# Fidelity to Mission: Our Strategic Strength

Celia Johnson

**Princeton University's** *Uwe Reinhardt and Kaiser-Permanente's David Lawrence urged the 1,400 assembly attendees to tap the market opportunities unique to mission-driven organizations. Catholic organizations' service to the patient and community, they insisted, tempers the harmful effects of the commercialization of healthcare. This message, coming from persons outside Catholic healthcare, was weighted with a heartening credibility. Echoing their belief were many other speakers, including keynoter Charles Dougherty, researcher Kevin Sexton, and David Whyte, a poet whose words reflected participants' confidence in mission's power as a uniting and strengthening force. The following report of some of the assembly's highlights captures the meeting's inspiring themes: mission as a source of strength; the ministry's practical operational strategies; and Catholic healthcare's essential voice for a healthcare system based on justice, the common good, and human dignity.*

# Tradition and Mission: The Strength of Catholic Health Ministry

Charles J. Dougherty

David Whyte

**Catholic healthcare has a unique source of market power: the sense of purpose its tradition encourages.**

**The traditions and mission** on which Catholic healthcare is grounded foster a sense of long-term direction among those who work in the ministry and provide them tools for coping with crisis, said Charles J. Dougherty, PhD, in the keynote address, which he copresented with Seattle-based poet and author David Whyte.

"Those without a past have no profundity in dealing with success or with failure," he said. "Our traditions, by contrast, foster risk taking and boldness in the face of change."

Dougherty, academic vice president, Creighton University, Omaha, and a member of the CHA Board of Trustees, noted that "commitment to our institutions sets us apart."

This commitment, he said, "will attract patients, professionals, and talented employees because we embrace the paradox that change is a constant feature of the changeless plan [God's plan] we serve. We will reinvent our institutions as needed again and again into the future. We have the confidence that comes from faith in the ultimate purposefulness, goodness, and success of what we strive to achieve." *See pp. 48-57 for the full text of Dr. Dougherty's presentation.*

**Those without a past have no profundity in dealing with success or with failure. Our traditions, by contrast, foster risk taking and boldness in the face of change.**

**– CHARLES J. DOUGHERTY**

**Employees' Personal Sense of Mission** In his part of the keynote address, David Whyte elaborated on how employees' personal sense of mission makes it possible for organizations to carry out their missions. All persons, he said, are "desperate to belong to something larger than themselves." In his work as an organizational consultant, he said, he finds that organizations which do not have a true sense of belonging "not only within their own ranks but a true sense of belonging to their world" are the ones that have great difficulty creating "any kind of morale, any kind of inspiration, any kind of passion, any kind of true sense of mission."

Catholic health organizations, Whyte said, "are actually at the frontier in a sense." For them, he said, "it's simply an act of remembering a mission that was absolutely integral to their identity in the first place." For the individual, using memory is not just remembering a dogma or set of beliefs, but drawing an individual sense of mission from the organization's memory and mission. Without a personal feeling of mission, it is difficult for an employee to have an abstract sense of mission for the organization, he warned.

Individuals and organizations who have a sense of mission are willing to be called into conversation with the world, Whyte said. Noting that the word "vocation" derives from the Latin for "voice," he quoted a passage from Robert Frost's "Two Tramps in Mud Time":

> But yield who will to their separation,
> My object in living is to unite
> My avocation and my vocation
> As my two eyes make one in sight.
> Only where love and need are one,
> And the work is play for mortal stakes,
> Is the deed ever really done
> For Heaven and the future's sakes.

Whyte said we must bring all of ourselves (as Frost used two eyes rather than one) to the workplace. He insisted, "It is absolutely imperative now to bring that part [our soul, or sense of how we belong in the world] to the workplace" because it can sustain us through stressful times. The organization, too, needs individuals to bring their soul—their sense of belonging—in order to realize its potential in the future, Whyte said.

# Group Calls for Revolution in Care of the Dying

**A new study shows that many Americans think healthcare organizations and professionals are insensitive in their treatment of dying patients and their family members.**

**Calling for radical changes** in the way society treats dying people, a small army of speakers—some live, some on videotape—explained to the assembly why such changes are needed. The speakers represented Supportive Care of the Dying: A Coalition for Compassionate Care (SCD), which recently completed a study called *Living and Healing During Life-Threatening Illness*. Each assembly-goer was given a summary of the study's results.

Sylvia McSkimming, PhD, director of nursing quality and research, Providence/St. Vincent Medical Center, Portland, OR, explained that the study was based on a nationwide series of focus groups in which SCD, a group of six major healthcare organizations, asked participants to discuss their experiences with life-threatening illness. The 407 participants fell into five categories: People who had suffered the illness; personal or family caregivers; people who had lost loved ones to illness; professional caregivers; and members of the community. The testimony of some of these participants, as rendered on tape by actors, was heard by assemby-goers.

Alicia Super, a pain consultant and supportive care specialist for Providence Health System, Portland, said most participants criticized contemporary healthcare for what they see as its ignorance and lack of sensitivity concerning death and dying. Super, who coordinated the SCD study, said the dying want above all to be treated as people, not pushed off in corners to suffer alone. "'When I am near death, my healthcare providers turn away,'" she said in interpreting participants' main message. "What they want to say is, 'Please help me to integrate this illness into my life.'"

Perhaps the most dramatic testimony was offered by Marian Hodges, MD, who is assistant director of medical education, Providence Health System. Hodges said that despite 14 years of professional training, she had not really understood the truth about death and dying until she joined the SCD study team. Like most of her colleagues, she said, she tended to focus on the technology involved in preserving life rather than on the more personal skills needed at life's end. "Physicians pass off the hard stuff—emotions—to chaplains," said Hodges. "I've done that myself."

But as a result of the SCD study, she said, she has vowed to make five changes in the way she deals with cases involving life-threatening illness. She will:

- Get to know such patients better, especially their hopes and values
- Get to know families and personal caregivers, realizing that they tend to see the patient's illness as a misfortune they share
- Learn more about the process of dying, especially about managing dying patients' pain
- Learn to watch for—and alert patients and caregivers to—the "last days," so that they can take advantage of this time, using it to heal frayed relationships and attain spiritual growth
- Behave differently with the family after death has occurred. "I often used to let my ego and sadness get in the way of helping," said Hodges. "Now I usually find it's best to just tell them, 'I'm sorry.'"

She urged assembly-goers to help other physicians and healthcare providers understand the process of dying and make similar changes. As moderator Ann Neale, PhD, CHA's senior associate for ethics, put it, "Our mission and values demand that we be remarkable in the ways we keep company with and care for those living the journey of life-threatening illness."

Sylvia McSkimming

Alicia Super

Marian Hodges

Ann Neale

# Remaining Not-for-Profit: Viable Strategy for Mission-Driven Healthcare Organizations

David Lawrence

**Commitment to patients and communities, not stockholders, creates public trust. The Kaiser organization has undertaken four key activities to reinforce trust and fulfill its mission.**

**"We are at a significant crossroads** in healthcare. I hope that all of us can go forward in a clear-eyed, tough-minded way to demonstrate the value of having a very clear, strong, unambiguous mission; and the value of having a very clear set of values for who we are and what we're trying to accomplish." This was the message of David Lawrence, MD, chairman/CEO, Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals, Oakland, CA, who delivered the Flanagan Lecture. Lawrence explained his organization's decision to remain not-for-profit despite the encouragement of Wall Street bankers to "flip" to for-profit status.

**We believe the commercialization, fragmentation, and disintegration of healthcare is not in the public interest. We believe healthcare is a special activity driven by human needs and conditions that cannot be addressed in a commercial model.**

**– DAVID LAWRENCE**

Kaiser's decision, he said, began with its mission: to improve the health of the members and the communities the organization serves. In making the decision, which he described as "relatively straightforward," Lawrence described the key beliefs that guided the organization:

- "We believe the commercialization, fragmentation, and disintegration of healthcare is not in the public interest," he said. "We believe healthcare is a special activity driven by human needs and conditions that cannot be addressed in a commercial model."
- "We believe that being not-for-profit is a distinct competitive advantage," Lawrence stated. "Lest you think this is unduly venal," he said, "at the root of the relationship between our members and patients and providers is trust."

Lawrence said consumers of healthcare have lost their trust in institutions and in physicians and caregivers. Kaiser, if it is to carry out its mission, must create a high level of confidence among the people it serves, he said. "To do that requires an absolute, unambiguous commitment to patients and the community, not to stockholders," Lawrence insisted. Introducing the investor into the mix of stakeholders in healthcare "introduces confusion in the mind of the consumer that further erodes trust," he said.

Lawrence described how his organization has undertaken four key activities to fulfill its mission:

- The organization "has made a strong commitment to market-leading performance"—to deliver superior care and service.
- Kaiser has pledged 3 percent of annual gross revenues to reinvest in the community. It will subsidize care, fund research and development in healthcare, and finance training of healthcare professionals.
- Kaiser has committed to preserving and building the not-for-profit sector. It has affiliated with other not-for-profits that may be threatened by the commercialization of healthcare.
- The organization has created an ethics council to help it deal with ethical dilemmas involved in balancing the needs of patients, community members, and healthcare workers "in a world of constrained resources."

Today's difficult times are "an opportunity to demonstrate what many of us have believed for a long time—what we've asked the American public to accept as an article of faith," Lawrence declared. "We've said, 'Trust us, not-for-profit care is better for you.' Now, we've got to show it. If we don't, the game is over. If we do, the people of the country have much to gain."

