MONDAY August 9th [redacted]

800 Marshall Street, Little Rock, Arkansas 72202-3591, (501) 370-1100

September 30, 1988

Ms. Hillary Rodham Clinton
Rose Law Firm
120 East 4th Street
Little Rock, AR 72201

Dear Ms. Clinton:

I am pleased to welcome you as a new member of the Board of Trustees of Arkansas Children's Hospital. Congratulations and thank you for your willingness to serve. I look forward to working with you during the course of your three-year term.

Janie McGhee from Dr. O'Donnell's office will be in touch with you soon to schedule an orientation luncheon during the next few weeks with Dr. O'Donnell and Dr. Betty Lowe.

The next Board meeting will be on Tuesday, October 25, 1988, at 4:30 p.m., in the second floor classroom of the main hospital building. You will receive a packet of materials prior to the meeting.

Thanks again and I look forward to seeing you on October 25.

Sincerely,

Doug Brandon

Doug Brandon
President
ACH Board of Trustees

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Thursday August 5, 1993

25% of hospital expenses are administrative

By Mike Snider
USA TODAY

Hospital administration and overhead accounts for nearly $1 in every $4 of hospital expenses, a new study finds.

The analysis, presented by a group in favor of a single-payer national health program, suggests that the expense diverts from patient care and that the $232 billion hospital administration bill could be cut in half.

"American hospitals are wasting billions of dollars on administration and paper-pushing," says Dr. Steffie Woolhandler, a founder of Physicians for a National Health Care Program and co-author of the analysis in today's *New England Journal of Medicine*.

The researchers got 1990 expense data from 6,400 hospitals accepting Medicare. Hospital administrative costs (including cost-accounting departments, review of services and medical records) ranged from 21% in Minnesota to 31% in Hawaii; average was 25%.

Canadian hospitals usually have 9% to 11% administrative costs, Woolhandler says. Cutting costs to that level could save the USA's hospital system about $50 billion. An additional $68 billion in waste could be cut elsewhere (doctors' offices, nursing homes and insurance overhead), she says.

Since 1968, hospitals have almost tripled the managers and clerks hired (to 1.2 million in 1990) while treating fewer patients. Insurers and managed care have toughened the criteria for patients to enter hospitals, says Dr. Sidney Wolfe, Public Citizen Health Research Group, in a sense "robbing patients to pay paper pushers."

Hospitals may have higher administrative costs than other industries, says American Hospital Association's Rick Wade, "but what do you compare us to? ... Compared to other industries, hospitals are people-intensive places ... open 24 hours a day." The AHA favors reform, but not in the form of a Canadian-style system.

Times Publishing Company
St. Petersburg Times

August 2, 1993, Monday, City Edition

SECTION: BUSINESS; CENTERPIECE; Pg. 12

LENGTH: 2381 words

HEADLINE: The bitter pill of health care reform

BYLINE: PETER WALLSTEN; DENISE SMITH AMOS

BODY:

After a four-decade career, Dr. Clinton McGrew of Spring Hill says he is finally the envy of Hernando County's medical community.

While the family doctor is keeping an open mind about President Clinton's plans for health care reform, he is not in the mood to put up with any more government regulations. So he's getting out while the getting's good. Solo practitioners like McGrew could become casualties of the reform.

"I quit," said McGrew, 62, a former Navy captain, who says he was western Hernando County's only doctor when he opened his practice in 1973. "I love to practice medicine but the government has killed it."

McGrew will watch from the sidelines as other health care providers - doctors, hospitals and insurers - take measures to save themselves from falling victim to reform.

For many, it's tough medicine.

Doctors will have to link up with each other and with other health providers in networks. Hospitals will have to share resources and join hands with insurers to market themselves. And insurers may become mere partners rather than bosses in their sometimes adversarial relationships with doctors and hospitals.

"The changes are dramatic," said Sharon Ogawa, the director of national health policy for the American Managed Care and Review Association in Washington.

"People are realizing, doctors are realizing, hospitals are realizing, "We can't do this alone. If we don't work together and change this, the government's going to do it for us.' "

The plan

Exactly how the government will do it is still unknown.

Release of the Clinton health care reform package has been delayed by the White House until this fall. The plan's goal is to provide affordable health care to all Americans. Estimates are that 37-million Americans now are without the benefit of health insurance. (See story, right).

Although the details are not yet known, health care reform is expected to stress managed care. Managed care is built on the idea that consumers will have limits on their choices for doctors, hospitals and other care providers, all of whom will agree to charge reduced rates.

If the national reform plan reflects Florida's influence, many experts say, consumers will be grouped in large purchasing organizations that will have power to bargain for lower health care costs.

In Florida, small businesses will be able to join 11 regional community health purchasing alliances (known as CHPAs or "chippas"), pooling their employees and their insurance dollars. The chippas will shop for health care services through accountable health partnerships, which are groups of doctors, hospitals and pharmacies formed by insurers or managed care companies.

Managed care companies operate health maintenance organizations as well as other kinds of health care networks.

"The market forces now are forcing the (health care) providers to get their acts together, to show purchasers the price is right and that the scope of service is what they need," said Jay Wolfson, director of the Florida Public Health Information Center at the University of South Florida.

"More people who are purchasing are going to be asking more questions about what they're getting for their money."

Physicians

Physicians are hoping to answer those questions by creating networks of their own to recruit patients. The solo practitioner may become a rare find.

"With all the health care reform on the horizon, it's difficult to say whether the solo practitioner as we know it can survive," said Gerald Soud, communication director for the Florida Medical Association.

It's a clear break from the independence that most doctors are accustomed to.

"Physicians take pride in their autonomy," Wolfson said. "It's something medical school teaches them. As patients we like that, until it affects the price we pay. Docs are going through a lot of schizophrenia right now."

But Dr. Michael Lynch, a doctor of hematology and oncology in St. Petersburg, said that solo practitioners allow for greater consumer choice.

"The dominant practices you find aren't large groups," Lynch said. "You'll find the dominant ones are small or solo. And you won't see them go away."

Nevertheless, even the association that represents doctors in Florida is trying to form a statewide network among its 17,000 members.

The Florida Medical Association's Accountable Health Partnership would group doctors in networks to give them more of a voice in the reform process. They would compete with other AHPs to keep costs down, Soud said.

Doctors want a chance to control their own fate, said Dr. John Lee, a general and vascular surgeon in St. Petersburg. Lee is head of First Florida Medical PA Inc., a so-called "clinic without walls" that combines administrative and insurance costs for a group of physicians but allows its members to operate independently. The group was incorporated earlier this year in Pinellas County and has about 50 members.

"My dream would be to have all the clinics and doctors working together in one group," said Lee.

Already, doctors nationwide have been joining managed care networks, such as HMOs, which emphasize preventive care to streamline costs. HMO patients get referrals from a primary care physician who acts as a gatekeeper into the network of doctors. More than 50 percent of all doctors belong to at least one such organization, Ogawa said.

"These days it's almost impossible to survive without participating," said Dr. Emile Commedore, an obstetrician and gynecologist in Tampa.

Commedore, who belongs to several such organizations but maintains some autonomy, doesn't like the changes.

"Patients are going to have fewer and fewer choices," he said. "We must trust patients to have the choice, without a gatekeeper."

Wolfson attributes the shift to managed care to market forces, but others say that it has more to do with reform efforts in Florida and on the national level.

"Physicians have a heightened interest in managed care primarily because they see that's where the Legislature is going, not necessarily (because) it's what they prefer," said Steve Keene, director of medical economics for the Florida Medical Association.

Specialists, such as cardiologists and dermatologists, may have a smaller role after health reform, observers say.

"Right before our eyes we're getting rid of a lot of specialists," said Art Dickerson, a senior consultant at William M. Mercer Inc. in Tampa, which advises companies on employee benefits.

"It'll be tougher to see one. Why should an internist removing a mole get $ 50 and a dermatologist get $ 350?"

Because an internist can't decide whether it's malignant, Dr. Lynch answered.

Hospitals

Doctors aren't the only ones worrying. Hospitals are looking to each other for group strength when negotiating with the chippas or establishing themselves in accountable health partnerships.

Throughout Florida some of the hospitals that used to compete against each other for patients and the latest technology now are forming alliances to share resources and market themselves jointly to insurers, the chippas and other health care consumers.

Tampa General has joined with six for-profit hospitals - South Bay, AMI Memorial and AMI Town 'N Country in Hillsborough County and Edward White, Clearwater Community and Palms of Pasadena in Pinellas County. Morton Plant in Clearwater is affiliated with St. Joseph's in Tampa and St. Anthony's in St. Petersburg and is exploring an association with Mease Health Care in Dunedin.

"There's a lot of people doing a lot of things to shore up their defensive postures," said Dickerson, the consultant at Mercer.

For example, each partnership would need a hospital with a birthing center, some heart surgery capabilities, a cancer center and other acute care specialties. The hospitals also link for geographic reasons, to better serve the chippas, said David Bussone, president of Tampa General.

Some of the hospital reconfigurations are more than mere affiliations.

St. Joseph's in Tampa bought Humana Women's across the street from it earlier this year to obtain women's services. And Tampa General bought the USF Psychiatry Center in Tampa to gain its inpatient and outpatient services.

Reform merely would reaffirm some of the cost-cutting measures hospitals already are taking, hospital administrators said.

For instance, hospitals already are building outpatient clinics and surgical centers to take advantage of lower costs and better reimbursement rates such facilities enjoy.

Outpatient plans consume much of Morton Plant's $ 100-million expansion plan, which will take 10 years to complete, said Frank V. Murphy III, president of Morton Plant Hospital in Clearwater. Tampa General, already a behemoth near downtown Tampa, is expanding through such community clinics and plans to decrease its number of hospital beds, so every patient has a private room, said Bussone, its president.

"We have to start thinking communitywide. We can't just think of this institution," said Lois Nixon, a USF associate professor who is also on Tampa General's governing board of trustees.

Insurers

As hospitals look to maintain their edge as care providers, the insurance industry is posturing itself for the unknown.

On the surface, reform hasn't changed much in the insurance industry but it has sped up existing trends. Insurers are merging with each other to grow larger faster, and they are transforming themselves into managed care networks to capitalize on the managed care emphasis of the Clinton plan.

"The marketplace is moving ahead of the (Clinton) administration," said James Buckley, the partner in charge of health care consulting at KPMG Peat Marwick in New York. "The health insurance industry is moving toward two distinct camps. There are the large, group health insurers investing in managed care. And then there's everyone else, and everyone else is scrambling."

Or, they are getting bought out.

Just last month, Kentucky-based Humana announced plans to buy the Washington-based Group Health Association for about $ 50-million. Group Health is a 56-year-old HMO with 134,000 members; Humana has 1.6-million members spread over 10 states.

