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CITRUS VALLEY HEALTH PARTNERS COVINA, CALIFORNIA

Background

Community

Citrus Valley Health Partners is located east of Los Angeles in the center of the area known as the East San Gabriel Valley. The area comprises 170 square miles and provides about 80 percent of CVHP's patients. The population of 880,000 is 51 percent Hispanic, with whites and Asians comprising most of the remaining ethnic groups. Competing with CVHP are three nonprofit hospitals and two for-profit hospitals. Community partners are located almost exclusively in the service area because as Tom McGuinness, senior vice president for Mission Integration and Community Care, stated, "It's easier to have an impact on a smaller area."

The valley is very mixed in terms of its residents' economic status. For example, the north and east sections are more middle-class, as is part of the southeastern section. But those living in the western sections have lower median incomes and less formal education than residents elsewhere.

Citrus Valley Health Partners

Two hospitals in Covina, Calif., had competed for 30 years: InterCommunity Medical Center, founded in 1930, was a not-for-profit secular hospital. Queen of the Valley Hospital was built in 1960 to provide Catholic healthcare to the community. The hospitals were 4.5 miles apart, and 75 percent of the medical staffs overlapped.

According to Peter Makowski, CVHP's current president/CEO, the community felt there was duplication of services, and a medical arms race was robbing the community of resources that could be better distributed. Consequently, a merger was effected in 1994. Each hospital retained its sponsorship status (secular and religious), but the system, Citrus Valley Health Partners, is secular.

Leading Practices

Investing in Education

Awakening Corporate Soul, a recently published management book, was used to re-envision leadership. A small group was constituted that was headed by Peter Makowski and included 13 other staff representatives who best reflect the values of the organization by their lives in the workplace. They are upbeat, positive, and passionate in the way they live and work. They include a therapist, nurses, and others. This group, called the Mission Core Team, launched its yearlong educational effort with a three-day retreat. As an exercise to guide this yearlong team learning, the team has begun to record their own experience of awakening corporate soul at CVHP.

Another initiative, Relationship-Centered Care, was introduced into the organization by sending the senior vice president for Mission Integration and Community Care to a retreat conducted by the Feltzer Institute. Peter Makowski, president/CEO, then invested in bringing the retreat to his board. Relationship-Centered Care helps people to examine and use their individual and

corporate wisdom, to talk meaningfully about important issues, and to make decisions based upon what fosters healing human systems. Subsequently, the medical staff leadership became so interested that the medical executive committee convened 23 leadership physicians, 5 administrative staff, and 4 board members in Santa Barbara to repeat the experience in a larger group that was more reflective of the overall healthcare community. This retreat was funded in part by the physician group and in part by the hospital. In general, these efforts were intended to rekindle the commitment of the board, leaders, and medical staff to the healing mission of CVHP.

Establishing an Executive Position with Priorities That Transcend the Institution

Like other leading practice sites, CVHP has a senior vice president overseeing community health efforts who reports directly to the CEO. In June 1993, Tom McGuiness, senior vice president of Mission Integration and Community Care, relinquished half of his job, dropping oversight of several inpatient clinical and support department areas and human resources. He wrote his own job description to match the obligations expected for his new focus on community health. His responsibilities include overseeing organizational development and community care. As required, his responsibilities have fluctuated. For the first four years, his job was 10 percent organizational development and 90 percent community care. Now, about 40 percent of his time is dedicated to organizational development. Among his specific duties, he is on loan for about one-third of his time to the L.A. County Department of Public Health, working on their system redesign process.

Throughout his tenure as senior vice president of Mission Integration and Community Care, McGuiness has deliberately avoided building a bureaucracy inside the organization. While many senior managers define the scope and depth of their organizational power by counting the size of their budget or the number of FTEs they oversee, McGuiness rejects this attitude as contrary to the interests of the organization and the community. Instead, he aims to develop leaders and organizational capacities that will improve the health of the community. This does not necessarily translate into additional investment in partner organization by the health system.

Using Consolidation as an Opportunity to Re-envision

Merger created an opportunity to re-envision the role of the senior vice president for Mission Integration and Community Care and to recharge commitment to the community. The merger was a signal—and community health improvement provided a rallying point for two cultures to merge.

Organizations therefore should consider merger for both business reasons and for higher purposes. Indeed, at one point, McGuiness suggested that organizations contemplate a shared mission to community first, for a year or two, and only then, perhaps in the third year, consider merging the business of care delivery.

Connecting with the Community through the Interview Method

Starting at the outset of his new responsibilities as senior vice president of Mission Integration and Community Care, McGuiness began an ongoing practice of conducting one-on-one interviews with colleagues, partners, prospective partners, and others. He has conducted more

than 900 of these interviews. One of McGuiness's main questions is, "Who are the people in the community that can make your dream for a healthier community come true?"

It appeared as though every participating partner had had one of these interviews early in their relationship with CVHP. Moreover, it is widely held among informants in Covina that these ongoing interactions produce numerous opportunities for synergies within McGuiness's head. He becomes a kind of messenger RNA, mixing and matching information from various sources, sorting it into usable bundles, and feeding it back to the larger system through other interviews or meetings

The 900 interviews conducted by Tom McGuiness provided the entree needed for CVHP to listen to the community's wishes. "And then one day, Tom knocked on the door" was a often-repeated remark from community partners. But the interviews were followed with lunches. And meetings were facilitated by content specialists. Through its outreach efforts, CVHP actively seeks ways to bridge to others so they can better provide their services in ways that plug gaps and deepen and broaden the community's capacities to serve one another. In part, this includes putting up seed money—but not a continuous flow of funds. Ultimately, projects that are supported will have to be self-sustaining. Other principles of CVHP at these meetings include teaching partners a common language. Likewise, CVHP attempts to be a low-cost vendor of choice for safety net providers by using downtime of services and equipment, such as lab, mammography, and radiology. Through such efforts, CVHP attempts to prove its trustworthiness by following through and by not hogging the glory. Typically they get multiple staff and board members directly engaged in partners' work or joint activities. Thus, community relationships must be not for PR or marketing purposes, but are essentially how the health system lives with and serves its community.

Giving Community Care, Not Charity

Charity care is about taking care of others. Citrus Valley Health Partners assumes that their partners desire not to be taken care of but to be helped to achieve their own valuable ends. CVHP avoids creating financial dependence among their public and private partners. They try to make investments that will enable partners to do what should be done on behalf of and with the community, without requiring a steady stream of handouts.

"Beware of the man bearing a model," cautioned Tom McGuiness. CVHP does not want to be a paternalistic partner and does not expect community agencies to approach it. Instead, perhaps because CVHP is based in a largely Hispanic community, the partners come together on an equal footing to discuss what can be accomplished by each to advance the health and quality of life of the entire community.

There is courage and a willingness to risk in establishing these many partnerships that demonstrates the trust between the CEO and the senior vice president for Mission Integration and Community Care.

Incentivizing Attention to Community Health through Compensation

The CEO's bonus is, in part, determined by involvement in community health and achieving certain outcomes. Specifically, the bonus opportunity is 30 percent of base salary; 50 percent of

the bonus is tied to financial performance, and the other 50 percent is based on programmatic goals that are tied directly to the CEO performance evaluation process. One of these programmatic goals is tied very tightly to a specific community health-oriented project. So about 12.5 percent of the compensation is tied to community health.

The senior vice president for Mission Integration and Community Care derives an even larger proportion of his bonus from community health activities as stipulated in the strategic plan. Indeed, all of the CEO's direct reports—with the exception of the head of the foundation—have their bonuses, in part, tied to community health involvement.

A reward and recognition system has been developed for all staff using a point system. Numerous symbols are disseminated such as pins, cups, T-shirts, caps, etc. to underscore the importance of involvement in community health.

Being a CEO Who Values Loyalty

Peter Makowski, like other chief executives at the leading practice sites, values loyalty—a feeling of mature love that can come from shared experience. This love is not just personal friendship. The ideals that cement this bond of loyalty between the CEO and his key staff are their shared commitment to a higher purpose. The degree of trust engendered by this shared loyalty allows the CEO to let staff have leadership over the design of the means of achieving the higher purpose of the organization. This, in turn, produces highly motivated and highly skilled managers who mature with the organization and make it increasingly strong. It is akin to the bond that worshipers develop toward their faith: It binds them to their fellows and ripens into even stronger ties with time.

Indeed, the senior vice president for Mission Integration and Community Care has been recruited by many individuals throughout the country, and he continues at CVHP “simply because the work is not done yet.” People are getting a chance to develop their job descriptions in these special organizations, and this engenders trust and loyalty. “It’s not about your career; it’s about this community.” Building relationships with the community takes both commitment and time—and by rewarding loyalty, community partners are served over the long term.

Evaluating Multiple Bottom Lines

Peter Makowski stresses to the management team and the board that CVHP has multiple bottom lines: “There is the financial bottom line that is critically important because you can’t go out and do these wonderful things and support these projects without the financial wherewithal. But the higher purpose is our mission that must be fulfilled.” John Izzo, co-author of *Awakening Corporate Soul*, has been hired to work with Makowski and other individuals on the Mission Core Team. These individuals represent all areas of the hospital (primarily staff, not management). These individuals are the best ambassadors for the organization: upbeat, positive, caring, compassionate. They live the values of the organization.

With this team, Makowski hopes to identify the behaviors where CVHP is doing well and not well. How are these behaviors measured? The senior vice president for Mission Integration and Community Care is staff to the team, and the mission officer is the CEO. Makowski now gets calls from around the country about organizational renewal. He noted that healthcare providers

are burned out because they are so focused on finances and affiliations. In such a situation, good care cannot be provided.

Tom McGuinness went to the Feltzer Institute, and he said he had a “sacred experience” on relationship-centered care. Makowski wanted his board to experience this in a weekend—to understand “the deep wisdom that exists within relationships” and to get in touch with their own individual deeper wisdom as well as their corporate wisdom as a board. This Relationship-Centered Care retreat was then requested by the medical staff executive committee (with a small group of administrators and board members present). This is being sponsored by the hospital and the medical staff cooperatively.