# Study Affirms Mission's Relevance In Collaboration

**For Catholic healthcare organizations forming linkages with physicians and other organizations, "the bedrock of mission" is more relevant than ever, according to a new study commissioned by the Catholic Health Association.**

**When Kevin Sexton,** senior vice president at The Lewin Group, Fairfax, VA, presented the results of a national study of mission-driven organizations, he reported: "The best news is that mission is not irrelevant or less relevant or even equally as relevant as it used to be. In this rapidly evolving world, mission is more relevant than ever. You really need a compass when there's noise and confusion and the terrain is no longer a straight line."

The Lewin Group conducted the investigation of Catholic healthcare organizations and the strategic collaborations they are pursuing. Study results—including lessons, case studies, best practices, and checklists—will be published this summer by CHA.

The study examined the experiences of six organizations: Franciscan Skemp Healthcare, LaCrosse, WI; Sisters of Charity of the Incarnate Word Health Care System, Houston; Carondelet Health Network, Tucson; St. Agnes HealthCare, Baltimore; North Iowa Mercy Health Center, Mason City, IA; and Providence Health System, Portland, OR.

**Successful Collaboration** The bad news, Sexton said, is that "as Catholic healthcare organizations form linkages with other organizations and closer linkages with physicians, you help yourself and make your job harder."

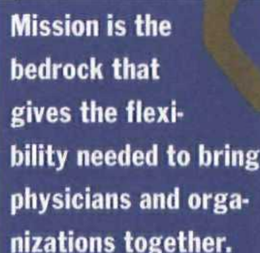
Sexton said the two most important ingredients in successful linkages are partnership fit—"What is it going to be like to live and work together with another institution?"—and strategic fit—"We can stand being together, but are we better together?" An organization's leaders are responsible for balancing strategic and partnership fit, he said.

Kevin Sexton

Brian Campion, MD, president and CEO, Franciscan Skemp, outlined the lessons his organization learned from its integration:

- Understand your motivations and your absolute requirements.
- Have a partnership imperative and evidence that your partner has operating principles and lives them on a day-to-day basis.
- Have a strategic imperative. "We used our market leverage to achieve our requirements."
- Make the written documents as specific as possible.
- Use physicians' key interests to uncover compatability.
- Develop physician leadership. "As we redesign our healthcare processes, physicians have a major role."

Daniel Wolterman, senior vice president for operations, Sisters of Charity of the Incarnate Word Health Care System, described his organization's partnership in the Houston area with the Memorial Healthcare System. Among the lessons learned, Wolterman said, is the need to address problematic issues up front. "Both organizations had a history of being 'nice,' and when difficult issues came up, we talked around them. That wasted time."



**Mission is the bedrock that gives the flexibility needed to bring physicians and organizations together.**

**– KEVIN SEXTON**

**Linking with Physicians** In a follow-up session on mission-driven organizations linking with physicians, Sexton said that "solving the physician-hospital relationship dilemma is critical." Mission is the bedrock that gives the flexibility needed to bring physicians and organizations together, he said. "The physicians who self-select because of mission are the ones with the best chance of success."

**Lessons from the Field** José Santiago, MD, corporate medical and community officer at Carondelet Health Network, said, "Physician

Robert Pezzoli

Sr. Jean deBlois, CSJ

productivity comes from providing them autonomy through governance and control of quality." Carondelet Health Network increased physician representation on its board from 6 to 18.

Robert Pezzoli, president and CEO at St. Agnes HealthCare, told the audience that the organization's mission was the starting point for integrating with physicians. After 18 months of study and negotiation with a planning group of 15 physicians, St. Agnes changed the organizational structure from a typical hospital structure. Two divisions were created, the hospital division and the physician division, Seton Medical Group, with an operating council of 80 percent physicians and 20 percent nonphysicians.

Among the lessons learned, Pezzoli said, was that some physicians may have unrealistic financial expectations. The organization developed educational materials to give doctors necessary information on legal and financial matters.

"Negotiate in good faith," Pezzoli added. "There's a sense of mistrust between physicians and healthcare executives. It's very important that contracts and other legal documents are physician friendly and don't intimidate them or insult their intelligence."

## Catholic Tradition Calls For Partnerships with Other Faith-Based Organizations

**The Church's ministry seeks to transform institutions and social policy to bring about the reign of God.**

**Although Catholic healthcare** organizations have a clear mandate to collaborate with one another, the call to partner with other faith- and values-based organizations is not so clear, said Sr. Jean deBlois, CSJ, PhD, vice president of Mission Services at CHA. Concerns about loss of Catholic identity, ethical integrity, control, and Catholic presence are not unfounded, she acknowledged.

**Achieving the reign of God requires the transformation of cultures, of societies, of social structures, and of institutions.**

**– SR. JEAN deBLOIS, CSJ**

However, the question about partnering with organizations outside the Catholic health ministry boils down to this: "What should we be about in the ministry?" At a breakout session, Sr. deBlois presented her initial theological analysis, which will be refined through input from CHA members and will form the foundational piece for case studies and tools for partnerships beyond the Catholic community. She began by examining four questions.

**Who Was and Is Jesus?** Jesus not only healed individuals, but also "brought radical healing to relationships, communities, structures, and ultimately creation," Sr. deBlois maintained. For example, Jesus did not just heal the leper; he addressed the social situation that made the man an outcast.

Our beliefs about Jesus have implications for how we see our own role, she added. "Jesus never limited his activity. He was here for everybody—challenging, confronting, making ultimate demands on everyone at every point," she said. "We call Jesus 'Lord of Creation' not because he wields power but because he turns the notion of power and authority on its head."

**What Is the Church and Its Mission?** Since the Second Vatican Council, Sr. deBlois explained, Catholics have believed that "the Church of Christ subsists in but is not limited to only the Catholic Church." Thus the Church's mission is not only conversion of individuals but evangelization to spread the reign of God—which is broader than the Catholic health ministry itself and broader than our institutions. Achieving this reign requires "the transformation of cultures, of societies, of social structures, and of institutions," she said.

**What Is the Kingdom, and What Does It Require?** The kingdom of God has at least three dimensions: It is God's decisive act of salvation in Jesus; it represents the complex of relationships defined in the person and the ministry of Jesus; it is "the already and the not yet."

The Church continues Christ's call to transform history "in every sphere of human activity," she said. When Catholic healthcare organizations form partnerships with others outside the ministry, Sr. deBlois explained, it is like adding yeast to flour and water and thus transforming it into bread. But, she added, "you cannot put yeast into bread without understanding that the leaven itself will change."

**What Is Ministry?** "Ministry is the response of the people of faith to the call to mission to build the reign of God," Sr. deBlois said. Quoting Rev. Avery Dulles, SJ, she said, "Faith is more than intellectual assent; it is more than hope in what God will do for us. It is a present participation in the work that God

is doing now through us."

Thus the Catholic health ministry seeks to build up the reign of God by calling forth the best in individuals, creating values-based institutions, and influencing social policy.

**A Call to Partner** Based on this tradition, which clearly "calls us to partner with whomever is out there for the purpose of building the reign of God," Sr. deBlois warned against both triumphalism and reductionism. "We don't have it all right," she said. "We're still in process, as is all of human history." At the same time, though, she advised against the type of partnerships where all the partners end up as "vanilla."

"We should strive to be ever more Catholic, not less," she advised. "In partnerships, we should go in with great clarity about who we are as Catholic health ministry in service in the world, and we should have even greater clarity when we come out at the other side of the partnership."

# Integrated Networks Require Innovative Strategies

**A study shows successful IDNs focus on community problems, core capabilities, and quality.**

**The overarching principle** shaping healthcare delivery is the ability of a network to add value. If networks can lower costs and maintain quality while meeting consumers' and purchasers' needs, they will "win the day," said Stephen M. Shortell, PhD, professor of health services management and organization behavior at Northwestern University, Evanston, IL. From his four-year study of 14 systems in the most developed managed care markets across the nation, Shortell has distilled the essence of integration.

The ultimate challenge of an integrated delivery system, he said, is to build a sense of community. Referring to the work of M. Scott Peck, Shortell said this sense is built by having an overarching vision, a psychology of abundance, a capacity for vulnerability, a willingness to learn, and a depth of leadership.

**Lessons on Integration** Shortell presented the integration lessons learned by those participating in the study:

- Focus on a few strategic priorities.
- Encourage a culture that both embraces and manages change.
- Put in place management and governance structures that enable the organization to implement decisions quickly.
- Adopt innovative strategies. "Saying 'we're on the right course, but we just have to redouble our effort' is not a winning strategy," he said. "That reflects an acute care mentality."
- Use population-based planning to "right size" the system's resources.
- Continuously focus on caregiver, governance, and management alignment issues.
- Invest in core capabilities.
- Have a deep knowledge of your community. "Understand the underlying problems," Shortell advised. "In some communities, dog bites are a major health problem."
- Remember it's a marathon, not a 100-yard dash. "Don't wear yourself out," he cautioned.
- Increase your pain threshold. "Some of this [integrating strategies] is not fun. We're changing professions," he told assembly-goers.

Integrated systems will become more adept at demonstrating their value, Shortell concluded, when purchasers begin basing their decisions on "quality, patient satisfaction, and outcomes and not just price."

**Statewide Delivery Networks** Panelist Gary Susnara helped the Colorado facilities sponsored by the Sisters of Charity of Cincinnati consolidate with the Denver-based Catholic Health Initiatives (CHI) to form a statewide delivery network. Susnara was named president of the new system's Mountain Region.

Before the dust had settled from the CHI consolidation, Susnara was looking for new partners within the state. At the time, he said, Columbia/HCA had 30 percent of the market and CHI had 8 percent. "We knew we had to partner, because if we weren't a significant presence in Denver, we wouldn't be able to be a significant presence in the state."

