TABLE OF CONTENTS

SECTION 3
DEMONSTRATION SITES

Evergreen Community Health Care, Kirkland, Washington............................75
Kaleida Health, Buffalo, New York.. 86
Maria Parham Hospital, Henderson, North Carolina.. 96
St. Joseph Healthcare, Albuquerque, New Mexico... 101
St. Mary Medical Center, Hobart, Indiana.. 110
Texas Health Resources, Irving, Texas... 118

APPENDIXES

Appendix A: Names and Contact Information for Leading Sites.................... 128
Appendix B: Names and Contact Information for Demonstration Sites.......... 130

EVERGREEN COMMUNITY HEALTH CARE
KIRKLAND, WASHINGTON
Demonstration Site Visit: August 2-3, 1999
Follow-up Site Visit: September 20-22, 2000

Community Background

Evergreen Community Health Care serves an area of north King and south Snohomish Counties in Washington. The area is east across Lake Washington and to the north of Seattle, about a 20-minute drive in good traffic. ECHC's service area is beautiful, verdant with evergreens and defined by sharp and craggy hills and outcroppings of modest size.

ECHC's service area has a population of 360,000. Where 8 percent of the people in ECHC's service area are 65 or older, in all of King County 11 percent of the people are 65 or older. ECHC's service area population (88 percent white and 5 percent Asian/Pacific Islander) is also less ethnically diverse than that of King County (82 percent white and 10 percent Asian/Pacific Islander). More than 10 percent of Washington State, 8 percent of King County, and 5 percent of the ECHC's service area residents live at or below 100 percent of poverty.

Residents in ECHC's service area mainly work for service industries, followed by wholesale and retail trade, then manufacturing and government sector employment. The area has low unemployment rates, and the projections for the next five years indicate continued growth, but with a slow rise in service area unemployment. The average (median) family income for the area in 1999 was $75,858, in part fueled by the high-tech industry located there.

Leading Practices

During our first visit to ECHC, a variety of leading practices were uncovered and examined. Brief descriptions of each follow:

Collecting Health Data
Evergreen Community Health Care benefits from being located in a community where the public health department conducts periodic surveys of health status. In addition, Keith Cernak was hired in 1992 as a community health status director to conduct a community assessment using interviews and bringing various groups together to talk about community needs and examine count and state data.

Systematically Investing in Community Health
Fifteen years ago, Andrew Fallat, FACHE, the hospital's chief executive officer, and the board decided to set aside and budget a portion of the regular levy of $180 million to address needs not then addressed for community health. This established 15 percent of the levy as dedicated to target chronically ill and disabled persons who would lose their independence without some assistance such as day health centers. Such funds were used to screen volunteers, provide CPR education and nutritional assessments, etc. and support education for staff. These dedicated community health resources were not used as grant funds; instead, they paid for hospital services to be provided to community agencies. The board instructs staff to design the programs, which must be integrated with the operations of the hospital. Funds from this systematic investment can

accrue and are still being used for the chronically ill and disabled. Now, 50 percent of the regular levy is used for community health programs. The clinical and programmatic outcomes of these funds are reported to the board semiannually.

Incentivizing Performance in Community Health
The CEO's bonus can amount to 30 percent of base salary. Specific goals are tied to the bonus. For example, in the year 2000, the following weights were associated with each goal:

Community service	25 percent
Security	20 percent
Financial	15 percent
Staff health and well-being	15 percent
Charitable foundation	15 percent
Physician leadership development	10 percent
Total	100 percent

Typically, the CEO attains 22 to 25 percent of the potential. For the eight or so top members of the management team, the maximum bonus potential is 18 percent of salary. This bonus is based in part on achieving various objectives and includes 10 percent devoted to community health status and 15 percent based on increasing community trust in the overall healthcare system. A sample of community members is canvassed to determine if these targets are achieved.

Creating a Health Information Unit
Along with the Department of Public Health, ECHC founded Partners for a Healthier Community, which now has seven of the leading healthcare providers as sponsors. Originally, Keith Cernak contacted other systems to determine if they would be interested in partnering on some key community health issues. The seven partners now each contribute $60,000 per year, which serves to underwrite the administrative costs.

Using focus groups and town hall meetings, the staff considered 27 areas for attention before narrowing the concerns to four. The four initiatives currently being pursued are domestic violence and child abuse, breast cancer, adolescent health risks, and maternal and child health. Thus, this unit of ECHC has become transformed into a catalyst for improved services throughout the community. The four initiatives are carried forward by 16 programs staffed by community volunteers. As executive director, Keith Cernak becomes involved with a few of them; others can be conducted mostly by volunteers. He is now focussed on developing measurable outcomes.

Cernak admits that while the data used to determine areas of greatest need are getting old, he is working to probe into areas of success and explore other opportunities within these four initiatives. Additionally, Partners is responding to requests from businesses in the area to provide specific programs to employees. For example, Microsoft has requested training in domestic and workplace violence.

Developing and Working with Strong Support Networks in the Community
About 14 years ago, an advisory group to the ECHC board of commissioners was assembled to help the hospital stay close to the community. The advisory group consists of 30 individuals who advise the hospital on community needs. They consider various issues that ordinary, full-powered boards might except for lawsuits and privileging of physicians. Included on the board are retirees, disabled individuals, and healthcare consumers from various walks of life. The board of commissioners shares educational programs with this group, including programs on ecology, community health initiatives, and more. In practice, the more articulate and involved members will often run for election to the main board.

New Practices

Based on follow-up discussions to the first site visit, ECHC planned on considering or implementing the following leading practices between September 1, 1999, and August 31, 2000.

1. Implementing strategic giving—a process for making strategic use of resources. ECHC may want to consider developing a systematic approach to disbursing levy funds to community partners and others. Through the development of a standard application form, community partners can be assured that they are being given consideration for funding, and at the same time, senior management can compare proposals along the same dimensions.
2. Providing joint education for board and management. While ECHC has invested in board education by national organizations and supported travel costs to seminars, some potential exists for the organization to bring in experts to train board and senior managers on a wide variety of topics. Such joint education may serve to help the board understand the perspectives of the managers and vice versa.
3. Issuing a report card. ECHC has an attractive quarterly publication that receives wide distribution. It could, however, be enhanced with the addition of information on (1) how levy funds are used and (2) community health indicators and how they are changing over time.
4. Developing an ongoing board improvement process. ECHC was considering several approaches to ongoing board improvement. Possibilities included using a neutral third party to analyze group dynamics during board meetings, developing a board process for identifying and encouraging potential candidates to run for election to the board, and integrating more explicit attention to community health in the board's performance evaluation activities.
5. Connecting to the community. ECHC already has an advisory board to help it gain a sense of community needs and wants. Perhaps additional thought could be given to the best use of the advisory board and to other processes that would ensure that the hospital's strategic plan reflects the desires of community residents and that full consideration of alternative initiatives is given by board and management prior to adopting a strategic plan.

Results

Environmental Changes
The independent practice association of ECHC went bankrupt, leading ECHC to write off a $1.5 million loss. An overestimate by about 250 percent, provided by Lewin Associates at the behest of the American Hospital Association, of gains from outpatient payments contributed to this failure. As ECHC has worked with its surgeons to develop a new surgery center, it has

emphasized the importance of both groups putting cash into the venture, so that both will have a long-term stake in it.

The CEO reported on the impact of the Balanced Budget Act and home care reductions in particular. Also, there were a number of personnel changes at the upper levels as well as the arrival of a new vice president for Medical Affairs. External relations with the medical school have improved markedly, in part because of a lecture series ECHC initiated for its leaders. The medical school's ob-gyn residents may serve their primary care rotations at ECHC, where more than 4,000 births took place in 2000.

Implementing Strategic Giving
ECHC was able in the study year to change its award-granting policy for the $3.6 million it distributes. First, it clarified target populations that would be beneficiaries of the award:

- Elderly people who lack access to care
- Disabled elderly
- Children with asthma

An executive guidance team developed award criteria and a proposal process. Three teams were developed, one for each target population. When a project is funded, a charter is prepared that provides businesslike rigor through careful project management. The charter also identifies an ECHC executive who is appointed to oversee, run interference, and open roadblocks as they arise. All projects that receive $25,000 or more must have such a charter. Also, the newly hired community health status director supports this process by providing information about health status so that programs can be selected and evaluated.

The team also developed and put into use a rating form where each proposal could be evaluated using the same criteria. During these inaugural evaluations, the team made a decision to award fewer but larger grants in order to improve management's ability to ensure appropriate oversight and care for each program and to maximize impact. As a result, grants given in the past to support Kirkland's Little League, health fairs, and teen centers were not renewed. Instead, ECHC has focused on domestic violence and school-based health programs. As Keith Cernak noted, "The course we have set will help us focus better and therefore have a bigger impact."

To assure adequate funding continues for the three targeted populations, the CEO will be expected to ensure that at least one community health improvement grant would be applied for.

Barriers to initiating this systematic approach to funding were few except that prior commitments had to be disengaged in a tactful and responsible manner. Many of these prior grantees were provided funds in smaller amounts for a couple of more years so that they could pursue other funding opportunities.

Providing Joint Education for Board and Management
The Learning to Learn Lecture Series is done in conjunction with the University of Washington. It covers a variety of topics that are of interest to the board, CEO, physicians, and key managers who are invited, along with community members, to attend. The first lecture focused on the

influence of genetics on the future of healthcare, and the second was about the implications of the Internet for the healthcare consumer.

The main barriers to implementing this leading practices concerned scheduling difficulties for some board members. Also, the topics were chosen by the hospital's CEO and the dean of the medical school. In the future, the audience might be polled as to their interests for joint educational programming.

Issuing a Report Card

Although not specifically a report card, in terms of providing consistent, quantitative "grades" on a particular set of items over time, a 1999 year-end outcomes report on the use of the levy for community health services was produced and distributed. It provides information on services and outcomes achieved for ECHC's 13 community-based programs. ECHC also produced and distributed an information sheet and a PowerPoint presentation, at the board's request, that summarize the 1999 year-end outcomes report, in order to facilitate communication with various audiences by various speakers throughout the community. Finally an insert was developed to be included with ECHC's quarterly newsletter, *The Monitor,* which is distributed to 100,000 residents in its primary service area.

Barriers to the year-end outcomes report on the use of the levy were few, although some interviewees suggested that the report was, at 15 pages, somewhat lengthy. High praise was given for the one-page summary flyer. In regard to the report placed in *The Monitor*, one interviewee suggested that this report card needs to include more than simple mortality and morbidity statistics. It needs to report on such preventive community health initiatives as "Teens Being Valued" as well as outcomes information. Thus, in the future, more of ECHC's preventive functions with actual outcomes need to be included in that publication.

Developing an Ongoing Board Improvement Process

Several years ago, ECHC adopted John Carver's Policy Governance approach to the board's work. During the course of this project's demonstration year, the board added two ends policy statements to its board's ends policy manual. These ends policies speak to the significance of the individual, the community, and overall health.

> *Global Ends Policy*
> "The Board of Commissioners affirms that the following global Ends Statement shall guide all decisions and activities of the Board and CEO."
>
> *Ends Policy*
> "Evergreen Healthcare will advance the health of the community it serves. Individuals will reach their highest potential for health through access to high quality, compassionate, cost-effective health care."
>
> *Ends Policy Substatement on Highest Potential*
> "Individual will maximize their health within their own physical, mental and spiritual capabilities. Community members will have the knowledge to live healthy lifestyles, prevent disease, and take responsibility for their own health and wellness."

To meet these ends, ECHC has adopted several new practices. Board members receive a quarterly report on the use of the levy funds, including systematic investments in community health initiatives. These reports not only inform board members but also help them communicate consistently and clearly with other groups in the community about the hospital's performance. In addition to quarterly written reports, ECHC management is providing the board members and others with a standard PowerPoint presentation package for use in public-speaking settings. ECHC is initiating an annual retreat to discuss community health status with executives, medical staff, and the board. This work can all be summed up as meeting the demands of an excellent question raised by some of the board members: "I want to continue helping this organization to serve our community as best it can; I'm going to be running for reelection someday. What am I going to tell people that we're doing with their tax money?"

Connecting to the Community

The vice president for Community Relations has attempted to learn about the community's wishes for its healthcare by conducing systematic surveys and focus groups. This process uncovered the general sense in the community that ECHC is a "high-touch, low-tech" hospital. Our informants stated that this is a misperception, but ECHC appears to be dwarfed by nearby large academic medical centers. To revise this image, ECHC is working to add a heart program and to better publicize its world-class maternal and child health program. But, more generally, improved acquisition and use of health information supports progress across all their initiatives. As Phil Terry said, "We want to build a model around excellent work in community health," and good use of data is central to excellence.

Developing Performance Management Systems

The CEO's performance objectives, especially those related to the bonus portion of compensation, already included community health activities. One difficulty, however, has been tying them in advance to the coming year's overall organizational strategy. The process of developing performance objectives had not been integrated into the overall planning process. This has typically meant that the board reviewed performance objectives that were developed well into, and to some extent independent of, the organization's actual performance for the year. The CEO's performance objectives are now developed and communicated in a more timely way so that the board's expectations can be firmed early in the year. This offers better, more consistent guidance to the CEO and his staff to ensure that their objectives, including community goals, are addressed and that the board can see this more clearly.

In addition, written performance expectations for executive team members were enhanced, specifically to emphasize that each team member is expected to be a community leader. Each member of the executive team must sponsor and/or participate in one of the three ECHC-sponsored community health status events. Each is expected to sponsor a table at one of three health fundraisers: Women for Women, Eastside Domestic Violence, Multi-Service Centers—East King County. They can also receive more positive evaluations if they serve on a community board or as a representative on a community health partner's advisory committee, personally speak in a community setting about ECHC's community health status programming, attend a community health status leadership conference, and attend two community-based community health status events.

Outcomes
Keith Cernak, executive director of Partners for a Healthier Community, a collaborative initiative of nine hospital systems and a large insurer, stated that there is some demonstrable evidence of changes related to health status suggesting ECHC and its partners' programs may be having an impact. It can be documented that breast cancer is being detected earlier in the ECHC service area than was previously the case. ECHC initiated a program of making sure that patients, in the hospital for any reason, are asked about the appropriateness of their colon cancer risk awareness, resulting in colorectal cancer screening of 80 to 90 percent of the patient population.

There is also evidence that the increase in the incidence of reported domestic violence and youth violence is slowing communitywide. This could mean that local efforts to increase reporting of violence have reached their peak effect, so fewer unreported acts of violence remain unseen in the community. It could also mean that the antiviolence initiatives are helping reduce the overall level of violence in the community. Either way, the local programs seem to be having an impact. Similarly, in ECHC's community—unlike many communities—smoking among pregnant women has decreased about 2.2 percent over three years.

