SPECIAL  SECTION

CATHOLIC HEALTHCARE'S FUTURE

Ten Models for Competition and Capitation

BY ALAN M. ZUCKERMAN & RUSSELL C. COILE

Catholic healthcare is being rebuilt for the twenty-first century. With a rush of major transactions and mergers across the United States, change is in the air—and in the headlines. The restructuring of Catholic healthcare can create controversy, however, as when a religious sponsor announces an affiliation with investor-owned, publicly traded companies such as Columbia/HCA Healthcare Corporation and Tenet Healthcare Corporation. In the next five years, every Catholic hospital and religious sponsor must establish an integration strategy and select partners for the next century.

Catholic-sponsored hospitals are already regrouping for a future of competition, capitation, and consolidation. Catholic sponsors currently own about 550 facilities, approximately 10 percent of the U.S. acute care hospitals and 15 percent of the beds.[1] A study by the Catholic Health Association (CHA) of 190 transactions found some 85 percent of the affiliations, acquisitions, and consolidations were between Catholic and non-Catholic organizations.[2] At the 1995 National Convocation for Catholic healthcare leaders, participants from 61 congregations agreed to proceed rapidly to initiate regional and national integration efforts. At the meeting, the first step in the *New Covenant* process to strengthen the Catholic health ministry through collaborative strategies, CHA President John E.

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Summary In the next five years, Catholic providers must select strategies that will involve affiliations, acquisitions, and consolidations with Catholic and non-Catholic partners. At least 10 options are available to meet the long-term trends of managed care, competition, and capitation.

- Vertical integration allows comprehensive patient care.
- Multisponsor management can help religious institutes expand their market share.
- Systems and one-hospital sponsors can affiliate their facilities to form Catholic networks.
- Community-based not-for-profit networks can include both Catholic and non-Catholic organizations bound by contracts and joint ventures.
- Joint ventures provide the benefits of integration to Catholic providers, who must be willing to commit substantial capital to create HMOs and other networks with non-Catholic partners.
- Acquisition of facilities and regional and statewide expansion can strengthen a Catholic system's market position in the face of declining acute care hospital services.
- Catholic/non-Catholic mergers risk consolidating and closing facilities but need not erase Catholic identity.
- Cooperation between affiliation and merger, or "co-opetition," involves creating new legal territory for Catholic/non-Catholic consolidation.
- Divestiture may be an ultimate strategy, but Catholic sponsors must proceed with caution in their dealings with plentiful buyers.
- Catholic facilities and systems are joining with Catholic Charities, other providers, and local agencies to create networks.

Curley, Jr., addressed the need for Catholic healthcare to achieve a "critical mass" to influence U.S. healthcare. In a recent survey of 472 CHA hospitals, 30 percent of pastoral care leaders and chaplains predicted that the changes would stimulate a renewed commitment to spiritual care and Catholic values.[3]

A Crucial Five Years Ahead

Catholic healthcare organizations will see more change in the next five years than they have in the past 20. The many scenarios that may develop include the following:

- National Catholic systems could consolidate from 63 small and mid-sized organizations to 15 to 20 megasystems, each owning or managing 10 to 100 or more hospitals.
- The recently launched Catholic Health Initiatives of Denver could expand to as many as 300 hospitals, thus becoming the largest U.S. Catholic healthcare organization and rivaling all but the largest investor-owned hospital chains.
- Single-sponsor hospitals could decline from 40 percent to 10 percent, and most of these religious institutes could either pursue new forms of sponsorship or—on the other hand—relinquish all operating control over their facilities.
- The number of Catholic religious communities that sponsor healthcare facilities could fall from the current 300 to as few as 200 as a result of mergers among religious groups.
- A national Catholic organization with multiple sponsors dedicated exclusively to long-term care could grow to rival the former Catholic Health Corporation as a management company for Catholic long-term care facilities.
- An estimated 95 percent of all Catholic hospitals will probably be managed by lay administrators; more than 50 percent of these executives may not be Catholic.
- At least 90 percent of Catholic health systems will be directed by lay chief executive officers (CEOs) in the year 2000.
- Fewer than 5 percent of Catholic hospitals will be owned or managed by dioceses, much the same as the current situation.
- Fewer than 2 percent to 3 percent of the 550 U.S. Catholic hospitals will be sold to publicly traded, investor-owned chains.