Buckley said larger companies will have a distinct advantage under the Clinton plan. "It's just the recognition that volume and size are helpful as reform moves forward," he said. "There will be significant consolidation as reform moves forward."

Such consolidations are a ripple effect indirectly resulting from the Clinton plan's focus on managed care, said Laurie Scarborough, director of investor relations for Humana.

Managed care plans restrict consumers' choices of doctors and hospitals to a specified network, whereas regular indemnity insurance has no such restrictions but is considered more expensive. Insurers, anticipating a shrinking market for indemnity coverage, are shifting their focus to forming managed care networks.

"We think it's our best hope in the '90s," said Richard Coorsh, a spokesman for the Health Insurance Association of America.

Insurance companies won't fade away under Florida's reform law. Doctors, hospitals, insurers - any of them can set up an accountable health partnership, but it has to be run by an insurer or managed care company, such as an HMO.

" Health care reform is creating a hybrid insurer/provider," Buckley said.

It remains to be seen whether insurers - who previously dictated prices and treatments to doctors and hospitals - will enjoy the same influence after reform.

"In some cases insurers will still be calling the shots," said Patrick Haines, a spokesman with the Florida Hospital Association.

"You may see hospitals owned by insurance companies, or insurance companies owned by hospitals. You will start to see existing insurers start to look at partnership agreements with health care providers. They will try to make themselves look as attractive as possible" to health care providers, he said.

Wolfson said he doesn't even call the businesses "insurance companies" anymore.

"I like to call them service agencies," he said. "They're no longer large-scale conduits for processing money."

Joining forces

Experts say that health care reform will change the relationships between consumers, health care providers and the middlemen between them, the insurers or managed care companies. Consumers are supposed to have greater clout.

The system now

Consumers often work through insurers or managed care plans, such as health maintenance organizations or preferred provider organizations, to obtain health care. Consumers: Individuals, employers, or governments pay premiums for coverage through insurers or managed care providers.

In the middle: Insurers take premiums, purchase health care services and reimburse providers for care. HMOs and PPOs take premiums or fees from consumers and employ or contract with health care providers for services.

Health care providers: Doctors, hospitals, clinics and pharmacies often are at the mercy of insurers, Medicaid, Medicare and managed care companies, which decide how much they will be paid and sometimes which treatment is necessary or allowed.

Where it's heading

Consumers will hold more bargaining chips by joining large purchasing groups. In Florida these groups, called community health purchasing alliances (CHPAs), will include small businesses employing 50 people or less as well as state employees and Medicaid recipients. The CHPAs obtain price and quality information from health care providers and insurers, who, themselves, are linking up in accountable health partnerships (AHPs).

Consumers: Individuals still can choose insurance or managed care providers. CHPAs will choose from AHPs for care. Any employer can still choose insurance or managed care.

Suppliers: Forming AHPs, doctors, hospitals, clinics, pharmacies, insurers and managed care systems will work together.

GRAPHIC: COLOR PHOTO, Huy Nguyen; COLOR PHOTO, Olie Stonerook; COLOR PHOTO, Fred
Victorin; BLACK AND WHITE PHOTO, Jim Stem; COLOR DRAWING, David Williams; Dr.
Michael Lynch examines patient Mary Johnson in his St. Petersburg office (ran pg. 1); Dr. Clinton McGrew, a solo family practitioner in Hernando County; Dr. John Lee; Dr. Emile Commedore; Drawing showing the health care system now and where it's heading

Times Publishing Company
St. Petersburg Times

July 18, 1993, Sunday, City Edition

SECTION: TAMPA BAY AND STATE; Pg. 1B

DISTRIBUTION: TAMPA BAY AND STATE

LENGTH: 796 words

HEADLINE: Many beg for home health care plan

BYLINE: JOHN A. CUTTER

DATELINE: ORLANDO

BODY:

Ruth Sherwin came Saturday and told of how her parents, married 64 years, might be separated forever because of illness and bureaucracy.

As Maxine Moul, a young mother and career woman, spoke, the microphone shook slightly, not just from stage fright but from the multiple sclerosis that threatens to rob her future and thousands of others.

And Regina Goslee took the audience at the health care forum inside the tiring world of caring for her husband, who at 77 has Alzheimer's disease, can't care for himself and doesn't recognize her or their children.

All were tragic tales, carefully chosen to show U.S. Sen. Bob Graham, D-Fla., and a panel of advocates for the aged and disabled what is wrong with the way government provides long-term care.

None of the three people receive much help, and all need it, officials said.

"This is one of the most important issues for this nation and (for) thousands of people in the state of Florida, " said Graham, who organized the forum at an Orlando retirement complex.

It is the first of a series of such forums Graham plans as he prepares for the upcoming release of President Bill Clinton's health care proposal. Others will focus on issues like primary health care.

Advocates for the aged and the disabled are lobbying Clinton to include more benefits to keep chronically ill people out of nursing homes as long as

possible. Graham said he expects Clinton to support such programs.

That Graham chose long-term care as his first topic shows its urgency for Florida, which has a higher proportion of people older than 65 and spends more of its health care dollars on their care than other states.

The tales offered Saturday are not unusual.

"These are stories we hear on a daily basis, 24 hours a day," Vivian Marshall, executive director of the Tampa Bay chapter of the Alzheimer's Association, told Graham.

Health care and government officials had no trouble pointing to the problem. About 70 percent of the $ 40-billion the U.S. government spends annually on long-term care go to nursing home residents. Florida spends about 90 percent of its money, $ 1-billion this year, on the same.

But most people say they would rather stay as long as possible in their homes or in community apartments that provide personal and health care assistance.

The state and federal government, however, provide little financial aid for in-home or community care. Such programs for the 200,000 severely impaired people in Florida are drastically under funded, with only about 10 percent of the people who need help getting it. Waiting lists last more than a year.

This often forces people into nursing homes, where they can qualify quickly for Medicaid, the government program for poor people or those who have spent or transferred most of their assets.

"Medicaid helps if he goes to a nursing home. But they don't need an institution," said Sherwin of Bradenton, referring to her father who recently entered a nursing home after a stroke.

But her father wants to return to live with his wife in an assisted-living center, which provides less intense medical care than nursing homes.

He likely will recover and could live again with his wife.

The problem is money. Sherwin's parents have little left, and there is no program that provides enough money for her father to return home.

Panelists proposed several solutions to Graham:

Creating standards for long-term care insurance policies to make them available and affordable to more people. The insurance also should cover more

in-home care, advocates said.

Passing flexible rules to allow states like Florida to use more of its Medicaid money for services other than nursing homes.

Expanding tax incentives for people who care for relatives at home.

Expanding the income eligibility level at which people can qualify for in-home programs like Community Care for the Elderly, and lobbying state legislatures to finance their share of the cost.

Providing families with more direct aid to help pay for the care of spouses and parents. "Some need only a few hundred dollars a month to delay or avoid nursing home placement," said Mary Ellen Early of the Florida Association of Homes for the Aging.

Convincing Clinton, Congress and the Florida Legislature that money invested in home and community programs for the aged and disabled ultimately will save the state money by keeping people out of nursing homes, where more than 60 percent of the people end up on Medicaid.

"The families are taking care of these people, and they need help," said E. Bentley Lipscomb, secretary of the Florida Department of Elder Affairs.

Graham said he is optimistic about change.

GRAPHIC: BLACK AND WHITE PHOTO, (2); U.S. Sen. Bob Graham; E. Bentley Lipscomb

CO-CONVENERS

National Medical Association
Congressional Black Caucus Foundation, Inc.

PLANNING PARTNERS

Association of Black Cardiologists, Inc.
The Black Caucus of Health Workers
Black Congress on Health, Law and Economics
Joint Center for Political and Economic Studies
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National Association of Black County Officials
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National Caucus and Center on Black Aged, Inc.
National Dental Association
National Pharmaceutical Association
National Urban League

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Student National Medical Association
Substance Abuse and Mental Health Services Administration
Tennessee Managed Care Network


VISITOR
RISKO

By doing good, an inner-city hospital in Washington, D.C. is also doing well.

Profits with a Purpose:
An Interview with Tom Chapman

by Nancy A. Nichols

Greater Southeast Community Hospital is a 494-bed acute care facility located in southeast Washington, D.C. With revenues of $145 million and 2,650 employees, it is both the largest private employer and the only medical facility in a troubled and isolated community called Anacostia. Nearly a quarter of the area's residents live below the poverty line, and almost half have not graduated from high school. The low level of education and unrelenting poverty of area residents have combined to give Anacostia the highest rates of infant mortality, cancer, and coronary disease in the entire D.C. area.

Yet unlike so many inner-city hospitals that are faltering because of the tremendous needs of the communities surrounding them, Greater Southeast is thriving. Strengthened by the leadership of a 47-year-old executive named Tom Chapman, Greater Southeast now sits at the center of Anacostia and offers a wide range of social services that at first glance have little in common with traditional health care. Under Chapman's leadership, the hospital has renovated housing, started day care programs for children and the elderly, developed stay-in-school programs, and created adult literacy programs. Both Chapman and the hospital have received national awards for their outstanding work in the community.

Chapman, who grew up in a housing project in New Haven, Connecticut brings to his job an innate understanding of inner-city problems. After attending St. Anselm's College in Manchester, New Hampshire on a basketball scholarship, he turned down an offer to try out with the New York Knicks, seeking instead "to make a difference" in communities like the one in which he was raised. In 1971, Chapman received a master's degree in hospital administration and public health from Yale University. After working both as a consultant and an administrator at several health care facilities, he joined Greater Southeast as president in 1984.

Last year, Chapman was promoted into his current position as CEO of the Greater Southeast Health Care System, where he is responsible for the operation of two hospitals, three nursing homes, a physician care network, and over 50 community programs. Chapman's greatest challenge is to keep his inner-city hospital viable while also pouring services into the surrounding community.

This interview was conducted by Nancy A. Nichols, who covers health care issues for HBR.

DRAWING BY ROBERT RISKO

cles, we may not be doing society a service after all. In fact, we are probably doing a disservice.

Certainly, we are wreaking havoc with our hospital budgets. Many of these complicated births are drug related. Usually the mother is on Medicaid. At Greater Southeast, we receive a flat fee of $4,000 from the government for each delivery we make. If we spend more than that, and we almost always do during a complicated delivery, we eat the difference. In some extreme cases, mothers will abandon the child to us altogether. At times, children have been with us upstairs in pediatrics for over a year. A hospital is a very expensive place to warehouse a child. It is also a totally unacceptable place to spend your first year of life.

> "By saving drug-addicted babies, we may be adding to society's problems."

Are you suggesting that the hospital's margins are inextricably linked to its mission?