Most respondents told us it was too soon to evidence any changes in health status over the past year, but one board member noted that juvenile asthma was being targeted and flu shots were given to all employees and their dependents as well as offered to Kirkland residents for a $5 co-pay. Another board member suggested that various screening programs had been enhanced: Colorectal screening is pursued to a greater extent than in the past, and more breast cancer information is being distributed.

There is more recognition of domestic violence and teen dating issues. New forms of therapy such as meditation, alternative medicine, and Tai Chi have been introduced, and a dental healthcare van has improved health in the community. Other improvements in the past year have been the growing registrations for CHIP (Child Health Improvement Program), a free immunization clinic, sports physicals for kids, and two senior clinics as well as a new Parkinson's disease center. It was this board member's belief that the future course for the community's health appears bright, in part because ECHC is now focusing better on top-priority problems, as a result of enhancements to management and governance practices.

Paul Murakami, regional health officer of the public health department, stated that since last year, the Partners program has gained momentum (see below) and two initiatives, Safestart and Workplace Violence, have improved community health.

One board member suggested that improved communication and publicity would be an important future practice that might strengthen the connection between the hospital and the community and produce more positive impacts on community health. This board member also suggested that ECHC should allocate a portion of its levy receipts to buy insurance for the 1,200 families in the service area that do not currently have coverage from the State of Washington. This person also noted that annexation of the town of Duvall, a small, isolated community adjacent to Kirkland, could also contribute to improved community health because that community is currently without any healthcare resources.

Relationships with Public Health
The site visit team interviewed Paul Murakami, district director for East King County Public Health Department. Murakami considers ECHC a strong partner and supporter of public and community health efforts. Murakami noted that Phil Terry, hired by ECHC to oversee its community health initiatives, is a former employee of the health department. He also pointed out that ECHC always invites a public health presence to its events and educational seminars.

"I've always thought Evergreen should be the model for hospitals in their collaboration on community and public health issues," said Murakami. In contrast to ECHC, Murakami characterized "less good" organizations as follows:

- Their number one priority is clearly the bottom line.
- They emphasize tertiary care and ignore prevention efforts.
- Their staff and leadership lack common vision and mission.
- Their internal political environment is not open to public and community health concerns.

Murakami mentioned a former employee of ECHC who had been a strong supporter of Washington's Basic Health Plan. Upon arriving at another hospital, however, the person was unable even to discuss it.

Murakami did note that a recent rapid growth in the Spanish-speaking Latino population, a 43 percent jump in five years, presented a new challenge for ECHC. He suggested that ECHC might begin to focus more on higher-risk populations of color.

Partners Program
While paid through ECHC—as is his project coordinator—Keith Cernak is really responsible to nine members of healthcare systems who each contribute $60,000 per year to address programs that will improve the health of the greater Seattle community. This collaborative program encompasses as many as 16 services including Safe Place (buying hotel space for victims of domestic violence), Cops and Docs (physicians and policemen give joint presentations in schools), Safestart Smoking Prevention for Pregnant Women, Youth Violence Prevention Programs, etc. Partners is housed at ECHC, but a neighboring hospital, Overlake, manages its finances.

Enablers
Each informant was asked to identify factors that enabled the development and implementation of practices to increase performance expectations for community health. These are summarized here.

The CEO noted that an enabler for developing and distributing a report card is having the right staff available. The competencies required for acquiring, organizing, and reporting complex data to the general public are not widely held. For ECHC commissioner Jeanette Greenfield, this represented new strengths for the organization that it would not otherwise have as a traditional medical care provider.

Another enabler for the CEO is having an executive who works with all members of the executive team to coordinate and feed the group's common understanding of market and community intelligence. At ECHC, Ron Novosek serves this purpose, building strategic intelligence into the work of all executive team members.

An important enabler adopted this year was the inclusion of executive staff in the development of the newly enhanced performance objectives for community leadership. Having them involved in developing their own performance objectives had payoffs related to the practicality of the objectives themselves and the enthusiasm with which senior managers adopted the new objectives.

Participating in this project has been an enabler in ways beyond the enhancements that have been designed and implemented. Participation in this project has been used as a selling point in the search for other grants to support community health initiatives. In addition, participation in this project has increased awareness of opportunities for better managing community health efforts. As Jeanette Greenfield observed, "I think that's where you helped us. You got different thought processes going. It made me think about *how* we're doing our business. Are we really reaching the community the way we should?"

Lynn Hagerman, vice president of Program Development, observed that it is an enabler when serving as a convener for community initiatives can be emphasized and valued on its own terms.

Having 10 organizations, or some formally identified and larger number, involved in a coalition helps to neutralize some of the "begging" that larger community organizations often face. In fact, a coalition can help identify a specific set of initiatives that many small organizations seeking gifts can subscribe to. The result is a better-managed process.

Another enabler is to identify synergies among partners in a formal coalition. What can one organization offer that another cannot, and vice versa? Then, among all those potential synergies, having specific initiatives helps the coalition avoid the trap of trying to plug every hole that comes to their attention, and thereby dissipating their effort and impact.

It is also an enabler to engage in *planned* change. Initiatives, performance objectives, budget, and other standard tools of business management help community health work become a process of planned improvement for which outcomes can be expected and tracked, rather than a series of disconnected initiatives.

Barriers

Each informant was asked to identify barriers to developing and implementing practices to increase performance expectations for community health. These are summarized here.

According to the CEO, the context of the times introduces a number of barriers to progress. The increasing financial constraints faced by hospitals are a major issue here. This particular community is at the same time experiencing rapid population growth and increasing demand. This points to two key questions for ECHC: How can ECHC continue to improve its community health performance in light of the financial challenges it faces, and therefore keep the trust of

people who already have faith in ECHC? How can ECHC build trust with the community as it grows and evolves, and yet remain a fiscally viable health delivery organization?

A barrier to progress identified by Lynn Hagerman is the real need for any organization to manage expectations. She noted the pragmatic concern about bringing in many voices for fear that too many different demands will be placed on the hospital.

Comments from External Community Representatives

In addition to Murakami of the public health department, the project team interviewed Karen Forys, superintendent of the local school district that most overlaps with ECHC's service area. Forys listed a number of partnership programs between the schools and the hospital, including school nurses, tobacco cessation, flu and pneumonia shots for school staff, and joint training for high school students in the healthcare professions. "I have a very positive view of this hospital. I've never been hospitalized here. And I've never visited anyone here in the hospital."

Forys went on to indicate that school nurses help with nonacademic sources of barriers to learning such as finding undiagnosed and untreated health problems. Nurses also offer social work services, including providing food or food stamps where needed. She indicated that while ECHC's childhood asthma initiative had not evidenced changes in her view as yet, domestic violence was a major new effort, and her role was to coordinate with both ECHC and the police. She had participated in an ECHC focus group on the topic.

Looking toward the future, she thinks her community will become more urbanized and attract more immigrants, transients, and families in crisis. For all these reasons, she predicts that ECHC and the schools will need to continue to work together closely.

Conclusions

ECHC already had a number of leading practices to ensure it was attending to its community health mission. But the leaders of the hospital created a number of new practices and enhanced existing practices in substantive ways. These improvements focus on two general areas: improved management of community health initiatives and better communication about ECHC's role and performance in community health.

ECHC has a new systematic process for approving and chartering investments in community partners. It is too soon to determine whether this guided approach to choosing partners will result in a greater bang for the buck. But it seems that scarce community resources are already being monitored more carefully than heretofore.

ECHC hired a vice president for Community Relations. ECHC enhanced performance objectives for management and adopted new ends policies to guide decisions that advance community health and maximize individuals' health knowledge. ECHC is initiating annual retreats to discuss community health issues and has implemented other practices to improve governance and management of its community health efforts.

Improved communication about community health can also be seen in a number of enhancements or new practices at ECHC. All the leaders we spoke with praised the joint education and noted the unintended and positive consequence of improved relationships with the medical school. Board members are particularly delighted with the one-page summary of the use of levy funds, and a report card to the community is a work in progress. As data on preventive programs and outcomes are introduced, one would expect that *The Monitor* will become a source of pride to Kirkland's residents.

All in all, ECHC made significant changes in its board and management practices, in its communication methods, and in its standards for performance in community health.

KALEIDA HEALTH
BUFFALO, NEW YORK
Demonstration Site Visit: September 7-8, 1999
Follow-up Site Visit: September 25-26, 2000

Community Background

Kaleida Health is located in Buffalo, N.Y., and has facilities in eight western New York counties. The population in the region is about 1.6 million; projections are that the elderly population will more than exceed the rate of increase of the elderly population of the United States as a whole. Socioeconomic indicators for the region are generally poor, with five of the eight counties showing higher than median numbers of people below poverty level in 1989.

Health statistics are equally poor: Four counties were above the New York State rate for ischemic heart disease deaths, six counties were above for lung cancer deaths, three counties were above for female breast cancer deaths, and seven of the eight counties were above the rate for unintentional injury rates. Based on a recently completed regional health risk assessment, the three greatest risks in the area are obesity, smoking, and lack of physical exercise.

Kaleida has targeted two communities in its strategic plan for intensive work. On Buffalo's east side, the African American community (45,500) has a median income of $12,915, and a quarter of those over age 25 have less than a 12th-grade education. On the lower west side are Hispanics (4,900), whose median household income is $16,329. Fifteen percent have less than a high school education. Treatment for chronic conditions in these communities is most often sought from hospital emergency rooms.

Leading Practices

During our first visit to Kaleida, we found a number of leading practices. They are as follows:

Using Consolidation as an Opportunity to Re-envision
Kaleida is the product of two hospital systems and a children's hospital merging to provide healthcare for the community. Included in the systems were Buffalo General Hospital, a teaching hospital; DeGraff Memorial Hospital; and Millard Fillmore, with its downtown Gates Circle campus and suburban hospital. Recently, as evidence of the re-envisioning process, Kaleida closed Columbus Hospital, Children's Hospital, and Millard Fillmore and combined them to build an $8 million Family Medical Center. The merger was needed due to a downward spiral in available financial resources for the community's healthcare assets. Contributing factors included decreasing Medicaid reimbursement by New York State, growing managed care and discounted contracts, and the Medicare cuts. Perhaps the most significant contributor has been the long-term loss of population and businesses in the Buffalo area.

According to Bryant Prentice, Kaleida's first chairman, merger became possible because the chair and either the chair-elect or the past chair from each of the merger entrants engaged in a series of meetings to discuss the reasons for the merger and the principles that would guide it. This "group of six" developed a set of merger principles, including establishing a steering

committee whose actions required the approval of the board of each organization. The first principle emphasized the merger entrants' "deep and genuine commitment to the health and welfare of the entire western New York community" and that "revenues generated through a merger (would be) reinvested in the community to improve healthcare quality, address unmet community health needs, and reduce costs of care." This establishment of a set of guiding principles prior to entering formal merger discussions represents a leading practice and also conforms to the AHA Board-Approved Principles and Guidelines for Changes in Hospital Ownership and Control established in 1997.

According to John Friedlander, president and chief executive officer of Kaleida, when the hospitals merged, each brought community programs with it. Today there are many programs, each with its own history, scattered throughout the new system. Kaleida leadership now seeks to design a strategic approach to community benefit so this large scattering of programs can be conducted, evaluated, and reported in a comprehensive and coherent fashion. This review of community benefit activities may also reveal duplicative or unnecessary investments by the system.

Linking Performance Evaluation and Compensation to Community Health
Kaleida Health uses a sophisticated system for guiding and evaluating management performance by objectives linked to the organization's overall strategy. This system was adopted from Buffalo General Hospital, which had been using it for several years prior to the merger. Performance evaluation and compensation are tied to annual, position-relevant objectives, which in turn are tied to short-term imperatives and long-term objectives that link upward to the organization's strategic plan and the vision. The Hay Group is involved as a consultant to some elements of this process.

The CEO's compensation is tied to achieving goals, with a bonus potential of 45 percent of base pay. The variable portion of his compensation is divided into long-term incentives, which are established for a three-year rolling period, and short-term incentives, which are evaluated yearly. The long-term incentives are intended to ensure attention to the long-term well-being of the organization. Indeed, the board knew that the merger's objectives would require at least three years to implement. At the time of the site visit, the CEO was in the middle of the first long-term cycle. This part of his bonus will not be awarded until early 2001.

The short-term objectives are established yearly. Performance and rewards are pegged to three levels of outcomes for each objective: threshold, target, and outstanding. In 1998, for example, these objectives for community health were directly linked to the strategic plan and included features such as creating a planning document, documenting Kaleida's contribution to the health of the community, conducting a community health summit in an underserved area, and expanding existing immunization activities. Six other senior managers are likewise remunerated based on their contribution to these strategic plan initiatives. Other managers' incentive compensation plans reflect their specific functional assignments in the organization.

In addition, all 125 managers at the department head level and above are evaluated, in part, on their involvement in the community. According to Carrie Frank, executive vice president, this sends an important message to them about Kaleida's vision and values.

Encouraging Staff Involvement in Other Community Organizations
Kaleida Health operates an outstanding program for encouraging voluntary employee engagement in community activities. The Ambassador program was adopted from a similar program at DeGraff, one of the founding hospitals. The Ambassador program encourages hospital personnel (including employees, physicians, volunteers, board members, and retirees of Kaleida) to volunteer to work at health screenings, nonprofit community walks, and other approved community initiatives. Those who volunteer for approved events accumulate hours outside of work time. Hours are redeemed for logo wear, tote bags, knapsacks, etc. Ambassadors are also recognized in the Kaleida newsletters and sent personal thank you letters by senior managers.

Participation can also contribute to positive performance evaluations. But nonparticipation is deliberately not used as a performance evaluation negative. Phyllis Gentner, program coordinator, stated that participation helps volunteers know who they are, meet colleagues in nonwork settings, and become exposed to Kaleida's community values. A companion program, Firestarters, is similar in that it seeks to increase employee morale and commitment to Kaleida's community vision. Basically, Firestarters rewards staff who go out of their way to identify and improve systemic barriers to organizational excellence. Next year, a budget will be developed to help institutionalize the Firestarters program.