Catholic healthcare sponsors should not overreact to headlines about multimillion-dollar acquisitions of Catholic hospitals by for-profit companies. The longer-term trends of competition, capitation, and consolidation will drive all healthcare organizations, not just Catholic hospitals and systems. U.S. Catholic hospitals will have to realign in response to price concessions to employers, the rise of managed care, and cutbacks in federal financing for health services to elderly and poor patients. Smaller Catholic hospitals may be especially vulnerable to these pressures. Hospitals with fewer than 100 beds constitute 16.6 percent of all Catholic facilities (see **Figure**, this page). Thus challenges to Catholic healthcare in the next five years will not be unique to Catholic hospitals or their sponsors.

Catholic healthcare organizations must reposition for the twenty-first-century environment of managed care, competition, and capitation. The remainder of this article discusses 10 strategic alternatives they should consider to meet this impending challenge.

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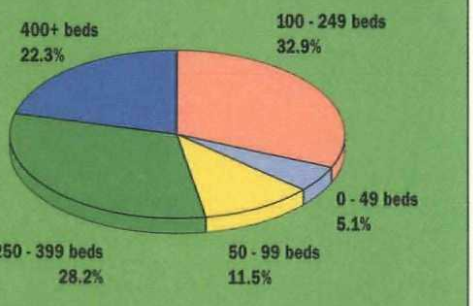
CATHOLIC HEALTH FACILITIES BY SIZE, 1996



Source: *Official Guide to the Catholic Health Association Membership*, Catholic Health Association, St. Louis, 1996.

Option 1: Vertical Integration

Catholic health systems' sponsorship of long-term care facilities is a major asset in a managed care, capitated environment. Managed care buyers will increasingly select vertically integrated healthcare organizations as preferred providers. These organizations provide "one-stop" patient care, offering a variety of levels and types of services. Managed care buyers can sign a single contract for a comprehensive array of services from vertically organized providers.

Catholic healthcare's holdings in long-term care may provide a significant advantage in marketing vertically integrated packages of care. More than 1,000 hospital-based and free-standing long-term care facilities are operated under Catholic sponsorship.[4] The facilities have a capacity of more than 100,000 beds in long-term care or residential units. Almost half of these are skilled nursing facilities, totaling more than 50,000 beds. Multihospital Catholic systems are deeply invested

in long-term care. Forty-four (out of 63) Catholic health systems operate more than 25,000 long-term beds in hospital-based or affiliated units. Catholic holdings in long-term care include skilled and intermediate care facilities, congregate and senior housing, hospices, and rehabilitation facilities. There are also Catholic-sponsored substance abuse centers, homeless shelters, orphanages, and group homes for mentally handicapped patients.

Catholic facilities have already developed long-term care partnerships for managed care contracting. In Waterbury, CT, St. Mary's Hospital is developing a vertically integrated, multilevel network with Hartford-based VNA Health Care, the largest not-for-profit home health provider in Connecticut. This partnership further strengthens St. Mary's ties with neighboring Hartford Hospital and Yale University School of Medicine in creating a regional integrated delivery network (IDN).

Combining vertical and horizontal integration on a local market basis repositions Catholic healthcare organizations for a managed care future. In Peoria, IL, the seven-hospital St. Francis Health System took a major step toward vertical integration by purchasing 22 physician groups.[5] Management and performance initiatives are transforming the physician network into an integrated group practice. Additional vertical integration programs of St. Francis include an inner-city outpatient facility, employee wellness, nurse triage, diabetes management, case management, and clinical education.

Option 2: Multisponsor Organization

Placing facilities under cooperative multisponsor management may be a viable option for hundreds of Catholic religious institutes. In Philadelphia, for example, three Catholic sponsors control seven community hospitals, a potential site for a multisponsor organization. Approximately 40 percent of religious sponsors own only a single hospital.[6] Beginning in 1980, Catholic Health Corporation of Omaha, NE, now, with other partners, known as Catholic Health Initiatives (CHI), pioneered the development of multisponsor organizations to manage Catholic health facilities. CHC resulted from a planning coalition initiated by the Sisters of Mercy, Regional Community of Omaha, who founded the organization with two other religious institutes.[7]

The expanding CHI could become a national organization by continuing to add sponsors who own facilities in other markets. CHI could strengthen its position in existing markets by adding other Catholic providers who also own facilities in the same markets. Alternatively, CHI could start "swapping" hospitals with other systems to gain market share on a regional basis.[8] The concept of a multisponsor operating company for Catholic facilities has grown in acceptance since the 1995 National Convocation.

