

Rekindling the Flame

A Casebook

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MEMORIAL HOSPITAL AND HEALTH SYSTEM SOUTH BEND, INDIANA

Background

Community

Memorial Hospital and Health System's community, according to Carl Ellison, vice president for Community Affairs, is chiefly St. Joseph County, Ind. Seventy percent of the hospital's patients come from this county of about 250,000. The rest come from outside the county. One of many challenges in the continual learning process posed by their commitment to "tithing" is attaining a geographic equivalence between the allocation of such funds and the revenues that generate them, from the counties within Memorial's regional community.

Memorial Hospital and Health System

There are two major hospitals in South Bend: St. Joseph's Regional Medical Center and Memorial Hospital. Competition is not fierce. Indeed, most of the 500 physicians on Memorial's medical staff are also on St. Joseph's staff. An annual medical staff party is held jointly, and several community projects have been co-sponsored.

For the past several years, Memorial has had a positive operating margin of 6 to 7 percent.

The board of Memorial is composed of a diverse group of individuals representing various constituencies. Physicians make up 40 percent of the board. Memorial invests heavily in educating its board, physician leaders, and senior staff on issues in healthcare. National speakers are routinely brought to South Bend. Competing hospital leaders are invited to these events.

Memorial seeks board members who are sound thinkers, with principle-based decision-making skills, evidence of concern for the community, and openness to new ways of looking at things. Rick Strickland, director of Grants and Community Partnerships, told us that the "board-staff" dynamics are an important key to the unique nature of Memorial's tithing. This may be a result of the fluid "nonboilerplate" nature of exploring prospective projects, the decision-making method for allocating funds to partners, and the intense education—both in and away from South Bend—that these two groups undergo, oftentimes together.

Memorial's community involvement is described by the president and CEO, Philip Newbold, FACHE, as being structured around "Four Ps":

1. *Community Plunges*. Board members, community leaders, and Memorial staff share a common experience for half a day, addressing a community issue such as teen pregnancy, domestic violence, or gangs. The Plunge is designed to bring them into direct contact with community assets, unmet needs, and the potential for improving the lives of citizens. This learning then drives a vision of what could be and fuels the excitement of imagining new approaches and new models for strengthening the community.
2. *Policy on tithing*. In what is described as the most successful strategy devised, Memorial Hospital and Health System dedicates 10 percent of its net revenue each year to fund its community initiatives. Criteria guide the decision-making process of selecting partners and

initiatives. Generally, each project has multiple partners, targets the underserved, focuses on prevention, has measurable outcomes, and has some prospect for self-sufficiency. All tithing funds are not invested in any given year. Unused funds roll over to the next year.

3. **Programs/Initiatives.** Memorial has not conducted community health surveys to determine its needs, acknowledging that sufficient data already exists and that recompiling data only gets in the way of the energy that seeks a more aggressive, proactive approach. Instead, it relies on a grassroots method whereby community organizations with a strong, mission-driven track record become partners in the innovation of new approaches—attempting, together, to reinvent the creation of health in its broadest definition.
4. **Performance.** Community partners and Memorial provide ongoing evaluation with data and/or stories that detail the successes and failures of their initiatives, to learn from their efforts and revise practices. At the core of all this activity is a deep commitment to sharing the learning.

Leading Practices

Systematizing Community Benefit Investment

Memorial Hospital and Health System created a systematic approach to its community benefit activities by organizing them around the 10 percent tithing of its positive net margin. The process *begins* with Memorial's strategic plan and its annual corporate goals and objectives.

Memorial's four strategic goals are

1. Improving community health
2. Developing the integrated delivery system
3. Ensuring highest quality, services, and value
4. Improving quality of work life

These strategic goals, and the 10 to 15 specific and measurable objectives for each, are ubiquitous throughout Memorial. Staff and trustees refer to them frequently. They are widely used as touchstones for planning and for evaluating the performance of senior managers.

Tithing funds are used for the community health goals and objectives identified in the strategic plan, while the other three goals (developing the integrated delivery system; ensuring highest quality, services, and value; and improving quality of work life) are funded through operations.

Proposals for community health projects are identified, reviewed, and refined through a Community Health Action Group. CHAG is composed of seven to nine members who are chiefly members of senior management. The biweekly CHAG meetings are essentially open to any staff person, board member, or community leader who wishes to attend. At the time of our visit, CHAG was considering a request from a board member to have a regular seat.

CHAG works directly with partner organizations to identify and refine community health project ideas and also decides which proposals are to be funded. One member of CHAG is appointed as champion for each evolving discussion and ongoing community health project. This relationship includes ongoing communication throughout the life of a project, which usually takes the form of

biweekly meetings between a champion and each of the projects he or she champions. Any three members of CHAG can approve up to \$10,000 in funding for a community health project. The process is consciously intended to be organic and somewhat chaotic. There are no forms, deadlines, or any other “templates.” The intent is to maximize the learning and innovation that can come from the tithing investments. The mental model is one of “collaborative learners”—not “check writers.”

A committee of the board, the Community Health Enhancement Committee, reviews the strategic goals and objectives quarterly and modifies them annually, as needed. In this context, the CHE Committee receives quarterly information about progress in its various community health partnerships and projects.

Dan Neufelder, chief operating officer, identified one of the not-so-obvious benefits of strategic tithing. He noted that creating and managing the tithing process promotes dynamics for a community-health-focused management structure. More important, the tithing policy represents a means of encouraging community-health-oriented behavior by the entire organization in a way that demonstrates true commitment of leadership. Staff are not expected to reduce investment in clinical services, for example, in order to invest in community health. Community health becomes, instead, another of the organization’s core business practices with its own budget—complementing, rather than competing with, other important goals of the organization.

Investing in Education

Memorial Hospital and Health System makes a substantial investment in the general education of trustees, staff, and community members. An important element of Memorial’s education investment is its focus on trends and the environment in healthcare, rather than a focus on specific problems or issues. The goal of this investment is to increase the general capacity of the board, staff, and community to understand and think strategically about healthcare and the system’s long-term direction. In addition, Memorial arranges these educational experiences so that mixed teams of trustees, staff, and community leaders participate together in educational events as a way of increasing common understandings and shared vision. Involving mixed teams in educational programming also reduces barriers between staff and board or other community leaders.

Much of this educational expense is paid for from the budget at the system level, rather than expecting department heads or individuals to underwrite expenses. Memorial easily spends more than \$100,000 per year on educational activities. These educational events include packaged events like Health Forum’s Best Practices Forums, governance programs of the Estes Park Institute, the Governance Institute, and others. In addition they create their own annual Board Forums, conducted in the Chicago area.

An especially valuable element of Memorial’s education investment, according to many participants, is what Memorial terms its “Community Plunges.” These Plunges are theme-based learning experiences designed around site visits to address community health issues. These site visits bring mixed teams of people to neighborhoods, schools, congregations, and human services agencies, usually for several hours, so that community leaders can gain a rich

appreciation of existing assets of the community, the gaps in those assets, and the prospective role of each person to help improve the quality of life in the community.

Plunges reflect two key attitudes that seem to undergird Memorial's approach to community health. First, the leadership of Memorial assumes that adult learning should be experience based—as hands-on as possible. Second, Memorial leaders assume that they start with little or no knowledge of the *real* determinants of community health problems. Instead, they seek to hear the stories of *real* people, who live with and through those issues every day. Because Memorial's leaders start with few or no presumptions, these perspectives and stories consistently provide new clarifications of the best opportunities for investing in community health and well-being.

Jeff Gibney, executive director of South Bend Heritage Foundation, a community development corporation that is one of Memorial's local partners, put it this way: "Phil [Newbold], Memorial Hospital and Health System's CEO, is willing to admit his ignorance. He digs deep. He digs sincerely. And he is not condescending. If he were, we would not have a relationship."

Establishing an Executive Position with Priorities That Transcend the Institution

Memorial has established a vice president-level position that serves as a community health intermediary, facilitator, and mediator with responsibilities at the national, state, and local levels. This position is based as much in the community as it is in the organization, reflecting the organization's broad approach to community health including social and economic issues. A main role of this position is to identify health needs, resources, and potential partners. Carl Ellison, currently in that role, has a background in community development.

Incentivizing Attention to Community Health through Compensation

A compensation committee of the board consists of the chairman and vice chairman of both the hospital board and the system board, as well as several other trustees. This committee reviews the annual goals and salary of the CEO and senior managers. Sometimes the medical staff president is asked to evaluate the CEO as well. The goals are modifiable.

Phil Newbold's bonus can be up to 50 percent of his base salary. As described above, one of the four annual corporate objectives is community health. Therefore, up to one-fourth of his bonus (13 percent of his base salary) can be earned for his performance in community health initiatives. He and 15 other senior managers are all held to these objectives. Some judgment is allowed the board when awarding bonuses. This incentive system has been in place for more than seven years.

