finance coverage expansions. Not only do their organizations devote more energy to payment issues than to expansion of coverage; they are also likely to oppose expansion proposals that would partially finance new coverage by limiting payments to providers. As a result, we cannot count very much on provider organizations to help us solve the problem.

Though we may forget it, each of us is in one way or another a part of the health care system. That being so, we must look beyond our private interests toward the kind of society we want to live in. Considering one's *social* interest is critical if one intends to take an ethical role in a public policy debate. Individuals must recognize what it is they are willing to give up. The thing given up may be money—settling for a smaller Medicare payment, for example. But it may also mean giving up the time and energy needed to hold one's professional organization and political officials accountable for achieving the goal one believes in. If we really believe in it, we will make that sacrifice. ■

NOTES

1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey," *EBRI Issue Brief*, no. 217, Employee Benefit Research Institute, Washington, DC, December 2000.
2. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6, pp. 142-149.
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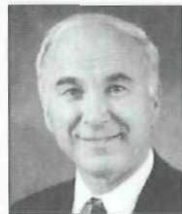
4. J. Gruber and L. Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs*, vol. 19, no. 1, pp. 72-85.

By Sr. TERESA A. MALTBY, RSM, DMin, & JOHN F. TISCORNIA, MBA, CPA

The Dynamics of Value



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In closing her keynote address to last spring's conference on integrity in the health care market, Ann Neale, PhD, challenged the health care community "to make of the market a graced instrument through which we advance the noble ends of health care." Earlier in her address, Neale named some of the fundamental differences between the approaches of a pure market economy driven by self-interest and the classic concerns for human need and the common good that have traditionally guided a member of the medical profession.

On one hand, Neale noted, is the pure market philosophy, which holds that "all goods and services, including health care, are fungible products that can be bought and sold. Nothing has intrinsic value." On the other hand, she observed, medical people have a "calling, a quasi-religious commitment" to their profession. Self-interest and material advancement take second place to the concerns of patients and community, social concerns with intrinsic value.

Within Catholic health care, the distinction between the two approaches has often been cast in terms of a tension between profession/ministry and margin/market. Given the fundamental differences in perspective, Neale said, tension between ministry and market is inevitable in the health care setting—but there should be no question which is dominant. The teachings of the Catholic Church make it clear that "the economy and production are for the good of the person and the community, and not the other way around."

To better serve the community, Neale said, Catholic health care must develop new models for managing its business. The ministry needs approaches that, first, open the way for more productive dialogue between ministry and the market and, second, reshape the way Catholic health care organizations allocate their time and money. As an example of such an approach, she cited the new "Value Dynamics" economic model developed by Andersen Worldwide SC.*

Like any other business, a health care organization creates value by making the most of its assets. Fundamentally, the value of a business is the value of its assets, both tangible and intangible. This value is determined by the marketplace and reflected in a for-profit's stock price and in the cost of borrowing for a not-for-profit.

The balance sheet—the traditional way of mea-

* Value Dynamics is a registered trademark of Andersen Worldwide SC.

suring and accounting for assets—lists only tangible assets, that is, physical and financial assets. In the new economy, Andersen suggests, the most important assets are intangible assets such as leadership, systems and processes, structure, and relationships with employees, suppliers, and customers. These assets, however, are absent from the balance sheet, and leaders frequently consider them difficult to measure and, thus, to manage effectively. The Value Dynamics model is an alternative framework that provides for measuring the impact of both tangible and intangible assets on the organization's market value. As such, it may be a particularly useful tool for transforming the debate between margin/market and profession/ministry into a dialogue that results in strategies that leverage all the assets to create value and express ministry values.

The Value Dynamics Approach

Managers are not unaware of intangible assets. In an Andersen survey of over 700 top-level executives, those involved in health care emphasized, first, customer relationships and, second, hiring and retaining the right employees as the top two elements of business success. Most of these same executives also reported that the measurements and management of these critical sources of success in their companies are not yet in place.[1]

The tendency to rely on the balance sheet and ignore the increasingly important role of intangible assets has very practical implications, especially when it comes to resource allocations.

