Book Reviews

Health Care for the Poor and Uninsured: Strategies That Work

Nellie P. Tate, PhD, and Kevin T. Kavanagh, MD, editors

Haworth Press, Binghamton, NY, 1992, 101 pp., $24.95

THIS TEXT IS A COMPILATION OF PAPERS from the Second Annual Conference on Health Care for the Poor and Uninsured (1990). The book is intended for planners, policy designers, and healthcare professionals involved in the planning and implementation of state healthcare programs that serve the medically indigent, especially children and pregnant women.

Six chapters address various aspects of maternal-child health: the increasing availability of obstetric care through utilization of nurse midwives, a maternity waiver program, the channeling of high-risk mothers and infants, the cost-effectiveness of screening selected newborns, a reduction in the infant mortality rate of blacks, and perceived barriers in the use of a comprehensive prenatal care program. The final paper explores long-term home care for the frail elderly and the needs of their care givers.

The authors of the first chapter discuss a successful program using nurse midwives in Alabama. However, they leave many questions unanswered: Was the availability of nurse midwives the main reason 89 percent of area women utilized these services? How did program administrators determine that "public health nurses did not have the time to add the case management function to their list of duties" (p. 17) and therefore that social workers should be incorporated into the prenatal care system in public health? What changed as a result of case management with social workers? What was different about the experiences of the 11 percent of clients who did not use the services?

Chapter five, which describes three demonstration projects in Tennessee aimed at reducing the infant mortality rate of blacks, also leaves many questions unanswered. Although these programs used alternative approaches to outreach and patient care and enhanced reimbursement methods, the authors do not discuss these. They instead discuss need, target population criteria, and some results and then recommend that "circumstances [surrounding insufficient care] should be analyzed" and "the issues or categories of barriers should be

BOOK BRIEFS

Managing in an Academic Health Care Environment

William F. Minogue, MD, ed., American College of Physician Executives, Tampa, FL, 1992, 213 pp., $40 (members), $50 (nonmembers)

Academic healthcare institutions often have multiple, conflicting roles. As research organizations, they provide highly technical care. At the same time, such institutions train tomorrow's healthcare providers. Academic healthcare institutions rely on a range of sources for funds for their operations, research, and teaching. Positioned as such, academic healthcare centers are ill prepared for the competitive battle that lies ahead in a reformed healthcare system.

Given all these obstacles, the book's contributors describe how academic healthcare centers can be managed successfully. They cover topics such as faculty practice plans, strategic planning, cost management, information systems, legislation, and the future of healthcare.

The Social Impact of AIDS in the United States

Albert R. Jonsen and Jeff Stryker, eds., National Academy Press, Washington, DC, 1993, 322 pp., $34.95

The authors help readers understand the impact of AIDS on social and cultural institutions and how those institutions have responded. They discuss how the disease characteristics of AIDS have posed challenges to the way Americans have traditionally delivered healthcare. For example, volunteers are stepping in to fill the gaps left by decreases in public health funding. In addition, the authors explore how HIV and AIDS have affected fundamental policies and practices in some of the nation's major institutions, how major religious organizations have dealt with often conflicting values, and how AIDS activists have brought about major changes in the way new drugs are tested.

Health Care Ethics Committees: The Next Generation

Judith Wilson Ross et al., American Hospital Publishing, Chicago, 1993, 198 pp., $34 (AHA members), $45 (nonmembers) (paperback)

During the past six years, the function of an ethics committee has changed from providing guidance on issues that have clear consensus nationwide to providing education and guidance on how to think about issues that have no clear consensus. Judith Wilson Ross et al. help ethics committee members understand their roles and how to accomplish their goals. Most of the 12 chapters

explored" (p. 77). Eighteen months is offered as "a relatively small time period to determine the documented impact on such a multi-dimensional problem" (p. 77). Even some initial hypotheses would have been helpful to providers and planners in this area.

Chapter six discusses a study on perceived barriers in the use of prenatal care networks. The study examined factors associated with the use of community-based networks by black women in three high-risk Chicago communities and found that "convenience factors" (job demands, travel time, and child care) did not differentiate those who used the network providers from those who did not use them. Traditionally, these factors have been viewed as influencing health-care use. The authors do not discuss how to address the lack of private providers' specialty training. In addition, two other potentially important barriers—lack of provider respect toward patients and inadequate time with the provider during the office visit—are not explored.

Even though many issues remain unexplored, the book does present several worthwhile ideas. The authors of the second chapter describe the maternity waiver program in Alabama and offer many specific examples of their primary provider network, home visits, and ways their maternity care coordinators provide nonmedical support services.

