PREVAILING ISSUES IN LONG-TERM CARE

CEOs See Urgent Need for Adequate Funding And Better Communications Among Catholic Organizations

BY CARLETON H. PEMBER III & EDWIN FONNER, JR., DPH

Perhaps no other part of the Catholic Church's healthcare ministry is asked to do more with less than long-term care. Sponsors and providers seeking to meet the need for these services must cope with increasingly inadequate reimbursement and the failure of the nation's healthcare system to adjust to the growing demand for long-term care.

The ongoing crisis forces chief executive officers (CEOs) and administrators of Catholic long-term care facilities to continually reassess their position within the U.S. healthcare system and define their response to the challenges they face. This article reviews those issues which, in the current climate, Catholic long-term care CEOs believe most urgently need addressing.

Our sources are two recent opinion surveys conducted by the Department of Research and Information at the Catholic Health Association (CHA). One survey, conducted in mid-1990, dealt with issues related to the management and governance of Catholic-sponsored healthcare facilities (see Edwin Fonner, Jr., "The Climate of Opinion," *Health Progress*, June 1991, pp. 64-69). The second survey, completed in late 1991, focused on collaboration within the Church's institutional healthcare ministry and among Catholic organizations in general. In both instances, the respondents included sizable numbers of CEOs of Catholic long-term care facilities.

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CATHOLIC LONG-TERM CARE: AN OVERVIEW

CHA records indicate that about 1,000 Catholic long-term care facilities were open in 1991. This figure does not include many infirmaries for

Summary The ongoing crisis in long-term care has forced administrators and chief executive officers (CEOs) to reassess their position within the U.S. healthcare system and define their response to the challenges they face. This article identifies the issues that Catholic long-term care CEOs find most pressing based on two recent opinion surveys conducted by the Catholic Health Association (CHA).

In the area of management and governance, the subject of a 1990 CHA survey, respondents rated as their top concern the inadequacy of funds to treat chronically ill elderly persons. Other important issues included threats to the tax-exempt status of healthcare providers, availability of healthcare for the poor, and scarcity of nursing staff.

Respondents to a 1991 survey that focused on collaboration within the Catholic healthcare ministry cited the lack of a forum for communications as the greatest hindrance to collaborative enterprises. A lack of available time to pursue and develop collaborative projects and the absence of compelling reasons to collaborate with other Catholic organizations were also identified as important issues.

Overall, the consensus among long-term care CEOs was strong on the importance of certain management and governance issues and on the need for Catholic organizations to work together more closely.

retired women religious located in or near convents. (CHA is currently verifying this number and the characteristics of these facilities.) About 850 freestanding facilities and 157 units attached to Catholic hospitals specialize in institutionally based services ranging from skilled nursing care for the public and for retired religious to congregate housing and independent living communities. The number of units attached to Catholic hospitals grew from 79 in 1982 to 157 in 1991, while the total number of long-term beds in Catholic hospitals increased from 7,268 to 14,072 over the same period. Freestanding facilities average about 140 total licensed and staffed beds; long-term care units attached to Catholic hospitals average nearly 80 beds.

Only 30 percent of the 280 freestanding long-term care facilities listed in CHA's *1991 Guidebook* are affiliated with a multi-institutional system. On the other hand, about 77 percent of the facilities attached to hospitals are in Catholic systems. In comparison, nearly 75 percent of the 608 Catholic hospitals reported a system affiliation to the American Hospital Association in 1990. CHA records indicate that, of the 57 Catholic systems open in 1991, only two focus exclusively on long-term care.

CHA records also identified 165 different Catholic sponsors of member long-term care facilities in 1991. Of this total, 120 religious institutes of women sponsor one or more facilities. Fifty-one of these groups of women religious govern only long-term care facilities. All nine religious institutes of men sponsor one or more long-term care facilities. Thirty-four of the 39 archdioceses and dioceses with healthcare facilities sponsor at least one long-term care facility, and 18 dioceses sponsor only long-term care facilities. Finally, two sponsorship entities called private juridic persons each have one long-term care facility.

Overall, 35 percent of these Catholic organizations sponsoring long-term institutional care govern only one facility. This number includes 38 religious institutes of women, 3 religious institutes of men, 15 dioceses, and the 2 private juridic persons. Few of these 58 facilities are affiliated with Catholic systems.