**If networks can lower costs and maintain quality while meeting consumers' and purchasers' needs, they will win the day.**

**– STEPHEN M. SHORTELL**

Thinking he might be able to find common ground with another faith-based system, Susnara sought out leaders in the Adventist health system. Within four months of the first talks and 20 months after Susnara arrived in Colorado, a new system—Centura—was implementing its consolidation plan. The faith-based system now has 24 percent of the Denver market, some of

Stephen M. Shortell

Gary Susnara

John P. Lee

Jacque J. Sokolov

which has come from Columbia, Susnara said, and 85 percent of the statewide market. The experience has shown that "you can compete and not lose your Christian values," he said.

John P. Lee, regional vice president, Sisters of Providence Health System, Portland, OR, noted that 40 percent of the Portland population is covered by managed care, and all Medicaid beneficiaries are in an HMO. The average length of an inpatient hospital stay is three days, and hospitals are under pressure to decrease that amount.

The shift to managed care has changed all the rules of the game, according to Lee, whose system has 40 percent of the market share and is the third-largest employer in the state.

Closing the gap between the vision of operating a capitated system and implementing the system has required a different mind-set for the CEO than that needed for operating an acute care facility or health system. Providence succeeded, Lee said, by organizing its network by geography rather than product line and combining the management, finance, and strategic planning functions at the state level. He said the system combines health services integration with the goal of health improvement. "Health plans need to demonstrate accountability to the National Commission for Quality Assurance, which emphasizes improving the health of a defined population."

**The most effective PSO is the integrated delivery system in which physicians are organized in a mixed model, consisting of group practices and independent practice associations.**

**– JACQUE J. SOKOLOV**

## Hospital Leaders Need Flexibility to Form Effective PSOs

**An understanding of the factors driving marketplace change and a thorough grasp of revenue streams are requirements for successfully managing capitated contracts.**

**Flexibility is essential** in adapting to rapid marketplace changes, according to Jacque J. Sokolov, MD, CEO of Advanced Health Plans, Inc., and AHP Development Corporation, Los Angeles. The shift of Medicare and Medicaid from fee-for-service reimbursement to managed care has radically shortened the time line for implementing strategic plans, he said. In some states, healthcare organizations have had to get ready for government managed care contracting within 12 to 18 months.

**Medicare/Medicaid Drive Capitation** Government policy is currently one of the biggest drivers of change, he said. "The reason Medicare is on the table is not related to Medicare," he said. Rather, Medicare's financing structure is being revised as part of a strong bipartisan push to balance the federal budget. Without significant policy change, Medicare's more than $115 billion deficit is "going to break the bank," Sokolov said. That is why Congress is currently considering legislation that would allow the federal government to contract directly with provider-service organizations (PSOs) for capitated care of Medicare beneficiaries.

If passed, the bill will restructure average-adjusted per capita costs and DRGs over the next three to five years. This is important, Sokolov explained, "because 40 percent to 60 percent of your business is Medicare. To preserve your revenue stream, you're going to have to form or join a PSO."

In the future, Medicare and Medicaid will be operated much like the commercial ERISA plans of today. Probably all three revenue streams will be capitated in the next 12 to 15 months, he predicted. "If beneficiaries aren't in your Medicare risk plan, they'll be in someone else's."

**Physician Integration** The most effective PSO, Sokolov said, is the integrated delivery system (IDS) in which physicians are organized in a mixed model, consisting of group practices and independent practice associations. "An IDS by definition has to have some kind of physician linkage. The challenge is to come together in a meaningful way. What's changed in the last three years is the nature of independent practice associations and IDSs. They've become more sophisticated in their ability to handle risk," according to Sokolov.

Management services organizations (MSOs)—which provide physician practice and network management, develop risk products, and build information linkages—are the glue that holds integrated delivery systems together and enables them to deal with managed care, he asserted.

The MSO will also be a critical factor in an IDS's ability to achieve financial success when managed care business becomes the predominant source of revenue. But the func-

tions of the MSO will also be the source of considerable tension between the IDS and health plan, Sokolov said. During the transition from fee-for-service to managed care, both will vie for control of the average 9 percent of revenues allocated for administration fees. "Why should the health plan get 9 percent to manage what you already do?" he challenged session participants.

**Managing Capitated Contracts** Sokolov then described six essentials PSOs need for managing capitated contracts:

- Understanding of the revenue stream, which services are included, and who patients are
- Knowledge of the cost structure
- Understanding of clinical outcomes
- Immediate access to updated key operational indicators
- Meaningful incentives
- An audit process

Unless you're clear on these points, Sokolov told participants, "you shouldn't be in the risk business."

# Sponsorship and Governance

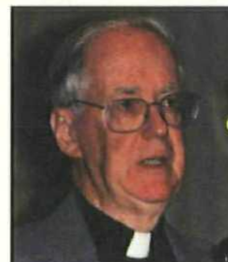
## Fidelity to Mission Is Key to Reading Signs Of the Times

**Some Catholic healthcare leaders may create "institutes" to train health professionals.**

**Catholic healthcare has entered** a time of confusion, according to Rev. John C. Haughey, SJ. Because of the growing dominance of the market, on one hand, and the diminishing numbers of clergy and women religious, on the other, "the healthcare ministry is harder to perform, even harder to see," said Fr. Haughey, professor of Christian ethics at Loyola University, Chicago. This obscurity may cause some ministry leaders to leave hospitals to create entirely new institutions, he said.

However, ministry leaders should not find the situation frightening, Fr. Haughey added. "Catholic healthcare has always been an extension of what Jesus did—healing." Over the centuries, ministry leaders have periodically had to realign their work to fit the available resources. "On the other hand," he said, "it's possible that the current restructuring will turn out to be the most convoluted and difficult so far."

Leaders must remain faithful to their mission, Fr. Haughey argued, but they should remember that in Catholic theology "fidelity" has two forms. In its *incarnational* form, fidelity has to do with institutions, whereas its *eschatological* form implies "trying to figure out God's current agenda," he said. "Catholics assume that institutions must change because they become affected by sin. So fidelity doesn't allow us to stand pat."



**Rev. John C. Haughey, SJ**

In their eschatological fidelity, Catholic healthcare leaders must be adept at "reading the signs of the times," said Fr. Haughey. In our culture, such signs currently indicate a diminished reverence for human life and an inclination to turn care for life into a commodity. Ministry leaders are bound to oppose these tendencies, which are symptoms of spiritual illness. "We must remember that the Christian conception of health is only secondarily physical," Fr. Haughey said.

Unfortunately, Catholic healthcare's insistence on the primacy of spiritual health does not fit well with the operations of a market system, he added. "However, we must remember that we are under God's sovereignty, not the market's. The bottom line can't be economic."

In the new age of sharp competition between healthcare facilities and systems, some Catholic organizations will have to perform "practically heroic" efforts to both survive and remain faithful to their mission, said Fr. Haughey. In other cases ("only a few, I

**A good board grounds its members in its mission. A bad board counts on its members to ground themselves.**

**– JAMES E. ORLIKOFF**

hope") the competition will be too intense. The leaders of those organizations must think about inventing "new forms of incarnation," alternative structures modeled perhaps on the parish nurse movement or home care organizations, he said.

Fr. Haughey predicted that some former leaders of Catholic hospitals may eventually create endowed, freestanding, multipurpose "institutes" that teach healthcare professionals about the Catholic ethos; train pastoral care workers; inform the public about how Catholics understand life and ethics; act as advocates for poor people; and evangelize. "Evangelization is too often muted in Catholic hospitals," said Fr. Haughey. "These new centers would allow us to do it openly."

James E. Orlikoff

## Boards Must Lead Change, Not Maintain Stability

**Effective system governance depends on understanding the big picture and controlling five levers.**

**Boards of trustees** of healthcare organizations need to understand the big picture, to "fly at 30,000 feet," not meddle in the trenches, James E. Orlikoff said. He warned against drowning boards in the details, forcing them to try to understand the healthcare environment (a practical impossibility) and management issues, rather than having them concentrate on the critical strategic issues facing the organization.

Referring to boards as "the last bastion of inefficiency in healthcare," Orlikoff (who is president of Orlikoff & Associates, Chicago) gave some cogent tips for changing a board from the caboose that slows down the organization to the engine that drives it. He said that many boards believe their role is to maintain stability, whereas in fact their job is to lead change.

Effective system governance depends on control of five levers, Orlikoff advised:

- Time. Board members' most precious commodity is their time together, and they need the discipline to ensure none of it is wasted. Orlikoff recommended that boards spend at least 80 percent of their time planning for the future.
- Agenda. Boards should identify their strategic goals and objectives for the year and then put those items first on the agenda. Other issues can appear on a consent calendar, or not at all.
- Information. Orlikoff suggested limiting board materials to 10 pages—covering only the most critical issues. Boards need to "disregard the noise"—the unimportant information that constitutes 95 percent of what they typically deal with.
- Structure. An organization's various boards must have clear roles and responsibilities, with no duplication of function or discussion. Orlikoff recommended a "zero-based committee" governance structure in which the board reassesses and reappoints committees each year, based on its strategic challenges. And he recommended a nonrepresentative board, in which all members work for the overall good of the organization rather than for the interests of one facility or group.
- Policy. The establishment of effective policy can occur only after the board controls the previous four levers, Orlikoff advised. If a board's decisions are based on identified and consistently applied criteria, they will be for the good of the organization, rather than "what's good for me."

"A good board grounds its members in its mission," Orlikoff said. "A bad board counts on its members to ground themselves."

