

# Enacting the New Covenant

*keeping faith with our tradition*



Linda Frichtel

The 81st Annual Catholic Health Assembly affirmed the importance of Catholic healthcare's mission for the more than 1,300 leaders of the Catholic health ministry who gathered in San Antonio, June 9-12. Advancing the *New Covenant* process, which promotes collaboration as a means to strengthen the ministry, leaders learned how values-based healthcare can be used as an asset in today's marketplace. The following report highlights the meeting's topics: Medicare/Medicaid restructuring, physician relations, sponsorship and governance structures, integrated delivery, and, in particular, mission and Catholic identity.

The 81st Annual Catholic Health Assembly

June 9-12, 1996



# History Is Source of Strength

"Everything we have today—our institutions, music, art, our hospitals, great universities, the laws we live by, our freedoms—we have because others before us had the imagination and had the faith" to create them. Many of our greatest leaders, from Thomas Jefferson to Truman, often felt unsure of themselves and inadequate, "but they found the strength within themselves to rise to the occasion."

David McCullough

"I can't imagine speaking to any group in America that has so much to be proud of, so much to draw strength from, as you have from your own history," David McCullough said in his keynote address. From remembering history, we can find power within ourselves, continued the historian whose Pulitzer Prize-winning biography of Harry S Truman, *Truman*, appeared on the bestseller list for 43 weeks.

"Everything we have today—our institutions, music, art, our hospitals, great universities, the laws we live by, our freedoms—we have because others before us had the imagination and had the faith" to create them, he said. He pointed out that many of our greatest leaders, from Thomas Jefferson to Truman, often felt unsure of themselves and inadequate, "but they found the strength within themselves to rise to the occasion" and they were able to perform in a manner greater than even they themselves expected.

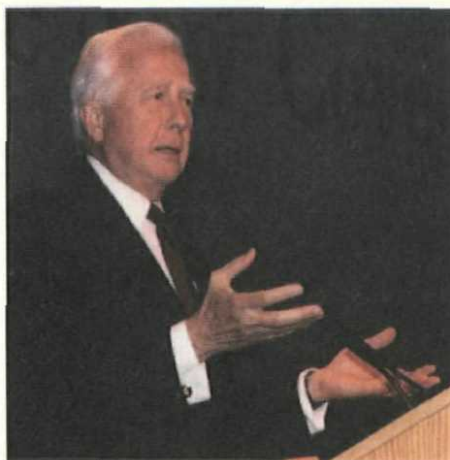
After the Johnstown, PA, flood of 1889, the Red Cross, under the direction of Clara Barton, came to the aid of people whose town had been destroyed. "Kindness, charity, compassion, consolation, humor, common sense—all of it was exhibited there, and all of it can be found in history," noted McCullough. "History teaches us how to behave and it teaches us gratitude."

McCullough pointed out another lesson of the Johnstown flood: "It is extremely dangerous to assume that because people are in a position of responsibility, they are behaving responsibly."

"Our past is filled with sadness, disappointment, and despair," acknowledged McCullough, who narrated Ken Burns's public television series *The Civil War*. But, although much about the story of this country is hurtful, he said, we can learn from it. He reminded the audience that people in the country's past were human beings who could not foretell the results of their actions and who acted according to the customs of their times.

McCullough insisted that a heritage lends confidence to a community. He said people who know the tradition they come from have the benefit of a larger human experience than their own.

"I learned a lot from Harry Truman—how to



David McCullough

handle defeat, how to maintain a sense of equilibrium and good cheer when times are at their worst." Truman never lost heart and never blamed others, he said.

America's strength "depends on a highly educated populace," warned McCullough, who is host of public television's *The American Experience*. "If we have no sense of how we got where we are, we have no

sense of where we are going," he said.

He pointed out that 60 percent of high school graduates today do not know the basics of American history. People tend to see children as the problem. But historical events teach us that in the problem often lies the solution. During the building of the Panama Canal, he pointed out, engineers worked out a way to use a river that was obstructing the construction. Like the engineers, he insisted, we must find ways for children to become the solution. "We have to start teaching our children about our story, about civilization, and about civilized behavior as early as possible."



## Assembly Themes

The 1996 Catholic Health Assembly was presented in three parts:

- Ministry as Strength:  
We Have Made a Difference
- Ministry as Strategic Asset:  
We Can Make a Difference
- Ministry as Covenant:  
We Must Make a Difference

Sessions in the three parts affirmed our heritage as the touchstone for our future; showed, in practical terms, how our mission can be an asset in times of heightened uncertainty; and highlighted the *New Covenant* process for strengthening our presence in healthcare.



# Carrying on the Legacy



Emily Friedman

**T**he greatest challenge to Catholic healthcare is not for-profit hospitals and health plans, nor is it reproductive health issues, said Emily Friedman in the Flanagan Lecture. "It is," she said, "that there will be fewer sisters in the future for myriad reasons." Somehow lay Catholic women and men will have to carry on their message, Friedman said.

She said the sisters are "the only group of people in this society who ever stood up and said, 'I'm female. I'm poor. I desire to be of service. And I expect to be, and demand to be, treated with the respect that is my due.'" Recalling the pioneering sisters described in *A Call to Care*, a CHA book and video introduced at the assembly that chronicles the Catholic women religious who built healthcare in America, Friedman noted that the sisters were fighters. "They fought the law, the mores of the time, their own superiors, the land, the weather, disease, war."

She cited stories of sisters who spoke out against poverty, racial bigotry, and ignorance. "They did so at the risk, and sometimes at the cost, of their lives—not because they held their lives so cheap, but because they held the lives of others so dear," Friedman insisted.

The sisters were the first to develop managed care, Friedman added. In the 1890s Sr. Amata Mackett sold Minnesota lumberjacks tickets for \$1 to \$5 for a year's worth of care from the Benedictines, she said. "The Benedictines' little HMO was so successful that the last ticket was cashed in in 1936." The Sisters of Saint Joseph in Kansas were paid \$80 and 15 tons of coal a month to care for the miners employed by Santa Fe companies, she said.

The integrated healthcare system was also a creation of the sisters, although they did not know it, Friedman said. "To them, healthcare was healthcare; if the patients had chronic illness, mental illness, or were just old and frail, or had acute conditions, it was all the same to them," she said. They founded orphanages, schools, nursing homes, and shelters for the aged and needy.

The sisters understood the concept of social medicine and healthy communities long before capitation made those ideas financially attractive. They would have known when 733 people died of heat last July in Chicago that heat can kill, she

said. "It killed some of them."

Friedman asked, How should the sisters' legacy be carried on in a country that tends to have, as David McCullough pointed out in his keynote address (p. 26), no sense of memory or of planning for the future? She suggested the key lies in


understanding how they expressed their vision and their faith.

The sisters, Friedman emphasized, acted out of genuine joy in taking care of strangers, not for money. Their accomplishment—building a healthcare system with no financial incentives, their patients being the forgotten and shunned—is unique in the history of the United States, she said. And she insisted that "their unwavering belief that doing the right thing will pay in the end should pervade Catholic healthcare to its soul, in every contract, in every business decision, in every hiring."

In no other endeavor—not in nursing, social work, or teaching—have women who disdained money and power become heads of multimillion-dollar organizations and CEOs and trustees of huge systems, she noted. Few people with that much money, prestige, and power have done so much good with it as have the sisters, Friedman continued. The sisters' pure charitable spirit and, most important, their insistence that service is a "matter of profound dignity" must be preserved, she said.

## Keep on fighting

Friedman urged the audience to keep on fighting as the sisters always have. She said today's adversaries may seem different from the ones the founding sisters faced, but the foes are always the same: "pain, suffering, abandonment, greed, heartlessness, and hatred." Pointing out that the early sisters, if they were alive today, would be "holding this country's feet to the fire" to care for the 61 million uninsured, for children threatened with loss of Medicaid coverage, and for the disabled, she reminded listeners of the sisters' promise: "We are going to do what needs to be done, and you can either join us or you can get out of our way."

 To order the book or video, *A Call to Care*, contact Dottie Freitag at CHA at 314-427-3458.

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Emily  
Friedman



# New Covenant Unleashes the Potential

More than 400 people have participated in self-directed regional convocations and initiatives through strategy action groups. Although the groups have "distinct personalities," they are exploring common themes, including managed care collaboration; cosponsorship; advocacy; linkages with other systems, Catholic Charities, and parishes; and healthy communities.

Marian Jennings

**"A**re you a quilt, or are you a fabric?" Marian Jennings asked Catholic healthcare leaders in a general session on the *New Covenant* process. "Quilt's fine; fabric's stronger," she said. "Can we pull together the fibers that we have and weave them together into the fabric of the Catholic ministry?"

Stressing the strength of the ministry if providers can learn to work together, Jennings, who is president of Jennings Ryan & Kolb, Hadley, MA, said the *New Covenant* process is intended to "unleash the potential" of Catholic healthcare. The session marked the beginning of phase II of *New Covenant*, a process that was launched last year to strengthen the ministry "through a formal commitment to specific strategies and actions at the national and regional levels." Involving a broader group of Catholic healthcare leaders in *New Covenant*, Jennings said, will "keep the momentum going."

## Progress to date

The National Coalition on Catholic Health Care Ministry, CHA, and Consolidated Catholic Health Care launched *New Covenant* at the 1995



Marian Jennings

Catholic Health Assembly because Catholic healthcare had reached a "critical juncture" occasioned by a variety of threats to the ministry's future. In one of several video segments sprinkled throughout Jennings's session, CHA Vice President of Mission Services Sr. Jean deBlois, CSJ, explained the "mission imperative": that "fidelity





to Jesus today mandates identifiable Catholic presence in the broader healthcare system."

