

HEALTHCARE REFORM

Catholic Providers Will Play a Central Role in Healthcare Reform

Hillary Rodham Clinton

The Catholic Health Association and its members will be at the forefront of the Clinton administration's healthcare reform efforts, Hillary Rodham Clinton predicted in the assembly's concluding session. "I think you already know better than perhaps some of the for-profit organizations how to put caring and service at the center of the healthcare system," she told the audience.

Speaking via satellite from Washington, DC, the first lady said she found it amazing that CHA's healthcare reform proposal has reached many of the same conclusions and recommendations as the White House task force on healthcare reform, which

she headed. "Your proposal is right in line with what we're thinking," Clinton told the audience. "Your role will be very much like what is outlined in CHA's reform proposal."

CHA's healthcare reform proposal calls for the creation of a unique public-private partnership to provide affordable, high-quality healthcare services to everyone in the United States. The proposal eliminates adverse incentives in the delivery system, complex bureaucracy, and system accessibility. Moreover, it provides strong incentives to providers to improve both the quality and cost efficiency of their services.

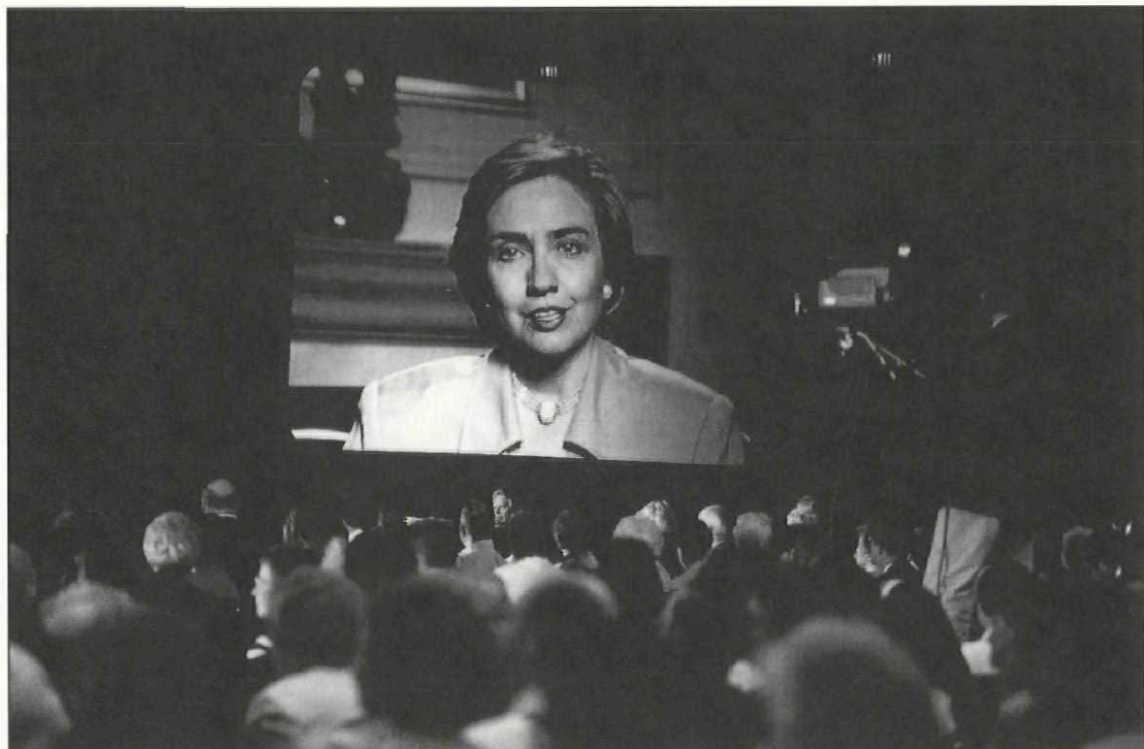
At the heart of CHA's plan is the integrated delivery network (IDN), a set of providers organized to offer a coordinated, comprehensive continuum of services. These networks receive risk-adjusted, capitated payments and are held accountable for improving or maintaining the health status of their enrolled populations. An important part of the vision is a national global budget administered through risk-adjusted capitated payments.

"I think the opportunities for not-for-profit, tax-exempt hospitals and their affiliated organizations should only increase in the years to come," Clinton predicted.

She said the president is moving

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—Clinton



Photos by George Long

toward final policy decisions regarding his administration's healthcare plan. First, the plan will call for universal access as soon as possible. "Security is what the healthcare debate is all about," she said.

When the reform plan is up and running, "every American will have a health security card that will guarantee all Americans access to a comprehensive package of benefits," Clinton said.

Cost control is a second fundamental goal of the reform plan. "We must strip away the incentives that reward doctors for doing more tests and procedures and encourage cost-effective, high-quality care . . . so decisions are not based on how something will be reimbursed, but on what a doctor thinks is best for the patient."

Other components of cost control she mentioned are to reduce bureaucracy and micromanagement, require healthcare institutions and providers to live within a budget, require drug companies to lower their prices, and require employers to cover their workers.

A third goal is a wholesale reduction in the paperwork that eats up healthcare dollars and time, she said. "Instead of a system where forms enforce the rules, we have a system ruled by the forms," Clinton observed. The new system would have one insurance form for everybody.

The fourth fundamental goal is to improve long-term care coverage for the elderly and disabled by expanding home and community-based care and improving coordination of services, the first lady said. She noted that during a visit earlier this year to Saint Agnes Hospital, Philadelphia, she learned the hospital could not get reimbursement for adult day care. So families who cannot afford the \$35-a-day fee are forced to put their elderly loved ones into nursing homes.

"The system is complex and disjointed, and it fragments the care people receive," she said. "If the long-term care system is left unchanged, all that will only get worse."

The final goal Clinton outlined is to improve the availability of healthcare in underserved areas such as rural communities and urban centers by targeting funds for these areas, strengthening their healthcare infrastructure, and providing incentives for doctors to practice there.

Clinton said she was especially proud that CHA had awarded an Achievement Citation to St. Elizabeth Health Care Center, Gould, AR, which serves a community that other providers had abandoned (see p. 67). Because of an enduring mission of advocacy for the poor, the center provides family-oriented preventive and curative healthcare services on a sliding scale for persons of all ages.

"The president's plan will bolster efforts such as these," she said, "and strengthen the healthcare infrastructure by linking

community-based centers to hospitals and other providers." But "achieving reform is not going to be easy," Clinton predicted. Many groups profit from the existing system, she pointed out, and will fight these changes.

"I hope that many of you and those you know and serve will be part of this effort to reform our healthcare system because you know what's at stake," she said. "We do not have the choice to stand still and accept the status quo."

Fight the "Prophets of Doom"

Sen. John D. Rockefeller IV

Fight the "prophets of doom" in Congress who want to preserve the status quo, Sen. John D. Rockefeller IV, D-WV, implored CHA members. Pledging his own support for President Clinton's healthcare reform plan, Rockefeller said: "Don't let the advocates for the status quo seize control" of the reform debate.

"Help us make reform a reality," he appealed to assembly-goers via videoconference. The senator decried politicians who are causing reform efforts to experience "death by delay." Such tactics only alienate people from Congress, he said.

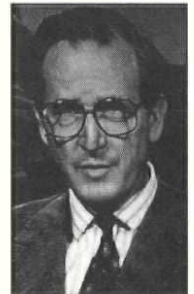
Rockefeller urged CHA members to inform the American public about the issues surrounding healthcare reform and enlist them in making the "prophets of doom" accountable. Although the Clinton plan has not been finalized, he said the White House task force on health reform has done its job honestly.

He characterized the Clinton plan as "competition under a budget. It proposes a marriage of free-market dynamics and regulatory discipline." The plan will be privately run and largely privately financed. The new system will cost more, but over time will squeeze out waste and abuse.

It will be free of bureaucratic tangles, he said. "I think we will be able to put the costs and sacrifices in perspective with what will be gained."

Two groups that will oppose the plan, predicted Rockefeller, are the insurance and small business lobbies. "The insurance industry is going to be reshaped, reformed, and diminished" in the new system, he said. "The small business people think it will cause them to go out of business. They are not going to look at the plan kindly."

He called for CHA to take the lead in



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—Rockefeller

organizing a core group of bipartisan supporters of the Clinton proposal. "It has to be an intense and ferocious group," he said. "The American public has to understand the cost of doing nothing." By the year 2000, the healthcare budget will grow to \$2 trillion, and 20 percent of American incomes will go to healthcare, he said. "Our economy will never regain its strength if these costs continue."

Keeping the Debate in Focus

Uwe E. Reinhardt, PhD

President Clinton's budget problems have stalled the momentum of the healthcare reform movement, Princeton University political economist Uwe E. Reinhardt told assembly-goers. He warned that the delay has given special interests an opportunity to change the terms of the debate and urged Catholic healthcare providers to speak out on the importance of universal access.

The United States has been unable to control healthcare costs in part because the government has been reluctant to establish mechanisms for deciding how healthcare should be distributed and providers paid, Reinhardt said. That reluctance stems from an ingrained set of assumptions that have historically made healthcare reform difficult in this country. These include the beliefs that:

- Healthcare should be available to all regardless of ability to pay.
- Only physicians and patients should decide how to treat a given illness.
- Someone in society should make the resources available to implement that decision.
- Someone in society should pay the supplier of resources "properly," without rancor or questioning.

To change the healthcare system, Reinhardt said, some of these assumptions will have to be contested. He predicted that many Americans will find such change profoundly unsettling. "To reform the healthcare system is to intervene massively in the life of America," he warned.

As the nation comes closer to enacting healthcare reform, Reinhardt said, people are going to have to decide which issue to concentrate on. Until recently, he noted, there seemed to be general agreement that the most urgent problem was guaranteeing everyone access to healthcare. But he said this consensus seems to be breaking down. "I'm astounded at how many people are now saying, 'Do costs controls first, then address the access issue,'" he told the audience.

Reinhardt suggested the argument that healthcare costs should be brought under control before guaranteeing access to people rests on the assumption that healthcare is a commodity. As such, he said, it can be viewed as a basic good, but not as something to which everyone is entitled. The competing ideology, which informs the Catholic Health Association's reform efforts, is that healthcare is "a social good that should be available to all on fully equal terms and at the same level of quality, regardless of income," Reinhardt explained.

"Mostly we debate this through euphemism," he pointed out. But he warned that a euphemistic debate at this stage in history is exactly what the proponents of the commodity view of healthcare want. For Catholic healthcare providers, the critical task now is to ensure that the public understands the terms of the debate and the moral and ethical assumptions that underlie the Catholic position. "There is no more time for being polite on this issue," Reinhardt emphasized. "If you ever wanted to shout, now's the time to shout and make yourself heard."