Chapter three authors discuss a South Carolina project in which high-risk patients are channeled to designated clinics. They offer many valuable insights through a description of the problems they encountered: unavailable vital records; lack of completed risk-screening forms, computers to track repeat screenings, and home data; reimbursement issues; medical discretion in designation of high-risk infants; and lack of behavioral risk factors, travel costs, and self-selection of exemptions to channeling.

Chapter four discusses Mississippi's cost-effective model of newborn screening for phenylketonuria, hypothyroidism, and hemoglobinopathy and the value of shared regional screening with Tennessee.

The author of the final chapter focuses on persons who care for an elderly parent or grandparent. The writer reflects on 10 years of personal care-giving experience that formed the basis for establishing the not-for-profit Long Term Home Care of the Frail Elderly Foundation in New York City. Three major gaps filled by foundation programs are discussed: respite for the care giver; a centralized national outlet for training, information, education, advice, and support; and advocacy for families providing long-term home care. Two tax-law reforms that address the concerns of many families about assets and long-term care expenses are proposed.

Despite these valuable ideas, on the whole I was disappointed with the book. As a healthcare professional with experience in medical indigency issues, I had hoped to find some innovative models for approaching clients, some discussion of ideas and concepts that might be replicated or at least that would evoke further reflection. Although the papers may have been helpful to those who attended the conference, as a reader, I often felt excluded from the heart of the matter. The almost-terse discussions surrounding the programs moved me to ask, How did these programs make a difference? I found few responses. I was left wondering whether the presenters were asked follow-up questions that the editors omitted.

Sr. Sally Smolen, RSM
Program Coordinator
New Steps
Detroit

include activities, exercises, and questions to help committee members think about a particular issue or committee process. Topics covered include methodology, how meetings work, case review protocols, when to write policies, and self-assessment.

Cost Management Strategies for Smaller Hospitals

Malcolm R. Hastings, American Hospital Publishing, Chicago, 1993, 124 pp., $36 (AHA members), $45 (nonmembers) (paperback)

Cost Management Strategies for Smaller Hospitals was written to help small hospitals (100 beds or fewer) position themselves for a more value-driven healthcare environment. The seven chapters address cost reduction and performance improvement techniques, budgeting and capital planning, control of labor and material costs, hospital-physician collaboration, and capitation.

BOOKS RECEIVED

Contemporary Environments for People with Dementia, Uriel Cohen and Kristen Day, Johns Hopkins University Press, Baltimore, 1993

Health Care Reform: A Catholic View, Philip S. Keane, Paulist Press, Mahwah, NJ, 1993

Lights in the Darkness: For Survivors and Healers of Sexual Abuse, Ave Clark, Resurrection Press, Mineola, NY, 1993

The Spirit of Community: Rights, Responsibilities, and the Communitarian Agenda, Amitai Etzioni, Crown Publishers, New York City, 1993

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if the new system adjusts payments for these needs. Catholic healthcare and other mission-driven community service organizations have traditionally reached out to these populations. The necessity for this will continue.

It is also likely that the new system of care will not meet all the health and health-related needs of enrolled persons. Even a fairly comprehensive benefits package may not include needed over-the-counter medicines and appliances, transportation to health services, counseling, and some desired, but not lifesaving, procedures and treatments. Low-income persons enrolled in a healthcare network are likely to continue to need some free and discounted services and supplies.

Catholic and other mission-driven healthcare organizations holding to the principle that "the poor have a moral priority" will continue to be needed in our healthcare system. These providers, whether they sponsor healthcare delivery networks or are part of such networks, will continue to need and deserve tax exemption.

It is likely that the new system of care will not meet all the needs of enrolled persons.

Community Benefit

Providing benefits to the broad community can also characterize a tax-exempt IDN and its component organizations.

Although a network will primarily focus on persons who are enrolled, it can and should show concern for the broader community. This community may be the overall geographic service area, or it might include an area remote from the network and most of its enrollees, such as an underserved rural or inner-city area. Benefits to the broader community include policies and programs that:

- Improve the health of persons in the community (helping them get and stay well)
- Improve the overall health within the community (preventing widespread disease and injury and acting on societal problems that tend to cause disease and injury)
- Contain healthcare costs and conserve scarce resources (avoiding unnecessary duplication of services and equipment and providing services in the most cost-effective and economic setting)

The Catholic Health Association's (CHA's) Standards for Community Benefit (see **Box**) present a framework for describing how an integrated delivery network can demonstrate it is meeting a charitable purpose as a community benefit organization.