CVHP operates within a mature managed care market where the majority of patients are enrolled in managed care programs that are increasingly risk-based. Therefore, according to Armando Gonzalez, chair of the system board, it makes good business sense to try to enroll a healthy population. “A lot of people say our mission is to benefit the community. But the real truth is that in the future, our margin will be *in* the community benefit.” CVHP is seeking ways to show a pro forma financial benefit from the community benefit investments they make, fully expecting to find financial payoff for the organization from their intensive work to improve the health and quality of life of the communities they serve.

Perspectives of the Partners

Every Child’s Health Option

This partnership started when Tom McGuinness went to the Baldwin Park community and asked the mayor, “When you think about the health and the quality of life in the community, who are the movers and shakers who make things happen?” McGuinness then called one of the people the mayor mentioned: Barbara Croft, a nurse executive at the school district. Together they hosted a meeting of all 14 school district nurse executives to talk about children’s health and the schools. He asked, “Where do the nurses send children without healthcare? How can we ensure that no child living in East San Gabriel Valley goes without quality healthcare?”

A number of organizations, including the county public health department, were involved in arranging for children’s healthcare. But the partnership that evolved was premised on the fact that turf was not important, the families’ and children were what counted. Those agencies that were approached agreed they would commit to the partnership for three years, knowing that there would be some hard feelings along the way. But the groups also recognized there was enough work (i.e., an abundant client base) for everyone.

Barbara Croft started by organizing physicians, dentists, pharmacists, and mental health professionals, and Tom McGuinness helped line them up. This free healthcare program expanded from 1 school district to 9 districts and finally to all 14 in the area. Though initially confined to urgent care for children, the program was broadened to include comprehensive medical care for children. And now, it is advancing further to include low-income uninsured parents, adult relatives, and siblings of the children in the school districts. The model they used was adopted from “Young and Healthy Pasadena,” and the partners acknowledge that they are willing to learn from anyone.

There were two stumbling blocks to effecting these advances in healthcare for children. First, the public health department was viewed negatively by the community. So CVHP became an advocate of the county, and through persistence, they built a compassionate and caring relationship. The public health department is now told what specialists are needed by the children in the ECHO program. The medical school doesn't just send the specialists who need experience, only those who can meet the needs of the community.

The second stumbling block that created conflict was how to respond to requests for proposals for grants from public agencies and private foundations. McGuinness observed that people in the community "would kill each other for that money. . . . The very money that was intended to unite us was the biggest obstacle in uniting (the community). CBO's would fight each other to get a couple of thousand dollars." This was overcome through opening up a dialogue and by coordinating the various community agencies. As a group, they decided who had the need—and who could meet it. Sometimes agencies would combine efforts to get grants. For example, one grant was directed to learn about the 2,700 homeless people in the East San Gabriel Valley. To accomplish the project, the consortium had former homeless people interview homeless people. Two years later there were cold weather shelters, two year-round access centers for the homeless, and more than 70 transitional living units.

When the recession occurred in California in 1995, and federal devolution hit, new battle lines were drawn between the nonprofit sector and the county. It was especially difficult to decide where to put the limited resources. At that time, the county was the biggest employer, yet many of the social services were outsourced to the nonprofits. So the issue became whether to lay off the middle-class people of color working for the county or to reduce the workforce of the grassroots-based nonprofit sector. This remains a sticky issue with the community to this day. But the partners maintain that the public sector has to be part of the dialogue. "There are no secrets anymore," said Tom McGuinness.

All grants are selected using co-applicants. Four principles (known as the scissors) are used by the partners before applying for any grant:

1. Self-sufficiency: Move toward self-sufficiency because money won't be there in the future.
2. Sustainability: Reject grant money that will go away after three years or so. Instead, the partners need to leverage their own money.
3. Replicability: Select projects that can be replicated elsewhere. "We're tired of hospitals and heroes—we don't care about that."
4. Privatize: Reduce dependence on government because it won't ever have enough money. We don't want to perpetuate entitlement structures and systems that have fallen under their own weight.

The main objective is to avoid building an infrastructure that is excessively grant-dependent. Indeed, there was an example in the community that served as a negative role model. A community-based organization of 52 faith communities began doing wonderful work, tithing, donating time to seniors and the poor. Then they got a grant from World Vision, and another, and a third. They built a large infrastructure after three years (hiring an executive director, a

secretary, and some support staff). But then the grants stopped, and they had to lay off people. Thus they built a nonsustainable infrastructure.

John Suggs, a regional consultant for the newly formed Institute for Community Leadership, which was started by CVHP, suggested that the idea of incremental change is “bunk”; organizations in the public and private sectors are imploding—they are patterned on a nonsustainable aspect of funding. The old science of change is invalid. In the new community partnerships spawned by CVHP, only the initial development funds come from CVHP and a few other institutional partners, but the programs must sustain themselves.

If the program can't sustain itself, then so be it. Some well-intended projects fail. Community development is complex and chaotic. For example, the Community Health Council was established to create communion among disparate partners (250 community organizations). Its function was to create a forum where the partners could discuss community needs and their true interests and, hopefully, work toward a common good. Even though the council served its purpose and is now defunct, the 90 partnerships that emerged are the beneficiary organizations. And, indeed, there is a successor organization known as the Community Health Cabinet, consisting of 22 people who head consortiums and projects that evolved from the council.

In addition, this sustainable philosophy allows for flexibility and fluidity and respects the actual experience of the agencies involved.

This system also avoids burning out leaders in the community—who oftentimes run after money rather than pursuing a relationship system. According to Tom McGuiness, “Many of our best community leaders turn out to be money chasers.” One needs to respond holistically and collaboratively rather than just throwing money to solve isolated problems.

Today, there is explicit coordination of who and what funds will be pursued. There is interdependence, but at the same time, each group still has to pursue its core work. They are working together to find a balance between partners as to who should go for what funding. Some continued mending and reconciliation will always need to go on. Those that go for funds alone won't be shunned, but personal feelings can be hurt.

The cabinet has begun developing a community master plan—certainly in terms of data such as health status measures, epidemiology, etc. And the relationships are in place as well.

How does a partner view the upper management of CVHP? Two years ago, Silvia Rodriguez, a community leader at ECHO, attended a meeting of the Community Health Council. What she saw was 30 to 40 individuals who “yelled” at each other but who basically trusted each other. Sylvia is on the CVHP payroll, but she is not an employee. She is “out in the community.” Tom McGuiness has been a great mentor to her and has evoked leadership capacities that she didn't know she had. Peter Makowski has been very generous and supportive—taking time to meet with her and some of her more challenging clients. In her view, Makowski represents the fact that the institution has heart. When successes are experienced, Silvia notes that Tom McGuiness insists “the people have done this.”

Institute for Community Leadership

John Suggs is the regional consultant for the Institute for Community Leadership, which was formally launched a week prior to our site visit. Its mission is “to enhance leadership capacity by educating and strengthening community leaders toward the transformation of their communities.” CVHP, along with three universities and the Department of Health Services, provided start-up funds for the Institute, which has four initiatives:

1. Leadership Conferences where nationally recognized speakers are brought in to speak to the leaders in the public as well as private sectors.
2. Two-year academy offering eight courses as follow-up to the Leadership Conference
3. Oral archives program to the stories of community leaders
4. Sabbatical residential program for community leaders (six to eight weeks to think, rest, reflect, study, and write—to be initiated in 2000)

The Institute is seen as a “Santa Fe Institute” for the community. Instead of having people listen to lectures, dialogue is sought to develop a vision and leadership skills.

The idea of the Institute arose from Tom McGuiness’s “one-on-ones” (900 hour-long interviews where it became evident individuals had great passion and capacities and wanted training). John Suggs had experience in post-apartheid South Africa helping leaders envision the future. Now the Institute presents an opportunity for him to facilitate leaders’ future thinking in southern California.

In addition to CVHP and the Los Angeles County Health Department, several universities are collaborating in the Institute, including UCLA School of Public Health, Immaculate Heart College Center, and the University of La Verne. There are different relationships between Tom McGuiness and John Suggs and UCLA and the L.A. County Health Department. Both UCLA and the county bought into the project based on a personal trust that was built over time. CVHP had done much of the groundwork in identifying the needs for the Institute.

The partners first worked on the Institute’s foundational principles. The partners emerged with 16 principles based on the fundamental belief that all resources and systems should serve to enhance and strengthen healthier communities. For example, the principle on women is that “the spirit and power of women’s voices are equally valued.” Interestingly, one of the potential partners objected to this principle, but John Suggs maintained that it was fundamental to the partners’ agreement and insisted it remain a tenet. When told that the principle on women was questioned, another partner stated that if it had been removed or even weakened, that partner would have withdrawn. Thus, the Institute walks a tightrope, trying to advance community leadership capacities while maintaining internal integrity.

Underlying the Institute’s approach is the concept of respecting individuals’ experiences. It is based in part on Miles Horton’s views as embodied in the Highlander Community—a training ground established in the 1950s and a program that civil rights leaders Rosa Parks and Martin Luther King, Jr., attended.

CVHP put up the first money for the project—and for a long time it was the only money for the project. These funds provided the Institute organizers with organizational and financial credibility and ultimately enabled them to bring along the other partners. Now 16 slots are filled by the county and 6 slots by CVHP to go through this academy.

Core instructors of the Academy are the initial planners plus outside instructors who are local experts and who receive a small stipend. The Institute will hold all of its conference and academy sessions in community settings—in schools, hospitals and similar buildings, not in hotels.

Advice

See above section on forming partnerships that need to stand or fail on their own merits.

Conclusions

How is CVHP different from the Cambridge Health Alliance? At the Alliance, they are using data, being deliberate, but they don't seem quite as self-conscious, quite as contemplative about their labors. At the Alliance they are doing and moving on. But at CVHP, there is a strong need to memorialize, to record the experience itself. Through retreats, the Institute for Community Leadership, the planned sabbaticals, the writer whom they hired to record their experiences, the people at CVHP are ensuring access for others to the inner workings of their own experiences.