One of the new annual goals for 1999 is to engage 5 percent of the entire Memorial staff in such community health initiatives. The rationale is to broaden and deepen the "ownership" of a community health perspective throughout the organization. At issue, however, is whether to use the tithing funds to compensate staff time or to expect department heads to find ways to release staff time as a kind of donation to the system's community health goals. This issue remained unresolved at the time of our visit.

Multi-branding Community Health

Memorial's partners explained that while they received support from Memorial, their projects were consistently identified as their own. Memorial was rarely identified as a partner. Even though Memorial's marketing department spends as much as 25 percent of its time on community health projects, the Memorial logo is nowhere to be found. Yet most community leaders know that Memorial is partnering with many of these agencies. On some projects, Memorial works with its competitors, e.g., the B.A.B.E. program.

Beds and Britches Etc. is an incentive program for perinatal care in which pregnant women and new mothers receive vouchers from participating physicians and social services agencies throughout St. Joseph County. B.A.B.E. stores located throughout St. Joseph County, in non-Memorial clinical and agency settings, offer new and used clothing for babies and young children, and equipment including cribs, car seats, and toys. Merchandise is obtained through coupons distributed by local collaborating agencies. The program has been adopted by many other communities.

Conducting Calendar Audits

Many difficult challenges compete for a health system executive's time and effort. The chief executive of Memorial conducts periodic calendar audits to monitor and adjust how his time is allocated. Since the board and the CEO have determined that 25 to 30 percent of his time should be focused on community health initiatives, he expects this to be evident when he reviews his appointments. He keeps a complete log of his appointments. Looking back over his appointments from time to time lets him estimate how much time he spent on community health, as well as the other major goals of the organization.

Perspectives of the Partners

HMS

Gwen DeLee, executive director of HMS (Home Management Services), indicated that her agency, founded in 1986, works to teach home management skills to women in the community. Specifically, they teach skills in managing finances, cooking, learning, and organizing a family and household. They attempt to befriend women and mentor them, imbuing their clients with a sense of self-responsibility, i.e., being problem solvers; integrity, i.e., doing things because they should be done; self-discipline and self-control; and the desire to pass these attitudes on to their children.

With 9,000 square feet of space atop an office building in downtown South Bend, HMS enrolls 70 women per year in classes. New programs are initiated continuously; creative parenting has recently been added. On-site programs will soon be offered to employers in the South Bend area for their workforce. Memorial has already offered the six-week prototype course to its staff.

DeLee relates to a senior manager (Reg Wagle) and one staff member of Memorial's organizational development team (Barbara Walsh). This has worked well. As one of Memorial's partners, HMS will be receiving at least \$26,000 a year for three years, in addition to diverse kinds of technical assistance, to support innovation and expansion. DeLee will hire a superb

editor to write the learning history required by Memorial as part of capturing the shared learning experiences.

South Bend Heritage Foundation

Jeff Gibney, executive director of the South Bend Heritage Foundation, began this community development corporation 25 years ago. Currently staffed by 20 individuals—8 devoted to property management for affordable housing—the agency offers a number of other programs, including specialized housing for the elderly and for AIDS patients, a commercial center with St. Joseph Hospital’s clinic, and Colfax Center, which houses a day care, a Head Start program, and mental health services. SBHF does advocacy work and studies bank lending policies, drugs, crime, and community corrections. It supports art and education for youth and works with the Martin Luther King Foundation and the Urban League. For technical support, they rely on the Center for Community Change in Washington, D.C.

Jeff told us that he was pleased to host a Plunge, where board members recognized that unsafe places contribute to most ER visits. Memorial asked SBHF to submit a substantial request. A five-year commitment of more than \$1 million (\$250,000 for four years and \$100,000 for the fifth year) was made to provide general operating support, reflecting Memorial’s confidence in the strength of SBHF, as well as a deep commitment to learning at the deepest level with this organization. This initiative raised their stature in the community and freed leadership from worrying about dollars to do their work. Currently they are buying up crack houses, restoring them, and then selling them at reasonable prices to lower-income families.

Apart from enabling SBHF to do its work, the partnership with Memorial has taught Jeff about tightening up management to meet the expectations of their partners. For example, planning is more routine, and two standing meetings are held weekly: one dealing with property, construction, and development and second dealing with the Colfax Center, fundraising, and general administration and community organizing. This has resulted in fewer emergencies, frequent emergency board meetings, and staff raises that formerly were impossible.

Center for the Homeless

Lou Nanni, executive director, has led the Center for the Homeless for eight years. Before him, three executive directors held the position for less than a year. His 150-bed center houses 150 guests and also offers a fully staffed medical clinic (paid for by Memorial), a mental health and alcohol treatment program, five certified family therapists, a Montessori school for children ages three to five, and services for AIDS, Medicare, Social Security, and legal problems. It is a national model for a comprehensive homeless shelter. Yearly, 13,000 visitors come to see what has been done.

Nanni has developed five key partnerships: First are institutional partners who consist of the power brokers in South Bend, e.g., University of Notre Dame, city government, Junior League, and 150 churches. Second are development partners who raise cash. For example, every year around Christmas, all the local television stations allot 30 minutes for a story about the Center for the Homeless. This has been an extremely effective fundraising tool. Third are operational partners like Memorial who provide in-kind help. For example, Memorial washes linens for the homeless, others provide carpets, and others give food, vans, etc. Fourth are partners who offer

services with other agencies to the community. Fifth are the guests—the goal is to empower the homeless.

Nanni insists that the progressive, aggressive leadership of Memorial as the second largest employer and a key power broker has made a difference in his agency's continued ability to provide needed services. He agrees that Memorial is not very visible and remains a behind-the-scenes player. Their success to date, he believes, is because Memorial's motives are altruistic first and public relations related second.

One recent success story occurred when Memorial placed its contract for landscaping with the Center for the Homeless. ServiceMaster actually trained the residents to perform the jobs, and now the homeless individuals have learned new skills that can be used to support the center. Thus, Memorial is branching out in its support—moving from providing operational support to buying services from the center.

Advice

From the Board Chairman to Other Boards

Stop conducting community health assessment surveys. Plunges work much better because they allow the board to see real-life stories firsthand and develop actionable programs.

From the CEO

1. Tie community health to the CEO's position description. Since Memorial's community health initiatives evolved over time and did not begin as an overt program, they've tied it to strategic planning.
2. Tie community health to strategic planning.
3. Develop clear policies and procedures about community health. For example, commit to tithing; develop criteria for community outreach.
4. Recognize that limits to community outreach exist—in Memorial's case it is due to the limited time of management staff who need to provide backup support, advice, and counsel to the partners.
5. Find positive ways to excite and engage all the subsystems that make up a community. Report cards are negative. Memorial uses a technique known as "Learning Histories" as a way of sharing the real learning. These are published regularly and can be found on the Internet at www.qualityoflife.org/learning.htm.
6. Keep a low profile. The broader community is best served by strong behind-the-scenes "capacity building."
7. Use a CQI approach to develop a history of experiences of the partners—what works and what doesn't.
8. Recognize that community health involvement must come from the top. Conduct an audit of the CEO's time: 25 percent of the CEO's day should be allocated to community health.

Conclusions

Unique to Memorial Hospital and Health System is its way of picking partners for community benefit. Instead of conducting a community needs analysis, Memorial uses its broad network of community informants to identify agencies and activities that are doing good things and that could use additional help—money, expertise, or in-kind services.

Also exceptional is that Memorial does not seek publicity for its community outreach activities. Possibly this is a reflection of the Midwest value of modesty, or perhaps it results from the fact that there are so few large institutions that can be looked to for support. But Memorial does avoid placing its banner on the agencies and programs it supports. In this age of public relations hype, Memorial's stance is unusual.

CROZER-KEYSTONE HEALTH SYSTEM SPRINGFIELD, PENNSYLVANIA

Background

Community

The service area of Crozer-Keystone Health System includes a half million residents of Delaware County, within which lies the city of Chester, Pa., an economically depressed area with a population of 40,000. Also within the county are some of the most affluent suburbs of Philadelphia, including Haverford and Radnor. Thus the community has a bimodal income distribution, and Crozer-Keystone is dedicated to serving both ends of the spectrum. More than 16 percent of the county is 65 years old or older, making Delaware County the second oldest county in the nation; 95,000 Medicare beneficiaries reside there. In race/ethnicity, 87 percent of the community is white. The dominant industries are retail trade, health services, and education.

