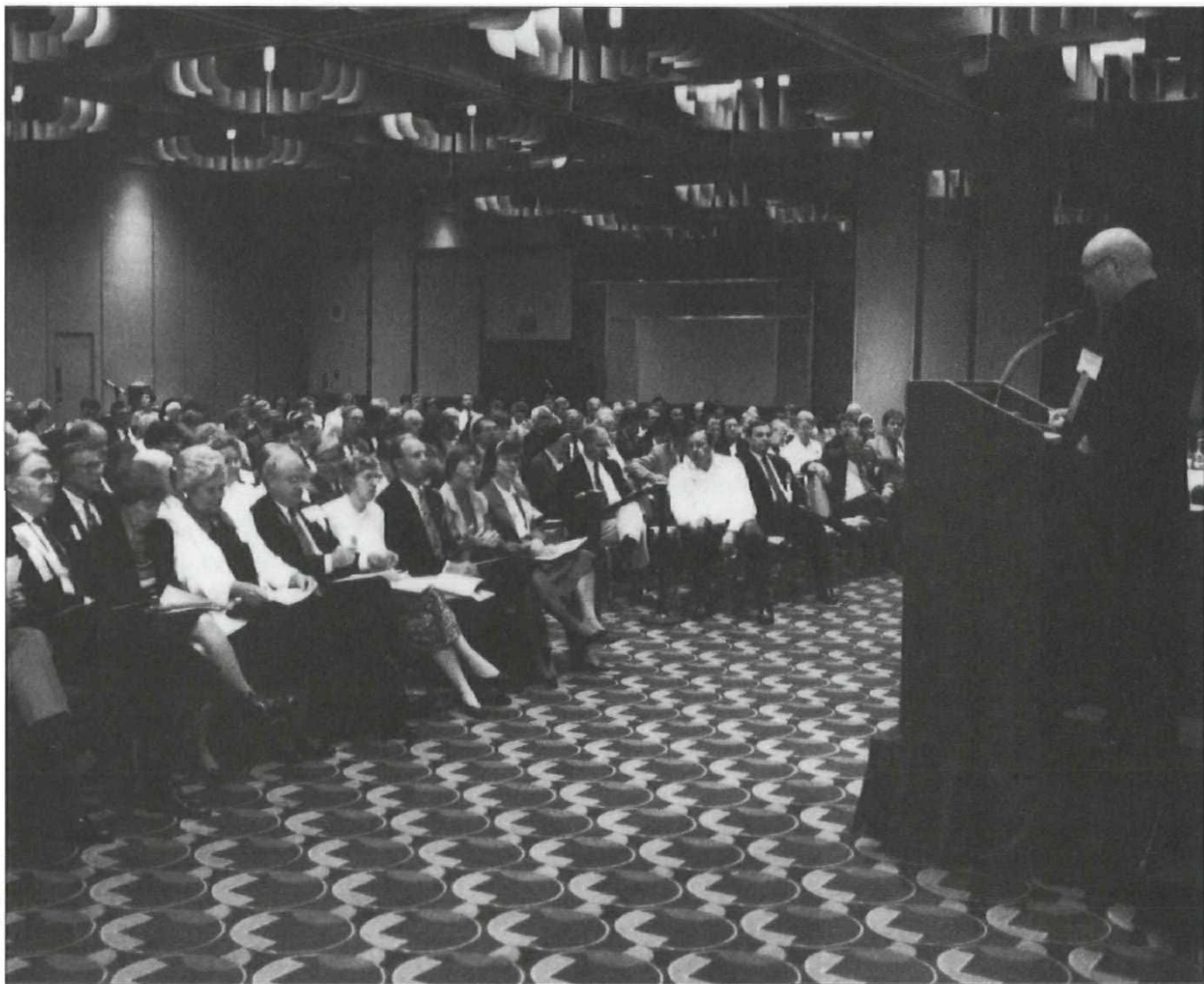


IN SIGHT: A VISION FOR A HEALTHY AMERICA



Photos by Jon Didier

Of all the problems facing today's healthcare providers, the need to reform the entire delivery system is the most complex—and

THE 77TH ANNUAL

carries the most far-reaching implications. This year's annual assembly featured an intensive day on the Catholic Health

CATHOLIC HEALTH ASSEMBLY

Association's (CHA's) working proposal for systemic healthcare reform, giving an in-depth look at its meaning for providers.

JUNE 14-17, 1992, ANAHEIM, CALIFORNIA

Other issues covered related to bioethics, managing change, and renewing mission. The following report highlights these themes.

HEALTHCARE REFORM

QUICK FIX WILL NOT HEAL THE NATION'S HEALTHCARE SYSTEM

ROBERT N. BELLAH, PhD

A quick fix will not cure our nation's economic, social, or healthcare ills. "Crisis intervention will have no lasting effect if people do not return to relationships, institutions, and communities that continue to nurture them and to call forth their own capacities for nurturing others," Robert N. Bellah, PhD, said during the keynote address.

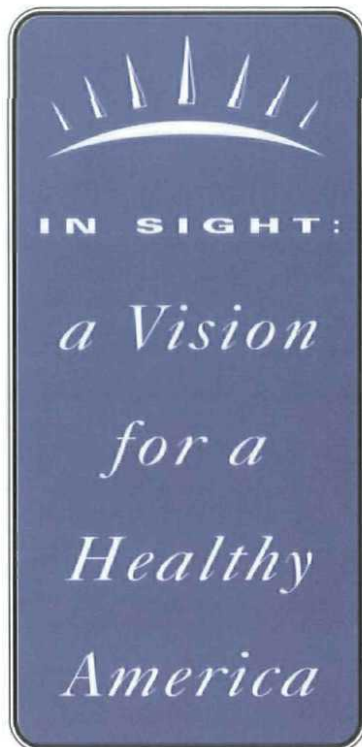
Bellah praised CHA for refusing to simply apply a bandage to the ailing U.S. healthcare system. He noted that CHA's healthcare reform proposal "would open up the actual provision of healthcare to the participation of its beneficiaries [and] would take seriously that health is a dimension of life for a whole community and not just a technical resource for atomized individuals, particularly those who can afford it."

Bellah, professor of sociology at the University of California, Berkeley, said that when healthcare becomes the end, not the means, "the intrinsic purposes no longer have priority and therefore can but suffer as a conse-

quence." He described the work of students at the University of California at Berkeley and at San Francisco who found that physician house calls have been virtually abandoned because of their inefficiencies. However, these so-called inefficient procedures may prevent costly hospitalizations because physicians can "observe aspects of the patient's situation that the patient would never have reported."

Bellah called attention to Americans' obsession with individualism. He noted that volunteers often say their activities make them feel good, implying their actions are "more for themselves than for the people they help." And this individualism is taking attention away from those who need it most. "Human beings exist in and through relationships and institutions, or they do not exist at all," asserted Bellah.

However, healthcare is only one aspect of our nation's illness, he observed. Economic, political, and social wounds must be healed first. He emphasized that CHA's reform pro-



posal "could not be expected to operate effectively in the absence of other elements of community strength." For the CHA proposal to be effective, Bellah said, it must go "hand in hand with economic, political, and social initiatives that would provide the context of coherent community that would make possible vital integrated delivery networks."

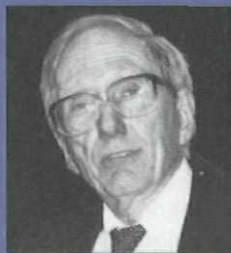
Bellah said that each community must begin to take responsibility for its residents by helping them obtain jobs or job training. "Where

communities are too shattered to take the initiative themselves, they must be assisted by funding and expert advice coming from higher levels of government and the economy," asserted Bellah, noting that this concept is borrowed from Catholic social teaching.

Bellah described American culture as an adolescent society. "What adolescents have not yet learned is that the future must be nurtured, attended to, that children must become parents, must find themselves in losing themselves in the care of children, other people, the planet itself," he said.

Bellah used psychologist Erik Erikson's term "generativity" to describe the care one generation gives the next. "But Erikson extends it far beyond the family," said Bellah, "so that it becomes the virtue by means of which we care for all persons and things we have been entrusted with." Bellah wondered what kind of society Americans would leave their children. "By focusing on immediate well-being," he said, "we have forgotten that the meaning of life derives not so much from what we have as from what

ROBERT N. BELLAH, PhD



When [Dan Quayle], a major representative of one of the most self-indulgent economic elites in American history, criticizes the decline of family values as the cause of urban crime, unemployment, and discontent, there is an extraordinary element of hypocrisy.

kind of person we are and how we have shaped our lives toward future ends that are good in themselves.”

Generativity is “central in the construction of community-based, integrated health systems,” such as CHA’s proposal, said Bellah. “Such systems, when they are working well, are a way in which healthy communities and healthy individuals in those communities can help each other stay that way.”

CHA’s proposal for healthcare reform “draws on the best resources of the Catholic tradition in a way that speaks to the needs and deepest values of all Americans.” He noted that CHA’s proposal does not focus on the financial aspect of healthcare reform “but on how we think about healthcare and on the institutions we have created to make it available.”

CHA’S PROPOSAL

The phrase “In Sight: A Vision for a Healthy America” describes CHA’s working proposal for healthcare reform. It is consistent with the values of the Catholic healthcare ministry:

- Healthcare is a right, a service to people in need.
- Health policy must serve the common good.
- There is a special duty to care for the poor.
- There must be responsible stewardship of resources.
- The system must have a simple structure.

The heart of CHA’s proposal is a system of integrated delivery networks (IDNs). IDNs, private organizations established by such entities as hospitals, insurers, and physician groups, will coordinate a variety of preventive, primary, rehabilitative, acute, and long-term care services to ensure the most efficient delivery of high-quality care.

