



DELIVERY REFORM TOPS EXECUTIVES' CONCERNS

As Americans wait for Congress to ratify healthcare reform legislation, Catholic providers struggle with how to position themselves for change. "We're just trying to figure out how we can best serve, based on who we are, where we're coming from, and how we view need," said Mark Dundon.

Dundon recently joined seven other leaders in Catholic healthcare (see **Box**)—from multi-institutional systems, acute care, and long-term care—in a roundtable discussion on how to remain viable providers—faithful to their missions—as the U.S. healthcare delivery system experiences transformation. Participants exchanged a variety of views and agreed that the changes occurring as a result of pending reform legislation affect all sectors of the healthcare system.

"The whole system is in transition," said John C. J. Cronin. "We're the people of the parentheses—between one system and the other. Reform will inflict pain on healthcare providers and create a huge shift in the way healthcare is delivered."

The "huge shift" on which roundtable participants focused is the move toward consolidation among healthcare providers. "It's not a matter of deciding whether we should collaborate and partner with others—I think that's an imperative," asserted Cronin.

*Healthcare
Leaders
Focus on the
Move
Toward
Consolidation*



"That's the beauty of change. It allows us to get real creative, throw off the blinders and barriers, and go for it."

—Mark Dundon

"The only question is, Who's going to be in what integrated network and which network is going to dominate?" Many roundtable participants affirmed that their organizations are discussing collaborative ventures with other providers or have already formed alliances and networks (see **Box**, pp. 46-47).

CONCERNS ABOUT HEALTHCARE REFORM

Catholic healthcare providers have been at the forefront of the reform debate since 1986, when the Catholic Health Association called for universal coverage in a redesigned healthcare system (*No Room in the Marketplace: The Health Care of the Poor*, p. xii). However, concerns about reform's meaning for Catholic providers still remain.

Cronin fears that, in the rush to implement reform, the changes policymakers introduce could be inadequate and inappropriate. He believes the United States must implement values in the reform package "that are going to ensure that reform has a long-term payoff, benefit, and impact."

Consumers need to be better educated about what healthcare services they need, noted Roberta Leibowitz. She believes persons may enroll in a network or plan that does not meet their needs simply because their physician is in that network. Not only is she concerned about residents; she worries that, in the rush to align with other providers, facilities may integrate with unsuitable partners.

Although healthcare networks are forming every day, in many cases the integration process has hit some snags. Gail Parrish described the barriers Flint, MI-based Genesys Health System faced in trying to achieve a patient-focused continuum of care. She noted that the "microregulatory apparatus"—all the certificates of need



Genesys had to apply for—imposed a barrier. “If care is going to be cost-effective,” she added, “we need to eliminate contradictory public policy and governmental and reimbursement barriers to integrated health system development.”

Mark Pastura agreed, adding that a lot of “time and costs are involved in trying to determine whether or not you can even have a legal match between two organizations” because of ambiguous antitrust laws.

Legalities are not the only roadblock. Area residents may also be averse to an integrated delivery network because they find it difficult to change how they view healthcare delivery. Parrish pointed out that in the development of Genesys, some Flint-area residents were concerned about inner-city access to services because the new hospital, one of three remaining in metropolitan Flint, would be suburban. She said Genesys had to explain to residents that “most healthcare won’t necessarily be provided in the inpatient hospital anymore.” What matters, Parrish stressed, is the presence of emergency, primary, and preventive care in their neighborhoods—something that Genesys will not be taking away.

In addition to these stumbling blocks, Catholic facilities must at times overcome the perception that they do not want to talk with non-Catholics about forming networks, noted Cronin. “There’s a lot of naïveté out there about what Catholic healthcare providers can do and are capable of providing,” he said. “Sometimes you might be surprised at the positive response you get by requesting to be included in a discussion on forming an integrated delivery network.”

Other Catholic providers have had positive experiences because of their Catholicity: “I can’t tell you the influence that being value- and mission-centered has made in the initial dialogue with other facilities,” said Sr. Romaine Niemeyer, SCC. “I feel encouraged when we’re talking about reform because Catholic providers have something that no one else has to share. It’s a wonderful opportunity for us to seize the moment and to move forward.” Cronin added, “Religious-sponsored institutions are optimally positioned for reform because they come closer to the core values that Americans hold.”