Crozer-Keystone Health System

Created by the merger of Delaware County Hospital and Crozer-Chester Medical Center in 1989, Crozer-Keystone Health System encompasses five hospitals with 1,350 licensed beds, four skilled nursing facilities with 800 beds, and a large physician network. The system is a VHA shareholder. In recent years, the operating margin has been around one percent. In fiscal 1999, Crozer-Keystone provided more than \$26 million in charity and free care on total net revenue of \$515 million.

Leading Practices

Investing in Education

Crozer runs an ongoing staff education function called Crozer College. This college gives 20 managers per semester a steeping in Crozer-Keystone culture and vision, as well as knowledge and skills for today's healthcare organization. Crozer College is composed of eight full-day sessions, which are delivered by members of the senior management team who teach components that are pertinent to their organizational roles. The participating managers are selected from throughout the organization on the basis of their past or likely future contributions to the organization's mission. At the time of our visit, about 200 managers had gone through Crozer College.

The following lists the fall 1998 curriculum for Crozer College:

- Welcome and College Purpose and Overview (2 hours)
- Managed Care (3 hours)
- Linking Behavioral and Physical Health Care (1.5 hours)
- Analyzing the Strategy for Maintaining a Healthy Community (2 hours)
- Transforming Health Care Delivery (1.5 hours)
- Creating an Environment for Innovation (2 hours)
- Analyzing the Complexity of Human Resource Issues (3 hours)
- Team Project Development Day (6-8 hours)
- The Legal Environment and Its Implications for CKHS (3 hours)

- Understanding Strategic Financial Decisions and Return on Investment (3 hours)
- Project Team Presentations (4 hours)
- Graduation Reception

Using Consolidation as an Opportunity to Re-envision

Crozer's experience shows us that undergoing consolidation can represent an excellent opportunity to re-envision the organization and its purpose at the most fundamental level. The leadership and staff of the two hospitals needed a banner under which they could become one strong system, and the health of the community became a rallying point.

In Crozer's case, successful consolidation meant figuring out how to deal with the values held by board members. As it happened, the board of one of the hospitals entering the merger had a strong and unshakable orientation toward mission, including the use of incentive compensation for top executives on the basis of some general community service goals. The other board had focused its chief executive's evaluation almost exclusively on the hospital's financial performance. "The possibility of de-emphasizing mission in the resulting organization," said longtime trustee Robert Welsh, "was a nonstarter." As a result of the mission-oriented board's insistence, the merger talks became infused with the question of how to ensure an emphasis on mission in the resulting organization. Incentive compensation on mission-oriented goals, as well as goals for finances and quality, became one method.

Another method for emphasizing community health in the new organization was a comprehensive assessment of community health problems. In 1992, a rigorous \$200,000 community health assessment gave the leadership of the merging organizations a clear view of the banner under which the new system could succeed. A large-scale community health assessment conducted by hospitals represented an unusual and foresighted activity at the time (by 1997, AHA Annual Survey data showed that more than 85 percent of hospitals now participate in some kind of assessment of community health resources and needs).

Indeed, the assessment was so rigorous and comprehensive that it captured the negative attention of the county medical society, which feared it would be used to criticize and indict the county's physicians for a poor state of affairs. The public health establishment feared the assessment, suspecting it would be used to criticize them, and others feared the creation of a county public health office (there has never been one in Delaware County) and the new bureaucracy and taxes it would bring.

But the serious attention given to the community health assessment turned out to be an excellent mechanism for focusing various groups in healthcare on the ultimate goals of Crozer-Keystone. It has been updated every two years since 1992 and now serves as one of the principal means of orienting physicians toward a community health perspective.

Connecting to Groups of Consumers through Information Systems

Crozer has aggressively pursued the use of new information technology to gather information from and get information to special groups of citizens. These efforts create the expectation of a community health focus among staff and the public. The first of these efforts was the creation of a directory of all the health and human services in the area. These Green Pages also offer a lot of

basic information about health and healthcare topics like understanding patients' rights, monitoring and lowering cholesterol levels, and managing stress.

The child health database represents one of the returns Crozer receives for its investment in information systems. About 4,000 births are recorded per year. Crozer communicates advisories every two months, informing consumers about immunizations that should be scheduled. At the time of our visit, about 25,000 infants had been logged into this registry.

Crozer has obtained a \$224,000 grant from the Department of Commerce to provide seniors with access to technology. Seniors are being given access to computers and the training to use them. Part of the hardware solution is the acquisition of off-the-shelf equipment like computers and WebTV consoles. The entry point in this senior information system is Crozer's Web page. That Web page (www.crozer.org) includes the Green Pages and has a number of hyperlinks to other resources such as the Social Security Administration. It also allows seniors to communicate with their own caregivers. Perhaps most engaging for many seniors is that this system gives them e-mail access to their friends and children, bolstering seniors' social support networks. Crozer also operates a call center, which provides another means of accessing the information found in the Green Pages.

As part of this investment in consumer information systems, Crozer has helped acquire computers for use by children participating in programs of the Chester Education Foundation. In addition, Crozer is one of a number of partners building a "smart building," which is being prepared to house product and business innovations by high-tech firms, health systems, and universities.

In the future, Crozer expects to use push technology to target specific audiences and to make these information resources more interactive.

Conceiving of Quality in Terms of Population and Community Health

Reflecting its focus on the new banner of a community health system, in 1996 Crozer commissioned a board committee to reconsider the organization's approaches to quality. The result was a committee that reviews the organization's performance on quality of care issues from a system- and health-management perspective, in addition to patient care quality and medical staff credentialing. The co-chairs, Robert Welsh and Joseph Stock, M.D., agreed to lead this committee with the stipulation that it not be relegated to playing second fiddle to the Finance Committee and its reports during the board meeting. The Crozer-Keystone board is now striving to adjust its agenda and reporting practices so that the Quality of Care Committee gets equal time with the Finance Committee.

Many of the indices tracked by this committee are measures of quality from a population or community health perspective, which are reported quarterly to the system board. *The First Annual Report on Quality, Fiscal Year 1998* included a number of measures that are benchmarked against Healthy People 2000 objectives. For example, the report notes that 72 percent of the people over 65 years old in their managed care population received influenza immunizations, which exceeds the Healthy People 2000 goal of 60 percent for this age cohort. Other indicators for which Crozer exceeded Healthy People 2000 goals include blood pressure

and cholesterol screenings, regular exercise by adults, breast exams, prostate exams, colorectal exams, mammograms, routine medical and dental exams for children, seat belt use, and bicycle helmet use. Crozer continues trying to improve community health performance in terms of the percent of females who get Pap smears and the percent of adults who smoke.

The board is now considering the ongoing use of rolling three-year measures instead of tracking a single year's performance. For one thing, some of the population and community health indicators Crozer is tracking are not very sensitive to change within one year. In addition, the heavy demands on communication with the community for some of Crozer's initiatives require months just to get started, and the eventual rewards of such efforts simply cannot be observed within one year.

The system produces and publishes reports on quality intended for consumers. These reports are very consumer friendly. Produced on card stock in a 3-by-9-inch 12-page brochure, they are brief and attractive with plenty of white space. The reports use icons of smiling faces to show where goals have been met and frowning faces where they have not. An even briefer communication of performance was produced and disseminated as *Focus on Community Health* in spring 1998.

For example, a recent report tracks the death rate in Delaware County and the United States from 1991 through 1995 as well as leading causes of death and the improvement over time of blood pressure and cholesterol screenings. One useful section discusses improving maternal and child health and compares, for example, the national goal of 50 percent of children using bicycle helmets to the 65 percent actually attained in Delaware County.

Embedding Values about Population and Community Health in Ongoing Strategy

Crozer does not regularly develop strategic plans, considering the market to be in such rapid flux that it would be pointless. Crozer does, however, establish strategic goals at various levels. Population and community health goals are embedded throughout these strategic goals.

Overall, there are goals for the system, goals for the five hospitals, and goals for the managed care network. The system goals are organized under the headings of finances, quality, and mission. The board reviews these on a quarterly basis. The goals for the hospitals represent the most comprehensive set and are organized under the headings of finances; service, program and market development; infrastructure; operational efficiency; quality of services; academic mission; community relationship; and philanthropic support. The management team of the healthcare delivery units reviews performance on these goals every month.

In these documents, population and community health goals are a part of the strategy just as much as finances. For example, under quality in the 1999 hospital goals, an objective is to ensure that 85 percent of all children born within the Crozer-Keystone Health System who receive infant care will have received a full schedule of recommended immunizations by age two. Under community relationship in the hospital goals, a goal is to expand educational efforts about healthy behaviors in local area schools. Under this goal, objectives include recruiting five TATU (Teens Against Tobacco Use) instructors and providing drug avoidance education to at least 500 elementary school students throughout Delaware County. Another objective under community relationship for 1999 is adding at least two congregations to the congregational nursing program

by conducting four health education seminars, CPR certification, and safety inspections for each congregation.

