MEETING MISSION CHALLENGES IN IDNS

Through Integrated Delivery Networks, Organizations Can Continue Their Ministry and Extend Its Reach

BY SR. TERESA STANLEY, CCVI, PhD

Sr. Stanley is senior associate for mission, Division of Theology, Mission, and Ethics, Catholic Health Association, St. Louis.

A likely outcome of national healthcare reform is that providers will be linked in networks that offer a continuum of services. The Catholic Health Association (CHA), the Washington Business Group on Health, and the American Hospital Association, among others, have advocated such networks as integral elements of their proposals for reform of the U.S. healthcare system.

INTEGRATED DELIVERY NETWORKS

In CHA's plan, care is delivered through integrated delivery networks (IDNs), sets of providers offering a coordinated, client-centered continuum of care designed to improve the health of the people enrolled in specific geographic markets while containing costs. Rather than competing with other IDNs on price, CHA believes IDNs should compete on the basis of quality and service provided to the community.

Whatever the final shape of healthcare reform, providers and sponsors are already collaborating with each other in various network arrangements (see **Box**, p. 31). Sponsors, systems, and organizations are grappling with many questions:

- Are we more concerned with survival and economics than with being a prophetic witness?
- What incentives drive us?
- Do we have a role in continuing healthcare in the community, or can others meet the need more effectively?
- In a reformed system where all the poor have healthcare coverage, how will we live out our preferential option for the poor?
- Are we willing to let go of our hospital-oriented services for a greater good?

Summary Whatever the final shape of healthcare reform, providers and sponsors are already collaborating with each other in various network arrangements. As they pursue these arrangements, they are asking questions about their role in a reformed system and whether the networks they participate in will strengthen their mission and ministry.

Documents published about five years ago by the Catholic Health Association (CHA) and the Commission on Catholic Health Care Ministry provided the rationale for CHA's proposal to form integrated delivery networks (IDNs) as part of a national healthcare reform plan. The documents called for a continuum of care with comprehensive community- and institution-based services and challenged Catholic healthcare leaders to work for a healthcare system that guarantees access to the needy and most vulnerable in society.

The central task for administrators today is to determine whether participating in an IDN enables Catholic healthcare providers to fulfill their original mission and purpose. To determine this, organizations must clarify their mission and evaluate their beliefs. They must also develop a shared vision of motives and goals among everyone with whom they collaborate.

IDNs' success in furthering the healthcare ministry will depend on leaders' ability to ensure that new corporate cultures which arise in cooperative ventures and arrangements support Catholic values and mission. In making the transition to a new environment, leaders should remember that aspects of IDNs support many of the goals of the Catholic healthcare ministry.

• Are we willing to continue the healing ministry with less control?

• What criteria should we use for selecting partners?

• What moral criteria will we use to evaluate our role in managed care?

• How will the role of Catholic multi-institutional systems change?

• Will participating in IDNs diffuse or enhance our mission?

Mark Fisher

• Are IDNs a threat, or do they offer an unparalleled opportunity to strengthen the mission and ministry?

To assist in answering these questions, CHA has developed a handbook to initiate planning and developing an IDN (see p. 46).

Early Visions of the IDN Concept

Two documents published about five years ago help answer questions of providers and sponsors. CHA's 1988 document *A Time to Be Old, a Time to Flourish: The Special Needs of the Elderly-at-Risk* planted some of the concepts. It called for a continuum of care characterized by comprehensive community- and institution-based services. The document advocated a client-centered approach that uses care management to meet both short- and long-term needs. It depicted a continuum provided through a network of healthcare providers and community organizations and stressed that meeting the frail elderly's holistic needs is a mission for Catholic healthcare sponsors and organizations and for the Church as a whole.

Another 1988 document provides insights for discerning and refocusing the mission of Catholic healthcare today. *Catholic Health Care Ministry: A New Vision for a New Century*, a report of the Commission on Catholic Health Care Ministry (a panel that included bishops, clergy, religious, and lay leaders), focused on creative new ways to meet "unprecedented challenges" to the future of the Catholic healthcare ministry in the United States.