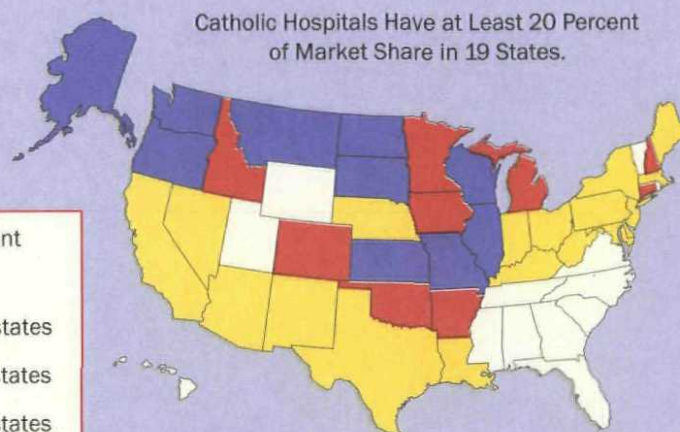
The first step in *New Covenant*, the October 1995 National Convocation of 173 ministry leaders, "served as a catalyst to get things moving," said Jennings, who facilitated the convocation. Since that time more than 400 people have participated in self-directed regional convocations and initiatives through strategy action groups. Although the groups have "distinct personalities" and are moving at their own rates, Jennings said, they are exploring common themes, including managed care collaboration; cosponsorship; advocacy, particularly at the state level; linkages with other systems, Catholic Charities, and parishes; and healthy communities.

Several of these action groups have already accomplished their objectives (e.g., obtaining approval in New York to start a statewide Catholic HMO). In addition, the *New Covenant*

## PERCENT OF ADMISSIONS IN CATHOLIC HOSPITALS

Catholic Admissions as Percent of Total in State

	Greater than 25%	10 states
	20% to 25%	9 states
	10% to 20%	19 states
	Less than 10%	13 states



Catholic Hospitals Have at Least 20 Percent of Market Share in 19 States.

SOURCE: Profile of Catholic Healthcare 1995



process has begun to change the organizations that started it (see p. 44).

## The strength of Catholic healthcare

Jennings demonstrated with some national and regional examples the concentration and potential power of Catholic systems and facilities, if they would only pull together. "There's tremendous strength and opportunity for you to build on," Jennings said.

For example, Catholic hospitals have at least 20 percent market share in 19 states and account for 16 percent of community hospital admissions (compared with only 9.8 percent for investor-owned hospitals). "You could buy the investor-owned systems if you don't like them," she joked. Even though Columbia/HCA has less than half the hospitals, beds, revenues, and assets of Catholic healthcare, the critical difference in the marketplace is that Columbia is "one unified entity," Jennings said. "Describing you that way, I think, would be a stretch."

Jennings also pointed to the potential strength to be found in partnerships with other Catholic entities: more than 1,400 Catholic Charities agencies and institutions, almost 2,000 social service centers, more than 1,000 day care centers, 159 orphanages, 93 schools for the disabled, and the phenomenal grassroots infrastructure of 199 archdioceses or dioceses and almost 20,000 parishes. "Rather than being concerned about shrinking," she said, "you should be working to grow the portion of the pie you represent."

Speaking to the sponsors in the audience, Jennings said "you can move mountains if you want to; the question is whether you want to." People are justifiably proud of what they've accomplished and reluctant to risk losing it, she said. But once they start working with one another, they will find the similarities between their cultures and values are much more pronounced than the differences. For some people, she said, the case to change is not compelling, and we should respect that choice "but not let the party least ready to change dictate the pace of change."

## Phase II: The movement accelerates

The second phase of *New Covenant* will accelerate the movement, broadening participation in existing self-directed groups and launching new initiatives. A series of fall regional meetings will focus on Medicare and Medicaid restructuring, and another fall meeting will bring together persons currently running Catholic-sponsored HMOs. (See **Box**.)

One truth that was brought home by the

National Convocation, Jennings said, is that "sponsors are out front in moving things forward," which is "not just a plus but a requirement." Jennings noted that Catholic healthcare providers generally are not risk takers. "The people who started this ministry took incredible risks. To transform it, we should be willing to take some risks too. . . . The spirit and traditions that brought you to where you are today are what is needed to transform the ministry for tomorrow."



## Next Steps in New Covenant



Assembly participants learned about CHA's New Covenant process, which is designed to enhance the organized expression of the Catholic health ministry through regional and national collaborative strategies. *New Covenant* is cosponsored by the National Coalition on Catholic Health Care Ministry, CHA, and Consolidated Catholic Health Care. Launched at a National Convocation of Catholic healthcare leaders in October 1995 in Chicago, the process is moving into its second phase. Following are some of the next steps in the *New Covenant* process.

### Fall regional meetings

A series of seven fall regional meetings to help CHA members deal with Medicare and Medicaid capitation. The meetings will focus on how to prepare operationally and financially for these programs' restructuring and how to advocate for provider-sponsored networks in the public policy debate. Following is a schedule:

November 12-13	Minneapolis
November 14-15	Chicago
November 19-20	San Francisco
November 21-22	Seattle
December 2-3	Dallas
December 9-10	Hartford/Springfield
December 11-12	Philadelphia

### Study of models

A major study of Catholic organizational and sponsorship models that use mission to advantage. See report of Kevin Sexton's talk, p. 30.



For more information on the fall regional meetings or the *New Covenant* process, call the CHA Member Hotline at 800-230-7823.



# Mission Gives Us an Advantage

*Catholic providers have a "natural advantage" in attracting Medicare patients. "Catholic healthcare delivers a higher percentage of care to the elderly than does the healthcare industry at large, but it also provides a huge range of services for the elderly beyond healthcare."*

*Kevin Sexton*

**H**ow federal and state governments change Medicare and Medicaid in the next five years will be "the single biggest force" affecting Catholic healthcare providers, predicted Kevin J. Sexton, senior vice president, Lewin Group, Fairfax, VA. Sexton, who has worked with several strategy action groups formed by CHA members as a part of the *New Covenant* process, updated assembly participants on trends that have emerged since he addressed them at the 1995 CHA Annual Assembly and since he spoke at the National Convocation of Catholic healthcare leaders last October in Chicago, where the *New Covenant* process was launched (see p. 28).

In Medicare, he told the audience, providers can count on two changes: the bundling of services around people, as capitation grows in importance, and tumbling payment levels. Both Democratic and Republican budget proposals would reduce DRG rates, he noted.

Medicaid changes will be important too, Sexton said. Less than 50 percent of poor people are covered by Medicaid, he pointed out, and most states want to cover more but do not think they can afford to. "Their goal is to squeeze reimbursement so they can raise eligibility. In Tennessee, hospitals have been left with lower reimbursement to care for the uninsured. This dynamic and how it plays out should be of critical importance to you in the future," Sexton told the audience. "Every year for the last several we have seen a continual increase in the number of people who work full-time without insurance."

## Gaining control of healthcare dollars

Noting that the private sector will take a greater role in managing government programs, Sexton said, "The best hope for you is to gain control of the funds flow and use it for the mission-driven areas you care about."

First, he said, Catholic healthcare providers must convince themselves there is a real problem. He reviewed data he presented at the National Convocation projecting that, based on a



Kevin Sexton

"midlevel" estimate of managed care penetration and the ability to move patients out of hospitals, "hospital business as we know it today" will have its revenues cut by \$80 billion.

This money, Sexton said, can be redistributed to other services that hospitals currently run or manage, such as home healthcare, nursing home care, and physician services. By

bundling such services, hospitals can care for the whole person and get paid for doing so at the same time. "In a shrinking market, this is one of the few opportunities to continue to exercise leverage for your mission," he insisted.

Catholic providers have a "natural advantage" in attracting Medicare patients, he said. "Catholic healthcare delivers a higher percentage of care to the elderly than does the healthcare industry at large," Sexton said, "but it also provides a huge range of services for the elderly beyond healthcare."

## Success factors

"At the Chicago meeting we identified what it takes to succeed" in today's changing market, said Sexton:

- Critical mass
- Linkage within and outside acute care
- The ability to take risks (insurance expertise)

Sexton said Catholic healthcare has strengths in these three areas. Recalling his National Convocation comparison of Columbia/HCA with the Catholic health ministry, he noted that, with its 600 hospitals (versus 300 for Columbia/HCA) and \$44 billion in assets (versus Columbia/HCA's \$16 billion), Catholic healthcare is "a huge force to be reckoned with."

He urged participants to use their strengths on three levels:

- *Local level.* Providers should nourish relationships with local publics by supporting population-based healthcare that meets community needs.

- *Regional level.* Catholic sponsors and providers must come together with a cohesive strategy for unified governance and partnership



models. "In rural areas where you have high market shares but everything is spread out, what management styles and communication vehicles can you use to come together to do collectively what you can't do individually?" Sexton asked.

• **National level.** The key issues are Medicare reform, provider-sponsored networks, and a level playing field with all providers, Sexton said. "It's important you ensure [in national advocacy efforts] the opportunity to succeed because if Medicaid starts covering 25 percent of poor people instead of 50 percent, you're going to have problems that make it almost impossible to do the right thing," he warned.

Catholic providers that have relationships with the housing authority, churches, and schools will have an advantage in contracting with Medicaid when it becomes a managed care program, "which is where it's going," Sexton insisted. Their expertise with special needs populations such as high-risk pregnant women, trauma patients, and cancer hospice patients also make Catholic providers attractive to managed care plans, Sexton noted.

Just as mission is a "huge facilitator" in relationships with other organizations, it can be equally helpful in forming relationships with physicians, Sexton said. In the past, hospitals and physicians played a "zero sum game" in which if one side gained power, the other lost it. Urging the audience to find ways to make negotiations "a win-win," Sexton suggested that organizations use flexible arrangements such as shared leadership and "decent" compensation,

but be "bedrock" about what is important.

"The key is mutual respect and a common concern for the patient," he said. "What will provide grease to get past the rough spots" is an abiding trust between parties and shared values, he said.

## National study

As a next step in the *New Covenant* process, CHA is sponsoring a major study by the Lewin Group "to find folks who are using their mission to effective advantage" to produce "a set of lessons for the Catholic health ministry to live by," Sexton said.

Looking at many situations and markets, the study will document common themes and specific examples of mission-driven responses that work again and again. The study will stress values-driven mergers, physician-hospital mechanisms that work, and ways to deal with Medicare and Medicaid managed care.

Study coordinators are looking for sites that have a range of strategies but a common purpose, Sexton said. "We're looking for a mix of sponsorship and organizational models, a mix of environmental issues, and a mix of specific tactics. Beyond those primary focuses, we think there are lessons to be learned about urban versus rural, service and cost efficiency, basic physician relations, Catholic and non-Catholic linkages, and linkages outside healthcare," he said.