Absolutely. At Greater Southeast, we want to provide medical care to people at the point at which it can be delivered most effectively, and that, incidentally, happens to be the cheapest point too. One of the major problems we face is that people in poor communities often can't and don't seek care unless the situation is extreme. There is such social and psychological apathy around any sense of future in this and many other inner-city communities. If people feel as if they're never going to be employed or they're never going to have decent housing or they're never going to have enough food, why should they care about good health care?

As a result, they often access the health care system at the most expensive point possible: the emergency room. About 40% of the children in our emergency room are there for nonemergency treatments. A woman who works all day long will come home to find her child has a temperature of 103°. She may not have a pediatrician, so she brings the child in to our emergency room. It costs $50 just to pass through the doors, before we've even touched the patient. It probably would have cost only $20 or $30 to treat the child in a doctor's office.

How do you solve this problem?

In part, it is just making things more convenient for people. In the past, health care services have been organized around providers' needs, not patients'. For instance, there is a city-run health clinic down the street that isn't open on weekends or after 5:00 P.M. We need to change that if we are going to offer quality care that people can access in a cost-effective manner.

One of the ways Greater Southeast has approached this problem is by forming a public-private partnership with the city of Washington, D.C. In 1989, we opened a health clinic in the local high school, and we will soon begin working in the middle schools. At the clinics, we can both monitor students for major diseases and treat minor problems that would otherwise end up in our emergency room. More important, we can also do a lot of health education and promotion that can lead to good habits and better life-styles.

School clinics are a simple solution, but they can be difficult to implement because the barriers between public health providers and private hospitals are huge and often insurmountable. For example, in the past, we had no links with the city clinic in Anacostia. So if a pregnant woman received prenatal care at the clinic and showed up here eight months later to deliver, we wouldn't have copies of a single medical report. Today we're trying to establish better record coordination and other links with the clinic. As a business, we can't afford to disassociate the community's public health needs from its emergency needs. In the end, it is all the same group of people with the same set of health problems. Sooner or later, we're going to have to deal with them. If we don't address it at one step, we are going to see it at another. There is no escaping it, and the longer we wait, the more expensive the problem becomes.

If the benefits of preventive care are so obvious, why do we see so little of it in our country today?

The incentives in health insurance programs are all built around the most intensive use of medical resources to address the short-term needs of specific patients and diagnostic groups. There is no incentive, from either private insurers or government programs, to provide preventive care or to make the best use of society's health care dollars overall. For example, Medicare will pay us for $30,000 for a hos-

> "The longer we wait, the more expensive the problem becomes."

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byists, and local groups. As this
Chapman shows, hospital man-
ever the skills of communica-
ion, the science of listening, the

director's ability to create a buoyant sense of purpose in a changing, perhaps shrinking organization.

With no single trajectory of change in the history of U.S. hospitals as a whole, and no consistent underpinning of political values, the ideas attached to hospitals and their policies may fluctuate widely between generations and sometimes between hospitals as well. Hospitals do not necessarily have to choose, once and for all, whether to be "public" or "private," profit-oriented or primarily community focused. All these ideas can exist in many institutions simultaneously. They are, as it were, a bank to be drawn on as conditions change.

The present mood among administrators, regulators, and providers suggests a dangerous indecision about what hospitals should be, an indecision that could stymie growth and waste time and money. Yet it is certainly possible to design modern community service systems that offer Americans health care technology with the same efficiency that they are offered electricity. And systems can vary from place to place.

Hospitals will always be more than just factories for treatment. They are social institutions through which the moral values of a nation are expressed. What U.S. hospitals do in the next decade will help to delineate how America sees itself as a nation: self-serving or caring; rigid and money oriented or technologically innovative in service provision. Hospitals are, after all, organizational chameleons.

Rosemary A. Stevens is dean of the School of Arts and Sciences at the University of Pennsylvania, Philadelphia. She is author of In Sickness and in Wealth: American Hospitals in the Twentieth Century *(Basic, 1989). This article was adapted from a lecture Professor Stevens delivered at the American Hospital Association Annual Meeting in July 1990.*

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$30,000 it can routinely cost to treat just one stroke victim, you can see where the savings come from.

Yet the government will not reimburse us for these prevention programs. And the more aggressively and efficiently we pursue these efforts, the more we slowly shrink our market share. That's the great irony: we need to keep the occupancy rate of the hospital up because that is how we fund all of our outreach programs. Yet the goal of these outreach programs is to keep people out of the hospital. So we're stuck.

Are you saying that the hospital is caught in a paradox: either do good or make good?

have to be willing to tie your fate to the community. We now have a program where high school students attend classes here at the hospital after school and work in different areas of the hospital. Then if we have openings, we hire them. We are getting good employees, and the kids are getting training in a field that is growing: health care.

What you are describing sounds like an informal partnership. Is that how you see it?

Everyone needs partners–on an individual and an organizational level. When I look back on my own journey out of the projects, I can remember several people who were willing to reach out and help me–a coach, a teacher, a counselor. One of the things I see nowadays is that adults are too threatened by teenagers to get involved. That's one reason we want to start a mentoring program to get these two groups together. We've recently received a grant from the Commonwealth Fund to start a school-to-work transition program, a sort of mentoring program for 50 high school students. The program will pair high school students with individuals, not necessarily hospital employees, who would work with them for a period of four years and be concerned about their homework and behavior at school. We plan to develop a business sponsorship that would come from outside the hospital. That is, to get not only the partner in the law firm or the executive to be a mentor but also to get the companies to provide young people with employment, advanced training, or financial support for college.

I want to create a network of participants, stringing together various organizations and players, each of whom have something special to contribute to urban problems. After all, a community is nothing more than a set of relationships. If you reach out and create a lot of partnerships, what you are really doing is creating a community.

Reprint 92602

GREATER SOUTHEAST HEALTHCARE SYSTEM

In 1955, concerned citizens formed the Greater Southeast Community Hospital Foundation, Inc. The Foundation's mission was and continues to be the improvement of the health status of its community by fostering high quality, cost effective health and health related services. The Greater Southeast Healthcare System has evolved into a system of hospitals, nursing homes, adult day care centers, pharmacies, and community service programs. Through its integrated network the system provides comprehensive health care services to more than 600,000 residents in the District of Columbia and Maryland.

Vital Statistics

Employees:	DC-2,309	MD-405	Admissions:	DC-16,057	MD-342
Hospital Beds:	DC-450	MD-33	Nursing Home Residents:	DC-366	MD-150
Home Health Visits:	DC-16,245	MD-3,718	Births:	DC-1,669	
Ambulatory Surgical			Emergency Room Visits:	DC-45,061	MD-15,799
Procedures:	DC-3,811	MD-2,824	Outpatient Encounters:	DC-28,106	MD-14,758

Operating Entities

Five entities, including the Greater Southeast Community Hospital Foundation, Inc. comprise the Greater Southeast Healthcare System. The Foundation governs the system and serves as a catalyst for economic development throughout its service area.

The Greater Southeast Community Hospital (GSCH)

Greater Southeast Community Hospital (GSCH) is a 450-bed acute care hospital located in southeast Washington, DC. More than 1875 employees support the hospital; 470 physicians have staff privileges. GSCH provides services in medical and surgical specialties, obstetrics and gynecology, psychiatry, pediatrics and 24-hour emergency services.

The Fort Washington Medical Center (FWMC)

The Fort Washington Medical Center (FWMC) serves residents of southern Prince George's and Charles County, Maryland. With 33 inpatient beds, FWMC provides general and surgical services, outpatient surgery, 24-hour emergency room services, home health services, a pharmacy, complete laboratory and radiology testing, and community education programs.

Center For The Aging (CFA)

The Center for the Aging (CFA) is a model for state-of-the-art gerontological programming. The Center provides a continuum of care to the elderly in Wards 6 East, 7 and 8 in Washington, DC and Prince George's and Charles Counties in Maryland.

The network of selected services for the elderly includes the Health Care Institute (HCI), a 183-bed nursing home and the Multi-Service Senior Center (MSSC), providing comprehensive medical adult day care services—both located on the Greater Southeast campus.
CFA also operates Project KEEN, providing congregate and home-delivered meals, literacy training, Call 'n Ride, transportation, recreation, health promotion, counseling and respite care to residents of Ward 7. CFA manages the Washington Senior Wellness Center, a multi-faceted health promotion program, whose primary mission is to lead older people to take charge of caring for themselves.

The Washington Post

May 29, 1991, Wednesday, Final Edition

SECTION: METRO; PAGE D1

Barry Passett

LENGTH: 1084 words

HEADLINE: A Helping Dose for the Poor;
SE Hospital Tries to Break Pattern of 'Crisis' Care for Children

SERIES: Occasional

BYLINE: Amy Goldstein, Washington Post Staff Writer

BODY:

In the noisy emergency room of Greater Southeast Community Hospital, Leroy Butler, 5, curled himself into his mother's lap one recent evening with a headache, a sore throat and a 104-degree fever.

He had been sick since midday with the kind of symptoms that prompt many parents to call their pediatrician for advice. But Lisa Butler, a 19-year-old Eastern High School senior who lives in Congress Heights, doesn't have a private doctor for her son. So she called an ambulance to take them to the nearest hospital emergency room.

She didn't have a car and didn't have anyone else to take them there, she said, as she stroked Leroy's sweaty skin, "and he needed to get here fast."

Their emergency room visit is an example of the erratic way some parents find medical care for their children in low-income neighborhoods east of the Anacostia River.

It also is an example of the burden in money and patients that drove Greater Southeast into a novel effort to improve medical care for children -- medical care that hospital officials, doctors, educators and city health administrators say is fragmented and sparse.

With a $ 139,000 grant from the Robert Wood Johnson Foundation, hospital officials are beginning a study with city and school administrators and community leaders. The idea is to find ways to improve access to doctors and coordinate health care for the 10,300 children, like Leroy, who qualify for Medicaid and others who have no health insurance at all.

Hospital emergency rooms, private pediatricians and public clinics do not now share medical charts. And once infants leave the hospital, there is little systematic way to follow premature babies or those born to women who are drug-addicted or had no prenatal care.

Officials involved in the year-long project will consider how to get more children eligible for Medicaid to visit the doctor, including improving transportation and offering more medical services closer to where children live, perhaps in churches, apartment complexes or elementary schools.

The study will explore an electronic method of transferring patient records between public clinics and the hospital. It also will examine whether clinic physicians, who lack hospital admitting privileges, can continue to treat their patients after they have been hospitalized. And it will consider whether a wider range of medical personnel can become eligible to treat children who qualify for Medicaid. "If you can do it here, you can do it anywhere," said Thomas W. Chapman, president of Greater Southeast.

The Ward 8 neighborhoods surrounding Greater Southeast -- like those just over the Prince George's County line -- have particularly unhealthy children.