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In New Jersey the Sisters of Charity of St. Elizabeth and the Sisters of the Sorrowful Mother have formed Via Caritas System, a parent corporation to sponsor all three of their New Jersey hospitals and affiliated corporations. Both sponsoring congregations will have equal status on the board, with a goal of establishing a Catholic network across New Jersey.[9] In the Midwest, three Catholic sponsors are moving to establish a similar joint operating company in northern Illinois. Under the proposed merger, Franciscan Sisters Health Care Corporation, Mercy Center for Health Care Services, and ServantCor would merge into a single system.[10]

CHC, before it became a founding member of CHI, obtained public juridic person status to provide a growth strategy and to perpetuate the ministry beyond the sponsors' lives.[11] The juridic person is defined as a mechanism that allows an organization to be formally "in the church." Because this was a new use of the public juridic person concept, it took the CHC until 1991 to gain formal recognition from the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life. Four Catholic healthcare organizations have now received public juridic person status.[12]

Option 3: Catholic Network

A multistate Catholic network is forming on the West Coast, stretching from Seattle to San Diego. Major sponsors include Sisters of Providence in Washington and Oregon, along with multisponsor Catholic Healthcare West and Daughters of Charity National Health System in California. The Scripps Health System in San Diego has joined the strategic alliance. Catholic Healthcare West's system alone now includes 35 hospitals in three states, more than 7,000 affiliated physicians, assets of $4.4 billion, and revenue of $2.7 billion.[13] Many opportunities are available across the United States for Catholic systems and one-hospital sponsors to affiliate their facilities in regional networks.

Many other Catholic facilities are creating local market alliances. In a regional model, seven Catholic hospitals in St. Louis joined to form a Catholic IDN to compete with the giant BJC Health System. SSM Health Care completed an arrangement with the Daughters of Charity

National Health System to link the DePaul Health Center with six SSM facilities. The sponsors believe that the IDN enhances the quality of services by developing a shared bottom line and the capacity for regional managed care contracting.

Catholic facilities are creating new models for regional integration. In Cincinnati, four local Mercy hospitals are forming an IDN under consolidated management.[14] A new "circular" organizational structure has been established that optimizes the contribution of each facility. Cross-functional teams of vice presidents and managers are identifying the best delivery and care process from each facility and redesigning them to align their services across the region. All entities have adopted the Mercy Health System logo. A regional board coordinates strategy, while local facilities concentrate on community health needs. Integration has reduced costs by 6 percent to 20 percent, allowing increased funding for employee compensation and community health initiatives.

Issues of governance and management must be addressed in Catholic IDNs. The arrangement may be "loose," meaning simply a joint venture with minimal staffing and commitment, or "tight," defined as tantamount to merger, as the sponsors agree to coalign their facilities under a consolidated management structure. In St. Louis, for example, three of the Unity Health System's seven facilities joined under single management, announcing their merger in May 1995.[15] The new governance entity is a jointly sponsored religious holding company that is part of Sisters of Mercy Health System–St. Louis. This is an interdenominational organization. Six hospitals are Catholic, but St. Luke's retains its Episcopalian-Presbyterian heritage.

Option 4: Community Not-for-Profit Network

The most flexible healthcare organization in the future may be a community-based not-for-profit network that includes both Catholic and non-Catholic hospitals. These networks are bound by contracts and joint ventures, not asset merger and debt consolidation. Although community-based networks are easy to start, their operation can be highly complex. All parties must agree to align their strategies voluntarily for community networks to succeed. Catholic-sponsored HM Health Services, which is part of the Humility of Mary Health Care System, has recently affiliated two of its facilities with the Cleveland Clinic in a 14-hospital regional network for the greater Cleveland area.[16] A similar affiliation has recently been negotiated with the Holy Redeemer System in Philadelphia and the University of Pennsylvania Health System, which will add the reputation and tertiary services of the university medical center to this regional health system.[17]

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Many Catholic systems that own only a few hospitals (the average is 6 to 10) will consider community not-for-profit network options. A statewide network is being formed in Louisiana through a cooperative effort of the Sisters of Charity of the Incarnate Word and the Franciscan Missionaries.[18] The sponsors will link their six facilities and share ownership of Healthcare Advantage, a managed care company with both a health maintenance organization (HMO) and a preferred provider organization (PPO) that is a three-way joint venture with the not-for-profit Touro Infirmary.