The Time for Healthcare Reform Is Now

Richard J. Davidson, EdD

American hospitals cannot afford for the president and Congress to fail to reform the country's healthcare system. That is the opinion of Richard J. Davidson, president of the American Hospital Association (AHA). "The opportunity for healthcare reform probably won't come again," added Davidson. "Clinton is the first president to stake out healthcare as an important campaign issue. Don't expect the next president to take on healthcare reform if Clinton fails."

Davidson said the success of Clinton's proposed budget is critical to the future of healthcare reform. "The president must take care of the budget problem first," Davidson said. "His reform proposal may come at the end of July; it may come after Labor Day. "[But] you don't need to wait for Washington, because reform is happening all over the country. If you are not already involved, I would urge you to move quickly into integrated delivery."

Davidson's vision of the future is one in which healthcare is local. "Our healthcare system is going to be rebuilt community by



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community," he said. "It's a 'made-in-America' approach." Institutions will move away from competition for market share into collaborations with other providers of health services.

Davidson called for unity and strength in a grassroots campaign. "Call your senator. We've got to win the struggle on this current budget debate," he said, cautioning that a retreat from the energy tax could bring about new cuts in Medicare and Medicaid. "Members of Congress still listen to their constituents at home. CHA and AHA can only quarterback this effort. You will deliver the goods. You must be activists in your role," he said.

States Pursue Reform Initiatives

Dick E. Merritt
Duane Benson
Richard Heim
William J. Hagens

Despite the push for healthcare reform at the federal level, states continue to pursue initiatives that address their citizens' unique needs, said Dick E. Merritt, director of the Intergovernmental Health Policy Project, George Washington University, Washington, DC. States have good reason to look for their own solutions to the healthcare crisis, he said, because access and cost issues are as acute at the state level as at the federal level.

He added that healthcare reform was an important campaign issue in many states and states need reform now. They know from experience they cannot assume that a reform package will come from the federal government, he said. Even if a healthcare reform proposal does pass Congress, states believe they will be better prepared to comply with its provisions or request adjustments if they have their own programs in place, Merritt said.

Most states have concentrated their healthcare reform proposals on the issue of access, Merritt said, but many are now beginning to tackle meaningful cost-containment measures and strategies to reform the delivery system.

One recently passed program that addresses all these issues is Minnesota's HealthRight Act. Minnesota state senator Duane Benson, an author of the legislation, said the act calls for the creation of local inte-

grated service networks that provide a continuum of services to enrollees at a fixed rate. "The approach combines cost-cutting measures with measures to improve access," Benson said. The act also sets a goal for the state to reduce healthcare expenditures by 10 percent a year.

In New Mexico, legislators are looking for ways to create access for the 28 percent of the state's citizens who lack health insurance and cannot wait for passage of national healthcare reform. Richard Heim, cabinet secretary of the New Mexico Department of Human Services, said the state has elicited pledges from providers to accept reductions in Medicaid reimbursement. In



addition, emergency room visits and inpatient hospitalizations have declined as a result of the Primary Care Network, a program available to citizens in two-thirds of the state's counties. The state covers care provided only by primary care physicians who are part of the network, Heim explained. Also, he said a newly created Health Reform Task Force is studying all options for healthcare reform in New Mexico.

Far-reaching initiatives are under way in Washington State, according to William J. Hagens, senior research analyst for the Health Care Committee of the Washington State House of Representatives. Last April the legislature passed the Washington Health Services Act of 1993, an employer-based model aimed at ensuring universal access by 1999. The act includes provision of benefits through a reformed insurance model, capitated managed care provided by existing health maintenance organizations or new integrated delivery systems, a five-member commission to administer the system statewide, and four healthcare purchasing alliances to give employers access to the plans in their region, Hagens said. Employers will be required to pay at least 50 percent of the costs of the lowest-priced benefit package available, and premiums will be capped.

Merritt, Benson, and Hagens describe state attempts to tackle access and cost problems.

PROVIDER INTEGRATION

CHA Handbook Will Help Members with Integrated Delivery

The Catholic Health Association's draft document *Renewing the Catholic Healthcare Ministry: A Handbook for Planning and Developing Integrated Delivery* articulates a contemporary expression of Catholic mission, Sr. Maryanna Coyle, SC, told attendees at a general session of the assembly. She said the document "describes how Catholic healthcare providers can move quickly to take a leadership role in what is our future." Sr. Coyle recommended that attendees use the handbook to evaluate their own readiness for integrated delivery, as well as the readiness of their communities and other providers in their areas.

CHA will incorporate member feedback on the draft document before it is published this fall. A copy will be sent free to all CHA members.

J. Michael Watt, vice president, Lewin-VHI, Washington, DC, and Timothy J. Eckels and Philip Karst of the Catholic Health Association, who have worked on the handbook, described the book's contents. The handbook covers the reasons for implementing integrated delivery, the elements of integrated delivery, how to implement integrated delivery, and practical accounts—vignettes—of healthcare providers who are dealing with change.

Putting the book together was daunting, speakers said, because of the diversity of CHA members. But the document takes these differences into account and is adaptable to all situations. The handbook has a "mission check" throughout.

The handbook explores how to develop a vision, examine options, determine a facility's readiness for integrated delivery, and build integrated delivery networks (IDNs). The handbook urges Catholic healthcare providers to be especially sensitive to needs of their communities and the per-

sons they serve. It offers guidelines for leaders to think through decisions they will face, including physician relationships and partnerships with insurers.

Three healthcare providers already implementing integrated delivery described what they have accomplished and what they have learned during the process. They stressed the importance of a tool like the handbook.

Florida now has on the books template legislation undergirding managed competition that calls for creation of purchasing cooperatives and "accountable health plans" in 11 areas across the state, according to Michael Bice, president and chief executive officer, Franciscan Sisters of Allegany Health System, Inc., Tampa. Allegany is developing IDNs in four areas—Tampa; St. Petersburg,



FL; West Palm Beach, FL; and Camden, NJ. The system is doing this, Bice noted, through acquisition and networking (e.g., joint ventures).

To achieve integration, Bice said that Allegany has learned it needs to "retool its corporate services," moving from a management culture to a development culture. Managers, he noted, should be spending 50 percent of their time on integrated delivery to make the kind of impact necessary for success.

John P. Lee, vice president for operations, Sisters of Providence Health System, Portland, OR, said that his organization began looking at integrated delivery systems 12 years ago. Eventually, "systemic injustice and our stewardship values called us to action," remarked Lee.

Since then, Sisters of Providence has

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—Sr. Coyle

developed a health maintenance organization, the state's largest home health agency, a nursing home without walls, and 12 off-campus clinics, and it is embarking on housing. A year ago primary care physicians in the area were all in solo practice. Today, they are employees of a multispecialty clinic, his system, or the other hospital in the area.

Five years ago Tucson had no managed care, said Sr. St. Joan Willert, CSJ, president and chief executive officer, Carondelet Health Services, Inc. "Today between 90 percent and 95 percent of our business is managed care," she said. She described her organization's foray into capitation through Mercy Care Plan, which offers care to Arizona's Medicaid recipients (see p. 57 for a more detailed description of Mercy Care Plan).

Strong Leadership, Reorganization Speed Integration

David A. Anderson

Integration of physicians and health-care systems and of functional areas like information systems appears to contribute to higher levels of effectiveness and performance. But preliminary results of a study of health-care systems indicate little movement toward physician-system and functional integration.

David A. Anderson, a partner in the National Healthcare Strategy Practice of KPMG-Peat Marwick, Chicago, presented the early findings and recommendations from the Health Systems Integration Study. The three-year study, begun in December 1990, surveyed board members, corporate and noncorporate managers, and physicians in nine healthcare systems throughout the United States, including the Franciscan Health System, Aston, PA, and Sisters of Providence Health System, Seattle.

The study, conducted by Anderson's firm and Northwestern University, is testing the hypothesis that higher levels of perceived integration within the system will result in higher levels of perceived effectiveness and performance. Survey results indicated board members often assume their systems are moving into integration more smoothly than they are. Board members may not be aware of their organizations' readiness for integra-

tion, Anderson said.

Based on early results of the study, Anderson recommended four prescriptions for higher integration and organizational effectiveness and performance: stronger leadership, governance reorganization, management reorganization, and an "integration tool kit."

To promote stronger leadership, he said, those sponsoring change must understand the resistance to change and have systems in place to manage that resistance. "Sponsors of change must increase the pain to promote stronger leadership. You have to create a sense that your people are standing on a burning platform," he added.

Anderson also advised that to strengthen leaders, "you must define the implications of strategy on people's jobs and their role in the system. Nobody understands strategy until they know what it means for their jobs."

Change agents need to define and better communicate how hospitals fit into the overall strategy, Anderson added. "Hospitals are used to thinking of themselves at the center of the system." In the future, he said, they will need to think about business ecosystems in which they are interactive participants.

With regard to governance reorganization, Anderson recommended reeducating some boards. In some cases, he added, it may be appropriate to completely replace a board with one that has the skills needed to ensure successful integration.

Anderson also advocated deemphasizing or eliminating local operating boards in favor of increased efficiency through a regional board governance. "Speed of decision making and clarity of responsibility are keys to success," he noted. Management reorganization might include a restructuring of the role of facility CEOs in a region, changing their focus from individual hospitals to broader, regional responsibility.



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Breaks between sessions gave attendees a chance to network.

The "How-to" of Integrated Delivery

Young S. Suh
John P. Lee

Executives from Genesys Health System in Flint, MI, and Sisters of Providence Health System in Portland, OR—two healthcare systems on the cutting edge of reform—presented the "how-to" of integrated delivery networks.

At one time seven hospitals (2,200 beds) served the Flint area, in which General Motors (GM) is the major employer, said Young S. Suh, president of Genesys. Layoffs at GM changed the economic picture, leading four hospitals, which had been staunch competitors, to affiliate to form Genesys, with the objectives of improving quality, cost, and access.

The consolidation calls for the building of a "revolutionary and futuristic" hospital, the first built specifically to meet the needs of "patient-focused care," Suh said.

When the new, 439-bed facility—Genesys Regional Medical Center, Grand Blanc, MI—is completed in 1997, the 908 beds of the four older hospitals will be converted from acute care to emergency and outpatient services. The consolidation will mean the elimination of some 600 positions, Suh said, but it will allow the system, which is sponsored by the Sisters of St. Joseph, Nazareth, MI, to operate with a high occupancy rate.

To fulfill its mission as a patient-centered care hospital, the medical center will have nontraditional structures in such areas as management, operations, and even architecture, noted Suh. Genesys predicts \$12 million will be saved each year as a result of the patient-focused approach, said Suh.

Suh explained that the patient-focused care concept will be complemented by a comprehensive computer information system that will allow information to be entered at patients' bedside and accessed by physicians in their offices.