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*Kevin Sexton*



## A Comparison

### Columbia/HCA

- More than 300 hospitals
- ~60,000 beds
- 3 states with > 20% share of admissions
- Revenues \$14.5b
- Assets \$16b

### Catholic Healthcare

- More than 600 hospitals
- ~140,000 beds
- 19 states with > 20% share of admissions
- Revenues \$40b
- Assets \$44b



# Cosponsorship: Are You Ready?

*Cosponsorship can enhance the congregations' ability to influence the healthcare system so they can help set the rules (rather than just responding to them) in the market, region, or state. "By bringing some Catholic critical mass together, you can facilitate your ability to participate with non-Catholic partners in local IDNs without giving up Catholic identity."*

Marian Jennings

**A**s congregations look into cosponsorship arrangements, the most important issue is not the particular model being used but whether the congregation is ready for change, insisted Marian Jennings, president of Jennings Ryan & Kolb, Hadley, MA.

Jennings, who has facilitated some meetings among Catholic congregations entering cosponsorship arrangements, said sponsors explore the model for both ministry and business reasons. As the number of women religious declines, she said, the prime ministry imperative is to increase the sponsoring congregations' effectiveness by moving to joint sponsorship.

In addition, Jennings pointed out, by increasing the size and power of the sponsored entity, cosponsorship can enhance the congregations' ability to influence the healthcare system so they can help set the rules (rather than just responding to them) in the market, region, or state. "By bringing some Catholic critical mass together," she said, "you can facilitate your ability to participate with non-Catholic partners in local IDNs without giving up Catholic identity."



Marian Jennings

## A framework for change

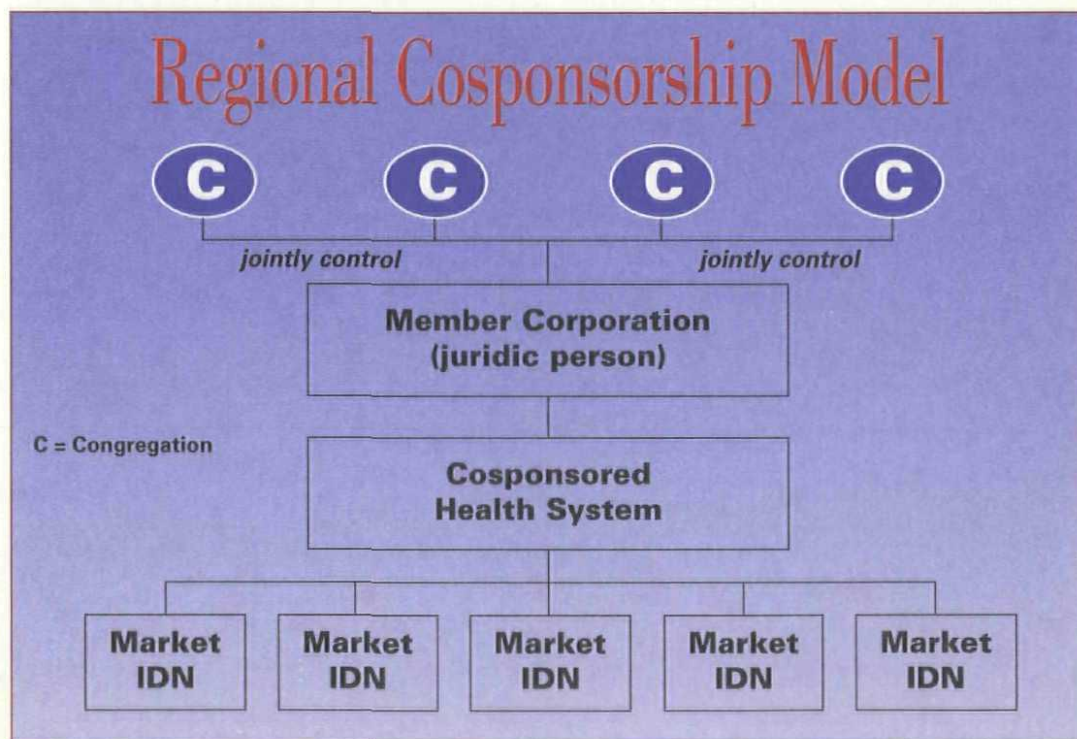
Jennings presented a framework for effective change, stressing that each step is equally important:

**Pressure for change + Capacity to change + Clear shared vision + Actionable first steps = Successful cosponsorship effect**

Just as most people do not change their lifestyles until something serious compels them to do so, Jennings said, "There's a very good chance a bunch of you will know you're compelled to change only after you have an organizational heart attack."

Jennings explained that congregations fall into one of four groups and should adjust their focus accordingly:

- Organizations favoring the status quo (feeling low pressure and having low capacity to change) should identify "trigger points" for change.
- Those resistant to change (high pressure, low capacity) should focus on concerns about change.





- Those who are adaptive (low pressure, high capacity) should focus on rationale.

- And those who are ready to change (high pressure, high capacity) should focus on models.

## Key questions

Once a congregation has determined it is ready for change (i.e., both willing and capable), it should explore cosponsorship models and principles, starting with some key questions:

- Are we looking for a regional or national model of cosponsorship, or should it be local? Local models, which only apply when the facilities are close enough to share services, should be structured to enable consolidation (e.g., by establishing one board to facilitate difficult decisions), Jennings said.

- Are we sponsoring "through" the cosponsor model (using the model as an administrative arm), or are we "jointly sponsoring" the ministry? The latter—the only true form of cosponsorship—means that the congregations sponsor all the facilities jointly and collectively, rather than merely being more involved in the ones they brought to the deal. Thus they "create something new, something powerful, linking traditions and values and building on it," Jennings said.

- How much change can we accommodate, and how quickly? "Go for as much change as you can at the outset," Jennings urged. Since people hate change, "a whole lot of baby steps will not be less painful" than one big change and will just result in sustained suffering, she said.

- Will the congregations' ownership of the new cosponsored entity be equal, or will it be proportionate to what they bring to the deal? While acknowledging that "almost everyone" would disagree with her, Jennings said that she thinks congregations' ownership should be proportionate to some assessment of value. Proportionate ownership will encourage larger organizations to participate, whereas equality will encourage smaller ones, she said. There are no right or wrong answers, she stressed, but sponsors must understand the implications of their decisions.

## A cosponsorship model

Jennings presented a basic regional cosponsorship model in which the congregations jointly control a membership corporation, which is a juridic person that carries out the congregations' short list of reserved powers (see **Figure**). Under this corporation falls a cosponsored health system, which is the locus of governance. The health system, in turn, controls a number of market IDNs, which are responsible for (in this order)

community needs, quality assurance, local advocacy, fund-raising, and financial viability. This flip flops the boards' usual priorities, Jennings said, and gives them responsibility for the financial viability of the whole market, not just one facility.

"What's missing in this model?" she asked. "Where are the existing systems? You don't need 27 layers between you and the people." In cutting out this extra layer of bureaucracy and potential for stalemate, Jennings advised the audience to consider the magnitude of the change—but also whether the system will work if they are unwilling to do it.

## Sponsors' new roles

In cosponsorship, the sponsors move out of the governance role into direct ministry, into setting the vision for the organization, and into cross-fertilizing local boards, Jennings said. "Take your sponsors where the action is," she advised. She noted that cosponsorship is only for those who want to sponsor in a different way. "If people want to bail out of healthcare and don't want to be sponsors, they should sell—not go into cosponsorship," she said.

Jennings recommended making the arrangement "hard to unscramble." "Until you're committed," she continued, "you'll fail to make the hard decisions necessary to make it work."

*"Go for as much change as you can at the outset." Since people hate change, "a whole lot of baby steps will not be less painful" than one big change and will just result in sustained suffering.*

Marian Jennings



# Lessons for Successful Cosponsorship

Marian Jennings offered the following advice for congregations interested in cosponsorship:

- Establish real partnerships based on mutual respect and trust.
- Know that creating an "ours" takes time, effort, and patience.
- View your transformed role as an opportunity to stay active in the ministry.
- Actively seek to cross-fertilize sponsors across the system.
- Devote time to articulating a compelling vision.
- Take the biggest possible steps at the outset.
- Empower the system board.
- Realize that perceived differences between congregations are often exaggerated by distance, a lack of familiarity, and fear.
- Make the arrangement difficult to unscramble.
- Don't let current systems obstruct your efforts.



# Joint Sponsorship Requires Risks

**S**ponsor-leaders agreed that joint sponsorship of healthcare—whether local, regional, or national—requires vision, a willingness to sacrifice to strengthen Catholic healthcare, and a recognition that there is no gain without pain.

## A local initiative

The local initiative that led to the formation of Via Christi Health System, Wichita, KS, stemmed from two congregations' realization that working together, although risky, could strengthen their ministry and maintain their shared values.

Sr. Veronice Born, CSJ, president of the Sisters of St. Joseph of Wichita, and Sr. Catherine Marie Hanegan, SSM, provincial of the U.S./Caribbean Province, Sisters of the Sorrowful Mother, said that taking the risks of joint sponsorship gave them the opportunity to fulfill the dream of an enriched joint ministry. Sr. Born emphasized that for joint sponsorship to be successful, "all the players—sisters, trustees, employees—must be together in mission." She added that shared mission "must be emphasized in season and out of season in every creative way."

Via Christi Health System, formed in 1995 with the merger of the CSJ Health System and the Sisters of the Sorrowful Mother—U.S. Health System, has more than 10,000 employees and owns and manages 30 hospitals, clinics, rehabilitation centers, and senior care facilities.

## A regional approach

The regional approach of joint sponsorship, initiated by Catholic Healthcare West (CHW) in 1986, rests on a commitment to strengthen Catholic healthcare, an alignment of values, and compatibility of culture of the seven sponsoring religious congregations. Sr. Patricia A. Sieman, OP, CHW chair, reported.

Sr. Sieman, who is vicareess, Dominican Sisters, Congregation of the Most Holy Rosary, Adrian, MI, added that a cultural assessment of each congregation's communication, decision-making, and organizational styles helps them determine their suitability for joint sponsorship with CHW.

Other factors, she said, are sponsor's sufficient influence on the system; marked synergies, and the need for regionalization; sponsors' need for increased influence on public policy; and their need for additional resources for advocacy.

Sponsors maintain their tradition and identity at the local facility and exercise canonical responsibility for the local facility, she said.

The pitfalls to shared sponsorship, as identified by Sr. Sieman, are the fear of losing identity and control and the feeling of being "forced or trapped" into joint sponsorship because of regional market trends. Despite what she called the "normal stresses of collaboration," CHW has succeeded because of sponsors' joint commitment to common vision and values, open and honest communication, shared leadership, and ownership of a collective charism and identity.

