planning. The goal was to provide less duplicative, higher-quality services, said Ann Fenton, the consortium's executive director.

Consortium Activities The consortium, which resulted from a planning process begun in January 1991, has developed five programs:

- Services for the medically indigent. In a six-month pilot program, started in January 1993, seven Denver hospitals, along with cardiologists and cardiovascular surgeons, are providing care to indigent patients.

- Educational conferences for physicians, nurses, and technicians on issues ranging from cardiac imaging to ethics in cardiology.

- Technology evaluation. Fenton said that, as a result of research by the consortium's technology planning committee, five hospitals abandoned plans to purchase separate positron emission tomography (PET) scanners, eliminating costly duplication.

- Data. The consortium's Research and Data Center is developing a uniform cardiology data base to enable consortium participants to study services' outcomes and cost-effectiveness. The consortium will use the data with physician study groups to change behavior, Fenton said.

- Clinical research. The consortium is able to attract major cardiovascular research projects, Fenton said, because of the large number of patients available through its members. For example, the consortium will participate in a four-year study of the efficacy of Coumadin and aspirin in preventing second heart attacks. In addition, the consortium is forming a central institutional review board that will review protocols to be implemented at multiple sites. A research committee will set research priorities and criteria for protocol review and acceptance.

Getting Started Six hospitals originally joined the consortium, contributing \$20,000 each. It was difficult, Fenton said, to convince hospitals that the organization would help them, and they need-

HOSPITALS IN THE ROCKY MOUNTAIN HEART CONSORTIUM

Denver

The Children's Hospital
Lutheran Medical Center
Mercy Medical Center
Porter Memorial Hospital
Presbyterian/St. Luke's Medical Center
Rose Medical Center
St. Anthony Central
Swedish Medical Center
University Hospital

Boulder

Boulder Community Hospital

Grand Junction

St. Mary's Hospital and Medical Center

Fort Collins

Poudre Valley Hospital

Colorado Springs

Memorial Hospital
Penrose Hospital

For more information, contact Rocky Mountain Heart Consortium, 1601 Milwaukee St., No. 626, Denver, CO 80206, 303-393-3951.

ed time to understand each other's culture and philosophy. The consortium has held a series of retreats for representatives of providers and managed care and consortium board members. Participants focused on defining an ideal cardiology system and developing standards of excellence.

Consortium Organization The Strategic Planning Committee, made up of the hospital chief executive officers and physicians, makes recommendations to the consortium's board of directors. The board is made up of community leaders from business, industry, and government, as well as two hospital representatives.

Consortium teams on indigent care, professional education, technology, data, and clinical research report to the Strategic Planning Committee. Team members come from a variety of areas, Fenton said. For example, a person from state government works on the indigent care team.

Future Needs The consortium's members are taking small steps toward eliminating duplicative services, Fenton said. "These areas are very hard because they involve egos and the bottom line," she remarked, but she said the consortium has succeeded because it has involved the right people in the community and has worked through win-win strategies. In 1993 the consortium will continue to focus on statewide cooperative planning.

CHRONIC CARE CONSORTIUM

The National Chronic Care Consortium (NCCC), Bloomington, MN, is the catalyst for local geriatric care networks (GCNs) that are being set up across the country (see **Box**, right). NCCC was established in 1991 by Altcare, a partnership between General Mills and the Wilder Foundation, to develop new methods of care for the frail elderly. Its 20 members, chosen for their leadership in healthcare innovation, are forming GCNs that will provide an integrated continuum of preventive, acute, transitional, and long-term care services. All will operate under common care protocols and quality measures.

The GCNs will offer specialized short-term services, including geriatric assessment, inpatient transitional care, geriatric rehabilitation, adult day healthcare, home health services, and care giver support services. The networks will use simplified procedures that allow clients access to all services from any point of contact within the network.

Care management, coordinated with primary care physicians, will be an attribute of all GCNs, Browne said. The GCNs will also offer patient education and training and self-help assistance, including technologies that allow clients to maintain their independence. Each GCN will have organizational capabilities such as strategic planning; financial management to link reimburse-

MEMBERS OF NATIONAL CHRONIC CARE CONSORTIUM

Amherst H. Wilder Foundation/ HealthEast, St. Paul	Intermountain Health Care, Salt Lake City
Baylor University Medical Center, Dallas	Lutheran General HealthSystem, Park Ridge, IL
Benjamin Rose Institute/Uni- versity Hospitals of Cleveland, Cleveland	Lutheran Health Systems, Mesa, AZ
Beth Abraham Hospital, Bronx, NY	Mount Zion Health Systems, San Francisco
Beverly Hospital, Beverly, MA	Philadelphia Geriatric Center/ Albert Einstein Medical Center, Philadelphia
Carondelet St. Mary's Hospital and Health Center, Tucson, AZ	Provenant Health Partners, Denver
The Eddy, Troy/Albany, NY	Rochester General Hospital/Park Ridge Health Systems, Rochester, NY
Fairview Hospital and Healthcare Services/The Ebenezer Society, Minneapolis	St. Mary Medical Center, Long Beach, CA
Group Health Cooperative of Puget Sound, Seattle	Sutter Health, Sacramento, CA
Henry Ford Health System, Detroit	
Huntington Memorial Hospital, Pasadena, CA	

For more information, contact NCCC, 5001 W. 80th St., Suite 449, Bloomington, MN 55437, 612-835-1915.