Ward 8 has the city's highest number of pregnant teenagers, the greatest proportion of premature babies and the largest number of infants who die before their first birthdays.

The ward also leads the city in the number of children and teenagers with AIDS -- 13 by the city's latest count. And only one-third of the ward's children have had immunizations recommended by the time they turn 2.

The patterns of poor childhood health partly reflect a shortage of doctors. The communities of far Southeast Washington have 25 percent of the city's children but only 6 percent of the pediatricians, according to planners at Greater Southeast.

And although Ward 8 has the city's largest number of poor children, only one of the District's 15 city-run clinics is situated there. With too many patients and too little time, "I fear I am not doing an adequate job," said Bertolome Javate, who has worked as a pediatrician at the clinic in Congress Heights for 15 years. "I feel frustrated and scared."

Some parents lack the money, time or knowledge to take their children for regular checkups.

"They are more or less crisis-oriented," Javate said. "The basic areas -- food, clothing and shelter -- come first." On a typical afternoon, he said, half the parents who have made appointments for their children at his clinic do not

show up.

"You develop a mentality [in which] you delay," said Randall McKennie, director of the District's first school health clinic, which opened last fall at Ballou High School in Congress Heights. "That child better be bleeding. That child better have pneumonia, [because] they don't have the money to get there, not [bus fare of] 85 cents."

The scarcity of pediatricians and preventive care means that Greater Southeast's emergency room often is the doctor's office of first resort. Nearly 40 percent of the children treated there do not have emergencies, hospital officials estimated.

Butler said she has brought Leroy there three or four times. Tanys Willis, 18, who brought in her 15-month-old son, Carl, with an ear infection, said she hadn't gotten a pediatrician even though "my mother was telling me to look for one before he got sick."

Despite the fragmented care, there have been community attempts recently to improve children's health services, the most significant of which has been the long-delayed opening of the Ballou clinic. Greater Southeast and District officials want to find out what effect such initiatives are having on children's health and how they can be fused with other sources of care.

As of the end of last month, the clinic has treated 425 students. It also is providing a glimpse into its patients' sporadic medical histories, said McKennie, the director.

Tony Hinkson, the physician's assistant, said the clinic has detected 10 students who were playing on intercollegiate teams while unaware that they had heart murmurs, and several students who had never known they had sickle cell disease. "We've had kids who couldn't see the blackboard and needed glasses," he added.

When the clinic staff finds a serious health problem, it must refer the student to a specialist. The staff makes the appointments and gives teenagers a referral form they are instructed to return as proof of the visit. But clinic staff members said that students do not always keep appointments and that it can be difficult to find a willing doctor.

In March, Hinkson said, he and the doctor found a breast lump in a student who is pregnant. She still has not had a mammogram to find out if the lump is malignant, nor has she gotten any prenatal care, Hinkson said. She cannot qualify for Medicaid because her parents have no health insurance but both work, he said. "It is a matter of trying to convince [doctors] to see someone for free," he said.

GRAPHIC: PHOTO, TANYS WILLIS HOLDS HER SON, CARL, AS THEY WAIT FOR MEDICAL HELP
FOR THE CHILD. FRED SWEETS; ILLUSTRATION, TWP

TYPE: DC NEWS

SUBJECT: DISTRICT OF COLUMBIA; HOSPITALS; HEALTH CARE FACILITIES AND SERVICES;
CHILDREN (AGE 3-12); MEDICARE; SURVEYS AND POLLS

ORGANIZATION: GREATER SOUTHEAST COMMUNITY HOSPITAL; ROBERT WOOD JOHNSON
FOUNDATION

ENHANCEMENT: STATISTIC

CO: GREATER SOUTHEAST COMMUNITY HOSPITAL; ROBERT WOOD JOHNSON FOUNDATION;

ACH is a member of AHA.

HRC became a member of the ACH in 1988, but this will be confirmed on 7/30 by Janie McGee (501) 320-8300

Sept 1988

This week's Modern Healthcare

AHA Audience

hospital CEO/Administrators
Senior management
VP of nursing - nurse managers
Supply + Purchasing managers
hospital social workers
" pharmacists
Venders - hospital supplies, computers, garments, food, etc.

attracting physician participation will be the key to OPTIMA's success" (Kevin Johnson/Leslie Berkman, L.A. TIMES, 8/4).

*6 FLORIDA: LOW-COST PLAN BEGINNING TO MAKE A "DENT"

PALM BEACH POST reports that a one-day summit will be held in Orlando today to address "some of the most important health care questions that remain unanswered" about implementation of FL's Health Care and Insurance Reform Act of '93 (see AHL, 4/30). As health care interests and state officials meet to "set guidelines for operation of the new health care system," one of the "critical decisions" to be made is defining the content and cost of the basic benefit package. The details need to be worked out by 10/1 when the HIPC boards are scheduled to begin operating. Agency for Health Care Admin. Dir. Doug Cook said he will appoint the first boards in South Florida, the Tampa/St. Petersburg region and Orlando this month. Cook also said he expects the nat'l health plan to be ready within a month, at which time Florida will apply for a Medicaid waiver in order to expand eligibility for its plan (Amy Driscoll, 8/1). TAMPA TRIBUNE reports that appointment of the board members has been delayed because state officials had difficulty finding applicants who didn't have ties to the health care industry. But qualified individuals have come forward recently, and Cook said he expects the HIPCs will still be able to offer health plans by 1/94. The boards must consist of 11 business reps., three consumers and three gov't reps. (Vickie Chachere, 8/4).

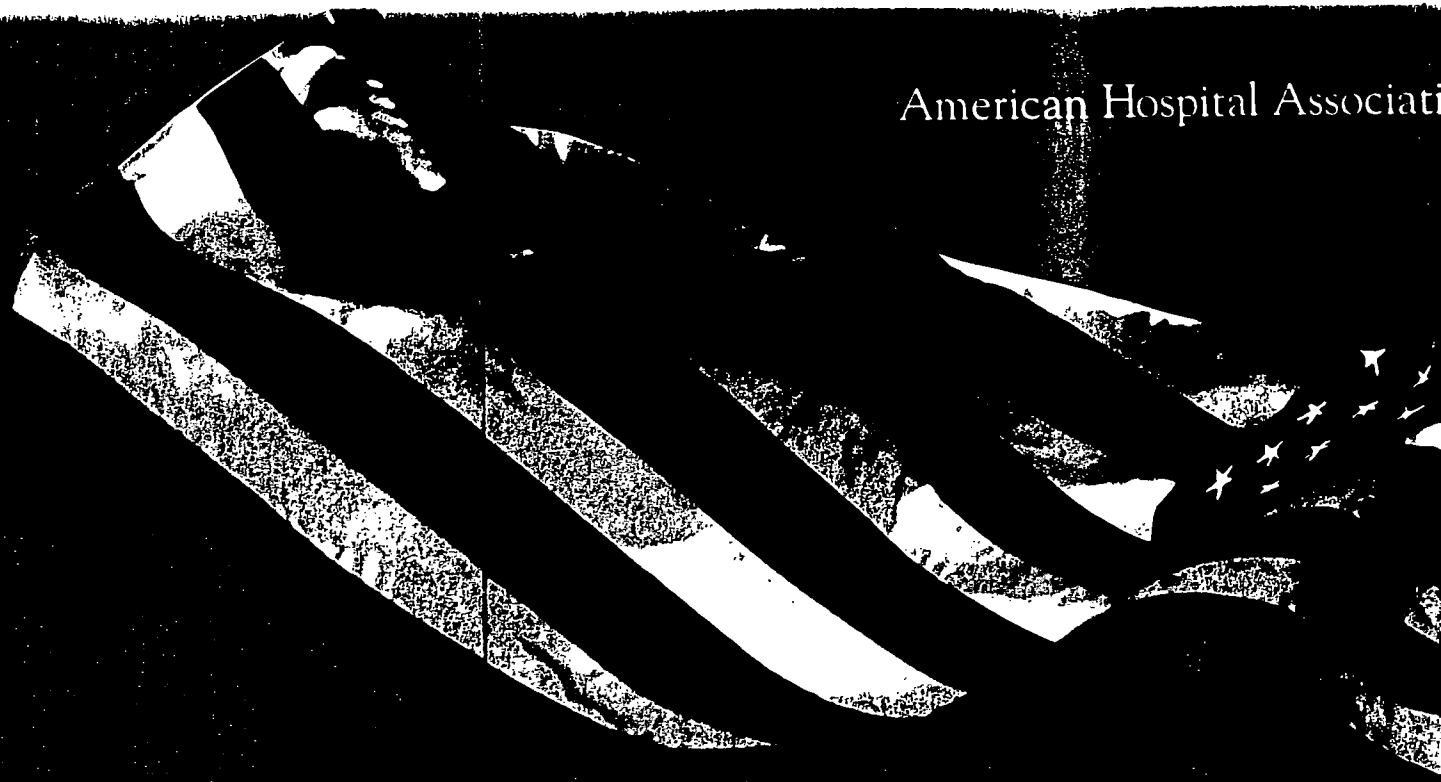
AND FROM THE PRIVATE SECTOR: PALM BEACH POST reports that Access to Healthcare, a low-cost insurance plan, became available in Palm Beach County 7/26. The plan, marketed by Palm Beach County's St. Mary's Hospital and WI-based American Medical Security, first became available in other FL counties earlier this year (see AHL, 5/13). American Medical Security's Gail Choate reports that the insurer has sold over 2,500 policies covering about 7,000 people: "We're making a dent. It is still just a beginning, but it is 7,000 people who weren't insured six months ago. We're really proud of that." Eligible applicants have been uninsured for at least six months. The plan is geared toward small businesses, but is also available to individuals and insured parents who purchase coverage for their children. Individual monthly premiums range from $52-$120, depending on age and gender, with family premiums ranging from $160-$304. Policyholders must receive hospital care from St. Mary's and pick physicians from a list of staff doctors. The policy provides 100% coverage after small copays. Rates vary in other counties where the plan is available. PALM BEACH POST reports participating hospitals and physicians have agreed to accept "substantially reduced fees to help reduce the uninsured populations" (Michael Lasalandra, 7/27). A PALM BEACH POST editorial says the plan "represents another step in the restructuring of Florida's health care system since the plan offers some of the lowest rates in the state and should force down other plans' prices." The hospitals' "goal is to get some payment for many people they're already treating free. The goal of the insurance company, which says the plan is a break-even proposition, is volume and good public relations that brings them new business in other kinds of insurance" (7/30).

*7 MAINE: IS PLAN BEST DEFENSE AGAINST DEFENSIVE MEDICINE?