## A national ministry

A national joint sponsorship arrangement—Catholic Health Initiatives (CHI)—came about because three systems and their sponsors pursued their vision of a national Catholic ministry in a creative delivery network. Sr. Maryanna Coyle, SC, reported.

Leaders of the three systems—Sisters of Charity Health Care Systems, Cincinnati; Catholic Health Corporation, Omaha; and Franciscan Health System, Aston, PA—began formal discussions in August 1994, signed a letter of intent in April 1995, and have targeted July 1, 1996, for CHI to begin operations.

Sr. Coyle, who is CHI board chair, described the pitfalls and challenges of forming various steering committees, task forces, and committees, and consulting with all the players involved—40 dioceses, 12 congregations' boards, and facility employees—making sure they all shared a clear mission and set of values. She emphasized that CHI was formed not because the partners were in financial crisis or threatened, but because they were committed to strengthening the ministry for the future.

CHI is a public juridic person in accord with the Church's canon law, and its governance is shared 50-50 by religious and laypeople. Sr. Coyle said that CHI has operational sponsorship of all its facilities in five geographic regions but that sponsors retain their own canonical stewardship.

For her own congregation, Sr. Coyle said that formation of CHI "carries out our mandate" of leadership and advocacy, is a "movement away from the power model, and is an appropriate response to the charge to read the signs of the times."

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*Sr. Patricia A. Sieman, OP*



# Joint Sponsorship Requires Risks

**S**ponsor-leaders agreed that joint sponsorship of healthcare—whether local, regional, or national—requires vision, a willingness to sacrifice to strengthen Catholic healthcare, and a recognition that there is no gain without pain.

## A local initiative

The local initiative that led to the formation of Via Christi Health System, Wichita, KS, stemmed from two congregations' realization that working together, although risky, could strengthen their ministry and maintain their shared values.

Sr. Veronice Born, CSJ, president of the Sisters of St. Joseph of Wichita, and Sr. Catherine Marie Hanegan, SSM, provincial of the U.S./Caribbean Province, Sisters of the Sorrowful Mother, said that taking the risks of joint sponsorship gave them the opportunity to fulfill the dream of an enriched joint ministry. Sr. Born emphasized that for joint sponsorship to be successful, "all the players—sisters, trustees, employees—must be together in mission." She added that shared mission "must be emphasized in season and out of season in every creative way."

Via Christi Health System, formed in 1995 with the merger of the CSJ Health System and the Sisters of the Sorrowful Mother—U.S. Health System, has more than 10,000 employees and owns and manages 30 hospitals, clinics, rehabilitation centers, and senior care facilities.

## A regional approach

The regional approach of joint sponsorship, initiated by Catholic Healthcare West (CHW) in 1986, rests on a commitment to strengthen Catholic healthcare, an alignment of values, and compatibility of culture of the seven sponsoring religious congregations. Sr. Patricia A. Sieman, OP, CHW chair, reported.

Sr. Sieman, who is vicareess, Dominican Sisters, Congregation of the Most Holy Rosary, Adrian, MI, added that a cultural assessment of each congregation's communication, decision-making, and organizational styles helps them determine their suitability for joint sponsorship with CHW.

Other factors, she said, are sponsor's sufficient influence on the system; marked synergies, and the need for regionalization; sponsors' need for increased influence on public policy; and their need for additional resources for advocacy.

Sponsors maintain their tradition and identity at the local facility and exercise canonical responsibility for the local facility, she said.

The pitfalls to shared sponsorship, as identified by Sr. Sieman, are the fear of losing identity and control and the feeling of being "forced or trapped" into joint sponsorship because of regional market trends. Despite what she called the "normal stresses of collaboration," CHW has succeeded because of sponsors' joint commitment to common vision and values, open and honest communication, shared leadership, and ownership of a collective charism and identity.

## A national ministry

A national joint sponsorship arrangement—Catholic Health Initiatives (CHI)—came about because three systems and their sponsors pursued their vision of a national Catholic ministry in a creative delivery network. Sr. Maryanna Coyle, SC, reported.

Leaders of the three systems—Sisters of Charity Health Care Systems, Cincinnati; Catholic Health Corporation, Omaha; and Franciscan Health System, Aston, PA—began formal discussions in August 1994, signed a letter of intent in April 1995, and have targeted July 1, 1996, for CHI to begin operations.

Sr. Coyle, who is CHI board chair, described the pitfalls and challenges of forming various steering committees, task forces, and committees, and consulting with all the players involved—40 dioceses, 12 congregations' boards, and facility employees—making sure they all shared a clear mission and set of values. She emphasized that CHI was formed not because the partners were in financial crisis or threatened, but because they were committed to strengthening the ministry for the future.

CHI is a public juridic person in accord with the Church's canon law, and its governance is shared 50-50 by religious and laypeople. Sr. Coyle said that CHI has operational sponsorship of all its facilities in five geographic regions but that sponsors retain their own canonical stewardship.

For her own congregation, Sr. Coyle said that formation of CHI "carries out our mandate" of leadership and advocacy, is a "movement away from the power model, and is an appropriate response to the charge to read the signs of the times."

*The pitfalls to shared sponsorship are the fear of losing identity and control and the feeling of being "forced or trapped" into joint sponsorship because of regional market trends. Despite the "normal stresses of collaboration," CHW has succeeded because of sponsors' joint commitment to common vision and values, open communication, shared leadership, and ownership of a collective charism and identity.*

*Sr. Patricia A. Sieman, OP*



# Integrating with Physicians

*The predominant concern of both physicians and hospitals should be how to effectively manage care across the continuum—not only to increase the organization's attractiveness to managed care contractors, but also to enhance its efficiency and quality of care and to fulfill the hospital's mission and tax-exempt purpose.*

*Bernadette Broccolo*

**H**ealthcare systems trying to compete for the managed care dollar are moving into the second and third generations of physician-hospital integration models, according to Bernadette Broccolo, partner with Gardner, Carton & Douglas, Chicago. At this point, she advised, "the structure issues should be put aside, and you should be looking at what is needed for real care management," that is, how the relationships and financing will really work.

The predominant concern of both physicians and hospitals, Broccolo said, should be how to effectively manage care across the continuum—not only to increase the organization's attractiveness to managed care contractors, but also to enhance its efficiency and quality of care and to continue to fulfill the hospital's mission and tax-exempt purposes.

"I sit many times listening to the [providers'] goals and objectives," Broccolo said. "The only words I hear are 'becoming more competitive,' 'capturing more covered lives,' 'competing with Columbia,' when in fact I know there is an underlying mission driving everything you do." Broccolo advised audience members to articulate and document that ultimate purpose and how the establishment of vehicles to deliver managed care will differentiate their organizations from other—even other tax-exempt—health systems.

In addition to fulfilling their mission to care, health systems' other objectives include achieving economies of scale and maintaining influence, if not control, over the delivery of care, Broccolo said. Physician objectives, on the other hand, include being relieved of certain administrative burdens, maintaining control over the delivery of medical care, achieving economic security, and obtaining access to capital needed to expand their practices.

## A continuum of models

Physician-hospital integration efforts fall along a continuum, with management service organizations (MSOs) and physician-hospital organizations (PHOs) being the least integrated, and foun-



**Bernadette Broccolo**

dation employment and equity models the most integrated, Broccolo said. She added, however, that "the most successful form of physician integration is not really a form of hospital-physician integration, but IPAs [independent practice associations]." IPAs are popular, Broccolo said, because they focus on managing the delivery of care. They use, for exam-

ple, case management protocols, utilization review, patient satisfaction measures, and outcome measures and emphasize physicians' roles as providers as opposed to investors.

In all forms of integration, Broccolo continued, the tax-exempt organization needs to be concerned with a variety of federal and state statutes and regulations, including those related to federal income tax exemption (e.g., prohibitions against private inurement or benefit), Medicare fraud and abuse, and the Stark law prohibitions against certain types of referrals.

## Management service organizations

The loosest form of integration, an MSO, addresses some physician goals and objectives, such as gaining access to capital, low-cost managerial services, and relief from administrative duties, Broccolo said. But MSOs fail to focus on the managed care aspects of hospital-physician integration.

In MSOs, as in some other structures, the tax-exempt organization needs to be certain that it is not, in effect, subsidizing the physicians' practices by charging fees that are too low or funding an activity that continues to lose money. "A tax-exempt organization cannot do indirectly what it cannot do directly," Broccolo cautioned. In addition to legal problems, she warned, a "subsidy for a subsidy's sake" will produce strategic and stewardship problems. However, the tax-exempt organization can provide services that subsidize the physicians' practice if it creates a business plan up front showing that the arrangement will benefit the hospital in the long run.

Some MSOs have successfully established information systems that benefit both the hospital and the physicians, who generally would not be able to finance such a system on their own.



*Some PHOs are forming "pods"—"risk groups within the PHOs that focus within their own unit on how to manage care."*

*Bernadette Broccolo*

Although "the IRS and Medicare will look to see if it provides inappropriate private benefit to physicians," Broccolo noted, this would not be a problem if physicians paid the MSO for the system as an ongoing operating expense. In addition, she said, the health system needs to write a business plan, approved by an attorney and the system's board, demonstrating that the MSO will become financially viable over time.

### Physician-hospital organizations

PHOs, established to integrate physicians and hospitals for managed care contracting, are usually not tax-exempt organizations, Broccolo said. To comply with the IRS's private benefit prohibition, in the past the exempt hospitals' share of board representation and financial return had to be exactly proportionate to its capital contribution. However, physicians will want at least 50

percent participation on the board, or they will all walk away from the deal, she warned.

The IRS has recently relaxed its requirement and now allows some disproportionality "in appropriate circumstances." When the healthcare entity spends more than its physician partners to establish the PHO, but has equal control and return, it needs to show that the PHO is viable and that the hospital will get its money back.

Second-generation PHOs look not just at the structure but at how the care is going to be managed, Broccolo said. Some are better at integrating primary and specialty care physicians and forming "pods"—"risk groups within the PHOs that focus within their own unit on how to manage care." Physicians decide who is allowed into their pods, "giving them a true economic stake as providers, not investors."