Having a Stable, Tenured Executive Team
John Friedlander, the current president and chief executive officer, has been associated with Buffalo General Hospital since 1984. When the merger was announced, his vision statement caused the board of the newly formed organization to select him to lead the merged group. He then resigned his position at Buffalo General and worked for a full year overseeing operational elements of the evolving merger before it was consummated. Similarly, many of the key executives we met were associated with the premerger organizations. The current executive vice president, Carrie Frank, was the COO at Buffalo General. The current assistant vice president for Community Health and Wellness, Gary Brice, was the vice president for Community Relations at DeGraff.

Issuing Report Cards
Kaleida has experimented with issuing various kinds of reports about its contributions to the community. The most recent report (1998-99) is a 12-page glossy newsletter containing photos that describe providing care across the spectrum, working with black leaders, providing international relief, and offering the Ambassador program. Its financial portrait shows that in 1998, nearly $9 million was achieved in net operating margin, but that $29 million was expended on charity care, contributions to government programs, and bad debt. The report also shows that more than two out of every three patients rated their care excellent or very good.

Gary Brice, assistant vice president for Community Health and Wellness, stated that the report cards could possibly include more statistical evidence of community benefit but that these were the best measures available for the new system. Tom Beecher, Kaleida's current board chairman, stated that the community report card was included in the *Buffalo News* and showed how the merger's savings went back into the community.

Developing an Institute for Community Health: Community Scholarship
Kaleida has developed strong and productive working partnerships with local colleges and universities. Together, they applied for a grant from the state to develop a community health index that promises to advance the state of the art on measuring the health of communities. This activity is being designed to serve the eight-county region. Kaleida's ties with D'Youville College extend to offering Daybreak Dialogues, a series of lectures on a variety of healthcare topics that are open to the community. In addition, the CEO of Kaleida teaches a class on leadership to D'Youville health services administration students, and Kaleida also offers them numerous internships. The strength and productivity of these working relationships with local colleges and universities represent a new leading practice.

Developing and Working with Strong Support Networks in the Community
Kaleida values its longtime board members as well as its executives. For example, Ed Hunt, former chairman at Millard Fillmore, is now on the Kaleida payroll as the executive director of the foundations. His familiarity with the business elite and his commitment to the merged healthcare organization have enabled Kaleida to capitalize on former community supporters.

To capitalize on its community support, Kaleida placed the former board members of the premerger hospitals on the Trustee Council, which now has approximately 140 members. These council members serve as ambassadors to the community, assist in marketing, and help staff Kaleida's board committees, including the Investment, Planning, and Quality Committees. The chair of the Trustee Council serves on the Governance Committee of Kaleida board's. When members of Kaleida's first board begin reaching the ends of their terms and rotate off, it is expected that the Trustee Council will serve as a farm team for the Kaleida board. In these ways, Kaleida has attempted to retain its institutional memories and harness the allegiance of influential members of Buffalo's community.

New Practices

Based on our discussions, Kaleida agreed to implement the following leading practices between September 1, 1999, and August 31, 2000:

1. Hosting a community summit by partnering with key community stakeholders. The summit would produce the following deliverables:
   - A list of health-related benchmarks that reflect the most immediate community health needs
   - A prioritization of regional community health needs
   - First-level discussions on a communitywide action plan to address the prioritized needs, building in the benchmarks as outcome measures
   - First-level discussions on the stakeholders' roles in the action plan
   - A commitment by the stakeholders to measure and report annually on action plan progress
2. Elevating community health and wellness to a top-level goal in the strategic plan.

3. Tying board self-evaluation and individual administrator performance evaluation to community health.
4. Bringing community health data and performance updates to the board's attention for review and deliberation via the Board Planning Committee.

Results

After a year, project staff returned to Kaleida to interview many of the same individuals interviewed during the initial visit.

Environmental Changes

John Friedlander, president and chief executive officer of Kaleida, presented the review team with the fiscal challenges that Kaleida managers were facing at the time of our follow-up visit. One of the objectives of the merger that formed Kaleida was to obtain cost savings of $150 million over five years. This had been achieved at the time of our follow-up visit. Using a profitability graph, Friedlander pointed to an excess of revenues over expenses in 1997 of $4.1 million and in 1998 of $8.7 million. But in 1999, losses of $8 million were incurred, and projected losses for 2000 were $4.6 million, assuming expense reductions are fully implemented.

Kaleida had planned three major initiatives to improve its fiscal position. The first initiatives include various methods of revenue management such as trying to negotiate better payment rates, hiring a contract manager, and working on billing effectiveness. Other growth initiatives include efforts for volume growth, increased philanthropy, and BBA relief in the amount of $5 million. A second set of initiatives deals with efficiency/effectiveness initiatives such as reductions in force, physician compensation, and support and management of length of stay. Indeed, at the time of our follow-up visit, Kaleida had a staff ratio of 3.5 FTEs per occupied bed compared to the national norm of 4.4 FTEs in hospitals of comparable size. The third initiative concerns collaborating with community partners to reduce costs and reduce redundancy in outreach and other programs.

Hosting a Community Summit

Kaleida was able to partner with the local Catholic health system, and under the aegis of the United Way, they held a community health summit for the eight-county area. According to Kaleida's COO, the real advantage of selecting communitywide health indicators is ensuring you are working on the right things. The summit was not Kaleida's event; instead the United Way was slated as the lead organization, and local D'Youville College helped organize it.

The summit developed invitational lists from Kaleida's stakeholders and various organizations in the counties. Efforts were made to incorporate both health- and nonhealth- related representatives, taking diversity into account. Each person from the initial list of 85 regional stakeholders was assigned to one of three committees: (1) logistics, (2) information and data, and (3) public relations. All committees included a Kaleida employee.

To minimize costs, a continental breakfast was served to the 260 participants, and the event concluded at 1:00 p.m. Paul Umbach, a consultant based in Pittsburgh, facilitated the event.

The summit was held at the fairgrounds—a site that was amenable to participants from both urban and rural areas.
The summit was scheduled seven months after the completion of the Western New York State of the Region report. Data from three sources were summarized for the summit participants:

1. Healthy People 2010
2. State of the Region report
3. Public opinion poll (distributed to 8,800 community members)

After the small-group breakout sessions, summit participants agreed on the following objectives.

- Physical activity and nutrition
- Access for the uninsured
- Youth development
- Disease prevention and wellness education

The five-hour session resulted in chartering teams to implement actions in all four areas. Specifically, a public relations team, an action and planning team, and a facilitation/management team (which develops structures, resources, and fund development) were established. These teams were beginning to meet at the time of our follow-up visit. For example, a "Move for Life" program was established at Kaleida.

The summit, while initiated and supported by Kaleida, was conducted so that all the partnering organizations received equal billing. Gary Brice, assistant vice president for Community Health and Wellness, told us that subsequent to the summit, the Catholic system called and wanted to co-propose a grant from the state. He observed that this would not likely have occurred prior to the summit.

Other positive outcomes included Patricia Kota's (CEO, Health Community Alliance, Inc.) observation that rural groups in particular felt welcomed by the choice of the easily accessible fairgrounds as the site for the summit. This was much preferred to an urban site. However, her attempts to recruit Native Americans to attend the event were unsuccessful.

Following is a listing of features that helped the summit achieve its goals:

- Early advertising and Leland Kaiser event helped recruit people.
- Planning meetings helped spread the word.
- United Way was the lead.
- D'Youville College offered assistance.
- The program had a low budget.

Following are some of the barriers:

- It was suggested that a mailing house be used.
- It was unresolved how collaboration will take place.

Elevating Community Health and Wellness to a Top-Level Goal in the Strategic Plan
A Comprehensive Operating Plan drives Kaleida's strategic plan. A year ago, there were three initiatives. Now, after the summit, there are seven. Moreover, these various elements of the COP entail collaborative responsibilities among various Kaleida departments. Each consists of a reportable item to the board and is included as an element in the incentive plan for designated managers.

Tying Board Self-Evaluation and Individual Administrator Performance Evaluation to Community Health
To modify the board's self-evaluation tool, an industrial psychologist was recruited to conduct a number of interviews and focus groups and to distribute and tabulate questionnaires intended to reveal board members' opinions on such issues as collaboration versus competition with community partners. The information was summarized and used at the board retreat. Based on this research, the board was able to confront a key issue that served as a principle driving the Kaleida merger, i.e., how to bring added value to the community and save money. In the view of the past board chair, the Kaleida culture has coalesced and embraced community health improvement. The industrial psychologist took it upon herself to revise the evaluation tool used by the board to better assess its achievements.

Management's current evaluation tool incorporates the seven COP objectives, which contribute to 10 percent of their incentive pay. In addition, a new proposed evaluation tool encompasses three major areas: (1) personal and professional development, (2) internal leadership, and (3) mission-focused community service. The 10 percent annual bonus opportunity requires managers to document various levels of contribution (including financial contributions) to organizations that are aligned with Kaleida's mission.

Voluntary service must be ongoing and applicable to the job held at Kaleida. Thus, personal choices such as church activities or those activities associated with the managers' children are not eligible for recognition. Instead, recommended activities are those that promote Kaleida's community health agenda as offered through the Ambassador program. Examples cited are VNA Flu Immunization Program; Regional Health Care Proxy Project; community health fairs and screenings; Variety club; school mentoring; American Heart Association, American Cancer Association, or American Diabetes Association walk.

This new tool offers clarification by the Office of Community Wellness, and a scale is provided where executives can grade their managers' efforts as follows:

- 0 = no evidence of ongoing community voluntary activity
- 1 = several examples of ongoing voluntary activity with organizations whose social service missions are aligned with the Kaleida mission; provides fiscal support
- 3 = several examples of ongoing voluntary activity, including filling a leadership role for the organization(s) whose social service missions are aligned with the Kaleida mission; provides fiscal support
- 5 = achievements as outlined in #3 plus community award recognition

The dollar contributions to voluntary organizations are not required to be disclosed, but a chart is provided to collect such information if it is volunteered.

Bringing Community Health Data and Performance Updates to the Board's Attention for Review and Deliberation via the Board Planning Committee

The board chairman told us a report is given at each board meeting about community health objectives. Data are used in board meetings. Every month the board gets a section of its packet on community health. Efforts are now under way to prepare a brief overview of the major Kaleida activities so that the board gets a sense of the many and varied partnerships.

Outcomes

There are real problems in showing if community health changed in the past year. For example, while the summit provided a good start in rallying various constituencies and even though planners at Kaleida worked with the public health department to rationalize services to underserved groups, it was too soon to say whether or not community health had actually improved.

How would changes be shown? Dr. Noe, vice president for Medical Affairs, stated the issue bluntly when he said the high prevalence of coronary heart disease and cancer can be reduced in a population but this takes time. More immediately measurable are process measures such as the number of smoking cessation program graduates, increased levels of exercise and weight loss, and decreasing hypertension levels or cholesterol levels in the community. Another process measure is the results of immunization campaigns; one could determine the percentage that has been immunized—especially children of preschool age. All of these process measures can be considered to help community health outcomes.

Noe also pointed out that it is difficult, if not impossible, to measure the impact of one system on an entire community's health status. Nevertheless, he had the sense that progress had been made in asthma intervention during the past year—especially school-based efforts. For example, the asthma program worked to identify school-age children who have problems; reduce their exposure to agents, especially in the home; and deal with issues of medication. He remarked that one parent, child, and teacher partnership could result in a 60 percent decrease in use of the emergency room. In fact, he has noted reduced emergency room use by asthmatics as well as an actual decline in the number of admissions of pregnant teens with low birth weight babies.

Another process outcome indicator might be the retention of community health staff. For example, Kaleida has committed five FTEs to the community health effort—a number equal to the entire planning staff for the system.

Relationships with Public Health

Since the study team's last visit, the commissioner of the Erie County Department of Health retired. We met with the new commissioner and his executive assistant. When asked what had changed during the past year, the commissioner stated that the Catholic systems are working collaboratively with other health delivery organizations in the community. But the public health department became directly involved in helping get the summit launched. For example, the

department helped distribute the opinion survey to various groups in the community including librarians, jurors, minorities, and others.

The department also initiated a trust fund initiative to develop an insurance plan for the uninsured called “Communities in Change.” In addition, in a subcontract to Kaleida, three initiatives were launched: (1) asthma coalition, (2) diabetes coalition, and (3) prostate initiative. In general, the commissioner felt that because of the various community efforts to define health priorities, the department is busier than last year. The commissioner suggested an umbrella group is needed to manage the process of coordinating the entire community’s health effort now that silos have been broken down.

The commissioner stated that he has met with Kaleida’s trustees informally. When asked about what changes in practice might help connect the hospital to the community and have more of a positive impact on community health, he suggested that work must be done on how to get the hospitals and systems more involved in the process. One particularly nice current outcome is to have the coalition meeting around the table.

Comments from External Community Representatives

From the Director, Institute for Local Governance and Regional Growth, State University of New York at Buffalo

John Sheffer, director, Institute for Local Governance and Regional Growth, State University of New York at Buffalo, said that the State of the Region report produced by his office was very useful at the summit. An annual or biennial report card is planned for the future. On it, 47 of the 98 indicators will be updated. Sheffer characterized Kaleida as “the big gorilla,” but by networking with other organizations and parts of the region in a way not done before, they have managed to change perceptions of the healthcare system. By not chairing the summit, they appear as more selfless.

In Sheffer’s view, community health has improved. The future looks more positive—both in regard to structure, research, and data collection. While the fruits of the collaboration are not apparent at this time, the foundations have been laid. The positive impact of the summit is apparent in contrasting the number of meetings required by various sections contributing to follow-up activities in the State of the Region report. For example, before the summit, eight meetings of the health community had to be initiated by the Institute; after the summit only three had to be initiated. In contrast, the governmental group and the economics group had to be called by the Institute six times to do their needed follow-up work.

Sheffer concluded that there has been a change in the relationship among healthcare colleagues, the community, and the press. Kaleida selflessly made something terrific happen, but it had to separate this from other healthcare efforts in the community. He stated that in the old days they didn’t have an assistant vice president for Community Health and Wellness. Now, “whatever he is paid is worth it because he transcends the role of merely handling complaints and lobbying.”

From Patricia Kota, Chief Executive Officer, Health Community Alliance, Inc.
Patricia Kota, R.N., has a master's degree in leadership and serves as CEO of the rural Health Community Alliance, Inc, which includes 4 hospitals (two of which are affiliated with Kaleida), 3 associations, 3 churches, and 16 school districts. Asked to describe what has happened in the community since last year, she indicated that the summit and the survey helped unite the community—particularly rural areas with urban areas. A future dream emerged of a western New York state that would be a Renaissance community in terms of education and health.

Since last year, not much change has occurred in terms of Kaleida's relationship to the community. In the rural areas she works in, there is strong allegiance to the local hospital, and many worry that the system will take over. However, Kota indicated that a van service (driven by church volunteers) afforded 200 (out of 300 total served) rural persons an opportunity to receive tertiary care at Kaleida.

