SYSTEM-DIRECTED GRASSROOTS ADVOCACY

Involvement At the Local Level Drives a System's Health Policy Efforts

BY C. KREGG HANSON

In 1990 the Catholic Health Corporation (CHC), Omaha, began developing a grassroots network to pursue advocacy efforts on healthcare-related public policy issues. A survey of leaders associated with the system, conducted in the summer of 1990, revealed a consensus that CHC should take a more active role in shaping public policy.

In response to the survey finding, system leaders decided to assign responsibility for CHC public policy efforts to one of the system's senior vice presidents. CHC also decided to concentrate solely on national public policy issues that had an impact on the system's facilities. The system initiated its advocacy program in December 1990.

Grassroots Organizing

Planners agreed that the first step in developing a grassroots network should be to specify a contact person at each facility who would be responsible for organizing public policy activities. Depending on the size of the organization, the contact person could be either the facility's chief executive officer (CEO) or someone designated by the CEO. This person would initiate public policy efforts through the local organization and any network the organization was involved with.

System planners also decided it would be more effective to encourage local community members to contact elected officials on public policy issues than for the system to engage directly in advocacy efforts. Corporate officials would be responsible for monitoring and assessing changes and developments in national healthcare policy and initiating advocacy efforts.

To improve contact between the system and members, CHC established two different forms of communications to be issued by the corporate office. For issues that required immediate attention, such as pending votes in Congress that affect healthcare, CHC would release a "Public Policy Alert" to contact persons throughout the

Mr. Hanson is senior vice president, northwestern region, Catholic Health Corporation, Omaha.

Summary In 1990 leaders at the Catholic Health Corporation (CHC), Omaha, decided that the system should take an active role in advocacy efforts on health policy issues. CHC determined that developing a grassroots network would be the most effective way to pursue advocacy initiatives. The system also decided that it should concentrate solely on national health policy issues with potential impact on CHC facilities.

Planners determined that the first step in creating a network would be to specify a contact person at each of the system facilities. They also decided that it would be more effective to encourage local community members to contact their elected officials on health policy issues than for the system to engage directly in advocacy efforts. The system itself would monitor and assess changes and developments in national healthcare policy and initiate advocacy efforts. Finally, a steering committee of facility chief executive officers (CEOs) would act as a liaison between system affiliates and the corporate office.

CHC corporate staff now establish a public policy agenda that identifies initiatives the system will focus on each year. The system sets performance goals for CEOs and encourages them to participate in strategic planning for public policy initiatives.

system. For general information and updates regarding trends or changes in public policy directives, such as changes in Medicare rules or physician payment reform, the system would issue a "Public Policy Update."

A steering committee composed of the executive committee of 10 system CEOs was also created. Because the executive committee meets formally twice a year with CHC senior officials and frequently communicates via conference calls, planners determined it would provide the most effective link between the corporate office and CEOs for input on public policy issues. The committee would also provide an opportunity for *timely* interaction on fast-developing public policy issues.

Public Policy Issue Agenda

Each January CHC corporate staff establish a public policy agenda that identifies the key initiatives the system will focus on each year (see **Box**). The initiatives, which are developed with input from the CEOs' steering committee and endorsed by the CHC board, address only major issues such as healthcare reform, not-for-profit facilities' tax-exempt status, and Medicare reimbursement.

CHC involves as many individuals as possible at the local level to pursue these initiatives.

CHC offers several sessions each year to assist facilities in setting up educational programs targeted to specific public policy issues.

System leaders believe that two management tools offer the most promise for effectively directing local activities: setting performance goals for CEOs and engaging in strategic planning. The system's regional senior vice presidents communicate corporate staff positions on public policy issues through these two mechanisms. CHC requires that the regional senior vice president ensure that each CEO participates in a performance plan and evaluation each year. Public policy efforts are incorporated into both activities with regular progress reports from the CEO to the CHC board and regional vice president.

System efforts to coordinate a public policy advocacy program have convinced many boards at CHC-affiliated institutions to become more involved in important healthcare issues and to use their influence to get local constituents involved as well. CHC has also discovered that effective education on the impact of public policy is a powerful tool for shaping attitudes of local communities. The system now offers several sessions each year to assist facilities in setting up educational programs targeted to specific public policy issues.

Lessons Learned

In the two years CHC has actively been pursuing its advocacy efforts, system leaders have learned a

Continued on page 65

TAKING ACTION ON PUBLIC POLICY

Since CHC began establishing a public policy agenda, it has organized efforts for advocacy on a number of issues. For example, in 1990-91, when the new resource-based relative value scale (RBRVS) payment plan for physicians was being discussed in Congress, CHC's CEO steering committee recommended that the system educate affiliates regarding the plan and the action they should take on it.

Committee members thought that the new payment system would have an impact on physician incomes, on physician-hospital relationships, on physicians' incentives to use hospital resources, and on the types of services hospitals would provide to their communities.

In response, the committee developed a plan calling on CHC to:

- Develop a background paper to inform facility boards, medical staff, and managers regarding the impact of the physician payment reform
- Direct facility CEOs or their designees to contact state hospital associations and, through the state hospital associations, the state medical associations regarding the issue of physician payment reform
- Provide information regarding the impact the program would have on hospital-based diagnostic physicians, specialists, and primary care physicians
- Conduct a study on the impact of the transition from an inpatient delivery system to a predominately outpatient system while evaluating the impact on reimbursement and physician incentives
- Evaluate the potential impact of physician payment reform on hospital-physician relations

As part of its educational efforts, CHC invited Glenn Marcus of the Washington, DC–based Health Policy Alternative to address the issue of physician payment reform at a January 1991 meeting of system CEOs. In addition, William Hsiao, MD, the Harvard professor who developed the scale on which RBRVS is based, spoke to participants at CHC's 1992 conference for facility boards, CEOs, and medical staff leaders regarding the program and its perceived impact on physicians.

SYSTEM-DIRECTED GRASSROOTS ADVOCACY

Continued from page 53

CHC puts leaders at its affiliates in contact with advocacy experts.

number of valuable lessons. The experience has, first of all, confirmed the wisdom of CHC's commitment to avoid becoming involved in local health policy issues and to focus solely on prominent national issues.

The system has also learned the importance of timing in communicating with Congress on key healthcare-related public policy questions. In certain instances, for example, CHC may delay input or emphasis on an issue even when popular interest in it is growing. Leaders of the system's advocacy efforts have come to consider the Catholic Health Association an excellent resource in determining the timing for effective input.

In addition, CHC now recognizes the importance of putting leaders at system affiliates in contact with experts in advocacy. CHC has invited the primary lobbyists for the major national healthcare associations to its semiannual CEO meetings to enable these persons to become acquainted with the system and leaders within the system. These meetings have also encouraged local CEOs to forward their input on healthcare issues to key lobbyists.

An Effective Force

Since initiating its program, CHC has been able to rally approximately two-thirds of its facilities to respond on any given issue. The method of working closely with local facility CEOs and boards has enabled CHC to achieve its vision of becoming an effective force in providing input on key public policy issues and a responsible steward of community healthcare. □