Incentivizing Attention to Community Health through Compensation

The CEO and 35 senior managers have their bonuses tied to achieving community health objectives. This came about because senior managers believe in the AHA and VHA mission of building healthier communities to regain public trust. Currently, hospitals are acting “too businesslike,” and new partnerships need to be forged with community healthcare organizations.

To effect this reorientation, community health needed to be defined. To begin, Crozer conducted experiments with local churches and invested in health programs there. Management convinced the board that linking bonuses to community health would be a sensible strategy.

Today, approximately 20 percent of the base compensation is a bonus opportunity for these senior executives. There are 12 to 15 major goals, and typically, about one-third of the goals are related to community health status. However, each executive must quantify his or her objectives unique to his or her area of responsibility. For example, Ed Baum, vice president for Community Health, has 50 percent of his objectives based on community health. In contrast, the vice president for the Primary Care Network may have preventive goals for patients as a major part of his bonus potential.

This system has been in existence for four years. The system sets salary levels at the 50th percentile. But typically, with bonuses, individuals end up receiving remuneration at around the 75th percentile.

At issue now is how far down the organization such incentives should go. There are 6,000 employees, and if the bonus system were to expand to them, a decrease in base salary would, of necessity, result. Then the question is, “How would the four unions react to this?” Especially in light of the recent bankruptcy of Allegheny, Crozer’s leaders feel they must be responsible in devising any changes to the compensation system.

Perspectives of the Partners

Chester Education Foundation

Founded 10 years ago, the Chester Education Foundation was initially created to funnel funds into the Chester school system from Pew, Boeing, and Scott Paper to establish accountability for funds they provided. The program was for at-risk kids—ages 14 to 17—headed for becoming dropouts. It expanded over time because it was decided all the children were at risk.

The foundation works with Pennsylvania’s Department of Employment and Training to run a summer work program. The foundation tries to be apolitical—and focus on young people and senior high school students. Charles Grey, chairman, is also an employee of the Delaware County Juvenile Court and is the county point person to oversee the programs.

One particularly fruitful collaboration has been the Health Academy. Beginning in the ninth grade, children are segregated and assigned to shadow a professional on the staff of Crozer-

Keystone. The advantages of this are just now appearing in the first class of 40 students, who have just completed high school. Most of the children are college bound, which is a departure from children not assigned to shadow professionals. They learn from their mentors and through special instructors that they are expected to go to postsecondary schools, and even parents become more involved with their children's education.

United Way of Southeast Delaware County

For 75 years, United Way of Southeast Delaware County, currently led by James Vojeski, president and chief professional officer, has been raising and allocating funds for human services. There has been a long-term relationship with Crozer-Chester—a reciprocal relationship has existed. As the largest employer, Crozer-Chester contributes to United Way, and similarly, United Way has funded emergency care, the mental health program, the Center for Family Health (Community Health Division), and the Smedley Wellness Center at the middle school—one of only a handful of school wellness programs with an on-site clinic.

There is a relationship with Chess-Penn Health Center—a community health center where Crozer provides administrative and financial support and United Way supplies funding. The program provides primary care and dental care for low-income residents. Thus Crozer-Keystone is involved in helping the community in a very tangible way. Chess-Penn's management is now much more professional thanks to the management agreement with Crozer-Keystone. The president of Crozer-Chester Medical Center serves on Chess-Penn's board. United Way feels comfortable now that management is under Crozer-Keystone's aegis.

One example of United Way's work with the education foundation concerns a conference held on October 23, 1998, that provided the history and a celebration for the delinquency prevention program spearheaded by the education foundation. More than 250 agencies were invited to celebrate the programs for youth recreation, employment, and housing. Because of the conference, every participant now knows how his or her organization fits into the larger picture.

Advice

From the CEO

1. The process of CEO evaluation has been in place since the mid-1980s; what has changed is the substance of the evaluation, which now includes community health goals. By adding something, the whole substance of performance has changed—away from internal measures (budget, market share) toward external measures.
2. Mission had always been a part of the CEO's evaluation; only in recent years has community health improvement become explicit.
3. The next steps in the CEO's evaluation process may be to alter the weights assigned to each of the three categories. Currently the allocation is as follows: finance = 50 percent; clinical and operations (which could be community benefit related) = 35 percent; and mission = 15 percent. Probably no major changes will occur in the next 2 to 3 years.
4. If you are considering a merger, establish something everybody can buy into—not just what the flagship hospital adheres to. Instead, let the various parties espouse the “right kinds of things” and you'll find it's hard to fight them. For example, once building a healthy community is placed on the table, it would take a pretty tough trustee to dismiss it.

5. It is not necessary to tally the benefits and costs of community health. What is important is that it be ingrained in the way the healthcare organization operates. If you can identify community health as a line item, it may not really be part of the organization. As to its benefits, the improved health of community members is, of course, a huge payoff. But perhaps the best benefit derived from community health initiatives is how the organization's members feel about themselves. In short, it's another form of compensation, and over time, those organizations that truly pursue such goals attract people who derive, in part, their compensation from such efforts.

Conclusions

Unlike some leading practice sites, Crozer-Keystone does not title its community benefit activities. Instead, it commits to conducting routine surveys, identifying needed programs and services, and subsidizing them to the extent that is possible. This system is exceptional in its pioneering efforts to harness information technology to link community residents not only to health information and to preventive measures such as child immunizations but also to a support network through e-mail access for seniors in the community.

CAMBRIDGE HEALTH ALLIANCE CAMBRIDGE, MASSACHUSETTS

Background

Community

While the name *Cambridge* conjures up images of ivy-covered walls and academia, the Massachusetts communities of Cambridge and Somerville have large working-class populations with a third of the 180,000 residents being nonwhite. At the local Cambridge high school, more than 60 different languages are spoken in the home. Biotech and retail trade are the principal industries in these cities, followed by health services. Lotus and Polaroid, both located in Cambridge, are large international firms that bring cutting-edge technology into the community. However, despite a high per capita expenditure in the schools, only two-thirds of the children can read by the third grade.

The mission of the Cambridge Health Alliance is to build healthier communities. In an effort to achieve this mission, the CEO has established a Medicaid HMO to reach out to the underserved. This plan currently has 10,000 members. Enrollment will soon increase to 18,000, for which providers will accept full risk for this high-risk population. Eventually, the CFO predicts that 40,000 low-income residents will be enrolled. The Cambridge Health Alliance and the Commonwealth of Massachusetts are exploring the possibility of capitating payments for uninsured individuals whose care is paid for through the uncompensated care pool.

The economically disadvantaged communities are experiencing gentrification because real estate has become very expensive in certain sectors. As its community changes, the Alliance will face a challenge in not only fulfilling its traditional safety net role but also attracting young professionals who are moving into the two cities.

Cambridge Health Alliance

The Cambridge Health Alliance is the product of a 1996 merger of the city-owned Cambridge Hospital with private, nonprofit Somerville Hospital. In an unusual blend between public and private sectors, the CEO also serves as commissioner of public health for the city of Cambridge. To govern effectively, three boards have been created: the Joint Public Health Board, the Joint Hospital Board, and the parent board. This structure enables the Alliance to capitalize on the public sector for improving the community health performance of the healthcare delivery system. A seven-year contract has been negotiated with the city to provide public health services. The Alliance employs 185 physicians, and all chiefs of service are full-time employees. The health system has had small surpluses in recent years, although—like many Massachusetts hospitals—it faces operating losses this year (1999) that are primarily attributable to the Balanced Budget Act of 1997 and flat payment rates from virtually all other insurers as well.

Leading Practices

Incentivizing Attention to Community Health through Compensation

Community health focus is a key business strategy for the Cambridge Health Alliance. In several important ways, this strategy contributes directly to the future strength of the organization. A focus on community health and primary care attracts committed and diverse staff who want to

work in a socially meaningful environment. A community health focus also makes good business sense. As a strategy for cost savings, working upstream on prevention can prove to be fiscally responsible as we enter an increasingly capitated world. This is seen as especially valuable to the system executives, who believe that they will continue to be the healthcare provider for this low-income, high-risk population throughout their lives.

John O'Brien, chief executive officer, is eligible for a performance incentive of up to 20 percent of the previous year's compensation. The incentive is determined by the Committee on Evaluation and Compensation of the Alliance (parent) board. The CEO samples some of his direct reports and clinical chiefs to evaluate him on a set of leadership competencies (see below). He summarizes their views and sends them to the committee. The committee reviews the document and then interviews the same individuals. They add commentary and prepare an improvement plan for the CEO. The two questions they answer are, "What does the CEO do well?" and "What could he do better?"