ABC's "American Agenda" examined the Maine alternative to curbing malpractice lawsuits and reducing the costs of "defensive

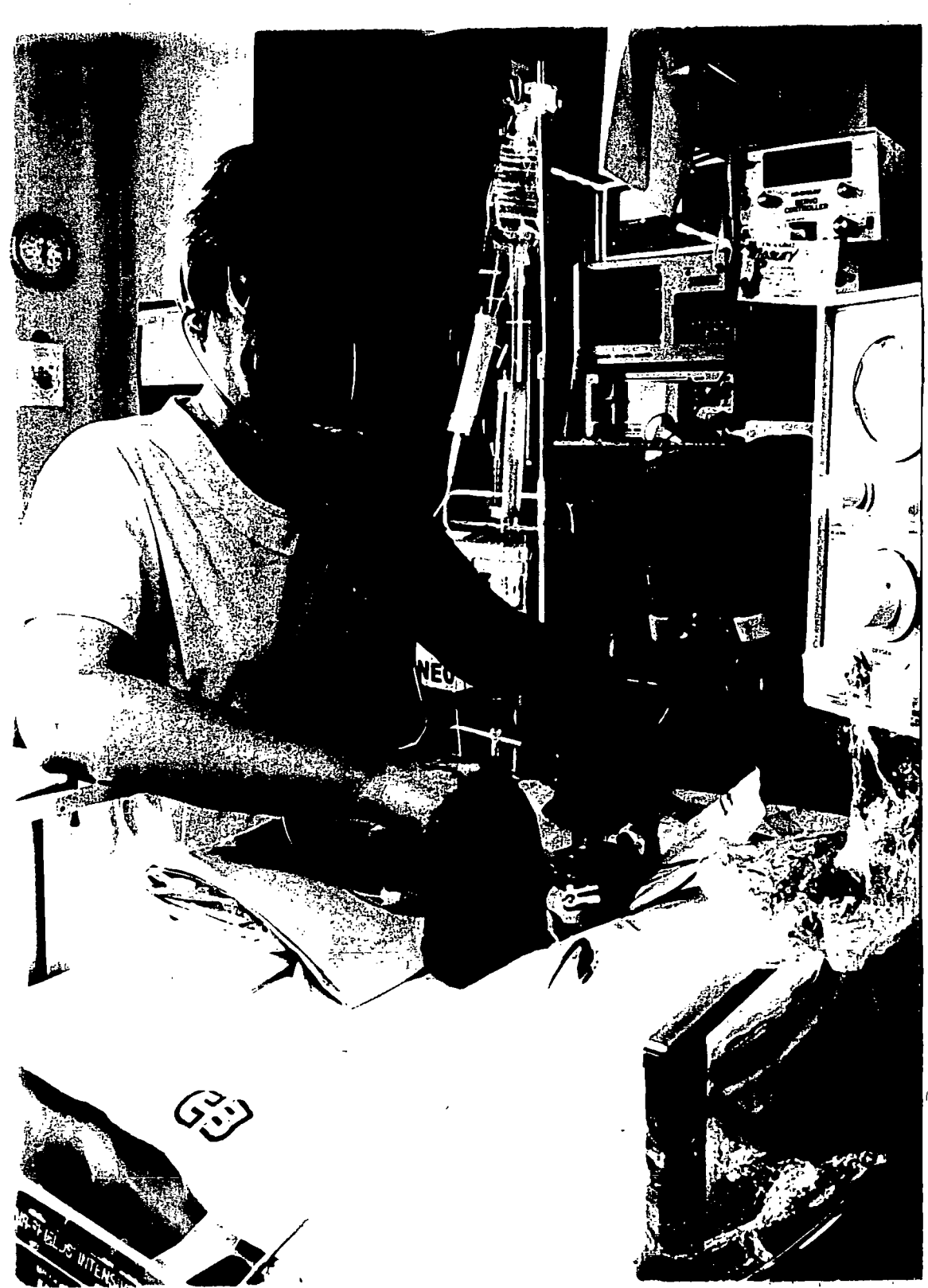
American Hospital Association

American Hospital Associati



Hospitals & Health Care Reform

A National Vision, Community Action



AHA's approach to health care reform is a bold vision.

It is also a sound one.

While our proposal calls for more dramatic changes for hos and other health care providers than most other proposa the changes are achievable. Why? Because they are base fundamental precepts that make good sense, from putting the patient a center of the health care delivery system to making the financial incent driving the system consistent for all providers.

Pioneer spirits have already reconfigured local health care delivery und these principles. Just a few of these efforts are highlighted in this docum It also contains a summary of AHA's proposal and shows how our basic principles are captured in what other major players are advocating. An gives you a test for measuring the strength of our health care reform pr posal against the most pressing problems in health care. The AHA visi passes with flying colors.

Take a few minutes to look through it. Share it with others. It is designe to help us take the next step toward reform—to be just as bold in wor to implement our plan as we have been in designing it.

Dick Davidson

RICHARD J. DAVIDSON, President
American Hospital Association

The American Hospital Association

Vision for Health Care Reform

The American Hospital Association's vision for health r addresses the fundamental flaw in almost every other reform failure to reconcile increased access and restrained costs plan is centered on "community care networks." Althoug form networks would take would differ according to local needs, their premise would be the same: each would offer a seamless health care sy from preventive care to long-term care, so patients would no longer l to patch together their own health care services from a multitude of u nected providers.

Community care networks bring a more rational set of incentives current delivery system by:

- Promoting the health of patients and preventing future, more illness.
- Encouraging collaboration among health care providers to avo duplication of services.
- Conserving health care resources by providing only appropriat necessary care.

AHA's Plan Provides Universal Access to Health Benefit Coverage

All Americans will have coverage for a basic set of services from prev care through long-term care. Those who don't have employer-spo coverage or an individual policy will be covered through an expanded program replacing Medicare and Medicaid. A phase-in period and financial incentives will help make employers able and willing to p coverage.

AHA's Plan is Patient-Centered and Focuses on Keeping People Healthy

As enrollees in local community care networks, patients will no longe to wander unguided through a fragmented system, but will have a entry point for all services needed. Precious resources now spent on

sive paperwork, unnecessary competition, and the administrative demands of multiple payers can be dedicated to improving patient care. All incentives will be geared to keeping patients as healthy as possible, emphasizing prevention, primary care, and wellness, and to improving the entire community's health status.

AHA's Plan Provides Integrated Care

Services of hospitals, physicians, and other providers will be offered as a package. Government, businesses, and individuals will contract with community care networks to provide care for enrollees, and the network will be paid a set annual fee for each enrollee's health care.

Exactly how a network will be organized and what role hospitals play will depend on what best suits the needs of the community the network serves. Hospitals, physicians, and private insurers could own and operate networks or co-own them with other providers. Or they could serve as providers of services under contract with a network.

AHA's Plan Contains Costs

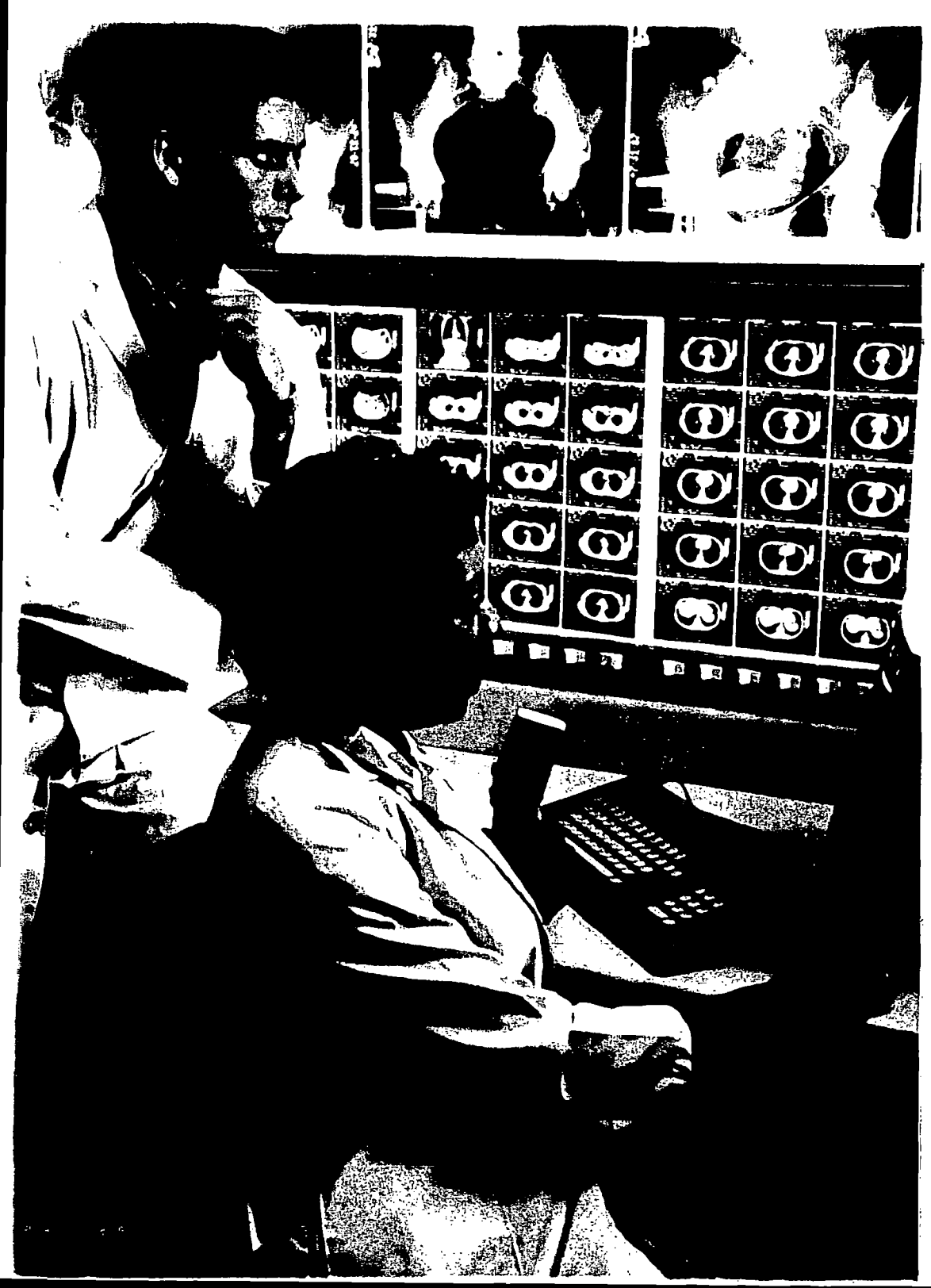
Community care networks will help to reduce the rate of health care cost increases. When providers are paid as a group, they will act as a group to monitor the use of health care resources and avoid unnecessary care. Over

time, excess capacity and duplication of services and technology w eliminated, bringing the "medical arms race" to an end.