## Physician-friendly Managed Care



**Henry Golembesky, MD**

Physicians looking to enter managed care arrangements seek partners with managerial talent and access to capital, according to Henry Golembesky, MD, a senior consultant with APM Management San Francisco. "You want to be sure you're the friendlier one," he advised, by offering:

- Continued access to patients and practice growth
- Practice autonomy, especially in clinical decision making
- Help with managed care contracting and cost control
- Participation in plans with high-quality panels and reasonable payment levels (though physicians now "expect to work harder for less money," he said)
- A fair means of dividing capitated revenues
- A collegial, professional atmosphere

In designing risk and reward systems that will help increase profitability, the integrated system's "financial incentives must be designed to motivate the management and delivery of high-quality patient care." He cautioned against incentives that focus only on cost-effectiveness and utilization. Instead, Golembesky insisted, they must also consider patient satisfaction and outcome measures.

He cited, as an example, a delivery system that tried to save money by working with physicians to lower cesarean rates from 25 percent to 12 percent—a level at which the outcomes became adverse and costs actually went up. This type of situation points out how critical it is to have adequate management information systems to support the analysis, monitoring, communication, and risk/reward processes, Golembesky said.

Another important factor in figuring physician compensation is to look at the level of utilization for the group of physicians as a whole, rather than focusing on each individual physician. In successful managed care organizations, Golembesky said, "the individual physician seeing an individual patient is the sole decision maker at that moment." He advised the audience to "give the physicians data on how the group as a whole is performing, but don't bother them if there aren't significant differences in utilization. If you try to limit care, the physicians just learn what to say to get the care they want."

Integrated systems must also ensure that the rewards and risks are significant enough to actually influence behavior. In general, he said, more than 20 percent of the physicians' income must be put at risk, or they won't be motivated to change. At the same time, he said, incentives must be aligned among all parties—primary care physicians, specialists, hospitals, and other providers. "If one of us makes money by taking advantage of a partner, over the long term that relationship won't be stable," Golembesky advised.



### Foundation models

On the other end of the spectrum, Broccolo said, the foundation model refers to "a professional corporation that sells its practice to an entity in the healthcare system and then stays on and provides services as an independent contractor." In other words, the health system buys all assets of the physician practice to more closely integrate delivery of care. "The employment model differs only in that the professional corporation goes away and the physicians become employees," she said. Physicians are drawn to these models, Broccolo said, because they believe they can retain more control over their practice and their compensation.

### Physician involvement in governance

Until last April, physician participation in the governance of tax-exempt organizations was limited to a safe harbor of 20 percent, Broccolo said. The IRS's new rule is that "the board of a tax-exempt integrated delivery system has to be composed of 51 percent independent civic leaders, and you have to have a strong and comprehensive conflict-of-interest policy in place," she said.

She pointed to one successful second-generation governance model where half the board members were physicians. Of these, Broccolo said, 32 percent were interested physicians and 18 percent, physician leaders from the community who had no interest in the organization. After the structure had been in place for some time, the interested physicians were so pleased they were considering putting more outside physicians on the board to free themselves up for clinical work.

According to the IRS's rule, Broccolo continued, the board could probably have gone up to 49 percent interested physicians (or interested parties of all kinds). But given the requirement for a strong conflict-of-interest policy, she said, "how many times would you get real meaningful decisions made? How many times would you have to recuse a good part of your board from even the discussion of an issue?"

### Intermediate sanctions

If a tax-exempt organization breaks the rules, the IRS's only current option is revocation of tax-exempt status—a drastic measure used only perhaps five times in the past decade with healthcare organizations, Broccolo said. However, Congress may soon allow the IRS to impose taxes of 25 percent to 200 percent on any excess private benefit that results from a transaction with a tax-exempt entity (e.g., paying more than fair market value for a practice).

If the IRS's proposal is adopted, it will be retroactive to September 14, 1995, "so effectively transactions you're engaging in right now may ultimately become subject to intermediate sanctions," Broccolo warned. Thus healthcare organizations must be cautious in, for example, ensuring they are charging fair market value for services and, similarly, in paying fair market value for assets (with substantiating documentation such as an independent, third-party appraisal).

### The bottom line

Even though healthcare leaders cannot ignore structure and legal issues, Broccolo recommended that they focus most on care management, including information systems, common protocols, utilization measures, and physician incentive compensation arrangements related to managed care performance. She advised providers to look at outcomes, patient satisfaction, increases in covered lives, costs per admission, and discharges, and factor those into the economic rewards for physicians.

"Start planning now," Broccolo said, "because you'll die on the vine if you focus only on productivity—that is, 'What you eat is what you kill.'"

*Providers should look at outcomes, patient satisfaction, increases in covered lives, costs per admission, and discharges, and factor those into the economic rewards for physicians.*

*"Start planning now, because you'll die on the vine if you focus only on productivity—that is, 'What you eat is what you kill.'"*

*Bernadette Broccolo*

Sidney Callahan, PhD, said that although assisted suicide might appear to fit feminist demands for increased choices and autonomy, it could easily become just another way society victimizes women.

Callahan, a psychology professor at Mercy College, Dobbs Ferry, NY, was the featured speaker at Health Progress's second annual Face-to-Face dinner, where 50 assembly-goers gathered to hear her make "A Feminist Case against Self-Determined Dying in Assisted Suicide and Euthanasia" and discuss her views. An expanded version of her talk will appear in an upcoming issue of Health Progress.





# Forming Risk-bearing IDSs

*In late 1994 and early 1995 a phenomenon took healthcare industry watchers by surprise. In some markets, more Medicare beneficiaries than commercial ERISA lives were enrolled in HMOs. In a situation never seen before, new plans exploded. In Florida, 40 new health plans came into the state. This "profoundly important evolution" occurred because the reimbursement for some Florida Medicare beneficiaries is very high.*

*Jacque J. Sokolov, MD*

**P**rovider service networks (PSNs) and provider service organizations (PSOs) are likely to gain increasing momentum in the coming months, according to Jacques J. Sokolov, MD, CEO of Advanced Health Plans, Inc., and AHP Development Corporation, Los Angeles. Advanced Health Plans develops and finances integrated delivery networks.

Sokolov explained that a PSO or PSN can assume risk for managing the medical loss ratio (the amount an HMO spends for delivering hospital and physician services) and contract directly with a financing entity, completely circumventing any HMO in its area. The financing entity, he said, could be a large corporation (whose employees would be covered) or the Health Care Financing Administration (HCFA), which the organization would contract with to cover Medicare beneficiaries. HCFA is expanding its demonstration projects with PSNs and PSOs, Sokolov said, and "within two years federal budget pressures will drive this concept to a higher level of importance."

In some states such as Texas and California, an integrated delivery system (IDS) can get a limited HMO license that allows it to bear risk for the entire medical loss ratio but not directly sign up beneficiaries. "This makes large for-profit HMOs more comfortable laying off risk to providers [letting them manage the medical loss ratio] because they won't go to their bread-and-butter consumers," he said. But "in environments where there aren't big for-profit HMOs and you become your own big IDS, there are reasons why you want a complete license, rather than a limited license," Sokolov said.

Where provider-based IDSs are already circumventing HMOs, the IDSs are in a competitor-partnership dilemma. "For example, if you're an IDS and you get 30 percent of your patients from Pacificare (an HMO) and now you go directly to Pacificare's patients, is Pacificare going to want to use you as its integrated delivery system? Probably not."

## Physician relationships

In physician arrangements, IDSs are employing a "very different strategy than just two years ago,"



**Jacque J. Sokolov, MD**

Sokolov said. "Then virtually everybody was pulling together primary care groups." Now the most popular approach is the mixed model in which a large multispecialty group "is surrounded by a network or independent practice association." The reason for the change, Sokolov explained, is that in markets where large numbers of fee-for-service beneficiaries are

available, the profit margins on a multispecialty group practice are substantially better than on an isolated primary care group. "In the transition from large amounts of fee-for-service to predominantly prepayment, the multispecialty group has proven to be a better cushion than the pure primary care group," Sokolov said, especially when the transition has gone more slowly than anticipated.

## Surprising market shifts

In 1992 the perception that national healthcare reform was on the horizon led providers to integrate. In places such as southern California, Oregon, and Arizona, five or six health plans were controlling 75 percent of the commercial ERISA market, he said.

But in late 1994 and early 1995 a phenomenon took healthcare industry watchers by surprise. In some markets, more Medicare beneficiaries than commercial ERISA lives were enrolled in HMOs. In a situation never seen before, new plans exploded. In Florida, 40 new health plans came into the state.

This "profoundly important evolution" occurred, Sokolov explained, because the reimbursement for some Florida Medicare beneficiaries is very high. Medicare reimbursement is based on a county's adjusted average per capita cost (AAPCC), which is calculated annually. The IDS or health plan receives 95 percent of the AAPCC for its region.

Although regulations require plans to enroll a commercial life for every Medicare beneficiary, they are willing to underwrite commercial premiums to get the Medicare beneficiaries, for whom reimbursement may be four to five times higher.

"I predict that Medicare in the next five years will have as much influence as commercial ERISA



plans have had in the past 10 years," Sokolov said. "In the next 24 to 48 months, we may see 20 to 30 markets driven to increased levels of managed care due to Medicare." Sokolov pointed to New York City, Philadelphia, Buffalo, Chicago, Flint/Detroit, all of Ohio, St. Louis, and New Orleans as "slam-dunk markets where you'll see an explosion in Medicare risk" health plans because of the relatively high AAPCCs and low managed care penetration. "Already Baltimore has 14 new health plans for Medicare risk," he noted.

## Predict your market

To determine whether to pursue a focused, collaborative approach as in southern California or a pluralistic approach as in south Florida, executives must understand what is likely to occur in their markets. Sokolov advised the audience to analyze three market segments in their areas: commercial ERISA, Medicare, and Medicaid. He urged them to find out what percentage of people are in fee-for-service plans versus HMOs; to project where they will be in 6, 12, 18, and 24 months; and to monitor the accuracy of those predictions in an organized process.

"Even if you understand the endpoints, the key to survival is managing the transition," he said. "If you're not appreciating that your revenue streams are evaporating from certain market segments, you're not in a position to make the management changes that are necessary."

Medicaid, like Medicare, can drive market configuration, as has happened in Tennessee, he added.

## How to prepare

In their business planning, Sokolov advised listeners to ask themselves: "Why am I building this integrated delivery system? Am I being asked to build it by HMOs? By insurance companies? Am I building it because it gives me better leverage with HMOs and the insurance companies? And how soon do I need to go to [an HMO] and actually negotiate a medical loss ratio contract?"