Geriatric
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ment with outcomes; information management to provide decision makers with common client, clinical, and financial data; quality assurance; and marketing. Each will offer managed care for chronic care clients.

One System's GCN When it joined the NCCC in January 1991, Lutheran General HealthSystem (LGHS), Park Ridge, IL, was already offering a wide continuum of services for the elderly. In addition to acute and long-term care, LGHS provided many community- and church-based services, housing, and a substance abuse program. However, the services were not integrated and people sometimes "fell through the cracks," according to Ellen Browne, who described the system's participation in the consortium. Browne, who is vice president of Aging Services, Parkside Senior Services, Park Ridge, said the system needed cooperation and internal communication mechanisms to ensure patients had access to all programs across the spectrum.

"When I was assigned to lead Lutheran General in implementing the goals of the consortium, I knew I had to do things differently," she said. "If we were to be successful at LGHS, we needed key people collaborating on the goals." The solution was to form committees "with very specific goals

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PRIMARY CARE PROGRAM

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FQHC requirements.

Catholic-affiliated organizations typically seek tax-exempt status by applying for membership in the *Official Catholic Directory* (OCD) and qualifying for the exemption under the group ruling given to the Catholic Church. However, because the FQHC corporation cannot be construed as being under the control or auspices of another organization, it must attain an exemption independent of the OCD listing process.

Other issues to consider before implementing the FQHC program include analyzing licensure and other regulatory issues triggered by FQHC status, documenting the relationships between the FQHC and its medical staff and provider hospital, analyzing insurance aspects of the relationship, and addressing potential alienation of property and other canonical issues.

COSTS AND BENEFITS

Participation in the FQHC program can significantly improve Catholic providers' ability to deliver primary healthcare services to populations in need. However, sponsors should be aware that implementing the program often entails complex licensure and regulatory issues. In addition, hospital administrators must realize that, in creating an FQHC organization, they are required to give up direct control over the delivery of primary care services.

Before committing to the program, then, providers must ask whether they can meet FQHC requirements and whether the program's benefits justify the effort needed to create an FQHC. For organizations that can answer yes to both questions, the FQHC program presents an opportunity to improve the level and quality of primary healthcare services available in their communities. □

HEALTH POLICY

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5. What are the implementation details; how is it really going to work?

These questions and more will need to be addressed in the coming months as Clinton prepares to submit his plan to Congress. In the interim, Congress has planned a busy schedule of hearings and briefings so that when the plan comes down from the White House, they will be ready. For instance, in late January Rep. Pete Stark, D-CA, who chairs the House Ways and Means Subcommittee on Health, began a series of hearings on healthcare reform. Part of the hearing blitz (30 to 40 are planned) is to educate the large number of new committee members. But another reason is that the sheer complexity of the issues and the difficult policy decisions that lie ahead demand such intensive debate. □

NOTES

1. Alain C. Enthoven, "Consumer Choice Health Plan: A National Health Insurance Proposal," Memorandum to Health, Education, and Welfare Secretary Joseph Califano, September 22, 1977.
2. Alain C. Enthoven, "The History and Principle of Managed Competition," *Health Affairs*, Suppl., March 1993.
3. Enthoven, "The History and Principle of Managed Competition."
4. Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheredge, "The Jackson Hole Initiatives for a Twenty-first Century American Health Care System," *Health Economics*, vol. 1, 1992, pp. 149-168.
5. Enthoven, "The History and Principle of Managed Competition."
6. Paul Starr, *The Social Transformation of American Medicine*, Basic Books, New York City, 1984.
7. Paul Starr, testimony before the Senate Labor and Human Resources Committee, December 17, 1992.
8. Paul Starr and Walter Zellman, "Bridge to Compromise: Managed Competition, Global Budgets, and Universal Coverage," *Health Affairs*, Suppl., March 1993.
9. Starr, testimony; Starr and Zellman.
10. John Garamendi, "California Health Care in the 21st Century: A Vision for Reform," State of California, Sacramento, February 1992.

ANALYSIS

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based on the attributes required for a GCN," Browne explained. Now 80 staff people from LGHS entities, as well as providers and community members, serve on 11 committees.

The committees, which meet every four to six weeks, coordinate activities in many areas, including finance, marketing, education, wellness, information systems, and research. The marketing committee, for example, eliminated separate brochures for each program and produced one brochure for all aging services in the system, Browne said. The education committee is creating training programs aimed at teaching employees to work effectively with older adults and instilling positive attitudes toward aging. The networking committee integrates external service providers into the GCN. And the central access/intake committee eliminates duplication in assessment.

Successful Cooperation "A spirit of collaboration" is integral to establishing a successful GCN, Browne said. "It is difficult for hospitals to treat others as equals," she said, but they must collaborate with consortium members and with outside providers. Also, all persons who work with older adults—no matter what hospital department they are part of—must function as part of a team to serve the chronically ill, she said.

"As we endeavor to reform the way services are financed, administered, and delivered to the chronically impaired elderly, we are asking people to plan and to eventually make some major changes in the way they operate on a day-to-day basis," Browne pointed out. She said that Lutheran General continues to incorporate into its daily operations the critical elements of successful internal and external collaboration. These include encouraging employees to work not only within the system but also with community players, ensuring that all stakeholders benefit from the arrangement, identifying effective processes and expected outcomes by allowing all players to speak freely about what they need to do their jobs, and evaluating processes to ensure accountability to the community.

—Judy Cassidy