State health organizations (SHOs) will charter and monitor IDNs to ensure they deliver the scope and quality of services guaranteed under the law. A national health board (NHB), an independent federal agency, will define benefits and control the rate of growth in national healthcare expenditures. The NHB will determine a risk-adjusted capitated payment to be paid to each IDN through the SHO.

Funding for healthcare will come from current federal expenditures, supplemented by payroll taxes and other targeted taxes that will spread the cost of healthcare equitably across the population. CHA’s proposal ensures universal coverage, eliminates risk segmentation, and provides strong economic incentives to IDNs to control costs and improve quality.

A DAYLONG LOOK AT CHA’S PROPOSAL

SR. BERNICE COREIL, DC

In a day of general sessions focusing on CHA’s working proposal for healthcare reform, assembly-goers learned about the plan, how experts outside the association perceive it, and what chances it might have for adoption.

Sr. Bernice Coreil, DC, chairperson of the Leadership Task Force on National Health Policy Reform, described the 15-month process the group used to develop the proposal. “The single most important decision our task force made came at the very beginning, when we concluded that we should design a plan focused primarily on the needs and preferences of patients and their families rather than on the immediate needs of institutions,” she said.

“This crucial decision enabled the task force to remain true to our Catholic identity,” she continued. “After all, our healthcare ministry was founded in response to human need, never to protect the status quo.”

She explained that the task force identified the specific values that should form the foundation of reform (see **Box**)—a critical step because the values guided the task force in making difficult strategic decisions. Since the national debate about healthcare reform is “mainly about competing value systems,” Sr. Coreil

said the values are perhaps the most important contribution the Catholic healthcare ministry can make to the debate.

The task force will remain active for some time, Sr. Coreil said. It will continue to seek CHA members’ input through many avenues, including three hearing forums in July, and will suggest refinements to the proposal based on recommendations from



SR. BERNICE COREIL, DC

members, outside experts, and policy-makers. Sr. Coreil urged the audience to send her their comments on the proposal. The task force will consider all comments, she promised, as it formulates its final report for submission to the CHA board in April 1993.

A STRATEGY FOR IMPLEMENTING REFORM

JOHN E. CURLEY, JR.
JACK BRESCH
JOANNE ELDEN BEALE
BRUCE M. FRIED

With a working reform proposal in place, CHA members must now work together to “earn for ourselves and for our vision of a healthy America a seat at the table where reform policy will be made,” said CHA President/CEO John E. Curley, Jr., during a panel discussion on CHA’s approach to implementing its reform plan.

Curley noted that the strategy would consist of three elements: a program to educate CHA members and the public about the working proposal; an organizing effort to build a coalition to support the plan; and an advocacy campaign targeting local,



JOHN F. DUNLEAVY, PRESIDENT OF HOLY REDEEMER HOSPITAL AND MEDICAL CENTER, MEADOWBROOK, PA, ASKED THE PANEL ON IMPLEMENTING CHA'S REFORM PROPOSAL WHETHER MEMBERS SHOULD "SELL" CHA'S PLAN TO THEIR CONSTITUENTS OR JUST INFORM THEM ABOUT IT. JACK CURLEY REPLIED THAT EDUCATION IS THE KEY: PEOPLE NEED TO KNOW WHAT THE PROPOSAL CONTAINS AND, IN TURN, CHA NEEDS TO KNOW WHAT THEY THINK OF IT.

state, and national policymakers.

CHA government liaison Jack Bresch stressed that the working proposal "conveys three essential, non-negotiable messages":

- Values are the starting point for healthcare reform.
- There is "an absolute need for *delivery* reform."
- The role of government in a reformed system must be defined.

Joanne Elden Beale, also a CHA government liaison, said the ultimate goal of CHA's educational efforts will be to "help shape the healthcare reform debate by including our message of values, delivery reform, and the role of government." Delivering this message to the public and key policymakers, she stressed, will be the work of CHA members throughout the United States.

But members must be thoroughly familiar with the plan before the public education process begins, Beale pointed out. In the coming months, she said, CHA will be distributing print and video materials to help leaders at systems and facilities educate their internal audiences. In addition, CHA will convene working groups to review the materials and suggest enhancements.

CHA's advocacy and coalition-building efforts will depend on how

well educated its constituents are, said Bruce M. Fried, senior vice president at the Washington, DC-based Wexler Group, a government relations firm working with CHA on its proposal. "Once we educate ourselves, we can move on to educating other hospitals groups, businesses, and communities," he noted.

Fried emphasized that coalition building will be essential to the plan's success. In the next few months CHA will be "drawing up a set of blueprints for coalition building," Fried added. "We'll be specifying how-to's for identifying like-minded people and groups." The ultimate goal, he said, is to invite other groups to "take possession" of the CHA reform plan.

When the time for active advocacy comes, Fried concluded, CHA members "must be prepared to speak clearly and forcefully to federal and state policymakers. Ultimately, it is up to us to convince policymakers that our values are important criteria that should be folded in *any* proposal."

FOCUS GROUPS REACT FAVORABLY TO CHA PLAN

JANICE BROWN

"The winner of the healthcare debate could very well be the team that is first to take to the field in a credible way," predicted Janice Brown, a principal of Market Strategies, Inc., Southfield, MI.

Brown conducted focus groups last March in five U.S. cities to gauge public reactions to CHA's reform proposal. Most participants agreed the healthcare system needs to be reformed, but few had even a tentative idea of the kind of reform needed. "No plan has grabbed the hearts and minds of the American public," she said, adding that "the window of opportunity is wide open" to all groups with reform proposals.

Although the public is not clear about the kind of change to be implemented, they do know what they want

the system to provide, Brown noted. Focus group participants cited reduced costs, increased access, maintenance of quality, and preservation of the right to choose care givers as their criteria for evaluating reform proposals. According to Brown, concerns about access are becoming more pronounced than ever.

Reactions to the CHA proposal were generally positive. Participants liked the values outlined in the plan—

JANICE BROWN



American values are at stake in the healthcare debate. The public is yearning for change in the nation's healthcare system, but future changes—unless they ensure choice, control, equity, and security—will likely only exacerbate the animosity that exists toward the current system.

particularly its emphasis on universal access, simplification of the system, and prevention, Brown reported. Focus group members, especially the elderly, also liked the idea of creating a delivery system that ensured comprehensive services.

But they were less enthusiastic about other aspects of CHA's plan. "The role of the federal government bothered people," Brown said. Participants doubted that the proposed national health board could be politically insulated and that the federal government could effectively implement and manage the system. They



THE ASSEMBLY PROVIDED AN OPPORTUNITY FOR NETWORKING.

were also skeptical that a federal plan would lower costs.

Brown added that all groups expressed concerns that the plan would limit physicians' ability to earn a fair return for the time and money they had invested in their education. "Participants associated a doctor's ability to earn a high income with quality medical care," she said.

Despite these reservations, the overall reaction to the proposal was clearly favorable. "The participants by a solid majority liked and endorsed the basic tenets, the underlying principles and beliefs, the goals, and many of the operating principles of the plan," Brown pointed out.

The current situation presents a unique opportunity for organizations like CHA to make their case for healthcare reform. "The demand for change is so strong that the public is willing to support just about any reform that appears credible," she said.

REFORM ISSUE MAY REVIVE PARTICIPATION IN DEMOCRACY

LOIS SALISBURY, JD

For all its problems, healthcare is the one political issue with the potential to revive the American people's involvement in the democratic process, according to Lois Salisbury, an attorney with Public Advocates, a not-for-profit public interest law firm

in San Francisco.

But attempts to deal with the problems in healthcare must overcome the public's despair about society's institutions. In the past 12 years, "our problems have become so profound and our democracy has accomplished so little that there is little any of us can feel good about," Salisbury said. "There's a sense of confusion and intense frustration."

Despite its challenges, healthcare remains an area of hope. "There's power in this issue," she said, noting that CHA is ahead of the government and most other groups with its reform proposal. CHA's concept is powerful because it is grounded in values, "and that distinguishes you from every other vested interest in this debate," she said.

CHA's proposal addresses the two elements necessary for a just, equitable healthcare system, Salisbury observed: budget constraints and a framework that includes the poor and those with health risks. "If you move away from the basics, you compromise your values," she cautioned. "But if the money is not there, your values are threatened."

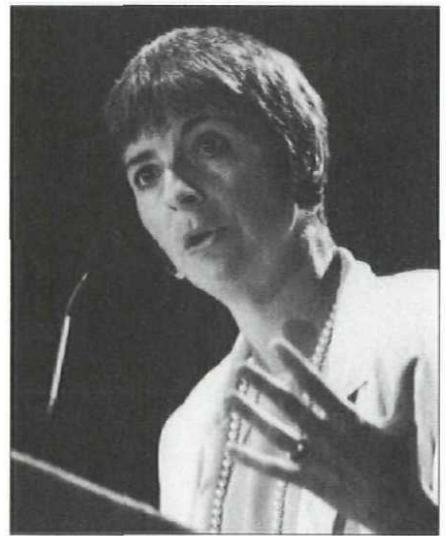
Salisbury compared CHA's proposal with that of Health Access, a California coalition of 135 organizations that she chairs, and a measure introduced by California insurance commissioner John Garamendi.

Characterized as "managed competition," Garamendi's plan "has become the darling of the *New York Times* and is being looked at by federal policymakers as a possible solution to the healthcare crisis, Salisbury said.

Both CHA's and Garamendi's plans feature a capitated payment plan, whereas Health Access advocates a fee-for-service system.

The major strengths of CHA's proposal are that it embodies public-private partnership and emphasizes competition based on quality of care. Garamendi bases competition on price, she said. Another strength of CHA's proposal is it raises questions about practical needs such as transportation and child care.