Vision for a Range of Services

As did *A Time to Be Old, a Time to Flourish*, the commission's report called for "a range of health-related services responsive to the needs of people." The commission predicted that the future ministry would be community based. Although the number of institutions would be smaller, ministry would involve providing a wide range of programs to meet the needs of society, especially of neglected groups.

The commission noted that special sensitivity will be required for Catholic organizations entering into agreements with those who do not acknowledge the Church's authority or accept Church teaching, but the agreements will provide opportunities to witness to Catholic principles.

The report called on leaders in Catholic healthcare to "keep the needs of the poor before the public and to transform the system of access and financing in favor of the needy and most vulnerable in society." According to the report, the system "will include broader coverage by an expanded and integrated network of private and public insurance." The commission urged Catholic providers to work with churches and civic groups to demonstrate new approaches to meeting the needs of the most marginalized.

The report further stated: "A variety of alliances, affiliations, mergers, joint ventures, shared sponsorship, and other cooperative arrangements among Catholic institutions and agencies will make it possible to continue the ministry and extend its reach into areas of new need."

New Approaches, Historical Mission

The two documents echo the principles underlying the mission on which the founders of

Catholic healthcare organizations based their ministry. Throughout history, religious congregations pursued healthcare as a means of meeting human needs. Their mission, grounded in the desire to carry on the healing tradition of Jesus Christ, was to care for people from all levels of society in a local community. For example, the call of the Sisters of Charity of the Incarnate Word was: "Our Lord Jesus Christ suffering in the person of the sick and infirm of every kind seeks relief at your hands."

Participating in an IDN requires a dramatic shift in thinking and attitude.

Rearticulating the Mission

The central task at hand for administrators today is to determine whether leading the development of or participating in an IDN enables Catholic healthcare providers to fulfill their original purpose and mission in the community they serve. The first step in making this determination is for the healthcare organization to clarify its purpose and mission by answering questions such as the following:

- Why was the organization founded?
- What purposes should the organization serve in today's healthcare environment? Are these purposes similar to those which guided the organization in earlier times? Should the organization rearticulate or reaffirm its mission statement?

The organization should also evaluate its beliefs. Beliefs, which are statements of faith rooted in an organization's history and traditions, express convictions about any number of aspects of healthcare, such as the value of the human person, one's responsibility to society or the environment, the purpose of life, ecumenism, cultural diversity, and relationship with God.

The organization should ask itself questions such as the following:

- What beliefs were important to the organization's founders? If they were alive today, what beliefs would they encourage us to hold on to as we determine the organization's role in meeting the community's healthcare needs?
- What beliefs should the organization articulate or clarify at this point in its history?
- What do people in the organization value most? What belief statements would help staff to be committed to the organization in a time of transition?

The organization should also assess the values it espouses: professional values, which are concerned with quality; economic values, which relate to stewardship of resources; and human/religious values, which are concerned with the organization's style of caring and sense of meaning of life. Every Catholic healthcare organization's mission encompasses all these values, but the primary focus should be on human/religious, spiritual values. CHA's 1991 document *Mission Integration: A Guide to Assessment* can help organizations evaluate how effectively they have lived up to their stated values.

Developing a Shared Vision

Once the organization has reevaluated its mission and concluded that participation in an integrated delivery system is compatible with its mission, then it must develop a shared vision among everyone involved, both within and outside the organization. A community needs assessment, such as CHA's *Social Accountability Budget* process, can be the basis for the vision. This vision is especially important today because participating in an IDN requires a dramatic shift in thinking and attitude and involves rapid change on the part of sponsors, chief executive officers, trustees, staff, physicians and other providers, as well as businesses and the public.

The vision helps focus people on the larger picture, motivate them, and make explicit what the organization wants to achieve with the support and effort of all involved. It helps people move beyond self-interest and evaluate plans against what they want healthcare to be.

To achieve a shared vision, discussions can center around questions such as the following:

- Given our stated mission and values, what do we want to create?
- What factors characterize a "healthy community"?
- What will a healthy community look like in five years?

Once the organization has a common vision,

the task is to translate the vision into reality, into structures that address complex situations, such as who will provide what services or which organizations will need to close or merge.