Adding a university medical center to a Catholic-sponsored community health network can create a "hub and spoke" model. In Richmond, VA, the four-hospital Bon Secours Health System has strategically affiliated with the Medical College of Virginia to create a powerful competitor to Columbia/HCA, the second major system in the Richmond area. Bon Secours also operates another four facilities in the Norfolk/Newport News region. Chris Carney, regional vice president of Bon Secours, said, "My motto for the late '90s is 'Anything's possible,' especially with relationships."[19] Bon Secours and Medical College of Virginia are "preferred partners" who are committed to competing with other systems in providing quality healthcare.

Can Catholic healthcare facilities and systems maintain their autonomy when faced with growing pressure to merge and affiliate?[20] The community-based network may be the answer that not only gives Catholic hospitals a place at the managed care table, but also protects the ownership autonomy of Catholic sponsors. Wilfred Loebig, Jr., president and CEO of Franciscan Services in Wheaton, IL, believes that partnerships with other community providers can be so arranged that they do not compromise the identity and integrity of Catholic facilities that will not provide services such as abortions.[21]

Many statewide not-for-profit networks may depend on Catholic participation. In West Virginia, five not-for-profit hospitals have formed a task force on the creation of a statewide managed care network.[22] One of the participants is St. Mary's Hospital, the largest in Huntington. Besides adapting themselves to managed care, the network stakeholders will evaluate various organizational structures for improving patient care and cost efficiency. The statewide organization positions the facilities to compete with Columbia/

HCA, which owns five hospitals in the state.

Networks may also be the answer as transition strategies for rural Catholic hospitals. A rural network, the Mid Plains Health Alliance, is taking shape in central and western Nebraska. Saint Francis Medical Center of Grand Island joined with six other facilities in what may become a 15-hospital network. The hospitals have joined together to share management expertise, physician recruitment, and medical education. In rural Oregon, 17 hospitals and physician organizations have created a managed care network through a joint venture with PAAC Health Plans, a regional managed care organization. The network is affiliated in a "hub and spoke" model with the University of Oregon.

Option 5: Joint Venture

Joint ventures may provide Catholic hospitals with some benefits of mergers without the loss of control. Joint ventures among Catholic hospitals and investor-owned companies may offer financial security, capital, and management. To acquire a not-for-profit hospital, the for-profit buyer typically creates a tax-exempt foundation with a similar mission and an endowment equal to the value of the not-for-profit entity. The acquiring company then buys the hospital's hard assets and manages the facilities. Seventy such transactions have taken place in the past five years, and included some that involved Catholic hospitals.[23] Two states, Nebraska and California, have passed legislation requiring state review.

Many potential joint venture partners will be available. In Arkansas, for-profit Tenet Healthcare Corporation has joined with the St. Vincent Infirmary to buy the 104-bed Methodist Hospital of Jonesboro.[24] Tenet and St. Vincent have formed a joint venture called HealthStar of Arkansas. In California, Catholic Healthcare West (CHW) has entered into an exclusive arrangement to share medical facilities with Kaiser Permanente, one of the nation's largest HMOs.[25] CHW's St. Vincent's Medical Center will provide hospital facilities and medical services for some of Kaiser's 2.4 million enrollees in southern California, replacing Kaiser's Los Angeles Medical Center, where Kaiser will cease inpatient care. CHW will also operate Kaiser's newest hospital in Baldwin Park, slated to open in early 1998. In both facilities, CHW-managed hospitals will treat Kaiser enrollees as well as other patients from the community.

Some joint ventures will build managed care companies. In Texas, St Mary of the Plains Hospital in Lubbock and St. Anthony's Hospital in Amarillo are teaming with the University Medical Center of Lubbock and Blue Cross/Blue Shield of Texas to launch HMO Blue-West Texas.