Based on her efforts supporting Health Access's proposal in the California legislature, Salisbury offered the following warning: "Our negotiations have failed every time because of one thing: budget constraints." She said that "hospitals are not willing to get out in front of doctors. It's not fun to break rank with others, especially doctors who are our gatekeepers, but it's got to do with doing right."



LOIS SALISBURY, JD

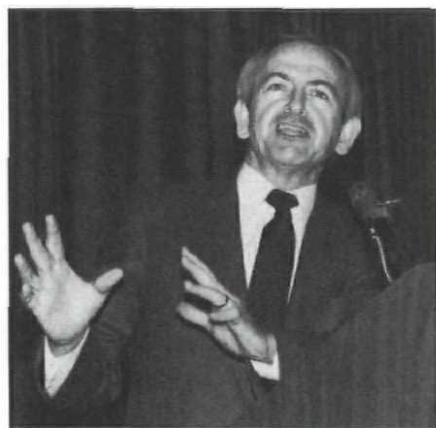
Another problem in the political debate on healthcare in California has been the lack of coalition building among hospitals, the business community, and labor. "You get involved in ideology real fast," without looking at the true financial picture, Salisbury said. "The only thing we agree to do together is trash the insurance companies."

She encouraged CHA to use the power and values embodied in its proposal to influence the rest of the hospital sector and other provider groups such as physician and nursing organizations.

WINDOW OF OPPORTUNITY WILL NOT BE OPEN LONG

EDWARD F. HOWARD

Although he doubts that any meaningful health-care reform will be passed before the 1992 election, Edward F. Howard believes current dissatisfaction among the American people does leave open a window of opportunity for rational change.



EDWARD F. HOWARD

"Healthcare costs and fear of how much higher they might go in the future are being brought home to mainstream America," said Howard, who is the executive vice president of the Alliance for Health Reform, a non-partisan effort to educate leaders about the urgent need for universal access to healthcare. Howard told assembly-goers that "people think the simplest reason for skyrocketing healthcare costs is greed," but still they seem more willing to pay for healthcare improvements.

Unfortunately, Howard said, interest groups in Washington are playing the "politics of paralysis": If their healthcare reform proposal is rejected, their second choice is always the status quo, he said. He praised CHA's plan as an exception to that rule in that it "recognizes that hospitals will have to sacrifice to make this healthcare reform movement go." Although he predicted that CHA's plan will attract opposition, particular-

ly from the insurance industry, he said that electoral politics of 1992, coupled with pressure for change from CHA and its members, could make a difference.

"The system is unsustainable as it is now," he said, "and I think that as more and more people understand that, and more and more people are squeezed out, the pressure for change is going to happen." He added that everybody working on this issue believes there will be radical restructuring before the turn of the century. "The only question is, Is it going to be rational? Is it going to meet people's real needs? Or is it going to be something that we reach up and grab for in a crisis when the whole thing blows up in our faces?"

HEALTHCARE PROVIDERS' SUCCESS MAY DEPEND ON COLLABORATION

PAUL TESLOW

Healthcare delivery systems in which physicians, hospitals, patients, and payers collaborate will survive into the next century. These types of plans are very different from traditional forms of healthcare delivery: They are transformational, Paul Teslow, president/CEO, UniHealth America, told assembly-goers.

Teslow commended CHA for its healthcare reform proposal, which focuses on integrated delivery networks (IDNs). "You're restructuring, on a systemic basis, American healthcare, and that has taken a lot of courage," he remarked.

Teslow described the growth of UniHealth America, a Burbank, CA-based healthcare system created in 1988. The system uses integrated healthcare delivery systems to serve the 14 million residents of the Los Angeles basin, a culturally diverse area. He compared UniHealth America's model, Commitment to Caring, with CHA's proposal.

Teslow said that UniHealth America has four goals:

- To regionally integrate
- To be quality and value driven
- To merge care and financing
- To create continuums of care

UniHealth America has achieved these goals, in part, through strategic alliances among physicians, payers, hospitals, providers of specialized services and products, suppliers, and



PAUL TESLOW

employers. A successful healthcare system will have to be pluralistic in its approach by offering many choices, such as many physician formats, health plans, and marketing approaches, noted Teslow. He said that nonaffiliated hospitals and small health maintenance organizations, "anything that does not have critical mass," will face a struggle to survive.

One key to a successful healthcare system is to fully collaborate with physicians and enhance their ability to practice, Teslow emphasized. UniHealth America supports physicians in solo practice and in small and large groups.

Another vital ingredient for success is a medical communications network connecting specialists, clinics and groups, hospitals, payers, home care givers, laboratories, and pharmacies. The goal, Teslow noted, is to create a longitudinal patient data base, to have a long-term data profile on each enrollee.

To integrate the many staffs and physicians in the myriad hospitals, clinics, laboratories, pharmacies, and other member providers, UniHealth America uses "heavy matrixing," said Teslow. In addition to daily functional matrix teams, all system CEOs meet for a day each month to "hammer out tough issues throughout our organization." Also, each hospital sponsors board retreats. Other activities include concerts given by Team UniHealth singers. "This is all part of the culture: to bring people together to believe in one another," Teslow said.

PRACTICE VARIATION RAISES PROBLEMS FOR REFORM

JOHN WENNBERG, MD

Regional variation in physicians' practice patterns raises questions about appropriate rates of service use—an unavoidable issue for the community-based health-care system of CHA's reform proposal. John Wennberg, MD, professor and director of the Center for Evaluative Clinical Services, Dartmouth Medical School, Hanover, NH, who has compared utilization of various services in Boston and New Haven, CT, and in communities in Maine, said resource supply (e.g., beds, specialists) is the reason behind excess utilization.

His research has revealed that hospital admission rates for cardiopulmonary disease, gastrointestinal problems, and low back pain are twice as high in Boston as in New Haven because Boston has more beds. Also behind high utilization rates, he said, is the lack of outcomes data on which physicians can base decisions. He described a study that found physicians prescribing prostrate surgery because they thought it would prevent future problems—a theory later proved wrong.

However, Wennberg predicted, the healthcare system can create "islands of rationality in an ocean of uncertainty and supplier-induced demand by asking two questions: What works in medicine, and what

does the patient want?" He said the healthcare system must adopt this new paradigm of pairing outcomes data with a shared decision model to determine appropriate utilization rates and thus appropriate system capacity.

Wennberg pointed out instances in which allowing patients to participate in decisions about their care has successfully lowered utilization. In one study in which patients were informed about options for prostrate treatment and asked their preferences, surgery dropped 50 percent, he said.

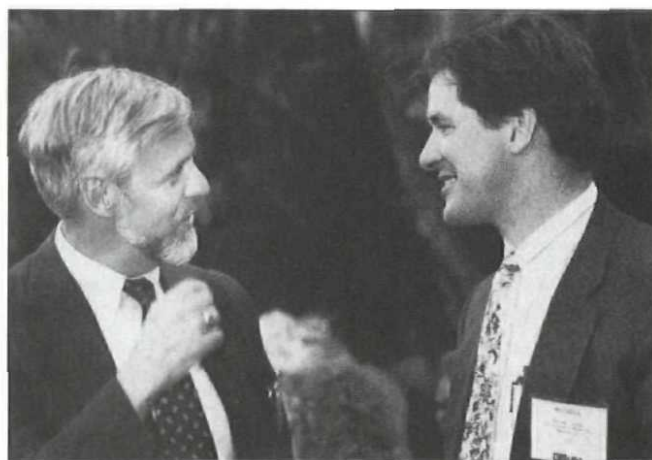
In formulating national health policy, "we need to declare we have massive excess capacity," including specialists who are ill trained for community-based care, Wennberg noted. Healthcare financing models can encourage constructive uses of excess capacity. Wennberg's solutions include making resources available for physicians to build structures that accommodate patient preferences and to take sabbaticals for retooling their skills. "While acting as a system builder, a student, or a researcher, the physician isn't providing services," he explained.

In the debate on healthcare reform, he said, "we must agree that community-based strategies are needed" to ensure services are provided efficiently and cost-effectively.

SUCCESSFUL HMO HAS IMPLICATIONS FOR IDNs

THOMAS SHEAHAN

When seven Milwaukee Catholic hospitals with 40 percent of the area's market share banded together to start a for-profit health maintenance organization



GUESTS AT THE WELCOMING RECEPTION ENJOYED THE RELAXED ATMOSPHERE.

(HMO), the results were impressive. In just five years, it became the second-largest HMO in the city. When it went public in 1991, it generated \$38.6 million from the initial public offering and earned the hospitals \$23.5 million.

Although it was a commercial success, the HMO fell short in the area of collaboration, according to Thomas Sheahan, who is chairman/CEO of Wheaton Franciscan Services, Inc., Milwaukee, and chairman of the HMO's parent corporation. The HMO's experiences have implications for integrated delivery networks (IDNs) in a reformed healthcare system, he said.

A goal in forming the HMO's parent company was to create a vehicle for continued collaboration on other ventures, Sheahan explained. Although the HMO lived up to many of its objectives, the inability to achieve expanded and ongoing collaboration prompted Sheahan to label it a "successful failure."

JOHN WENNBERG, MD



The entanglement of physician preferences and lack of outcomes data leads to variations. We can bring rationality to the system by outcomes research and changing the doctor-patient relationship. The old model of physician decision making is being replaced by physicians not prescribing without asking patients what they want.

Lack of a common vision was perhaps one of the biggest impediments to continued collaboration that the participating hospitals faced. "We had the right words in our mission statement," he said, "but we didn't have a common understanding of what those words meant."

Timing of the venture was another problem. The holding company was ahead of its time, Sheahan said. None of the hospitals understood IDNs, and because they were doing well financially, they had no incentive to work together.

"We discussed expansion, but not one of us was interested in giving up competitive programs," he said. "In the end, competition prevailed over collaboration."