Although sponsors are still predominantly institutes of religious women, laypersons have become increasingly involved in the direct management of these Catholic facilities. For example, half the CEOs of freestanding facilities are lay, as are more than 90 percent of the CEOs of units attached to Catholic hospitals. The remaining facility CEOs are primarily women religious.

The most important concern identified by CEOs of Catholic long-term care facilities was the inadequacy of funding for healthcare of chronically ill elderly Americans.

Management and Governance

CHA sent *The 1990 Catholic Healthcare Ministry Survey of Leaders' Opinions* to 1,871 leaders in Catholic healthcare and the Church. Of the 499 CEOs of freestanding long-term care facilities polled, 199 completed and returned surveys. A majority of responding long-term care CEOs (52.1 percent) believed that the U.S. healthcare system works poorly and needs *major* improvements. Virtually all the long-term care CEOs who responded (98.5 percent) thought that at least some changes, whether major or minor, are required. Sponsors, bishops, long-term care CEOs, system CEOs, and hospital CEOs varied significantly in their responses on this issue (see **Figure**, p. 40).

The 10 top-ranked survey issues for long-term care CEOs are listed in the **Table** on p. 41. Top issues for Catholic hospital CEOs are also listed for comparison. Between 50 percent and 90 percent of the respondents rated each issue reviewed below as very important, giving it a rank of 6 or 7 on a scale of 1 to 7. The overall rankings themselves are based on the arithmetic average of responses on each issue.

Inadequate Funding Among the nearly 50 survey issues, the most important concern identified by CEOs of Catholic long-term care facilities (with a mean response of 6.5) was the inadequacy of funding for the healthcare of chronically ill elderly Americans. Sixty-eight percent of the responding long-term care CEOs indicated this was a very important issue. Even as the size of the elderly population increases, adverse economic conditions are reducing the ability of many to afford medical and long-term care. Minority poor elderly are likely to fare worse than average.

More than 80 percent of these CEOs ranked the lack of availability of healthcare services for the poor and disadvantaged as a very important issue. Indirectly, this is also a funding issue because inadequate reimbursement and other financial stresses force many providers to narrow the scope of services they offer to the uninsured or those otherwise unable to pay for care.

Ethical Dilemmas Another major concern among long-term care CEOs (with 85 percent of respondents ranking it as "very important") was the ethical issues raised by the use of life-prolonging medical technology. Nearly two-thirds of respondents indicated that the National Conference of

Catholic Bishop's *Ethical and Religious Directives for Catholic Health Facilities* is an important source of Church teaching for guidance on these and other ethical issues.

Administrative Challenges A number of administrative issues were also important to survey respondents. The current scarcity of nursing staff and the inadequate training and education of healthcare workers ranked high among long-term care CEOs' concerns. Long-term care CEOs placed more emphasis on these two issues than did any other group of respondents. Almost 90 percent of them rated the nursing shortage as a very important issue, while 61 percent believed that inadequate training was a very important concern. Unfortunately, the recent OBRA legislation has placed even more pressure on long-term care facilities to compete for already-scarce nurses and other medical specialists. The pressure has been especially severe for facilities that had never employed licensed nurses in the past. And although signs indicate that the scarcity is becoming less acute in the East and West, it remains a significant problem in the Midwest.