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In the next five years, Catholic healthcare sponsors cannot afford to be timid in developing joint ventures with other Catholic and non-Catholic partners. They must commit substantial capital to jointly sponsored projects such as acquiring HMO licenses, taking Medicare risk contracts, and developing regional physician organizations. In the competitive marketplace of the future, joint ventures must be developed on a scale that will provide the participants with the benefits of integration. Only large-scale ventures that develop substantial healthcare businesses will be equipped to respond to marketplace pressures favoring larger organizations.[26]

Managed care partnerships are creating Catholic-sponsored HMOs. More than 50 in 29 states have been launched with Catholic sponsorship and capital.[27] In St. Louis, for example, Mercy Health Plans is building equity in a joint venture HMO with two local Catholic networks, Unity Health Network of Southern Illinois and the St. Louis Health Care Network.[28] In Houston a Catholic hospital and community not-for-profit system are cooperating in providing a provider-sponsored organization (PSO) demonstration site for the federal Health Care Financing Administration.[29] These managed care initiatives are providing Catholic networks with expertise in managing enrolled populations, coordinating care across a regional provider network, and assuming capitation risk.

In some states, antitrust laws may limit the options for alliances, because mergers would result in overconsolidation of a market. In Asheville, NC, a two-hospital town, St. Joseph's Hospital and Memorial Mission Medical Center agreed in March 1994 to create a community not-for-profit organization that will guide the future of both hospitals.[30] The hospitals are taking advantage of a 1993 North Carolina law that exempts hospitals from state antitrust laws for certain cooperative ventures. A 17-member board of directors runs the corporation, with six seats held by Memorial Mission, five by St. Joseph's, and six from the community. The new organization will coordinate joint planning for strategy, operations, and service development.

Option 6: Acquisitions and Expansion

In a shrinking market, expansion may provide a stronger market position and greater stability. Some Catholic health systems are acquiring more facilities, broadening their acute care hospital

capacity, and extending their geographic distribution across regional and state markets. However, buying hospitals runs contrary to the rapidly shrinking demand for beds, as managed care reduces admissions and patient days. Many market observers are predicting sizable market contraction in the need for acute care services in the next 5 to 10 years.[31] Managed care consultants report that hospital use falls from 486 days per 1,000 enrollees in traditional insurance plans to about 150 days in capitated HMOs.[32]

Anticipating a declining demand for acute care hospitals, some Catholic health systems are expanding aggressively to broaden their financial base and increase market share. Acquisition of other community hospitals is increasingly common, with Catholic-purchased hospitals including both not-for-profit and for-profit facilities. In 1995 Bon Secours Health System of Maryland ran a quarter-page advertisement in *Modern Healthcare* seeking "acquisitions of hospitals, home health care companies and related facilities."[33] As a result of aggressive acquisition efforts, Bon Secours has expanded to 16 hospitals in six states, with net revenues of $1 billion.[34] In Richmond, VA, the system recently purchased two hospitals and created a 50-50 joint venture with a third facility, Mary Immaculate Hospital in Newport News, doubling the size of the Bon Secours system in the region.

Option 7: Catholic/Non-Catholic Mergers

Mergers between Catholic and non-Catholic hospitals are becoming more common. The goals of such mergers are to strengthen strategic position, increase market share, and create more sustainable institutions, as facilities align administrative and clinical services. Mergers may also be short-term tactics that result in consolidating and closing facilities. However, a merger need not mean the end of an institution's Catholic identity.

Announcements of such mergers have come with increasing frequency in the recent past, including the following:

- Intracoastal Health Systems of West Palm Beach, FL, was formed through the merger of St. Mary's Hospital and Good Samaritan Medical Center. The hospitals are located within three miles of each other and have consolidated clinical services and administrative positions.
- Sisters of Providence announced the consolidation of its facility, Columbus Hospital, with its community hospital competitor in Great Falls, MT. Sisters of Providence has pursued consolidation strategies in several two-hospital markets in which it operates.
- St. Joseph Memorial Hospital of Murphysboro, IL, which was sponsored by the ASC Health System, has been acquired by Southern Illinois Hospital Services. This allows the 61-bed Catholic facility to maintain its religious status and mission, while joining a solid system of other community hospitals in southern Illinois that is expanding to serve a regional market.

More Catholic/non-Catholic mergers are likely in the next five years, as financial pressures and market consolidation make the merger option more attractive for financially vulnerable facilities. Federal antitrust guidelines on hospital mergers were eased in the fall of 1994, allowing financially weak facilities with fewer than 100 beds to merge with stronger facilities without challenge by the Justice Department or Federal Trade Commission (FTC). However, the Justice Department challenged the proposed partnership between Mercy Medical Center and Finley Hospital in Dubuque, IA, a two-hospital city.[35] Conflicting signals from the Justice Department and FTC are slowing, but not halting, merger talks and affiliation agreements among Catholic facilities with other community partners.