Moreover, CVHP has developed some rigorous principles in working with partners. Through a broadly integrated network, community agencies have learned to work together for mutual gain. The cabinet's future goal—to develop a master plan—is a natural product of the trust that has grown between CVHP and its partners over time.

Finally, CVHP shows that when the CEO initiates a program to reincorporate “soul” into the organization, there are specific steps that can be pursued to facilitate this. Partners testified that at CVHP, the hospital heart has re-emerged. This was also evident in the open affection displayed by staff, physicians, and even former staff toward the CEO as he walked down the hospital's corridors.

MISSION HOSPITAL REGIONAL MEDICAL CENTER MISSION VIEJO, CALIFORNIA

“To care for the Dear Neighbor.”

—Sisters of St. Joseph founded in DuPuis, France, in 1650

Background

Community

Mission Hospital Regional Medical Center is situated in the heavily populated area encompassing Orange County along southern California’s coast, midway between Los Angeles and San Diego. Its service area comprises 450,000 people in a rapidly growing area extending from the El Toro Y down to San Clemente—roughly, about 35 square miles. Demographically, they are 77 percent white, 14 percent Hispanic, 7 percent Asian, and 1 percent black.

Orange County and Mission Viejo, the city, is a relatively affluent area. The median household income is \$64,700, although 11 percent earn less than \$25,000 per year. Orange County has a very low unemployment rate—2 percent at the time of our visit. Despite this, there is a sizable Hispanic community, some of whom are recent immigrants from Mexico. Their healthcare needs pose a challenge to care providers in the area, and providers sometimes find themselves at loggerheads with officials of the Immigration and Naturalization Service. Thus the area has a bimodal population—many wealthy residents along with pockets of poor people clustered in three communities: Dana Point, San Clemente, and San Juan Capistrano.

Mission Hospital Regional Medical Center

Mission was originally formed in the early 1950s by a group of enterprising physicians. Incorporating it as a for-profit hospital, the physicians continued to own the hospital as they aged. Finally, as the partners got too old to practice, they sold the hospital to the Sisters of St. Joseph of Orange County in 1995. Peter Bastone, the current president and chief executive officer, joined the hospital in 1996.

Mission currently has about 40 percent market share. There are three major competitors, all nonprofit. There are two investor-owned hospitals that do not pose a threat. The market share measure includes the Children’s Hospital at Mission, a pediatric specialty hospital. Mission is one of three trauma centers in Orange County and is the only trauma center in South Orange County. Peter Bastone told us that in the past, chases by the INS up the freeway oftentimes ended in car crashes, and the undocumented victims would end up as charity cases in Mission’s emergency room.

Leading Practices

Incentivizing Attention to Community Health through Compensation

At Mission Hospital Regional Medical Center, all staff from department managers up receive bonuses based on corporate goals. This includes all 35 department managers and the 9 members of the senior management team. For 1999, the corporate goals are

- Healthy communities
- Integration and seamlessness of regional delivery systems
- Human resources
- Physician partnership and integration
- Clinical quality and service improvement
- Advocacy
- Stewardship
- Managing growth

At the system and the hospital level, measurable objectives are developed annually for each goal. Managing growth was not identified as a goal at the system level. It should also be noted that goals are evaluated and sometimes changed, but they represent a relatively long and strategic view with little change expected over a three- to five-year period.

Of the eight goals, three are linked to community health issues. These three goals, and the specific measurable indicators being used to track performance on them, are

1. Healthy communities
 - Camino Health Center, measured as the number of visits
 - Family Resource Center, measured as the numbers of classes and visits
 - Senior transportation, measured as the number of transports
 - Care for the poor, measured as the number served
 - Safe rides, measured as the numbers of rides and volunteers
2. Clinical quality and service improvement through the inclusion of
 - communitywide indicators on breast cancer, expressed as a percent by stage of the disease throughout the county
 - community-acquired pneumonia, expressed as LOS
 - percentage of births by C-section (Mission's births only)
 - low birth weights (throughout the county)
 - customer service, via Press-Ganey patient satisfaction surveys
3. Advocacy, measured as
 - the number of enrolled children in the service area
 - prenatal care, expressed as the number of people served

The above goals and measures are used explicitly in reviewing performance and determining bonuses. The exact methodology for the CEO is that 50 percent of the evaluation is tied to financial measures, and the remainder deals with other issues such as human resources and community service. In practice, about 15 percent of the CEO's compensation is directly affected by the community benefits part of the bonus.

A minor complement to incentivizing attention to community health may be found in Mission's treatment of staff who participate in traditional outreach activities, like health fairs and screenings. Staff who participate in such events are paid, and they receive overtime pay for participating during their normal off-hours.

Tithing to Create a Pool of Funds for Social Accountability

Mission Hospital Regional Medical Center dedicates 10 percent of its net operating margin each year to the Social Accountability Budget. Seventy-five percent of this contribution is retained locally and is specifically allocated to care for the poor. The Camino Health Center consumes the bulk of these funds. The remainder is invested by the Community Benefit Committee in other priorities identified by Mission's community assessments. For example, Mission has recently funded

- The purchase of vans for senior transportation services
- The creation of pediatric dental capacity in the Camino Clinic
- The creation of a Family Resource Center
- The contribution of a staff person to the Family Resource Center, a trained social worker who serves as FRC's executive director

The other 25 percent of funds go to the St. Joseph's Health System Foundation. The largest allocation of these funds is to a Disaster Fund, which receives 75 percent of the system foundation's portion. Twenty percent of the system's portion is contributed to an endowment, which totaled about \$12 million in 1998. Five percent of the system foundation's portion from the member hospitals is used for the Icon Award Program.

The Endowment Fund is intended as start-up or seed money for new investments in local communities. Member hospitals and others submit applications to the Endowment Fund seeking support for new efforts. For example, Mission submitted a request for support of an asthma education program for the schools. This asthma education program, which was supported by the Endowment Fund, relies on collaboration with the Saddleback Unified School District. As with other Endowment-funded projects, staff members are expected to find ways of making the asthma program self-sustainable. In this case, staff are communicating with insurers to encourage them to provide financial support for the full-time asthma educator in the schools.

In addition to the 10 percent tithe, 1.5 percent of operating costs are dedicated to healthy community initiatives. These efforts include education, cancer screening, smoking cessation, and other ongoing and more traditional efforts to promote health and well-being.

Linking Strategy with Community Health through Data

In 1995, Mission initiated a yearlong community health assessment. While required by the summer of 1996 as a result of California SB 697, community benefit legislation, Mission had started its assessment prior to passage of SB 697.

This 1995 assessment involved two committees. One was a blue-ribbon panel of mayors, agency heads, and business leaders. This group served mainly to grease wheels, lend credibility, and ensure that the assessment avoided political challenges. The other committee was a working committee, including staff from local colleges, utility companies, civic organizations, social services organizations. The goal in composing this second group was to include anyone who was already working with the community, so as to have as much local intelligence as possible from the outset.

The 1995 assessment included a telephone survey of 400 residents of Mission Viejo and Laguna Niguel. These two cities comprised 37 percent of the patient service area. The survey results were used to determine an appropriate design for focus groups with citizens about the causes of the problems and issues identified by the survey. The focus groups were followed by key informant interviews, which were intended mainly to flesh out the team's understanding of the issues and their causes.

As a result of the 1995 surveys, Mission Hospital's Community Benefit Committee established its priorities in care for the poor. These priorities led to investments in senior transportation, pediatric dental care at the Camino Clinic, and the Family Resource Center.

A new assessment was launched by the county in 1998. Forty-two hospitals, including Mission, each contributed \$2,500 to underwrite the county health department's efforts in this assessment. This assessment used three different instruments, all by telephone interview. These instruments assessed (1) behavioral health, (2) physical health, and (3) quality of life and personal behavior. The data collection phase was completed in the summer of 1998.

Unfortunately, the county's contract with California State-Fullerton did not anticipate the need for data analysis and reporting. Hence, Mission is now determining how it can help the county conduct analyses and produce local reports. Local reports will focus on the three poorest cities in Mission's service area: Dana Point, San Clemente, and San Juan Capistrano. So far, St. Joseph Health System is loaning a statistician, Azar Queresh, M.D., Ph.D., to the county so that small area analyses can be completed and reports generated for the participating hospitals.

Meanwhile, three organizations partnered to achieve a grant from Orange County for the purposes of canvassing low-income communities. Catholic Charities, The Mission of San Juan Capistrano, and Mission Hospital partnered to form CHEC, Community Health Enrichment Council. CHEC designed and oversaw a door-to-door quality of life assessment in the poorest neighborhoods of their service area. California State-Fullerton received a contract to hire and train locals from these neighborhoods to conduct the surveys.

As a result of this survey on quality of life, CHEC is figuring out how to deliver parenting skills in Spanish in the poorest neighborhoods. These parenting skills are already being taught in English in other parts of the service area. CHEC will also use the data to design other programs for the poorest neighbors.

Investing in Board Education

Mission invests generously in board education. All new board members undergo an orientation. The orientation includes a session during which the Sisters of St. Joseph review their history and mission and the role of the congregation in governance. In addition, senior managers and members of the Executive Committee explain Mission Hospital's market and community context, its values and services, and board roles and expectations.

Board members regularly attend outside educational events, such as Estes Park Institute programs and local opportunities conducted by institutions such as the University of California at Irvine. Edie Fee is a board member with a distinguished career as an asset manager for real estate

and property management firms. She noted, “The more I do for and with Mission Hospital, the more supportive management is of the need to provide me with educational opportunities.” She added, “As we say in real estate, you cannot make the best and highest use of an asset unless you have been well educated to do so.”

David Reed, chairman of the Mission Hospital Regional Medical Center board, freely admitted that as the former system CEO, he used to be a bit cynical about healthy communities. He had always been supportive of care for the indigent and other foci inside the hospital. But the idea of fixing a bend in the road to prevent auto accidents was a bit of a stretch for him at first. Through attending Health Forum’s healthier communities program and conducting a health assessment of the community, he became aware of population-based healthcare.