At some time, "you'll go to the big [HMO] companies," he said, and negotiate for the medical loss ratio plus a percentage of the premium for administration. Reinforcing this point, he said U.S. Healthcare (an HMO) has signed six contracts in which it gave the IDS the medical loss ratio plus 4 percent for administration. In general, an IDS has to be functioning for 12 to 18 months before having the infrastructure for this negotiation, he said.

## Choosing partners

"There is almost no organization in this room that doesn't have a partner in its future," Sokolov said.

"The question is, How do you look at these relationships—from strategic alliances, to joint ventures, to investor partnerships, to mergers and acquisitions?" Sokolov advised healthcare providers to answer questions such as the following:

- How much of my IDS is going to be contractual versus structural; that is, how much am I going to build or buy versus contract for?
- What vertical and horizontal linkages should I form?
- Who is building the integrated clinical delivery/disease management infrastructure the IDS needs?
- Within my IDS what are the five most expensive subpopulations of patients? Within those five, what are the ten most expensive episodes of care?
- Does my capital acquisition strategy involve debt or equity vehicles?

*"If you're not appreciating that your revenue streams are evaporating from certain market segments, you're not in a position to make the management changes that are necessary."*

Jacque J.  
Sokolov, MD



## New Animals

Jacque Sokolov advised providers on several emerging trends in care delivery.

### Physician management services companies

From \$500 million in 1990, the physician management services industry has grown to a more than \$6.5 billion industry today. These companies have many capabilities. Some are involved in primary care practices; some build independent practice associations and management services organizations; some take full capitation; some own their own HMOs; some work with hospitals. Although partnering with a physician management services company may not always be the right choice, one advantage is that the company brings equity (stock) to the table. "Instead of floating debt and buying a practice, you can do it with stock."

### Women's health

"This is a critical area for you to review," Sokolov said. Clinics that provide integrated care for women, addressing the needs of menopausal and frail elderly women as well as those who need obstetrical care, make sense for patient care and can be a powerful marketing tool to differentiate an IDS from others.

### Workers' compensation

Sokolov predicted that workers' compensation, which comprises \$60 billion in fee-for-service health claims, will quickly follow the managed care track.



*"You have to survive a tough period of brutal price competition."*

Jacque J.  
Sokolov, MD

## For-profit warning

Sokolov predicted that in the future the average HMO will receive \$21 per member per month (PMPM) for hospital inpatient services, \$17 PMPM for specialists, and \$17 PMPM for primary care physicians. For comparison, he cited respective figures of \$34, \$32.50, and \$16, which the average HMO received in the past.

He cautioned that although not every hospital and every specialist will be so direly affected by the drop in payment levels, some will do worse. "As consolidation occurs, it's important for you to keep this in mind," he warned, because "for-profit hospitals aren't in business to see profits drop. They expect lots of hospitals not to be there at the end of the day.

"You have to survive a tough period of brutal price competition," Sokolov told participants. In the next three to five years, IDSs will move from a centralized, gatekeeper approach, which attempts to lower costs by reducing length of stay and man-

aging the number and intensity of referrals, to a decentralized approach that lowers costs by managing care. The concept of a patient care management team has saved money, he said, when it involves developing patient care protocols and social services like transportation and child care.

"It's important to get your managed care vision in line," Sokolov advised. When different market segments start to move into capitation, similar movement in the other market segments accelerates rapidly. When the Medicare segment goes to prepayment, since the IDS has to have a 1:1 ratio of Medicare to commercial lives, the commercial segment accelerates its move to managed care. When commercial market segments go to capitation, Medicare and Medicaid follow because the IDS already has the ability to deliver the care at risk.

*CHA is cosponsoring seven fall regional meetings to help members deal with Medicare and Medicaid capitation. See Box, p. 29, for more information.*



# Managed Care Requires New Strategies



Greg Van Pelt

Managed care offers Catholic providers the opportunity to fulfill their mission by doing more innovative things, according to Greg Van Pelt, chief executive, Providence Health Plans, Portland, OR. But with these opportunities, managed care presents challenges different from those of acute care delivery.

To succeed in managed care, he said, health plans must meet employers' expectations in:

- Education and prevention opportunities
- Coordinated services and information, including fewer forms to fill out
- Quality standards
- Premium prices that are competitive with others in the marketplace

Van Pelt recommended that health plans develop strategies in four areas:

- *Sales and marketing.* These strategies encompass identifying purchasers and developing products that meet their needs, com-

pleting the sale, providing ongoing service to purchasers, and promotion, which Van Pelt called "a tremendous challenge."

- *Enrollment.* Applied when an individual selects the health plan, enrollment strategies include having sufficient primary care physicians to assign to each member providing members with information about their benefits, exchanging information between the plan and the group purchaser, and immediately soliciting information from new members about their health status.

- *Access.* Strategies to facilitate patients' access to care include processes for referral and authorization of service and establishment of positive relationships between patients and primary care physicians. Van Pelt said the Providence plans are working toward "seamless access" so that new members can be registered with every physician and hospital when they join.

- *Healthcare delivery.* Delivery strategies include health promotion and disease prevention, management of episodic disease, and provision of palliative care. Van Pelt added, "Our biggest push in the next decade will be in managing chronic disease."

- *Performance measurement.* Strategies to assess and document a plan's performance include benchmarking performance, designing reports, developing the internal capability to explain report card results, and capturing and analyzing data.



# Needed: A "Religious Ferocity"

*Catholic care givers must have a vision that embraces all of society, that sees communities "in the context of their wholeness, not their separateness. We shouldn't see poor people and people of color as 'problem people,' but rather as people with problems."*

Reed V.  
Tuckson, MD

**H**ealthcare workers today need some of the same "religious ferocity" that drove the founders of Catholic healthcare in this country, said Reed V. Tuckson, MD, president of Charles R. Drew University of Medicine and Science, Los Angeles.

The nineteenth-century sisters who built hospitals for lepers or prowled Civil War battlefields caring for wounded soldiers were able to lead lives with "great clarity of purpose," said Tuckson. Unfortunately, contemporary healthcare work—which involves huge organizations and sophisticated technology and must be done in a society scarred by race and class—is much more complex and offers less clarity, he said.

But the founders of Catholic healthcare taught us that "this ain't a game—it's a matter of life or death," Tuckson said. "The founders made a difference, and so can we."

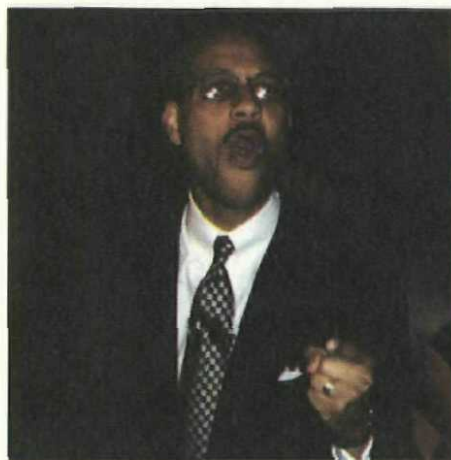
## The forgotten community

The great problem facing healthcare today is America's fractured sense of community, he argued. Care givers tend to treat individuals, forgetting that both illness and health have communal roots, he said. "Jobs and decent housing are also healthcare issues," Tuckson said, adding that physicians see many "self-aggravated social illnesses caused by hopelessness and rage."

Tuckson confessed that he himself has sometimes understood healthcare too narrowly. He described trying to teach poor women how to examine their breasts for lumps and becoming impatient with them because of their apparent reluctance to learn. "If I had taken full histories, I might have discovered that such women were fearful because they were the sole support of their families and so couldn't 'afford' to have breast cancer," he said. "Those of us in healthcare need the courage to listen to our patients, to take risks, to get deep into what's going on."

## Managed care and the community

"A hundred women will cry themselves to sleep tonight" because they have babies who will not survive their first year, Tuckson said, adding that



Reed V. Tuckson, MD

such tragedies are especially common in the inner city. "And politicians are not even talking about this yet."

But the coming of managed care gives us the opportunity "to celebrate a new vision: the individual as a member of the community," Tuckson said. Capitation will force managed care entities to focus on illness prevention, including the causes of illness, he

said. "Under managed care, there will at long last be a marriage of prevention and clinical epidemiology—a genuine concern for public health."

Nevertheless, managed care will bring its own problems, said Tuckson. "The ethical problem we will then face is the temptation, not to give no care, but to give *too little* care." He predicted that, under managed care, mission and ethics specialists will have to struggle to ensure care for the entire community. "Tensions in Catholic hospitals will grow," he said.

Catholic care givers must have a vision that embraces all of society, that sees communities "in the context of their wholeness, not their separateness," Tuckson said. "We shouldn't see poor people and people of color as 'problem people,' but rather as people with problems."

## Healthcare for all

In this context, Tuckson cited the women religious of Meridian, MS, who, during the civil rights battles of the early 1960s, insisted that everyone who needed it should get healthcare, regardless of race or class.

Tuckson said he had a dream in which churches again become the communal centers of inner-city neighborhoods. "I see police wrapping their yellow crime-scene tape around churches to set them off as sanctuaries for kids," he said. "I see hospitals sending their mobile clinics to the churches. I see the churches as anchors for the community's new infrastructure."

Religious people must be among the leaders in the new world of healthcare, Tuckson said. This will especially be true of Catholics, who "have the advantage of hundreds of years of history, experience, and vision—history, experience, and vision that others in healthcare simply don't have."



# Antitrust, Tax Law Concerns

*"The justice department looks at about 100 proposed healthcare mergers a year and challenges two or three of them." For example, the department has in recent years forced Columbia/HCA to divest itself of a number of hospitals. "But the basic antitrust question today is: Does a merger increase or restrict consumer choice?"*

*Phillip A. Proger*

**N**ew developments in two areas of importance to providers—antitrust and tax law—were described by legal experts at the assembly.

## Antitrust law

"No area of law has caused so much confusion and consternation—and so many speeches—as antitrust law," said Phillip A. Proger, a Washington, DC, attorney who is counsel for Bon Secours Health System, Inc., Marriottsville, MD.

Proger gave a historical overview of antitrust law, tracing it back to the Magna Carta. In the United States, he said, the two major pieces of legislation—the Sherman Antitrust Act of 1890 and the Clayton Antitrust Act of 1914—were populist laws meant to protect smaller competitors from big corporations. Because both acts were broadly worded, "almost all subsequent law in this area has been court created, the interpretations of various judges," said Proger. This is why antitrust law causes confusion and consternation, he said.