The effort was also weakened by the fact that the seven sponsors were not involved in the collaboration. "We have got to learn to work well together," Sheahan observed. "There's a real fear about the risk of mission. If we can't risk our mission for the good of the community, then what can we risk it for?"

"The big lesson learned from this experience was that we talked with each other, but we didn't learn from each other," he continued. "We didn't take the collaboration to its logical extension."

BOARDS CAN PLAN NOW FOR HEALTHCARE REFORM

MICHAEL A. SCAVOTTO
RICHARD E. THOMPSON, MD

To prepare for healthcare reform, hospital boards must adopt an effective approach to planning and setting priorities, according to Michael A. Scavotto, president of the St. Louis-based Health Strategies Group.

Scavotto warned board members against "succumbing to the tendency to think about reform as too big, too nebulous, and too difficult to plan for." Providers can make broad predictions about changes in the health-care system and develop strategy accordingly, he said.

Richard E. Thompson, MD—president of Thompson, Mohr and Associates, Inc., Dunedin, FL—added that hospitals can begin "internal" reform now by ensuring they deliver dependable medical services. "We have to reestablish public trust in our facilities," Thompson told the audience, "and we can do so by taking a patient-centered approach to our work."

Whether change is internally or externally driven, productive strategic planning requires flexibility and good communications between the board and the CEO, Scavotto said. "It's very difficult to deal with large-scale change if the board and the CEO aren't working together," he noted. "And organizations that refuse to change direction in response to new opportunities or altered circumstances are courting disaster."

To plan successfully, Scavotto advised the board to "achieve a solid understanding of members' priorities and devise a method for establishing consensus." A first step is to have each board member independently rank

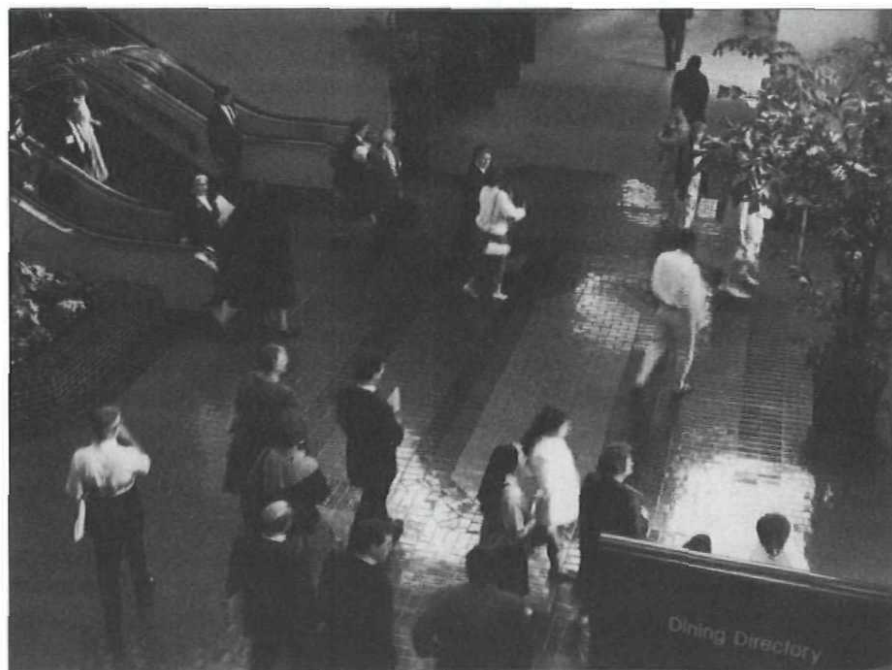


RICHARD E. THOMPSON, MD

certain issues (e.g., quality of medical services, medical staff relations, profitability) in terms of importance and then present the cumulative result to the entire board. According to Scavotto, such an exercise:

- Enables the board to critique strategies in terms of prioritized issues and relative future importance
- Fosters group consensus
- Provides a baseline for future board performance evaluations
- Improves communications with top management

A workable plan requires a perspective of about three to five years, Scavotto concluded. Once a plan is in place, he said, the board must ask whether the facility can accomplish it with its current organization, how and where the services will be delivered, what will suffer, and what impact the plan will have on the organization.



ASSEMBLY-GOERS HEAD FOR THE NEXT SESSION.

BIOETHICS

SUPPORT FOR PHYSICIAN-ASSISTED SUICIDE MUST BE QUELLED

REV. RICHARD A. McCORMICK, SJ, STD
NANCY HOOYMAN, MD

Physician-assisted suicide remains a crucial issue for healthcare professionals, despite the defeat of Initiative 119 in Washington. California is facing a similar initiative, and Michigan may be the next state to put physician-assisted suicide on the ballot.

Five cultural drifts are "providing powerful support for physician-assisted suicide and a change of public attitudes," according to Rev. Richard A. McCormick, SJ, STD, John A. O'Brien Professor of Christian Ethics at the University of Notre Dame, Notre Dame, IN.

"In the past 20 years we have moved from paternalism to an era of patient autonomy," said Fr. McCormick. This "absolutization" of autonomy, he insisted, plays right into the hands of proponents of physician-assisted suicide because they say that if the patient wants assistance in suicide, it is the right thing to do. Fr. McCormick sees the emphasis on autonomy as a rejection of dependence and of the social responsibility we have as members of a community.

"Increasingly we're making decisions about ourselves as if we were isolated atoms," said Fr. McCormick. "We have to put autonomy into a larger context, a context of our obligations toward each other, of our dependence on each other."

In addition, Fr. McCormick sees a drift toward secularization of medicine, separate from its moral tradition. A primary manifestation of this is medical professionals' preoccupation with the business aspects of healthcare. This

REV. RICHARD A. McCORMICK, SJ, STD



emphasis on making money leads to the secularization of medical judgment, said Fr. McCormick. "The form that this takes is simple accommodation to the patient's wishes, doing anything the patient wants."

Inadequate pain management is another contributor to the push for physician-assisted suicide. Fr. McCormick noted that many physicians do not believe they have been adequately trained in pain management. If pain were better managed, he said, the requests for physician-assisted suicide would begin to disappear.

The treatment of patients in persistent vegetative states (PVS) also adds support for physician-assisted suicide. "We know we can maintain people like this indefinitely," said Fr. McCormick. "The question is, Is it in their best interest?"

Some groups believe artificial nutrition and hydration bestows a great benefit—the preservation of life. But "we must distinguish a medical effect on an organ from patient benefit," noted Fr. McCormick. "If we continue to approach this problem in the way that we have seen it done recently, we are in a certain sense driving people into the arms of the Hemlock Society, and I think it will open wide the doors to physician-assisted suicide."

Financial pressure on healthcare is also driving the push for physician-assisted suicide. "Physician-assisted

The Catholic tradition has exercised a leadership role in treatment of the dying. . . . And so we are in a position to exercise enormous influence if we only keep up with that and reexamine constantly the policies and vocabulary...to see if they are adequate to our time.

suicide is not budget neutral," said Fr. McCormick. "It saves a great deal of money and can be an enormous temptation at a time when there is pressure on the system to cut costs."

Working from the premise that it is never permissible to kill another human being or to assist a person in committing suicide, Nancy Hooyman, MD, chief of the Division of Geriatric Medicine, St. John's Mercy Medical Center, St. Louis, asserted that "the physician is culpable," even if the patient requests suicide assistance. "The doctor is killing, and in no way can the action be interpreted as allowing an eventually inevitable death to occur earlier."

Hooyman views the physician's roles with the dying person as one of adviser, friend, and priest. The physician must advise the patient on treatment options and their possible outcomes. "The physician must provide the best medical management he or she is capable of, including the intelligent use of analgesics, identification of burdensome treatment and the recommendation of their discontinuance, and the provision of the best physical comfort possible," said Hooyman.

As the patient's friend, the physician is there to offer some hope of relief. When adopting the role of friend, the physician can also allow the patient to share his or her suffering, said Hooyman. The "friend" must take care not to become too empath-

ALEXANDER CAPRON



To what extent does knowledge of genetics diminish us, make us seem to ourselves less as human beings with some power to direct our lives, rather than as automatons playing out the genetic message? To what extent does the whole notion of genetic manipulation threaten our sense of human uniqueness?

ic, however, and feel the patient's pain too deeply.

"Because the physician has frequent contact with death, the religious dimension of medical practice is intensified and the sensitivity to the patient's needs is magnified. This puts the physician in the best position to accompany the patient in his or her journey of dying," said Hooyman. But she emphasized that, as an agent of God, the physician does not have the final authority to decide whether a death is too slow or too tedious.

Physicians simply must say no to requests for assistance in suicide, she asserted. Instead, she recommended physicians look for opportunities of grace. "Put on the cloak of friend and discover the patient's real needs, their spiritual dimensions," she said. Having cared for many patients with dementia, Hooyman said, "Even when everything is gone for these patients—speech, ambulation, continency—the single thing that they had most feared losing—their dignity—remains." She concluded that we should never

destroy the chance to care for patients' "humanness and spirit to the very end, when God decides it is time."

GENETIC TECHNOLOGY MAY THREATEN UNDERLYING VALUES

ALEXANDER CAPRON
REV. ROBERT BAUMILLER, SJ, PhD

Even though genetics offers a great opportunity for enhancing human health, "we must not allow technological magic, and the lure that has for us, to cause us to forget our basic values," Alexander Capron cautioned assembly-goers. Particularly in a healthcare system that fails to provide appropriate care for all, our fascination with genetics must not overwhelm greater needs in society, said Capron, who is a professor of law and medicine at the University of Southern California—Los Angeles.

He also warned that healthcare providers run the risk of creating a demand for genetics, as they have with fertility services. Justice may be threatened in such a system of commodified healthcare. "Who will have access to the technology?" he asked. If therapies are expensive, only the rich may receive them, giving them further advantages over those excluded from

the healthcare system.