The St. Joseph system conducts an annual trustee conference. It focuses on governance responsibilities, roles, values, culture, and the system’s goals and foci. The hospital, too, conducts an annual trustee conference. It is attended by medical staff leaders and senior managers and emphasizes Mission’s strategic issues.

The effect of a more intensive investment in board education is to enable board members to realize the values of the system and the hospital in their decision-making role. For example, in the 1997 flu epidemic, the hospital could have put three people per room, with positive benefit to its financial bottom line. But this practice was rejected by the board in favor of offering the highest care to all patients, reflecting the core value of dignity. The patients who could not be accommodated were transferred to other hospitals.

Developing and Working with Strong Support Networks in the Community

The foundation was started by the previous physician owners of the hospital with the purpose of providing community benefit. When the Sisters of St. Joseph took it over, they decided to shift support to the hospital and transform the foundation into a control foundation—its role is to support the hospital’s need for philanthropy, which includes community programs. In fact, the community health programs impact all of the foundation’s activities. Winnie Johnson, its president, has a board of 27 members and has been with the foundation for three and a half years.

Johnson thinks the foundation can be viewed as a model for quick adaptation to new directions. All the dollars they raise come from members of the community, including employees, physicians, corporations, and individuals. They are extremely successful: They recently received a \$1.5 million gift; and they raised \$3.5 million in their first capital campaign. Now they are completing their second capital campaign for \$1.6 million.

But more than bricks and mortar are involved. Winnie Johnson is repeatedly told by community leaders and donors that the hospital’s community programs have motivated their giving. Structurally, they have organized several groups to support their efforts.

1. CEO’s Advisory Council: This communication council meets quarterly with about 30 attendees of 50 total members. The members are community leaders, and the council’s purpose is to make them aware of Mission’s programs and obtain their input. The chair of the hospital board serves as a member of this board as well. One or two foundation board

members serve as members of the council, one of whom recruits other potential members to the council. Indeed, the council is used as a farm team to develop relationships and recruit to the foundation board. The purpose of the council is communication, and members are not solicited for contributions. Peter Bastone, president and chief executive officer, gives updates, and a standing agenda item is advocacy updates—to be aware of issues with the state and county in regard to children and patients’ rights, etc. Sometimes a member of the council will communicate back to the CEO relative to some proposed activity, and this kind of feedback has resulted in the appointment of a council member to the hospital board.

2. Women’s Advisory Council: Winnie Johnson, president of the foundation, staffs this council, which meets quarterly and addresses women’s issues—not labor, delivery, and menopause but how to deal with children, businesses, and elder care. Recently, senior services were described for the region. Again, leading women of the community are approached to serve. One woman owns the largest property management agency in the county. She discussed property development in her area and how that might influence healthcare. Eventually she will spend some time with Peter Bastone (and make a contribution). This council has been most successful.
3. Community Benefits Committee: This committee is staffed by the vice president of Mission and chaired by a member of the hospital board, with some physicians but mostly community members. This committee determines what the real priorities are in the community. The committee is driven by a community needs assessment (see below). Camino gets the majority of the Community Benefits Committee funds.

The foundation board has four support groups—each with a cause. The foundation board members all serve on one of the support groups:

1. Camino Health Center: The center was founded to provide indigent people with primary healthcare, dental care, and WIC (women’s and infants’ care). The foundation raises money and obtains service donations from dentists, for example. Winnie Johnson is working with the Latino community to ask them to help support a move to a more accessible location over the next three to five years. In fact, the foundation is helping to organize leaders in the Latino community, and this “will help us learn from each other.”
2. Thrift shop: The shop’s goal is to provide an economical source of goods and to support Camino Health Center. Its role is to teach residents about ways to obtain free (MediCal) healthcare. With 65 volunteers and one paid manager, they are all aware of the values of Mission Hospital.
3. Grant proposals: This groups helps with grant proposals for Camino, Family Resource Center, asthma education, etc. Their job is to develop programs and services that donors want to support (which may not coincide with what the hospital or other caregivers most desperately think they need).
4. Valiant Women: This group raises funds and provides educational experiences for donors or prospective donors on health including financial health, women’s health, mental health, etc.

Building Loyalty to Mission by Retaining Key Staff

As in many of the leading practice sites, leaders at Mission Hospital Regional Medical Center value experience and relationships. The senior management team is essentially the same team it was six years ago when Mission was owned by a group of physician-investors. The only changes

in the senior management team have resulted from a retirement by the CFO and a change in chief executive.

Four new senior management positions have, however, been created. This allowed the organization to establish a better gender balance within its leadership team. Prior to the merger, only one of five senior management positions was held by a female. At the time of our site visit, females held five of nine senior management positions.

Several of the senior managers noted their longevity as a team and speculated that their high standard of performance may depend in large part on their experience as a team. In addition, several senior managers expressed strong positive feelings about their association with Mission. Several noted their thrill, in particular, at the attention to a higher purpose, the mission of Mission that became a part of work after St. Joseph's acquired the hospital.

Peter Bastone, president and chief executive officer, commented that six months after he arrived at Mission, others in the system asked him about his leadership team. He conducted a SWOT analysis and determined that the leadership team looked good, and after a year, the system leaders had to agree. Members of the leadership team are an excellent mix of specialists. Also, the hospital has invested in human resources and benefits and is at the leading edge of benefits and pay packages—especially in Orange County.

The fact that the hospital was formerly for-profit gave it an edge that other hospitals may not have had. These managers have been challenged in a different way and were at the hospital in both good times and bad. The COO has been especially helpful in transitioning the organization, especially vis-à-vis the physicians. The new CFO has a broad background as a hospital consultant and in the corporate sector. The continuity of leadership has made them stronger.

The long tenure of management has facilitated the development of community linkages. Kristan Schlichte, executive director of Catholic Charities in Orange County for the past 13 years, told us that her long-standing relationship with Sister Martha Ann, the hospital's vice president of Sponsorship, helped her establish CHEC along with Bishop Driscoll, who has been the vicar of charities in Orange County for 28 years. This long-standing relationship among the parish, the charities, and the hospital promoted the trust that is needed when partnerships are successful. In fact, even though the current CEO has only been formally associated with Mission for three years, he has had broad experience in the Catholic health system nearby, having worked in the Daniel Freeman Hospital for several years before coming to Mission.

Promoting Community Health by the System

As part of the St. Joseph Health System, Mission contributes 25 percent of its tithe to the system headquarters. In addition, the system sets the standard for each of its hospitals for financial allocations to its community benefit program, its care for the poor program, and selection of the CEO. Recently, for example, the system increased its community benefit allocation from one percent of annual total costs to 1.5 percent. Similarly, because of a favorable net margin, the system increased each hospital's care for the poor budget from 5 percent to 10 percent.

Apart from finances, the system establishes the values for its member hospitals as well as the strategic goals, which are translated by each hospital to specific initiatives over a three-year period. The process of establishing goals is explicitly laid out and involves both system-level and member hospital collaboration. First, the 12 hospital CEOs (and vice presidents of Sponsorship) convene in a Leadership Conference and receive the system's proposed goals. The 12 CEOs then take these back to their respective management teams and alter them to suit their specific community needs. These then are transmitted to the system and its executive team. Their comments are reviewed and possibly modified and given back to the 12 member hospital CEOs. After the 12 CEOs approve the goals, they are then sent to the planning committee of the system and finally to the system board. This structured system is part of the corporate culture and the timelines are "etched in stone."

Every year, the system supports community health by pumping \$60 to \$80 million into its hospitals' communities. The system has a foundation, which provides grants for specific programs. For example, Mission received a grant from the system for Kids Doc, an asthma education program for the Saddleback Unified School District. Since there is a children's hospital on Mission's campus, they were able to determine that most of the school-age admissions were associated with asthma. Because of the volume of pediatric inpatient visits, Mission partnered with Children's Hospital of Orange County to open an after-hours kids care unit in part to avoid using the more expensive emergency room.

To obtain foundation monies from the system, hospitals must show they are providing care for the poor, and they need to show how this will be sustained in the future. Statistics on absenteeism from school and admissions to the ER convinced the system this was worthy. After the third year, Children's Hospital approached Mission about sustaining the initiative. The program started as a part-time venture; now it may go full time. Currently, pharmaceutical companies are being targeted to provide sustaining funds for the Kids Doc program. Already, fanny packs with inhalers and educational materials are being provided by private companies.

Sister Martha Ann, as vice president of Sponsorship, facilitates the mission, vision, and values of the organization. For example, she serves as the hospital's representative on several system-level committees: Healthy Communities Roundtable, Sponsorship Executive Committee, and other ad hoc committees.

The Healthy Communities Roundtable meets semiannually to discuss best practices among the system entities and plans to hold a Healthy Community Summit in March 1999. This summit will require each hospital to prepare a video of its accomplishments in improving one quality of life indicator for the members of their communities. Quality of life includes safety, education, healthcare, clean water, employment etc. Each hospital will send 20 representatives to the summit.

Another committee that Sister Martha Ann sits on at the system level is the Sponsorship Executive Committee. It sponsors a recognition program called Values in Action and functions to recognize those who embody the core values of the St. Joseph of Orange system. The committee also considers policies and procedures that help advance the mission and values by

promoting the orientation program. The goal of the system is that healthy communities is a concept that all the hospitals in the various communities will embrace.

Sister Martha Ann speculated that the current allocations, which separate funding for care of the poor and other funding for healthy communities, may in the future be combined. But in reality, she believes that there will always be medically underserved people and their needs may always need to be targeted. Right now, the 1.5 percent targeted for healthy communities is a larger pot of money (\$1.4 million) than is the care for the poor fund.

Another method that the system uses to promulgate its community focus at the local level was detailed to us by David Reed, present chairman of the board of Mission Hospital Regional Medical Center. He indicated that in selecting the hospital CEO, a search committee is created at the system level. The committee would be composed of the system CEO, a couple of sisters, and perhaps another system board member. This committee screens candidates and makes recommendations to the local board's search committee. Candidates that are referred to the local board have met the criteria of the system. Religion does not constitute a factor in CEO selection—the "best" candidate is selected.