Many health care organizations continue to invest heavily in such physical assets as hospitals, ambulatory clinics, and medical offices. These assets are tangible—they can be seen and touched and are thought to be stable and durable. These investments are perceived to be less risky than investments in such intangibles as people, ideas, and relationships. However, some of today's most successful companies are creating new business models; these models allocate resources for precisely those intangible assets that health care organizations have often discussed but seldom put to maximum use. These companies realize that the *real* risk in today's economy is to be too heavily invested in tangible assets.

The Value Dynamics model can help health care leaders see how using the full range of their assets can improve both the way they create value and the way they express their values. The Value Dynamics approach demonstrates how intangible assets are sources of economic value and how physical and financial assets are tools for expressing the organization's ministry values.

The Value Dynamics approach focuses on the interaction of five asset categories (see **figure** below):

- Physical
- Financial
- Employee and Supplier
- Customer
- Organization

The approach is designed to create strategy that leverages the full portfolio of assets and relationships, owned and not owned, and to capture the value created by the entire portfolio, not only those reflected on the balance sheet.

The Value Dynamics approach shows how intangible assets are sources of economic value.

Some of the organizations cited in the following examples were familiar with the Value Dynamics model and some were not. However, all of the examples demonstrate how both tangible and intangible assets are used to increase market value.

Physical Assets

Physical assets, including land, buildings, equipment, and inventory, are tangible evidence of value. All can be found on the balance sheet.

For many health care organizations, the value of their land and buildings is the foundation of their financial structure. In a time of lower inpatient census and changing physical plant needs, the goal of such organizations is to maximize the use of these assets in ways that contribute to

Value Dynamics Framework

financial success. Some health care facilities have gained additional revenues by renting out unneeded space to commercial tenants.

In the Value Dynamics framework, physical assets can also be used to create value as an expression of the values of the organization. Some hospitals with unused space have developed innovative ways to use their buildings to improve community health status by offering education programs, health screenings, and fitness activities. Others have contributed to community projects, such as lending land for a neighborhood garden.

In the Value Dynamics model, virtually everyone is an asset—including part-time employees.

Financial Assets

The balance sheet also lists financial assets, including cash, receivables, and investments. Historically, financial assets have added value in themselves. In the Values Dynamics model, however, they not only add value in themselves, but are also a tool for creating intangible assets that increase the organization's overall value. In the project we are about to describe, it may appear that financial assets are being converted to physical assets in the form of houses. In fact, the houses are part of a reconstructed neighborhood—an intangible but very real asset for the hospital the neighborhood surrounds.

St. Bernard Hospital and Health Care Center, Chicago, has found an innovative way to use its financial assets to advance both its ministry and its margin. Founded in 1904, St. Bernard serves an impoverished neighborhood called Englewood. Twenty-five percent of Englewood's population is unemployed; 40 percent of its families live in poverty. Over the last four decades, the neighborhood has lost a third of its housing, and what remains is run down and often owned by absentee landlords.

St. Bernard and its partners have invested $15.5 million in the construction of affordable housing on abandoned property adjacent to the hospital. The development encompasses 90 single-family and duplex homes, selling for as low as $130,000 and $180,000 respectively.

"We believe the strength of a hospital has a direct correlation with the vitality and well-being of its surrounding community," says Sr. Elizabeth Van Straten, St. Bernard's president and CEO. "And, in turn, this reestablishment of homeowners and commitment to an improved community helps our patients through their own healing processes."

Many of the health problems the hospital treats—ranging from rat bites to pulmonary disease—can be traced to the lack of heat, inadequate ventilation, and unsanitary conditions that typically accompany substandard housing. The new housing will help alleviate those problems. St. Bernard's leaders also believe that, by encouraging home ownership, the project will help stabilize the neighborhood economy and attract further investment to it.