A RENEWAL OF MISSION

Reform introduces unprecedented challenges; however, Catholic healthcare providers view many such demands as opportunities. And although Catholic healthcare providers may need to return to their roots—to refocus on their mis-

sion and values—roundtable participants emphasized that the Catholic healthcare ministry may be more relevant now than ever.

“As sponsors, as board trustees, as providers, we need to refocus on our mission and think about healthcare reform within the context of how we want to influence, what services we want to emphasize, and what kind of change we want to direct around the values that we hold,” stated

ROUNDTABLE PARTICIPANTS



Photos by Tom Ebenhoeh

John C. J. Cronin, President/Chief Executive Officer, Fanny Allen Hospital, Colchester, VT

Les Donahue, President/Chief Executive Officer, Saint Francis Hospital, Charleston, WV

Mark Dundon, Chief Executive Officer, Sisters of Charity of Nazareth Health System, Nazareth, KY

Roberta Leibowitz, Assistant Administrator, Ozanam Hall of Queens Nursing Home, Bayside, NY

Sr. Romaine Niemeyer, SCC, President, Holy Spirit Hospital, Camp Hill, PA

Gail Parrish, Vice President, Advocacy and Government Relations, Sisters of St. Joseph Health System, Lansing, MI

Mark Pastura, Vice President of Aging Services, Mercy Health System, Cincinnati

Barbara Wagner, Administrator, MariaCare, Red Bud, IL

FACILITATORS

Philip J. Karst, PhD, Associate Vice President, Division of Member Services, Catholic Health Association, St. Louis

Beth Llewellyn, Senior Associate, Division of Member Services, Catholic Health Association, St. Louis



Cronin. Les Donahue added, "Now is the time for us to go back to the humanitarian purposes that this industry was established upon and form more of a community-wide approach."

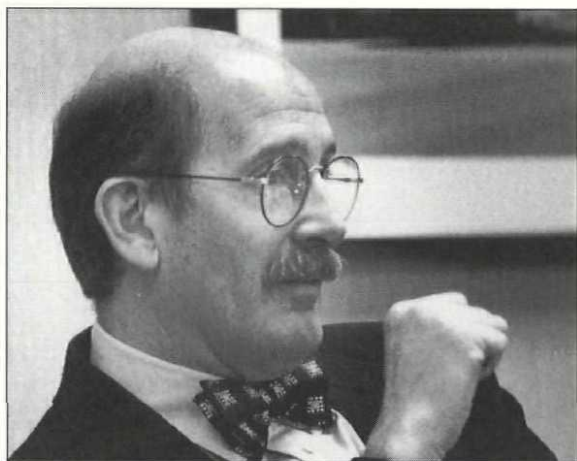
Roundtable participants emphasized that some patients want to be cared for at a Catholic facility. At Ozanam Hall of Queens Nursing Home, "we find that most of our residents come to us to be in a Catholic environment and to feel part of the Catholic and Carmelite mission," said Leibowitz.

Some health-care organizations have seen the value of returning to their roots and their mission. Donahue described how two years ago Saint Francis Hospital was organizationally and financially distressed, having lost more than \$3 million. "We went back to the mission, back to the values," he reported. The next year the hospital was \$1.5 million in the black. "I've seen that refocusing on values really changes an organizational culture," Donahue said.

Saint Francis Hospital's environment shifted from a hierarchical culture to one of a value-driven, continuous quality improvement (CQI) process. The empowerment embodied in CQI is consistent with Saint Francis Hospital's values and mission, and the CQI process served to regenerate its staff and open up communication. In addition, employee-directed task forces guided the revision of human resource policies. Saint Francis staff came to understand, as an organization, that they were interdependent rather than independent.

LONG-TERM/ACUTE CARE CONTINUUM

In the race to secure a viable position in the reformed healthcare system, providers are scrambling to decide whether they should venture into new areas of care or continue to provide the same type of care they have always provided. Home



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—John C. J. Cronin

healthcare and subacute services will be important in a reformed system, but such services will not replace the need for acute or long-term care. Participants pointed out that acute care providers could gain insight from long-term care providers, and vice versa.

"Long-term care providers bring a special body of knowledge that most of the power players at the reform table don't have," asserted Dundon. If long-term care representatives can continue to demonstrate measurable value to the rest of the healthcare delivery system, Dundon believes they can have a tremendous influence on healthcare reform.