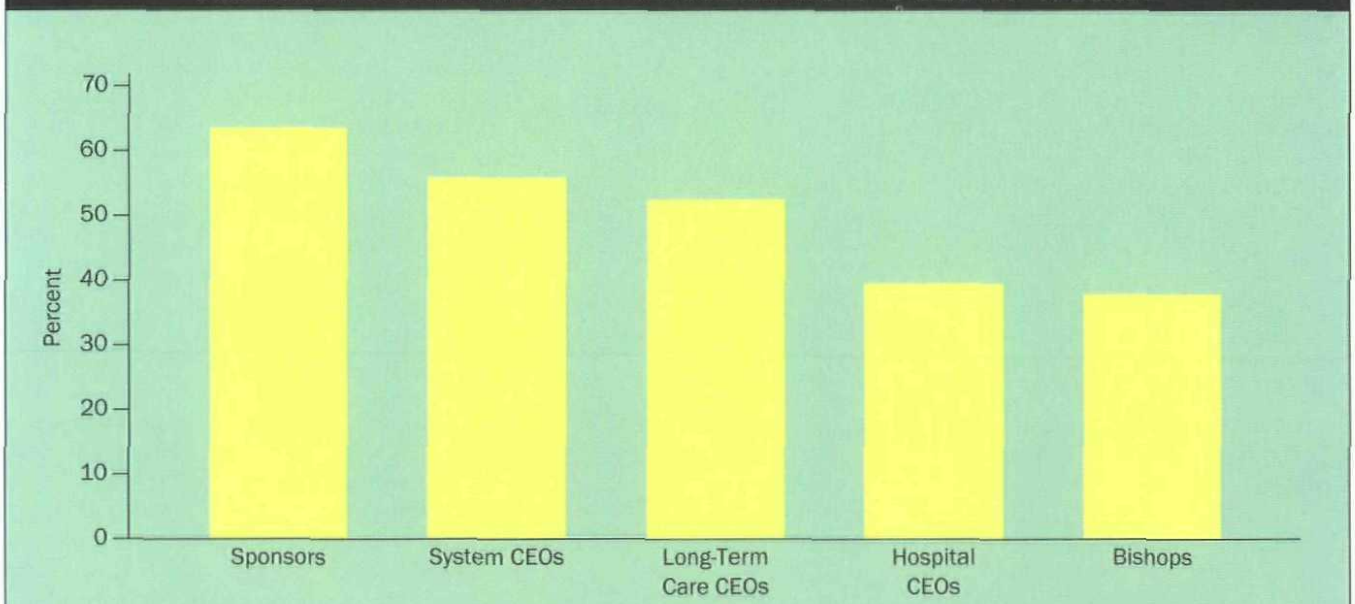
The need to reduce administrative requirements imposed on healthcare facilities by governments, payers, and other groups was of greater relative importance to long-term care facility CEOs than to any other group of responder The relatively small administrative staffs at m long-term care facilities have difficulty keepin with the deluge of paperwork. More than 66 pe cent of long-term care CEOs ranked this issue as very important.

Threats to tax-exempt status ranked high among these respondents' concerns.

Financial Viability Long-term care CEOs placed particular emphasis on a "bottom line" set of issues related to preserving the financial viability of Catholic long-term care facilities. Threats to the tax-exempt status of long-term care facilities (ranked second-most important in the survey and as very important by more than 80 percent of respondents) and the problem of costs exceeding revenue (expressed in the survey as "the declining capacity to generate adequate resources to continue our missions in Catholic healthcare") ranked high among these respondents' concerns.

Denial of or reduction in payments for the utilization of health services was, in many CEOs' opinion, yet another factor exacerbating facilities' difficulties in covering patient care expenses. The expense involved in acquiring medical technology (to remain competitive) and limited opportunities to secure revenues from nonpatient sources (to offset losses from patient care) were also

AMERICA'S HEALTHCARE SYSTEM: HOW DOES IT WORK?



Ministry Leaders Who Believe the Healthcare System Works Poorly and Needs Major Improvements

OPINIONS OF LEADERS OF CATHOLIC LONG-TERM CARE FACILITIES AND HOSPITALS

Issue	Ranking	
	LTC Administrators	Hospital CEOs
Issues of Greatest Importance		
Inadequate funds to treat chronically ill elderly persons	1	7
Threats to eliminate the tax-exempt status of healthcare providers	2	8
Availability of healthcare for the poor	3	1
Scarcity of nursing staff	4	–
Ethical issues raised by the use of life-prolonging medical technology	5	5
Costs exceeding revenue	6	4
Capacity to generate adequate resources to continue the mission	7	2
Physicians' commitment to Catholic values	8	–
Development of dedicated leaders for the Catholic healthcare ministry	9	–
Working relations between sponsors and administration (either systems or facility)	10	10
Growth in the number of uninsured and underinsured patients	–	3
Denials or reductions in payments for the utilization of heath services	–	6
High cost of acquiring medical technology and information systems	–	9
Factors Hindering Effective Collaboration		
The lack of a forum for communications prevents coordinated action.	1	1
The additional time required to work together is a diversion and inconvenience.	2	5
Absence of any real compelling reasons to collaborate with other Catholic organizations limits options.	3	4
Fear of financial losses from the added risk of collaborative relationships prevents meaningful discussions.	4	6
Decisions by sponsors and systems located outside the immediate area precludes collaboration.	5	8
The possiblity of local leaders losing autonomy and control prevents meaningful discussion.	6	3
Geographic isolation from other Catholic organizations prevents coming together.	7	2
Projects That Lend Themselves to Collaboration		
Form a Catholic advocacy network for influencing state and national health policy	1	2
Joint sponsor formation and leadership development for healthcare personnel	2	4
Implement local programs for the poor and disadvantaged	3	1
Form a Catholic advocacy network for influencing local health policy	4	3
Integrate programs to form an area-wide continuum of care	5	5

important issues for respondents.