The hospital has reached out to public and private groups in the city to gain support for the project. Neighborhood Housing Services of Chicago, for example, is providing home-buyer education and counseling (the project's would-be buyers are required to enroll in the education program). A city program called New Homes for Chicago is providing up to $30,000 in assistance to interested families.

By mobilizing the community and spending a portion of its financial assets on affordable housing, St. Bernard has fulfilled part of its ministry of serving its community. In the words of Cardinal Francis George, the project is "helping to recreate a healthy neighborhood where families can live with dignity and pride." At the same time, the hospital has improved its own long-term economic prospects.

Employee Assets

This category recognizes that an organization's intangible assets include employees and other people and processes not necessarily owned by the organization.

In the Value Dynamics model, virtually everyone at every level of a health care organization is an asset—including part-time employees, contingent workers, and independent contractors. From this perspective, position, tenure, and salary level are not dependable indicators of an individual's ability to create organizational value. The newest nurse may come up with a better way to treat burn victims; the lowest-ranking pharmaceutical line employee may devise a better way to package pills.

Recognition of every employee's potential for contributing to market value is the impetus behind the "Spirit at Work" initiative at Franciscan Health System (FHS), Tacoma, WA. In the winter of 1998, FHS developed a strategic plan based on the realization that the system needed to regain its traditional reputation for compassionate care. The plan had four primary areas of focus: *workplace culture, growth and performance, systems of care,* and *advocacy and community health.*

Although all four areas were important, CEO Joe Wilczek saw the creation of a distinctive FHS culture as especially important. "Successfully implementing the strategic plan depends on the quality, satisfaction, and engagement of staff and physicians," he noted. In the South Puget Sound area, staffing shortages (and resulting wage increases because of overtime and employment agency use) underscored FHS's need to become the employer of choice. The Spirit at Work initiative, focusing on what has been called the "employee-customer profit chain," has proven to be the key strategy for accomplishing the overall plan.[2]

Spirit at Work is led by a "Guiding Coalition" comprising employees, from all levels of the organization, who are informal leaders among their peers. "Champion Groups," which are multidisciplinary teams representing all levels of the organization, and "Service Excellence Teams," focused at the department level, complete the initiative's structure. The initiative involves extensive training, development of tools and resources, the integration of "service excellence behaviors" into job descriptions, performance reviews, compensation plans, and recognition programs—all of which requires significant investments of dollars, time, and energy. But they are investments in the development of intangible assets, a means of increasing overall market value.

A critical success factor is patient, staff, and physician satisfaction. Guided by the Gallup Organization, FHS now measures employee "engagement"—which blends job satisfaction with productivity and profitability—instead of simple "satisfaction." In Gallup's first survey, FHS ranked in the 60th percentile of the consultant's health care clients. Gallup plans to survey again this fall. Meanwhile, patient satisfaction scores have steadily increased over the past three years; physician satisfaction monitoring has begun.

Increased market share growth and recent awards and recognition attest to the success of the Spirit at Work initiative. In 1999, one FHS member, St. Joseph Medical Center, Tacoma, WA, received two Consumer Choice Awards, one for overall quality and image and one for cardiac care services.* In 2000 another FHS program, "Improving Care Through the End of Life," earned national recognition from the American Hospital Association. In the same year, HCIA-Sachs named FHS's St. Francis Hospital, Federal Way, WA, one of the nation's top 100 hospitals for high value to customers through effective use of resources, efficient care, and high-quality outcomes.†

Customer Assets

In this category, the source of value is the customer. "Customers" include not only those who receive health-related service but also those who provide the services and products that are part of the overall delivery system. None of these is treated as an asset by traditional accounting systems. As a result, such systems fail to recognize customers as assets that can be used to help guide decisions about investments and customer-related opportunities for creating market value and expressing ministry values.

Organization assets include leadership, structure, processes, and intellectual property.