Until the 1970s, most healthcare facilities were local and did not involve interstate commerce; as a result, they were rarely considered proper targets for antitrust lawsuits, Proger said. In a series of cases in 1975 and 1976, however, the Supreme Court allowed the U.S. justice department to file such suits against some hospitals, he added. Antitrust law is now held to apply as much to healthcare organizations as to any other sort of endeavor, said Proger. "But healthcare organizations can still do 99 percent of what they want to do," he said.

"The justice department looks at about 100 proposed healthcare mergers a year and challenges two or three of them," Proger said. For example, he said, the department has in recent years forced Columbia/HCA to divest itself of a



Phillip A. Proger



Bud Lee



John J. Salmon



Richard E. Connell

number of hospitals it has purchased. "But the basic antitrust question today is: Does a merger increase or restrict consumer choice? Yes, Columbia/HCA is a healthcare giant," Proger said, "but the justice department doesn't object to its mergers as long as they don't appear to eliminate choice."

But this rough rule of thumb may be changing, he added. "The Federal Trade Commission is holding hearings this summer on competition in healthcare," Proger said. "Everyone now expects it to issue a report which considers some market efficiencies—including increased services and higher quality—more important than consumer choice. If it does, the government may allow some mergers it wouldn't allow before."

## Tax-exemption issues

Assembly-goers got both sunshine and rain at a session on tax-exemption issues.

The sunshine was provided by Bud Lee, president of the California Association of Catholic Hospitals (CACH), who said that not-for-profit organizations have basically won the tax-exemption battle in his state. In 1994, Lee said, a CACH-led coalition persuaded the state legislature to pass a bill that defined tax-exempt status in a way that was friendly to not-for-profit organizations. "The issue has now dropped off the radar screen politically," he said.

A darker picture was drawn by Richard E. Connell, a Harrisburg, PA, attorney who is counsel for the Pennsylvania Catholic Health Association. "Our state's situation is puzzling at present," said Connell, adding that a recent series of contradictory verdicts in state courts has tended to confuse not-for-profit healthcare organizations about their tax-exempt status.

Even worse, Connell said, "we have a public-perception problem because of these litigations." News stories have made Pennsylvanians



more cynical about not-for-profit organizations in general, he said, and have helped undermine the sense of mission of employees of not-for-profit hospitals.

An overview of federal tax issues was given by John J. Salmon, a Washington, DC, attorney who represents CHA before congressional committees and the Internal Revenue Service (IRS). "We don't need to fear the IRS, but we do need

some guidance from it," he said.

Salmon said CHA and the IRS were currently discussing the tax-exempt status of integrated delivery networks (IDNs). The IRS has promised to issue guidance on IDNs' tax-exempt status in October, and Salmon said he expects it to be friendly to CHA members. "There are good people at the IRS," he said. "They often understand our position better than Congress does."

*News stories have made Pennsylvanians more cynical about not-for-profits in general and have helped undermine the sense of mission of employees of not-for-profit hospitals.*

*Richard E. Connell*



## A Successful Public-Private Partnership

An innovative public-private partnership formed to bring healthcare to impoverished Camden, NJ, shows what can be done when organizations pool their resources.

The project was launched in a city in which 60 percent of the residents are on welfare and a third of the babies are born to teenagers, said Ruth Wexberg Poh, PhD, director of programs at Our Lady of Lourdes Medical Center, one of the project's sponsors. "When community people talk about healthcare, they don't mean medical coverage," added Owen McNally, Lourdes' director of total quality management. "They're talking about protection from drugs and violence—about staying alive."

The project began in 1992 as a partnership of Lourdes, the Diocese of Camden, and the city's school board. After Lourdes provided \$500,000 in seed money, the partners spent the first year trying to define the city's major healthcare needs in a series of meetings with community members, Poh said. She recalled these meetings as sometimes "explosive." "We had to learn to be honest and open, to leave our private agendas at the door," Poh said. Marion Proffitt, Camden's assistant superintendent of schools, explained some of the reasons for the tumult. "The doctors and sisters didn't always respect community people," she said, "and some community people just wanted to get their hands on grant money."

In the second year, Poh said, the partners selected two neighborhoods—one predominantly black, the other mainly Hispanic—in which to concentrate their efforts. "Local churches donated space in

the two neighborhoods where we set up what we called 'community living rooms,'" said Poh. Neighborhood residents were encouraged to visit the living rooms to discuss local healthcare needs with a staff person.



**Ruth Wexberg Poh, PhD**

In the fall of 1995, the project's third year, the partners hired two "healthcare facilitators," one for each of the neighborhoods. "The facilitators have become our eyes, hands, and feet in the community," said McNally. Working from the community living rooms, the facilitators show neighborhood residents how to get access to healthcare and act as the residents' advocates among healthcare professionals.

McNally said the original project partners have been joined in the past year by two other local hospitals and Campbell's Soup, a major Camden employer. The partners are now inviting managed care companies to help fund the project, he said, adding that "we're also recruiting physicians to join the project, to reach out to the community."

In addition to bringing healthcare into the community, the project partners are trying to "raise" home-grown healthcare professionals, Proffitt said. In 1994 Lourdes donated a floor in its former nursing school for the establishment of the Camden Medical Arts High School.



# CHA Sharpens Its Focus

*CHA "will retain and strengthen our core services—especially advocacy and ethics consultation. We will also begin some new initiatives to address the needs outlined in our objectives. But, in doing so, CHA will focus on a tightly defined set of projects for which we have unique capacity and can bring 'added value' to our members."*

*Jack Curley*

**T**he officers of CHA's Board of Trustees, in a general assembly session, presented a blueprint for organizational change that will mirror the changes CHA's members are undergoing. The result will be "a more sharply focused CHA—a CHA more responsive to its members and better equipped to support our ministry as it moves . . . into the next century," said Sr. Ruth Marie Nickerson, CSC, CHA's outgoing chairperson and the new speaker of its membership assembly.

Jack Curley, CHA's president and CEO, reminded assembly-goers that it has been more than a decade since the organization last revised its mission and structure. At that time, he said, "we were still in an era dominated by indemnity insurance, cost-based reimbursement, and largely autonomous healthcare facilities."

But those days are gone, Curley continued. "Now we have entered an entirely different era. Change—more unpredictable and volatile than what we have previously experienced—has become the order of the day."

Sr. Nannette Gentile, DC, CHA's new secretary-treasurer, discussed the implications of the organization's *New Covenant* process. "*New Covenant* holds great promise," she said, "but only if there is an effective vehicle for fostering a national sense of identity and purpose in Catholic healthcare."

CHA's board has revised the organization's mission, vision, and goals in view of market changes and the *New Covenant* process, Sr. Gentile told the audience. "The board's work kicks off what will now be a continuous and systematic process at CHA," she said.

"CHA is committing to a year of fewer things done exceptionally well," said Curley. "We will retain and strengthen our core services—especially advocacy and ethics consultation," he continued. "We will also begin some new initiatives to address the needs outlined in our objectives. But, in doing so, CHA will



**Sr. Ruth Marie Nickerson, CSC**



**Jack Curley**

focus on a tightly defined set of projects for which we have unique capacity and can bring 'added value' to our members."

Curley said organizational restructuring is essential "because, in today's dynamic healthcare context, CHA must be agile enough to respond to its members' rapidly evolving needs." When the restructuring is complete, he said, CHA's staff will be organized around the following management principles:

- Annually, and in conjunction with the board, CHA's senior managers will formulate and coordinate the association's mission and strategies.

- Work at CHA will be organized into projects and carried out


by teams drawn from the different focus areas of the association, such as advocacy, mission, and sponsorship.

- Internal organizational boundaries will be organic, expanding and contracting as team relationships are changed to fit the needs of any given project.

- All CHA programs and projects will be justified by their role in maximizing customer value.

As an example of CHA's new focus, Curley said, the association and its *New Covenant* partners will cosponsor a series of regional meetings on Medicare and Medicaid restructuring. "The meetings—subtitled 'Ministry Challenge, Ministry Opportunity'—will provide practical, mission-based guidance to senior management teams, sponsors, and trustees," Curley continued. (See **Box**, p. 29).

We all have concerns for the future, Sr. Nickerson told assembly-goers. "Let's face it," she continued. "We are bound to experience trepidation. . . . What we need is a burst of the same creativity, imagination, courage, faith, and foresight that animated our founders. . . . CHA must help its members further this vision so that Catholic healthcare can continue to stand as a beacon for the primacy of human dignity within the U.S. healthcare system."

 For a copy of the board's report, *Making a Difference: Mission, Goals, and Objectives for a Re-founded CHA*, call Dottie Freitag at 314-253-3458.







# A Refounded CHA

## CHA's mission

Support and strengthen the Catholic health ministry by being a catalyst for:

- A transformed healthcare delivery system infused with ministry values
- Future-oriented forms of ministry sponsorship
- A membership united in ministry

## CHA's vision

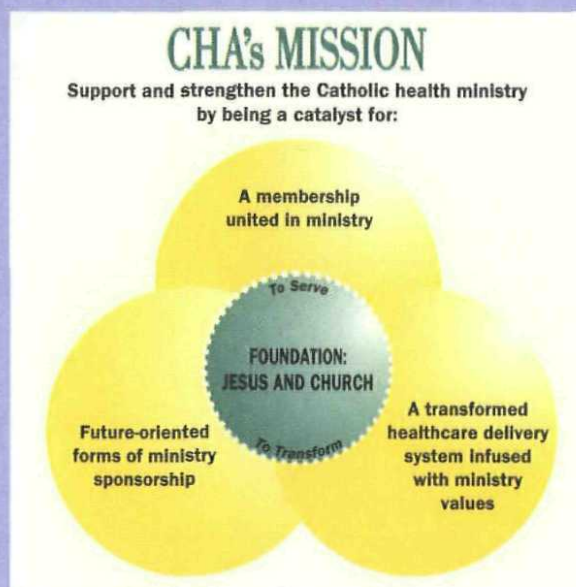
Anchored in Jesus' healing mission, the Catholic Health Association works with its members to promote justice and compassion in healthcare, influence public policy, shape integrated delivery, and strengthen ministry presence and influence in the U.S. healthcare system. It acts as a catalyst through advocacy, education, facilitation, and research and development.