Community health measures impact up to half of the bonus potential (10 percent of total compensation). Until now, the board has been focusing on the major reorganization efforts the CEO has implemented in the public health department. Since the CEO took on the role of Cambridge's commissioner of public health three years ago, his major community health objective has been to reorganize and professionalize that agency. To date, the board has been pleased with the changes he has implemented. But he expects that soon the board will use quantified health measures to determine this part of his bonus. O'Brien prefers such measures since it will impose greater discipline on his evaluation and will permit a continuous quality improvement approach to community health improvement.

Conducting an Ongoing Board Improvement Process

The Cambridge Health Alliance parent board conducts monthly meetings with a set two-hour agenda. The first hour is typically occupied by the review of a consent agenda and the presentation and discussion of major strategic issues requested by the board. During the latter half of the meeting, the CEO presents an administrative update on the state of the organization and its performance. This segment is often interactive and takes up one-quarter of the entire meeting. The final 30-minute segment of the parent board's meeting focuses on board self-evaluation and improvement.

The board self-evaluation and improvement is an unfinished process that was initiated in 1994 when a prominent physician expert in performance improvement was recruited by the CEO to join the executive team. A March 1997 board retreat focused on the board improvement process with special attention to the board's role in the community. The other chief roles that emerged from this board self-improvement process were mission definition, high-level policy setting, and monitoring of performance against policy.

Perhaps the most unusual practice that was established at the board retreat was the chairman's receiving personal one-on-one feedback on his practice in chairing the board. The current vice president for Organizational Development was invited to a board meeting, and when she gave a few reactions to the chairing of the meeting, Dr. de Filippi requested that she continue this practice to improve his leadership with the board. Typical feedback includes how the chairman

could include more members in the discussion, how debate can be furthered, how issues can be more completely explored, etc. Again, the practice of ongoing process improvement is evident, in this case, in how board meetings are conducted. Obviously, this kind of feedback can only succeed with a secure board chairman and a skilled and tactful counselor.

While the composition of the parent board is fixed by the enabling legislation that created the public authority, the Joint Public Health Board is undergoing its own improvement process. Established to ensure coordination on community health efforts across the two cities, the Joint Public Health Board is aggressively revisiting its composition.

The Joint Public Health Board has focused its energy on ensuring that it reflects the diversity of the community it serves. It has been largely successful through the use of such interesting approaches as advertising the availability of board positions in two major weeklies in Cambridge and Somerville and on the radio. However, there has been a persistent dearth of participation by certain linguistic minority groups that make up a large portion of the community's population.

To achieve better diversity and retain an appropriately skilled and capable board, all current members were asked to sign a tender of resignation. Each was also asked to indicate whether he or she would seek a one-, two- or three-year term or would prefer to resign from this board but continue to volunteer in some other capacity. In the context of a series of discussions about the need for the board to improve itself, in part, by better reflecting the composition of the community, this approach is expected to accelerate progress in achieving the board's goals in composition, as well as create opportunities for "new talent." Several members have left the board as a result of this reorganization and will stay on in other volunteer capacities. More important, the Hispanic, Haitian-American, and Portuguese-speaking communities are now better represented.

Instilling Values about Community Health in Ongoing Strategy

The business plan of the Cambridge Health Alliance is directly tied to community health outcomes. For example, an Agenda for Children was developed in Cambridge that was the product of a citywide effort. It consists of 25 elected officials plus parents and other community leaders representing 45 community agencies.

There were multiple ongoing efforts that related to improving the lives of children, some of which were duplicative and with little or no coordination. The Agenda for Children, with involvement of the Kids Council, School Department, Human Services, and the Alliance, was established to coordinate the activities and set citywide priorities. After several meetings, the group decided on two major initiatives for the near future: that all children should be able to read by the third grade and that there should be an adequate supply of high-quality supervised preschool and after-school activities. The latter program is especially needed for children ages 11 to 14 whose parents both work. Interestingly, access to healthcare ranked eighth out of nine programs considered by the council, a commentary of the health systems' success in this area.

One key structural factor that allows the Alliance to effect community health initiatives is the fact that all chiefs of services are full-time employees, and 185 physicians are employed. This

now includes not only all primary care physicians but also all surgeons, emergency room physicians, anesthesiologists, and pathologists.

Another example of tying business planning to community health concerned the possible closing of the obstetrics department, where 500 deliveries occurred per year resulting in a loss of \$1.2 million annually. To respond to the community's preference for easy access to obstetrical services, the Alliance heard the pleas of staff and the community and established a nurse-midwifery program. The nurse-midwifery program is more cost-effective than the traditional obstetrical care also provided.

A final example of tying business to community plans concerns the financial arrangements by which public health is provided in Cambridge. Through a seven-year contract with the city, the Cambridge Health Alliance provides a vast array of public health services for annual city support totaling \$7.5 million. Tying public health activities with the services of an integrated delivery system has thus far served the community by attempting to ensure coordination of preventive, curative, restorative, and palliative care.

Drilling Leadership Competencies into the Organization

Apart from the compensation arrangements of the CEO, staff of the Cambridge Health Alliance use a largely standard approach to performance evaluation. Senior staff write a self-assessment, which is then reviewed and used as an improvement tool by their supervisors.

While this process is not particularly unusual, it does drive a valuable set of leadership competencies into the organization due to the criteria that are used for this evaluation. These criteria include such leadership competencies as modeling collaboration, continuous quality improvement, and diversity leadership. While originally designed as part of the CEO performance evaluation, these leadership competencies have been introduced to senior and middle managers throughout the organization. Some of these other managers now make regular use of the leadership competencies in completing their own performance evaluations, as well as evaluations of their staff. This process had not been highly formalized and had not entered all parts of the system at the time of our site visit.

Establishing an Executive Position with Priorities That Transcend the Institution

Though she does not report directly to the CEO as others in her position have, the director of Network Community Affairs "exercises shared accountability for all outcomes of community health status." Indeed, though she reports to the COO/CNO, Linda Cundiff has a unique responsibility to improve quality and performance using information on customer needs and expectations, promote staff learning and development, and educate the public health board about the optimal use of resources. Trained as a nurse and later in community public health improvement, Cundiff coordinates strategic planning for community programs; aligns strategic, operational, and budget commitments; and assesses local needs and mediates competing demands.

Communicating Report Cards to the Community

A report card showing community health statistics for both Cambridge and Somerville and comparing the two communities to Massachusetts and Healthy People 2000 benchmarks is

published and widely disseminated every year. The report card, in an approach borrowed from Marion County, Ind., gives information on 16 different indicators in six different areas:

1. Access to health and prevention services
2. Encouraging healthier behaviors
3. Preventing violence
4. Reducing injury
5. Reducing substance abuse
6. Preventing AIDS and other STDs

Indicators, based largely on data available from primary and secondary sources, include cigarette smoking in the past 30 days by children in grades 9 through 12; immunization rates by age two; deaths due to cancer per 100,000; and the number of persons with AIDS in the community.

Prior to the merger, Somerville Hospital had done a comprehensive evaluation of community health as part of the Somerville Community Health Agenda process in the early 1990s. Somerville has repeated its assessments every two years since then. Cambridge Hospital started conducting similar assessments from 1994 to 1997. However, these data were not used for a community report card, a format designed for easy access and use by the general public, until 1998. More recent assessments include thorough reports on the plans for action that result from the community health assessments and accompanying review of results by the various partners in the community.

Creating a Health Information Unit

The Cambridge Health Alliance has created a Health Information Unit, which is part of the public health department. Using largely public sources of data, the unit collects information about the health status of the two cities. The unit also assists Somerville in the collection, organization, and analysis of community health data for that city. Since the merger, the unit has offered technical skills and report development and production for both cities. The unusual relationship between the public authority that oversees healthcare delivery and the Cambridge Public Health Department (John O'Brien is chief executive officer of the Cambridge Health Alliance and commissioner of public health for Cambridge) makes the utility of this unit for improving the communitywide healthcare delivery system especially great. It reflects a very high degree of integration between medicine and public health.

Negotiating a No-Fly Zone

Recently, the Cambridge Health Alliance confronted a major issue about allying with one of two large vertically integrated systems that are competing head-to-head. Partners, the system that owns Massachusetts General Hospital and the Brigham and Women's hospitals, had the allegiance of about two-thirds of the Cambridge and Somerville physicians. Caregroup is the other system, which owns the neighboring Mount Auburn Hospital and is strongly affiliated with about one-third of the Alliance's physicians.