### Challenges Facing Boards

James E. Orlikoff identified a number of challenges boards are currently facing:

- "Governing polarity," that is, reconciling seemingly inconsistent forces, such as the financing of care, on one hand, and the delivery of care, on the other
- Overcoming a misplaced loyalty to edifices and names
- Controlling the organization's fundamental means of production—its physicians—in terms of the care ordered, the cost, and the outcomes
- Adopting the business ideas of the for-profits (e.g., medical loss ratio) without adopting the ethic
- Understanding the relationship among the facility's capacity, demand in the market, and the organization's efficiency—and manipulating these factors as managed care grows
- Combining dozens of separate bills into one, so facilities can determine exactly what the cost of a particular service is and begin to pinpoint and control inefficiencies
- Being willing to invest as much as 12 percent of the organization's annual revenues in information systems
- Moving from institutional to system authority, which may require some sacrifice for individual entities to achieve the promise of the system

## Ethics Committees Moving Beyond Clinical Concerns

**With broader approaches, ethics committees can foster values-based actions throughout the organization.**

**In a session that focused** on maximizing the use of ethics committees, Barbara Prosser and Barbara Cox, RN, said an institutional ethics committee helps a facility and its employees answer two fundamental questions:

- What do we value?
- How should we live and work?

Ethics is a "system of values and principles tied together in a reasonable and coherent way to make society and our lives as enriching as possible," said Cox, president, Enriching Leadership, Spokane, WA.

Too often, she claimed, ethics committees have focused narrowly on whether an action or omitted action is right or wrong. She advocated, instead, that the ethics committee take a "healthier approach" and ask, "What is good? How can we honor our patients and our employees better?"

The speakers noted that ethics committees should broaden their concerns beyond clinical ethics, which examines whether outcomes are professionally sound, ethically justifiable, legally defensible, culturally sensitive, and economically feasible.

Topics "ripe for education and discussion" for ethics committees and staff are privacy and confidentiality, respectful use of power, palliative care, use of language, dependence and independence, suffering, and conflict resolution, according to Prosser, administrator, Nazareth Living Center, St. Louis. She suggested some widely used educational tools—for example, brown bag lunches, journal clubs, an "ethics corner" in newsletters, and seminars.

Prosser said the challenge today is to re-create and reenergize ethics committees and move them beyond the education stage so that they do not become "exclusive think tanks." The ethics committee can "provide the tools to unravel tangled situations by asking questions, assuring organizational policies are honored, and attending to the roles and responsibilities of each of the stakeholders in decision making," she noted.

Barbara Prosser

Barbara Cox

**The challenge today is to re-create and reenergize ethics committees and move them beyond the education stage so that they do not become exclusive think tanks.**
**– BARBARA PROSSER**

## Making Assisted Living Succeed

**Facility developers must clearly define their services, clients, and costs.**

**Assisted living is possibly** the fastest-growing area in healthcare, with as many as 50,000 to 60,000 units opening in 1997, according to Stephen H. Press, vice president of acquisitions, Meditrust, Needham Heights, MA. In some cases, however, "assisted living" is just a sexy marketing term for a traditional nursing home. So what exactly is assisted living, and how can its providers make it succeed?

**Defining Assisted Living** Although a universally accepted definition of assisted living is not yet available, Barbara Manard, PhD, consultant, Chevy Chase, MD, said that "we know it's a better mousetrap," since nursing home census is declining. Defining assisted living is critical to ensure quality, given the vulnerability of the population being served, she said. The U.S. Department of Health and Human Services is sponsoring the National Study of Assisted Living to begin to see how the facilities are organized and operating and ultimately to link this to outcomes.

In general, Manard pointed out, assisted living offers a cross between a nursing home and a residential setting. She said that it entails a philosophy concerning "the dignity of risk," which involves keeping residents safe while allowing them freedom and control; emphasizes living rather than dying; and focuses on what residents can do rather than what they cannot.

Keren Brown-Wilson, PhD, president/

Keren Brown-Wilson

CEO, Assisted Living Concepts, Inc., Portland, OR, said that assisted living falls into three major niches:

- The hospitality model. These facilities offer many amenities, large apartments, hotel-type services (meal, laundry, housekeeping), and transportation. They serve minimally impaired clients.
- Personal care model. This is the most prevalent variety, offering a mixture of residential and institutional features. Some of these facilities are similar to nursing homes, with hall bathrooms and double bunking, whereas newer versions offer more amenities, but still more assistance than the hospitality model.
- Aging in place. This type of facility provides both special care services (such as those related to dementia) and routine nursing service. Residents' impairments range from moderate to high, and about 65 percent to 75 percent die in the facility.

**Keys to Success** The growth of assisted living is related to many factors, including its appeal to consumers and its lower cost compared with a nursing home (about $85 versus $150 a day, according to Press). Even with this cost advantage, however, assisted living facilities can rapidly go out of business if they fail to anticipate clients' needs and preferences. "The more you try to waffle and the less defined you are, the more difficulty you will have marketing your product," Manard advised. "Don't try to be everything to everybody."

**Assisted living facilities can rapidly go out of business if they fail to anticipate clients' needs and preferences. The more you try to waffle and the less defined you are, the more difficulty you will have marketing your product. Don't try to be everything to everybody.**

**– BARBARA MANARD**

Facility operators must have a clear vision of what services they will provide and also their costs, Brown-Wilson said. Developers need to estimate the cost of doing business (particularly the financing, labor, and food) and see whether or not they can compete in the marketplace, she said. "If you can't, don't do it."

In addition, Brown-Wilson recommended:

- Ensuring that the building design is simple and accommodates residents' disabilities in order to hold down costs over the long run
- Not becoming dependent on a single source of payment, since such dependence will make the facility less market competitive
- Using buffet-style pricing (with one flat rate for all services, rather than an à la carte approach)
- Providing financial credit to families who help with care or services (e.g., do the laundry or housekeeping)
- Training both workers and managers in the assisted living philosophy and integrated approach to delivery of services

# New Approaches to Long-Term Care

**Three organizations develop creative long-term care policies and reaffirm their values and mission.**

**Breaking out of the mold** of established long-term care practices isn't easy, but three organizations that have successfully done so found a revitalized sense of mission through innovation.

Rodger Accardi, DMin, president and CEO of Franciscan Ministries, Inc., the housing and human development corporation of the Wheaton Franciscan System, Wheaton, IL, described two examples in which Franciscan values were prominent in program design. In a general strategic planning program, Accardi said, "The process was even more important than the product. We kept reinforcing our values, both in word and the way we developed our plans and priorities." In a specific program, the values guided a needed cost-cutting program. "We started by making honesty our priority. We didn't call it reengineering or redesign. We had to cut program costs, so we said so. We also said we wanted to do it in a respectful and responsible way, and that's the way we proceeded."

Charlene Boyd, administrator of Providence Mount St. Vincent in Seattle, told how her facility was transformed from one of the finest traditional long-term care facilities to one of the finest untraditional facilities. Using the concept of "resident-centered care," the organization changed the way it looked, who delivered services, and how services were provided. From a typical "long-corridor" facility, Providence Mount St. Vincent developed "neighborhoods" where residents of varying disability levels live. The neighborhoods are run by a coordinator, with nurses, recreation therapists, social workers, and others as staff. Resident assistants help with laundry, meals, and general care. Meals are brought to the neighborhoods and can be

served or reheated, depending on a resident's meal, sleep, and activity preferences.

In his presentation, Charles Kondis, director of governance and strategic planning at Mercy Medical in Daphne, AL, described a full continuum of care built on the premise that residents have potential for rehabilitation and healing. Services and settings are structured to promote the ability of older and chronically ill persons to reach their potential in an environment that supports their dignity and growth. Kondis illustrated this philosophy of care with the story of a woman who suffered a serious stroke and might have been placed in custodial care for the rest of her life. With rehabilitation, support in assisted living, and home care, this woman now scoots around the grounds in an electric golf cart, living relatively independently with a satisfying quality of life.

# Public Policy and Advocacy

## Beware of For-Profit Conversions

**Transactions such as joint ventures with for-profits victimize the communities that originally helped build not-for-profit institutions.**

**"Joint venture"** is a misnomer for the business relationship forged between not-for-profit and for-profit healthcare organizations, said Frank J. Kelley and Linda B. Miller. The for-profit partner nearly always winds up with the controlling interest, the two agreed, so the transaction is in effect a sale.

Both decried the increasingly common conversion of not-for-profit healthcare organizations to for-profit status. Miller, president of the Volunteer Trustees Foundation for Research and Education, Washington, DC, described such transformations as "the largest redeployment of charitable assets this country has ever seen."

Miller said these conversions are wrong because they take property in which an entire community has invested resources and restructure it to profit a relatively few stockholders and executives. She criticized the Clinton administration—and particularly the Internal Revenue Service—for its "silence" on for-profit conversions. "That's why it's so important that some state attorneys general are acting to defend charities," she said.

Kelley, who is Michigan's attorney general, described his campaign to prevent a planned joint venture between Michigan Capital Medical Center, Lansing, MI, and Columbia/HCA. In that deal, announced in 1995, Columbia/HCA "would have taken 100 percent control of the hospital in exchange for 50 percent of its value," Kelley said. (The other 50 percent would have been used to establish a foundation.) "If you were to approach General Motors with a proposal like that, they'd send armed guards to escort you to the parking lot," Kelley said.

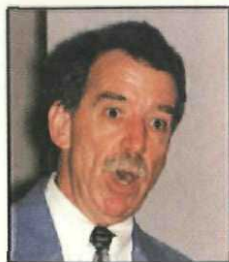
The deal eventually fell through after Kelley organized a public hearing and hundreds of Michigan citizens showed up to testify against it. In addition, a court ruled that the joint venture violated state law concerning not-for-profit enterprises. "Columbia/HCA has appealed that decision, but the deal seems dead," Kelley said.