## CHA's goals and objectives

### Goal I: A transformed healthcare delivery system infused with ministry values

#### Objectives

- A. Advocate access to healthcare for all, especially the poor and vulnerable:
  1. Promotion of healthcare as a right
  2. Progress toward universal coverage
  3. Strengthened access for underserved populations
  4. Responsible restructuring and financing for Medicare and Medicaid
- B. Develop and promote leading-edge templates for integrated delivery networks anchored in and strengthened by ministry values:
  1. Coordinated continuum of care focused on improving the health of persons and communities
  2. Partnerships with faith-based and other organizations
  3. Partnerships with physicians
  4. Linkages with other services
- C. Demonstrate the unique advantages of Catholic identity and methods for employing mission as a strategic asset in new partnerships.
- D. Prepare members to participate effectively in restructured Medicare and Medicaid programs by offering values-driven guidance on provider-sponsored networks.



- E. Enhance member capacity to maintain effective not-for-profit delivery systems.
- F. Support member capacity to design the future of medicine and healthcare, reflecting a holistic approach to caring rooted in ministry values.

### Goal II: Future-oriented forms of ministry sponsorship

#### Objectives

- A. Develop, assess, and promote innovative sponsorship models.
- B. Work with members to ensure an effective leadership development program.

### Goal III: A membership united in ministry

#### Objectives

- A. Support regional and national strategies for optimizing the collective strengths of Catholic healthcare and related ministries.
- B. Promote partnerships with health and other organizations that sustain ministry presence and amplify compatible values.
- C. Provide guidance and innovative models for sustaining Catholic identity and strengthening ethical integrity in business relationships with non-Catholic entities.
- D. Promote communication to enhance relationships among bishops, sponsors, and organizational leaders.



# Religious Healthcare's Essential Role

*America is turning to market forces, specifically managed care, to reduce healthcare costs. The nation is about 12 years away from "wall-to-wall HMOs," with managed care membership growing at 12 percent per year. But managed care must be managed.*

*Alain C. Enthoven, PhD*

**"R**eligious health-care plays an essen-

tial role in today's health-care system. It is very important for you to maintain and strengthen your presence in healthcare," Alain C. Enthoven, PhD, told assembly-goers. "It would be wrong for healthcare to go for-profit," said Enthoven.

"Healthcare is not a commodity," he continued, urging the audience not to sell out to Columbia/HCA. "We must not lose the values of charity, justice, caring, honesty, and support of essential community services," he said, because sick people are vulnerable and dependent on providers. "Good medicine is based on trust" and does not fit the model of an "arms-length transaction," insisted Enthoven, who is a Stanford University professor of health research and public and private management.

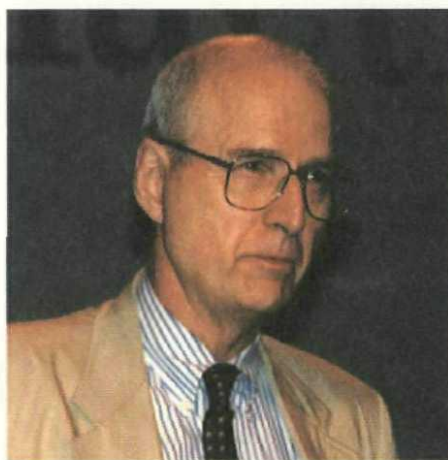
## Religiously based providers' role

The challenge for religious healthcare providers, Enthoven said, is to relentlessly pursue the improvement of the value of their services while carrying out their essential roles of providing services for the poor, advocating for the disadvantaged, and witnessing to religious values and their practical expression in the marketplace.

## Managed competition

America, Enthoven said, is turning to market forces, specifically managed care, to reduce healthcare costs. He predicted that the nation is about 12 years away from "wall-to-wall HMOs," with HMO membership growing at 12 percent a year. But managed care must be managed, said Enthoven, agreeing with Cardinal Joseph Bernardin, archbishop of Chicago, who recently voiced this caveat. Enthoven said the healthcare system must have "a framework of rules and incentives to do the right thing. I call it 'managed competition.'"

For managed competition to fulfill its potential for lowering costs and maintaining quality, he said, per capita prepaid health plans must offer annual enrollment and multiple choices. Demand



**Alain C. Enthoven, PhD**

must be price elastic so that sellers risk losing customers if they raise their price. Plans must provide standardized benefits for all market segments and information on quality. Managed competition, he added, should justly compensate providers who serve a disproportionate number of very sick patients.

All persons in a rating class should be charged the same premium, he continued, and no one should be excluded for a preexisting condition. Managed competition, by holding providers accountable for costs—including the costs of poor quality—can reward innovation and the allocation of resources to education and preventive services, he said.

## Responding to the marketplace

Enthoven said faith-based hospitals must respond to the changing marketplace. He commended the strategic moves of Catholic Healthcare West (CHW), a large system based in San Francisco, as an example for others to look at (see p. 34). CHW, he said, set specific goals:

- Community needs assessment
- Regionally based integrated systems
- Restructuring of operations for quality and productivity

He noted that Mercy Healthcare Sacramento, a CHW entity, has saved millions of dollars by placing five hospitals under one board and management, combining administrative and support functions (e.g., information systems, contracting, risk management), consolidating clinical services, seeking total capitation with medical groups, and closing a hospital.

## Improving financial access

Such savings must be used to improve financial access to care, according to Enthoven. He said cost reductions will improve access, as will making coverage portable and building health insurance purchasing cooperatives (HIPC's) to make coverage affordable for small groups. If large numbers of people were in insurance pools, health risks could be spread widely and coverage could be expanded at a reasonable price, he said. People who lost their jobs could continue to



belong to the HIPC.

Enthoven advocates another step to improve financial access: Make employer-paid health insurance contributions taxable income, but give employees a tax credit in the form of a universal voucher to purchase healthcare.

An alternative approach, he suggested, would be an individual-employer mandate in which employers would place a limited amount (cents per hour) in a fund for each employee's health coverage. Although employers have opposed reform proposals because they feared an employer mandate would force them to pay for

healthcare regardless of the cost, they could live with this limited approach, he said.

"If we did these things, we could make substantial progress in getting more people covered," Enthoven said. The public direct care system, with its resultant reduced burden, could better care for the people who inevitably do not get into the system, he said.

"We need to work toward universal coverage," Enthoven said, "but in ways compatible with our political culture, which prefers decentralized decision making and individual responsibility."



## Partners Focus on Values



**Bernita McTernan**

Focusing on common ground—on how potential partners are alike rather than how they differ—should set the context and content for networking with non-Catholic providers. It is amazing that such partnerships have been hampered over the years because of presumed differences, Bernita McTernan and Cornelius J. Kelly, PhD, lamented.

McTernan, who is vice president, mission services, Catholic Healthcare West (CHW), San Francisco, reported that CHW membership has grown from 10 facilities in 1986 to 35 in 1996.



**Cornelius J. Kelly, PhD**

In a case study report, she explained that Sierra Nevada

Hospital, Grass Valley, CA, came to be a CHW member after the prospective partners recognized their common values, mission, and culture. A cultural assessment determined that each partner held common views on the values of informed consent, treatment of people with dignity and respect, adequate consultation, social responsibility, care of the dying, confidentiality, spiritual care, advance directives, and abortion.

"This is an exciting era for Catholic healthcare," McTernan said, because some presumed barriers to partnering are being removed and new opportunities are opening up for developing healthy communities and cultural integration.

The question for Catholic healthcare providers, Kelly said, is how to retain religious identity and still perform efficiently in today's marketplace and political and economic climates. He is vice president, ethics, Sisters of Charity Health Care Systems, Cincinnati.

Recalling Rev. Bryan Hehir's thesis at the 1995 Catholic Health Assembly, Kelly said the only way Catholic healthcare organizations—an enormous social asset in themselves—can influence the culture is through an institutional presence.

Kelly admitted that Catholic healthcare continues to be problematic because "the passage of time brings new challenges and requires dynamic development and the expansion of Catholic identity."

Kelly said that Card. Joseph Bernardin, in an article in *America* magazine, noted significant development in ecclesial understanding of Catholic healthcare. In the past, that understanding focused too narrowly on reproductive issues. Kelly pointed to Card. Bernardin's observation that recent experiences with healthcare reform and social accountability have brought about a broader, more nuanced understanding of Catholic identity.

Centura Health, a management company for all Sisters of Charity Health Services Colorado and Adventist Health System facilities, is a current example of how two partners are sustaining their identities, Kelly said. Centura Health has 10 hospitals, 7 managed hospitals, 5 senior centers, and 4 physician organizations.

Centura Health has faced such strategic issues as managing a merged organization with disproportionate equity interests and governance representation; integrating two strong values-based systems whose constituencies have differing expectations; and dealing with staff anxieties.



# CHA Board of Trustees

*Pictured here are  
the Members of the CHA Board of Trustees for 1996-97.  
New members, who were installed at the  
June 11 business meeting, are marked with an asterisk.*



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Institutional Trustee,  
St. Louis



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**VICE CHAIRPERSON**  
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**Sr. Maureen Comer, OP**  
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Providence Centralia Hospital,  
Centralia, WA



**SECRETARY-TREASURER**  
**Sr. Nannette Gentile, DC**  
Visitatrix, Daughters of Charity of St.  
Vincent dePaul—West Central Province,  
St. Louis



**\*Michael D. Connelly**  
President/Chief Executive Officer,  
Mercy Health System, Cincinnati



**SPEAKER,  
MEMBERSHIP ASSEMBLY**  
**Sr. Ruth Marie Nickerson, CSC**  
President/Chief Executive Officer,  
Saint Agnes Medical Center,  
Fresno, CA



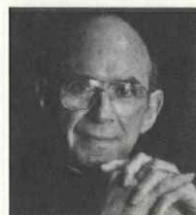
**Charles J. Dougherty, PhD**  
Vice President, Academic Affairs,  
Creighton University, Omaha



**PRESIDENT**  
**John E. Curley, Jr.**  
President/Chief Executive Officer,  
Catholic Health Association,  
St. Louis



**Mark W. Dundon**  
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Sisters of Charity of Nazareth Health  
System, Inc., Nazareth, KY



**Card. Joseph Bernardin**  
Archbishop,  
Archdiocese of Chicago



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Executive Director,  
St. Leonard Center, Centerville, OH





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President, Institute of the Sisters of Mercy  
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St. John Medical Center, Inc.,  
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