Leibowitz and Pastura noted that the long-term care sector has experience with reform, which began when the Omnibus Budget Reconciliation Act placed stricter quality-of-care and quality-of-institutional-life requirements on nursing facilities wishing to receive Medicare and Medicaid reimbursements. "What's happened since 1987 has been positive for the nursing home industry," asserted Leibowitz. "The general public may be unaware of the changes that have occurred as far as improved resident care, addressing quality-of-life issues, and the positive approach that long-term healthcare is all about. It might be a good idea for hospitals to take a look at what's happened in the nursing home industry."

"Long-term care and transitional care are going to be a lot more integrated than they are today because they are going to be essential," predicted Dundon. "I believe surgery centers will either be built next to or within long-term care facilities. But it's so difficult to initiate integration of this type with no model already in place."

Pastura believes long-term care providers should also make use of acute care providers' ser-

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vices. For example, if an acute care provider has an education department, a nursing home may be able to access it to educate its nursing assistants. In addition, Pastura believes long-term care providers need to learn the sophisticated planning techniques acute care providers use.

Leibowitz agreed, noting that long-term care providers are often reactive rather than proactive—in part because filled beds and an adequate reimbursement rate left them with no motive to plan for difficult times. "But I worry long-term care providers may lose the opportunity to choose who they would like to partner with," she added.

Pastura expressed an even more pressing concern: that Clinton's reform proposal ignores nursing home care. "I'm afraid that long-term care providers may not be represented when the important decisions are made." He added, "Long-term care providers need to prepare and begin efforts toward integration."

Barbara Wagner agreed: "Nationally, not much is happening. I don't see literature about long-term care providers becoming involved in collaborative ventures." She pointed out that most of the long-term care facilities in southern Illinois are independently owned and for-profit. "I don't see that they have much incentive to network. Change may occur as a result of healthcare reform because care delivery will become more community ori-



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ented, negatively affecting the number of residents in a long-term care facility. That will be for-profit facilities' motivation for networking," asserted Wagner.

Multi-institutional Systems In the face of such changes, being part of a multi-institutional system can be advantageous for long-term care providers. Pastura believes long-term care facilities benefit from being affiliated with acute care organizations because such organizations have experience in dealing with the elderly in various settings such as home health and community outreach services. He added that long-term care providers can benefit by collaborating with their acute care counterparts in areas such as group purchasing discounts, human resource assistance, and joint pharmacy ventures.



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Wagner reported that MariaCare and fellow-ASC member St. Clement Hospital are involved in a collaborative purchasing program. Since November 1993 St. Clement has been responsible for purchasing and stocking MariaCare's supplies. MariaCare simply requisitions supplies from St. Clement when needed, and the hospital bills the long-term care facility for it.

Covenant Health Systems, Inc., Lexington, MA, of which Fanny Allen Hospital is a member, is



questioning whether it should play a leadership role in long-term care and elder services. Cronin believes geographically dispersed systems like Covenant are "beginning to think about this role and the issue of maintaining Catholic identity. Long-term care just seems like the natural direction because it's the one area you can target where the needs exist."

Home Health As acute care providers add long-term care to their repertoire, long-term care facilities need to offer home health services, incorporating day care and acute convalescence, asserted

Leibowitz. "Unless the long-term care facilities start looking at options such as offering subacute services, they're going to experience difficulties five years from now." But she emphasized that there will always be a need for traditional long-term care. Leibowitz pointed out that even with 24-hour home care, supervision may be required because residents experience little social interaction, and their families worry from shift to shift whether aides will come to the home. If a loved one is in a long-term care facility, many of these concerns are resolved.

REGIONAL INTEGRATION TRENDS

Several roundtable participants' health-care organizations are involved in integrated partnerships. Some participants expressed apprehension about these new arrangements; however, all were eager to share their experiences, as well as to learn about those of their colleagues.

KENTUCKY

Even though they are competitors in three of the larger Kentucky market areas, the Sisters of Charity of Nazareth Health System, Nazareth, and the Baptist Health System of Kentucky, Louisville, are working together to bring high-quality care to their communities, according to Mark Dundon.

In Lexington the two systems will sponsor a family practice model in a poor area of the city that has no health-care services. "The Sisters of Charity of Nazareth is also identifying other organizations with similar values who are good providers of healthcare," Dundon said.

ILLINOIS

In Red Bud, IL, MariaCare (a long-term care facility) and St. Clement Hospital (both part of ASC Health System) are helping launch a local parish nurse program. MariaCare Administrator Barbara Wagner has some misgivings about the limited scope of the venture. "I wish we had directed it toward a parish health program. I think parish nurse is too limited. Why not get emergency medical tech-

nicians, physicians, physical therapists, dietitians, and others involved?"