A for-profit will typically launch its conversion attempt in a clandestine manner, first wooing a handful of the not-for-profit's physicians and trustees and then using them to persuade their colleagues, Miller said. She noted that although for-profits often create foundations with part of the money they pay for not-for-profits, these foundations are increasingly controversial. "Often you can't find out how the foundations use the money," Miller said.

Kelley and Miller said that, in most states, only the attorney general has the legal status to fight a conversion effort. They urged Catholic healthcare leaders to educate both attorneys general and local communities about the danger of takeover attempts.

Frank J. Kelley

Linda B. Miller



Michael Hash

# Extending Coverage To Children Is Politically Palatable

**Congressional action shows bipartisan support for incremental healthcare coverage.**

**Having learned lessons** from the demise of the Clinton administration's attempt to provide universal healthcare coverage, the nation is coming into the "age of incremental coverage," starting with children, Michael Hash observed.

> **The United States has had a progressive history of trying to deal with a variety of possible mechanisms of healthcare coverage.**
>
> **– MICHAEL HASH**

Hash, who is principal, Health Policy Alternatives, Washington, DC, remarked that the United States has had a "progressive history of trying to deal with a variety of possible mechanisms of healthcare coverage." But he admitted that in 1997 the country lacks the capacity to provide universal coverage. The only politically palatable way to expand any coverage is on an incremental basis. And extending some coverage to children seems more popular, he said.

In 1995, Hash reported, the United States had 10 million uninsured children, 66 percent in families with at least one full-time worker. He added that coverage of children in employed families depends on the size of the employer. For example, if the family member's employer has at least 1,000 employees, 80 percent of children will have health insurance. If, on the other hand, the firm has 10 or fewer employees, then only 44 percent of children are covered.

Employer coverage of children has been eroding, Hash reported. He cited as "a disturbing trend" the fact that between 1987 and 1995 the number of children covered by Medicaid has increased by 8 percent and employer coverage has decreased by that same percentage.

Hash offered three reasons for the erosion of employer-supported healthcare benefits:

- Increased cost of premiums. From 1989 to 1996 employer premiums increased by 13 percent to 20 percent.
- Family coverage premiums were 30 percent to 35 percent higher than those for employees only.
- Employers no longer have a strong commitment to family coverage. He cited a survey which revealed that 42 percent of employers believe their healthcare contributions should not exceed 50 percent of the premium.

Hash sees some hope in Congress's "so-called balanced budget agreement," which commits $16 billion for children's coverage over a five-year period. The agreement, he said, shows that there is bipartisan support for the goal. Congress has spoken but public policymakers are uncertain of widespread public support, however.

## Proposals for Insuring Children Inequitable

Proposals for extending healthcare coverage to children are "well-intentioned, but wildly inequitable," according to Richard E. Curtis, president, Institute for Health Policy Solutions, Washington, DC. For example, he said that under one proposal 30 percent of workers who make $14,000 a year would be required to pay healthcare premiums of $2,400 or more annually.

Curtis also claimed that many proposals "won't work over time." He said employers could escape requirements by going to contract employment or by simply dropping healthcare coverage as a benefit in lieu of higher wages.

Given the complexity of administering federal and the various state plans, Curtis said, each member of a family of four could be eligible for four different plans.

He cited a program in Colorado which covers children whose family income is under 185 percent of the poverty line. But, Curtis said, "Colorado is banking on employers not to reduce their contributions." He cautioned, however, that "nothing in federal law precludes an employer from discriminating against low-wage workers in their contributions policy."

Richard E. Curtis

Curtis defended attempts to cover children because "children are an investment in our future"; because preventive services are more beneficial for the younger population; and because of the budget reality that "government can cover a lot more kids for a lot less money [than it costs to cover adults]."

## Speakers Predict Passage Of PSO Legislation

**Congress is considering two bills that would give Medicare beneficiaries more choices in the care they receive.**

**At some point this year,** Congress is expected to enact legislation allowing hospitals and physicians to create integrated networks called "provider-sponsored organizations" (PSOs) that would provide care on a capitated basis to Medicare beneficiaries. Two speakers at the assembly addressed this topic.

Karen Milgate, senior policy associate, American Hospital Association, Washington, DC, said the AHA has proposed two measures—one a stand-alone bill, the other attached to budget reconciliation—enabling PSOs to look to the federal government for licensure. Licensing of such organizations is currently done at the state level, a lengthy process involving much red tape, Milgate said.

There are, she said, three main issues involved in the proposed legislation:

- The "50-50 rule," under which no more than half of a plan's enrollees may be Medicare beneficiaries
- The waiving of state licensure requirements
- The establishment of solvency standards

Milgate said Congress will probably approve the budget reconciliation measure, thus expanding opportunities for Medicare managed care.

Richard W. Todd, president and chief operating officer, Memorial/Sisters of Charity Health Network, Houston, said passage of federal PSO legislation would help organizations like his to offer healthcare to rural areas, where it is especially needed. "At present, only 12 percent of Medicare enrollees are covered by managed care plans," he noted. "By passing PSO legislation, we could greatly boost that percentage practically overnight."

Karen Milgate

Richard W. Todd

# Clinical Responses

## Case Studies in Applying *Ethical and Religious Directives*

**Analyzing an act's intentions guides health professionals in making treatment decisions.**

**Applying some of the** *Ethical and Religious Directives for Catholic Health Care Services* is difficult because of new scientific knowledge, disagreement in Catholic thought, or confusing language, according to Rev. Kevin D. O'Rourke, OP, JCD, director, Center for Health Care Ethics, Saint Louis University Health Sciences Center, St. Louis. His session explored applying the directives in cases of ectopic pregnancy, rape, and withdrawal of artificial nutrition and hydration.

In determining the moral action in these cases, Fr. O'Rourke distinguished the direct, proximate intention of an act from the remote intention. "First, assess your proximate intent. You don't determine the morality of an action by examining remote intent," he said.

The proximate, or direct, intention must not be evil, O'Rourke said. "You have to make sure you're not doing something evil to fulfill a good remote intention." For example, he said, it is morally acceptable to use methotrexate to treat ectopic pregnancy because the proximate intention is treatment, and the death of the fetus is an unavoidable result.

In treating rape victims, Catholic health facilities may have the proximate intention of preventing conception, but they must not have the direct intention of abortion, he said. Administering a drug to prevent ovulation (and thus conception) may raise questions because it is difficult to know if abortion could also result. Thus Catholic healthcare facilities must decide whether to have a policy regarding the use of such medications or whether to send victims of sexual assault to another institution for treatment, he said.

In withdrawing artificial nutrition and hydration, Fr. O'Rourke advised distinguishing between the proximate intentions of withdrawing futile treatment and performing

Rev. Kevin D. O'Rourke, OP

> **Our intent was not to take over, but simply to enlarge the circle of healthcare providers and enlarge the expertise in providing supportive care for those persons and their families.**
>
> **– ALICIA SUPER**

euthanasia. He pointed out that both actions have the same remote intention—to end suffering. But the proximate intention of forgoing treatment is to end an intervention that is of no benefit to the patient. The proximate intention of euthanasia is to terminate the patient's life.

He noted that some people believe that artificial nutrition and hydration is a care method, not a therapy. However, the two criteria for evaluating care and therapy are the same: Does it benefit the patient? *Or* does it impose excessive burden for the patient, the family, or the community? When artificial nutrition and hydration offer no hope of benefiting the patient—for example, allowing the person with no cognitive function to form relationships—it may be withdrawn, he said.

## Supportive Care Promises Higher Quality, Lower Costs

**A supportive care team dramatically reduced patients' pain and their treatment costs.**

**Alicia Super, RN,** pain consultant and supportive care specialist at Providence/Portland Medical Center, Portland, OR, said that initiation of a supportive care team at her hospital has yielded significant reductions in patients' pain and savings to the facility of $5,000 per case.

A supportive care team was started at Providence/Portland after an inpatient hospice unit closed in January 1991. The team consisted of a nurse manager, several nurses, a part-time chaplain, a social worker, and mental health counselors specializing in grief and loss. "Our job was to be a roving team, to go wherever patients and families were throughout the acute care setting and adjacent 20-bed skilled nursing facility. Our intent was not to take over, but simply to enlarge the circle of healthcare providers and enlarge the expertise in providing supportive care for those persons and their families," Super said.

In the year before it closed, the hospice unit had 149 admissions. The supportive care team received 415 referrals in its first year of operation. "We were being called to see people in crisis—not necessarily dying, but facing emotional, relational, or spiritual crisis," she said. The team consulted on pain management for postoperative patients, patients in the skilled nursing facility, and psychiatric patients admitted for depression following chronic pain.

The team instituted a pain management quality improvement program in the hospital. In April 1993, the average pain intensity at Providence/Portland was 6.3 on a 10-point scale (0 for no pain, 10 for the worst pain imaginable). The hospital made it a standard that a patient's pain would be less than 5 on the scale and to the patient's satisfaction, and team members conducted mandatory education for nursing staff on pain management. "We empowered patients to talk to us about their pain, gave them the language, skills, and expectations. Within 18 months, the average pain intensity fell from 6.3 to 2.32," Super said, "and what happens then, of course, is that the entire acute care team become pain managers."

Last year referrals to the supportive care team topped 1,300; meanwhile the average length of stay for patients seen by the team had fallen. "Our patients don't spend time in critical care once we intervene," Super said. The cost of care was $5,000 less per case, and families reported a high satisfaction with care and with the medical team's responsiveness and attention to their needs. Donations to the hospital from the families, friends, and businesses of the team's patients increased fourfold. Super said the cost per case for supportive care team service was less than $200 and that patients are not charged for the service.