Another value at stake is dignity. "We have to clearly differentiate between the person and the gene," Capron said. For example, we must be certain that a desire to eliminate cystic fibrosis does not translate into a desire to eliminate all carriers of the gene. "If we rail too hard against a gene," he said, "we may end up turning our back on children born with the disease."

A confounding factor is that genes causing defects may also have benefits, like the resistance to malaria conferred by sickle cell disease. Capron raised the possibility that in the future a plague may kill everyone except those with a certain genetic makeup. If we eliminate a gene because it causes a disease, we may lose our "hybrid vigor," he said. "At what point are we so confident that we dare to make a change and potentially damage unconsenting people in the future?" he asked.

Rev. Robert Baumiller, SJ, PhD, dean of the School of Health Sciences at the University of Detroit—Mercy, raised privacy as another issue surrounding genetic advances. He noted, for example, that the gene for susceptibility to alcoholism may affect one in four Americans. "Do I want the information? Who else should have it? And how should it be used?" he asked. "We need to figure all this out."

We run the risk of creating a group of "genetically marginalized" people, Capron said. Already some persons have been denied health insurance or



TRUSTEES REFLECT ON CHA'S REFORM PROPOSAL.

jobs because they have certain genetic diseases, such as PKU or Huntington's chorea, he said. "Those with genetic disease may be seen as a threat."

In some circumstances, he added, "enhancement of choice actually diminishes choice." For example, if couples know they might produce offspring with severe genetic defects, their choice to marry or reproduce may be limited, whereas previously they would have married, had children, and made the best of the situation. In addition, widespread use of genetic therapy may create social pressure to use it and may make it impossible to find a facility that will treat patients "the old-fashioned way," Capron said.

Fr. Baumiller raised an additional issue: "Where do you come down on the responsibility of people to avoid problems due to their own behavior?" For example, when we are able to pinpoint the gene for cystic fibrosis, will parents who take genetic risks in choosing to reproduce be censured by



PARTICIPANTS ENJOYED BETWEEN-SESSION BREAKS.

society? And what about the parent who wants to enhance an offspring's height or IQ? Who will make the decisions about whether and how to use genetic technology remains undecided.

Despite the challenges, Capron noted that genetic therapies will become increasingly useful and we must not be afraid to use them. "We're given the powers, but are we

using them in a responsible fashion?" he asked. He said that attempts to raise a child's IQ, for example, would be better accomplished through good prenatal care and education. "We must not allow the lure of a technological fix to divert us from much simpler solutions," he said. "Most of the things we care about will not be corrected by genetic therapy."

MANAGING CHANGE

STRONG RIGHTS AND STRONG RESPONSIBILITIES

AMITAI ETZIONI, PhD

Healthcare has been turned into the garbage can for all the problems society does not want to deal with, sociologist Amitai Etzioni, PhD, said during the Flanagan Lecture.

Americans feel they are entitled to certain rights, but they do not want to accept the responsibility for those rights, he said. For instance, Americans assume that if they are convicted of a crime, they will be tried by a jury of their peers. But they do not want to serve on juries.

"It is untenable to take and not to give," noted Etzioni, who is the guru of the communitarian movement.

"Strong rights assume strong responsibilities."

To talk about a right but not the responsibility is an incomplete idea, according to the George Washington University sociologist. Communitarians, he said, want to restore the responsibility side of the picture. The movement's goal is to restore the tra-

dition of laying moral claims on one another.

Etzioni cited a decline of values in America as one of the roots of today's problems. In the 1960s, he said, society attacked all figures of authority. "But it's easy to destroy," he declared; the problem was the nation did not reconstruct.

AMITAI ETZIONI, PhD



All the problems society doesn't want to attend to, they dump on the healthcare system and ask us to fix it. Then society turns around and complains we are using too much of the money of the community. We need to turn the table and say to them, "Don't bring me the gunshot wounds, take away the guns."

jobs because they have certain genetic diseases, such as PKU or Huntington's chorea, he said. "Those with genetic disease may be seen as a threat."

In some circumstances, he added, "enhancement of choice actually diminishes choice." For example, if couples know they might produce offspring with severe genetic defects, their choice to marry or reproduce may be limited, whereas previously they would have married, had children, and made the best of the situation. In addition, widespread use of genetic therapy may create social pressure to use it and may make it impossible to find a facility that will treat patients "the old-fashioned way," Capron said.

Fr. Baumiller raised an additional issue: "Where do you come down on the responsibility of people to avoid problems due to their own behavior?" For example, when we are able to pinpoint the gene for cystic fibrosis, will parents who take genetic risks in choosing to reproduce be censured by



PARTICIPANTS ENJOYED BETWEEN-SESSION BREAKS.

society? And what about the parent who wants to enhance an offspring's height or IQ? Who will make the decisions about whether and how to use genetic technology remains undecided.

Despite the challenges, Capron noted that genetic therapies will become increasingly useful and we must not be afraid to use them. "We're given the powers, but are we

using them in a responsible fashion?" he asked. He said that attempts to raise a child's IQ, for example, would be better accomplished through good prenatal care and education. "We must not allow the lure of a technological fix to divert us from much simpler solutions," he said. "Most of the things we care about will not be corrected by genetic therapy."

MANAGING CHANGE

STRONG RIGHTS AND STRONG RESPONSIBILITIES

AMITAI ETZIONI, PhD

Healthcare has been turned into the garbage can for all the problems society does not want to deal with, sociologist Amitai Etzioni, PhD, said during the Flanagan Lecture.

Americans feel they are entitled to certain rights, but they do not want to accept the responsibility for those rights, he said. For instance, Americans assume that if they are convicted of a crime, they will be tried by a jury of their peers. But they do not want to serve on juries.

"It is untenable to take and not to give," noted Etzioni, who is the guru of the communitarian movement.

"Strong rights assume strong responsibilities."

To talk about a right but not the responsibility is an incomplete idea, according to the George Washington University sociologist. Communitarians, he said, want to restore the responsibility side of the picture. The movement's goal is to restore the tra-

dition of laying moral claims on one another.

Etzioni cited a decline of values in America as one of the roots of today's problems. In the 1960s, he said, society attacked all figures of authority. "But it's easy to destroy," he declared; the problem was the nation did not reconstruct.

AMITAI ETZIONI, PhD



All the problems society doesn't want to attend to, they dump on the healthcare system and ask us to fix it. Then society turns around and complains we are using too much of the money of the community. We need to turn the table and say to them, "Don't bring me the gunshot wounds, take away the guns."



THE ASSEMBLY OFFERED MEMBERS A CHANCE TO RENEW ACQUAINTANCES.

Then came the 1980s, the "watch out for number one" age, which maximized self-interest under the guise of creating a healthy economy. Now, in the 1990s, the list of domestic problems keeps swelling.

To heal society, he suggests beginning with families. Children are born without a conscience, and "the family must act as the moral agent of society," he said. At the same time, society must become more family friendly by offering flexible hours and family leave.

The public schools ("which 88 percent of our children attend") must also develop the character and values of the nation's children, Etzioni suggested. *Currently, schools spend all their time teaching cognitive skills. "But they fail to see you can't load a vessel that has not been formed," he said.*

The community is the third part of society through which people acquire a moral voice, he said. Unfortunately, too often the community has a strong voice where appearance is concerned, but is weak when it comes to laying moral claims.

The political system also came under sharp criticism. "It is a sad fact that today legislation is too often bought by the highest bidder" and does not have the public interest at heart, Etzioni said.

The time is right to return to a community with stronger values, he told the audience. "Imagine a world where patients would not file claims unless they were really hurt; where drug companies would share only

information about drugs rather than push us to buy them; where physicians would do only necessary procedures and not try to satisfy requirements; and where lawyers would file claims only for true injuries. It would be," he conjectured, "a world where healthcare costs would drop immediately—a healthier, more honest and decent world."

BRIDGING THE LEADERSHIP GAP

KATHRYN E. JOHNSON

Healthcare leaders overwhelmingly prefer a future that includes a reformed delivery system and a primary focus on community health, but they predict a much less desirable picture, according to research recently completed by the Healthcare Forum.

"We believe the gap between the preferred versus the predicted view of the future speaks directly to the need to 'retool' our leaders," Kathryn E. Johnson, president and CEO of the San Francisco-based healthcare association, told a general session audience.

"Life in the twenty-first century will be different," Johnson said. "Tremendous advances in the biomedical sciences will affect us. Healthcare itself is a breeding ground for change."

Futurists and management experts, she added, have noted an emerging

shift in leadership and management in recent years. Organizations are moving from current, short-term business practices to longer-term, systemic, and integrated approaches. "We believe transformational leadership is needed to move healthcare into the twenty-first century," she said. "Transformational leaders go beyond the conventional. They are willing to retire outmoded skills and assumptions."

The Healthcare Forum's national study surveyed more than 2,500 healthcare opinion leaders, including the leaders of CHA member institutions. The study asked, first, what twenty-first century healthcare will look like.

Responding to three proposed future scenarios, 87 percent of those who responded to the Healthcare Forum Survey indicated a preference for a scenario labeled the "New Civilization," a "humanistic" vision of the future that included national healthcare reform, an emphasis on health promotion and wellness, and healthcare spending stabilized at 12

KATHRYN E. JOHNSON



During our study, we discovered a useful framework we call GEO. It's an acronym for the three rivers of change—globalization, empowerment, and orchestration of technology—and a framework for thinking about the shift from here to twenty-first century leadership.

percent of the gross national product by 2001. When asked to predict which scenario will occur, respondents were split between a continuation of the current situation—with expanding healthcare technology and costs and unequal access—and a scenario in which political revolt over rising healthcare costs leads to a frugal, Canadian-style, national health insurance system.