To ensure that the values and vision are embodied in key candidates, interviews are conducted to "ease out of candidates their personal philosophy of management, does he recognize social composite of an institution in terms of how he manages, is he sensitive to community needs, what is his experience in developing programs in response to community need." Thus candidates from proprietary hospitals could be at a disadvantage—because they're responsive to shareholder needs rather than community needs. "You can also look at the hospital a candidate comes from to determine what kind of social mission it has and what the CEO's role and involvement was." To evaluate the CEO, the regional executive who works for the system CEO meets with the executive committee of the local board to discuss the CEO's performance. There are two sessions where the local board chairman visits with the system CEO and the regional representative. In addition, the local board's executive committee, which includes the hospital's chief of staff, participates.

A final benefit to the community of being part of a larger system was revealed by Winnie Johnson, president of the hospital foundation. She indicated that a portion of the 25 percent of net operating margin that is sent to system headquarters is used to fund an endowment fund so that some of the community projects can be continued even if profits fall in the future (or if one of the hospitals cannot sustain its charity commitment).

Perspectives of the Partners

New Covenant Project

Kristan Schlichte, executive director of Catholic Charities, described a collaborative effort called the New Covenant Project. The project is a joint effort of the Catholic Health Association, the St. Joseph Health System, and Catholic Charities USA—to bring their respective strengths together to benefit the community. Catholic Charities USA is the largest private, nonprofit social services network in the United States.

The bishops of the dioceses are responsible for organizations that carry the name “Catholic.” Two years ago, bishops of the 12 dioceses in California got together with representatives from the Catholic Hospital Association and the 12 Catholic Charities in California’s dioceses and decided to try an experiment in collaboration. Using the well-established Orange County members of their organizations, the New Covenant Project was designed “to try to be a stronger presence in the county since we are motivated by the same gospel principles, we share the same values, and we care about the same people.” It was understood it would take time and effort to respect each other’s procedures and systems.

Their first undertaking was a meeting facilitated by Peter Bastone with Sister Martha Ann and Kristan Schlichte as a representative of Catholic Charities. The group decided to develop a program that might help preserve families: the Family Support System. Catholic Charities applied for and received federal monies administered by the County of Orange to provide social services at the neighborhood level to people who were underserved, had low language skills, or were for some reason out of the mainstream for social services as they were being delivered.

Their success in this joint effort then prompted them to approach the Catholic Parish of San Juan Capistrano to attempt to improve healthcare for the poor. Called the Community Health Enrichment Coalition, its purpose was to study, serve, and measure health outcomes. The parish was a critical group to include because it serves as the contact point for many Hispanic people—many of whom are newcomers and are afraid of the social service system. Three neighborhoods were targeted that comprise 25 percent of San Juan Capistrano.

The three partners invited other service providers to come together and developed an advisory board—other nonprofits and churches, etc. The board directed the work of CHEC, and it determined a survey was needed to assess and prioritize needs for the community. The survey was administered by the Social Ecology Department of California State-Fullerton. They determined to recruit local residents who were well known to the target population to conduct hour-long interviews. These interviewers were trained and remunerated for their work.

Apart from the manifest goal of improving the health outcomes, CHEC enabled residents to obtain funded jobs and new skills as interviewers. Many of these interviewers have been retained to serve as community organizers. Another immediate outcome was that the bilingual interviewers accompanied the residents to meetings of the homeowners’ association. Many of the residents did not understand the role of the homeowners’ association in their own communities. Rules were not understood mainly because the residents couldn’t read English. Thus one of the first successes of the surveyors was to improve the residents’ understanding of what was expected of them as tenants.

A health fair was conducted by CHEC at the mission parish, and all the advisory council member organizations were present with food, music, and noninvasive health products. The entertainment was what the people wanted—and the whole concept was to develop bottom-up approaches that would provide opportunities for people to talk about what they felt they needed. Once people are provided with their perceived needs, then it becomes possible to provide other types of services and supports around those perceived needs.

The health fair was held in September 1998. A memorandum of understanding among the partners and some funding were acquired in the year since the formation of CHEC. But the border patrol had some cars stationed at one of the main apartment complexes of the residents. Many people refused to come to the health fair—showing the level of fear and concern that many of these native-born Americans have for the INS. The partners are now addressing this intimidation issue relative to the INS. The members of the collaboration were disappointed.

The results of the interviews showed that some of the residents' needs were not in CHEC's purview, e.g., creating parks and constructing play areas for children. However, the partners can help the city understand that this is what's needed. Other needs clearly could be addressed by CHEC, e.g., activities for teens, parent education, drug addiction, substance abuse—all are main contributors to family dysfunction. Still other needs are remediable by the residents themselves, e.g., litter removal from areas around the housing complexes.

In sum, partners went through the following steps:

1. We decided to work together.
2. We identified something we could do that was a mutual focus of the major partners.
3. We spent a year trying to meet the people and identify the people's perceptions of their needs.
4. Now we must focus on our services to meet those needs. In the process, we must apply our professional knowledge to add a certain value onto what people need.

Schlichte indicated the three founding partners recently revised their memorandum of understanding, recommitted funding for another year, and put themselves on a new schedule for meeting and dialoguing their progress. As a result of the past two years, Schlichte learned that to ensure the collaboration is successful, main representatives of the three major partners must remain personally involved and cannot delegate it out to members of the advisory committee. Specifically, Sister Martha Ann from the hospital, the pastor of the parish, and Schlichte need to meet regularly. Staffs of these three principals then meet with the other advisory committee members. Since the goal is to make sure the systems are working together, this arrangement is necessary—if only to be able to commit needed resources to the partnership.

This group is a pioneer partnership group among the California dioceses. This has been facilitated because of their history of working together and the long tenure of the principals. Schlichte has been head of Catholic Charities for 13 years; the pastor, Monsignor Martin, has been in his position for 20 years; Bishop Driscoll, the vicar of charities, has been head of the diocese since its founding in 1976. Peter Bastone was the “new kid on the block.” While at the Freeman Hospital, he was involved with midnight basketball and was familiar with the holistic view of health—that it is physical, emotional, economic, and spiritual.

Peter Bastone mentioned that before the three CHEC partners got together, each had its own lingo and was pursuing its own goals. Speaking metaphorically, he suggested each was “in the same city but in different neighborhoods.” Now, as a result of CHEC, they are getting together in the park.

Catholic Charities of California, California Catholic Conference, and the California Catholic Health Association will be meeting in October 1999, two years after the initial conference in Burlingame, to see how this pilot project worked out.

Advice

From Dr. Marvin Posner, Medical Staff President:

Physicians need to understand the population of the community—not just the existing patients but the entire community’s needs. Also, they need to know the resources that are available to help meet the entire community’s needs. It is helpful to conduct community surveys to learn about needs.

Doctors need to treat not just diseases but the people. It will make practice more rewarding. If you don’t get paid, you do get admiration, and providing care is very fulfilling.

From Winnie Johnson, President, Mission Hospital Foundation

1. Do your own work—determine what your community wants to support.
2. Determine where your support is. Find out where the leadership is and listen to their needs and try to convince them that your mission is worthy. There is a dialogue that happens here between what the community wants and the organization wants.
3. Convince the partners that you will stick to a program even when the going gets tough.
4. Learn what the community wants—through needs assessments, for example. You have to adjust to the styles of the people whom you are serving. Sometimes people don’t return phone calls or forget what the program is about, but we have to adapt to their differences.

From Kristan Schlichte, Executive Director, Catholic Charities of Orange County

1. Seek out peers in other institutions and discuss the benefit of working together to the community and to the prospective partners.
2. Be committed. If the leaders are not committed to participating directly, they should not begin. Community partnerships are not something that can be delegated. Perhaps after year 4 or later, a systematic routine will have been worked out.
3. Designate support staff who are friendly and not threatened by working with other highly skilled and highly motivated people.
4. Give up the notion of being top dog. Know that this can’t be done without the support of all the partners.
5. See success as the success of all the partners.
6. Make sure you have board support. Board backing is critical; there will be loss leaders in these efforts. There is a lot of time investment up front without an immediate measurable result. This time will be especially long for those without a history of working together. To make up for this lack, there may need to be retreat time or extra time praying together, playing together, and getting to know each other better.

From David Reed, Chairman, Mission Hospital Regional Medical Center Board

What expectations are set for the board and managers to adopt a community orientation? It starts with the corporate culture. A system needs an adhesive to bring it together. Corporate culture needs to be embodied by the top guy all the way through the organization. Commitment to

community care can be played out in numerous ways, and of course a poor hospital will have a hard time doing such things—but even then, there are actions the hospital can take.

For example, reporting about the community is critical. At every MHRMC board meeting, a report is provided by the Community Benefits Committee chairman, and Sister Martha Ann is a frequent speaker. The system board has a regular advocacy report—a big part of that budget is care for children. The system lobbyist works toward getting grants for children to a greater extent than obtaining more reimbursement for care provided.

One of the advantages of the system being headed by the Sisters of St. Joseph is that the organization has a basic philosophy that persists. Moreover, 50 to 60 of the 300 St. Joseph sisters are in healthcare. These 50 to 60 are invaluable in advancing the mission of community healthcare, and the Catholic systems have an edge in having a built-in philosophy and developing a corporate culture. That said, the sisters do an excellent job of retaining key staff because they compensate the staff very well.

The incentive compensation plan is part of the corporate culture, and it must reward participation in community health. Likewise, the board must have a sense of its mission—if people on the board don't have this sense, the CEO must educate them.

There are many CEOs who would prefer not to have social activists on the board because they're a burr under the saddle. But such people are critical for the board—people who have a good sense of the community's needs should be part of the board. Such CEOs should not surround themselves only with key executives of the community who focus on the bottom line and don't have a feel for the community.

When recruiting CEOs, proven success in another industry will not dictate success in the health field. This a real concern today—especially people who are not trained in the health field.