The CEO was reluctant to align his organization exclusively with either system, knowing that it would inevitably affect the collaborative relationships that the Alliance had with both systems. He persuaded both systems to affiliate with the Alliance and agreed to build a firewall between

administrators and physicians at Cambridge who are responsible to each system so as to protect confidentiality and ensure compliance with antitrust regulations.

This exceptional “no-fly zone” was accomplished because of the recognition that the Alliance is committed to the entire community’s well-being and plays a unique role as a safety net provider. It also enabled Cambridge to preserve its existing referral networks to other area hospitals.

One additional benefit of this arrangement is that the three organizations agreed to jointly fund an Institute for Community Health that will conduct research on effective clinical and community health programs using the expertise of the researchers from all three systems.

Perspectives of the Partners

Concilio Hispano

The mission of Concilio Hispano, a 30-year-old agency, has evolved from providing Latinos with health and human services to a new, holistic view of empowerment, and from a concern for the welfare of primarily elderly people to a concern that also focuses on young people and their multiple problems of truancy, drugs, violence, and lack of support. Focused on people who are at greatest risk, Sylvia Saavedra-Keber, executive director, said that her agency is seeking to be the hub for addressing the community’s myriad needs.

The Cambridge Health Alliance has provided needed support to Concilio Hispano including providing free rental space, cleaning and maintaining the offices, offering grant support, employing multilingual caregivers, and aligning strategic plans. The CEO of the Alliance is unique in his understanding that embracing diversity means more than being aware—it means developing competencies to reach out and include all elements of the community. Moreover, the CEO considers health to be an all-encompassing concern including challenges faced by immigrant populations such as language and cultural barriers. Finally, Saavedra-Keber indicated that the CEO is exceptional in his willingness to communicate, to listen, to incorporate suggestions, and to create partnerships. He has promoted collaboration between all of his staff and community partners, which also has increased the community’s sense of trust. Above all, he has gone beyond the line of duty—he is always accessible and never condescending.

Most recently, staff from the Cambridge Health Alliance helped to prepare a grant and has placed the agency on better financial footing. Saavedra-Keber suggested that the community report card be prepared in multiple languages. This recommendation has been acted upon by the Alliance this year.

Community Action Agency of Somerville

Community Action Agency of Somerville was founded in 1961; Jack Hamilton, executive director, arrived in 1983 and has led the agency since. The agency’s mission is twofold. About 80 percent of their effort is to provide Head Start and early childhood education programs. The remaining 20 percent consists of housing advocacy, including preventing unjust evictions. Much of the work also involves obtaining and maintaining public benefits for families with young children, such as welfare, food stamps, Medicaid, or access to healthcare for those with no insurance.

Since the merger of Somerville Hospital and Cambridge Hospital, the communities have experienced gentrification and, at the same time, an influx of poor immigrants. The positive effects of the merger have been that where before Hamilton found it necessary to deal with individual departments regarding health matters, now there is one contact for all these issues. In addition, because of the strong financial position of Cambridge Hospital, additional resources have been extended to address public health concerns in Somerville, particularly for the new immigrant population. Finally, Hamilton believes that Cambridge's efforts to diversify the Joint Public Health Board will be of enormous benefit to the community in the short and long term.

In general, the partners seem to have benefited from the Alliance's involvement in their organizations. Sometimes this has been to provide human and financial resources, other times it has provided a sense of empowerment and validation of the real concerns that clients of these agencies experience. Throughout, it appears that the Cambridge Health Alliance is a true partner—providing resources and expertise, but also listening to community members about their perceptions of their own health needs.

Advice

From the Board Chairman to Other Boards

1. Read Harvard Business School publications, "Governing Not for Profit Organizations" by James Austen, and "Boards That Make a Difference" by John Carver.
2. Become involved in your state hospital association's trustee group.
3. Be committed—dedicate at least 10 hours per month.
4. Experience the hospital's service unadulterated.
5. Select members according to the recommendations of "Shining Lights on Boards" (To get more community health commitments, you need to make sacrifices—e.g., public sector luminaries need to be included on the board and not simply business sector representatives).
6. Ask yourself the question, "What really worries you" about the hospital. Then address the issue, be it CEO succession, payor mix, or whatever.
7. Be aware that advocacy will be an ever-increasing future role of board members.

Conclusions

The Cambridge Health Alliance is unique because it has shown how a nonprofit hospital and a city-owned hospital can merge and jointly learn about community needs through systematic collection of data, diverse board representation, and the integration of public health activities with the traditional work of hospitals. Tying the CEO's performance assessment to community health improvement is a fundamental approach by the board to ensure health system accountability. Time will tell to what extent this arrangement will result in improved access, continuity, and quality of care for the residents of Somerville and Cambridge.

MEMORIAL HEALTHCARE SYSTEM HOLLYWOOD, FLORIDA

Background

Community

Memorial Healthcare System is located in the heart of Florida's South Broward County—south of Fort Lauderdale and north of Miami. The county is the 17th most populated county in the United States; combined, it has more people than the state of Hawaii. Its health problems are manifestly large as well; for example, it ranks 11th in AIDS cases among all counties in the United States.

MHS currently has about a 67 percent share of the market with competition from two investor-owned hospitals—one owned by Tenet and one owned by Columbia HCA. Much of the industry deals with tourism and other services, followed by retail trade. Jobs are abundant, but transportation poses barriers to reaching jobs and most jobs are poorly remunerated.

Memorial Healthcare System

MHS is composed of four hospitals and one nursing home: The hospitals are Memorial Regional Hospital, Joe Dimaggio Children's Hospital, Memorial Hospital West, and Memorial Hospital Pembroke; the nursing home is Memorial Manor. The system is owned by the South Broward Hospital District, and board members are appointed by the governor of Florida. Five of the seven board members represent a specific area of the district, and two additional board members serve at large. At the time of our visit, the board was very diversified in terms of race, gender, ethnicity, and experience.

Frank Sacco, FACHE, chief executive officer, acknowledges that over the past five years, MHS has taken action to improve both the health and the quality of life in Broward County because acute care hospitals “have less than a 10 percent effect on the overall health status of their community.” MHS's commitment to community is measured through biannual progress reports on community priorities, including progress reports on key health and human services issues. Moreover, health status is measured through quarterly reports to the board, consumer satisfaction surveys and forums (see below), biannual communitywide health status reports, and annual progress reports.

Community benefit has been a growing focus in the past four or five years. Before Frank Sacco became the chief executive officer in 1987, the former CEO envisioned the hospital as an acute care provider—he believed in a strict construction of the hospital's role in the community—that should not get involved in community outreach or primary care. Sacco believes, in contrast, that MHS

“needs to be a community health resource—as long as we can afford to—because what we really exist for is to improve the health status of the community; we need to try to get involved. If you take care of the community the community will take care of you. You need to be involved in healthcare elements and quality of life elements—so much relates to ultimately what our mission is. If we can relate to dropouts, truancy, pregnancy, and

substance abuse—these are all interrelated . . . we need to be involved. It is also good conservative fiscal policy. To reduce teen pregnancy is to reduce low birth weight babies.”

The hospital district now delivers primary care, and fragmentation is eliminated. Formerly, access to care was a problem; the county depleted its primary care pharmacy budget every year. People were told that for lack of a \$30 prescription they should go to the emergency room and they would be admitted—sometimes for \$30,000 care. Then Frank Sacco asked to take on the county’s primary care caseload, and he received \$900,000. This cost MHS \$4 million to match it:

“It was a bad business decision but we completely expanded access to care. I will tell you that ever since we’ve taken this community-based mission on, our reputation has been enhanced in this community and most importantly our business volumes have increased not only with the uninsured but with the insured patients. . . . Part of that is that we have many patients tell their physician who want to put them in the for-profit hospital that ‘Memorial was there for me when I needed them and I couldn’t afford to pay them, so I’m going there now that I have insurance.’ That’s not uncommon.”

Leading Practices

Instilling Values about Community Health in Ongoing Strategy

MHS cooperates with other organizations—notably the Coordinating Council of Broward County—to conduct periodic telephone interviews. These interviews are designed to discover how the sampled 2,000 county residents feel about the state of families and communities, safety, education, the local economy, environment, government, and healthcare. The survey report provides trend information for the county and comparative information for Florida. In addition, goals are projected for the years 2000 and 2010.

Other data are collected by census tract. These data enable the hospital to track community needs and are used in conjunction with focus groups of residents to lend reality to the information.

MHS leaders advise that strategic plans serve a community health perspective better when they are less focused on a set of specific community health status measures. They prefer, instead, to use a broad array of health and quality of life information. MHS’s use of community quality of life data for direction setting and performance monitoring started through United Way’s Compass methodology. MHS then contracted with David Smith, of Smith Abt, to conduct a Community Health Needs Analysis. This effort started with South Broward but was expanded to include both South and North Broward.