### A Talk about Alternative Medicine

Corrine Bayley, the featured speaker at *Health Progress*'s third annual Face-to-Face dinner, described what she called a "spiritual journey" toward complementary/alternative medicine. Bayley, senior vice president for mission and values, St. Joseph Health System, Orange, CA, told about 50 mission leaders that a desire to move beyond her role as a healthcare administrator led her to investigate such alternative therapies as Ayurveda, chiropractic, Chinese medicine (including acupuncture), homeopathy, naturopathy, holistic medicine, and osteopathy. She offered thumbnail descriptions of these therapies, which, she suggested, Catholic healthcare providers could use to minister to their own staff members as well as to patients.

Corrine Bayley

## Dilemmas of Managed Care Require Reflection

**Catholic healthcare organizations must wrestle with questions of social justice as they make decisions regarding managed care and other health policies.**

**Managed care is squeezing** out the time for executives and management teams to reflect on the societal and institutional ethical dilemmas of the healthcare system, warned John W. Glaser, STD. Only through such reflection will Catholic organizations be able to deal with the pressures that pull them in directions that do not complement their mission, he insisted.

In reflecting on the Catholic tradition and its relation to managed care, "we first and foremost think about the common good," said Glaser, who is vice president, theology/ethics, St. Joseph Health System, Orange, CA. From a Catholic point of view, he said, the fundamental question about managed care is, Will it be an ally in promoting the common good?

Catholic healthcare organizations' commitment to their communities requires that they reflect on what makes a good and virtuous society, a virtuous institution, and a virtuous individual, Glaser said. He noted that although people in Catholic healthcare are unaccustomed to grappling with societal and institutional questions, they must begin to do so. This requires casting aside narrow definitions of healthcare. "We know the number-one predictor of health status of a community has little to do with hospitals. It has to do with standard of living," he said. Glaser said that organizations need to ask how healthcare relates to other social goods that are required so that people can flourish, such as education, housing, and national defense.

To foster reflection on these issues, he said, organizations need systems that clarify the organization's values (e.g., governance and management responsibilities, job descriptions); assign accountability (e.g., standards, plans); support reflection; and guide personnel policies (e.g., criteria for selection and promotion).

Glaser cautioned Catholic healthcare organizations: "We will be no better than the larger system allows us to be. . . . We'll only flourish, if the system is unjust, by participating substantially in that injustice." He urged Catholic organizations to wrestle with ethical issues so they can be a voice in the larger community—a "beacon of justice."

John W. Glaser

## A Time to Manage Care, Not Access

**Assessing their ability to manage risk by managing clinical care is key to organizations' success.**

**So far, the managed care industry** has managed *access* to care, not care, said David E. Vogel in a session that explored strategic options in the continuum of risk sharing. HMOs have concentrated on administrative concerns such as claims processing and marketing. "Now it's time to manage care," said Vogel, president, David E. Vogel & Associates, Corrales, NM.

David E. Vogel

Vogel insisted that 80 percent of effort in managed care should be focused on managing clinical issues. "HMOs are too far from the doctor-patient interface to do this. That's where you come in," he told the audience.

He urged that, before they enter a capitation arrangement, providers should think strategically about the problems the arrangement might pose. To illustrate his point, he presented two theoretical models and identified issues that each of them raised—for example, the degree of control a hospital might have in benefits design or in its ability to steer services to various entities in the plan.

Vogel advised thinking strategically and knowing the market well before entering into an arrangement. It is especially critical to determine carefully what services will be capitated, he said. Capitated services can lie along a continuum—from limited primary care physician services to all physician services to all healthcare services (including hospital services), he noted. "The assumption of risk without the ability to manage that risk results in financial and clinical failure."

# Using Ministry's Advantage in Market Strategies

Connie Curran

**In meeting the challenges of managed care, Catholic providers must be as bold and resourceful as their ministry's founders.**

**"Be bold and tough,** *not humble and passive,"* Connie Curran urged the leaders of the Catholic health ministry. "Passivity doesn't fit this market and these times."

The women religious who founded the ministry in this country were certainly not passive people, she reminded the audience. "I hear a lot these days about 'stewardship,' but that sounds too passive for me. Our founders weren't concerned about holding on and preserving things. They wanted to go new places and do new things."

Curran, a former nurse who is now president of CurranCare in North Riverside, IL, advised boldness in marketing, for example. She said that while traveling recently in Kentucky, she saw a billboard bearing a photo of a sister and this message: "Some healthcare organizations report to the Fortune 500, and some report to a Higher Power. Which do you prefer?" This is the way Catholic organizations should advertise, Curran said.

**Healthcare is not the place for profits. This is not a time for nostalgia and humility— what's needed is some passion and some risk taking.**
***– CONNIE CURRAN***

She urged boldness also in designing the ways healthcare is delivered, citing, for example, a study showing that most U.S. hospitals have a 30 percent readmission rate for patients with congestive heart failure. But one hospital, Curran said, began teaching its home care workers to watch for congestive failure symptoms on their visits—thereby reducing the readmission rate to 8 percent.

She described another hospital that, instead of sending elderly inpatients with hip fractures to rehabilitation, discharged them directly to their homes and had their physical therapy performed there. A survey showed that patients were happier with this treatment and that its costs were 40 percent lower. "To persuade the insurance company to support us, we told them we had lowered costs by *10* percent," Curran said, drawing an appreciative laugh from the audience. "That's what I mean by bold and tough."

*In their attempts to cut costs,* many healthcare organizations are trying to reduce the length of acute care stays, but it is better to reduce the number of admissions, Curran said. To achieve that, providers should aim at providing care not in hospitals but in "the least secure venues." Such venues include the physician's office or—better still—the patient's own home, she said.

Curran said that some people in the Catholic health ministry seem to think managed care will never affect them—which is a delusion. "If your primary concern is managing acute care more effectively, you're probably missing the boat. Managed care *is* coming. You can run but you can't hide."

Because managed care is inevitable, every healthcare organization must aim at attracting both employers and individual patients, Curran said. To accomplish this it must:

- Become the area's low-cost provider
- Demonstrate the high quality of its care through some set of measurements

Catholic providers should not forget that they have one big market advantage over competitors, Curran said. "Our respect for life, our devotion to excellence is something everyone wants, regardless of creed." And the ministry must not hesitate to exploit this advantage, she added.

Curran said she recently saw in the *Wall Street Journal* an advertisement describing what it called the "mission" of a for-profit healthcare provider. "I'm worried that our purpose in healthcare will be pirated off by the for-profits, and that we are going to sit passively by and see ads that attribute our words, our rich tradition, and our history to the Fortune 500."

That would be an unfortunate development, she added. "Healthcare is not the place for profits. This is not a time for nostalgia and humility—what's needed is some passion and some risk taking," Curran told the audience. "Your founders had those things. You must provide them now."

# For-Profits Cannot Continue the Mission

**When Catholic healthcare facilities sell to for-profit chains, the community loses a distinct kind of hospital care—one dedicated to compassionate care of the poor.**

**With growing numbers** of uninsured and increasing pressures to contain costs, Catholic hospitals' mission to provide charity care will be increasingly threatened, warned Uwe E. Reinhardt, PhD, professor of economics and finance at Princeton University, Princeton, NJ. But he cautioned that "if you want a Catholic presence with a Catholic mission in a community, selling to a for-profit hospital will not get you there."

Reinhardt noted that for-profit hospitals' social mandate is to "maximize shareholders' wealth without violating the law of the land." Given this, "I do not like to see for-profit hospitals prattle on about charity care. You cannot count on it. That is not their mission. And they will abandon it if the bottom line demands it."

Reinhardt acknowledged several potential benefits of Catholic hospitals selling to for-profit chains, including the ability to rid a community of excess capacity and to deploy the dollars in another way (e.g., in clinics focused on prevention or in parochial schools). On the other hand, in such a sale the community would lose control over local assets and would sacrifice a distinct kind of hospital care.

"Yes, we need to eliminate a lot of hospital beds in America," he said. "But not every bed is the same. Not every bed has the same culture around it." In Catholic hospitals, patients are more than "a biological structure yielding cash," Reinhardt asserted.

He cautioned, too, against joint ventures with for-profits. Even though the deal may start out as a 50-50 venture, he said, more capital will soon be needed, the for-profit will have it more readily available, and the ratio will change. "When you do a joint venture, think of it as having sold your facility," he said. "Joint ventures are Trojan horses, and Trojan horses carry all kinds of surprises in their bellies."

If all Catholic hospitals were sold, Reinhardt said, it could be economically defensible but would mean the disappearance of CHA. "We wouldn't have this powerful moral force—one of the few left that still has the guts to get before Congress and talk about moral issues, to talk about the uninsured—and brazenly talk about it whether these people like it or not."

Reinhardt pointed to an unfortunate shift away from the traditional American credo in healthcare, which asserted that healthcare should be available to everyone, and that someone in society should pay for it. "There was a time when we did not consider compassion another form of socialism," he said. "There was a time when we considered compassion an inherently American thing."

In the new environment, Reinhardt urged CHA members to "exploit the inevitable." This means that Catholic healthcare organizations need to "securitize" patients and physicians (i.e., acquire more covered lives and physician practices so they can control the rights to the cash they produce) and learn revenue management (i.e., price services accurately based on costs and demand, "the way airlines do"). "Securitization is inexorable," Reinhardt explained. "But your opportunity is that mission; your opportunity is to present a particular style of healthcare, a brand name that has to do with the noneconomic things that you do.

"When all is said and done, you can probably survive better than other hospitals that don't have a particular schtick," he concluded. "If you have faith in your mission, God will give you more market power."