Leadership Development and Key Working Relationships The continued formation and development of leaders dedicated to the Catholic healthcare ministry was another major concern among long-term care facility CEOs. Physician commitment to Catholic values and effective working relations between sponsors and administrators were also important issues.

The Call for Collaboration

Another group of respondents from the Catholic long-term care community had a similar opportunity to express opinions related to effective working relationships among Catholic organizations. CHA sent *The 1991 Catholic Healthcare Ministry Survey of Leaders' Opinions* to 3,110 leaders in the Catholic healthcare ministry and the Church. Responses were received from 167 of the 664 Catholic long-term care facility CEOs polled.

The objective of this survey was to assess Catholic CEOs' preferences for and commitment to collaborative initiatives. The survey attempted to determine how frequently Catholic organizations in close proximity to one another discussed the possibility of collaboration. It also asked respondents to identify the factors they believed to be hindering collaboration, as well as those programs in which Catholic organizations are most likely to collaborate.

How Much Dialogue? Slightly more than one-third of the long-term care respondents reported that they discuss collaboration with leaders of other local Catholic organizations either frequently or very frequently. On the other hand, 27 percent indicated that they rarely or never had such discussions (see **Figure**, right). About 45 percent of the respondents thought *major* improvements are needed in the dialogue among local Catholic organizations, whereas slightly more than 10 percent thought little or no improvements are needed.

Nearly half the CEOs indicated that their organizations should be initiating collaboration, followed in preference by diocesan representatives and sponsors. Three-fourths of the respondents thought that, to succeed, collaboration should be coordinated locally, rather than regionally or nationally.

Factors Hindering Collaboration As the **Table** indicates, CEOs of long-term care facilities ranked only one business-related issue (fear of financial losses) as an important hindrance to collaboration. The principal factor hindering effective coordination among Catholic organizations, in the respondents' opinions, is simply the absence of a forum for communications. Lack of time and an absence of compelling reasons were also considered important hindrances. Long-term care CEOs were less concerned than hospital CEOs about the possibility of losing autonomy and control.

> Long-term care CEOs were less concerned than hospital CEOs about the possibility of losing autonomy.

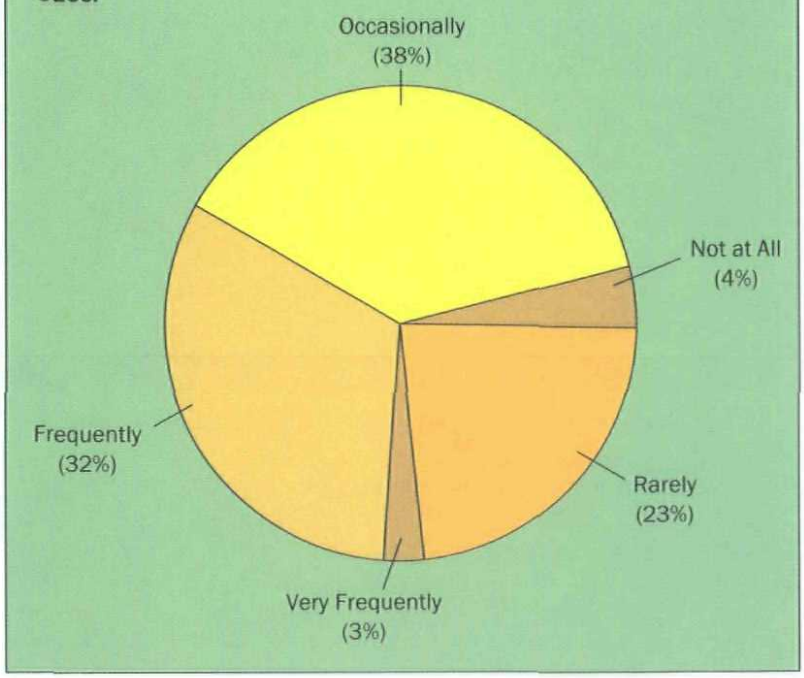
Opportunities for Collaboration Catholic health policy advocacy networks, jointly sponsored leadership development programs, and coordinated services for poor or disadvantaged populations were most frequently mentioned as the types of initiatives for which collaboration would be more effective (see **Table**). Few differences in preferences are apparent when long-term care CEOs are compared with hospital CEOs.