The study also asked what competencies and values healthcare executives will need to lead in the next century. Johnson said that opinion leaders clearly identified six key competencies and values: mastering change, systems thinking, shared vision, continuous quality improvement (CQI), redefining healthcare, and serving public and community.

“Three of these six—mastering change, systems thinking, and CQI—showed the biggest gap between current practices and future importance,” Johnson told assembly-goers. “While they are lightly practiced today, they will be very important in the future,” she said.

Johnson said her organization is now investigating interventions to effectively bridge the gap between current practices and future requirements, to bring about “transformational leadership.”

“Transformational leaders have a vision of the future they want to create. They enroll and empower people. They exhibit behaviors that support high performance, continuous improvement, and adaptation to change,” she said.



EVEN SERIOUS SESSIONS HAD THEIR LIGHTER MOMENTS.

CREATING AN ENVIRONMENT WHERE ALL CAN FLOURISH

PAUL MULLINGS

Women and immigrants make up the fastest-growing segment of the work force, yet they are underrepresented in management positions and in occupations in which labor shortages are projected,

will be difficult to tap the potential of our human resources if we don't create organizations that will work comfortably for everyone,” he said. “We need to create an environment where all can flourish.”

A diverse work force increases employee involvement and morale and leads to a better understanding of customers, Mullings added. When linked with continuous quality improvement, a diverse work force can provide a competitive edge and increase profitability.

As director of corporate diversity, Mullings educates the board and

PAUL MULLINGS



The melting pot is no longer the American way. People are less willing to assimilate, even for eight hours a day. There's more of an attitude of, "I'm different and proud of what makes me so. I'll join your team, but only if I can do so without compromising my uniqueness."

according to Paul Mullings, director of corporate diversity, Mercy Health Services, Farmington Hills, MI.

Mullings described a two-year effort being undertaken by the health system to open up its work force—especially top management—to women and people from a variety of ethnic groups. “From a mission standpoint, we say we are committed to justice,” he noted. “But it's difficult to talk about mission and see where our organization is. We want to bring the two closer together.”

Leaders must learn to manage diversity for business reasons as well, according to Mullings. As the baby boom generation retires, the labor pool will shrink and competition for the best talent will increase. “It

senior management teams about the organization's commitment to and goals for increasing the number of minorities in management positions. He also helps the health system divisions and subsidiaries develop action plans to analyze data and develop strategies for improving minority hiring. The divisions regularly report back on the candidates considered for open positions and who was finally hired.

Convinced that “networking gets you to the top,” he encourages Mercy's senior management to work with minority groups such as the Hispanic bar association to begin mentoring programs. Additionally, the health system is funding a healthcare scholarship and has asked that it go to a minority student.

“Everyone has differences, and in this society we tend to view difference as weakness,” Mullings said. “If we value diversity, it can have a positive effect.”

IMPROVE LABOR RELATIONS BY INVOLVING EMPLOYEES

PAUL SCHROEDER, JD
PATRICK McENEANEY
KAREN McGRATH
JOHN GALLAGHER

In the next 36 to 48 months healthcare facilities will see a gradual increase in union organizing activity, predicted Paul Schroeder, an attorney with Bryan Cave, St. Louis. He was a member of a panel that discussed dilemmas in labor relations. Organized labor will learn how to speak to healthcare workers, he said, and the recent U.S. Supreme Court decision allowing up to eight bargaining units in hospitals will make it easier to organize workers.



PAUL SCHROEDER, JD

Eighty percent of healthcare employees are women, he noted. "Healthcare has the fastest-growing percentage of single-parent female heads of household of any industry in the country," he said. Schroeder also noted that these women are attracted to the same issues that their fathers were 40 years ago when they joined unions—an adequate salary to support their family and health insurance. Unions will appeal to these needs and may emphasize healthcare benefits that are portable from job to job, since healthcare workers are mobile, he said.

To communicate with employees in terms they understand, organized labor will reach into the ranks of healthcare workers to find organizers, Schroeder predicted.

Patrick McEneaney, vice president of human services at Catholic Medical Center of Brooklyn and Queens, Jamaica, NY, advised facilities that do not yet have unions to "take this win-



PATRICK McENEANEY

dow of opportunity to develop working relationships with employees." Although many employees at Catholic Medical Center are in unions, the medical center, to minimize union activity, is involving employees in the health and safety committee. The medical center has also formed a panel to give nonsupervisory employees a vehicle for appealing a termination. The panel, whose members are not medical center employees, arbitrate cases and issue rulings that are binding on the organization.

Karen McGrath, director of labor relations, Washington State Nurses Association, said nurses' main concerns are issues of input, not economics. As licensed professionals, they are accountable to the client for the quality of care they give, she said. But the institution shares the same goal as the nurse: "to provide care to the client in a manner that respects the client, the institution, and the care giver."

Facilities should not be intimidated by the unionization process, which "does not have to be adversarial," she said. If nurses and other service work-

ers have chosen a union, healthcare facilities' best approach is to work with them, according to McGrath.

Papal social teaching provides guidance in labor-management relations, said John Gallagher, director of corporate ethics, Holy Cross Health System, South Bend, IN. The most important teaching, he said, is that the primary purpose of work is to benefit the community, not the individual. "As employers, we need to create an environment that enables people to see the social significance of their skills as providers of healthcare and sustainers of the healthcare facility," he said.

Healthcare organizations should involve workers in governance issues, he said, and should reward team performance rather than the performance of individual "star" employees.

THE CHALLENGE OF TREATING IV DRUG USERS WITH AIDS

REV. JON D. FULLER, SJ, MD
CLIFFORD L. MORRISON

Intravenous (IV) drug users with AIDS represent a great challenge to Catholic healthcare providers, according to Rev. Jon D. Fuller, SJ, MD, president of the National Catholic AIDS Network and assistant clinical director of the Clinical



CALIFORNIA SUNSHINE BROUGHT THE DISCUSSIONS OUTDOORS.



REV. JON D. FULLER, SJ, MD

AIDS Program at Boston City Hospital.

Fr. Fuller noted that chemical injection is responsible for one-third of all new AIDS cases, affecting drug users, their sexual partners, and their children. Several members of the audience described a reluctance among people with AIDS who are not active drug users to allow drug users into housing and other programs. Drug users are seen as a problem population, one participant said, and residences for persons with AIDS often bar them.

Fr. Fuller issued a gentle reminder that "Catholic tradition says, 'We take you the way you are and help you take the next best step.'"

He suggested that residences or programs for people with AIDS might prohibit active injection on site. "It's a mistake to say 'These kinds of people never shape up,'" Fr. Fuller added. "Get underneath what drives them to use drugs," he suggested.

Rev. Rodney DeMartini, executive director of the National Catholic AIDS Network, asked those present if they are open to learning from the different populations with AIDS. "Let people with HIV and AIDS be in the front of the room to talk about what they want or don't want," he urged.

Clifford L. Morrison, deputy director of the Robert Wood Johnson Foundation AIDS Health Services Program, warned healthcare providers that if their facility has not yet begun to plan for the epidemic, "your institu-

tion is in trouble."

The epidemic and its changing epidemiology force healthcare providers to do proactive planning, he said. "We can't keep reacting to the crises that come up."

Morrison said that 75 percent of the AIDS cases diagnosed are no longer in the five metropolitan areas that had the most cases at the epidemic's onset. "AIDS has moved into middle America," he said.

Fr. Fuller pointed out that AIDS is now the number one cause of death in New York City for black women of childbearing age. Nationally, it ranks fifth among all women of childbearing age. And for young men in New York, Los Angeles, and San Francisco, it is the leading cause of death.

He issued a grim prediction: HIV disease will be with us for the rest of our lives. And then a grim reminder: We have to give permission for people to die from HIV and AIDS in this country without being ashamed.

LINKING MEDICINE AND SPIRITUALITY

KATHLEEN K. PASSANISI
LAWRENCE G. SEIDL

To truly reform the healthcare system, providers must go beyond reforming areas such as access and financial arrangements and learn how to merge medicine and spirituality, according to Kathleen K. Passanisi and Lawrence G. Seidl.

"We must seek scientific advance-

ment with spiritual enlightenment," said Seidl, CHA's senior associate for pastoral services.

Linking spirituality with medicine may be difficult, added Passanisi, president of New Perspectives, Lake St. Louis, MO, because medical professionals and spiritual care givers speak different languages. Terms such as "quality of life," "wellness," and "spiritual" have different meanings to each group. To overcome these barriers, Passanisi suggested that persons from all aspects of healthcare—medicine, pastoral care, nursing, housekeeping, administration—meet regularly to exchange information on physical, emotional, and spiritual care.

The key to merging medicine and spirituality is education, said Passanisi and Seidl. Once facility staff are educated on the negative effects of loneliness and hopelessness, for example, they may be able to foresee problems patients may experience, noted Seidl.

Hospitals need to provide in-service education programs for staff, teaching them how to be more healthy and how to better care for themselves, Passanisi said. She and Seidl agreed that staff cannot care for patients' bodies, minds, and spirits until they see to their own health. Care givers must learn the benefits of joy, love, support, and laughter, said Passanisi.

"Catholic healthcare facilities must become institutions of hope," asserted Seidl. Passanisi noted that healthcare providers cannot guarantee health and are afraid to offer hope. This must change, she said, "because hopefulness predisposes patients to wellness."

CLIFFORD L. MORRISON



As long as people with HIV have to worry about being discriminated against, civil rights will be a major issue in AIDS treatment. . . . Most of us have failed dismally in dealing with IV drug users. We have to work on our attitudes before we can have success with these persons.