If you can convince your employees to be ambassadors out in the community where they live about the role of the hospital in healthier communities, you have a major ally.

Conclusions

This case showed that a system can serve to emphasize and enhance a hospital's community outreach efforts. Unique to Mission Hospital Regional Medical Center were (1) the corporate prescreening of candidates for a hospital CEO position to ensure their commitment to the mission of the system and (2) a tithing process that requires 7.5 percent of net operating margins be returned directly to the community and 2.5 percent be allocated by the system headquarters principally for extra community needs such as disaster relief but also for seed money for investments in local communities. Moreover, member hospitals within the system share best practices in regard to their community efforts. Finally, as described in the New Covenant Project section, there are synergistic effects the partnership engendered in terms of providing the community's parishioners access to care.

CAMCARE CHARLESTON, WEST VIRGINIA

Background

Community

The service area of Camcare includes 12 counties with a total population of about 563,872. When considering the entire Partners in Health Network, a rural health network established with Camcare as a charter member, the system's area of influence comprises 26 counties. Medicare, Medicaid, federal and state employees, and nonpaying patients make up a large proportion of the area's population. Only 36 percent of the people in the service area are covered by commercial insurance.

Camcare

Camcare is West Virginia's largest not-for-profit, multihospital health system. Camcare includes four hospitals (CAMC-Memorial Division, CAMC-General Division, CAMC-Women and Children's Hospital, and Braxton County Memorial Hospital), five primary care centers, and the Carelink Health Plans, which covers more than 64,000 people. Camcare also includes the Camcare Health Education and Research Institute, the CAMC Foundation, Home Care Services, Corporate Health Services, SVI reference laboratory (serving 156 providers across the state), and about 30 affiliated Partners in Health Network members. Partners works with and supports 24 rural hospitals, clinics, and public health departments throughout central and southern West Virginia. All told, Camcare has 6,000 employees. Charleston Area Medical Center is the three-campus, hospital-based core of the system, accounting for \$580 million in revenue in 1998. CAMC is the chief site of care for the poor in its service areas, serving about 90 percent of the uninsured in the community. CAMC serves an average of 231 emergency patients per day and is the seventh-busiest Level 1 trauma center in the United States. In 1998, CAMC had an average daily census of 601, 611 outpatients per day, 85 inpatient surgeries per day, and 10 deliveries per day. Meanwhile, Camcare's home care agency delivered 157,000 visits in 1997.

Leading Practices

Developing a Stable, Tenured Leadership Team

Camcare, like the other leading practice sites, enjoys the expertise of a stable and tenured leadership team. Until very recently, the system had experienced virtually no turnover since 1984-85. For example, the chief executive has been in his position for 12 years and in the system 17 years, and the chief operating officer has been in his position for 16 years. The vice president of Human Resources has even longer tenure and represents a link to the institutional memory from the era preceding the merger that produced CAMC. Even in corporate health and wellness, product lines that are relatively new thrusts for most health systems, Camcare benefits from a director-level executive with a decade of experience leading those programs. The excellence of the leadership team may be noted by the many awards that Camcare has won. For example, Camcare has won VHA's Community Health Leadership Award, was the first business in America to receive the Wellness Councils of America Gold Well Workplace Award, and has received an honorable mention in the C. Everett Koop National Health Award. Carelink Health Plans received NCQA Accreditation and had full compliance for all prevention standards in 1999.

The benefits of this stability extend far beyond having particularly competent and experienced leadership. Stronger relationships enable better coordination across units, as well as in external relations with other organizations. A key benefit, though, is that leaders who have long since learned to perform excellently in their core functions become able and empowered to share and advance a common vision. The stability of the leadership team seems to have been a key factor in Camcare's evolution toward excellence in clinical trials, patient care, and community health performance.

At Camcare this stability is ascribed to several factors. One is the satisfaction that is obtained from having a consistent and higher purpose—a community health orientation. Another factor is the use of an incentive compensation and benefits package that provides professional satisfaction and incentive for senior managers to stay in the Camcare system. A number of informants at Camcare made special note of the high quality of life available in the Charleston area. Charleston has only 65,000 inhabitants and is truly the center of a large rural region. However, it offers a number of recreational and entertainment opportunities, including fishing, hunting, skiing, many good restaurants, an excellent symphony orchestra, satisfactory airline connections (and a superbly accessible airport, only about seven minutes from downtown), as well as being not inconvenient to Washington, D.C., or Pittsburgh. The site visit team was struck by the number and size of the larger buildings in downtown Charleston, as well as the evident vibrancy of the downtown area. Charleston is now in the process of developing an \$80 million center for the performing arts. Many informants noted that everyone wants to stay in or come back to the Charleston area.

As part of developing excellence in its management team, Camcare has engaged in a 10-year team-building process. This process involved a variety of techniques. Chief among these are Rule #1 Conversations. Rule #1 Conversations are private and confidential conversations between members of the team-building group and the private consultant who has facilitated the entire 10-year process. Rule #1 Conversations are conducted twice a year with each member of the group. The content of these conversations is kept strictly confidential, but knowledge of sensitive issues by the facilitator enables him to design improved mechanisms for exposing and resolving management team issues without threatening individual members. Minimally, at the end of each year, the facilitator frankly reports issues to the CEO while continuing to protect the identity and interests of individual members of the leadership team.

Other techniques that have been used include developing and sustaining common language, prompting conversation corners, participating in grab bag issue forums and brown bag Q&A sessions, conducting 360-degree performance assessments, and taking part in issue examination circles based on readings. Developing and sustaining common language was driven through the use of Modelnetics, a facilitated technique for teaching and using 151 terms and metaphors for common management and leadership issues, each module of which takes about seven minutes to introduce. One example metaphor is Watering the Tomatoes, which refers to the management problem of growing too many different potential fruits to make productive use of them. If leadership plants too many tomato plants and waters them too well, a large number of the leadership's outputs will rot on the vine or on the ground.

The facilitator prompts conversation corners whenever two members of the leadership team need to resolve an issue but have been unable to bring it to the surface on their own. The technique involves setting a private appointment for the two team members and delivering to each of them a question to discuss that engages them in the issue but that is phrased in a way to avoid personalization of the problem. Grab bag issue forums happen when the facilitator feeds questions, typically uncovered in Rule #1 Conversations, for the chief executive to address into a “grab bag.” During a leadership team meeting, the CEO pulls out questions and leads a discussion. Brown bag Q&A sessions, which are possible after the leadership has come to work and interact as a team, are simply brown bag lunches during which members of the team raise sticky management issues for discussion.

During 1994-95, the leadership team conducted 360-degree reviews. Each member of the team underwent both quantitative and qualitative written evaluation by peers, B’s and A’s. B’s are people who report to you; A’s are people to whom you report. This terminology is preferred in this context as a way of communicating the importance of both kinds of evaluations. For the chief executive, A’s included a sample of board members and other community leaders. Finally, the Camcare team-building process employed issue examination circles based on readings. Each member of the team was provided with a copy of a book and later participated in discussion groups guided by soliciting comments about quotes from the book. Books included *The Different Drum*, *The Empowered Manager*, *The Fifth Discipline*, and *The Seven Habits of Highly Effective People*.

The team-building process started with 14 executives, one of whom was female. During the fourth year, a conscious effort to link senior management with service line administrators (SLAs) resulted in a team-building group of 27 leaders in the organization. In addition to expanding the reach of the team-building process, the addition of SLAs was also seen as a means of creating more opportunities for females to participate in the system’s leadership. Since that time, a number of females have advanced into more senior positions in the organization.

Embedding Values about Population and Community Health in Ongoing Strategy

At Camcare, three enduring strategic goals emerged from a 1994 strategic-planning process. Today, these same goals remain the bedrock of Camcare’s strategic decision making, lending a consistency in direction that is necessary for excellence. Additionally, community health was made a fourth strategic goal in 1996. Each year, these goals are revisited and verified as still relevant. These goals are

1. To position Camcare as the region’s cost-effective integrator of quality care capable of simplicity, stability, and competence to the purchasers of healthcare
2. To operate Camcare as a seamless system
3. To enhance the efficiency and effectiveness of our services as demonstrated through measurable quality improvements
4. To improve the health status of the communities we serve

At the same time, a new set of annual objectives is identified for each of the major strategic goals. For example, following are the three 1998 objectives under the fourth goal:

1. Maintain the focus of community health as a defining characteristic of Camcare through education to the board of trustees, management, medical staff, and community.
2. Work with segments of the population to address community health.
3. Measure outcomes and report progress on new community health initiatives targeted to improve health status.

The mission statement, a statement of the strategic plan, the four strategic goals, and their respective objectives are all communicated on one side of a single sheet of paper. This clear and information-packed page is ubiquitous for Camcare managers and trustees. It is used as the guide for board self-evaluation, evaluation of the chief executive's performance, evaluation of other managers' performance, and as an outline for much more detailed performance data collection and reporting. It is used for Camcare's report card to the community, in departmental and management meetings, and by department heads and above when they are determining their personal performance objectives each year. Every site visit informant that was asked had a working knowledge of the document and a clear understanding of Camcare's strategic goals.

In fact, there is strong evidence that familiarity with Camcare's strategic goals is high throughout the organization. As part of quality improvement efforts, Camcare conducted a staff survey, following the Baldrige Award criteria. More than 3,600 of the organization's 4,200 staff returned their confidential surveys. Even more impressive, the results showed that 80 to 90 percent of staff know and understand Camcare's strategic goals.

Establishing a Staff Position with a Communitywide Scope of Responsibilities

Like most of the six leading practice sites, Camcare has a full-time staff person with a scope of responsibility that is communitywide and not defined by the system or its hospitals or its specific initiatives. In this case, the position is coordinator of the Kanawha Coalition for Community Health Improvement. The coordinator's salary and benefits are paid for by the Charleston Area Medical Center Foundation and the Thomas Hospital Foundation. This position reports internally to the director of Community and Corporate Health. This relationship enhances opportunities for linking community-determined priorities internally. However, the coordinator reports, in practice, to the Kanawha Coalition's Steering Committee. It was the view of the system COO, who is also CEO of Charleston Area Medical Center, that having this position distanced from the system CEO created greater opportunity for her to function effectively as the Coalition's coordinator. The Coalition cannot be viewed as a Camcare activity if it is to be a successful collaborative effort. Therefore, historical as well as current competitive issues are avoided since the coordinator operates for the Coalition, where all members have an equal voice and vote, versus being seen as senior manager for the system.