Frank Sacco currently serves as chair of the Coordinating Council of Broward. Data from the health component of the survey were considered, and nine initiatives were submitted to the MHS board for their consideration. The board, representing the various geographic areas MHS serves (and population segments), prioritized these nine to focus on seven areas. These initiatives became the basis for MHS’s strategic initiatives:

- Physician development

- Quality improvement
- Community commitment
- Viability—financial and operational
- Organizational development
- Customer focus
- Market development

Sacco noted that the initiatives have broadened over time. For example, initially the focus was on South Broward County, MHS’s primary service area. Likewise at first, the board considered only adult healthcare services, but then they added children’s healthcare to the list of goals. Indeed, in the most recent strategic plan, health goals have been expanded to include more general, quality of life issues so that today, children’s and seniors’ services, as well as cultural diversity, are part of MHS’s agenda.

One major thrust is to attract light industry to the service area to provide better-paying jobs. Duncanson, the current board chairman, has pushed for this initiative. Other community health efforts are spearheaded by the Community Health Subcommittee of the board.

Establishing an Executive Position with Priorities That Transcend the Institution

MHS has an executive with a communitywide scope of authority. John Benz, strategic business and development officer, dedicates 40 percent of his effort to oversight and leadership for staff in the following community health-related areas: government relations, community benefit, community relations, marketing, and public relations. These are relatively mature areas in MHS, each having staff with substantial experience carrying out these functions. MHS is a tax-assisted hospital (less than 6 percent of MHS’s revenue comes from ad valorem tax), and Benz relates dollars spent to health promoted and illness constrained. Thus, he credits the lack of a tax millage increase in nine years to the prevention of premature births.

At the time of our visit, 50 percent of Benz’s effort was dedicated to managed care contracting, which was relatively more than normal because it was an area of more recent development at MHS. In addition to managed care contracting, he is responsible for planning, marketing, and public relations.

Benz grew up in this community, knows nearly everyone, and plans to retire from MHS. Some refer to him as “Father John” because of his missionary zeal to collaborate with others to improve the community. Several of the community representatives we spoke with said that the linkages developed, the open sharing of information, and the lack of duplicated efforts are directly attributed to his efforts.

A 1995 Fellow of the Health Forum, Benz insists that experience allowed him to meet with others who are committed to community health. These contacts are maintained; virtually every day he receives an e-mail from a colleague who attended the Health Forum Fellows Conference with him. Once you get into the fellowship,

“there’s a foxhole mentality—once you learn that process and you learn that love, you will never ever let go and its your support system once you get there. When somebody

goes to Type A accountability, or really pressures the issues on community issues, you can always reach out and get a helping hand.”

Later when he, the CEO, and the board attended an Estes Park conference, Benz helped implement community outreach efforts. Such a protagonist is necessary, for as Benz suggested, “The CEO can’t do it alone; he needs a co-chairperson to implement [the program] because the process is long and has hurdles [to overcome].”

Multi-branding Community Health

Like the other leading practice sites, MHS participates in a variety of partnerships on a wide array of initiatives. The partnerships in which MHS participates emphasize a high degree of interagency involvement, as well as targeted citizen involvement. MHS typically lends its name and corporate logo to these efforts, along with those of its partners.

Several informants told us that MHS works along with other community agencies to effect positive change. For example, through efforts by the South Florida Regional Planning Council’s executive director, MHS was awarded a MacArthur Foundation grant to develop community leaders. Now MHS will enact the grant. MHS displays its logo prominently on the primary care clinics and the women’s clinics it runs. The executive director of the Regional Planning Council, John Werner, said that some staff in his office who volunteer on the Healthy Start program work for John Benz as well.

Sometimes MHS will work with another agency so that it can obtain funding. For example, MHS and the Regional Planning Council worked with the school board to launch the Healthy Kids Program, which provides health insurance for indigent children.

Skip Johnson, executive director of the Coordinating Council of Broward, said of MHS’s CEO, “Frank uses the hospital as a tool to improve the community.”

Integrating Evaluations of CEO, Board, and Organizational Performance

MHS integrates CEO performance evaluation, board self-evaluation, and the board’s evaluation of the organization’s performance into a single annual cycle using the same strategic initiatives and performance criteria. In March, Frank Sacco, chief executive officer, sends performance evaluation forms to the board members and to the system’s four chiefs of staff. Both types of forms reflect MHS’s strategic priorities and focus on the evaluator’s satisfaction that each of a series of goals were well met, but the form used by the chiefs is less detailed. Completed forms are returned and aggregated. The board chair and the CEO use this information in the review of the CEO’s performance. The criteria used in this review include (1) fiscal management, (2) community benefit and planning, (3) peer review, (4) quality improvement—risk management, and (5) board and medical staff relationships. Community-related performance comprises about 25 percent of total performance, and this has grown over the past decade.

The CEO’s salary increase is dependent on this review. The CEO’s salary is pegged at a multiple of the staff’s, and the chairman can increase it from 0 to 5 percent annually. (The full board could increase it more if requested.) No bonus is awarded to MHS’s executives; the CEO has an executive employment contract.

In the early fall, the board conducts a special self-evaluation meeting. The same completed forms that had been used in the CEO's performance review are used by the board members to assess and identify areas of improvement for their own performance and for the organization's performance. For example, if the board raises concerns about accounts receivable, it is likely that Frank Sacco will be expected to address this issue both in terms of the board's education and in his own subsequent evaluation. Such congruency creates a reinforcing system that can focus the leaders' development in a short time span.

This annual cycle of evaluation also includes a reevaluation of the strategic initiatives and the performance review criteria.

Restructuring Board Committees

The MHS board, as a public institution in Florida, operates under strong sunshine provisions; i.e., meetings must be open to the public. In addition, the board bylaws call for only seven members. Moreover, with its commitment to community health and quality of life, MHS pursues a broad agenda. To meet objectives related to these characteristics, the MHS leadership has adopted a staff-intensive board committee model.

There are 14 board committees. Each committee is chaired by a board member. At any point in time, most board members chair 2 committees. The remainder of each committee, however, is made up of senior management, including the CEO, and the physician leadership.

This tight bond between senior management and individual board members apparently increases the board's opportunities to have access to accurate and thorough information and enables them to be more familiar with management's efforts to implement the board's strategic directions. Moreover, board members serve as content experts to the whole board and sometimes as representatives of the hospital to other community agencies.

For example, Mary Washington is chair of the board's Community Relations Committee. In her regular daytime work as the director of the Hallendale Center for Human Services, which provides after-school programs for children, 4-H clubs, nutrition programs, and other services, Washington is in contact with many individuals in need. Most recently, she has become aware that while the primary care clinics located in the health department are now well staffed and open to the public for extended hours and on the weekends, the clinic itself is inaccessible to public transportation. She has become involved as one of MHS's representatives with the Coalition for a Healthy South Broward—a group of civic-minded individuals representing various community groups. At the meeting we attended, Washington praised the transportation department officials who were attempting to provide greater public transportation access to these clinics.

Overall, it seems evident that fixing individual board member accountability has fostered active, involved governance with dedicated and knowledgeable staff to promote MHS's community-oriented goals.

Connecting with the Community through the Olive Garden Method

Every community-active organization experiments with ways to identify and engage citizen or neighborhood leaders who might otherwise be unknown to a hospital or health system. MHS has

used a method that involves inviting groups of known community leaders from specific areas to “two for \$13” lunches at a local restaurant. These groups are asked to identify and discuss two questions: (1) What are the top three problems in our community? (2) Who in our community knows more about this than I do? The second of these questions identifies people to be invited to lunch.

With each progressive cycle of identifying problems and leaders, three outcomes are achieved: (1) confirming the top community issues that need resolution, (2) identifying new leaders who could help solve the problems, and (3) acquainting local opinion leaders with MHS’s efforts to understand issues from their perspective. Hence, the circle of participation has grown and so has local support. As the cycle continues, the top problems become clearer, setting the stage for efforts to engage local partners in ways to address those problems.

Using this approach, John Benz determined that in MHS’s primary services area (South Broward County), getting jobs was a key issue. He then used the techniques of total quality management to determine what prevented people from obtaining and keeping jobs. Using a fishbone diagram, Benz and his group of community advisers determined that east-west public transportation presented a major barrier for many job seekers. Therefore transportation became the key agenda item for countywide resolution.

Investing in Education

MHS makes a substantial and regular investment in board member education. Each year all members of the board and the chiefs of staff are invited to an Estes Park Institute retreat in Naples. On a more frequent basis, board members’ intensive work with staff, as described under the topic of board committee structures, gives the board members a very high level of familiarity with issues faced by the organization.

