

Rural Partnership Improves Access to Care



INTEGRATED
DELIVERY
NETWORKS

Despite growing incentives to form partnerships, healthcare providers must still overcome significant obstacles before they can work together effectively. These difficulties can be particularly acute in markets where few collaborative arrangements exist. Providers in such areas have little evidence of what partnerships can

accomplish, nor have they seen first-hand what creating a partnership entails.

ACCESS TO APPROPRIATE CARE

Coordinators of the Northern New York Rural Health Care Alliance, Watertown, NY, realized from the beginning that the alliance would have to be inclusive if it were to achieve its goal of improving access for residents of its three-county upstate service area. According to Chandler Ralph, chief executive officer of Mercy Center for Health Services, Watertown—the only Catholic member of the alliance—the key factor driving the formation of the alliance was providers' realization that many people were not getting the proper care in the proper setting.

"Getting people to the right source of care is always a challenge in a rural area," Ralph says. "For us, it has been partially a transportation problem and partially a result of poor communication between the agencies in our area. But it has been primarily the result of not planning and working together so that we can identify which needed community services are lacking. These are all issues the alliance is addressing."

BROAD REPRESENTATION

Efforts to form the alliance began in January 1992, and the organization was incorporated this past December. In addition to three hospitals,



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alliance members include Mercy (which offers nursing home, diagnostic and treatment, renal dialysis, home health, and other services), three other diagnostic and treatment centers, and representatives of area consumer groups, medical societies, and public health services. A total of 15 members make up the group.

"It was critical that we have this many members because it ensured that everyone with a stake in the success of the alliance has a seat at the table," Ralph says. "But it also meant that we had 15 different interests coming together, and that meant we had to cope with considerable territorial disputes and cultural differences."

OPEN COMMUNICATIONS

One obstacle to the alliance's formation has been a reluctance to share information. "The system we live with today encourages secrecy," Ralph says. "If we want to work together, we'll have to find ways to break out of that."

Such fears have slowed down the planning process for the alliance, Ralph notes. For example, some members, including Mercy, argued that members ought to collaborate to perform a needs assessment and develop a strategic plan for healthcare services. But others have resisted. To get out of this impasse, Mercy voluntarily shared its own strategic plan with the group.

Ralph explains that Mercy's gesture was important for a number of reasons, not the least of which that it increased trust among alliance members. "Sharing the plan underscored our commitment to the alliance's larger goals," she says. She adds that, without such communication, the alliance will face significant practical problems achieving its goals.

"If another agency had an objection to something we planned to do, we wanted that identified. Then we would have a number of possibilities open. We could work with that agency collaboratively to accomplish the same thing, decide that the agency already has the service adequately covered, or go ahead with our plans because we

feel that the service isn't adequately covered by anyone. We can't coordinate services if we don't talk about what we're doing."

MEDICAID MANAGED CARE

One of the alliance's goals for 1994 is to be the Medicaid managed care provider for the Watertown area. In 1992 New York State began requiring Medicaid managed care offerings in every county, with the alliance's service area being targeted for 1994. Managed care arrangements have been slow to develop in New York State, particularly in rural areas, Ralph says, and there is still no managed care agency in the county served by Mercy Center.

The alliance is waiting for the state to determine how it will handle reimbursement, with options ranging from total capitation to some mixture of capitation and fee-for-service. Once the department of social services determines its compensation arrangements, the alliance will do a pro forma to decide whether to proceed with its plans. The organization has recently hired an executive, which will facilitate its plans to move forward, Ralph says.

Although the alliance may in the future consider offering managed care to other populations, Ralph believes that its goals for the near term will remain more limited. "Quite a few of the agencies involved serve the poor," she explains, "and so concentrating on Medicaid managed care will

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Ralph says.

be more consistent with our mission."

She also anticipates that the alliance will limit itself to healthcare delivery. "I'm not sure we are prepared to be an insurance company. In my opinion, we should be in the business of providing care to patients, and not of working out actuarial tables and calculating risk. If the need arises, we can look for a linkage to an experienced insurer, but we should be spending *our* energies on patient care and cost control."

UNITY AND COORDINATION

Ralph sees several key advantages to forming the alliance. One is that it gives the parties involved a unified voice in dealing with state regulatory agencies. "This is extremely difficult in New York State," she notes. "But we've worked really well with the Office of Rural Affairs in looking at how pieces of the reimbursement system need to change to facilitate access to healthcare in rural areas."

She also sees significant potential benefit in the opportunity to work closely with other providers. "If we jointly plan where we're going, we can save tremendous amounts of money and really enhance services to the community."

FUTURE CHALLENGES

Important challenges remain, Ralph acknowledges. Perhaps the most significant problem is

Continued on page 25

RECENT INTEGRATED DELIVERY ACTIVITIES

This listing of recent integrated delivery activities updates a list published in the December 1993 issue (pp. 54-55).

Please keep us informed as you begin to integrate with other providers. Call or send your press releases or notices to *Health Progress*, 4455 Woodson Road, St. Louis, MO 63134. We will continue to update our listings in upcoming issues.