Today, Genesys hospitals have eight hierarchies of management, noted Suh; Genesys Regional Medical Center will have four.

A physician office building will be integrated with the medical center. Suh said that the goal is for specialists to walk for no more than 30 seconds to reach a patient.

The medical center will be jointly owned by the health system, a newly formed

physician-hospital organization, and an existing health maintenance organization (HMO). Because the HMO covers procedures that conflict with Catholic moral teachings, many moral and ethical issues of the new arrangement still need to be worked out, Suh said.

In Portland, the Sisters of Providence Health System is working toward an integrated health system that will serve the full range of people's healthcare needs. "We have stopped investing in acute care," said John P. Lee, vice president for operations. Instead, the system is spending some \$30 million to purchase primary care physician practices and establish ambulatory care settings.

Sisters of Providence is following several strategies in regard to primary care, said Lee. The system now employs 45 primary care physicians, but has a goal of 200. And the system sponsors a medical staff organization for primary care physicians who are in solo or two-person practices and do not wish to become system employees. The system also is developing strategic alliances with large clinics that want to remain independent. Finally, part of the program in Portland includes retraining physician specialists to become primary care givers, Lee said.

For the future, Lee noted that healthcare providers should prepare for increased numbers of patients in HMOs; more physicians as employees; increased numbers of physician extenders, such as nurse practitioners and physician assistants; and significantly fewer patient days.

Lack of Primary Care Physicians: Achilles' Heel Of Reform?

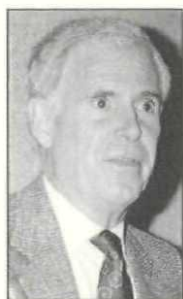
Gerald C. Keller, MD
Ronald G. Blankenbaker, MD

Under a reformed U.S. healthcare system, all Americans will have a primary care provider to coordinate their care, provide basic care, and walk them through the maze of subspecialists. But a severe shortage of primary care providers could be the "Achilles' heel of healthcare reform," according to Ronald G. Blankenbaker, senior vice president of medical affairs and academics, Erlanger Medical Center, Chattanooga, TN.



The patient-focused care concept will be complemented by a comprehensive computer information system that will allow information to be entered at patients' bedside and accessed by physicians in their offices.

—Suh



"If you want to integrate and you don't have enough primary care physicians, you better start doing something about it now."

—Keller

Only 30 percent of U.S. physicians are primary care providers, down from 50 percent in 1961, said Gerald C. Keller, a physician and teacher at Oschner Clinic, Mandeville, LA. In contrast, 50 percent of Canada's physicians and 70 percent of England's are in primary care, he said.

With the shortage of trained primary care physicians—that is, family physicians, internists, and pediatricians—obstetrician/gynecologists and subspecialists may be tapped to fill the role after healthcare reform, Keller noted. But they will not be effective substitutes, he claimed. Subspecialist physicians are taught to use technology, not to provide cost-effective treatment, and, compared with primary care physicians, tend to overprescribe some technologies. Although physicians' salaries are about only 20 percent of the annual healthcare bill, Keller pointed out that their behavior—the tests and treatments they order—make an enormous difference.

Moreover, subspecialists' training is too narrow, neglecting such basics as treating an ingrown toenail or performing a vaginal examination, Keller said. "Family physicians need a broad spectrum of knowledge," he said. They have a background in acute and preventive care, as well as in psychology so they can communicate with their patients. They are trained to handle 85 percent to 90 percent of the problems that patients come in with, and they know their own limitations, when to refer patients, and to whom.

Furthermore, added Blankenbaker, primary care physicians "must be willing to deal with abstracts and the unknown." Specialists tend to want to know everything about an organ or disease and order expensive tests to discover the exact cause of a patient's problem. Primary care physicians, on the other hand, are generalists who know a little about a lot, Keller noted. They are taught to order tests only if the results will affect their treatment plan.

To prepare for healthcare reform, Oschner Clinic (a tertiary care center with satellite clinics throughout New Orleans) has hired 25 to 30 primary care physicians and established a residency program in primary care. Keller noted that the clinics are not making enough to pay for all the primary care physicians but are committed to carrying them to ensure their availability later, when demand will be higher.

To increase the supply of primary care physicians nationwide, Keller said the education system will have to teach students in ambulatory settings, not just hospitals. Schools also need to examine their admission criteria to give greater weight to why candidates are applying (salary or service?), where they want to practice, and what they want to specialize in, he said. And healthcare

providers will need to correct the inequities in salaries for primary care physicians, who are at the bottom of the pay scale.

Despite this inequity, studies have shown a positive correlation between a community's health status and percentage of primary care physicians, Keller said. This will be important in integrated delivery networks of the future, which will compete on cost, quality, and, most important, outcomes.

Hospital-Physician Integration Takes Varied Forms

Wende L. Fox

Sr. Suzanne Brennan, CSC

Travis Froehlich

Market pressures are driving physicians and hospitals along a continuum of increasing integration, according to Wende L. Fox, principal, APM, Inc., Chicago. Fox told assembly participants that physicians are fearful of the future, afraid of losing control.

Fox said her firm looked at 46 markets across the country with regard to managed care penetration and physician-hospital integration. The evolution goes from an "unstructured" condition—no longer very common—to a "managed competition" model.

In between, markets may demonstrate a "loose framework" stage, in which health maintenance and preferred provider organizations (HMOs and PPOs) are gaining market clout and hospitals and physicians are beginning to discount services. This will be followed by the "consolidation" phase of mature HMOs, physician groups growing, and physicians and hospitals forming united fronts in contracting.

The APM study showed only one market, Minneapolis, operating in the "managed competition" model, with most markets currently at the "loose framework" stage.

Fox has worked with a number of clients to develop physician-hospital organizations (PHOs). She advised healthcare executives beginning a PHO to offer physicians a range of options, from managed care contracts to employment, to accommodate physicians at different levels of readiness.

She warned the audience to head off conflicts by involving physicians early in discussions about PHO design. "Have physicians as the principal authors of the program.

Have a high percentage of primary care physicians, and offer options to accommodate physician diversity," she said.

Joining Fox in the presentation were Sr. Suzanne Brennan, CSC, president and chief executive officer, Mercy Hospital Anderson, Cincinnati, and Travis Froehlich, vice president for program development, Seton Medical Center, Austin, TX.

Sr. Brennan, whose hospital has recently developed a PHO, shared lessons learned. "The creation of a PHO must be a response to market trends," she said. In Cincinnati managed care has a 30 percent market penetration. Employers are forcing providers to examine excesses in inpatient capacity, she said, and a third of the city's hospitals may close in the next three to five years. "We had to overcome physician fears

of losing control," Sr. Brennan said, "and we learned that managing health is very information dependent."

Froehlich described Seton's challenges in entering a PHO: gaining physicians' understanding, accepting legal restraints on the hospital, and finding experienced talent to implement the PHO. He cautioned listeners to "be sure to integrate the new organization into the parent organization to avoid 'fighting children' in the future."

"PHO development requires more time than I ever imagined, but it pays off," he said. "You must maintain a structural preference for primary care. Trust is hard to earn from physicians, and you must reinforce it daily. But once the medical staff is ready for change, they want it done instantly."

Symposium Explores Strategies For Urban Healthcare Providers

Involving community agencies and restructuring services to meet community needs: These approaches secured the survival of their urban hospitals, according to speakers at a one-day symposium that preceded the assembly. The June 5 conference, "Building Community Partnerships: Strategies for Urban Health Ministries," attracted 175 participants.

JoAnn Mower, president of Misericordia Hospital, West Philadelphia, PA, told attendees that a needs assessment conducted with more than 100 community agencies led the hospital to establish women's healthcare programs and a center to reduce the community's morbidity and mortality from cardiovascular disease and cancer.

St. Joseph Hospital, North Providence, RI, formed a community liaison committee, reported hospital President John Keimig. With the committee's guidance, the hospital replaced its misused emergency room with St. Joseph Center for Health and Human Services, a primary care facility.

Patrick Madden, president of St. Mary's Hospital, Rochester, NY, has focused on social problems—homelessness and unemployment—to improve the community's health. By threatening to close St. Mary's, Madden convinced major companies in Rochester to pledge \$5 million to build a community college near the hospital and to found a development corporation to renovate homes. Madden also described how he aggressively recruited primary care physicians and opened 16 primary care centers. "We have become the model of primary care in the state," he said, noting that New York pays St. Mary's a higher Medicaid rate for patients receiving care through the centers.

MISSION INTEGRATION

Church Brings Rich Resources to Healthcare Debate

Rev. J. Bryan Hehir, ThD

Few participants bring richer resources to the current American healthcare debate than the people of the Catholic healthcare ministry, Rev. J. Bryan Hehir said in his keynote address.

Fr. Hehir, a parish priest in Cambridge, MA, and a professor at the Harvard University Divinity School and Center for International Affairs, said that those committed to healthcare reform can benefit from reflection on where healthcare fits in the larger ministry of the Church, where the Church fits in the framework of American society, and where Catholic healthcare's voice and vision might fit in the U.S. healthcare debate.

The American Catholic Church in the 1990s is in one respect a postimmigrant Church, Fr. Hehir observed. Over the past 150 years the Church's schools and other institutions have succeeded in moving its immigrant members from the social and economic edges of society to the center. Catholics are now present in every sector of American society and thus have a powerful voice in effecting social and economic change.

At the same time, he added, "we are also a newly immigrant Church," with members recently arrived from Latin America and East Asia who are struggling at the edges of society. He noted that few institutions in the United States span this "center-edge" dichotomy and that the Church's commitment to both these populations challenges it to be a mediator and reconciler, bringing the resources of the center to address the problems at the threatened edges of life.

Between the center and edge, Fr. Hehir added, exists a newly vulnerable population one or two paychecks away from losing their homes and their health insurance. He emphasized that the healthcare reform

debate touches all three of these groups. "To get healthcare reform," Fr. Hehir said, "we must take the political center with us. Without healthcare reform, the problems of the newly vulnerable population will deepen and persons at the edges of society will be worse off than ever."

The Catholic Church brings three major concerns to this debate, Fr. Hehir told assembly-goers: healthcare as a social justice issue, healthcare as a bioethical issue, and institutional pluralism.

In the area of social justice, he said, the debate has moved beyond whether healthcare is a right to determining whose obligation it is to fulfill that right. Fr. Hehir noted that the Catholic argument gives healthcare professionals primary responsibility for guaranteeing access to healthcare. "For Catholics," he explained, "professionals have always been moral agents, with a covenanted responsibility to society." He said that corporations and governments also have a role in ensuring that the right to healthcare is honored.