Kota could not attest that community health had improved in the past year. It was necessary to create baseline measures. With the findings of the summit, however, the community knows which path to take. She felt the summit demonstrated excellent preparatory work and accomplished much in half a day. She has the impression that there will be follow-up. Here sense is that the findings of the summit need to be communicated back to the community.

Asked what changes in practice would help connect the hospital to the community and have more of a positive impact on community health, Kota suggested outreach and education. Specifically, she has seen expensive mobile van services fail. Essential for success is for physicians and nurses from both Kaleida and rural hospitals to work together to ensure good referrals.

Conclusions

In the past year, the number of goals in the consolidated operating plan concerning community health grew from three to seven. Moreover, the board's self-evaluation tools and management's evaluation tools were modified to better illustrate community health concerns and improvement efforts. Finally, the board will be given a comprehensive assessment of the many community health initiatives Kaleida currently participates in.

The practice of involving community stakeholders was a major undertaking, and revising the board's self-evaluation also took effort. Kaleida used outside help in both instances, and board members and administrators appeared pleased with the results. One unintended consequence was the increased activity noted by the department of public health at other health systems in the area. Thus, practices initiated by one system appear to have exerted a ripple effect in other segments of the health community. Kaleida's partners attested to the increased interest in community health and stated that the summit was an important catalyst for change, as was the day-to-day work of the assistant vice president for Community Health and Wellness.

MARIA PARHAM HOSPITAL
HENDERSON, NORTH CAROLINA
Demonstration Site Visit: September 1-2, 1999
Follow-up Site Visit: October 5-6, 2000

Community Background

Vance County is in central/northeastern North Carolina, about a two-hour drive north/northeast of Raleigh-Durham, the nearest community with an airport served by major national carriers and larger aircraft. Vance is also about three hours distant from Petersburg, Va., and numerous national historical preserves associated with the final days of the Civil War. The area's topography includes numerous rivers, year-round creeks, and slight valleys and rises. Much of the land is put to agricultural uses.

According to 1997 estimates, Vance County has a total population of 41,585. Per capita income is $18,423. The county's racial makeup is 51 percent Caucasian, 49 percent African American, and less than one percent other. Local government accounts for about 12 percent of the county's jobs, paying an average weekly wage of $399. Textile mills represent the second largest employment sector, with 10 percent of all jobs and somewhat higher wages at $428 average per week. Health services was the number three employment sector, accounting for 7 percent of all jobs in the county and a higher average weekly wage of $450. More than 40 percent of the county's residents over 18 years of age have no high school diploma, and only 2 percent have graduate or professional degrees.

Leading Practices

Compensating Management
MPH management and the entire hospital staff are eligible for incentive compensation. Earning the incentive is contingent on achieving the overall net margin target. The hospital board reviews financial results and takes into account any special considerations that may have affected financial performance during the past fiscal year. The amount of incentive earned is discretionary for all employees. The management team has a separate bonus program that can go as high as 15 percent of annual base salary depending on hierarchical level. Management performance is gauged against the goals of the annual business plan. Goals related to community health are not highly quantified. For example, the annual plan may specify holding a number of health screening events, but it does not require that a specific number of community residents be screened.

Multi-branding Community Health
MPH seeks to have multiple partners in meeting medical care and health needs of the population in its service area. Through a 1994 Duke Endowment grant for the Healthy Carolinas 2000 Program, MPH and other community organizations began to address the issue of teen pregnancy. Despite the availability of further philanthropic support, MPH has resisted seeking further funding of this effort in its own name. Instead, MPH is supporting efforts of other community groups to assume the leadership role on this problem and to avoid duplication of efforts. Working with support from the Kate B. Reynolds Foundation, MPH has worked with the Rural Health Center in Granville County to provide information to Hispanic residents on accessing the

healthcare system. MPH is also partnering with the Duke University Health System and the neighboring Granville Hospital to bring radiation oncology resources to the service area. Concurrently, MPH is partnering with the UNC Health System to establish a family practice clinic and has already brought in a critical care ambulance.

Connecting to the Community through Interviews: Systematic Sampling and/or Reputational Approaches
MPH is an organization that uses information to develop strategies and action plans. Some of the information is based on data collected through health surveys by other organizations. However, MPH accesses primary data by means of focus groups and via the carefully selected board members. Representing different geographic, economic, professional, economic, and ethnic segments of the service area, the board experiences "intense, incidental contact" with residents and organizations that provide information about health needs and quality of service by the hospital.

New Practices

As summarized above, Maria Parham Hospital exhibits activity in a number of the leading practice categories. Based on our discussions, MPH decided to work on strengthening the following leading practices between September 1999 and September 2000.

1. Making community health an explicit part of the board's work. MPH conducts a thorough board orientation process, which starts with interviews of potential candidates by two current members of the board. Roles, responsibilities, and demands of the board position are emphasized in these interviews. The orientation itself is a half-day session reviewing the organization's structure, mission, and strategic goals, as well as the healthcare environment and major issues facing the board. One enhancement discussed at MPH was the possibility of building an explicit segment into the orientation during which the hospital's mission and strategy can be connected to a community and population health perspective. It also may be useful to regularly include an agenda item on community health in board meetings.
2. Communicating with physicians about community health performance.The leadership of MPH acquires and uses community and population health information for its strategy and planning purposes. This information is drawn from several sources, including the Health Information Network of the North Carolina Hospital Association, the quality improvement and benchmarking initiative known as The Maryland Indicators Project, and the health department. The physicians working through MPH may see great value in including several community and population health indicators in their regular quality improvement reports. These efforts may be especially important given MPH's strong local market share and its physician-hospital organizations.
3. Communicating publicly about community health performance. MPH now typically uses community and population health information to provide local environmental context to decision making, as well as to conduct gap analyses from which new service offerings can be identified. Reporting on community and population health information to the general public, in a format people can easily appreciate, could help improve MPH's reputation in the community even beyond the favorable views now held by many. Such efforts could improve MPH's already strong local market share, as well as link public expectations to the hospital's

future as a regional rural medical center. A significant advantage to such reports would be their value in communicating how important other partnering organizations are to advancing community health programming.

Results

After a year, project staff returned to MPH to interview a number of the same individuals interviewed during the initial visit. A notable exception was that the chief executive officer from the first visit was no longer at MPH at the time of our second visit.

Environmental Changes
The area continues to grow in population. There had been a sudden change in leadership at the hospital. The board of directors decided that it would be financially prudent to develop a pilot project for the planned Healthy Access Program (using the Four County Health Network to screen uninsured populations) in order to assess the impact of the program prior to initiating the entire project. The pilot will contain 100 Vance County uninsured enrollees for a six-month period. An assessment of the project's value will be made before beginning the full program.

Four County Health Network
Healthy Access and the Four County Health Network are two of the principal initiatives of Maria Parham Hospital that link the hospital's destiny to its broader community. Healthy Access operates through FCHN to serve the uninsured and unenrolled. At the time of our visit, FCHN, which was conceived in 1996 and won its first direct contract in 1998, was beginning more aggressively to seek contracts with self-insured employers. FCHN coordinates the services of 51 physicians in its IPA, two hospitals in the four counties, as well as with the Duke University and University of North Carolina medical schools. FCHN enables coordination with 1,500 physicians networkwide and with the public health services available in the area. Within the past year, several new direct contracts were entered, including Paxton Media Group, publisher of the *Daily Dispatch,* with 100 covered lives; Ideal Fasteners, with 400 covered lives; and Pacific Coast Bedding, with 800 covered lives in the area.

The Duke Foundation and the Kate B. Reynolds Foundation have provided grants to FCHN to enable Healthy Access, starting on January 1, 2001. Healthy Access is an evolving patchwork quilt of services for the uninsured and unenrolled. The current grants, for example, underwrite subsidized prescriptions—capped at $750 per individual—and Patients In Need home visits for benefits explanation.

Making Community Health an Explicit Part of the Board's Work
One of the areas of progress identified after the first visit to MPH was to make community health an explicit part of the board's work. At the time of the second visit, the board was deeply involved in the early stages of a strategic-planning process. The board still had only two committees: Finances and Medical Advisory, although they insisted "this is not a place where the Finance Committee work outweighs everything else." The two board members interviewed, Swanson Dodd and Don Siefert, evinced the attitude that in a small town like theirs, community members know how and to whom they should communicate about expectations, resources, and needs in the community. There were two positive indications with respect to the board's work:

The board is increasing the level of administrative support to the board, creating the possibility of better-informed and more actively engaged board members; and "one of the reasons for redoing out strategic plan (was to learn) how well we're doing, and how we can do better, on community care."

Communicating with Physicians about Community Health Performance and Communicating Publicly about Community Health Performance
Ties with the physicians have tightened as the Four County Health Network has matured, and it was no doubt in part in response to physicians' concerns that goals for Healthy Access were greatly reduced.

There were plans to hire a marketing director in order to improve communication with the public. Advertisements, press releases, public service announcements, flyers, and a quarterly newsletter, *Health Matters*, were identified as the principal means of communication with the public available to MPH. *Health Matters* is sent to 15,000 homes in the four-county area. It is targeted to women, hospital employees, and families that meet an income minimum. As part of the strategic-planning process, a new, more aggressive marketing plan is being developed.

Relationships with Public Health
The Vance-Granville Health Department sees itself not as being mainly a service provider but as being responsible for ensuring that quality services are available. Roddy Drake, M.D., the county health officer, observed, "You don't have to have the health department do everything. Your job is to ensure that the goals are accomplished." The local public health department, therefore, sees its relationships with, and the performance of, local health providers as central to accomplishing its goals.

Drake expressed the view that collaboration between the health department and MPH had improved. He ascribed this improvement to "talking. We just discuss the possibilities and then figure out how to act on them." Drake described several examples of collaboration:
The health department uses the hospital's auditorium for health education activities. The hospital has created a clinic to serve referrals from the health department for people with STDs, an especially progressive step for a hospital in a small town in the South. The local health department administers Carolina Access, the state's Medicaid managed care program. In 97 of the 100 counties in North Carolina, Carolina Access is administered by Social Services. The ongoing Four Counties Health Network, in which MPH plays an essential role, enables better access and quality at lower costs to a network of primary care physicians for Carolina Access in Granville and Vance Counties.

Drake did acknowledge that there could be better coordination between the health department and the healthcare providers in the area. The health department is obligated to produce a community health status report every two years, drawing statistics from the Center for Health Statistics and the National Association of County Health Officers and opinions collected locally.

Comments from External Community Representatives

The only external community representative the project team met, other than the public health officer, was the mayor of Henderson, Robert G. "Chick" Young. Young has been mayor of

Henderson for 21 years. Young was most interested in the topic of accountability, particularly how citizens in a small town keep the mayor accountable. The mayor, who is an ex officio member of the hospital board, described the hospital as a regional health center, not a major critical care facility. He expressed confidence in the hospital as a low-cost provider of high-quality and low-intensity services. And he expressed confidence in the hospital's leadership: "The hospital board members were perfectly qualified. I felt like I wasn't needed on this board, confident that the board had the right people and the hospital was doing the right things and going in the right directions. So, after four years of service, I was able to stop attending, freeing me from the hospital board meetings."

Young said that the area was blessed to have large numbers of retired people moving in and that the hospital does much rehabilitation therapy at the YMCA's pool and gymnasium. They've had success attracting employers to the area, and the hospital is one of the chief assets of the area. He also noted that the Cigna-underwritten group insurance plan offered through the National League of Municipalities sponsors a health fair, and the hospital staffs all the screening and education booths.

Conclusions

Despite the departure of the CEO during the study year, MPH was able to make some progress in pursuing community health practices. Thus, the board was working on a strategic plan, with one of the objectives being to determine how to improve community care. Communication with physicians had improved as the goals for the Healthy Access program were scaled down and thus conformed to physicians' preferences. Finally, *Health Matters* (the hospital's quarterly newsletter) and the planned hiring of a marketing director helped move the hospital toward better public communication about the community's health status.

ST. JOSEPH HEALTHCARE
ALBUQUERQUE, NEW MEXICO
Demonstration Site Visit: August 17-19, 1999
Follow-up Visit: September 18-19, 2000

Community Background

St. Joseph Healthcare consists of a tertiary medical center, two community hospitals, a specialty rehabilitation hospital, a home health program, a 52-member primary care physician group, a Program of All Inclusive Care for the Elderly, a nursing home, a senior services program, and a S.E.T. program designed for underserved individuals with education on self-care and empowerment. It participates in joint ventures consisting of a commercial laboratory company, an eye surgery center, a heart hospital, and an assisted living facility.

The population of the service area is about 590,000. Population growth is only about 1.3 percent per year. Thirteen percent are elderly. Thirty-two percent of the population are Hispanic. Health statistics are poor for the primary service area, with higher than national standard mortality ratios. In addition, teen pregnancy in the South Valley community was the highest in the nation. New Mexico leads the nation with the highest proportion of uninsured residents (25.6 percent in 1999), and the Albuquerque market had one of the highest managed care penetrations at 63 percent in 1998.

SJH identifies among its three most important community initiatives its sponsorship of Healthcare for the Homeless, Supportive Care for the Dying, and the South Valley project dealing with teen pregnancy.

Leading Practices

Using Consolidation as an Opportunity to Re-envision
SJH is now part of Catholic Health Initiatives and has used this merger as an opportunity to reinvigorate their mission. CHI is a new entity formed by the merger of the Sisters of Charity Health Care Systems, Franciscan Health System, and Catholic Health Corporation. Though SJH has taken on the language of CHI, SJH continues to hold to its original mission and values and attempts to reassure the community that its mission and values have not changed.

Embedding Values about Population and Community Health through Goals
SJH's values embrace population and community health, and this is evident through one of its core strategies. The strategy is designed to improve the health of the communities SJH serves. This has played out in Healthcare for the Homeless, a Program of All Inclusive Care for the Elderly, and an innovative program to prevent teen pregnancies among Hispanic young people in low-income communities.

Two Right Things to Do (Gap Analysis)
A gap analysis that compares the epidemiologic profile of SJH's service area with national norms and also over time is conducted by SJH in preparation for its report to the community.

Compensating Management
At SJH, criteria have been developed for compensating managers related to community health performance improvement at the vice president level and above (in conjunction with CHI). As of January 1, 1999, Steve Smith, FACHE, the CEO, was assumed to be a CHI employee and participated in the CHI performance evaluation system. Financial hurdles need to be met first, and then bonuses are awarded based on other objectives, including community health targets. Each manager has his or her unique community health target, and the CEO's role is to convene teams to assure these targets are achieved.