Uwe E. Reinhardt

**I do not like to see for-profit hospitals prattle on about charity care. You cannot count on it. That is not their mission. And they will abandon it if the bottom line demands it.**

**– UWE E. REINHARDT**

# President's Address: Catholic Health Ministry Will Succeed

John E. Curley, Jr.

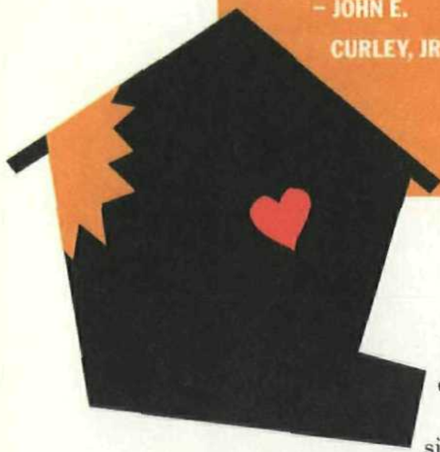
**In an address Wednesday, June 11, CHA President and CEO John E. Curley, Jr., reflected on his years of association service and the power of the ministry to meet the challenges ahead.**

**In June of 1979** I addressed the Catholic Health Assembly for the first time as CHA president. I was starting an uncertain journey. However, I was filled with hope in the future of the ministry. Today I am preparing to end that journey, and I am even more filled with hope in our ministry's future. It is about that future that I wish to speak to you today.

Although much has changed since 1979, I believe now, as I did then, that you and I continue the healing ministry of Jesus. Indeed, after participating in almost two decades of rapid and sometimes disruptive change in our nation's healthcare system, I am struck most by what has remained constant: that a compassionate God continues to love and heal through our commitments and actions.

**We will be called on to develop a true continuum of care—coherent systems that provide for seamless, patient-friendly transitions among levels and settings of care as needs determine.**

**- JOHN E. CURLEY, JR.**



Although there is much uncertainty in life, there is little doubt that the healthcare needs of people will grow, as will our Church's opportunities to serve. At the same time, there should also be no doubt that the pace of change will continue to test our resiliency and resolve. Most of the resulting challenges will likely have more than one solution. What will distinguish our choices—and our efforts—will be our commitment to finding the solutions that not only "work" but also evidence the value tradition of our Church. Faithfulness to Christ's healing mission defines who we are.

With prediction comes peril. But since you have indulged my taste for risk-taking these past 19 years, I hope you will grant me a few more minutes to offer my thoughts on what lies ahead. What are some of the challenges that our nation and we face now and in the future? Why do I believe that ministry leaders will succeed in meeting these challenges?

**Challenges in Caring** The first set of challenges I would cite relate to our essence as ministry, caring for the poor and vulnerable.

Despite the current moderation in the growth of healthcare costs, a recent report predicts that by the year 2002, we as a nation will spend $1.5 trillion on healthcare. At the same time, the proportion of our citizens covered by private health insurance is steadily declining, from 75 percent in 1989 to 71 percent in 1995. Most alarming is that coverage of children has dropped even more sharply so that now one in three of our children—23 million out of 71 million—is without health insurance for a significant portion of any year. It will come as no surprise to this assembly that almost half of these children are from Hispanic and African-American families. Nor is it surprising that Medicaid rolls are growing as private coverage shrinks. Yet to be seen is the effect of so-called welfare reform. There is every reason to fear that, as access to welfare—and in many cases, Medicaid—is curtailed, the number of uninsured will grow.

The issue of availability of care to the vulnerable also includes the frail elderly and the dying, and their respective needs for compassionate care. As the Baby Boom becomes the Senior Boom, we must meet the challenge of financing and delivering care far more efficiently than ever before.

The financing issues are familiar. For example, the Medicare Hospital Trust Fund is projected to be exhausted by 2001, and elected officials are thinking of how many ways there are to cut payments to providers. Beyond the immediate crisis in Medicare financing lies the challenge of providing care for an elderly population that will triple by the middle of the next century and will include a far greater proportion of the "oldest old"—those over 85—than America has ever known.

In serving this vast population we will be called on to develop a true continuum of care—coherent systems that provide for seamless, patient-friendly transitions among levels and settings of care as needs determine. Only such systems will allow us to

deliver patient-centered care that is compassionate, high quality, and cost-effective.

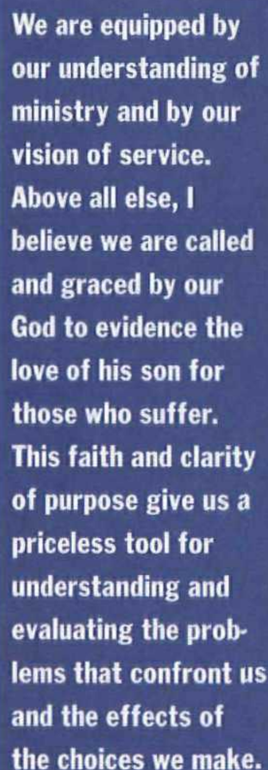
So this set of challenges revolves around two central themes: First, the continuing deterioration of our already fragile public-private health insurance system is putting more and more Americans, particularly children, at risk of being uninsured. And, second, demographic imperatives of the next century will test our creativity and commitment in providing care at the end of life. As always, we are called to act with all the ingenuity, energy, and resources at our disposal as we seek a healthcare system that is just and equitable.

**Challenges of the Market** A second set of challenges centers on the new market realities. At the core of these realities is the growth of competition and commercialization in healthcare over the past decade. While there has always been competition among healthcare providers, the focus of competition has changed, from an emphasis on quality to an emphasis on price—almost to the exclusion of other considerations. This unhealthy obsession has fueled the contention that healthcare is a commodity to be bought and sold rather than the provision of an essential service to one's fellow human beings.

In this context, we see growing strains between providers based on a perceived need to protect and preserve economic self-interest as opposed to the patient's or the community's interest. We also see growing strains between providers and patients, as some profit-driven managed care plans try to induce providers to put plan interest ahead of, or on a par with, the patient's interest. The caregiver's role is compromised and the patient's trust is undermined. Indeed, the business emphasis threatens the very intimacy of the healing experience.

**Challenges of Church Ministry** A third set of challenges are Church related. We are experiencing an extraordinary and rapid period of transition in which the fact of increasingly fewer numbers of religious and clergy has inspired fuller lay participation in ministry leadership. One example of this change is that lay leadership of Catholic acute care institutions has risen from fewer than 30 percent 20 years ago to more than 80 percent today. Coupled with the emerging need to pursue alternatives to more traditional forms of sponsorship, operations, and control, the ultimate challenge is the changing nature of ministry leadership itself.

There are risks. On the one hand, those of us who are currently entrusted with leadership must not resist or deny the signs of change we see. We must not succumb to the tempation to feel threatened or beset. On the other hand, those who aspire to leadership must understand and accept their responsibility to earn the trust of our Church. Future ministry leaders will help the Church, not only to care better, but also to articulate contemporary moral understandings arising from the healthcare intersection of teaching and practice.




**Well-equipped Leaders** These challenges seem daunting. However, these are just some of the ones we can envision at present; the greater challenges are likely to be the ones that surprise us. But it is clear that Catholic healthcare leadership is well equipped to meet the tests to come—known and unknown.

We are equipped by our understanding of ministry and by our vision of service. Above all else, I believe we are called and graced by our God to evidence the love of his son for those who suffer. This faith and clarity of purpose give us a priceless tool for understanding and evaluating the problems that confront us and the effects of the choices we make.

We are equipped by our tradition of Gospel values. We are called to translate our Church's value tradition into healthcare imperatives. This responsibility respects the sanctity of each human life and the dignity of each person, and recognizes that healing is about humanity first and institutions second. It means that we are a ministry that is hope filled—a seeker of justice for all—and that, within our American experience, we are especially committed to access based on need, not economics, nor immigrant status, nor other considerations.

It means a commitment to each community in which, and through which, our services are provided, recognizing that the well-being of the individual often depends on the health of the community.

We are equipped by our "track record" of caring. Catholic healthcare is shaping the values of our nation by all of the ways in which service is transformed into ministry. And, most often, it is the little ways that mean the most to the people for whom we care.

- It is bereavement programs to support

children who have lost a parent; or to support couples who have just experienced a child's death, miscarriage, or stillbirth; or to console the elderly surviving spouse who is now alone.

- It is caring for the abused child or the abused adult or the rape victim.
- It is providing free examinations for segments of the population, or providing special services for special people—for example, the physically or mentally handicapped.
- It is supporting and encouraging adult independent living, or making balanced meals available to the needy elderly, or caring for persons who are victims of chemical abuse.
- It is caring for persons with AIDS or providing bereavement programs for their loved ones and families.
- It is reducing children's fears of healthcare, or educating people to take better care of themselves, or acquainting students with ministry-related careers.
- It is CPR classes, or nurse-reentry programs, or industrial safety inspections, or natural family planning, or classes for babysitters, or health orientation efforts for educators, or sports medicine clinics.
- It is assisting the elderly to enter nursing homes; it is compassionate care of the dying in all its forms.
- It is maternity clinics, or expectant parent education, or outreach maternity care, or values-based childbirth for pregnant adolescents.
- It is programs for the lonely and despondent, or financial assistance, or preparations for a medical emergency or disaster.
- It is reaching into neighborhoods to assist the poor, to provide support for the homeless, or to provide respite for the emotionally disturbed.
- In short, it is everything that you do every day to touch the lives of people.

Thus, the Catholic health ministry brings a formidable presence to the challenges ahead. We are a sign of hope, especially for those who are most in need.