The AHA proposal calls for an independent national commissio would determine a comprehensive set of basic health care benefits. W commission's advice, Congress would set a target figure for public pr expenses. The commission would translate this figure into a set of s that the money would cover, taking patients' and providers' need account. The decision-making would be open to public scrutiny and make plain the trade-offs that budget decisions require. The set of s covered under the public program would be the minimum that must b ered in the private sector.

AHA's Plan Can Be Phased In

AHA's vision builds on what is familiar—health coverage through e ers for those who are employed, and government coverage as a safety those who are not or who cannot afford private coverage. It would p what is best about our system, and, in an orderly, step-by-step fash what needs fixing. As interim steps, AHA encourages federal legisl implement antitrust, insurance, and medical liability reform; reform state level; and the development of provider networks at the com level.



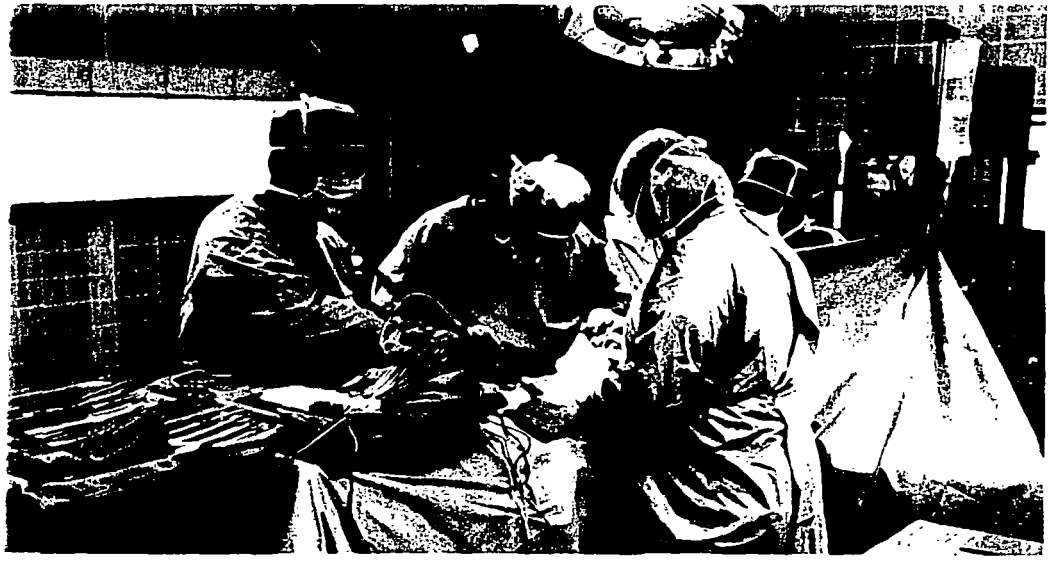
The Evolution of the Debate and AHA's Approach

Concern about our country's health care system has reached
cal mass. That is, enough segments of our society have
their attention to it, from Washington think tanks and c
sional leaders to health care providers and insurers, fro
President of the United States to the man on the street, that action is

In fact, action is likely this year, now that both the White Hou
Congress are in Democratic hands. The pressure is on, as voters made
to put aside political wrangling and get down to business in solvi
nation's problems. Quite a bit of progress has already been made, stim
and supported by congressional study commissions, academic paper
plans crafted by providers, business, and insurers. One of the most e
aspects of this progress is the degree to which there is emerging agre
on basic approaches.

For example, toward the end of 1992 the political debate on healt
reform moved from the edges of the political spectrum toward the
While earlier in the year we heard quite a bit from the left about the
ability of a single-payer Canadian-style system, and from the right abo
virtues of market-based reform, by the end of the year we were hearin
and more about solutions nurtured in the middle of the political spe
These proposals were called by many names, from "managed compe
to "rational regulation," but all were centered on the idea of maintain
current pluralistic public-private system under broad governm
parameters.

Even more exciting from the American Hospital Association's p
view is the degree to which the emerging political agreement is com
with our own vision of health care reform. We have crafted an appro
believe not only works better for patients and providers, but has p
viability as well. And, our plan has legs outside of Washington,
because the basic building blocks of our approach are also found i
proposed by business groups, from the Washington Business Gro
Health, representing Fortune 500 and other large employers, to the N
Federation of Independent Business, representing small business.



Our belief that we are on firm ground with our health care reform proposal is reinforced by the fact that other health care interests, including the Catholic Health Association and the Blue Cross and Blue Shield Association, have also proposed plans that are compatible with AHA's vision.

AHA's plan, as laid out in the first section of this booklet, is centered on community care networks. These networks are made up of a range of providers, from hospitals and physicians to home health agencies and nursing homes, that will cooperate in providing the whole spectrum of services a patient will need, from preventive care to long-term care.

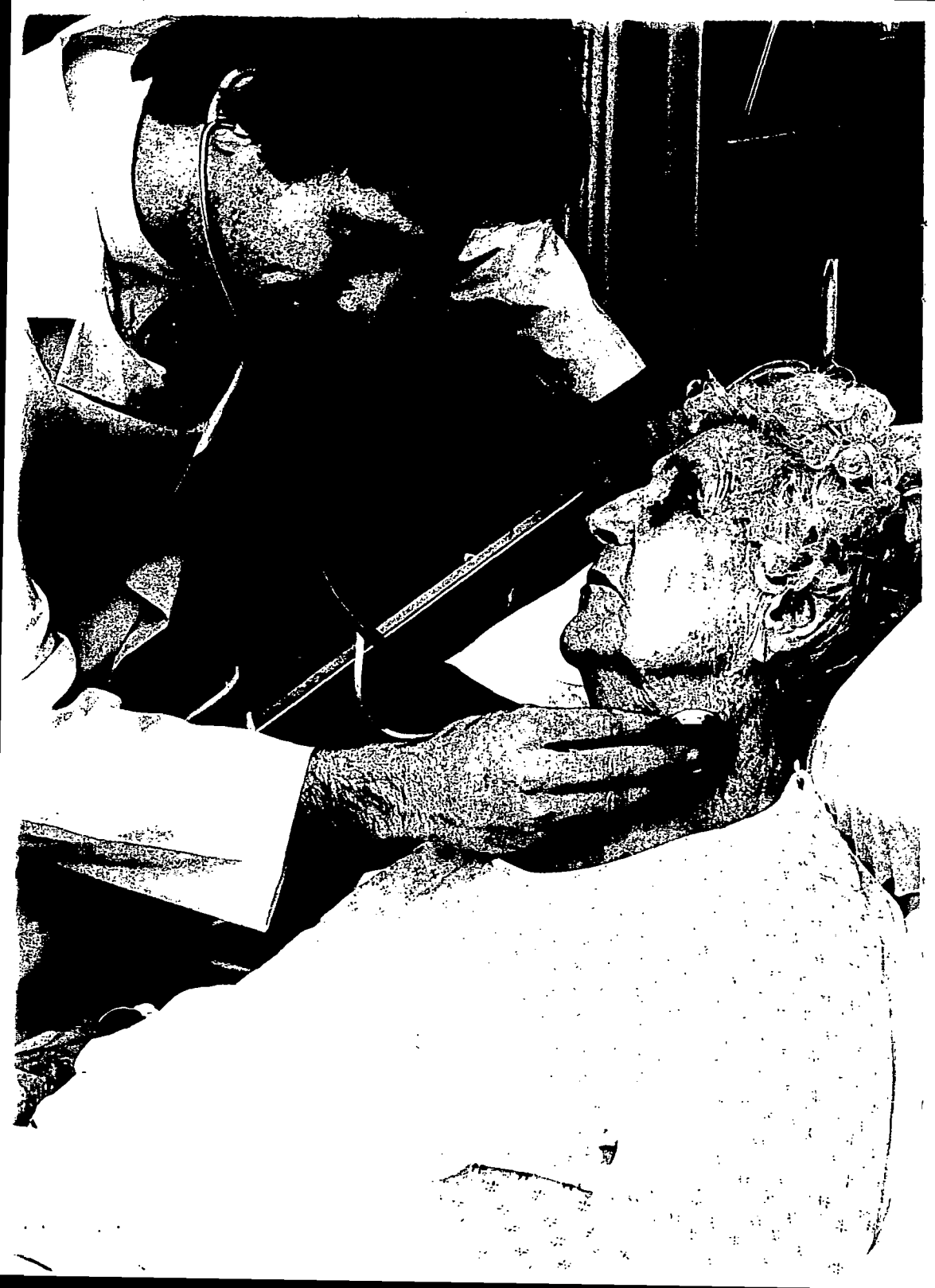
The basic idea of better and more cost-effective care through provider cooperation is echoed in a number of proposals:

- The Washington Business Group on Health proposes "movement towards *organized systems of care*. The detachment and fragmentation in the current delivery system will be replaced by the *integration* of all health care stakeholders."
- The National Federation of Independent Business, representing small business, suggests that "the use of *coordinated care systems* can lead to lower costs and better quality care."
- The Blue Cross and Blue Shield Association suggests in its plan that "services (be) delivered through new *cooperative service delivery arrangements called 'community care partnerships.'*"
- The Catholic Health Association (CHA) proposes "*Integrated Delivery Networks*" to serve patients. As in the AHA approach, the CHA networks would receive capitated payments to encourage an emphasis on prevention and wellness.

- The Health Insurance Association of America calls for increase reliance on managed care delivered through "responsible health systems." These systems would integrate all levels of care and c bine all sources of funding, including government, with the deli of care.
- The American Nurses Association (ANA), while not specifical mentioning networks, does call for a "restructured health care s tem that focuses on consumers and their health." The ANA pr posal also calls for required use of managed care in a public plan and recommends case management to reduce the fragmentatio of our current system.

There is also a congressional proposal that is compatible with A reform vision in a number of ways. That is the Conservative Demo Forum's health package, introduced in the last session of Congress as 5936. Rep. Jim Cooper (D-TN) is its prime sponsor. The legislation en ages the formation of "*accountable health plans* (AHPs)," partnersh providers and insurers that will be publicly accountable for cost and q of care. AHPs will offer a basic benefit package and be responsible for ing after the total health of individuals. A national board will establis uniform set of effective health benefits and oversee the health m much as the Securities and Exchange Commission oversees the fin market. It will also develop factors for risk adjustment of Accou Health Plan premiums.

In general, the CDF bill echoes the AHA vision for health care ref its call for a restructured delivery system. The bill's "accountable plans" would accommodate AHA's community care networks.