Establishing a Curriculum That Incorporates Community Health
Leadership competencies on such topics as change management, values, and leadership are developed by using 10 training modules initially developed by the Sisters of Charity, SJH's founding system. Caryn Relkin, vice president for Organizational Development and Human Resources, noted that a further goal is to explain to new employees how they can live these values in the organization, thereby demonstrating how core values become actualized.

SJH provides information back to employers about the health of their employees so that they can construct programs to improve the health of their employees. For example, in working with a major airline, SJH discovered high rates of hypertension among the employees. This information has been used to promote preventive care in the management of hypertension by the employer.

Having a Vice President for Community Relations Who Reports Directly to the CEO
The vice president for Community Relations reports directly to the CEO. This allows for direct communication on community outreach and initiatives. Also, we learned that Sally Piscotty, vice president for Strategic Programs, is a Health Forum Fellow. This allows her to call upon various techniques to relate to SJH's communities and, further, to rely upon a network of similarly trained colleagues to help in developing community relationships.

Encouraging Staff Involvement in Other Community Organizations
Senior staff is expected to be involved in other community organizations. At other levels, staff is involved, but not in the same planned manner as are the health system's executives.

Having a Stable, Tenured Executive Team
Overall, the executive team has had long tenure at SJH; Steve Smith has been in his position for 8 years, and one senior executive has been in the office for 30 years.

Multi-branding Community Health
SJH is working with partners in South Valley. Included here are the Albuquerque schools, First Choice, a federal primary care center, the Department of Health, Catholic Social Services, the Middle Rio Grande Collaborative, and the Women's, Infants, and Children's program. Importantly, the collaborative program is called the "South Valley Collaborative," not the "St. Joseph Collaborative."

Connecting to Consumers through Information Systems
SJH is connecting to consumers/customers through phone links, and this will soon change to Web links as their information system develops. Individuals who don't own computers will have

access to them through schools and libraries. SJH also has plans to use its Web site for further collection and dissemination of data. In the future, consumers can enter their own health data and have it linked to SJH's master patient index (inpatient and outpatient). Thus patients' records will be available to physicians wherever they are cared for in the system.

Issuing Report Cards
Data are collected and disseminated through an annual community benefit report. These reports include disease-specific information as well as financial data quantifying how SJH benefits the community. Such reports began in 1994. At the board level, the report receives attention from the Finance Committee rather than the Mission and Quality Committee—at least in its first draft.

Establishing a Committee of the Board to Discuss Quality and Population Health
A committee of the board focuses on mission and quality, meeting every other month.

New Practices

Based on our discussions, St. Joseph Healthcare agreed to implement two leading practices:

1. Developing a CEO evaluation process that integrates community health as a criterion
2. Developing a board self-evaluation process that integrates community health as a criterion.

Results

After a year, project staff returned to St. Joseph Healthcare to interview many of the same individuals interviewed during our initial meetings in 1999.

Environmental Changes
Sr. Mary Kennan Kudlacz, vice president, Mission Services, and Caryn Relkin, vice president, Organizational Development and Human Resources, had apprised the review team of a seriously deteriorated financial situation well in advance of the 2000 visit.

At the time of our 1999 visit, a number of environmental factors suggested that the status quo was precarious for the entire healthcare system of New Mexico and that adjustments were virtually inevitable for the state's health system and for individual provider organizations. Certain factors operating in the external environment have been working a particular hardship on St. Joseph Healthcare. These include the following:

- The hospital operates in the overbedded Albuquerque environment (2,500 beds when barely 1,000 are needed) with three other hospitals nearby.
- New Mexico is a state in which two physicians leave for each new one that arrives because reimbursement levels are so stingy compared to surrounding states. Nurses and other clinical workers are also in exodus.
- SJH is the only faith-based healthcare organization in a state with managed care penetration approaching 65 percent; consequently, the burden of caring for the uninsured and underinsured continues to fall disproportionately on SJH. At least 20 percent of the population is totally without any insurance, not including another 15 percent of the population who are Native Americans nominally covered through the Indian Health Service.

- There is one major provider, Presbyterian Healthcare Services, that directs care for an overwhelming share of covered lives through its managed care networks. This dominance has reduced utilization at SJH. This uneven playing field is perpetuated by New Mexico's Republican governor, who has repeatedly vetoed any-willing-provider legislation proposed by the Democrat-led state legislature.

Exacerbating the external threats have been two strategic business start-ups by SJH that resulted in negative financial consequences. First, the Medicare Plus Choice PSO for seniors incurred unanticipated high levels of utilization in a state that receives one of the lowest levels of reimbursement from HCFA. Second, the new Heart Hospital (in which CHI has one-third interest) has siphoned utilization from St. Joseph Medical Center to the new facility. The shift has been so dramatic that St. Joseph Medical Center has closed two patient floors.

Faced with an inferior market position, declining financial results, and the resignation by CEO Steve Smith, Catholic Health Initiatives, SJH's parent corporation, brought in an interim president/CEO, Arthur Dunn, from the Hunter Group. At the time of our visit, CHI was deliberating whether SJH would remain open or continue in its existing structure.

Since his arrival in April 2000, Dunn has made adjustments that have (1) reduced staff and reduced the number of executives, (2) brought the management staff from the corporate office location at a distant site (referred to as "The ROC") back to the main medical center campus, and (3) exhorted physicians to bring their discretionary utilization (not locked up by utilization directives of managed care contracts) patients to SJH. August 2000 was the first month in which financial results were positive.

Nevertheless, despite these stern measures, SJH had not yet curtailed its commitment to activities that support its community health mission. That continuing commitment extends to those leading practices SJH decided to implement between September 1999 and September 2000.

Developing a CEO Evaluation Process That Integrates Community Health as a Criterion
In deciding to develop a CEO review process that integrates community health, SJH undertook a leading practice that necessarily involves effectively partnering with the most senior human resources executives of Catholic Health Initiatives. The relationship that Steve Smith had with Jim Kaskie of CHI was an important asset for this undertaking. Smith's departure and the continuing challenge that rapid growth is posing for a large and far-flung system such as CHI has meant that this leading practice has not progressed much.

Board member and former CEO Sr. Celestia Koebel indicated that CHI presently employs a standardized evaluation form for its CEOs, and CHI conducts its hospital CEOs' evaluations through its regional officers. It was difficult for Steve Smith and the SJH board to learn much about the CHI process because Smith reported to four different regional officers in a very brief period and his review was conducted on short notice by an individual who was leaving the regional officer position on the day he reviewed Smith's performance. As a result, neither Smith nor the SJH board received any useful feedback. Caryn Relkin indicated that she initiated several starts on this task with her corporate human resources counterpart, but other priorities have overridden instituting this leading practice.

Certainly one priority was providing immediate replacement leadership upon Steve Smith's departure. CHI, with the urging of the St. Joseph Healthcare board, secured the interim services of Arthur Dunn through the Hunter Group. Sister Celestia was acquainted with Dunn from his prior work for CHI as interim CEO of Centura in Denver.

Dunn received a 15-item list of priorities from CHI. Despite the concern attendant to severe financial losses, priority one was "Focus on patient satisfaction and quality of services and enhance outcomes; design care delivery system and track outcome indicators, such as CHI data." Naturally, several of the priorities related to reversing financial trends by reducing costs and increasing revenues, but there were also clear directives to enhance communication and relationships with all constituencies, including "key community persons/organizations." One of Dunn's "win-win" accomplishments has been reaching an agreement that enables SJH's master's-credentialed nurses to supervise clinical rotations of students from the University of New Mexico School of Nursing.

Clearly, until there is resolution concerning the financial viability and future organizational role of St. Joseph Healthcare in CHI and in the Albuquerque community, establishing a new CEO performance assessment process should not be expected to advance more than incrementally, if at all.

Developing a Board Self-Evaluation Process That Incorporates Community Health as a Criterion

SJH has made great progress in developing a process for board self-evaluation that integrates community health as a criterion. This is a laudable accomplishment given the challenges facing the organization. However, owing to a number of factors, it is not an unexpected accomplishment. Among these is a history of conducting a board self-evaluation. This had been last done in 1997 at the board's annual retreat.

Also, SJH's commitment to community health traces its roots back to its founding in New Mexico around 1900. This commitment has been made manifest in the current board structures and processes. The board itself is not large. It consists of 2 inside trustees (SJH's president and the CHI-Mountain Region president), 3 medical staff trustees, and a maximum of 10 outside trustees. The Nominating Committee selects the board's outside members in part through the application of screening criteria that help identify an ideal candidate:

- Possesses prior governing board experience
- Has attained professional achievement that accords the candidate credibility with the community at large and with other board members
- Presents a varied array of strategic skills and personal experiences that enable the candidate to provide advice and consultation to the SJH board and president and to offer perspectives reflecting the ethnic, racial, and gender diversity of the community
- Is a team player
- Possesses influence beyond the purely fiscal as indicated by personal stature within the community, a high degree of social consciousness, and time to devote to worthy causes

- Has a positive, long-term connection with SJH, perhaps based on having had a personal or family health problem resolved by SJH
- Has a special interest and identification with the SJH mission, vision, and values, possesses and demonstrates compassion, and operates with high moral and ethical standards
- Is willing to serve at least a full three-year term and appreciate that value as a trustee increases through continuity of service perhaps up to the limit of three consecutive three-year terms as provided by the bylaws
- Is receptive to training and to participating in a formal and ongoing assessment training program

The effort to develop a board self-evaluation began at its annual retreat in late September 1999. Following the retreat, SJH formed a three-member team to initiate the project. It consisted of executive team members Sr. Mary K. Kudlacz, vice president of Mission Services; Caryn Relkin, vice president of Organizational Development and Human Resources; and Sr. Celestia Koebel, a member of the board and its Quality and Mission Committee. The bylaws provide that this standing committee shall "monitor, review, evaluate and assist in the planning of the Corporation's programs in Quality Management and Improvement, as well as those involving Risk Management and Mission Effectiveness." Typically, the committee meets every other month.

Throughout the final quarter of 1999, these three individuals collaborated as a subcommittee of the Quality and Mission Committee. In December 1999 they developed a proposal that comprehensively addressed the goal of developing a board self-evaluation process that incorporates community health as a criterion. The proposal contained the following recommendations to the Q and M Committee:

- The Q and M Committee should conduct a review of its "charter" in order to clarify and allow discussion of its appropriate functions.
- The first one-half hour of every *board meeting* (emphasis added) should be devoted to an educational session, to include a focus on mission and healthy community issues. The time scheduled for board meetings may need to be extended by one-half hour.
- The board should receive a written summary report from the Q and M Committee at each meeting that would review issues that have been presented to the committee.
- The board should conduct an annual self-assessment that will include community health as a criterion.
- A community health needs assessment should be presented to the board on an annual basis.

By the time of our visit, only parts of the comprehensive proposal had been implemented. Not every board meeting could incorporate an educational session on mission and healthy community issues. Given the urgency of the fiscal issues facing SJH, board meetings increased in frequency to monthly from every other month. However, the subcommittee did develop the Board of Directors Self-Assessment. Although the instrument contains four principal sections (Governance Roles; Mission and Values; Board Structure and Relationships; and Information, Reporting and Communication), it is intended to guide the board in answering the following questions:

- Is the board doing what it should be doing?
- Is the board operating appropriately?
- Is the board achieving what it intended?

The assessment instrument was distributed to board members during the second quarter of 2000 with a request that the completed survey be returned to Arthur Dunn. Results of the assessment were an agenda item during the annual board retreat in late September 2000. It has been well received by the board.

Comments from External Community Representatives

From Tom Scharmer, Epidemiologist, New Mexico State Department of Health District One

Tom Scharmer, epidemiologist for the New Mexico State Department of Health District One, described the challenges facing community health advocates and coalitions both in District One, a seven-county area that includes Albuquerque, and across the state. We posed follow-up queries regarding observations during our 1999 visit that the department's infrastructure had been allowed to decay. Scharmer reported that the administration had not appreciably increased support. To illustrate, he reported that the Healthier Communities unit within the department had disappeared virtually overnight. It was replaced by programmatic thrusts directed at substance abuse among youths. Also, at the district level, the Health Promotions unit had its number of authorized positions increased, but funding was frozen so they could not be filled.

One way the department is able to assist community coalitions and community health partners is by enabling them to meet their need for data. Such data are often requested by external funding sources both public and private. Community groups throughout the Albuquerque area are very distinct. They are differentiated by race, ethnicity, religion, and immigrant status (documented or undocumented) and how recently they arrived in the area.

These communities have a tradition of developing "grassroots" leadership, but this does not necessarily enhance collaboration. Working with Nina Wallerstein, director of the Master in Public Health program at the University of New Mexico, Scharmer interviewed nearly 30 leaders of distinct community coalitions. These contacts gave him insight into the contributions these groups are making. They support development of a Turning Point Project aimed at establishing a community health data clearinghouse to benefit providers and other voluntary social service organizations.

Helping foster this kind of collaboration, Karen Briseno, director of Health Education for the Learning Resource Center of St. Joseph's Women's Care, agreed to participate in the 2000 Summit on Partnerships on Community Health scheduled for October 6, 2000, in Albuquerque. Objectives of the summit included achieving agreement around community-to-community learning, system change, and community councils.

Scharmer has become familiar with some of St. Joseph Healthcare's community health-oriented programs through his work. He noted that through the S.E.T. for Health Program (Service, Empowerment, Transformation), the entire provider community, not just SJH, has experienced a

40 percent decline in inappropriate utilization. Under the direction of Sr. Linda Chavez, this program has afforded many underserved individuals with education on self-care and empowerment. Its publication, *Healthwise,* is so well regarded that Presbyterian Healthcare has adopted it for educating its clients too.

From Sigrid Olson, Director, Healthcare for the Homeless
Healthcare for the Homeless (HCH) was founded as an SJH subsidiary in 1985. Its mission is providing comprehensive medical services for the homeless. Services include medical and dental care, substance abuse counseling, and outreach to nearly 6,000 homeless individuals annually. Sigrid Olson directs the program. SJH employs her in that her salary and benefits come from SJH; however, Olson was interviewed and selected by the board of HCH.

SJH also provides support for the HCH management infrastructure by including human resources administrative support and support for information management services. SJH employees and physicians volunteer their time and service both in medical and community outreach and in governing capacities. SJH also donates pharmaceutical services and drugs. Perhaps most important, SJH recently provided a low-interest loan that enabled HCH to consolidate its services in a single location in a modern building specifically designed for HCH.