The provision of healthcare cannot be left to market forces, he added. "The market may guarantee efficiency, but by itself will never guarantee justice. That's why the debate must be framed in a wider set of principles that make sure that certain goods the market does not know how to value, such as healthcare, are given their proper moral status," Fr. Hehir said.

The key value from the Catholic perspective, Fr. Hehir said, is the protection of human dignity from the beginning to the end of life. This emphasis on human dignity is the basis of the Catholic argument on both bioethical and social justice issues (e.g., abortion and healthcare access), he noted. Despite this common root, Fr. Hehir suggested "the most difficult problems come up when you connect these issues."

He acknowledged, however, that the Clinton administration's reform proposal might make such a connection inescapable. If abortion is included in the benefits package, Hehir advised, "we're going to have to pursue an argument knowing that there are two moral goods at stake: how to protect human life and how to preserve and foster human life through healthcare."

The argument for institutional pluralism is less urgent morally, but a concern if Church institutions are to continue to make a useful contribution to the public good, Fr.



"The market may guarantee efficiency, but by itself it will never guarantee justice. That's why the debate must be framed in a wider set of principles."

—Fr. Hehir

Hehir said. He suggested that the position need not be argued from a perspective of self-interest, but in terms of efficient, effective care. "A pluralist system gives you more opportunities to reach the range of different needs in American society. A community like ours that covers the ground from the center to the edge has good empirical reasons for saying, 'We need the space to function according to our own religious, moral traditions as part of the wider public arena,'" Fr. Hehir said.

But the most difficult challenge facing those who present the Catholic argument in a debate of this scope and intensity, Fr. Hehir concluded, will be "to keep in mind what's at the heart of the discussion." Those who present the Catholic position must constantly emphasize "that healthcare, before it is a commodity, is a moral good, and it is a moral good because it is linked uniquely to the reality of human life and human dignity."

Integrated Delivery Challenges Sponsors, Systems

Judith C. Pelham

As providers restructure to form integrated delivery networks, Catholic ownership of "bricks and mortar" may give way to "intellectual" property exercised through influence, predicted Judith C. Pelham, president, Mercy Health Services and Sisters of Mercy Health Corporation, Farmington Hills, MI.

One of the major challenges for the Catholic healthcare ministry "is to move from a position of institutional and congregational loyalty to one of community conscience," she said. "The paradigm shift calls for different strengths, not our ability to provide beds, bricks and mortar, and facilities. We'll need to try a variety of approaches, keep what works, and discard what doesn't."

—Pelham

Addressing the implications of healthcare reform for Catholic sponsorship, she said, "We will emerge transformed by these challenges, but the question is, transformed into what?" Pelham predicted that Catholic identity in integrated delivery would be expressed in one of three ways.

In communities where the Catholic provider is dominant, which she said is not



Pelham touched on emotional issues at the heart of sponsors' ministry.

typical, the non-Catholic operations will be merged into those of the Catholic facility. "That may not always be acceptable to the community," she said, and "it raises questions about how to handle issues in the *Ethical and Religious Directives for Catholic Health Facilities*."

In the second and most common scenario, the Catholic organization is not the dominant player and may contract with a delivery system. This may be the first step in the consolidation process, Pelham said. "It raises fundamental issues of what is most important in terms of Catholic identity and witness to our values."

The third possibility is multiple Catholic providers coming together to form one or more integrated delivery networks, especially in large cities with several Catholic providers and sponsors.

The concern in this scenario is whether there will be "a consensus or basis for Catholic identity to replace congregational identity," she said. "These are very emotional issues that lie at the heart of sponsors' charisms and concepts of how they sponsor ministry."

The role of multi-institutional systems is also being reevaluated in the reform debate, Pelham said. A system with geographically proximate facilities that can be integrated into a network may have a different role from a system with widely dispersed facilities. How the system continues as a vehicle for sponsorship and whether it adds value to integrated delivery networks are other unresolved issues.

In dealing with these challenges, Pelham reminded participants of the pioneers who founded Catholic healthcare in the United States. "They let go of the structures of the past, as they did in leaving the safe havens of their home congregations and countries," she said.

"As we are faithful to our values, we will be faithful to our founders and foundresses and committed to Catholic identity through social justice. The vision of integrated delivery provides a contemporary expression of our values. That will be what sustains us."

"The paradigm shift calls for different strengths, not our ability to provide beds, bricks and mortar, and facilities. We'll need to try a variety of approaches, keep what works, and discard what doesn't."

Canon Law Offers Flexibility In Collaborative Relationships

Rev. Frank Morrissey, OMI, JCD, PhD
Br. Peter Campbell, CFX, JD

As healthcare reform progresses and integrated delivery networks become a reality, religious institutes that sponsor healthcare facilities are faced with how to preserve their Catholic identity in collaborations with other Catholic and non-Catholic entities. Although the issues are complex, two experts on canon and civil law offered optimistic advice regarding the possibilities for creative new arrangements.

One of the most important steps in preparing for integrated delivery, according to Rev. Frank Morrissey, OMI, is for religious communities to inventory their works to see which are juridic persons, that is, the equivalent of civil corporations. Fr. Morrissey, who is a professor of canon law at St. Paul University, Ottawa, Canada, said congregations must separate their assets from those of sponsored healthcare facilities to avoid losing assets if they later enter into a collaborative arrangement. Congregations with older apostolates—such as hospitals founded at the same time as the congregation—may have to go through historical documents to determine whether they are juridic persons. “You can’t do this in 30 days,” he said, “and if you wait until it’s too late, the congregation may lose all its assets.”

Morrissey said canon law makes no specific reference to hospitals or healthcare facilities—an advantage that provides flexibility. He noted, however, that parallels can be drawn from “*Ex Corde Ecclesiae*,” Pope John Paul II’s “Apostolic Constitution on Catholic Universities” (1990). This document’s approach to determining catholicity is less rigid than that of the Code of Canon Law, with less direct involvement of Church authorities, Fr. Morrissey said, and makes it easier for Catholic organizations to enter into agreements with others.

But the bottom line is “It’s Catholic if the bishop recognizes it as Catholic,” Morrissey said. A hospital could be considered Catholic on one side of a river and pagan on the other, depending on the respective bishops’ interpretations, he said. “So when you’re thinking of new arrangements, don’t let the bishop be the last to know,” he advised. “Bring him in from the beginning, and remember you may need to educate one another.”

Our current understanding of sponsorship is changing, emphasized Br. Peter Campbell, CFX, senior attorney at the Catholic Health Association, St. Louis. “If we stick to the traditional structures and the long list of reserved powers that are held up at the top, collaboration may be difficult if not impossible to achieve,” he said. Although sponsors have emphasized control in the past, they may need to stress influence or support more in future relationships. He said it is important to distinguish the powers that protect Church interest from those which are needed to run an operation efficiently.

Br. Campbell said religious institutes have “lots and lots” of options in choosing joint sponsorship arrangements. Sponsors coming together can form an entity in which each has an equal voice, although the assets they bring to the table may differ. Alternatively, he said, they may have a proportional arrangement, in which one partner holds more power than the others. Or they may work together for a time and then one partner may move on to other ministries.

“Whatever you decide to do,” Fr. Morrissey advised, “reassess it in three to five years to ensure it’s still what you want.” He and Br. Campbell stressed that mistakes will be made as new canonical arrangements are tried. But they offered hope for freedom and creativity—provided sponsors are careful in drawing up new arrangements.



“When you’re thinking of new arrangements, don’t let the bishop be the last to know. Bring him in from the beginning, and remember you may need to educate one another.”

—Fr. Morrissey

Catholic Identity in Cooperative Ventures

Joseph DeSilva
Rev. Michael D. Place, STD

To carry on the traditions of Catholic healthcare, providers must begin to participate in regional healthcare systems that integrate Catholic and other providers, physicians, and managed care plans, Joseph DeSilva told attendees.

DeSilva, president and chief executive officer of St. Joseph’s Hospital and Medical Center, Phoenix, said his hospital’s commitment to regional networking prompted it to take a leading role in the establishment of the Arizona Healthcare Alliance. The alliance consists of 1,500 physicians, 8 hospital campuses, 4 long-term care facilities, and other ancillary services. St. Joseph’s is the only Catholic hospital in the network.

According to DeSilva, one of the cri-

teria for selecting hospitals to join the alliance was whether their mission, philosophy, and values were congruent with those of St. Joseph's. With such mutuality, he said, "any barrier can be overcome. On the other hand, if you don't have mutual vision and philosophy, even the smallest differences become insurmountable."

A second criterion for finding partners, DeSilva said, was whether the healthcare organization under consideration helped to meet the community's need for cost-effective, accessible, high-quality healthcare in a vertically integrated system.

To ensure that alliance contract negotiations respected the *Ethical and Religious Directives for Catholic Health Facilities*, St. Joseph's leaders required prospective members to adopt policy statements that provided clear direction for at least three issues: abortion, charity care, and an ongoing ethical review process.

A critical question for St. Joseph's was whether participation in the alliance would create a public perception that the hospital was involved—even remotely—in the provision of services inconsistent with its Catholic identity. "We came to the conclusion," DeSilva said, "that there is a fine line between protecting Catholic values and imposing those values on others. We therefore decided we could not require the other hospitals to abide by our values, but we insisted that our values be protected at our hospital in the context of the contract negotiations."

Learning how to frame such ethical questions will become increasingly important for Catholic hospitals as they enter into cooperative ventures with other providers, Rev. Michael D. Place told the audience.

Fr. Place, research theologian for the Curia, Archdiocese of Chicago, said fundamental issues of identity and integrity arise in any such venture. The identity question provides the fundamental perspective for the principles that guide ethical exploration of integrity issues, Fr. Place said. The two basic principles that have evolved in Church teaching to address the ethical integrity of specific actions are toleration of evil and material cooperation with evil.

An example of the application of the first principle would be for a Catholic provider to buy a laundry jointly within another healthcare entity that performs elective sterilizations. The arrangement into which the Catholic provider enters with the other entity does not relate to the sterilization issue, and the Catholic facility can "tolerate" the other's practice because it is not required to combat every evil in the world.

The second principle, which asks to what extent a person or organization may cooperate with the performance of an evil, can guide Catholic providers in addressing

the thornier issues that arise when they enter into more complex arrangements with other healthcare organizations. The ethical challenge is to determine the nature of the cooperation and when it becomes a violation of integrity, Fr. Place said.

"Formal cooperation" (e.g., if a Catholic hospital were to espouse a prosterilization policy for an integrated delivery network [IDN]) is obviously unethical. "Immediate cooperation," in which an action would not occur without the participation of the provider, is also unacceptable. An example would be a Catholic hospital owning a clinic that performed abortions.