Developing a Vision-Oriented Chief Executive and Senior Operations Staff

Successful visionary leaders spark respect because they achieve remarkable results. Often the most acclaimed results are those observable in the marketplace. Typically, organizations are admired for achieving dominance or sustained profitability. Sometimes, though, during a turbulent era such as that characterizing healthcare in the United States today, organizations qualify for admiration because they sustain their viability.

Results of this nature stem, in part, from the efforts of a leader with unique talent. This talent includes the capacity to anticipate change and to foresee how his or her organization can take advantage of an evolving market situation. Leadership experts identify this part of the job as “doing the right thing.”

However, outside observers may miss the remarkable internal accomplishments a leader with a vision must also produce to enable the organization to shift from one with a history to one with a future. These are results that require eliciting contributions by the leader’s colleagues at all levels of the organization. Leadership experts refer to this part of the job as “doing things right.” In Phillip Goodwin, FACHE, Camcare enjoys an effective visionary leader.

The Vision: Two Right Things to Do

Concisely, Goodwin considers it Camcare’s job to find a gap with health needs to be met and then see that something happens to improve it. The means of improvement is integral to Goodwin’s vision for Camcare. The Camcare approach is to identify some group or somebody with a reason to pay attention to the gap, then aid them in taking ownership for it. Camcare has been an incubator for a significant number of community-related entities that now stand on their own. Among these are West Virginia Health Right, Ronald McDonald House, a progressive nursing home (Hodges Center), and the Kanawha Coalition for Community Health Improvement.

Camcare’s distinct focus on community health and wellness arose because it was the right thing to do for the organization’s own employees. Nearly a decade ago there began a continuing emphasis on prevention, health risk appraisal, and fitness as parts of the Camcare culture. So attractive was this emphasis that it spawned the corporate health market as businesses approached Camcare seeking similar benefits for their own employees. This example of customer demand exerting “pull” for wellness illustrates how market forces can reinforce the need for change that propels a leader to create and pursue a new vision of an organization.

The Mode: Doing Things Right

Internally as well as externally, Goodwin is conscious that the changing healthcare market represents a lever by which to produce necessary and desired changes. Goodwin clearly accepts that care management in a continuum must ultimately predominate over the current episodic mode of treatment and payment. He recognizes that most people will not voluntarily abandon the rewards and security of the waning paradigm. The effective visionary leader must show the way and encourage those who are involved in the change.

Goodwin recognizes that the market can be a lever for change because it rewards those whose behavior aligns with its economic incentives. Corporate and governmental healthcare purchasers have become cost and quality conscious. They will contract selectively for high-value services even when the preferred vendor is no longer the local doctor or hospital. By demonstrating to the market that Camcare is improving health and producing superior outcomes, the organization begins to align with the evolving incentives of a market composed of prudent purchasers. Also, Camcare has established organizational and personal accountability for valued outcomes and aligned its internal reward structure with achieving those outcomes.

Incentivizing Attention to Community Health through Compensation

The salary and bonus of all executives are tied to the four enduring strategic goals, including community health status improvement. Camcare's system of linking performance to pay is described as having three legs. The first leg is the use of surveys and an outside company to establish base pay at the 50th percentile for comparable organizations in other markets. Camcare evaluates all positions and specifically identifies outliers for more detailed analysis. All executive job descriptions have recently been redone. The second leg is an incentive program that links 50 percent of the bonus of every executive from managers and up to system goals via individual goals that each manager helps to create for herself or himself. These bonuses are paid only when a positive margin occurs, which has occurred every year in the 1990s except for 1991 and 1998. The third leg of linking performance to pay is a rich three-tiered benefits program. The first tier is composed of the typical benefits. The executive tier typically includes an auto allowance, health club membership, financial-planning services, will preparation, and association dues. The third tier is called ExecuFlex and emphasizes benefits that encourage stability, such as special life and disability insurance, special insurance for spouses, a capital accumulation plan, and a flex allowance plan that permits additional acquisition of investments. Approximately eight top executives also undergo performance and pay evaluation on the basis of explicit linkages with mission, plan, and annual goals for the system overall.

The chief executive's performance evaluation plan includes a 360-degree review. This review seeks input from all board members, chiefs of staff, and direct reports. The CEO is rated on a four-point scale by each of these individuals, from whom comments are also solicited.

Developing and Using Extensive Community-Health-Oriented Data

Camcare conducts quarterly reporting on a wide array of performance indicators, including many related to community health. The Camcare System Performance Indicators Report is organized around the four enduring goals of the system. These four goals are repeated below, with illustrative performance measures given for each:

1. To position Camcare as the region's cost-effective integrator of quality care capable of simplicity, stability, and competence to the purchasers of healthcare
 - CAMC return on assets
 - Carelink market share
 - Carelink member satisfaction
 - Primary care physicians to population
2. To operate Camcare as a seamless system
 - CAMC regional charge comparison
 - CAMC average length of stay
 - CAMC Medicare/Medicaid unreimbursed services
 - CAMC ER utilization
3. To enhance the efficiency and effectiveness of our services as demonstrated through measurable quality improvements
 - Camcare employee opinion survey
 - CAMC community opinion survey results
 - Carelink customer service
 - CAMC unscheduled readmission rate

- CAMC appropriateness of care/breast biopsies
4. To improve the health status of the communities we serve
- Health risk appraisals
 - Community health assessment
 - Carelink population-based indicators
 - CAMC community health education/screening

About 50 indicators are regularly tracked. The indicators are reported at different intervals, some quarterly (such as patient satisfaction), some semiannually, and some annually. This staggered tracking and reporting of indicators makes a more manageable process and also enhances the system's ability to make use of the data in educational efforts with board members, physician leaders, and the overall community.

Camcare uses Lyons Software's community benefit reporting software, developed by VHA and the Catholic Health Association. And Camcare conducts a Community Leadership Profile, which logs the organization, type of work, number of hours, and estimated economic value of voluntary labor given by Camcare employees to community organizations. Managers are encouraged to support their employees in volunteering to work with community organizations.

Multi-branding Community Health

Camcare has served as an incubator for a community health agenda, leading to a number of ways of "selling" the idea of community health. The Kanawha Coalition for Community Health Improvement is one of several means by which Camcare can participate in community-health-oriented work without branding the activity as the system's. Camcare was a major force behind the launch of the Coalition, paying two-thirds of the coordinator's salary and operating expenses through the CAMC Foundation. (Thomas Hospital contributes the additional one-third.) However, in the interest of enjoying a neutral and equitable framework for community health efforts, Camcare has deliberately avoided promoting its own corporate identity in these efforts.

The Coalition, on the other hand, is recognized by opinion leaders in the community as a neutral ground for joint leadership on community health issues. The Coalition allows all partners to participate on the basis of an equal voice and stake. Priorities established by the community for the Coalition include tobacco use, heart disease, and lack of physical activity. Outside of the Coalition, community health efforts for the system have focused on extending the health improvement process to other areas such as Fayette County, working to measure community health processes and outcomes with the Partners in Health Network, focusing on the African American population through the church community, and supporting other local neighborhood efforts.

Camcare has also been an important partner in the background for Health Right, a free clinic. Camcare has contributed financial support, pharmacy services, physician services, and volunteers. Camcare also provided space to Health Right at its inception, as well as construction support during remodeling of Health Right's facility. Health Right receives the predominance of its financial support from private sources, including the other two hospitals in the area. Health Right has been successfully duplicated in five other communities throughout the state.

Reporting Publicly on a Broad and Community-Responsive Set of Indicators

Camcare's employees have learned that the organization, working through its individual staff members, is committed to delivering increased value through improvements in quality, service, and cost. Through its annual report card, Camcare publicly accounts for its progress in improving its structures, processes, and outcomes to increase the value of the organization's contributions.

The report card is a product derived from a much more comprehensive and detailed reporting mechanism, the Camcare System Performance Indicators. These measures, in turn, are indicators that track progress toward accomplishment of the four enduring goals in the Camcare strategic plan: (1) be an integrator of care, (2) be a seamless system, (3) *measurably* improve quality, and (4) improve community health status. Annually, report cards are mailed to purchasers of Camcare services such as business members of the Chamber of Commerce, insurance companies, public agencies, and other healthcare systems. In 1999, Camcare prepared an advertisement-style report card to be placed in local newspapers so that community residents can have access to this information.

The enduring goals of Camcare's strategic plan align with the incentives present in a prudent purchaser market. Annual incentive payments to executives and managers of Camcare also align as they are partially contingent on achieving both corporate and individual objectives related to the enduring goals. By "drilling down" expectations and incentives to the department manager level, Camcare's leadership has created virtually universal understanding among its staff of the objectives, measures, and personal contributions required to realize the mission of Camcare. Since 1996, all redesign efforts have focused on improving quality, service, or cost and thereby enhancing value. At the department level, specific, measurable objectives are developed. Camcare staff learn of achievement through the quarterly and annual Camcare System Performance Indicator Reports. The community learns of achievement through the Camcare report cards that are published. Both documents deal with patient satisfaction, for example, but the system performance indicators are much more detailed. Other highly readable information concerns comparisons of average charges for a variety of DRGs.

Investing in Education

Camcare makes a substantial investment in education to improve systems thinking and population and community health awareness. Camcare conducts a three-and-a-half-day orientation for new board members. Board members are encouraged to participate in educational events, and their expenses for doing so are reimbursed. Camcare regularly conducts board retreats. Board members also participate in local forums conducted by the Kanawha Coalition for Community Health Improvement, along with many other community members.