**A Course of Action** We must be prophetic in our advocacy for justice in healthcare. And we should not spurn incremental steps, such as the health insurance portability protections that

## CHA Board Reports on a Year of Engaging Members

Just as its members face critical challenges in the marketplace, CHA will face a series of challenges over the next year, including the selection of a new CEO and examination of its membership and dues structure. Nevertheless, David R. Lincoln, incoming board chairperson, assured attendees at the membership business meeting that "this ministry has a strong natural advantage over almost all other entities in healthcare. That advantage is our potential for working together."

Lincoln pointed to CHA's 1997-98 Strategic Plan (see pp. 67-78 and p. 80), which he said is premised on the notion "that CHA can help the ministry harness its collective strengths for activities that are best carried out *together*—activities that add value to our efforts as individual organizations."

### CEO Selection Process

Member input will be vital in the selection of a new president and CEO of CHA, as Jack Curley retires in the coming year. The search committee's process involves interviews with leaders from the Catholic health ministry, the Church, and the larger healthcare community, as well as group input sessions at the assembly, said Charles E. Thoele, the board's 1996-97 chairperson and chair of the CEO Search Committee. The goal "is to obtain as much help as possible from CHA's members regarding the competencies, traits, and qualities they think the next president and CEO of the association should have."

The search committee and its consultant, Heidrick & Struggles, will develop a position description by early August and then begin to screen and interview candidates. "If all goes according to plan," Thoele said, "CHA's new CEO will assume office early next year." Curley has agreed to stay on (at the board's discretion) until a new president is in place.

David R. Lincoln

### Membership/Dues Task Force

CHA is facing change in a second major area: its membership and dues structure. Sr. Phyllis Hughes, RSM, cochairperson (with Sr. Nannette Gentile, DC) of the Membership/Dues Task Force, said that pursuit of integrated delivery raises a host of questions. "Most current constituent members are systems, hospitals, and nursing homes," Sr. Hughes said. But the task force is examining how the membership criteria might change in relation to other organizations along the continuum of care, HMOs and other entities that transcend institutional providers, other-than-Catholic partners of CHA members, and not-for-profit entities. In addition, the task force is looking at issues related to CHA dues, including whether to institute a system-based dues structure.

The task force interviewed members and other associations earlier this year and held a series of focus groups at the assembly. Sr. Hughes encouraged CHA members to send additional comments to her at CHA. The board will present any suggested changes to the Membership Assembly at the 1998 Catholic Health Assembly in New Orleans.

Congress passed last year, or the increase in coverage for children being considered by this year's Congress. But neither should we allow such measures to distract us from the ultimate goal—a just and equitable healthcare system.

At the same time, our nation must be generous with its resources and find ways to assure an adequately funded Medicaid program. Similarly, welfare reform must be amended to make Medicaid accessible to legal immigrants.

The care of the poor and vulnerable is not and should not be an exclusively governmental role. Alarmingly, recent data suggest that uncompensated care is not keeping pace with need. Price-competitive markets do not make it any easier to provide uncompensated care. But we must reaffirm in a thousand places and in a thousand ways our commitment to those who suffer without adequate healthcare. Social accountability budgeting can help keep this aspect of our mission in sight.

Facing the new market realities tests our ability to maintain the uniqueness of our identity while becoming more efficient and more effective. We should look at new delivery paradigms as new opportunities for ministry expression. Our faith tradition embraces both compassionate service and careful stewardship. Our challenge is to find ways to achieve both.

We must persist in the development of integrated delivery systems to achieve continuums of care. Integrated care offers the ideal framework for addressing the holistic needs of the individual and the local community. Such systems foster economies of scale, allow for the geographic spread, permit the range of services sought by managed care plans, and can form the basis for provider-sponsored networks.

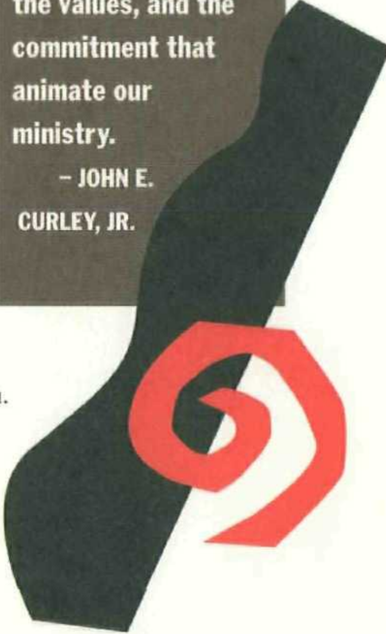
As the *New Covenant* initiatives suggest, our size and our diversity, as Church, must increasingly be our strength. In many cases the components of a cooperative network—hospitals, nursing homes, home health services, elder care and housing facilities, parish-based services, adult day care, and other services—exist side by side. We must candidly confront the long-standing cultural divisions that have stymied cooperation in the past. Collaborations with Catholic Charities and with diocesan, parish, and religious-sponsored agencies and institutions can leverage collective strengths while maximizing our mission values.

In a similar vein, our Catholicity invites collaboration with other faith-based and values-centered providers as we seek, with them, to grow in service within our respective communities. In reality, all the pieces of the continuum are there; now is the time to bring them together.

As I have noted, our leadership and our ministry are in transition. To succeed in this transition, our executives and sponsors must be well prepared for their leadership roles. Everyone involved in Catholic healthcare leadership—lay and religious, Catholic and non-Catholic—must share a common understanding of the essentials of our ministry and see one another as partners in achieving our ministry future. Building on local and regional practices and on rich sponsorship traditions, our future demands a strong cadre of leaders who are steeped in the spirituality and core values of the Church's healing ministry.

**I challenge ministry leaders to come together to create a pool of executives, managers, and other leaders who share the faith, the culture, the values, and the commitment that animate our ministry.**

**– JOHN E. CURLEY, JR.**



I challenge ministry leaders to come together to create a pool of executives, managers, and other leaders who share the faith, the culture, the values, and the commitment that animate our ministry. Some give-and-take will be required to make this initiative a reality, but it is essential to our future. We can do everything else right and still not succeed unless we start now to build a ministry-wide collaboration to systematically develop, support, and encourage ministry leaders.

Individually and collectively you are the ministry future in which to have hope. With that thought in mind, I conclude with the opening two paragraphs of my 1979 speech:

> I believe in CHA. I believe in you. In fact, it is precisely because of my respect for you that I have such enormous confidence in the future of CHA!
>
> You are unique. Not only because you are Catholic—not only because you profess a faith and values which transcend our human experience and not only because you are the contemporary and apostolic expression of a tradition of dedication and sacrifice which is rooted in Christ himself—but because, like Christ, you strive to serve the world, all of God's people. Perhaps more than any other apostolate, you are an ecclesial community interwoven in the fabric of the world. You are the cutting edge of Christ's penetration of society. You are Christ healing.

Thank you for the privilege of serving you these past 19 years.

# CHA Board of Trustees

Pictured here are the members of the CHA Board of Trustees for 1997-98. Members who were elected at the June 10 business meeting are marked with an asterisk.

CHAIRPERSON
**David R. Lincoln**
President/Chief Executive Officer, Covenant Health Systems, Inc., Lexington, MA

VICE CHAIRPERSON
**Sr. Doris Gottemoeller, RSM**
President, Institute of the Sisters of Mercy of the Americas, Silver Spring, MD

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

SPEAKER, MEMBERSHIP ASSEMBLY
**Charles E. Thoele**
Institutional Trustee, Sisters of Mercy Health System, St. Louis, Inc., St. Louis

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

**Michael F. Collins, MD**
President/Chief Executive Officer, Caritas Christi, Boston

**Sr. Maureen Comer, OP**
Administrator, Providence Centralia Hospital, Centralia, WA

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

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

**Mark W. Dundon**
President/Chief Executive Officer, Sisters of Charity of Nazareth Health System, Inc., Nazareth, KY

**Brian E. Forschner, PhD**
Executive Director, The Franciscan at St. Leonard, Centerville, OH

**Sr. M. Therese Gottschalk, SSM**
President/Chief Executive Officer, St. John Medical Center, Inc., Tulsa, OK

*C. Kregg Hanson
President, Upper Midwest Region, Catholic Health Initiatives, Bloomington, MN

Sr. Phyllis Hughes, RSM
President, Sisters of Mercy Regional Community of Burlingame, Burlingame, CA

*Else Marie Kiefer
Consultant, Catholic Healthcare West, San Francisco

*Sr. Jane Marie Klein, OSF
Board Chairperson, Sisters of St. Francis Health Services, Inc., Mishawaka, IN

*Bp. John J. Leibrecht, DD, PhD
Bishop of Springfield–Cape Girardeau, Springfield, MO

*John S. Lore
President/Chief Executive Officer, Sisters of St. Joseph Health System, Ann Arbor, MI

Richard J. Mark
President/Chief Executive Officer, St. Mary's Hospital, East St. Louis, IL

*Sr. Kathleen Mulchay, SSCM
Provincial Superior, Servants of the Holy Heart of Mary, U.S. Province, and Board Chairperson, ServantCor Human Service System, Kankakee, IL

P. Terrence O'Rourke, MD
Board Chairperson, Centura Health, Colorado Springs, CO

Robert E. Pezzoli
President/Chief Executive Officer, St. Agnes HealthCare, Inc., Baltimore

John T. Porter
President/Chief Executive Officer, Presentation Health System, Yankton, SD

Greg Van Pelt
Chief Executive, Providence Health Plans, Providence Health System/ Oregon, Portland, OR

Sr. St. Joan Willert, CSJ
President/Chief Executive Officer, Carondelet Health Care Corporation, Inc., Tucson, AZ