Cases of "material cooperation," in which the actor is to some extent involved in the performance of an evil, are most directly relevant to the ethical issues that arise when Catholic hospitals join IDNs. Here the key question is whether the cooperation promotes a good greater than the evil it allows. Thus a Catholic hospital might agree to provide fertility testing and counseling when some other facility in the IDN performs in vitro fertilization. "In such a case, the good of maintaining the whole may outweigh the evil of the specific procedure," Fr. Place said.

The one consideration that overrides all others, he noted, is when a contractual arrangement between a Catholic and a non-Catholic entity creates the potential for the

At a concurrent session, members break into small groups to discuss board leadership.



"We must not allow our deep commitment to preserving the charism of Catholic healthcare to lead us to an 'end justifies the means' approach, nor can we allow ourselves to retreat into the sectarianism of a purely Catholic approach."

—Fr. Place



perception of scandal. "If it appears that a hospital's claim to be merely another contractor in an organization will unduly confuse people, that can be grounds for not entering an IDN," Fr. Place said. "This area will give bishops the most trouble in appraising."

In the end, Fr. Place said, the Church must avoid either of two extremes in addressing the ethical issues related to participating in IDNs: "We must not allow our deep commitment to preserving the charism of Catholic healthcare to lead us to an 'end justifies the means' approach, nor can we allow ourselves to retreat into the sectarianism of a 'purely' Catholic approach."

Religious Life: A Time for Assessing Mission

Rev. David J. Nygren, CM, PhD
Sr. Miriam D. Ukeritis, CSJ, PhD

It is time for religious institutes to assess and reaffirm their mission and focus their energies and resources to address critical unmet needs. This was a conclusion of the three-year Religious Life Futures Project, a survey of more than 10,000 religious sisters, priests, and brothers conducted by Rev. David J. Nygren, CM, and Sr. Miriam D. Ukeritis, CSJ. They led a discussion of the issues facing religious institutes as they look at cultural and values integration. Fr. Nygren is director of the Center for Applied Social Research, DePaul University, Chicago, and Sr. Ukeritis is a research associate there.

The study described and analyzed changes begun during the Second Vatican Council, identified underlying values that distinguish religious life, articulated an understanding of commitment and mission, and provided strategies for selecting and shaping a desired future.

Fr. Nygren said the population of the United States has increased 40 percent since Vatican II and the number of U.S. Catholics has grown 35 percent, but membership in religious institutes has steadily declined. The number of Catholic elementary schools has dropped 30 percent, and Catholic-sponsored hospitals declined 23 percent, he said. In light of these facts, the Religious Life Futures Project indicates the next decade will be a time for religious congregations to clarify their vision and hold members accountable for putting that vision into practice.

It is imperative, the researchers said, that religious congregations identify potential leaders and give them the authority to position their communities to renew their dedication to serving human needs. They said the survey indicates that successful leaders have a deep faith in God, a need for personal achievement, and a clear vision of the congregation's potential impact.

During the past 30 years, they said, many religious communities have concentrated on finding jobs for every member with little attention to how these positions relate to the institute's mission and charism. To reach their goals, however, institutes need to focus on collective intention. Many respondents involved in the healthcare ministry indicated a commitment to work with the poor but also felt unprepared. The researchers recommend

ed providing education and mentoring for members. They said more than 90 percent of religious are willing to work in sponsored institutions, which indicates an opportunity for religious institutes to address this area of their mission.

As the healthcare system is restructured, Fr. Nygren and Sr. Ukeritis recommended religious congregations focus on:

- Protecting the mission and Catholic character of their institutions and providing for the unmet needs of those they serve
- Speaking out on ethical issues, including the dignity of person
- Working toward collaborative efforts, such as integrated delivery networks
- Providing leadership development

Moral Leadership Needed to Respond to AIDS

Mary Fisher

When she thinks of the 14 million or more people with the AIDS virus, Mary Fisher thinks of a long, shuffling band of pilgrims. "I visualize that band as a rag-tag army of people drawn from every race and tribe, color and character," said Fisher, a member of the National Commission on AIDS who drew national attention when she addressed the Republican National Convention last year.

She uses the pilgrim metaphor, she explained in the Rev. John J. Flanagan lecture, so those who are HIV positive know they belong somewhere, in a great crowd of common people. "I want them to know they have a common destiny based on what is rapidly becoming a terribly common virus," said Fisher, who is infected with the AIDS virus. "And I want them to think of themselves as moving not only toward AIDS but also toward God."

Fisher said she also uses the pilgrim band image "as a reproach to the religious community in America. The images and metaphors which have been used as brands to mark people in the AIDS community . . . have often reflected moral and religious stereotypes that are unworthy of our great religious traditions," she said.

It is important that religious leaders hear her story, she continued, because it is also their story. "You are the ones who call for faith, even when your own is fragile. You are pressed to give answers of certainty, even

The survey indicates that successful leaders have a deep faith in God, a need for personal achievement, and a clear vision of the congregation's potential impact.

—Fr. Nygren and Sr. Ukeritis



"The barriers between the community of faith and the community of need must be taken down if we are to move forward."

—Fisher

The process of working from a values base to a clear position on healthcare reform "enables you to evaluate various national and state proposals with a clear idea of whether they achieve what you want."

—Kramer

when you are uncertain; to offer prayers, even when you doubt the value of prayer."

Faith, she said, "reminded me that I am not the giver or keeper of my life, and that I cannot save it; therefore I would be wise to give it away before it is squandered. Faith made a difference. Because faith matters, you matter," she went on. "Your insistence that in all things there is God's handiwork, that the whisper of comfort drifting over the pilgrim band is God's voice . . . it matters."

Fisher asked attendees to apply strong moral leadership in responding to AIDS. "Let the core of your policies be the essence of your faith," she advised. "The barriers between the community of faith and the community of need must be taken down if we are to move forward. If you are not the ones to do that, who is? And if this is not the time, then when?"

A System Develops Values-Based Reform Policy

Richard Kramer

Sr. Susan Vickers, RSM

Providers can establish a position on healthcare reform by taking a structured, values-based approach to defining and resolving critical issues, said Richard Kramer, president of San Francisco-based Catholic Healthcare West (CHW).

Kramer cautioned that arriving at a consensus about what an organization should advocate is often difficult. In its first attempt to define a position on healthcare reform, CHW asked each of its three regional boards to choose one of the following broadly defined options: a modified public utility approach, an approach mandating employer-based insurance, or an incremental reform approach.

When this produced no consensus, the system turned to its senior managers, but they were also split. Finally, CHW adopted an approach that began with values and built from there to healthcare reform positions. "We decided we should begin by focusing on key issues and evaluating the range of options available on each," said Sr. Susan Vickers, RSM, CHW's director of advocacy.

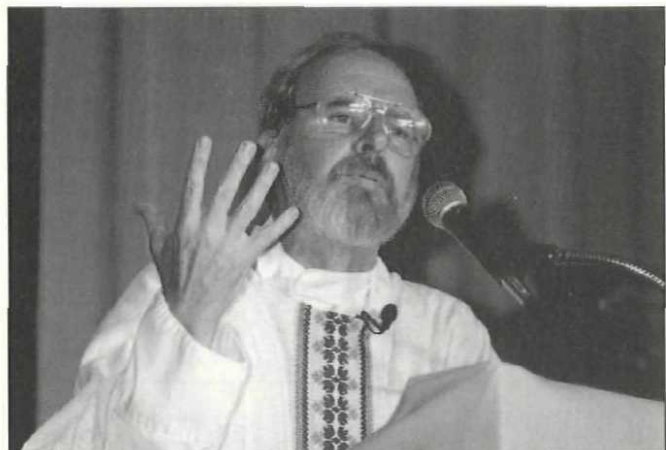
The system convened a series of four sessions at which more than 100 people throughout CHW examined how a reformed healthcare system would address three key issues: universal access, shared financial responsibility, and allocation of limited resources. After being introduced to the overall issues,

participants broke up into small groups, where they pursued a decision-making process involving the following steps:

- State the issue as a question
- Present options with supporting rationale
- Discuss relevant value questions
- Identify value conflicts and how they can be resolved
- Take time to reflect to bring all factors into the light of religious beliefs, traditions, and personal conviction
- Discuss options for action and agree on a recommendation and action plan or final decision

With this values-based approach, CHW arrived at a consensus. The system's final proposal calls for a national definition of a uniform benefit package that emphasizes health promotion and primary, preventive, and long-term care. CHW also advocates unitary financing with a reformed delivery system. On the issue of allocating limited resources, the system called for the creation of a national policy-making board with state or regional assessment of health needs.

Kramer noted that the process of working from a values base to a clear position on healthcare reform has some immediate tangible benefits for an organization. "First of all, it enables you to evaluate various national and state proposals with a clear idea of whether they achieve what you want out of a reformed healthcare system." He added that going through the process makes managers and sponsors effective advocates for the organization's position because they can articulate and defend it with peers from other organizations.



At the assembly's opening liturgy, Rev. John Francis Kavanaugh, SJ, PhD, told participants that the desire to know and to love is what "generated the founding of religious orders of men and women who respond to the great suffering of the world and who speak of a community of care, of justice, of personal integrity." Fr. Kavanaugh, who is professor of philosophy, Saint Louis University, urged persons working in the Catholic healthcare ministry not to lose heart, reminding them that God loves the world and will "rescue it from chaos." In response to God's love, "the greatest gift we can bestow on this world is our yes, which is the affirmation of life, the affirmation of love," noted Fr. Kavanaugh.

MANAGEMENT ISSUES

Making Capitation Work

Leonard Kirschner, MD
Sr. St. Joan Willert, CSJ

To prepare for healthcare reform, hospitals and state and local governments can study the experience of payers and providers with the Arizona Health Care Cost Containment System (AHCCCS, pronounced "access"), Leonard Kirschner told an assembly audience.

AHCCCS was formed in 1982 as an experimental Medicaid program. In 1981, with the state's county health system breaking down financially, the Arizona state legislature met in an emergency session to set goals for a Medicaid system that would contain costs and improve access to care.

In place of the standard retrospective fee-for-service system, the legislature called for the creation of networks that would bid competitively for enrollees with prepaid capitated contracts. A primary care gatekeeper network would ensure that enrollees had access to appropriate healthcare services, and copayments would help control utilization. Organizations winning contracts with the state would ensure their clients access to a full continuum of services, but the clients' freedom of choice would be significantly restricted.

Kirschner, who until recently was the director of AHCCCS and is now director of healthcare initiatives for Dallas-based Educational Data Systems, said the state had to secure a number of waivers from the federal government to make the program work. For example, AHCCCS is allowed to have only one plan in rural areas, whereas Medicaid law requires at least two. In addition, a person who qualifies for the AHCCCS program must be enrolled in an approved health maintenance organization (HMO). Arizona is also exempt from rules stipulating that a certain percentage of enrollees in an HMO be non-Medicaid clients.