However, UnitedHealth Group, a health and well-being company based in Minnetonka, MN, is an organization that is making the most of its customer assets. In the late 1990s, physicians and their professional groups were attacking the long-standing HMO policy under which treating physicians had to secure an insurer's approval before sending patients to a hospital or for specialized treatment. Patients were increasingly angry about and frustrated by the policy. Class-action lawsuits blamed HMOs, rather than doctors, for poor medical results. Congress was considering legislation that would give patients the right to sue HMOs for malpractice.

UnitedHealth Group responded to this situation by announcing that it would no longer require physicians to clear treatment decisions. Doctors could treat their patients without having to get preauthorization.

According to the organization's leaders, their decision was based on several factors:

- Both physicians and patients had become more aware of the need to limit costs, so the policy was unnecessary.
- The HMO had found itself placed uncomfortably in the middle of patient-doctor relationships.
- Substantial savings could be realized in processing referral and procedure requests.

The chief factor, however, was UnitedHealth's belief that the policy change would differentiate the company from its competitors, thereby winning public approval. By making it easier for its customers to get better care, the organization increased the likelihood that they would remain in the UnitedHealth fold. The policy change was also likely to attract new customers. The organization was thus able to create new value with its customer assets while improving health care for its customers. As William W. McGuire, MD,

*Consumer Choice Awards, sponsored by the National Research Corporation, Lincoln, NE, are announced annually in *Modern Healthcare*.

†HCIA-Sachs is now Solucient LLC, a company specializing in "benchmarking" information for health care organizations.

chairman and CEO of UnitedHealth Group, put it, "Our view of value in the marketplace has included not just the measurement of the price of services, but also their convenience, quality, and consistency with the underlying values of the customer."

Organization Assets

In the Value Dynamics framework, organization assets include its leadership, structure, processes, systems, culture and values, brands, and intellectual property. Together these operate as the organization's nervous system, connecting all the other assets into an effective whole. Organization assets are not found on a typical balance sheet, though they obviously would affect any effort to judge an organization's worth.

The Value Dynamics framework can also help a board of directors search for a new CEO.

Consider, for example, organizational structure, typically represented on a chart and indicating the organization's chain of accountability and responsibility. To the degree that it provides a clear road map for the human interactions that deliver margin and uphold the ministry's values, structure is a critical factor in any organization's future.

In 1999, the cosponsorship of the Daughters of Charity National Health System, St. Louis, and the Sisters of St. Joseph Health System, Ann Arbor, MI, created Ascension Health, the nation's largest Catholic health care system. While the sponsors were developing a new mission and vision, Ascension's leaders saw that they must also change the structure and function of the new system's national office in relation to its local health ministries.

To increase both the tangible and intangible value of Ascension's structure asset, the system's leaders put in place what they termed a "distributed leadership model" and identified five "distinguishing characteristics" that would serve as the model's strategic direction. The five distinguishing characteristics are *clinical excellence, well-run organization, work-life community, innovation,* and *voice for the voiceless.*

With the new leadership structure, Ascension's leaders were not encouraging decision making by consensus but hoping to tap a wide range of experiences and viewpoints from among all ranks of the system's leaders. They intended it to be flexible enough to allow leaders having the appropriate knowledge to make high-quality decisions. Ascension's leaders believed that, by tapping into the leadership talent existing throughout the system, they could reduce the number of high-level executive posts at headquarters.

Today Ascension is organized around five strategy teams, one for each of the distinguishing characteristics, all charged with moving the system's transformation agenda forward. The changes sought by the teams involve some of the other organization assets recognized in the Value Dynamics model.

Clinical Excellence Ascension's Clinical Excellence Team, having borrowed a term from the field of finance, is dedicated to creating an "obligated clinical group" that will continually improve clinical outcomes and patient safety.