CATHOLIC HEALTH ASSOCIATION STANDARDS FOR COMMUNITY BENEFIT

As members of the Catholic Health Association of the United States, we share a historical mission and tradition of community service. In order to continue our tradition of providing benefit to the community, we affirm that:

1. The organization's mission statements and philosophy should reflect a commitment to benefit the community and that policies and practices be consistent with these documents including
   - Consideration of operational and policy decisions in light of their impact on the community served, especially the poor, the frail elderly, and the vulnerable
   - Adoption of charity care policies that are made public and are consistently applied
   - Incorporation of community healthcare needs into regular planning and budgeting processes
2. The governing body should adopt, make public, and implement a community benefit plan that
   - Defines the organization's mission and the community being served
   - Identifies unmet healthcare needs in the community, including needs of the poor, frail elderly, minorities, and other medically underserved and disadvantaged persons
   - Describes how the organization intends to take a leadership role in advocating community-wide responses to healthcare needs in the community
   - Describes how the organization intends to address, directly and in collaboration with physicians, other individuals, and organizations
     - —Particular or unique healthcare problems of the community
     - —Healthcare needs of the poor, the frail elderly, minorities, and other medically underserved and disadvantaged persons
   - Describes how the organization sought the views of the community being served and involved community members and other organizations in identifying needs and developing the plan
3. The healthcare organization should provide community benefits to the poor and the broader community that are designed to
   - Comply with the community benefit plan
   - Improve health status in the community
   - Promote access to healthcare services for all persons in the community
   - Contain healthcare costs
4. The organization should make available to the public an annual community benefit report that describes the scope of community benefits provided directly and in collaboration with others.

Mission and Philosophy The standards suggest that mission statements and other descriptions of philosophy should speak to the organization's commitment to community service. The mission statement of the Alexian Brothers Medical Center (see **Box**, below) is an example that an integrated delivery network could use as the basis of a community benefit statement.

The CHA standards suggest that policies, as well as mission statements, can reflect an organization's community benefit orientation. These could include policies on:

- Financial assistance for enrolled and nonenrolled persons
- Advocacy for improved public policies
- Physicians' and employees' role in community benefits
- Employee benefits and the work environment
- Selection of contractors and other partners
- Treatment of poor and other minority persons
- Selection and participation of board members
- Energy and resource conservation and the environment
- Decision making, considering impact on community
- Planning and budgeting, incorporating community health concerns and community benefit

Community Benefit Plan A growing number of community-oriented healthcare organizations are developing an annual community benefit plan, as suggested by CHA's standards. This can be an excellent way both for ensuring that the healthcare organization is being adequately responsive to community needs and for documenting commitment to community well-being.

Community benefit plans can include:

- The organization's mission and tradition of service
- A description of the community served
- Identification of unmet healthcare needs in the community
- How the organization intends to address, directly and in collaboration with others, particular or unique healthcare problems of the community, and the healthcare and related needs of the poor, frail elderly, minorities, and other medically underserved and disadvantaged persons
- How community members, organizations, and businesses were involved in identifying the needs and developing the plan

Provision of Services The ultimate demonstration of meeting a community benefit purpose is the provision of services. CHA's standards describe community benefit services as those designed to improve health status in the community, to promote access to healthcare services to all persons in the community, and to contain healthcare costs.

A growing number of healthcare organizations are developing an annual community benefit plan.

Some examples of community benefit services include:

- Being part of community-wide efforts to decrease infant mortality and morbidity, to protect children against vaccine-preventable disease, to address the problem of violence in the community, or to help homeless families.
- Reaching out to minorities, the poor, and other underserved persons, whether or not they are enrolled in the integrated delivery network. This could include providing multilingual information on child health or offering employment opportunities to persons who are developmentally disabled.
- Implementing programs that promote health and avoidance of injury and illness through campaigns to decrease teen drinking, promote the use of car seats for toddlers, and institute surveillance systems that detect unusually high incidences of cancer, certain infections, or other possible indications of systemic community health problems.

Community Benefit Report Finally, CHA's standards suggest frequent and regular reports on what the organization understands to be the healthcare needs in the community and how it is responding to those needs. This reporting is not a self-promotion. Rather, it is a way of being accountable to those in the community responsible for tax policies, to those who volunteer their time in governance and direct service, to those who contribute financial support, and to the medical staff and employees who want to be part of a mission-oriented organization. □

MISSION STATEMENT OF ALEXIAN BROTHERS MEDICAL CENTER, ELK GROVE VILLAGE, IL

The mission of Alexian Brothers Medical Center is to serve the health care needs of the community with a constant striving for the highest quality care, innovative and responsible use of resources and an abiding regard for the individual.

The health care provided here is the outward sign of the Alexian Brothers' enduring vision, holistic perspective and sensitivity to the dignity of every person, advantaged and disadvantaged. It is care illuminated by the teachings of Christ and his Church.

We deliver health care in partnership with those who would share our ministry. Only with and through the community can we fully and faithfully serve those who come from the community to find healing and blessing.