AHA's Approach Addresses Virtually Every Concern Abo Today's Health Care System

This year promises to be a critically important year for hospit the health care environment you work in. Congress, the Ad tration, the public, and providers themselves all agree t must address the significant and growing problems plagui health care delivery system. Such widespread agreement means the o high that substantive health care reform will happen.

Much preparatory work has already been done. On Capitol H Pepper Commission, smaller work groups, and individual Mem Congress all have wrestled with how to make our system work better extensive reports and legislative proposals. President Clinton has pr to put health care reform high on his Administration's agenda, and th strong indications that he will carry out that pledge. While the publ not yet know what specific steps it wants taken, opinion surveys show does indeed believe that fundamental health care reform needs to h And many health care provider groups, including the AHA, have spe months crafting their own reform proposals.

So we are poised on the edge of an extremely critical period for the of our health care delivery system. Hospitals have an important role in this drama. For our patients and the communities we serve, we m our very best to make a constructive and significant contribution health care reform debate. It won't be easy; others are just as determ shape the discussion. But we are well-equipped for the fray with our p based on community care networks. It is a strong proposal becau based on ground-up restructuring of the delivery and financing syste truly believe that its core—delivery of health care through commun networks—is a structure that can see us into the new century.

So serious getting-down-to-business begins. There will be lots of We will have to be prepared to examine other options and measu

against our own to decide whether they further our vision. What method can we use to make this judgment?

There's actually a simple test. It is to formulate a list of our key concerns regarding how we deliver health care today. When you consider a proposal for health care reform, measure it against your own concerns. A strong proposal will be one that solves the greatest number of problems confronting today's "non-system" of providing services.

We can start by making a list of these common concerns and measuring AHA's approach to reform against them. Not surprisingly—because it is so strongly based on logical incentives; because it is so firmly patient- and community-centered — our plan responds to virtually *every* concern raised about our health care system today.

For example:

If we are concerned about putting patients first, about having a truly patient-centered health care delivery system...

The AHA approach does it, through restructuring the system around community care networks that coordinate care, sort out access to specialists, and reduce paperwork hassles for consumers. Other consumer benefits include a payment structure that allows for preventive care and for strengthened community outreach and education.

If we are concerned about replacing micromanagement of health care transactions with an appropriate level of good regulation ...

The AHA approach does it, through its independent national commission that would set a basic benefit package for public programs (that would serve as a floor in the private sector) and broad operating parameters for community care networks. Decisions regarding how to shape networks and what services will be emphasized will be left to individual communities and their health care providers to decide.

If we are concerned about providing affordable universal access...

The AHA approach does it, by extending health care coverage to all through a combination of employer-based and public programs that deliver efficient and effective care through community care networks.

If we want to have a process—in the open—that makes tough choices about health care resources as a society...

The AHA approach does it, through its independent national commission that would gather public input and then shape a basic benefit package for the public program balanced against available resources. A benefit/resource mismatch would be thrashed out through public debate and in the Congress, which would set funding levels upon the advice of the commission.

If we want to reduce paperwork and provide for standardization of reporting, utilization review, and access to medical records...

The AHA approach does it, because coordinated care is delivered through community care networks. This allows standardized record keeping, including setting uniform data requirements and implemen ing electronic collection and sharing of community and patient dat across providers.

If we are concerned about maintaining private medicine at the community leve

The AHA approach does it, because the network concept is flexibl reflecting the needs and preferences of each community. Ownershi and governance of networks could take a not-for-profit, investor-owned, or public form, depending on local values, interests, and pra cal realities. Employer-sponsored private coverage preserves local li between purchasers, consumers, and providers.

If we are concerned about maintaining some appropriate level of healthy competition...

The AHA approach does it, because in most areas consumers woul have a choice of networks as they became available in each commu nity. Required annual open enrollment would ensure that no one is locked into an unsatisfactory network.

If we are concerned about ridding the system of unhealthy competition and moving toward cooperation and collaboration...

The AHA approach does it because it is based on community care networks, which would provide patients with integrated care organized at the community level. Once providers are linked within a network, the financial incentive will be to avoid duplicative facilities and services that have been encouraged by the competitive system.

If we want to align physician, hospital, and other provider incentives...

The AHA approach does it because it makes financial incentives consistent for all providers. Today physicians are paid for each service rendered, giving them an incentive to provide more services. Hospitals, on the other hand, are often paid a fixed amount per patient for each admission, particularly for Medicare patients. Once a patient is admitted, hospitals are encouraged to conserve health care resources by providing medically necessary services, but no more. There is no incentive today, however, to keep people out of the hospital in the first place.

If we want to strengthen physician relations...

Physicians are essential to the formation and operation of networks. Patients build strong relationships with their physicians. For many people, their primary care physician is the first point of entry into the health care system. Networks must actively involve local physicians in order to coordinate and manage patient care. Hospitals, physicians, and others might share in the operating results of their network.

If we want to provide care in a coordinated manner across the continuum of services...

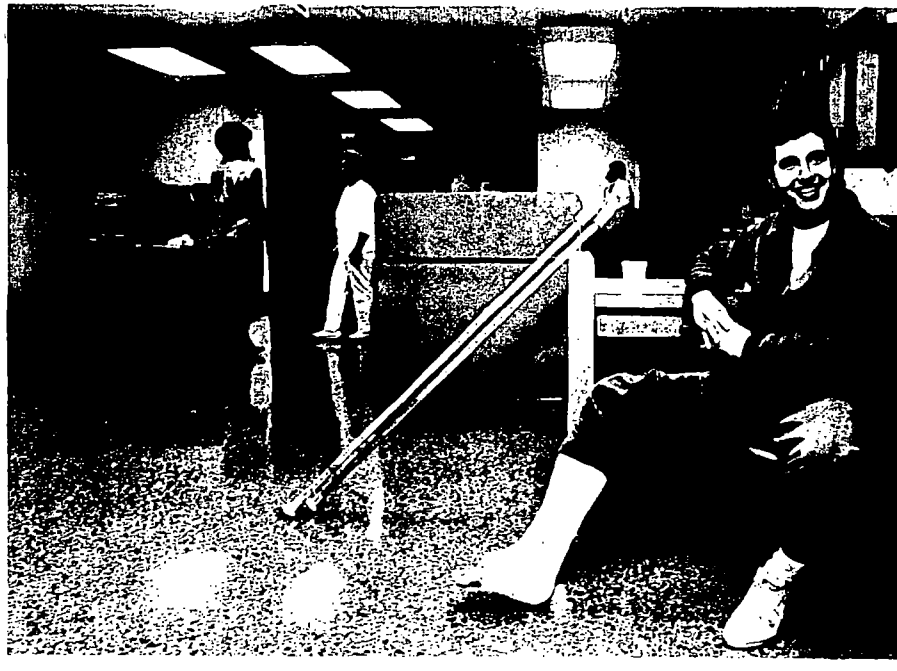
The AHA approach does it because networks would be responsible for providing all of the services covered for their enrolled population and would coordinate patient care over time and across various provider settings.

If we are concerned about the level of infant mortality and other health problems in the nation and in our communities...

The AHA approach addresses it because its capitated payment system provides resources for preventive services and for strengthened community outreach programs. For example, network emphasis will be on providing prenatal services and reducing the incidence of low-birth-weight babies and other risk factors contributing to infant mortality.

If we want to eliminate excess capacity and empty beds in a non-punitive way...

The AHA approach does it because its financial incentives encouraging collaboration and coordination will, over time, reshape local health care resources to efficiently meet local needs.



If we want to eliminate the medical billing system that frustrates consumers an providers alike...

The AHA approach will do it because its delivery of coordinated c through community care networks paid for on a capitated annual b obviates the need for itemized bills.

If we want to reform the health insurance market and eliminate the fly-by-nig operators...

The AHA approach does it because required employment-based co age would be preceded by insurance reforms. Underwriting practice such as pre-existing conditions clauses, designed to avoid rather th manage risk would be precluded. Reinsurance mechanisms and ins ance pools would be developed where necessary to spread risk so th more affordable insurance is available to small businesses and to se employed and medically uninsurable individuals.

If we are concerned about steady improvement in quality of care...

The AHA approach does it because its emphasis on effective care will make use of outcomes research to identify where care currentl provided to patients yields marginal benefit to their health or quali of life. The development and use of medical practice parameters w be essential. Practice parameters use what we learn from outcomes research to improve our understanding of what types of care are appropriate under specific clinical circumstances.

Network Building in Action

The concept of community care networks may seem like a total transformation of the way health care is delivered. But in reality, the seeds of networks exist all around us. While the AHA is gathering support for its vision and encouraging federal and state legislators to take both incremental and major reform steps, individual communities, hospitals, and physicians are demonstrating the benefits of collaboration for patients, communities, and providers.

Instead of permitting conflicting economic incentives to drain already overburdened resources, these pioneers are forging new and productive partnerships at many different levels and in many different forms. These are the true laboratories for health care reform.

Here are some examples highlighting three key characteristics of community care networks: collaboration; a focus on community health status; and capitated, or per person, payment.

Collaboration

St. Patrick's Hospital
Community Medical Center

Missoula, Montana

Less than 10 years ago, St. Patrick's and Community Medical Center were embattled institutions, competing fiercely with one another. Today, they still are competitors but they also are collaborators. Together they developed a mobile lithotripsy network for hospitals in western Montana. Together they joined with the city to form Partners in Home Care, which also operates a hospice program and case management services as separate subsidiaries. And together they just purchased tiny Clark Fork Valley Hospital, a failing rural facility 100 miles away.

The two share high-tech services that neither could afford alone: St. Patrick's bought an MRI and leases it to Community; they share a microwave link to relay results to physicians off-site.

In another joint venture, the hospitals provide managerial support laboratory and emergency services for Partnerships for Access, a com nity-based health care plan for the indigent. The other partners in this ject include 120 primary care physicians and the city of Missoula.

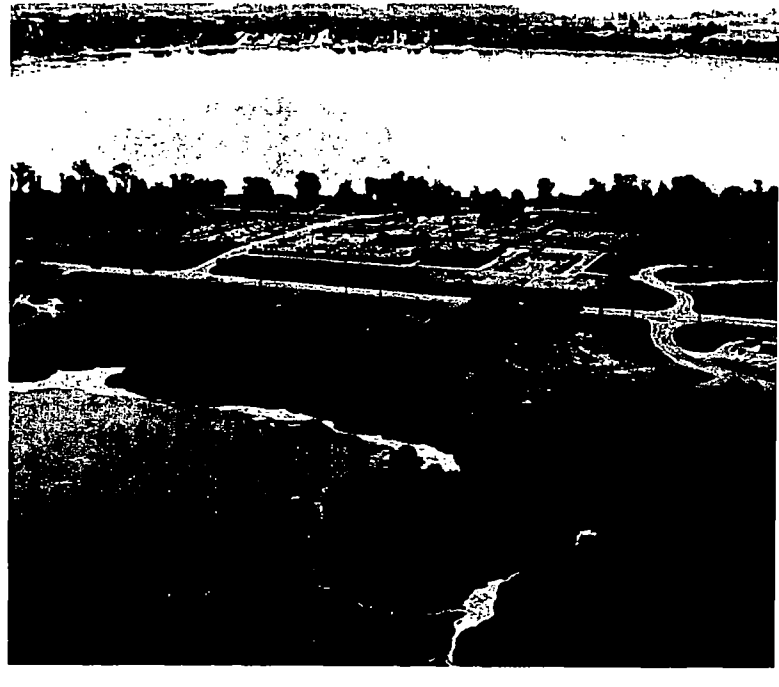
See "Collaboration: Hospitals find that working together is tough, rewarding— vital." *Hospitals*, 12/5/91.