Future Possibilities Nearly half the respondents from Catholic long-term care facilities believed it likely that significant collaboration will occur

Continued on page 58

COLLABORATION IN LONG-TERM CARE

How frequently are there conversations between your organization and other Catholic organizations in your area focused on working together in healthcare? Responses from Catholic long-term care CEOs.



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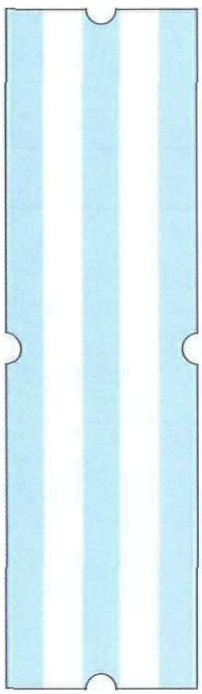

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Continued from page 42

among sponsoring groups and between Catholic hospitals and long-term care facilities in the next five years. On the other hand, about 8 out of 10 long-term care CEOs thought that significant collaboration is *not* very likely between sponsors and dioceses, between Catholic acute care hospitals and Catholic charities, and between Catholic and non-Catholic organizations.

MEDIATING PRESENCE

Aside from the high degree of concordance among CEOs of Catholic long-term care facilities on the importance of certain issues, one other result warrants attention. As a group, the degree of emphasis that long-term care CEOs placed on a number of issues fell midway between that of bishops and sponsors on one hand, and hospital CEOs on the other. This applied to management and governance issues, ethical dilemmas, and other Church-related issues. Bishops and sponsors were at times distinctively different from hospital CEOs (especially lay CEOs) in the emphasis they placed on certain issues. Thus CEOs of Catholic long-term care facilities, because they tend to occupy the middle ground, may be better able to empathize with either extreme, mediate differences of opinion, and help improve communications between these important groups of leaders.

The collective ability of this growing community of leaders to advocate improvements in the healthcare system, as well as to unify sponsors, bishops, system CEOs, and hospital CEOs, may be a key to strengthening the Church's mission of ensuring the dignity of the infirm elderly. Regrettably, at least in the short term, the Catholic long-term care ministry can expect to come under even greater pressure, if for no other reason than that the number of elderly Americans will increase dramatically in the coming decades. □

CARE MANAGEMENT: QUELLING THE CONFUSION

Continued from page 46

organization location (provider-based or freestanding care management agency), professional groups to be care managers, and identification of at risk populations.[6] If care management is a function of a provider agency, such as home health, the care manager's challenge is to provide a service package that does not inequitably benefit the provider and infringe on the care manager's role as client advocate.

Care management is moving rapidly out of the broker model and into the service management and managed care models. As a result, many ethical issues related to persons' freedom of choice or autonomy, admission criteria, informed consent, assessment of need, financial negotiation, conflict of interest, service planning, and coordination of services need to be addressed through policy development or ethical decision-making processes.

Care management implies client advocacy so that the care plans meet needs in a manner acceptable to them. The risk to managed care clients is in whether the care manager has the ability to be both an advocate and a controller of the financial liability for services. □

NOTES

1. M. Wool et al., "Negotiating Concrete Needs: Short Term Training for High Risk Cancer Patients," *Health and Social Work*, August 1989, pp. 184-193.
2. R. Applebaum and C. Austin, *Long-Term Care Case Management: Design and Evaluation*, Springer Publishing, New York City, 1990, pp. 6-10.
3. *Applebaum and Austin.*
4. C. McKenzie, N. Torkelson, and M. Holt, "Care and Cost: Nursing Care Management Improves Both," *Nursing Management*, October, 1989, pp. 30-34.
5. P. Kemper, "Case Management Agency Systems of Administering Long-Term Care: Evidence from the Channeling Demonstration," *Gerontologist*, vol. 30, no. 6, 1990, pp. 817-824.
6. Applebaum and Austin, p. 16.