HCH is supported through grants that are provided to address identified needs. While other hospitals also participate in supporting HCH activities, they do so to a lesser extent than SJH in what Olson describes as a "visiting player" manner. Mainly, HCH supports itself through its aggressive and effective grantsmanship efforts, which secure resources in advance of offering services. Consequently, when Arthur Dunn, SJH's interim president/CEO, made a "due diligence" visit early in his tenure, he was able to report that based on the importance of the HCH mission and the fact that HCH operates in the black, there would be no change in SJH's level of involvement and support.

Conclusions

SJH and its collaborative partners have achieved measurable successes in addressing community health challenges. The teen pregnancy rate in the South Valley community has decreased about 5 to 6 percent. There has been improvement in managing diabetes, with a notable improvement in the standard mortality ratio for those ages 65 years to 74 years as reported in the SJH 1997 Community Benefit Report (a ratio of 139 compared to the national rate of 100) and the 1999 Community Benefit Report (a ratio of 126 compared to the national rate). This is an improvement among those in the target population of the Service, Empowerment, Transformation program

Nevertheless, Sigrid Olson was one of a number of observers who view overall community health as deteriorating. The reasons she gave relate to the diminishing access for those in the population with already limited access. The population in this predicament now includes those beyond the target populations of classic Healthier Communities-related programs. Olson specifically noted the following examples:

- Elderly citizens who experience diminished access resulting from the closing or potential closing of the Medicare +Choice plans (St. Joseph MedicarePlus, Presbyterian Healthcare Services, Lovelace Health Systems, and QualMed Plans for Health—all in Albuquerque)
- Insured citizens who are losing access to whole categories of specialists who have left New Mexico
- The general public that increasingly visits emergency departments due to a shortage of medical specialists and nurses
- Decreasing access to primary care

These are issues that have resulted from problems in the funding of healthcare services. Arthur Dunn has personally embarked on advocacy efforts involving the media and the business community to alert them to the need to advocate for changes in the Medicare and managed care payment systems and New Mexico's gross receipts tax on medical services. Albuquerque has in effect become a laboratory experiment to demonstrate the validity of the maxim "No margin, no mission."

Nevertheless, despite the dire financial straits SJH has encountered, it was able to incorporate one of the leading practices it planned—i.e., conducting a board self-evaluation that includes attention to community health. This result of our demonstration effort shows that such practices are possible even in the tumultuous environment of implementing employee cutbacks and during a time when the system is undergoing enormous change in its strategic direction.

ST. MARY MEDICAL CENTER
HOBART, INDIANA
Demonstration Site Visit: July 26-27, 1999
Follow-up Site Visit: October 3-4, 2000

Community Background

St. Mary Medical Center is located in Hobart, Ind., about 35 miles southeast of Chicago. Its primary service area comprises five communities with a population of 138,000. Most admissions come from the city of Hobart, whose population is 30,000. St. Mary's annual operating budget is approximately $70 million, and its net operating margin in 1997 was 11.9 percent; in 1998, 8.3 percent; and in 1999, 5.5 percent. About 8 percent of the population are under capitation agreements.

The population is mostly white and also fairly stable, with an annual growth rate of 0.2 percent. However, the stable growth rate belies variations in projected growth of various age-groups. For example, the elderly population (65 and over) is expected to grow to 16 percent of the total population by 2003; declines are expected in the under 44 age-group.

Hobart is a working-class community; in 1999 the median family income was $45,548. In contrast, the median income in 1999 for the state of Indiana was $52,875. The hospital is the biggest employer in Hobart, with 836 FTEs. The school district employs 400, and the city employs 300. A sizable blue-collar segment drives north daily to work in the steel mills and in mass production companies making such things as model plastic toys or catalytic converters. Siemens Westinghouse also employs a number of Hobartians who make turbo engines, and others are employed at similar precision mechanical firms.

Health statistics show that the population of Lake County outpaces other areas of Indiana and the nation relative to premature deaths from heart disease and cancer. Also, the murder rate was more than double the national average. The majority of the higher-than-average deaths can be blamed on a sedentary lifestyle and a diet of high-fat foods. To address these problems, St. Mary applied for and achieved a "Well City" designation. This entailed enlisting 20 businesses and at least 20 percent of the workforce who are actively engaged in business-sponsored wellness programs. In 1999, St. Mary chose two initiatives to focus on—hypertension and physical inactivity—based on senior management's determination of their importance and ability to have an impact on these issues.

Leading Practices

The leading practices that we observed during our initial visit to St. Mary Medical Center follow:

Participating in the President's Council
In late 1998, the hospital CEOs from throughout the Ancilla system participated in a President's Council in Chicago. Also in attendance was the board of directors of Ancilla, as well as key staff from the system headquarters. Each CEO gave a 15-minute presentation covering the two or three community health initiatives, goals, and objectives for her or his hospital for 1999. This

created a mechanism by which the system board could learn about, discuss, and approve steps being taken at each hospital to advance the community health mission of Ancilla. The 1998 President's Council was the first one. The results were summarized and placed in advertisements in the newspapers of the communities in which Ancilla operates hospitals. These placements made a very public statement about the Ancilla hospitals' commitment to community health and represented, for the Ancilla hospitals, the closest approximation of a report card on community health.

Tying Incentive Compensation to Community Health and Drilling It into the Organization
Some managers have a portion of their pay, typically in the form of bonus, tied to community health goals. Depending on the manager's position in the organization, financial and clinical quality goals are likely to be included as well. The maximum bonus below the CEO's level is 15 to 20 percent of base salary. At the department head level, the maximum is 7 to 10 percent. For these bonuses to be paid, the hospital must first meet financial goals.

Using the Goal Sharing Program
In addition to incentive compensation for unit managers and above, every employee of Ancilla can participate in the Goal Sharing Program (Employees covered by the service union contract excluded themselves via the terms of their contract.) Whenever certain financial goals are met, employees can earn bonuses by achieving mission-related goals of their choice. Some employees, for example, meet their goals by volunteering for community health activities.

Creating and Supporting a Community Health Institute
Ancilla established HealthVisions Midwest through proceeds from the sale of a hospital in Fort Wayne. HealthVisions, a separately incorporated, not-for-profit community health institute, is described as "a new ministry" for the Poor Handmaids of Jesus Christ. HealthVisions serves as a community health resource throughout the Ancilla system and in partnerships with other organizations in the region. The executive of HealthVisions had previously served as vice president for Planning and Corporate Strategy for the system.

The sisters of the Poor Handmaids of Jesus Christ contribute to HealthVisions each year. HealthVisions' first initiatives were to establish senior wellness services in Fort Wayne, support a regional lead-abatement effort that focused on inner city areas, and develop school-based health clinics.

HealthVisions' number one purpose now is to identify and make available good, objective community health data for guidance of the system and the hospitals. HealthVisions also operates a community health improvement process, based on a continuous quality improvement model. Health Improvement Councils, which operate at the zip code level, review and set community health priorities. HealthVisions also supports the Indiana natal care network in collaboration with the Minority Health Coalition.

Connecting to the Community through Interviews
Conducted by the vice president of Marketing as a recruitment effort for the Well City project, interviews with business owners also include efforts to understand their health needs. In fact, these discussions have resulted in establishing a women's fitness center. Through discussions

with senior management, a cost-effectiveness study helped St. Mary executives and board members decide on the two goals they planned to pursue this year—hypertension control and exercise promotion.

Embedding Values about Population and Community Health through Goals
The headquarters of the system serves, in part, to suggest goals for the hospital. For example, Sister Kathleen, chairman of the system, typically attends the bimonthly St. Mary board meeting and presents on mission effectiveness. Ancilla is interested in providing care to the unfortunate, and this vision dictates using monies collected from member hospitals to underwrite care activities in particularly depressed communities like Gary, Ind., and Cairo, Ill.

Promoting Community Health by the System through Required Sharing of Revenues
St. Mary contributes approximately $2.5 million to the system headquarters. The system, in turn, selects special sites to fund, e.g., Sojourner Truth House in Gary, where four nuns reside and help abused women by providing housing, clothing, and other support. The system also helps abused children in East Chicago, Ind., and uses the Ancilla Foundation to supplement other charitable projects. As discussed above, the Ancilla Foundation is seeking grants so that it can go to several other communities, e.g., Cairo, Ill., to assist this economically depressed area, and South Bend, Ind., to help with the parish school health program.

Milton Triana, president/chief executive officer of St. Mary, indicated that this year, $40,000 had been allocated to help realize the two community health goals of the hospital—hypertension control and exercise promotion. Such funds are appropriated by the board with approval from the system headquarters.

Holding Recognition Events to Honor Community Health Activists
Over the past two years, St. Mary has actively participated in a new program launched by Ancilla to honor community health activists. St. Mary (along with the other hospitals in the system) nominates an employee and either a board member, physician, or community volunteer for this award, called the Katherine Kasper Award after the founder of the Poor Handmaids of Jesus Christ. The two awardees are selected by St. Mary and honored at a luncheon with a video presentation of their work, receive a beautiful crystal sculpture, and have their names engraved on a plaque in the hospital's lobby.

New Practices

Based on our discussions, St. Mary agreed to implement the following leading practices between September 1, 1999, and August 31, 2000:

1. Creating a Community Health Council. St. Mary can expand community health efforts by enlarging the role of the Mayor's Wellness Council. The plan was to organize a community group to decide and work on the next project(s) to make Hobart a healthier community. Members would be recruited from all areas of the community including government, schools, churches, businesses, etc. The group would create its own vision, with consulting assistance from HealthVisions Midwest, a subsidiary of Ancilla. The vision would, in part, be formulated by using the Lake County 2000 health assessment. Once the vision was created,

the group would decide what to address first, using the importance of each initiative and the group's ability to have an impact on those targeted areas as guidelines. The goal of the group would be not to take ownership of each initiative but to identify areas to work on and create synergies within the community to address these issues.

2. Integrating the board of directors into the healthy community process:
   - A member of St. Mary's board of directors will serve on the Community Health Council described above.
   - The board's Quality Committee will review the work of the community group and provide feedback.
   - The chairman of the Quality Committee will report on the community's efforts to the board as a permanent agenda item.
   - The hospital will add the measurable progress toward healthy community initiatives on a two-page color-coded summary report used by the hospital COO to provide a snapshot of key hospital indicators at each board meeting.

Results

After a year, project staff returned to St. Mary to interview many of the same individuals interviewed during our initial visit.

Environmental Changes
Milton Triana, president/chief executive officer of St. Mary, told us that as a result of the Balanced Budget Act of 1997, which significantly reduced reimbursements for Medicare patients, St. Mary was just above breakeven on its operating margin. Medicare accounts for 65 percent of St. Mary's reimbursements. Because of this, bonuses would not be given this year.

Creating a Community Health Council
As head of the Community Health Council, the mayor convened a premeeting to discuss the purpose of CHC, the kind of commitment required of participants, and who else might contribute to the discussions. The meeting was co-chaired by St. Mary's community affairs coordinator and the president of HealthVisions Midwest, a foundation of the Ancilla system. It was not difficult to organize this meeting in principle because a momentum had been built up due to the prior work of the Mayor's Wellness Council, which coordinated and successfully launched the Well City project.

In fact, many of the individuals who had served on the Mayor's Wellness Council were identified for the Community Health Council. St. Mary's board members and CEO helped recruit new members. Most of the appointed individuals were CEOs of their organizations; others were people who had special expertise or interest in improving Hobart's quality of life. For example, the head of the YMCA is a council member. On the other hand, the superintendent of schools designated the head nurse to represent the schools on the council. A special effort was made to recruit a spokesperson for the poor; for this reason, the head of the local food pantry was recruited.

Letters of invitation were sent that indicated there would be five one-hour meetings held at the mayor's office during the coming year. The letters indicated that the function of the council was

to increase the community's quality of life. A. C. Castello, St. Mary's community affairs coordinator, said that the committee would follow a wheel of processes to achieve its goal:

- Brainstorming
- Planning
- Problem statement
- Data gathering
- Analysis
- Referral to subcommittee
- Evaluation and revision

At the time of our visit, the first meeting was scheduled to take place three weeks hence. It was decided that the president of HealthVision Midwest would facilitate the meeting as a consultant while the St. Mary community affairs coordinator would serve as chair.

Following are factors that facilitated the initiation of the Community Health Council:

- St. Mary had nurtured a good relationship with the mayor.
- A facilitator attended informal meetings of non-St. Mary organizations.
- Many of St. Mary's senior staff were active in various civic and charitable groups, so they knew the likely members of CHC (e.g., CEO serves on Chamber of Commerce, Economic Development Committee, etc.).
- St. Mary informed the mayor how the new council would advance the government's own goals.
- The mayor's sister works as a nurse at St. Mary.

Following are barriers:

- The main barrier was people's schedules. It took a great deal of advance planning to convene the first meeting.
- A few individuals may have been appointed who work primarily as facilitators rather than doers. Doers are what will be required for the council.

Another potentially unsettling issue was the appointment of a local newspaper reporter to CHC. St. Mary staff stated they felt that the discussions of CHC would be held confidential and that they need not fear bad press. Instead, they felt that this journalist would help publicize the healthy initiatives CHC planned.

Integrating the Board of Directors into the Healthy Community Process
According to the president/chief executive officer, Milton Triana, the board's Quality Committee is more involved in community health activities than previously. Composed of the CEO, the system's vice president for Mission Effectiveness, the vice president for Patient Care Services, the TQM executive of the corporate office, the committee also includes six physicians on the staff of St. Mary and board members such as Doris Blaney, past president of the Indiana Nurses Association and 30-year incumbent as dean of the Indiana Academy of Nursing.

Board chair Bob Welsh stated that each meeting's agenda includes a report from this committee, which includes attention to community health. In addition, Milton Triana has added the annual goals for community initiatives to the summary report provided to each board member at the bimonthly meeting.

A final planned element to achieve this objective is for the head of the board's Quality Committee to be appointed to the Community Health Council. This individual would report on the activities of the Community Health Council at each board meeting. At the time of our visit, these steps were not completed.

Outcomes

Quantified health outcomes were developed for St. Mary in 1999. Specifically, the organization had two objectives:

1. Identify 53 individuals within the Hobart community who have high blood pressure and help them take measures to control it by attending an educational program.
2. Improve the health risk status of 60 Hobart workers by increasing their physical activity levels.

In 2000, St. Mary pursued the hypertension screening objective and added two others:

1. Increase the number of people age 65 and older who are immunized for influenza by one percent in Hobart, Portage, and Lake Station.
2. Increase the number of people age 50 and older who have had a fecal occult blood test within the last two years by one percent in Hobart, Portage, and Lake Station.