RENEWING MISSION

HOSPITAL TURN-AROUND BASED ON PROCESS THAT EMPHASIZES MISSION

JAMES O. DAGUE
SR. NANCY GLYNN, CBS

When James O. Dague became the CEO of Bon Secours Hospital, Baltimore, in December 1989, it was \$5 million in debt, with a \$2.5 million deficit in the previous year. By the end of the fol-

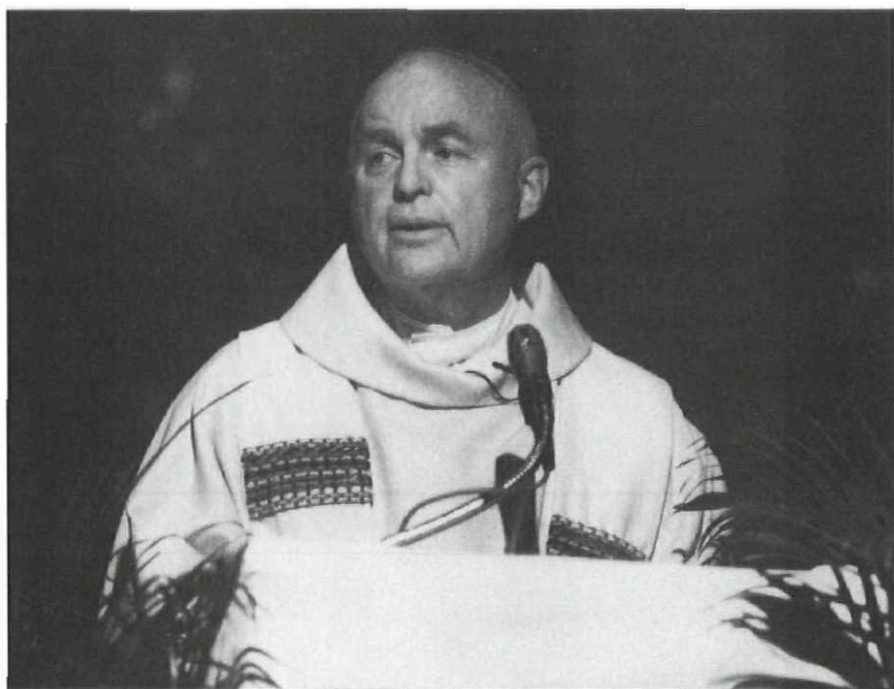


SR. NANCY GLYNN, CBS

lowing year, the hospital had made a \$1.5 million bottom-line profit and paid its corporate dues for the first time in several years. The reason? "When the mission is hitting, the margin's going to be there," Dague explained.

He introduced a process at Bon Secours that places the mission at the basis of budgeting and planning. "The key is constancy of purpose through mission statement development," Dague said. Division personnel write their own mission statements, drawing on that of the hospital, to pinpoint "key result areas" (KRAs) that form the basis for annual resource allocation.

The process of developing a mission statement, KRAs, and finally a budget entails participation by division managers and employees, with ap-



AT THE ASSEMBLY'S OPENING LITURGY, BP. JOSEPH M. SULLIVAN, DD, AUXILIARY BISHOP OF THE DIOCESE OF BROOKLYN, NY, TOLD OF A BURDENED CARE GIVER WHO "IS SUSTAINED NOT BY THE LOVE SHE RECEIVES BUT BY LOVE SHE'S BEEN ABLE TO GIVE." HE CONCLUDED THAT "SUFFERING CAN PERFECT US AND CAN CALL OTHERS TO SALVATION."

proval by vice presidents at each stage. The final budget approval step is a "kangaroo court" held by the CEO, chief financial officer, vice president of mission effectiveness, and management engineer. Division managers present their mission statements, a market analysis (including a SWOT analysis and definition of key customers), quality indicators, KRAs (which later become objectives), and budgets.

"The kangaroo court provides an opportunity for department managers to sit and talk personally with their CEO about what they want to do, and to get it funded," Dague said. Sr. Nancy Glynn, CBS, Bon Secours's vice president of mission effectiveness, added that the CEO's presence at these budget hearings is key because of the relationship that develops between the top administrator and department managers.

In the second year, the process was modified, with managers developing department-specific mission imple-

mentation plans that "bring values down to action steps and add a monitoring function," Sr. Glynn said. For example, to carry out the value of respect, the emergency room staff decided to introduce themselves to patients by name and to use the patients' names; weekly interviews with patients monitor whether this is being done.

In addition, Dague said, "we have stringent controls to be sure the business side doesn't get away from us." The divisions give monthly reports on budget and quality indicators to enable them to take corrective action, if needed, and to monitor and document improvement.

Department managers are evaluated each year on the completion of their objectives, as well as on management skills, abilities, and behaviors. "If a manager fails to attain at least 50 percent of his or her objectives at the target level," Dague said, "no increase will be granted." Still, he insisted, it is

not an arbitrary process: "People have a say in where they're going and what the funding is."

One vital ingredient to success is flexibility, so the process can be continually tailored to the needs of the organization, Dague emphasized. In the third year, for example, divisions began choosing "key customers"—defined as "the customer most affected by a process within your department or someone with whom you need to improve a process/relationship"—and "key quality characteristics"—a process outcome that is most important to the key customers, based on analysis of customer data. For example, the admissions department could choose patients as the key customer and waiting time as the key quality characteristic.

For employees to be able to admit to their supervisors and the CEO that they need improvement in such areas, Dague said, the environment needs to be open and nonjudgmental. "That way, they're not afraid to share their weaknesses and work together to improve them."

"The process builds community in mission because it enables managers to bring their information forward and get a hearing," Sr. Glynn added. It also breaks down barriers between departments, channels energies, and brings "a sense of excitement and of new beginnings," she said.

A RELIGIOUS INSTITUTE DECIDES TO CONTINUE ITS MISSION

SR. ROSE MAE RAUSCH, OSF
SR. BEATRICE EICHTEN, OSF
MITCHELL A. SELTZER

In the late 1980s members of the Franciscan Sisters of Little Falls, MN, began to ask whether the institute should continue its sponsorship of Franciscan Sisters Health Care, Inc., a multi-institutional system based in Little Falls.

"Many questioned whether we could continue the mission with fewer sisters," explained congregation President Sr. Rose Mae Rausch, OSF. "The sisters also worried that health-

JAMES O. DAGUE



care created a 'big business' emphasis that was not consistent with the Franciscan charism."

To decide whether the congregation should continue sponsorship, the congregation and system boards established a task force to initiate a "two-track" strategy to plan system activities and congregational activities with a bearing on healthcare, explained Sr. Beatrice Eichten, OSF, the system's president. The boards also decided to hire a consulting firm to help explore:

- Vision development
- The effect of a changing healthcare delivery system on sponsorship
- The institute's willingness to continue sponsorship
- The public image consequences of continuing involvement in corporate healthcare
- Appropriate mechanisms for holding healthcare facility boards accountable for articulating and carry-

The mission is a powerful source. People really want to do good. They stay with us because of the mission aspects of working in an inner-city hospital. The problem is the administration hasn't been focusing them on what they can do that ties in with the accomplishment of a greater role. Through this process we've been able to accomplish that.

ing out the congregation's mission

Seltzer Daley Companies, Princeton, NJ, were hired as consultants. Representatives of the firm met with a large number of the sisters to get a sense of the community's personality and then conducted one-hour interviews with 96 sisters. On the basis of these responses, the firm's president, Mitchell A. Seltzer, and his colleagues devised a process that allowed the institute to translate its values into concrete operational goals hospital managers and administrators could grasp and put into practice.

After a yearlong process of discernment, the Franciscan Sisters of Little Falls decided to remain in the healthcare ministry. In October 1991 the system and institute formally accepted a new vision statement committing the system to offer community-based, holistic care consistent with Franciscan values.



ASSEMBLY SESSIONS PROVIDED FOOD FOR THOUGHT.

BUSINESS MEETING

CHA MEMBERS MUST EMBARK ON AN "UNCHARTED COURSE"

JOHN E. CURLEY, JR.
SR. MARY ROCH ROCKLAGE, RSM

Calling the movement toward healthcare reform an "uncharted course," CHA President/CEO John E. Curley, Jr., encouraged members to embark on the journey despite the uncertainties.

"We're on a pathway no one has ever walked before," he told CHA's Board of Trustees and members at the Annual Business Meeting. But the fact that the course is uncharted need not be a deterrent, he said. "Your call is the course. As we share that call, we can't say no. We can't avoid the journey."

Despite some uncertainty about the future, CHA will continue to work toward its clear vision for 2000 and the following six goals: leadership

development; advocacy for Catholic values in healthcare; integrated sponsorship networks; a redesigned healthcare delivery system with universal access, equitable financing, and effective cost controls; furtherance of health, wellness, and well-being; and advocacy on public policy issues, such as tax exemption and Medicare payments.

Curley lauded the board and members for their courage in the face of uncertainties. "When times become frustrating and we look to the future and can't see exactly where we're going to end up, I ask you to do what you always have done: Continue with your support, encouragement, and engagement," he said.

Earlier in the business meeting, Sr. Mary Roch Rocklage, RSM, reported on the Membership Study Task Force, established as a result of CHA's visioning process, "CHA 2000," to determine how the association's membership should be structured. Since last March the task force has been consulting with the full membership, explained Sr. Rocklage, who

is chairperson of the group. After receiving additional input at CHA's fall regional meetings, she said, the task force will formulate recommendations for membership models and present them at the 1993 assembly.

TRUSTEES ELECTED

At the Annual Business Meeting seven new members were added to the CHA Board of Trustees and officers were installed. As incoming chairperson, Ronald R. Aldrich spoke of CHA's healthcare proposal as a "wake-up call" (see article on p. 12).