Camcare invested in a large-scale, ongoing reengineering project to become more community based and develop strong physician partners throughout the community. The program ended in 1998. A chief motivation for this investment in education for physicians and staff was the \$24 million Camcare spent in 1998 to develop the Carelink Health Plan, which lost about \$13 million in 1998. While enrollment and participation demonstrate that the plan is well regarded and growing, physician behavior was a main cause of the loss.

Camcare is appealing to doctors as doctors, rather than through the MSO, because the MSO has been too identified with the doctors' financial interests. Among the steps taken by Camcare to improve physician education is to include physicians more intimately in system governance and leadership. The system has established a full-time medical officer, and doctors are engaged in leadership committees. For example, on the Capital Allocation Committee, 5 of 10 members are doctors. On the Operations Redesign Steering Committee, 4 of 8 members are doctors. Fifty doctors engaged in a change dynamics process in 1998, an intensive, 30-hour course for unfreezing old habits.

A key education tool for physicians that Camcare has been learning to use more aggressively is evidence-based performance reporting. For example, careful review of information regarding the care patterns of diabetics revealed that five basic tests should be conducted regularly with all diabetics: eye exam, foot check, protein check, hemoglobin A1C, and blood sugar monitoring. Only 30 percent of Carelink diabetics had been receiving all five of these exams. But the system has been able to show cost reductions of \$2,000 per member who is regularly receiving all five exams, largely due to increased and improved self-care, more frequent visits, higher drug expenses coupled with far less usage of more expensive services. Reports on this information are being delivered to individual enrollees, and doctors are regularly receiving information about the proportion of enrollees who are receiving all five exams. Asthma is undergoing a similar program of using evidence-based performance reporting to align physician behavior with system and health outcomes.

Camcare conducts many kinds of educational programs for the community. These include school-based wellness centers and many screening and health promotion efforts. Camcare has been instrumental in the Well City efforts of the Kanawha Coalition for Community Health Improvement. The Coalition's Well City reports a number of major successes experienced by local businesses, including an average absenteeism rate of only 1.2 days per year for Eastern American Energy Company, \$144,450 in savings from the wellness program for the Federal Energy Technology Center, and a 92 percent seat belt use rate for CAMC employees.

Perspective of a Partner

West Virginia Health Right, Inc.

West Virginia Health Right, Inc., is a voluntary not-for-profit organization that was formed and directed by Patricia White. Its mission is providing primary care and prevention and health promotion programs to the uninsured residents of Kanawha and the surrounding counties.

Prior to 1980, White had been on staff of the West Virginia Health Systems Agency in Parkersburg. In that capacity, she was charged with developing a regional not-for-profit primary care health system. She did so successfully. In 1982, Pat was involved in a new activity—assisting homeless citizens of Charleston. She was approached by volunteer medical residents, physicians, and nurses from the Charleston Area Medical Center. They desired to provide primary care in association with Manna Meals, a noontime soup kitchen sponsored by a local church. After that effort was successfully launched, the volunteers sought to offer an evening clinic using the facilities of Covenant Hours, another social services agency.

When demand outstripped the services they could deliver in two nights per week, White and the volunteers sought a permanent home for their free medical clinic. In 1983, Charleston Area Medical Center offered free use of the third floor of the old McMillan Hospital building, home of a predecessor organization subsumed in the merger that created CAMC. This move allowed them to expand services and operate four days and two nights per week. This site remained the home of Health Right until 1989 and the “the night the boiler blew up.” That event was the final straw in coping with a fully depreciated structure, and Health Right relocated to its present location on Smith Street. The organization has continued growing and soon will move into a new facility that triples its space and will enable Health Right to serve an ever-growing number of clients.

The partnership between Health Right and Camcare has always been largely informal; there is no Camcare representation on Health Right’s governing board. Nonetheless, the relationship, which began through volunteer efforts, has solidified and been characterized by cooperation and support that has been enduring and multifaceted. Some salient examples include the initial impetus to offer a free medical clinic from CAMC’s medical residents and faculty. Presently, some 92 physicians volunteer at Health Right at least two to three hours per month. Well over 90 percent are from Camcare.

When in 1989 it became clear that Health Right must relocate, Phil Goodwin dedicated a CAMC staff member to assist in locating a facility and developing it. Volunteer tradesmen from CAMC stepped up and aided in constructing the new Smith Street clinic. Other CAMC volunteers assisted in the physical relocation so that ultimately not one clinic day of service was lost.

Soon Health Right was serving 5,000 clients annually. As the importance of providing pharmacy services grew, CAMC responded to a request for assistance by allocating to Health Right the services of a hospital pharmacist. When the pharmacist just could not make the cultural adjustment to serving an indigent clinic population, Phil Goodwin intervened to find a replacement who fit better with the distinct requirements at Health Right. Subsequently, CAMC has become a provider of laboratory, radiology, MRI, emergency room, and inpatient services for Health Right clients. Also, CAMC removes trash for Health Right and provides incineration services for the clinic’s medical waste. A next step will be integrating Health Right’s laboratory work with CAMC’s new laboratory information system. Although direct financial support from Camcare has been limited, Health Right benefits immensely from the in-kind contributions it receives from Camcare and other local providers. According to Pat White, Health Right funds on its own about \$400,000 of its annual budget and receives an estimated \$6,300,000 of in-kind support from its informal provider partners. CAMC is by far the greatest source of such support.

Advocating on behalf of Health Right as a worthy partner is another form of support Camcare has delivered through testimonials by Phil Goodwin. Health Right has helped launch five similar clinics throughout West Virginia. Goodwin has spoken directly with hospital executives in other communities to confirm the benefits that have accrued to Camcare and Charleston by partnering with Health Right. By lending his personal credibility and professional esteem, he has helped overcome initial concerns about welcoming Health Right-type clinics in those communities. In Morgantown, his advocacy overcame local resistance. In Beckley, it generated sufficient enthusiasm to produce an invitation for Health Right to come and develop such a clinic.

Why has this relationship flourished? There are two clear reasons. First, it is a relationship that exemplifies the incubator philosophy that is pervasive in the Camcare leadership philosophy: Find a need and then find an individual or group with a stake in meeting that need. Then empower that group to solve the problem. The Health Right-CAMC partnership is perhaps the quintessential example of that philosophy turned from thought to deed.

Second, this partnership flourishes because of the mutual self-interests it serves. Health Right serves its client group, now exceeding 11,000 people, with the support of Camcare and other hospitals. Were there no Health Right, then the hospitals would become the source of primary and acute care for the uninsured. It is cost-effective for hospitals and the community to provide coordinated service to such medical consumers. And it benefits the medical education of residents at CAMC.

Advice

From the Medical Center Chief Executive Officer

1. The key is strategic thinking, starting at the mission. From there, consider that if it's just compassionate, high-quality patient care, much potential is missing from the outset. On the other hand, if it's just another nice project, attention turns back to the basics of everyday operations and experiences. Neither is strategic.
2. Adequate resources must be dedicated. The small number of people in a hospital or health system with daily responsibilities obviously linked to community health cannot produce much systematic change by themselves. Timelines and goals must be realistic. And a community health perspective must be carefully bred into the fabric of what an increasing proportion of staff do.
3. To link the business of healthcare and community health in a hospital or health system requires physician involvement, especially on board committees.
4. Systematic quality improvement efforts, such as those guided by the Baldrige criteria, are essential. Staff and the community must be exposed to a broader set of information on quality.
5. New employee and board member orientations should be imbued with the vision and values of the organization, not as a topic, but throughout discussion of all topics.
6. Management meetings should adopt the practice of linking each "topic of the day" back to the organization's enduring goals.

From the Hospital Foundation President

Other foundation presidents push community health from the outset. If these issues don't have access to the CEO, don't take the job. Get these issues regularly included in board meeting agendas. Volunteer to help on board committees. Be included as a member of the executive management team, even though you will have little to offer on some of the essential operational issues. On some essential operational issues, the community health perspective is overlooked.

From a Medical Center Board Member

1. Invest in board education by sending board members to educational events. Otherwise, no one in the organization will understand the broader lifestyle and environmental issues that the

organization faces today and tomorrow—the issues that make a community health perspective essential.

2. Conduct a board retreat. Get Leland Kaiser to facilitate if you can and you haven't already.
3. CEOs: Embrace the idea of a very strong and informed board. Such a board will be your best ally, not your worst enemy.

From the Coordinator of the Community Health Coalition

1. You must figure out how you're going to show people that your work is making a difference. People are accustomed to tracking certain kinds of indicators, such as return on investment. You have to help them learn that there are other ways of evaluating performance.
2. On the other hand, there must be a commitment by the leadership. Don't think you can make it happen. It won't happen unless the organization's leaders recognize the potential for benefit to the organization and its purpose.

From the System Community and Corporate Health Director

1. Remember that it is amazing what can be accomplished when you don't care who gets the credit.
2. Know your community. It is vital to get the right people around the table—problems get solved and duplication can be eliminated.
3. Measure outcomes; build this into every activity possible.
4. Provide opportunities for employees to be involved.
5. Keep information about efforts and success stories before the board and administration.

From System Board Members

1. Communicate values and vision from the very start. Board members start with little knowledge about their job specific to the organization, but they learn quickly. The board orientation must set the stage. Use the board's naturally broader set of interests and concerns as a balancing point to blend the business interests of the organization with the community interests of the organization's purpose.
2. Select a CEO who emphasizes a broader view of the performance of hospitals and health systems. Without the chief executive, a vision can't go anywhere.

Conclusions

Camcare has pursued the incubator approach to its community outreach efforts. As exemplified by its relationships with West Virginia Health Right, Inc., and the Kanawha Coalition for Community Health Improvement, Camcare discerns a health need in the community, finds some group or some person that cares about these needs, empowers the individuals to take ownership, and gets out of the way.

Another significant feature about Camcare is its ability to convey its mission for community care to the entire organization. The fact that at least 85 percent of Camcare's staff know its strategic goals and community health initiatives to educate, work with community segments, measure outcomes, and report progress on community health status is key to effecting the vision and mission of this regional health system.