The parish nurse program is nevertheless taking root. Once a month, nurses offer parishioners blood pressure screenings after church services. Needs are being assessed through a mail questionnaire that asks parishioners their age, sex, health problems and concerns, and wellness needs. The results of the assessment will guide the program's future directions.

Wagner also described the Belleville Diocesan Conference for Hospitals and Homes for the Aged. The group, which includes representatives from Catholic healthcare facilities, Catholic social service organizations, and each of the deaneries in the Belleville Diocese, provides an opportunity for participants to update one another on regional, state, and national healthcare issues and their impact on the Belleville Diocese. The group's goals include identifying and meeting community needs; avoiding duplication of services; and establishing collaborative ventures among parishes, social service agencies, and healthcare facilities.

VERMONT

Fanny Allen Hospital leaders decided that the hospital's "role in the community really should be focused on addressing the issues of unmet need," said John C. J. Cronin. "Out of that came a redefinition of the hospital's identity and the

decision that it should aggressively meet those needs," he added.

Fanny Allen Hospital has implemented a joint planning process for creating an integrated delivery system in which the hospital, the local medical school, and the faculty practice plan each jointly and equally participate. The network would be responsible for service delivery and would include everything from design of information systems to program and service design. Although the network is in the early planning phase, boards of trustees for the organizations involved are committed to it.

On the state level, Cronin added, "there are currently several reform plans on the table in Vermont. They all have one common feature: regional integrated systems that are community controlled. The systems will receive capitation for at least part of the business in their area."

MICHIGAN

Michigan "couldn't be more dissimilar [from Vermont]. It's still kind of cut-throat," responded Gail Parrish. "Everybody believes that in Michigan we're going to end up with four or five major systems, but if you did a secret ballot, everybody would draw a different picture of how healthcare will be reformed in the state. A strained state budget, the predominance of the big three automakers and the United Auto Workers, and numerous behind-the-scenes affiliation discussions (combined



ETHICAL ISSUES

Like other healthcare providers, roundtable participants struggle with ethical questions such as euthanasia, artificial nutrition and hydration, care for the dying, and employee issues.

Jack Kevorkian, MD, has been stirring up the physician-assisted suicide debate across the nation but especially in Michigan. Parrish provided insight into how Michigan citizens feel and how Catholic healthcare facilities are dealing with Kevorkian's activities. Even though Church teaching opposes suicide, she said, polls show

that a majority of the public believes there are instances in which persons should have the right to choose suicide.

To counter this trend, Sisters of St. Joseph Health System is telling the public, "To eliminate suffering, you should not have to eliminate the sufferer." The system's members have rededicated themselves to pain management and compassionate care of the dying, reported Parrish. The system is looking at how to educate physicians and other care givers in these aspects of care. Dundon said that the Sisters of Charity of

with an election year) are all factors that will drive a lot of how a reformed health-care system will look," Parrish added.

Despite the difficulties, members of the Sisters of St. Joseph Health System are becoming involved in collaborative activities. Borgess Health Alliance in Kalamazoo has affiliation agreements with several non-Catholic, small, single-community hospitals in southwest Michigan. St. John Health System, Detroit, recently entered a joint venture agreement with Mercy Health Services of Farmington Hills to jointly own and operate two merged hospitals in Port Huron. Genesys Health System, Flint, is seeking state approval for a joint mental health program with Hurley Medical Center, Flint, a public inner-city hospital.

PENNSYLVANIA

Near Harrisburg, the state's capital, Holy Spirit Hospital, Camp Hill, is involved in the Capital Region Health Futures Project—a volunteer, community-based, regional health planning initiative, explained Sr. Romaine Niemeyer, SCC. The United Way of the Capital Region sponsors the project, and a council of the region's business, medicine, labor, education, government, and human resource leaders directs it.

The project's goals are to define the capital region's health status issues, problems, and opportunities; to prioritize the issues; to develop a shared vision of the region's desired healthcare future; to

design a series of initiatives to implement the vision; and to evaluate the project's effectiveness and its initiatives. Participants are currently doing a cost assessment of services they provide.

Sr. Niemeyer reported that for eight years Holy Spirit Hospital tried to secure certificate-of-need approval for a low-risk diagnostic cardiac catheterization laboratory. Area hospitals blocked the effort until one hospital recently collaborated with Holy Spirit in a joint venture on the project.