A more subjective appraisal of changes in health status over the past year was provided by A. C. Castello, community affairs coordinator. She indicated that the hypertension program, with its emphasis on diet management, exercise, and medication, yielded improvements for those who took it. Moreover, the efforts to increase exercise were visible because more people were walking on the track at the hospital than previously. Additional evidence was observed as she talked to various business owners in Hobart about their smoking policies. For example, in her experience, smoking is more restricted now—especially among blue-collar workers. In general, her "gut" feeling is that Hobart has been improving as a well city when one considers the seven dimensions of wellness: social, emotional, environmental, vocational, intellectual, physical, and spiritual.

Relationships with Public Health

At our initial visit in 1999, we did not interview any public health officials. The hospital's management team said there simply wasn't much interaction with them. During the follow-up visit, however, we interviewed Nick Doffin, administrator of the Lake County Board of Health. He informed us that public health was also involved in providing blood pressure screenings to communities throughout the county. Also, while St. Mary may have had a 2000 objective to increase the number of people over age 65 who receive influenza immunizations, the Visiting Nurses Association is also conducting such efforts throughout the county. It was Doffin's view

that despite St. Mary's efforts to promote fitness and screen for hypertension, there were no changes in population health outcomes during the past year.

Doffin observed that in areas such as immunizations and hypertension screenings, the hospital needs to pay for such services even though the patients are not charged. The revenue source can be from a foundation or some other source. The public health department tries not to "compete" with private practitioners in the area, but it does offer free flu shots in its clinics throughout the county. Doffin observed that the public health department and the hospital might be more effective—especially in providing flu shots—if they were more careful about segmenting the population. The clinics are providing as many flu shots as ever, indicating that the hospital's preventive outreach efforts are only one element of the community's broad effort to prevent disease.

A recent development has drawn the public health department closer to the Ancilla system. Specifically, its community foundation, HealthVisions, in conjunction with Indiana University determined that lead poisoning was a major hazard. Screening, treatment, and abatement programs are being planned, and a potential role for the hospital is in the screening aspect. Thus, St. Mary may draw blood and refer affected individuals for dietary consultations. Agencies such as HUD will be responsible for correcting the structural defects in homes in Hobart.

Doffin concluded by saying he supported increased communication between his agency and the hospital. However, hospital officials thought that the public health department, though well intentioned, was too pressed to really provide complete preventive services to all the communities under its jurisdiction.

Comments from External Community Representatives

From Dale Polomchak, Executive Director, Hobart YMCA

Dale Polomchak, executive director of the Hobart YMCA, told us that St. Mary plays an important role in improving the quality of life in Hobart. St. Mary helped his effort to secure funding for a new building, and several programs are facilitated by St. Mary. For example, he works with individuals at the hospital to help set up rehabilitation programs at the YMCA. Occasionally, the hospital will provide speakers for their programs. Polomchak sits on the board of the Community Health Council.Ultimately, he hopes that a full-time nurse will be made available for patrons of the YMCA with St. Mary's help. He cited the city of Bloomington, Ind., as an example of excellent collaboration between a community hospital and a YMCA.

From Jack Leach, Superintendent of Schools, City of Hobart

Jack Leach, superintendent of schools for Hobart, serves on St. Mary's board and related that over the past year, the quality report became a regular feature of the board meeting in which community health initiatives were discussed. He mentioned that in the CEO's annual evaluation, the board was especially pleased with his outreach efforts. Leach discussed how St. Mary's wellness initiatives—especially increasing exercise—were embraced by his own organization. The problem, however, is to find a way to integrate this into the existing full schedule of students and teachers.

Even though the schools were currently experiencing economic difficulties, a recovery plan had been formulated, and Leach was confident that it would be successful. To encourage healthy behaviors, St. Mary has participated in health fairs at the schools and recently offered to teach abstinence in middle schools. When asked what St. Mary could do in the future to improve community health, Leach responded, "Do more of the same things—provide more convenient and available screenings, conduct health fairs at the schools, and try to have someone available to answer health questions. All of this requires time, resources, and people."

Conclusions

St. Mary Medical Center has begun to collaborate with others in the community to set goals for community health. The board has been routinely exposed to community health activities over the past year, and partners—such as the schools—have benefited from St. Mary's outreach efforts during the past year. The relationship with the public health department will likely grow as a result of the discovery of lead-based paint in many of Hobart's older homes. Whether or not this relationship intensifies in the future will depend on St. Mary's leadership decisions to include public health officials in their outreach work as well as public health's ability to respond with resources—human and financial.

In terms of adopting leading practices, St. Mary Medical Center shows that including community groups to help set direction is not fraught with great difficulties. Nor was it hard to incorporate reports into the board meeting. Two practices have been successfully implemented at this demonstration site.

TEXAS HEALTH RESOURCES
IRVING, TEXAS
Demonstration Site Visit: August 12-13, 1999
Follow-up Site Visit: October 12-13, 2000

Community Background

Texas Health Resources is an affiliation of 14 hospitals of the Harris Methodist Health System and Presbyterian Healthcare Resources. Texas Health Resources is committed to moving beyond the community education and outreach programs of its precursor organizations. For example, Harris Methodist had developed a program to promote wellness and prevention guided by Healthy People 2000, while Presbyterian had used the Healthy Communities model to develop initiatives in the nearby Vickery neighborhood (for which it received the AHA Nova Award).

THR's community is the 22-county area served by hospitals of the THR system. In 1998, the area had a population of 4.9 million concentrated in Dallas, Tarrant, and Denton Counties. The population is projected to increase by 8 percent by 2003. Approximately one-fourth of the population consists of women of childbearing age. The over-65 population constitutes 9.7 percent of the region, but this varies greatly. More elderly are located in rural counties.

There are 1.8 million households with a median income of $43,463. The median home value is $ 96,325, and the average length of residence is 7.5 years. Less than 5 percent of the population is covered by capitation arrangements, and in recent years, the operating margin for THR has been negative 1 to 2 percent.

Leading Practices

Embedding Values about Population and Community Health through Goals
THR has established five strategic system goals: financial, clinical, service, employee effectiveness, and community health. This year, the community health goal is focused on family violence. Each hospital can also develop additional goals that speak to the specific needs of its community. For example, in Plano, Texas, drug overdose has been identified as a major problem, while in Fort Worth, Harris Methodist is focusing on asthma—a decision reached by all the nonprofit healthcare organizations and the department of public health subsequent to their comprehensive survey in 1998.

Douglas Hawthorne, FACHE, president/chief executive officer of THR, told us that while the board is focused on the benchmark, his intention is to "cut a wider swath" when it comes to achieving the goal of addressing family violence. In addition, the Community Health and Benefit Department is establishing indicators to measure the success of regional and local initiatives to track progress and to report the results.

Hawthorne also noted that the system is in the process of developing an affiliation with 4,500 physicians to create a leadership group that will focus on patient/physician relations and on quality. The group will have 50 representatives from the former Presbyterian system, 50 from the Harris system, and 50 from the Baylor Health System. Then, a supragroup of 20 will be selected

to lead the effort. He believes that the most common area of concern for his group will be focusing on community health initiatives.

Compensating Management

All managers in the system are part of an incentive-based bonus system whereby they can achieve a bonus of 10 percent if the financial target is met. The exact amount of the bonus depends on how many of the goals are attained.

At the hospital level, presidents are compensated partly for meeting the system's preestablished goals and partly for meeting the local board's goals. On the whole, the local board's evaluation tends to be more objective, while the system's evaluation is more subjective.

Collecting Health Data

Needs assessments have been conducted beginning in 1992. While these assessments are required by the state, THR has gone further than complying with the letter of the law. Since 1992, Presbyterian Healthcare System in Dallas has joined other nonprofit hospital systems and the DFW Hospital Council in conducting an annual health needs assessment. In 1998, Harris Methodist Hospital of Fort Worth led other nonprofit hospitals, joined by the DFW Hospital Council and the Fort Worth Department of Health, in conducting a community health needs assessment. Both personal interviews and telephone surveys were used to gather the data.

Providing a Health Forum Fellowship

One of THR's vice presidents, Helen Holman, is a Fellow of the Health Forum. Community partners were extremely complimentary about her other-directedness, ability to foster a team environment, and skill at working with other organizations. Specifically, the Vickery Meadow Improvement District, a neighborhood Property Improvement Development, was successful in large part due to the skills of Holman and her predecessor.

Having a Vice President for Community Health Who Reports Directly to the CEO

Dr. Gerry Gunnin, senior vice president, Community Health and Benefit, reports directly to the president/chief executive officer, Douglas Hawthorne, and is responsible for strategic planning and reporting to the corporate boards. Responsible, too, for leading in accountability, he introduced the Institute of Medicine's community health improvement process model. His role is to relate to others in the THR communities. We confirmed with at least one partner, Letha Aycock at the public health department in Fort Worth, that Gunnin relates to her, invites her to meetings, and serves as her link to the system.

Encouraging Staff Involvement in Other Community Organizations

Employees at THR are given time off for community service in such areas as PTA, Adopt a School, Soup Kitchen, and Meals on Wheels, or they can design their own projects such as mentoring. According to the CEO, staff is released for up to 16 hours per year, without a reduction in their pay, to do community benefit projects on company time. Moreover, many senior executives serve as board members of community organizations, and employees volunteer on their own time through such programs as Spring Into Community Service.

Having a Stable, Tenured Executive Team
Senior managers have been with THR (or its predecessor constituent hospitals) for a long period of time. While THR is only one year old, the person with the least tenure in senior management has been associated with the system for seven years. The CEO has been with the system for his entire professional career, which spans 30 years. According to the executive vice president, such long tenure serves to benefit the system because the managers are seen as part of the community and have the ability to develop and maintain long-standing physician relationships.

Developing and Working with Strong Support Networks in the Community
Many of the hospitals in THR's system have established a Community Health Council. Composed of a broad cross section of the hospital's service area, the councils serve to generate ideas about community needs. The councils are about four years old and are composed of police officers, school employees, business representatives, governmental employees, and others. Oftentimes these individuals serve as feeders to the local hospital boards.

One exceptional success story is the Vickery Meadow Improvement District. The board is composed of 13 individuals including members of the Presbyterian hospital and the Baptist church, condominium owners, and others involved with real estate. In addition, the Vickery Community Action Team meets every month and represents more than 40 agencies.

Connecting to the Community through Interviews, Systematic Sampling, and/or Reputational Approaches
One new leading practice emerged from THR—the use of partners to help select individuals who would head up the community health ministries within the THR system. Thus, THR screened candidates and presented the six or seven finalists to the Vickery Community Action Team. The team evaluated the candidates and ranked them. In fact, the highest-ranked candidate was offered the position based principally on his ability to develop quantifiable outcome measures of their work.

New Practices

Based on our discussions, Texas Health Resources agreed to implement the following leading practices between September 15, 1999, and October 15, 2000.

1. Including community health as a regular item on board agendas.
2. Including community health as an item on board self-evaluation forms.
3. Listing community health as a core competency on executives' annual performance evaluation forms.
4. Developing a strategy to systematically fund community health.
5. Incorporating community health goals into local hospitals' annual strategic plans.

Results

After a year, project staff returned to THR to interview many of the same individuals interviewed during the initial visit.

Environmental Changes
According to Douglas Hawthorne, president/chief executive officer, THR experienced several years of a negative operating margin. In 1997 it was negative 1.12 percent; in 1998, negative1.67 percent; in 1999, negative 2.0 percent. But in 2000 he expected a positive operating margin of 2.0 percent. In February 2000, THR sold its health plan, and the organization has improved its managed care contracts. Other reasons for the improved financial status were efficiencies in staffing and organization. Capitation was always minimal at THR; recently it has only amounted to 3.5 percent. Per diems or flat rates or fee for service are the dominant modes of reimbursement.

In June 2000, an anticipated merger of THR with Baylor Health System was called off. This event enabled THR to begin new projects that had been delayed pending the consummation of the merger.

Including Community Health as a Regular Item on Board Agendas
This goal was achieved when considering the system boards. However, it is not universally found on some of the local hospital board agendas. Every hospital board considers community health at least periodically, however. The system is trying to standardize some components of the local hospital board agendas this year.

Topics that are addressed on the system boards' agenda include (1) an overview of THR's philosophy, (2) an update on the family violence prevention initiative, (3) an update on the activities of the Community Health Councils, and (4) information on conducting a year-end review. Usually 15 minutes is allocated to this update. Douglas Hawthorne, president/chief executive officer, told us that community health was placed in the committee report section because there needs to be action on this topic and board input is needed.

At the spring board retreat, attended by 175 people, the board was oriented to the activities of the Community Health and Benefit unit. The changing paradigm for health was discussed, and the public health model was described to physicians as well as its potential and their role. Local hospital CEOs helped champion community health. The retreat also referred to an employee survey done on an entity basis that describes the percentage of employees who said their entity has something to do with community health status.

Our discussion with Andy Thompson, chairman of the board of Harris Methodist Health Foundation, helped us see the perspective of the new structure that would help oversee the community health and benefit activities of THR. Thompson stated that hiring the new executive vice president of Corporate Affairs, Margaret Jordan, would help focus the activities of both the Harris Foundation and the complementary Presbyterian Foundation relative to community health and benefit. She would help determine which activities should be worked on independently and which should be worked on together. He stated that it was essential to keep the two foundations separate (one focusing on communities in the west, the other, the east) because community donors want money spent in their communities.

Including Community Health as an Item on Board Self-Evaluation Forms
THR's CY 2000 Performance Management System incorporated board self-assessment targets under "Success Factor #4: Operational Effectiveness." Improving the THR and THS board self-assessments in several areas, including community health and benefit oversight, was identified as a success factor/metric. Accordingly, community health and benefit oversight was added as section 6 of the assessment form. Board members are asked to rate the following three statements as either "excellent, good, fair, or poor":

1. The Board has received a briefing on the broader definition of health, which extends our mission and underlies the THR community health improvement work.
2. The Board is knowledgeable of and understands how community health improvement fits into the overall mission of THR.
3. The Board periodically reviews and discusses the initiatives of the Community Health Councils and the community health improvement initiatives.

The target established for this section of the self-assessment is "85 percent scoring excellent or good." Scores will be reported in December.

According to Margaret Jordan, executive vice president of Corporate Affairs, a survey of trustees was conducted on what their communities needed. The survey focused more on finance and quality but also touched on their responsibility and oversight for community health and benefit. It was her impression that a newsletter might be needed to help achieve this objective.