A number of experiments in cooperation and affiliation between Catholic and non-Catholic facilities will emerge in the next five years.

Option 8: Cooperation and "Co-opetition"

One option for organizational cooperation goes beyond affiliation but stops short of merger. Under the watchful supervision of federal antitrust authorities, some community hospitals are exploring the boundaries of institutional cooperation, usually in settings where antitrust would be an issue.

Many hospitals in small markets are watching an emerging model that creates new legal territory for consolidation. In Florida the Morton Plant Health System in Clearwater and nearby Mease Health Care in Dunedin have been allowed to collaborate on specific clinical and administrative services through a joint venture. The hospitals scrapped merger plans after being sued by the Justice Department.[36] Under a settlement agreement, however, the systems and their three hospitals have been allowed collectively to set prices and negotiate joint payer contracts if a payer asks them to do so.

A number of experiments in cooperation and affiliation between Catholic and non-Catholic facilities will emerge in the next five years. Thomas Barone, president of the Good Samaritan Medical Center in Zanesville, OH, calls this process "co-opetition."[37] Good Samaritan has launched a broad-ranging experiment to operate jointly several clinical and support services with long-time community rival Bethesda Hospital. In another

closely watched association, St. Vincent's Health System and Baptist Health System of Jacksonville, FL, have received approval for consolidation from the state's attorney general. St. Vincent's is a member of the Daughters of Charity National Health System, whose former CEO, Sr. Irene Krause, DC, is the chairperson of the new corporation.

Option 9: Divestiture

The ultimate "exit strategy" for Catholic health organizations may be to sell their facilities. Eight to 15 Catholic hospitals have been closed, sold, or merged each year since 1989. Divesting hospitals may be painful but necessary. The sponsors can sell off excess capacity or facilities that are no longer viable. Some Catholic sponsoring organizations with only a few facilities may sell their acute care hospitals to concentrate on long-term care, or they can use the money for other purposes such as education.

Buyers are plentiful. Early on, expansion planners for Columbia/HCA and other major for-profit chains aggressively targeted Catholic hospitals for acquisition. At the height of Columbia's targeting efforts, William Cox, CHA executive vice president and head of its Washington office, described Catholic healthcare as "under assault" from the investor-owned giant.[38] Columbia/HCA has until its recent difficulties continued to pursue aggressively the investor-owned conversion of Catholic facilities. However, new regulations and community resistance are slowing the pace of acquisitions. In 1996 Columbia/HCA made eight acquisitions of not-for-profit hospitals and entered into joint ventures with eight others.[39]

Tenet Healthcare Corporation bought St. Francis Hospital in Memphis for $92 million in 1995. Tenet also acquired Mercy-Baptist, a two-hospital system in New Orleans that includes Mercy Hospital, a Catholic facility that had merged with Southern Baptist Hospital. Proceeds of the transaction flow back to the sponsors of the two facilities, paying off about $90 million in debt.[40]

Catholic officials worry that their weaker hospitals will be picked off by for-profit companies. Columbia/HCA announced in January 1995 that it had signed letters of intent to purchase three Chicago-area hospitals, also indicating it was looking at as many as 11 more facilities in the area.[41] The late Card. Joseph Bernardin rallied Chicago's Catholic facilities with a 20-page speech on the dangers of investor-owned domination of healthcare. Rev. Michael Place, STD, research theologian for the Curia, Archdiocese of Chicago, stated, "We want to preserve our presence to the poor."[42]

The community health network model is driven by mission and values, not market economics or managed care.

A buyout can recapitalize a once-Catholic hospital or system, providing new facilities or services. In Worcester, MA, Tenet's purchase of St. Vincent Hospital will infuse $215 million in capital for a complete replacement project that will be the centerpiece of a downtown redevelopment plan.[43]

Divestiture of Catholic facilities to investor-owned healthcare organizations may be subject to increasing regulatory review. In California, not-for-profit hospital conversions are now subject to review by the attorney general under new legislation that went into effect in this year.[44] State legislatures in Arizona and Georgia are considering legislation that would require that all sales of not-for-profit hospitals be subject to state review, including public disclosure of the terms of the transaction.[45]

Conversion of Catholic hospitals to for-profit status is controversial. The CHA board recently reiterated the organization's traditional policy that only not-for-profit organizations be allowed to join the organization.[46] The move reversed a short-lived policy shift made in 1993 that unintentionally would have allowed investor-owned facilities, such as the formerly Catholic AMI's St. Joseph in Omaha, to be CHA members. No investor-owned facilities currently are allowed to join CHA, even in the rare instance when they are recognized as Catholic by the local bishop.