In preparation for more such collaborative efforts, Holy Spirit is working with McManus Associates, Inc., to identify criteria for Holy Spirit to use when choosing partners. A collaborative assessment has been completed, and the hospital's board of directors and sponsoring congregation have approved the collaborative strategy. Holy Spirit leaders have met separately with leaders of three institutions to discuss collaborative ventures.

Facilities are not the only ones getting involved in collaborative ventures in Pennsylvania. To ensure the survival of the five major local hospitals, as well as to protect their own survival, area physicians of the Pennsylvania Medical Society met with representatives of local hospitals' chief executive officers, boards of directors, and physician contingents in fall 1993 to propose an initiative. After these initial discussions, they decided the initiative was fraught with

antitrust risks and was discontinued. The projection is that perhaps there will eventually be two major networks in the Harrisburg area.

WEST VIRGINIA

The state's hospital association has been active in reform, reported Les Donahue. However, the West Virginia legislature has pulled back on reform. Its failure to pass a sweeping healthcare reform measure, with the key provision of creating a five-member healthcare authority, has resulted in no action this year.

Now the West Virginia Hospital Association has withdrawn its support of the healthcare reform plan after the legislature changed it substantially by attempting to add a hospital rate-setting package.

At any rate, the West Virginia Hospital Association remains committed to its 10 principles of reform, which Donahue shared with roundtable participants:

- Universal access
- Shared financing
- Managed care
- Community regional provider networks
- Information systems
- Individual responsibility for health
- Simplified administrative procedures
- Insurance liability reform
- Antitrust reform
- Adequate mix and training of health-care professionals



Nazareth Health System is handling the euthanasia and physician-assisted suicide issue in the same way—through education.

At Ozanam Hall of Queens Nursing Home, end-of-life issues are a recurrent theme, remarked Leibowitz.

She noted, "The facility's mission and philosophy are available in writing. Residents and their families are made fully aware of the mission and philosophy before admission. Still,



end-of-life issues are brought up time and time again. To prepare Ozanam Hall staff to face ethical dilemmas, each month the ethics committee discusses various ethical and moral issues. Usually a case study is presented."

The ethical issues on the minds of providers are not confined to patient care. They also struggle with questions about treatment of employees and of social justice. "We don't often think of ethical issues associated with how we treat our employees or those who work with us—how we pay them, their benefits. There's a lot of issues around incentive compensation," said Dundon.

Parrish added, "There are other corporate ethical issues that we do not often think of. For example, What do we do when, despite our best quality-assurance efforts, a mistake is made that adversely affects a patient? Do we drag people through several years of a lawsuit, or do we try to compensate them fairly?" She described her system's leadership program, Leadership in a Christian Organization, which strives to define what it means to be a values-based organization. "It's how we act with each other every day, the kind of decisions we make, everything we do: whom we hire, how we fire, and how we handle mistakes."

EMPHASIS ON HEALTH AND WELL-BEING

Roundtable participants believe that to have a truly reformed healthcare system, each person must take responsibility for his or her own health by eating right, exercising, and not smoking. Healthcare reform is "not going to work in the long run unless there's a way to build into it responsibility, something that affects us as indi-

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viduals so that we have an incentive to stay healthy," said Dundon.

Leibowitz remarked, "The only way that wellness is going to really take hold in our society is by educating the young. Today's 30-year-olds, 40-year-olds, and 50-year-olds have some idea of prevention, but they haven't really bought into it. We have to start in preschool, teaching about wellness and preventive measures."

Some roundtable participants hypothesized that a formal shift to a wellness approach to healthcare delivery will not occur unless it is tied to capitation. "Only then will the financial incentives be in place for all the players to keep folks healthy and deinstitutionalized," Dundon said.

CHANGE SPURS CREATIVITY

No matter what direction reform takes, leaders in Catholic healthcare must ensure that their faithfulness to their healing missions will be upheld. Roundtable participants agreed that for this to be accomplished, the lines of communication among providers have to be kept open.

Integration is new and a bit frightening, but it is also exciting. Dundon stated, "That's the beauty of change. It allows us to get real creative, throw off the blinders and barriers, and go for it."

—Michelle Hey



"Care delivery will become more community oriented, negatively affecting the number of residents in a long-term care facility. That will be for-profit facilities' motivation for networking."

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