Leaders to Guide the Future

It is essential that the organization's leaders share the vision and understand the mission as the driving force for all integrated delivery endeavors. IDN participation will require change in the organization's culture, and the leader, more than ever before, must ensure that the corporate culture adapts to and supports the organization's basic values and continues its mission.

This task becomes more complicated when two separate organizations collaborate equally to provide services, as did Santa Rosa Health Care and Southwest Texas Methodist Hospital (see **Box**). In such cases, a new culture in which the parties have agreed on common values must emerge. For example, if Santa Rosa and Methodist build a new facility, leaders will be challenged to ensure that the joint culture supports Catholic values, although the entity would not be wholly Catholic.

Peter Senge contends that the leader must be a designer who develops the organization's overall shape (*The Fifth Discipline: The Art and Practice of Creating Learning Organizations*, Doubleday, New York City, 1990). The leader must craft strategies, constantly checking for alignment between mission and values and operational activities and asking, What structures and systems must we design to be true to our mission and values?

In a time of transition, a leader must design a bridge from the current system to the new one so that change is accomplished with the least disruption. This involves identifying barriers to achieving the vision and designing processes to overcome them.

In this role, the leader is responsible for being a teacher, helping people understand the changes that achieving the shared vision requires. Downsizing, closures, and the blurring of identity in mergers and partnerships may cause pain and sacrifice for staff at all levels. It is critical for the leader, who models the organization's human/religious values, to educate and involve all persons in the organization during the transition to help them overcome resistance, denial, stress, and fear.

The Commission on Catholic Health Care Ministry provides a helpful description of leaders as persons who have the ability to:

- Involve and enable employees at all levels to be contributing members of the ministry
- Recognize that justice in employment conditions is basic to a unified and purposeful staff
- Acknowledge individual contributions
- Involve people in decisions about their work situations

The commission also called for "qualified and prepared spiritual leaders who would animate the ministry from within and ensure its continuity and fidelity to the mission." In referring to "spiritual leaders," the commission seems to be speaking of the inner transformation required of leaders. Through reflection and self-evaluation, leaders can discover their core values and develop the inner strength that fosters trust in those they guide.

Continued on page 40

COLLABORATIVE ARRANGEMENTS PROLIFERATE

Catholic healthcare organizations and sponsors are forming affiliations with Catholic and non-Catholic entities. The following are some examples:

- In San Antonio, Santa Rosa Health Care affiliated with Southwest Texas Methodist Hospital in May 1993 to form Children's Regional Health Care System. This new not-for-profit corporation will operate the services currently provided at Santa Rosa Children's Hospital and the pediatric services of the Methodist hospital. The new corporation will immediately expand and improve local pediatric health services by bringing basic healthcare to inner-city areas where people do not have access to adequate primary care.
- In Sacramento, CA, Methodist Hospital affiliated in April 1993 with Mercy Healthcare Sacramento, a five-hospital division of Catholic Healthcare West, San Francisco. Methodist Hospital will retain its name and continue to operate as a community-sponsored hospital.
- In St. Louis, the sponsors of the city's 12 Catholic hospitals (Sisters of Mercy, Daughters of Charity, Franciscan Sisters of Mary, Alexian Brothers, Sisters of St. Joseph of Carondelet, Sisters of Charity of the Incarnate Word, a private association of the Christian faithful, and St. Louis University) completed a community needs assessment in 1990 and have funded three joint projects. The group continues to explore additional ways to work toward integrated delivery.
- In Omaha, Bergan Mercy Medical Center formed Community Health Vision (CHV) in January 1992 with Immanuel Medical Center. The purpose of CHV, a jointly owned not-for-profit corporation, is to improve the community's health status by coordinating delivery of care and expanding access through a care network. CHV's initiatives include two neighborhood health centers and strategic planning alliances with Project Hope (which provides mobile medical services to the homeless) and the Indian-Chicano Health Center (which serves uninsured and underinsured clients). Also planned is Lakeside HealthPark, which will contain health education, fitness, and child care centers; outpatient surgery; and urgent and rehabilitation services.