CHICAGO-AREA INTEGRATED DELIVERY NETWORK

Mercy Center for Health Care Services, Aurora, IL; Alexian Brothers Medical Center, Elk Grove Village, IL; Columbus Hospital, Chicago; Holy Cross Hospital, Chicago; Little Company of Mary Hospital and Health Care Centers, Evergreen Park, IL; Loyola University

Medical Center, Maywood, IL; Mercy Hospital and Medical Center, Chicago; Our Lady of Resurrection Medical Center, Chicago; St. Bernard Hospital, Chicago; St. Cabrini Hospital, Chicago; St. Elizabeth's Hospital, Chicago; St. Francis Hospital and Health Center, Blue Island, IL; St. Francis Hospital, Evanston, IL; St. James Hospital and Health Centers, Chicago Heights, IL; St. Joseph Hospital and Health Care Center, Chicago; St. Therese Medical Center, Waukegan, IL

Hospital representatives have formed a task force to study a consultant's recommendation that could lead to a 6,000-bed network of Catholic hospitals in Illinois' Cook and Lake counties.

CLEVELAND-AREA HOSPITAL COLLABORATION

St. Vincent Charity Hospital, Cleveland, OH; St. Alexis Hospital Medical Center, Cleveland, OH; Marymount Hospital, Garfield Heights, OH

Hospitals are discussing possible collaborative arrangements to strengthen the presence of Catholic healthcare in the Cleveland area.

FLORIDA-NEW YORK PROVIDER AFFILIATION

St. Mary's Hospital, West Palm Beach, FL; Mount Sinai Hospital, New York City

Mount Sinai will provide clinical specialty consultations to St. Mary's medical staff and offer St. Mary's patients treatments not available locally. St. Mary's staff will offer care to Mount Sinai patients who visit or live part-time in Florida.

that some alliance members have not truly bought into the process. "Some are still stuck in the Lone Ranger syndrome, thinking they can do better by going it alone. They participate, but they really haven't embraced the concept of collaboration."

She also cautions that alliance members may believe that membership in the organization could exclude them from entering into other collaborative arrangements. "With healthcare reform on the horizon," Ralph emphasizes, "it's absolutely critical that we be flexible. Whatever challenge presents itself, we need to be able to structure an answer to it, and the alliance may not always be the answer." She noted, for example, that if a health maintenance organization indicated it was interested only in primary care, she would consider contacting other diagnostic and treatment centers both inside and outside the alliance to suggest formation of a primary care network.

FORUM FOR CATHOLIC HEALTHCARE

Despite the obstacles, Ralph believes the experience of forging partnerships with other providers and agencies has built momentum in the community for an effective, coordinated healthcare delivery system. Participation in the alliance has also enabled Mercy to share with others its own goals and aspirations.

"It has been exciting to sit down at the table with institutions and agencies we've never had contact with before," Ralph says. "The alliance has been a wonderful forum for showing non-Catholic providers in the community what the Catholic healing mission is really about, that it is defined much more broadly than in terms of reproductive rights. The discussions have been a real learning experience for everyone involved."

—Phil Rheinecker

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• Prudential judgment

Toleration of Evil The principle of toleration speaks of detachment, of permitting something evil to happen, if not actively opposing it. Augustine tolerated prostitution in the city of Hippo even though he had the power to stop it, Schindler noted, because stopping it would have prevented him from accomplishing other things. Augustine's decision shows that "when you have goods and bads tied together, you have no nice, easy, pure way out," Schindler said. In some situations, it is possible to tolerate evil because in stopping it, other greater goods would be lost.

Material Cooperation The principle of material cooperation goes one step beyond toleration of evil and deals with situations in which one is somehow involved in the evil. Schindler explained that, according to the principle of material cooperation, just the fact that one is actually involved in an evil activity does not in and of itself rule the activity out as a possibility. The activity is judged according to the degree of evil and the actor's proximity to the act. The greater the evil, the greater the distance one must have. Within the Catholic tradition, acts like abortion and direct sterilization are not judged to be on the same level, he said. Abortion is understood to be a greater evil.

Another important aspect of the principle is weighing the good to be achieved and the evils that will likewise come about. Schindler explained that "the lesser the evil and the more the good to be achieved, the closer we can

be to it [the act]. Conversely, the greater the evil and the less the good to be achieved by it, the greater the distance has to be." The principle recognizes that in the face of evil we do not automatically walk away. The principle allows us to work through whether we can cooperate in some way as long as we maintain some distance, Schindler said.

Prudential Judgment A third methodology of looking at situations was enunciated by the U.S. bishops in their 1986 pastoral letter on the economy, in which they stated, "We are aware that the movement from principle to policy is complex and difficult and that although moral values are essential in determining public policies, they do not dictate specific solutions. They must interact with empirical data, with historical, social, and political realities, and with competing demands on limited resources." The pastoral shows that once a value has been established, the policy which upholds that value must take into account the entire concrete situation, Schindler explained. "It is in the social justice realm [see **Box**, p. 16] that the complexities of situations we're dealing with become apparent," Schindler said.

He said the Church has a history of "openness to human reason," and the Catholic tradition does not suggest that a specific answer is absolutely apparent and rule out any further consideration. Catholic healthcare organizations should be in dialogue with the bishops as they deal with complex situations, Schindler advised.

—Judy Cassidy