Not all sales of Catholic facilities are to for-profit chains. Sometimes the buyer is another not-for-profit organization. Mercy Health Services, a two-hospital system based in Charlotte, NC, sold its facilities to the Charlotte-Mecklenburg Hospital Authority for $115 million in January 1995.[47] The sale ended a five-month effort to create a partnership between the two systems. The deal foundered on the complexity of managed care contracting and competition within the framework of a partnership. Mercy's divestiture strategy consolidates three or four hospitals under the Hospital Authority, which is protected from antitrust laws because it is a public entity.

Option 10: Community Health Network

The community health network model is driven by mission and values, not market economics or managed care. By definition, community health networks are organized to address unmet health needs. Catholic-sponsored hospitals, health systems, and long-term care providers currently are engaged in diverse community health partnerships with Catholic Charities, other healthcare providers, and local voluntary agencies. These partnerships have tremendous potential. Through the programs of Catholic Charities and related

social services, the Catholic Church is the largest provider of human services in the United States.[48]

Hospitals and health systems are working harder to demonstrate their commitment to community health. A recent American Hospital Association report revealed that 93 percent of all hospitals included community health within their mission and that 75 percent were working with other providers, public agencies, and local governments to conduct local health status assessments.[49] The following examples of Catholic-sponsored community health networks illustrate the range of purposes, structures, and activities within this diverse category:

- In Baltimore, St. Agnes Healthcare and Catholic Charities of the Catholic Archdiocese of Baltimore have established a continuum of care for older adults. The two organizations are cooperating on seven related projects, including a 24-bed subacute unit at the St. Agnes Hospital. Catholic Charities, which manages this unit, also owns and operates nearby St. Elizabeth Home for Nursing Care.
- In Denver, Centura Health, an IDN sponsored by CHI, has partnered with Catholic Charities of the Archdiocese of Denver to establish a Catholic Medicare-certified home hospice program for its continuum of care. Through referrals from the Centura hospitals, the hospice has quadrupled its census.

For many Catholic hospitals and systems, community health networks simply may be voluntary multistakeholder consortium models that overlay other governance structures. However, the community health network could become a new structural alternative for free-standing Catholic facilities or small systems when the facilities are given by their sponsors to the diocese and merged with the diocesan Catholic Charities organization.

Catholic Healthcare Needs Partners

Even with 550 hospitals, the U.S. Catholic healthcare system is too small and spread too thinly to succeed without partners. Under the demands of competition and capitation, only tightly organized regional and statewide networks have the bargaining strength to deal with HMOs and employer purchasing coalitions. Not enough Catholic facilities exist in most areas for the creation of all-Catholic regional or statewide delivery systems. Catholic sponsors must find mission-compatible business allies, including managed care plans. Catholic health facilities will announce many transactions and linkages, because the alternative of "going-it-alone" isolation is not sustainable. Catholic healthcare providers must pursue strategies of integration, or they may fail to carry out their mission in the twenty-first century. □

Even with 550 hospitals, the U.S. Catholic healthcare system is too small and spread too thinly to succeed without partners.

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(Required by 39 U.S.C. 3685)

1. Title of publication: *Health Progress*
2. Publication number: *0882-1577*
3. Date of filing: *Sept. 30, 1997*
4. Issue Frequency: *Bi-monthly*
5. No. of issues published annually: *6*
6. Annual subscription price: *$40 domestic, $45 foreign*
7. Location of known office of publication: *4455 Woodson Rd., St. Louis, MO 63134-3797*
8. Location of headquarters of general business offices of the publisher: *4455 Woodson Rd., St. Louis, MO 63134-3797*
9. Names and complete addresses of publisher, editor, and managing editor: *John E. Curley, Jr., publisher; Judy B. Cassidy, editor; 4455 Woodson Rd., St. Louis, MO 63134-3797*
10. Owner: *The Catholic Health Association of the United States, 4455 Woodson Rd., St. Louis, MO 63134-3797*
11. Known Bondholders, Mortgagees, and Other Security Holders: *None*
12. *The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes has not changed during the preceding 12 months*

13. Publication name: *Health Progress*
14. Issue date for circulation data below: *September-October 1997*

	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
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