A simplified eligibility system is another valuable AHCCCS feature. "Two percent of America's population goes through a Medicaid-eligibility determination every month, and we as a nation spend \$10 billion a year on the eligibility process,"

Kirschner noted. "If we went to some sort of national health insurance with universal access, we could do away with this madness."

Of Arizona's 3.8 million citizens, 500,000 are now enrolled in the AHCCCS program, which contracts with 14 different health plans. Capitation rates are developed based on cost and utilization patterns of clients within a particular system. In the past decade, Kirschner said, the state and providers have built up a strong public-private relationship, resulting in reduced costs, improved quality, and enhanced client satisfaction.

AHCCCS has also proven to be popular with the Arizona provider community, Sr. St. Joan Willert, CSJ, told the audience.

In 1985-86 Sr. Willert, who is now president and chief executive officer, Carondelet Health Services, Inc., in Tucson, helped form Mercy Care Plan, which currently provides network services in five Arizona counties. The HMO was developed jointly by the Health Care Corporation of Sisters of St. Joseph of Carondelet, St. Louis (which sponsors three hospitals in Arizona), and San Francisco-based Catholic Healthcare West (which sponsors one hospital in the state).

"Our goals at the time," Sr. Willert said, "were to improve collaboration between the two systems, to find a way to continue our mission and better serve the poor, and to contribute to the success of the AHCCCS program by providing it additional stability."

Sr. Willert noted that the state's cooperation with organizations offering plans under AHCCCS has contributed much to the program's success. For example, AHCCCS officials will inform an organization if they think a bid to provide services to a certain county is high or low. But working under a capitated reimbursement system remains a challenge, Sr. Willert warned. To succeed, organizations have to establish utilization and quality oversight programs, develop effective information systems, learn how to manage complex cases, and learn to live with fixed reimbursement for a two-year period, knowing that many forces, some of them unpredictable, can affect costs.

Sr. Willert added that AHCCCS providers must also ensure that physicians and hospitals are wellness oriented. To achieve this, Mercy Health Plan has set up a nurse case management program; developed



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—Kirschner

a patient-centered nursing program that places resources at the point of care; and joined a national chronic care consortium, which explores innovative ways to address chronic care issues.

Transformation to Integrated Delivery Requires A Shared Culture

Donald A. Brennan

Catholic multi-institutional systems have a strong sense of shared ministry and mission. But their corporate cultures, centered around strong institutional management, could impede their transition to new delivery models in which hospitals play important but not dominant roles.

This was one of the lessons Donald A. Brennan, president and chief executive officer of Sisters of Providence Health System, Seattle, learned from participation in a study on health systems integration. "A high degree of shared values does not translate into other measures of systemness," such as clinical, human resource, and marketing integration, he said.

Administrators at the health system agreed on the central hypothesis that "transformation to integrated delivery systems requires a shared culture throughout the organization," Brennan said. But when a management team began examining the system's corporate culture, it discovered some potential barriers to integration.

The team looked at three cultural elements: identity, values, and norms of behaviors. "All three together form a powerful entity that can be difficult to change," Brennan said. "So a vision is essential if we're going to shape change."

In terms of identity, the team decided the system would need to move away from a culture defined by strong, dominant hospitals. The system is expanding its non-acute care activities, such as long-term, home, and hospice care. And it is beginning to form integrated systems at the regional level.

Brennan also stressed the need to retain the richness of the organizations' histories and heroes. "We need to think about how we can bring some of those stories forward with us while trying to create new stories" in integrated delivery systems, he said.

Sisters of Providence Health System

also looked at some of its key management values that "may be dysfunctional in the culture that's transforming our system," Brennan said. For example, "fresh new ideas may be far more valuable than hard work alone." And the system will have to alter its analytical, risk-averse decision-making process in a world that is changing quickly, he said.

Finally, the management team looked at the system's behavioral norms, which Brennan said are ingrained, almost ritualistic, and thus difficult to change. Among the findings, he said, was a reluctance to relinquish control that may impede building bridges with other providers. He also pointed to a need to make decisions based on the interests of the total system rather than its individual components.

One of the system's first steps toward integration came with the reorganization of its facilities in Portland, OR. Now, they have one hospital administrator instead of three; a director of clinical integration across the region; and combined human resource, finance, and information systems.

Brennan said healthcare systems seeking change must overcome a number of barriers:

- Existing titles, structures, and departmental boundaries that stifle coordination and cooperation
- Lack of vision and leadership to alter "memory and traditions frozen in place"
- Internal resistance to change
- The past success of the system's dominant hospitals
- The fear of failure and the tendency to focus on short-term results and profits
- Limited expertise outside of that required to manage hospitals
- The need to develop new management, human resources, and information systems that allow integration

Challenges to Tax Exemption Growing

Richard E. Connell, JD

The tax-exempt status of hospitals is a privilege, not a right, and it is a privilege that increasingly is being challenged, according to Richard E. Connell.

Connell, a partner in the law firm Ball, Skelly, Murren & Connell, Harrisburg, PA, said it is time to "sound the alarm" about the efforts of state and local governments to impose tax burdens



Identity, values, and norms of behaviors "form a powerful entity that can be difficult to change. So a vision is essential if we're going to shape change."

—Brennan

on not-for-profit healthcare institutions. Thirty-two states have mounted tax challenges to various charitable institutions, he said, and 12 states have considered withdrawing tax exemptions across the board.

Hospitals account for 1 percent of all tax-exempt organizations but 40 percent of tax-exempt organization revenues, Connell said. And healthcare represents a potential windfall of \$3.5 billion in new tax money to government.

As not-for-profit healthcare institutions behave more and more like for-profit businesses—with high salaries linked to bottom-line financial performance, opulent buildings and offices, mergers and acquisitions, aggressive collection activity, and minimal donations from benefactors—it becomes more difficult for them to show they are entitled to tax exemptions, he said.

"There are no standards; there is no basis on which to measure your perfor-



Members exchange views on healthcare reform.

mance," Connell said. He noted that Pennsylvania has imposed five criteria that must be satisfied by all charitable organizations, but the criteria are imprecise and impossible to understand, leading to long and involved legal battles for those resisting the challenge. He also warned that tax enforcers in different states communicate frequently and share ideas for getting more revenue out of not-for-profits. Therefore it helps to be aware of what is going on in other states.

To preserve their tax-exempt status, Connell said, healthcare facilities must ask themselves a vital question: Are you fulfilling your mission? Connell advised attendees to take the initiative in demonstrating that they provide service to their communities. He recommended using the Catholic Health Association's *Social Accountability Budget*, a workbook that helps facilities review and document their contributions to the community. In addition, he said, CHA's Community Benefit Standards can help facilities strengthen their standing in the community.

Connell also advised administrators

to update their bylaws and mission statements to reflect a commitment to community benefit and, even more important, "make sure those at the working level know what you're about."

He added that administrators must become "legislatively sophisticated." Get to know your representatives and senators, he advised, and make sure they understand what you do. "You have to begin your humble self-praise," he said. "Don't sit back and wait until you have to justify yourselves later."



Update your bylaws and mission statements to reflect a commitment to community benefit and, even more important, "make sure those at the working level know what you're about."

—Connell

Communications Technologies: New Vistas For Integrated Care

Woody Ritchey

Enhancements of communications technology will enable healthcare providers to improve patient care, control costs, and distribute resources more efficiently, according to Woody Ritchey, division manager of product marketing for AT&T's Global Business Communications Systems, Bridgewater, NJ. Ritchey said the pace of improvements is accelerating in part because of collaborations between vendors who "match their strengths to deliver the best integrated products available." Such cooperative ventures have led to enhancements in real-time and non-real-time voice communications, as well as video, image, and data transmissions.

Interactive videoconferencing, Ritchey suggested, should be at the center of any hospital's plans for telemedicine implementation. This emerging technology will allow physicians and other care providers to make "video housecalls" to patients, lowering healthcare costs and at the same time enhancing accessibility. In-home diagnosis via video may be the best source of medical treatment for many rural persons, Ritchey noted.

He added that improvements in teleradiology will also make healthcare delivery more efficient, pointing out that images can now be transmitted more quickly and with greater clarity than ever before. Increasingly powerful computer networks are also making teleradiology more effective.

But as vendors position themselves to furnish better, more cost-effective services, healthcare providers face an inevitable ques-

tion, Ritchey said: "How will I know the best vendor with which to partner, and which technologies make the most sense for my facility?"

Ritchey acknowledged that these questions have no simple answers, but he cautioned providers to examine vendors' commitment to standards. "Virtually every technology has a corresponding standards body that drives its development. . . . It is certain that all these technologies and applications will continue to evolve in the years ahead. Adherence to standards will be one more assurance you won't be left in the lurch as your needs change."

Thriving on Change

Carol Kinsey Goman, PhD

You don't have to like change to thrive on it. With that thought, Carol Kinsey Goman, president of Kinsey Consulting Services, Berkeley, CA, discussed her research and observations formed while working nationally and internationally with industries that have experienced various forms of change. "We cannot direct the wind," she said, "but we can adjust our sails."

Goman said she knows three things for sure:

1. Change is occurring in every country and industry; so the challenge is how to help people cope.

2. The pace of change is accelerating; so the challenge is how to position change as "business as usual."

3. The most difficult change is changing what made us successful in the past; so the challenge is to avoid becoming obsolete.

In a rapidly changing environment,

Goman said, it is important to deal with individuals honestly and show appreciation on an ongoing basis through verbal and written comments and gifts and awards. Providing for professional and personal growth also builds peoples' confidence and feelings of being appreciated.

Goman listed five characteristics of people who thrive on change:

1. Confidence. It is important to be aware of one's strengths and use each change as a learning process. "In the future, people will be hired on their ability to learn."

2. Love of challenge. Optimists see the opportunities, but pessimists' first reaction is negative. With information and enough time to adjust, pessimists can be turned into "cheerleaders of change," Goman said.

3. Coping strength. When change is introduced, people go through stages. During denial, they want as much information as they can get, quickly. In the resistance stage, they need a place to talk about the change. During the grieving stage, people finally start to let go, arriving at the exploration stage, when they ask how the change will affect them.

4. Counterbalance. Individuals who handle change most effectively have outside interests and take care of themselves through such means as exercise, proper diet, hobbies, and religion.

5. Creativity. "We are now in a world of multiple right answers," said Goman, "and sometimes our own expertise can get in the way of being creative. When that happens, it might help to bring someone new into the discussions."

During times of change, Goman said, it is impossible to overcommunicate with people. Individuals need to be told the good and the bad news, and then we must trust that they will make the best decisions for themselves and the organization. "Progress always involves risk," said Goman. "You can't steal second base and keep your foot on first."



"We are now in a world of multiple right answers, and sometimes our own expertise can get in the way of being creative. When that happens, it might help to bring someone new into the discussions."