Like many of the leading practice sites, a key senior manager has participated as a Health Forum Fellow. This year MHS expects to invest in additional fellowships as a means of developing the leadership skills of an additional senior manager and two of MHS’s local partners. MHS has also invested in special learning processes through the Forum, such as the Accelerated Community Transformation process.

Encouraging Staff Involvement in Other Community Organizations

MHS encourages its management and staff to volunteer in other community organizations. This encouragement ranges from providing time off to serve at state and local meetings that advance opportunities for disabled children to attending Chamber of Commerce meetings that promote economic development. Perhaps MHS has unwittingly realized benefits from such participation as, for example, when one MHS staff member was volunteering at the Regional Planning Council. When the community relations director sought to build a relationship with the council, the presence of the staffer helped elicit the trust of the council’s executive director.

Developing a Stable, Tenured Executive Management Team

Frank Sacco is only the third chief executive officer to run MHS since its founding in 1947. Each of his predecessors has had a long tenure, the first for 14 years and the second for 20 years. Sacco joined the MHS management team in 1974 as a department head and assumed his current

role in 1987. Asked if he thought this was good for the hospital, Sacco answered, “It’s good if you’ve got the right people.”

Likewise, John Benz, strategic business and development officer, has worked at MHS since he grew up in this community, knows nearly everyone, and plans to retire from MHS.

While each of the board members has lived in the community for 20 to 25 years, their tenure has not been as long as the staff’s. Since they are appointed to four-year terms with possible reappointments by Florida’s governor, only one board member remains who served when Frank Sacco became the chief executive officer in 1987. And only two others have been on the board for as long as eight or nine years.

Perspective of the Partners

South Florida Regional Planning Council

A multipurpose planning agency for Dade, Broward, and Monroe Counties, the South Florida Regional Planning Council has evolved from macro land use issues to a concern for developing a comprehensive regional health plan including human services (capital) planning. Under the leadership of Carolyn Dekle, executive director, the agency functions not as a regulator but as a convener of agencies involved in these areas. John Benz had originally had negative feelings toward the agency because SFRP applied for a grant that had traditionally been given to MHS. But one day, Benz visited and saw their Geographic Information System, and while passing through, he met a staff member who also volunteered in his hospital. This personal connection helped engender trust between the two executives.

A partnership system was developed in Broward County: SFRP serves as primary staff for the Coordinating Council of Broward relative to census tabulations and management of information services. Dekle’s role now is to help translate data-gathering activities into effective coordinated policies. Dekle found it novel that John Benz was willing to take an interest in general (nonhealth) policy issues. They are both involved in CCB on an ongoing basis, but through their CCB work, Benz was introduced to the efforts of the state planning commission to develop plans based on other population surveys.

The two organizations (MHS and SFRP) have a relationship apart from CCB; for example, MHS will sometimes ask SFRP to help map services and programs. The relationship could grow in the future—especially since MHS will be more involved with the community’s health and since SFRP is concerned with avoiding or minimizing duplication. The Web sites of the two organizations are hyperlinked to avoid duplication.

Dekle and Benz have had breakfast every three weeks for the past year and a half. Each talks about what he or she wants to see happen six or nine months hence. Through this dialogue, they help each other reach their respective goals. Recently, for example, SFRP obtained a grant from the MacArthur Foundation to develop a leadership institute for the community, and Dekle wants to target three communities in Broward that CCB is focusing on. She is asking John Benz to develop some of the curriculum for the leadership institute. He has other reasons he wants to do it—but it’s a synergistic relationship.

Dekle likes to be the hand behind the action, so she would not be upset if MHS took some credit. In fact, she likes stable institutions with resources and political clout being given recognition for making things happen. She maintains that MHS knows that SFRP was behind the scenes in making it happen. Hopefully MHS will someday obtain the recognition for what they've done so far.

Dekle regards Frank Sacco very highly. He's pragmatic, and she likes the way he thinks—she feels he can teach her and he is running things. She's fascinated that he's involved in the community, and she's not sure that he and John Benz think about community in the same way. Sacco is a doer—one community representative asked him for five computers, and the next thing that happened was five computers were delivered. That's pretty amazing. While Dekle usually has taken an academic approach, she is also accustomed to working with such pragmatic activists.

One of the main motivators for MHS work is John Benz. Carolyn Dekle characterized him as a bulldog. They love to win in the legislature; it's almost like a sports activity and they are winning—they're being recognized widely.

Broward County Health Department

Initially, the county provided primary care to the indigent. The state health department delegated this to the county, and clinics were established in various towns throughout the county. In 1984-85, the state established a primary care network providing \$1.4 million to the county. While the county was giving good services, there wasn't enough care available, and prenatal care visits were being scheduled after the mothers' due dates.

Tom Anthony, president of the Broward Regional Health Planning Council—an appointed leader—began a primary care monthly meeting of hospitals and public health officials. Initially, obstetrical services were transferred from the county clinics to the district hospitals, then children's services were transferred, and finally, adult primary healthcare was transferred. To learn about diverting nonurgent use of emergency room services, John Benz visited three hospitals in other parts of the country. After that, the county health department transferred primary healthcare to the hospital.

MHS is special in its way of communicating its community health philosophy. The idea expressed so forcefully by John Benz was that “if we keep the community healthy we're going to reduce the cost of healthcare—long range.” But David Roach, administrator of the Broward County Health Department, maintained, “One can't build a plan on that assertion. It can't be proven, but they believed in it and have a commitment to it. They began to realize what public health was while establishing clinics in poor areas. Family planning may now be given up to the hospital; this enables better continuity of care.” Roach noted that many in public health are concerned about losing their function in society. He is not concerned: “Public health will always have a function—hepatitis C is coming up now.”

Roach is instrumental in providing health indicators information for the county. The Institute of Medicine's *The Future of Public Health* recommended that this is the kind of activity public health departments should be doing. Specifically, assessment, policy development, and assurance

were suggested as the most useful functions of public health departments instead of providing direct care. Indeed, Broward County's data show that numerous health indicators such as AIDS cases, teen pregnancies, infant mortality, etc. have improved—notably among nonwhites—in large part because of the dollars infused by MHS.

In his position, Roach has been able to make data available to hospital executives—especially in primary care and what needs to be done. Even now, they are working to coordinate distribution and financing for drugs for family planning. His relationship with John Benz is superb—“he’s like a brother.” And Roach has “all the respect in the world for Frank [Sacco]. It’s a team effort.”

Yes, there have been bumps. Mostly it’s important to protect egos; for example, MHS’s sign was larger than the public health department’s sign. David Roach is fighting the state to get an equitable sum for primary care, which he passes on to MHS. Roach is at the same time willing to give up immunizations to the primary care physicians—despite the fact that the state has developed an information system to identify children in need of immunization. Now they have a system without data. But as far as efficient delivery, Roach is only too happy to yield this function.

Advice

From Mary Washington, Board Member and Chairman of the Community Initiative Committee, to Other Board Members

1. Don’t only focus on finances and building—focus and publicize your efforts on behalf of the people of the community.
2. Change medical staff attitudes in the direction of providing service to the community.

From John Benz, Strategic Business and Development Officer

To make community benefit happen you need three things: a history of hospital involvement with its community, a champion to push through community programs, and board awareness.

From Carolyn Dekle, Executive Director, South Florida Regional Planning Council

If I were to go to another town to do regional planning again, I’d set up an appointment to visit the hospital CEO and the board chairman the first week there—since they are the principal deliverers of community services. “I’ve thought to set up appointments with the school board and the business types, but it never occurred to me to consider the actual service providers first.” Conversely, hospitals that want to impress regional planners need to show what community improvements they’ve made.

The real leaders must be present in the coordinating council’s meetings. “You cannot delegate this to staff. You can’t contribute your \$30,000 per year and never show up.”

Also, build on the resources in the community regarding planning and external strategy. To planners and CEOs of hospitals, she suggests, “Learn what resources exist in planning and issue raising and get hooked up to it.” It isn’t necessary to start from scratch.

From David Roach, Administrator, Broward County Health Department

Roach recommends incorporating public health into community outreach efforts of the hospital because “we’re crossing over into each others’ territories. The public health departments are going to fight against this like mine, because the hospitals are treading on their turf. But if this change is going to happen, instead of fighting, they have to be part of the solution.”

John Benz has become one of the public health experts in the community. Such expertise is rare in the hospital—and he learned from David Roach. Public health officials need to educate hospital executives.

Conclusions

MHS represents a government system that is constrained in its board structure. But through the risk-taking efforts of its CEO and the efforts of the head of the public health department, MHS has emerged as a leader in community outreach. The main hospital has the look and feel of a voluntary community organization. Through its leading practices, MHS has transcended its origins and expanded its role and value to the citizens of South Broward County.