Listing Community Health as a Core Competency on Executives' Annual Performance Evaluation Forms
A community health improvement system imperative has been inserted into the 2000 Officer Performance Evaluation Form under "Part 2: System Imperatives and Leadership Core Competencies." System imperatives are defined as THR initiatives essential to the development of the organization. They are directly relevant to all employees but none more than THR officers. The community health improvement imperative and core competency has been drafted as follows:

> "Demonstrates understanding and support of THR's Community Health Improvement and Benefit philosophy and initiatives. Articulates the broader understanding of health as an extension of the THR mission. Models support of the community health improvement programs including the Community Health Council and Family Violence Prevention Initiative. Actively and visibly promotes the Community Health Improvement Process (CHIP). Holds self and direct reports responsible for achieving the community health improvement goals in the THR strategic plan. This level of performance was demonstrated by: (Individual KPIs inserted here)."

Executives have been asked to consider how the community health improvement imperative specifically applies to their individual roles as an officer of THR. They shall each identify, document, and prepare an action plan for individual key performance indicators (KPIs) to measure results in the area of community health improvement. A development plan shall be put

into place for any officer who is rated less than “3—meets expectations” for an imperative upon evaluation at year-end.

Community health improvement has also been added to THR’s 360-feedback evaluation and will become part of directors’ self-evaluations.

Helen Holman, vice president, Community Health Ministries Outreach, noted that there was some difference in implementing these performance evaluations between the premerger hospitals, i.e., Presbyterian system and Harris Methodist system. That is, while both groups were willing to add the evaluation criterion, there was some issue about how to measure it. For example, CTO (Community Time Off) policy is a benefit and cannot be made into a performance criterion since this would transform a benefit into an imperative. Moreover, CTO needs to be approved by a supervisor.

Douglas Hawthorne, president/chief executive officer, specified that the community health improvement process was being promoted in overall performance measurements to ensure that everyone had knowledge of THR’s objectives. In addition, Community Health Councils were being developed at the local and system level to ensure that knowledge of community health needs gets transferred into actions. However, his view is that the 360-degree assessment is not a real performance evaluation; instead, it is a knowledge-gathering device and does not affect compensation.

The development of Community Health Councils will likely take on a different role depending on the size of the community. For example, for smaller communities, boards will instruct community councils on what benchmarks should be achieved—this is a good system where good information is available. In larger communities, however, the Community Health Council will need to arrive at objectives by assimilating information from various stakeholders.

Developing a Strategy to Systematically Fund Community Health
This deliverable is still under discussion. Current strategies include the following:

- Reducing corporate overhead allocation to hospitals while increasing desired benefits and outcomes by repositioning and reframing THR’s community health and benefit function
- Reviewing desired benefits and outcomes of community health and benefit work in terms of both mission and margin; i.e., making a “business case” for community health improvement as well as a “mission case”
- Linking the organization’s commitment to community health and benefit more closely to the organization’s strategic directions, so that business strategy and community mission can help discipline each other
- Working with our foundations (PHE, HMHF) to identify additional sources of community support (local, state, and national) for community health improvement initiatives

The cancellation of the merger caused THR to review the corporate structure overhead. community health and benefit was one of the first areas to be reconsidered. It was decided to consolidate two Presbyterian and Harris director positions into one, consolidate two Presbyterian and Harris coordinator positions into one, and eliminate the community development positions.

In all, $2 million from both the THR and Presbyterian foundations was dedicated to the community health and benefit area. Revenue sources to underwrite this function at the system level will be needed from other foundations as well as corporate philanthropy.

At the same time, there was no common definition of what constituted community health and benefit. Therefore, to get a common definition and understanding, interviews were conducted with all 14 local hospital presidents, other members of the system leadership councils, the system CEO, executive vice presidents, board members (local and system), and physicians. At the time of our visit, a planning retreat was being arranged for 10 to 12 key stakeholders to be mediated by Herman Gyr, who initiated the Dynamic Enterprise Model for Change. The retreat is expected to clarify what functions for community health needs to take place—at the system level or the local level.

Hawthorne indicated that at the system level, the Community Health and Benefit Policy Council consists of about 25 individuals, including 4 physicians, 1 board member, community health staff members, 2 system operations systems individuals, 2 hospital presidents, and 2 local representatives. Their current agenda includes attention to the system's family violence prevention initiative as well as several policy matters.

During our visit, Jerry Farrington, chairman of the board, THR, stated that the board is considering funding sources for community health—in part as a result of our site visit. He also suggested that though a merger was not consummated with Baylor, it is possible that THR and Baylor could collaborate on community health initiatives in the future.

Both Douglas Hawthorne and Margaret Jordan stated that systematically funding community health is a great challenge. A business case can be made for some community health activities to help achieve the mission. A new system-level position has been created for community health evaluation. This role will enable hospitals to see the benefit of their community health activities.

Jordan expects that over time, she will have more involvement with foundations to fund community health. She would like such funding to be integrated in the budget rather than allocated as a separate line item.

At the level of the individual hospital, Hawthorne said that each of the 14 hospitals should have some resources dedicated to community health and benefit. It was his view that these should be locally funded and should encompass more than buildings and technology.

Incorporating Community Health Goals into Local Hospitals' Annual Strategic Plans
As of September 1, 2000, community health goals have been incorporated into the 2001-2003 strategic plans of every local hospital but one. Work continues to progress around the remaining plan. This will be accomplished by year's end.

Helen Holman stated that it was difficult to achieve consistency in this practice. Some hospitals have included goals that are very broad; others included clinical indicators. Margaret Jordan stated that the individual hospital administrators were taught how to conduct a community health

improvement process. All have adopted family violence prevention, the systemwide initiative, at the local level.

Outcomes

Paulette Standefer of DFW Hospital Council informed us of some of the results of the Dallas County health assessment for 1999. The assessment is funded by nonprofit hospitals, which each pay $3,000. She indicated that Dallas had a higher prevalence of heart disease and diabetes compared to the national average. In addition, other outcomes were a “mixed bag.” For example, while teenage pregnancy was down, single parenting was on the rise. Programs on smoking cessation and screenings for diabetes and cholesterol were implemented. Also, the increase in the number of expressways is thought to have contributed to a general rise in hypertension. Moreover, obesity is increasing, especially among the young. There is no neighborhood sports system. Sports are organized by the city, and young people have difficulty traveling to athletic sites.

A special emphasis this year was to target black and Hispanic youth and the physicians who care for them. Specifically, focus groups of black males and their caregivers showed that black males were angry about not being informed about the ravaging effects of diabetes and perceived that physicians were arrogant and displeased when their patients were noncompliant in caring for their diabetes.

Douglas Hawthorne stated that a laboratory is needed to discover best practices in the field of community health and benefit. Through the Internet or through publications, hospitals nationwide would benefit from knowing what programs work best, how funding can be arranged, and how to measure improvements.

Relationships with Public Health

Paulette Standefer of the DFW Hospital Council noted that the county commissioners assigned public health responsibilities to Parkland Health and Hospital System. Public health is essentially viewed as care provided for those on welfare and has fallen in status; the public has little understanding of its value. There is a conflict between the city health department and the county and 20 or more separate agencies. Right now, public health is focused on weapons of mass destruction (nuclear, bacteriological, and chemical). They are planning training programs for hospitals in emergency preparedness.

Letha Aycock, assistant director, City of Fort Worth Public Health Department, described recent collaborations with Harris Methodist Fort Worth Hospital, a member hospital of THR. One useful collaboration has been the development of Harris’s mobile prostate and breast screening unit. The city public health department will publicize the availability of this unit as part of the health fairs it sponsors. Her view is that such connections will make public health goals attainable, yet regrettably, public health is not rewarded for such collaborations. For example, the city confines the public health department’s activities to its geographic boundaries, but public health is universal, not jurisdictional. Thus, there are structural problems that need to be overcome to achieve the most benefit from collaborations.

A council has been created with Harris initiating the leadership team. The council includes representatives from Tarrant County, the Red Cross, local utilities, and various city departments of Fort Worth—notably the police and fire departments. Together, there is a consensus to have an emergency preparedness team in place. The team concept grew out of a devastating incident at Wedgwood Baptist Church in Fort Worth, where several teenagers were shot in September 1999. Then, in March 2000, a tornado hit the area, and there was poor coordination between health providers, emergency workers, and city officials. Now the collaborators are working on the following:

- Drug overdoses
- Asthma
- Hypertension
- Shootings and terrorism
- Tornado alerts

A metropolitan response system for emergencies has been developed, and special hot lines have been instituted to link the collaborators.

Comments from External Community Representatives

From John Neill, Chairman, Vickery Meadow Improvement District
John Neill, chairman, Vickery Meadow Improvement District, discussed how this blighted area of Dallas had been rehabilitated with the help of THR and Presbyterian Hospital in particular. Through interactive community policing activities and an athletic program for teens and with funding from the hospital and the Junior League for a community liaison position, many improvements have been seen in this community. Also, a Vickery health center was established by partnering with Parkland Health and Hospital System, which provided staff, and Presbyterian, which provided funds for construction and operating expenses.

Key to the success of the district was the devotion of several Presbyterian community health staffers. Since 1993, a series of individuals filled this role but, importantly, each devoted themselves full-time to these activities. Neill was concerned that in the future, THR might seek to spread the time devoted by these individuals to other communities, thus diluting the energy needed to improve this community. In fact, Presbyterian Hospital of Dallas is in the process of hiring a community health staffer to work with Vickery Meadow and other community health improvement programs.

Neill reported that there were a number of outcome indicators that showed how the community had improved. Occupancy is up, rent levels are higher, slumlords are out, and tax valuation is higher. There are more neighborhood activities such as National Night Out and FunFest, and these are well attended. He noted that turnover is virtually nil on the community's soccer team; 24 out of 25 players from last year returned this year. The Vickery Learning Center's program for English as a Second Language grew, and there is less stranger-on-stranger crime. Moreover, more domestic violence is now reported, and the volume is up at the primary care center. While property values declined 70 percent between 1987 and 1992, they are now up to 83 percent of what they were in 1987. The median property value in 1986 was $36,000; today it is $30,000.

According to Neill, activities that our demonstration site needs to accomplish to continue its good work are as follows:

- Continue its support and not pull out. If an individual assigned to the community liaison needs to leave, THR needs to replace that person as soon as possible. Neill's view is that this good program could die if there is no continuity in staff involvement.
- Keep the local hospital tied to community programs, and do not tie all of the effort to the corporate level. Presbyterian needs to have the flexibility to meet the needs of the community.

Conclusions

THR has experienced an eventful year. It sold its money-losing health plan, and the anticipated merger with Baylor Health System was aborted. Now on firmer financial footing, THR has been able to fully implement three out of five new leading practices: (1) including community health as a regular item on board agendas, (2) including community health as an item on board self-evaluation forms, and (3) listing community health as a core competency on executives' annual performance evaluation forms.

In regard to the fourth practice, developing a strategy to systematically fund community health, senior executives are working to make a business case for community health and are considering ways to raise funds for community health programs through its foundations. One might expect that if operating margins remain positive in future years, THR might begin tithing as a way to systematically fund its community health efforts.

As for the fifth hoped-for practice, incorporating community health goals into local hospitals' annual strategic plans, all 14 hospitals were able to accomplish this. But such goals were not uniformly "community health" oriented; in fact, some were clinical indicators. The fact that all of the hospital administrators were taught how to conduct community health assessments was a useful first initiative to make this practice a reality.

Finally, THR taught the project team several things: First, community groups can be used to help screen prospective candidates for liaison positions with hospitals that are reaching out to partner with them. Second, the financial exigencies of the contemporary healthcare environment can affect the funds available for community health. Third, achieving adoption of system goals among 14 hospitals, some of which are accustomed to relative independence, takes some time. Fourth, strong leadership by the system CEO and commitment by the corporate boards is essential to a large system's accomplishment of community health improvements.

APPENDIX A
NAMES AND CONTACT INFORMATION FOR LEADING SITES

Peter F. Bastone
President and Chief Executive Officer
Mission Hospital Regional Medical Center
27700 Medical Center Rd.
Mission Viejo, CA 92691
(949) 364-1400
(949) 364-2056 Fax

Phillip H. Goodwin, FACHE
President/CEO
Camcare
P.O. Box 1547
Charleston, WV 25326-1547
(304) 348-5432
(304) 348-7696 Fax

Peter E. Makowski
President/CEO
Citrus Valley Health Partners
210 W. San Bernardino Rd.
Covina, CA 91723
(626) 938-7577
(626) 859-5865 Fax

John C. McMeekin, CHE
President/CEO
Crozer-Keystone Health System
100 W. Sproul
Springfield, PA 19064
(610) 338-8200
(610) 338-8230 Fax

Philip A. Newbold, FACHE
President and CEO
Memorial Hospital and Health System
615 N. Michigan St.
South Bend, IN 46601
(219) 234-9041
(219) 284-3670 Fax

John G. O'Brien
Chief Executive Officer
Cambridge Health Alliance
1493 Cambridge St.
Cambridge, MA 02139-1099
(617) 498-1000
(617) 498-1003 Fax

Frank V. Sacco, FACHE
Chief Executive Officer
Memorial Healthcare System
3501 Johnson St.
Hollywood, FL 33021-5421
(954) 985-5805
(954) 985-1438 Fax

APPENDIX B
NAMES AND CONTACT INFORMATION FOR DEMONSTRATION SITES

Arthur Dunn
Interim President/CEO
St. Joseph Healthcare
7850 Jefferson NE, Suite 100
Albuquerque, NM 87109
(505) 727-2801
(505) 727-2813 Fax

Andrew G. Fallat, FACHE
Chief Executive Officer
Evergreen Community Health Care
12040 NE 128th St.
Kirkland, WA 98034
(425) 899-2621
(425) 899-2624 Fax

John E. Friendlander
President and Chief Executive Officer
Kaleida Health
907 Washington St.
Buffalo, NY 14203
(716) 843-7525
(716) 843-7595 Fax

Douglas D. Hawthorne, FACHE
President/Chief Executive Officer
Texas Health Resources
600 E. Las Colinas Blvd., Suite 1550
Irving, TX 75039
(214) 818-4510
(214) 818-4651 Fax

Michael L. Shields, CHE
President/Chief Executive Officer
Maria Parham Hospital
566 Ruin Creek Rd.
Henderson, NC 27536
(252) 436-1100
(252) 438-3690 Fax

Milton Triana
President/Chief Executive Officer
St. Mary Medical Center
1500 S. Lake Park Ave.
Hobart, IN 46342
(219) 947-6000
(219) 947-6037 Fax