Well-Run Organization The Well-Run Organization Team works to improve the performance of Ascension's process and system assets, both in the national office and among the various hospitals and medical facilities (known internally as the "health ministries"). A separate company is being created to redesign the system's supply chain, and a new shared-services unit will seek economies of scale and facilitate the transfer of information among the ministries.

Work-Life The Work-Life Community Team is creating a work environment that integrates spirituality, recognizes employees' changing needs, and ensures that employees' feel the worth of their contributions to the mission. Special initiatives also focus on creating a diverse and inclusive workplace.

Innovation The Innovation Team is dedicated to reinforcing Ascension's culture and its commitment to pushing new ideas ahead rapidly, moving them throughout the system, and learning from both successes and failures. This team will also create new business opportunities to bring in additional revenue, thereby adding to the system's ability to fund its mission imperatives.

Voice for the Voiceless Although some of Ascension's changes are meant to improve the system's margin by improving efficiency and effectiveness, all are intended to increase the common good. Ascension continues to seek policies that will create a more just health care system in the nation. Indeed, the whole transformation of the system's structure assets has been presented to employees and the public as a reflection of its vision, "rooted in the loving ministry of Jesus as healer," to serve all in need, but particularly those who are poor and vulnerable.

Organization assets also include leadership. The Value Dynamics framework can be a useful tool for a board of directors in its search for a key leadership asset, a new chief executive officer.

Board members might begin, for example, by recognizing the immediate impact this person will have on the economic value of the organization. Does the CEO candidate have a track record that will instill confidence in the marketplace? Has he or she demonstrated recognition of the importance the market now places on intangible assets? Is his or her experience going to be transferable to this institution or system?

Does the CEO candidate have real insight into the operation of a hospital system? Did he or she, in previous positions, demonstrate an ability to increase the value of intangible assets as well as tangible ones? Has he or she increased revenues, market share, and profits? Has he or she established closer connections with customers, inspired employees to greater achievement, and developed closer and mutually beneficial relationships with suppliers? Is he or she comfortable with the new medical technologies?

The board will want to be sure that the new CEO has shown a capacity for changing an organization, because change is the hallmark of the "Information Age." It will ask whether the CEO:

- Has reengineered processes and systems
- Has altered corporate structures and shown skill at selecting high-performing staff members
- Has built a top-notch medical staff
- Has firmly established or enhanced the cultures of his or her organizations
- Knows how to create the sense of challenge and urgency that is the essence of true leadership

Above all, the board will want to be certain that the new leader supports the organization's culture and values. The candidate's business skills may be formidable, but his or her actions must also have demonstrated a commitment to the ministry function. And because a leader's *personal* commitment is not in itself sufficient, the candidate must also possess in abundance the people skills, dedication, and charisma necessary to instill these values in employees, thereby ensuring that those values are manifest in the institution's every action. A CEO with these qualities can negotiate the current health care marketplace with integrity as a Catholic health ministry leader.

A New Opportunity

The Value Dynamics approach is not the sole effort today to recognize and give full value to intangible assets. Nor does the Value Dynamics model resolve the inherent differences in the motivation of the market and the motivation of the medical profession and the ministry. It does suggest, however, that there may be a new way of framing the debate between margin and ministry. Indeed, it suggests that that debate might better be understood as a dialogue through which the market and the profession/ministry can work together to contribute to the margin and provide faith-based health care. ■

NOTES

1. Edward J. Giniat and Barry D. Libert, *Value Rx: It's Time to Manage and Measure What Matters in Healthcare*, HarperBusiness, New York City, 2001, pp. 27-28.
2. Steven P. Kirn, Richard T. Quinn, and Anthony J. Rucci, "The Employee-Customer-Profit Chain at Sears," *Harvard Business Review* January-February 1998, pp. 82-97. The "employee-customer profit chain" represents the cause-and-effect relationship among an organization's various aspects. Effective leadership that demands internal quality will lead to increased employee satisfaction, loyalty, and productivity, which will in turn lead to increased customer satisfaction and loyalty, resulting in profitability and growth.

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