—Goman



Twelve general sessions and eighteen breakouts gave assembly attendees food for thought.

CARE INTEGRATION

Capitation Works for Long-Term Care

Jennie Chin Hansen

Providing a full range of capitated health and social services to a population certified as nursing home eligible, with an average age of 83, is old hat to On Lok. The success of On Lok—a not-for-profit, community-based long-term care organization for the frail elderly located in San Francisco—has implications for health policy-



Long-term care is manageable, Chin Hansen reported.

makers, according to Jennie Chin Hansen, director of On Lok Senior Health Services. Long-term care *is* manageable, and the model can be successfully replicated, she said.

On Lok means “peaceful, happy abode” in Chinese and is built on the philosophy of primary, home, and adult day care provided in the community. The model’s 360 participants receive a comprehensive range of services, including transportation, meals, pharmaceuticals, and hospital care. Because the model emphasizes preventive services for this frail, at-risk elderly population, only 6 percent of On Lok participants are in a nursing home, while 94 percent live in the community. When hospitalization or nursing home placement is required, On Lok pays its contract hospitals and skilled nursing facilities out of its capitated fees and has been

able to keep its capitation days for acute care to about 0.5 percent.

The On Lok model differs from more common managed care arrangements because it actually provides the care. On Lok employs four full-time physicians who monitor participants through their nursing home or hospital stay, delivering truly personalized care.

On Lok’s success has spurred a number of replication projects called PACE (Program of All-Inclusive Care for the Elderly). Currently, 12 PACE sites are operational, including one sponsored by the Sisters of Providence in Portland, OR.

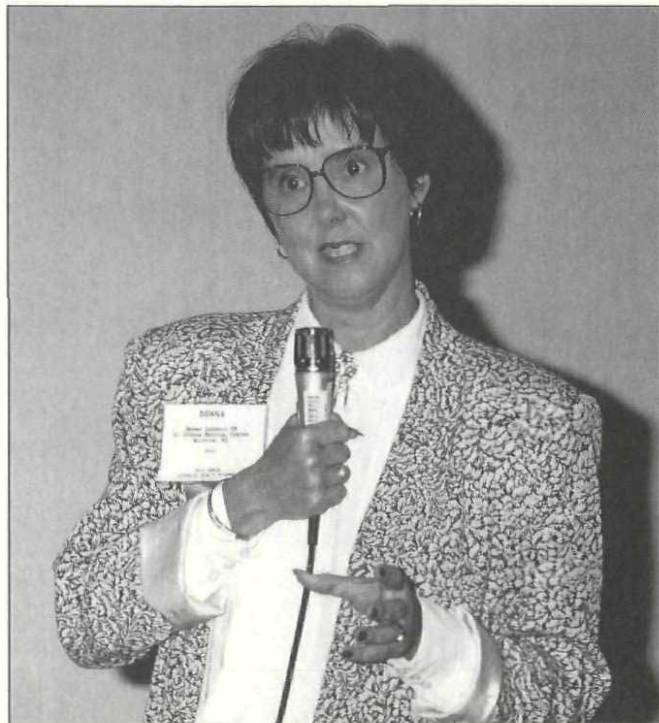
Nurse Case Managers Reduce Admissions, Stays

Jennie Weyant, RN
Donna Swindle

In an enlightened healthcare delivery system, patients make informed care choices based on their needs, abilities, resources, and personal preferences. In Wichita, KS, they can do this through St. Joseph Medical Center’s Community Based Nurse Case Management program. Nurse case managers offer clients personalized care in an otherwise impersonal healthcare system, asserted Jennie Weyant, a nurse case manager at St. Joseph. Weyant emphasized that the



Friends greet each other between sessions.



Program originators had to show how nurse case management could offset costs, Swindle explained.

one-on-one care provided by nurse case managers and the trust relationship they build allow them to get to the core of patients' problems, something physicians may not have the opportunity or time to do.

To secure the go-ahead for the Community Based Nurse Case Management program, program originators had to show how it could offset costs, said Donna Swindle, St. Joseph Medical Center's senior vice president, Patient Care Services. Thus they set a goal of shortening length of stay by one day and reducing by 50 percent the number of patients readmitted. The program has been a success. Average length of stay per admission is down to 10.3 days from 11.1 days, a 7.2 percent reduction. The average number of readmissions per patient dropped from 1.8 to 0.7.

St. Joseph's launched the program in 1989 with two nurse case managers. The goal was to provide integrated, cost-efficient, round-the-clock care outside the hospital, Weyant said. Today each of the eight case managers cares for 20 persons. Four are pediatric patients. To become a case management client, persons must have at least two hospital admissions and \$7,000 in hospital charges.

At first, program originators targeted frail elderly patients on Medicare because they believed the program would have the most immediate and positive effect on that population. Now, said Weyant, the program reaches out to any population with chronic illnesses and is participating in a Medicaid

demonstration project.

St. Joseph Medical Center offers addiction treatment, psychiatric care, rehabilitation, wellness care, and acute care. Nurse case managers integrate all these services as they coordinate patients' care over time, according to Swindle. The program emphasizes the continuum of healthcare and enables nurses to use their full expertise in promoting health.

To become fully integrated into St. Joseph's system of care, the program had to be part of the medical center's strategic plan and infrastructure, Swindle explained. Nurse case managers collaborate with other staff to ensure that social workers, home health nurses, and physicians refer clients to the case management program when appropriate and to avoid duplication of services. The program also has created processes for review, feedback, medical record documentation, and evaluation.

Managing the Shift to Ambulatory Care

Craig Holm

The day is coming when ambulatory care will make up half of a hospital's revenues. And the revenues may come from some surprising sources. For instance, today's indigent population may become lucrative ambulatory care patients after healthcare reform, predicted Craig Holm, a principal with CHI Systems, Inc., Philadelphia.

Holm said community hospitals report twice as many outpatient visits as inpatient days. Ambulatory care now accounts for about one fourth of total hospital revenues.

But in their rush to ambulatory care, hospitals sometimes apply the mistaken theory, "If you build it, they will come." Many times, people do not come, he said. A thorough operations-planning process is necessary before building a facility, Holm insisted, to understand the role of ambulatory care in the organization and the community. Hospitals should develop positioning strategies and ways to enhance access, according to Holm.

In the end, he said, success in ambulatory care depends on the same factors that determine overall success: market control, aggressive anticipatory behavior, and responsiveness to market needs.

COMMUNITY INTEGRATION

Lessons in Providing, Publicizing Community Services

William Dowling, PhD
Sara Lyon
G. Richard Erick

Being accountable to the public, reporting community benefits, and taking leadership positions in collaborative efforts will become increasingly important as newly formed health delivery networks assess and respond to community needs. Many healthcare organizations are in a good position to "serve as the catalyst and offer leadership skills in a community needs assessment process," said William Dowling, vice president, Sisters of Providence Health System, Seattle. Equally important, he noted, is involving knowledgeable people from outside the organization to gain a better understanding of problems and garner community support.



Ann Neale of Franciscan Health System, Aston, PA, raises a question during a general session.



Lyon praises CHA's Social Accountability Budget.

Dowling recommended assigning to one person the management responsibility and authority for the community service program, "just as we assign department heads for oncology and cardiology."

He cautioned that external demands on healthcare providers will intensify as others learn of their commitment to community service and outsiders become involved. But community service will strengthen the organization's public accountability, responsiveness, and support.

Dowling said that the Catholic Health Association's *Social Accountability Budget* "crystallizes" healthcare organizations' ongoing effort to help their communities and offers a systematic and structured method of including community benefit when they are planning and budgeting. Sara Lyon, vice president of marketing, Franciscan Health Services, Tacoma, WA, added that system member St. Joseph Hospital & Health Care Center, Tacoma, found that the *Social Accountability Budget* provides guidance on inventory systems, cost analyses, measuring and monitoring programs, and reporting results for community benefit programs.

G. Richard Erick, administrator, St. Joseph Villa, Salt Lake City, believes the 175-bed long-term care facility would not have had its tax-exemption status questioned in 1986 if it had had the guidance of CHA's

St. Joseph Hospital & Health Care Center launched its community benefit program because "we felt the erosion of the community's faith in hospitals and healthcare organizations and systems."

—Lyon

Holistic Approach Will Transform Healthcare Services

Thomas B. Drummond, PhD
Sr. Carla Przybilla, OSF, PhD

The holistic health movement will be a driving force in revolutionizing today's healthcare system, especially acute care hospitals. Catholic healthcare providers have the resources and the courage to transform current thinking on health to a body-mind-spirit relationship, according to Thomas B. Drummond, president, and Sr. Carla Przybilla, OSF, spiritual director, New Life Center, The Plains, VA.



New Life Center is one healthcare organization that uses the body-mind-spirit approach to healing. Opened five years ago, the center is a coed residential community that can house six clients at a time. It offers an alternative to hospitalization for religious and clerics who have psychological disorders. According to Drummond, the goal of New Life Center is to help clients find the core beliefs that control their lives and get the life they want for themselves when they return to their religious communities.

Drummond noted that persons with no resources require hospitalization; however, those who have at least one resource, such as the desire to overcome depression, can learn strategies to return to their communi-

Management teams from member facilities attended this year's assembly.

Social Accountability Budget. Failure to communicate its community services cost more than \$70,000 in legal fees and four years in hearings and other proceedings at the local and state levels, he said. This experience, as well as the *Social Accountability Budget*, has shown the facility the importance of assessing community needs and working with others to meet them.

In 1991 St. Joseph Villa conducted its first community needs assessment, a survey completed by persons and service providers familiar with community needs. Based on the information received, a team comprising employees of St. Joseph and other healthcare facilities and representatives from community advocacy groups decided its first community benefit program would be a quarterly newsletter for all elderly persons in Utah. The newsletter contains information about available services from various providers, the cost of these services, and how to access them.

Erick insisted long-term care facilities will be included in partnerships for providing health services if they lead in assessing the elderly's needs and act on those needs with others now. If they delay, they will lose their potential to lead in the future, he warned.

In describing what prompted St. Joseph Hospital & Health Care Center to launch its community benefit program, Lyon asserted, "We felt the erosion of the community's faith in hospitals and healthcare organizations and systems."

To stop this erosion, the organization established a Community Health Advisory Board (CHAB) to:

- Identify unmet community health needs
- Foster programs and services to address those needs
- Report programs' progress to the community

CHAB members include St. Joseph employees, employees of St. Joseph's competitors, and other community advocates. At its first meeting in November 1992, the committee reviewed a community health assessment from the county health department and decided to implement a child immunization program. A CHAB subcommittee developed vision and mission statements to guide the collaborative program.