For a complete list of the 1992-93 board, see pp. 62-63. In addition, newly elected to the CHA Nominating Committee were Sr. Helen Marie Burns, RSM, St. Joseph Convent, Marion, IA; Otto L. Cox, president, St. Elizabeth Hospital, Appleton, WI; and Sr. Barbara Haase, CSJP, administrator, Sacred Heart General Hospital, Eugene, OR.

CHA HONORS

ACHIEVEMENT CITATIONS RECOGNIZE PROGRAMS TO IMPROVE ACCESS

CHA awarded Achievement Citations to three programs designed to improve access to care for the healthcare poor.

The Clark Street House of Mercy, Des Moines, provides resi-

dential and support services for needy mothers.

Begun in 1988, the House of Mercy's current services include an after-care alcohol and drug rehabilitation program for mothers who have completed an inpatient substance abuse program; an adult transitional living program for homeless mothers; a comprehensive teen pregnancy and parenting program; an on-site, state-licensed child development center; and a free medical clinic for uninsured and underinsured residents of Des Moines's inner city.

The four Sisters of Charity of

Leavenworth Health Services Corporation (SCL/HSC) Clinics for the Uninsured serve persons who do not have Medicaid, Medicare, or any other kind of health insurance.

Saint Vincent Clinic, Leavenworth County, KS—the first of SCL/HSC's "Clinics in the Cracks"—has had more than 13,000 patient visits since it began operation in 1986. Marillac Clinic in Mesa County, CO, has reported nearly 12,000 patient visits since it opened less than four years ago, and Marian Clinic in Topeka, KS, has had more than 15,000 patient visits over the same period.

The newest facility, Duchesne Clinic, is in Wyandotte County, the poorest county in Kansas. The clinic serves homeless persons from Kansas City, KS, at two area shelters and a food kitchen.

The mission of **Catholic Charities Physician Referral Service (CCPRS), Rolling Meadows, IL**, is to provide Medicaid clients access to healthcare and to distribute these clients equitably among participating volunteer physicians. A collaborative project of Alexian Brothers Health System and Alexian Brothers Medical Center, Elk Grove Village, IL, and Catholic Charities of the Archdiocese of Chicago, CCPRS has helped more than 2,000 persons find physicians since the program began in October 1990.

The service is limited to Medicaid clients from specific Chicago-area suburbs. In CCPRS's first year the number of participating physicians grew from 116 to 330. Fourteen hospitals are part of the program as well.

FIFTY-SIX HOSPITALS REACH CHA MEMBERSHIP MILESTONES

Fifty-six hospitals celebrated 75, 50, or 25 years of membership with CHA.

The following 50 hospitals marked 75 years' membership: **St. Mary's Hospital and Health Center**, Tucson, AZ; **St. Bernard's Regional Medical Center**, Jonesboro, AR; **St. John's Regional Medical Center**, Oxnard, CA; **Mercy General Hospital**, Sacramento, CA; **St. Mary's Hospital and Medical Center**, San Francisco; **Saint Joseph Hospital**, Denver; **St. Mary-Corwin Regional Medical & Health Center**, Pueblo, CO; **Saint Francis Hospital and Medical Center**, Hartford, CT; **St. Mary's Hospital**, Waterbury, CT; **Saint Joseph's Hospital**, Savannah, GA; **Saint Alphonsus Regional Medical Center**, Boise, ID; **Saint Joseph Hospital and Health Care Cen-**



A PHOTO EXHIBIT SHOWED THE CATHOLIC HEALTHCARE MINISTRY'S IMPACT ON PERSONS' LIVES.

ter, Chicago; **St. Mary's Hospital**, Kankakee, IL; **Saint Anthony Medical Center**, Rockford, IL; **Saint Anthony Hospital and Health Centers**, Michigan City, IN; **Saint Joseph's Medical Center**, South Bend, IN; **Samaritan Health System, Inc.**, Clinton, IA; **Mercy Hospital**, Council Bluffs, IA; **Mercy Hospital**, Fort Scott, KS; **Central Kansas Medical Center**, Great Bend, KS; **Saint Joseph Hospital**, Lexington, KY; **Saint Joseph Hospital**, Baltimore; **St. Elizabeth Hospital**, Wabasha, MN; **Saint Francis Medical Center**, Cape Girardeau, MO; **St. John's Regional Medical Center**, Joplin, MO; **St. Anthony's Medical Center**, St. Louis; **SSM Rehabilitation Institute**, St. Louis; **St. James Community Hospital, Inc.**, Butte, MT; **Saint James Hospital of Newark**, Newark, NJ; **St. Joseph's Hospital and Medical Center**, Paterson, NJ; **Calvary Hospital, Inc.**, Bronx, NY; **St. Mary's Hospital of Brooklyn**, Brooklyn, NY; **Benedictine Hospital**, Kingston, NY; **Good Samaritan Hospital**, Suffern, NY; **Mercy Hospital, Inc.**, Charlotte, NC; **St. Joseph's Hospital and Health Center**, Dickinson, ND; **St. Elizabeth Medical Center**, Dayton, OH; **St. Anthony Hospital**, Oklahoma City; **Holy Rosary Medical Center**, Ontario, OR; **Saint Agnes Medical**

Center, Philadelphia; **Saint Joseph Hospital**, Reading, PA; **Bon Secours-St. Francis Xavier Hospital**, Charleston, SC; **Saint Thomas Hospital**, Nashville; **Fanny Allen Hospital**, Colchester, VT; **Providence Hospital**, Centralia, WA; **Providence Hospital**, Everett, WA; **St. Joseph Hospital and Health Care Center**, Tacoma, WA; **Saint Mary's Hospital, Inc.**, Rhinelander, WI; **St. Nicholas Hospital**, Sheboygan, WI; and **Sacred Heart Hospital**, Tomahawk, WI.

Four hospitals celebrated 50 years of CHA membership: **St. Elizabeth Community Hospital**, Red Bluff, CA; **Saint Mary's Hospital of Athens, Inc.**, Athens, GA; **Bon Secours Hospital**, Grosse Pointe, MI; and **St. Clare Hospital**, Monroe, WI.

Two hospitals celebrated 25 years as CHA members: **Holy Spirit Hospital**, Camp Hill, PA; and **St. Joseph Hospital**, North Providence, RI.



MEMBERS PONDER THE COURSE AHEAD.

CHA BOARD OF TRUSTEES

PICTURED HERE ARE THE MEMBERS OF THE CHA BOARD OF TRUSTEES FOR 1992-93, INCLUDING THE NEW MEMBERS INSTALLED AT THE ANNUAL BUSINESS MEETING, JUNE 16. THE NEW MEMBERS' NAMES ARE MARKED WITH AN ASTERISK.



CHAIRPERSON—
RONALD R. ALDRICH

President/Chief Executive Officer, Franciscan Health System, Aston, PA



VICE CHAIRPERSON—
SR. MARYANNA COYLE, SC

President, Sisters of Charity of Cincinnati, Mount St. Joseph, OH



SECRETARY-TREASURER—
JUDITH C. PELHAM

President/Chief Executive Officer, Daughters of Charity Health Services of Austin, Austin, TX



SPEAKER, MEMBERSHIP ASSEMBLY—
WILLIAM E. KESSLER

President/Chief Executive Officer, Saint Anthony's Health Center, Alton, IL



PRESIDENT/CEO—
JOHN E. CURLEY, JR.

President/Chief Executive Officer, Catholic Health Association, St. Louis



SR. HELEN AMOS, RSM

President/Chief Executive Officer, Mercy Medical Center, Baltimore.



*SR. MARY LUANN BENDER, SND

Administrator, St. Charles Care Center and Village, Covington, KY



RONALD G. BLANKENBAKER, MD

President, Ron Blankenbaker, M.D. & Associates, Inc., Indianapolis



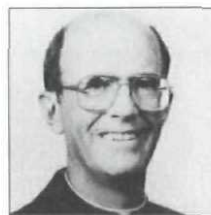
SR. MARY CANAVAN, SC

General Superior, Sisters of Charity of St. Elizabeth, Convent Station, NJ



*SR. MAUREEN COMER, OP

Administrator, Providence Hospital, Centralia, WA



BP. JOSEPH P. DELANEY, DD

Bishop, Diocese of Fort Worth, Fort Worth, TX



SR. NORMA JANSSEN, OSF

Chairperson, Board of Directors, Franciscan Sisters Health Care Corporation, Mokena, IL



*ABP. JOHN L. MAY, DD
Archbishop, Archdiocese of St. Louis, St. Louis



SR. RUTH MARIE NICKERSON, CSC
President/Chief Executive Officer, Saint Agnes
Medical Center, Fresno, CA



SR. KATHLEEN QUINN, PHJC
Chairperson, Ancilla Systems, Inc., Hobart, IN



DANIEL F. RUSSELL
President/Chief Executive Officer, Eastern
Mercy Health System, Radnor, PA



SR. MARY JEAN RYAN, FSM
President/Chief Executive Officer, SSM Health
Care System, St. Louis



JOHNSON L. SMITH, JR.
Administrator, Conway County Hospital,
Morrilton, AR



*EUGENE J. SULLIVAN
Chairman Emeritus, Borden, Inc., New York
City



SR. PATRICIA CLARE SULLIVAN, RSM
President/Chief Executive Officer, Mercy
Health Center of Central Iowa, Des Moines



CHARLES E. THOELE
Consultant, Sisters of Mercy Health System, St.
Louis



*SR. PATRICIA A. UNDERHILL, SC
President/Chief Executive Officer, Mercy
Health System, Cincinnati



*DAVID J. WARD
Senior Vice President/Operations, Long Term
Care and Geriatrics, Catholic Health Corpora-
tion, Omaha



*CHARLES E. WINDSOR
President/Chief Executive Officer, St. Mary's
Hospital, East St. Louis, IL



DANIEL J. WOLTERMAN
President/Chief Executive Officer, Holy Cross
Health Services of Utah, Salt Lake City