Lyon shared the lessons St. Joseph Hospital & Health Center has learned in addressing community needs:

- The community health assessment must focus on the underlying causes of poor health, rather than medical intervention.
- Collaboration means giving up power and control.
- The board and chief operating officer must have a "paradigm-busting" vision.

Many healthcare organizations are in a good position to "serve as the catalyst and offer leadership skills in a community needs assessment process."

—Dowling

ties as holistically healthy persons.

While at New Life Center, clients design their own life programs by first making a list of 10 desires. They then learn negotiating skills to achieve them. Clients practice these skills with the group as they learn how they will integrate their life programs when they return to their communities, he said.

Our health, asserted Sr. Przybilla, is affected by our roles as members of families, communities, and cultures—our relationships with the world around us. Similarly, through the Catholic Health Association's proposed integrated delivery networks, providers' vitality will depend on how successful they are in their roles as members of their own networks, communities, and cultures.

People "make their own reality," said Sr. Przybilla. If we decide we will be well, we will stay well, she added. Healthcare providers can make healthcare reform a positive force by integrating holistic healing into their services. The call for holistic healing is coming from all directions, she said:

- Patients who are shying away from medication
- Healers who are looking for alternative care options
- Payers, who see prevention as a way to control costs

Sr. Przybilla believes every person needs to have a philosophy—a mission—to live by. She said we need to ask ourselves every day, "Why do I exist?" The same can be applied to healthcare institutions, many of

which are finding they must change their mission so they provide appropriate services to the communities they serve.

Citing a report on how holistic healing will affect the future of acute care, Sr. Przybilla noted that change will not come without some pain: Jobs will be eliminated; and legislators will struggle to amend health policy. She said the few remaining acute care hospitals will act as repair centers for crisis care, and many medical centers will be used as health education and fitness centers.



Providers' vitality will depend on how successful they are in their roles as members of their own networks, communities, and cultures.

—Sr. Przybilla

HMO's Programs Promote Community Health

William Beery

Group Health Cooperative of Puget Sound believes the health of the whole community affects the health of its members. The Seattle health maintenance organization (HMO) has adopted community service principles that include a commitment to high-quality healthcare beyond its enrollee population, said William Beery, Group Health's director of community services. The principles emphasize health promotion and disease prevention services for the poor and medically underserved.

Group Health Cooperative, a staff model HMO, provides healthcare services throughout the state of Washington. It has 480,000 enrollees, 8,000 employees, 700 physicians, 3 hospitals, and several primary care clinics.

Through its Department of Community Services, Group Health participates in outreach programs to prevent HIV disease in drug users, their sexual partners, and prostitutes. Other programs address child immunization; infant mortality, particularly in the African-American population; and healthcare for the homeless. With the Seattle Zoo and Pacific Science Centers, the HMO has produced health promotion programs for children and adolescents.

Group Health contributes \$250,000 annually to fund the Department of Community Services. Grants and contracts with program partners raised the total department budget to \$1.5 million in 1993.

Measuring the impact of his department's activities is difficult, Beery said, but Group Health is developing community service evaluation techniques with a grant from the Kaiser Family Foundation.

Board member Daniel J. Wolterman addresses the membership assembly.



CHA EVENTS

Assembly Broadens Membership, Elects New Trustees

The Catholic Health Association's long-standing commitment to improving the efficiency of the delivery system and ensuring access to healthcare is one reason for the association's extraordinary impact on the healthcare reform debate, CHA President and Chief Executive Officer John E. Curley, Jr., said at the annual business meeting. (The complete text of Curley's speech appears on p. 14.)

To adapt to changes in the healthcare system and pursue its vision of CHA 2000, the association today changed its articles and bylaws to broaden membership.

The Membership Assembly unanimously adopted six amendments that will enable any organization to belong if it promotes Catholic values, supports CHA's mission, and has its bishop's approval. Formerly, only sponsors, systems, and acute and long-term care facilities were eligible to be members.

Recommended by the Membership Study Task Force, the changes will enable CHA's membership to reflect the new types of structural arrangements likely in a reformed healthcare delivery system. And, for the first time, taxable entities will be able to belong to CHA if other requirements (including the bishop's approval) are met.

According to Dan Wolterman, chair of the bylaws committee, eliminating the previous membership categories "will enable all forms of Catholic healing ministry to join CHA and collaborate in pursuit of our vision of the future."

Wolterman added that the prior categories and the tax-exemption requirement were artificial and no longer necessary.

Following passage of the bylaws amendments, Sr. Maryanna Coyle, SC, was installed as chairperson. In her acceptance speech, Sr. Coyle remarked, "When I accepted this nomination, I didn't know I was

being called to lead a revolution." But based on the prospects for healthcare reform, Sr. Coyle invited all CHA members to be revolutionaries.

"Engage in an internal revolution of discernment and dialogue," she urged. "Renew and release your institutions for the new partnerships, structures, and relationships needed for integrated healthcare."

Outgoing Chairperson Ron Aldrich reviewed the history of CHA's healthcare reform efforts and the association's influence on reform. In particular, he cited meetings with Hillary Rodham Clinton, testimony before the administration's reform task force, and meetings with White House and Capitol Hill staff.

In other actions the assembly elected Dan Russell to chairperson-elect and elected eight new board members. (For a complete list of the 1993-94 board, see pp. 68-69.)

In addition, newly elected to the CHA Nominating Committee were Sr. Annelle Fitzpatrick, CSJ, vice president, mission, Catholic Medical Center of Brooklyn & Queens, Jamaica, NY; Sr. Patricia Forret, RSM, senior vice president, sponsorship, Eastern Mercy Health System, Radnor, PA; and Osborne W. Strickland, Jr., vice president, corporate affairs, Benedictine Health System, Duluth, MN.



"Catholic healthcare will find ways to thrive. We will continue to find ways to grow in the service of people. We will find new ways to bring Christ to the people we care for."

—Curley

Innovative Programs Lead Healthcare Revolution

Today, persons most in need of crucial social, healthcare, and mental health services often find it difficult to secure them. Three programs that provide such services have proven themselves leaders in the healthcare revolution. CHA awarded them Achievement Citations at the awards banquet.

In Philadelphia homeless mothers and pregnant women who wish to improve their lives through education or job training can turn to the **Drueping Center/Project Rainbow**, sponsored by Holy Redeemer Health System.

"Engage in an internal revolution of discernment and dialogue. Renew and release your institutions for the new partnerships, structures, and relationships needed for integrated health-care."

—Sr. Coyle

Launched in 1987, Project Rainbow offers participants housing (for two years), day care, social services, early childhood intervention services, medical services, referrals and housing assistance, after-care services, and a children's library. Contact Sr. Veronica Schuck, CSR, for more information on Project Rainbow (215-769-1830).

Urban areas like Philadelphia are not the only ones needing health and social services. In many rural areas throughout the United States, such services are difficult to obtain. Before the Daughters of Charity National Health System—West Central Region established **St. Elizabeth Health Center**, residents of Gould, AR, most of whom lived in poverty, faced an 18-mile trip to the nearest physician.

Open since December 1990, St. Elizabeth Health Center has had more than 6,000 patient visits. St. Elizabeth provides family-centered preventive and curative healthcare services on a sliding fee scale for persons from the surrounding area of all ages. Sr. Seraphine Ferrero, DC, can provide more information on St. Elizabeth Health Center (501-263-4317).

In addition to social and healthcare services, mental health services are often essential to persons' overall well-being. Since 1982 the **Indochinese Psychiatric Clinic**, sponsored by St. Elizabeth's Hospital of Boston, has helped Southeast Asian refugees deal with traumatic events such as losing a family member, surviving near starvation, or being a victim of sexual assault or torture.

Psychiatric services are free to patients. St. Elizabeth's Hospital pays 50 percent of the clinic's operating costs. State and federal funds cover the remaining 50 percent. Contact Richard Mollica, MD, or James Lavelle for more information about the Indochinese Psychiatric Clinic (617-782-3400).

Forty Hospitals Celebrate Membership Milestones

Forty hospitals celebrating 75 or 50 years of CHA membership were honored at a reception preceding the assembly.

The following 36 hospitals, observing 75 years' membership, joined CHA in 1918: **St. Edward Mercy Medical Center**, Fort Smith, AR; **St. Joseph's Regional Health Center**, Hot Springs, AR; **St. Michael Hospital of**

Texarkana, Texarkana, AR; **Mercy Hospital**, Bakersfield, CA; **Mercy Medical Center**, Denver; **Mercy Medical Center**, Durango, CO; **Saint Joseph's Hospital of Atlanta, Inc.**, Atlanta; **Mercy Center for Health Care Services**, Aurora, IL; **St. Francis Hospital of Evanston**, Evanston, IL; **St. Mary's Medical Center**, Evansville, IN; **St. Mary Medical Center**, Gary, Gary, IN; **St. Joseph Hospital**, Mishawaka, IN; **St. Joseph's Mercy Hospital**, Centerville, IA; **St. Joseph Community Hospital**, New Hampton, IA; **Marian Health Center**,



Sioux City, IA; **St. Joseph Hospital**, Concordia, KS; **St. Anthony Medical Center**, Louisville, KY; **Mercy Hospital**, Portland, ME; **Alexian Brothers Hospital**, St. Louis; **Catholic Medical Center**, Manchester, NH; **St. Elizabeth Hospital**, Elizabeth, NJ; **Our Lady of Mercy Medical Center**, Bronx, NY; **Mercy Community Hospital**, Port Jervis, NY; **Mount Carmel Medical Center**, Columbus, OH; **St. Joseph Hospital & Health Center**, Lorain, OH; **Mercy Hospital**, Toledo, OH; **St. Elizabeth Hospital Medical Center**, Youngstown, OH; **St. Elizabeth Hospital & Health Care Center**, Baker City, OR; **St. Anthony Hospital**, Pendleton, OR; **Saint Vincent Health Center**, Erie, PA; **Mercy Hospital**, Scranton, PA; **St. Joseph Hospital and Health Center**, Memphis; **Saint Joseph Hospital**, Fort Worth, TX; **St. Joseph's Hospital and Health Center**, Paris, TX; **St. Catherine's Hospital**, Kenosha, WI; and **Divine Savior Hospital & Nursing Home, Inc.**, Portage, WI.

Four hospitals commemorated 50 years of CHA membership: **Saint John's Hospital and Health Center**, Santa Monica, CA; **St. Joseph Medical Center**, Stamford, CT; **Providence Medical Center**, Portland, OR; and **Saint Eugene Community Hospital**, Dillon, SC.

Outgoing Chairperson Ron Aldrich passes the baton—in this case, an umbrella—to Sr. Maryanna Coyle, SC, CHA's chairperson of the board for 1993-94. In an address to the assembly, Uwe Reinhardt had suggested that grassroots advocates of healthcare reform use umbrellas to "smack the cars" of politicians who do not support universal access.