Chisago Health Services

Chisago City, Minnesota

In the mid-1980s, the physicians of the Chisago Lakes Medical Center, and the publicly elected trustees of the Chisago Lakes Hospital Di decided that the best way to meet the challenges of a changing health delivery system and a rapidly growing community was through collabora On June 1, 1986, they combined the resources of the two organizations created a new not-for-profit organization, Chisago Health Services. The corporation leased all facilities and equipment from the hospital distric is governed by a board that reflects both the community hospital and medical practice components. In coming together, the two organiza were able to combine their resources to serve an expanded marketp provide new programs and services, and deliver one consolidated am tory care function. The result was collaborative, total health care delive

Combining the resources of the physicians, clinics, and hospital di



enabled Chisago Health Services to make significant strides in its diagnostic and surgical capabilities and to provide expanded physicians' clinics at two satellite locations. The organization has added home health, occupational health, and rehabilitation programs, and has been remarkably successful in recruiting new physicians, including several medical specialties. Most physicians like the structure because they are freed of administrative tasks and able to focus on patient care.

The mission of the combined organization has been refocused not only to care for people when they are sick but to help keep them well through a growing network of community outreach programs that find Chisago Health Services staff working closely with schools, senior citizen organizations, and other community service agencies. Chisago Health Services also collaborates with other nearby hospitals and physicians' clinics to share physician specialists.

Chisago Health Services operates a 49-bed hospital, a 40-bed nursing home, and three physician clinics, currently has 22 physicians on staff, and employs 600 persons.

St. Mary's Hospital
Cabell Huntington Hospital

Huntington, West Virginia

Back in 1987, the county medical society passed a resolution calling on the two hospitals in Huntington to collaborate in the rational planning and delivery of services. The hospitals have succeeded to a remarkable degree. For example:

- Most of the community's 300 physicians serve on the staffs of both hospitals; monthly medical staff section meetings are held at alternating hospitals;
- the two hospitals provide Level II trauma care on alternating days;
- a free-standing MRI center is a joint venture between the two hospitals;
- a foundation, formed by the hospitals and physicians, among others, promotes the medical services of the entire community throughout the surrounding region.

Each hospital has chosen to concentrate on separate centers of excellence. While they continue to compete for general medical-surgical cases, each specializes in a set of tertiary care services. While the two hospitals have never sat down and formally divided up specialties—a practice that runs into antitrust questions, in any event—they have developed complementary, not competing, centers of excellence.

See "Physicians, hospitals work together to control costs," *Hospitals*, 10/20/92.

Focus on Community Health Status

Greater Southeast Community Hospital

Washington, D.C.

Back when Greater Southeast was a single, acute care hospital, it was gi
away 11% of its care to the uninsured. Simply in order to stay solvent
hospital decided to attack the problems that propelled them to offer
care in the first place: poverty, illiteracy, drugs, violence.

Today, Greater Southeast comprises a network of community-based
ties, including two hospitals, three nursing homes, and a multitude of a
latory programs. Together they have renovated housing, set up day
programs for children and the elderly, started literacy programs and
school mentoring programs and stay-in-school programs. And, they
joined in partnerships:

- with the D.C. public schools and Public Health Commission, to open a health clinic in a local high school;
- with a group of local black churches to provide blood pressure screening in local churches and barbershops;
- with the city clinic to establish better coordination of medical records.

Greater Southeast is still situated in the middle of a community w

nearly a quarter of the residents live below the poverty line. But today the hospital is thriving.

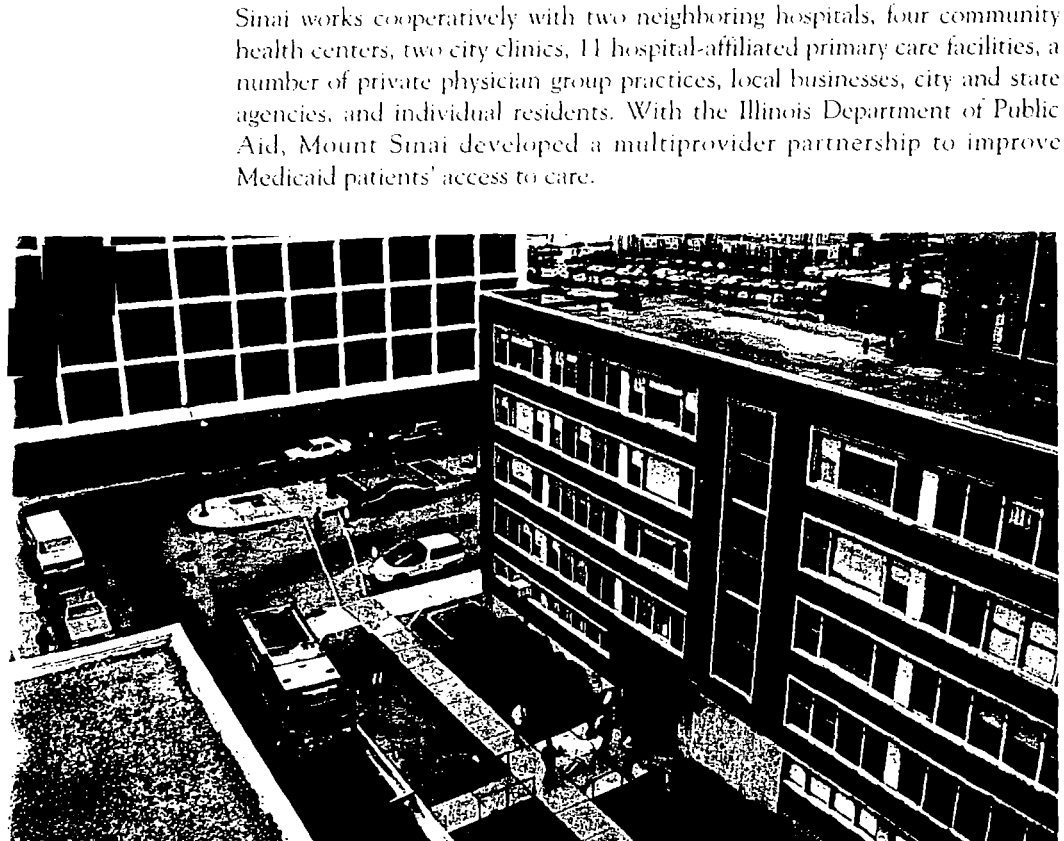
(See "Profits with a Purpose: An Interview with Tom Chapman," *Harvard Business Review*, November/December 1992.)

Mount Sinai Hospital Medical Center

Chicago

In one of Chicago's poorest communities, where poverty, crime, and despair are lasting legacies of the 1968 riots, sits the winner of the 1992 Foster G. McGaw Prize for excellence in hospital community service. Mount Sinai has not only developed extensive primary care programs for its medically underserved neighborhood, but also created jobs, nurtured community organizations, and generated more than $50 million in leveraged funds to improve neighborhood housing and infrastructure.

Its primary vehicle for getting the job done in the community is the community itself. As a member of the West Side Health Partnership, Mount Sinai works cooperatively with two neighboring hospitals, four community health centers, two city clinics, 11 hospital-affiliated primary care facilities, a number of private physician group practices, local businesses, city and state agencies, and individual residents. With the Illinois Department of Public Aid, Mount Sinai developed a multiprovider partnership to improve Medicaid patients' access to care.



Among the reasons Mount Sinai was awarded the McGaw Prize are t

- 17 health centers in senior centers, high schools, and public hou developments;
- targeted health and sex education programs in elementary scho
- and school-based clinics in three high schools that provide direc medical service, education, and case management.

See "Mount Sinai: Good neighbor despite looming capital crisis," *Hospitals*, 8/20/92.

St. Luke's Hospital

Cedar Rapids, Iowa

As one of 49 national demonstration sites for the Hospital Comm Benefit Standards Program, St. Luke's is obligated to demonstrate a sy atic approach to community service. And that is just what it is doing programs such as the Five Seasons Day Care Center—product of a s partner consortium, including corporate sponsors and the school distr and the Child Protection Center of East Iowa, which coordinates se and centralizes access for abused children.

St. Luke's owns and manages 15 rural clinics with 23 physicians manages three rural hospitals. Many of its cooperative endeavors are p private ventures. Take, for example, Healthy Linn 2000, an eight-year to increase the span of healthy life for residents of Linn County, re health disparities, and achieve access to preventive services for all sponsored by the Linn County Health Department in conjunction St. Luke's, Mercy Medical Center, the United Way, and numerous c organizations.

Likewise, St. Luke's community programming has multiple fu sources, including local, state, and federal government, national and charitable organizations, and patient fees. St. Luke's contributes ap mately 20% of the $2.6 million needed to support community out efforts, along with in-kind services.

Capitation

Ochsner Medical Institutions

New Orleans, Louisiana

The Ochsner Medical Institutions are a physician-directed integrated h care system that is a half-century old. It began in 1942 with a 19-m group practice. Today it includes a 400-physician group practice, a n profit medical foundation, a 532-bed teaching hospital, seven New O metropolitan area neighborhood primary care clinics, a regional mult

cialty clinic in Baton Rouge, with its own neighborhood clinics, and a closed-practice HMO serving both cities.

The Ochsner Health Plan is a 60,000-member federally qualified HMO that is jointly owned by the foundation and group practice. The largest HMO in the state, it provides everyday family care to its members as well as the specialty care for which Ochsner has always been known. The HMO has been the vehicle for the significant increase in the number of primary care practitioners in the Ochsner system.

Key to the success of the Ochsner Medical Institutions is close coordination among the hospital, the group practice, and the HMO. A 24-member joint governing board composed of the clinic's nine-member board and the foundation's 15-member board directs the overall system. Traditionally, the CEO of the foundation and the Medical Director of the clinic have been the same physician executive. With this organization, differences are easily reconciled, financial and utilization incentives are aligned, and the organization is able to provide patient-centered seamless care.

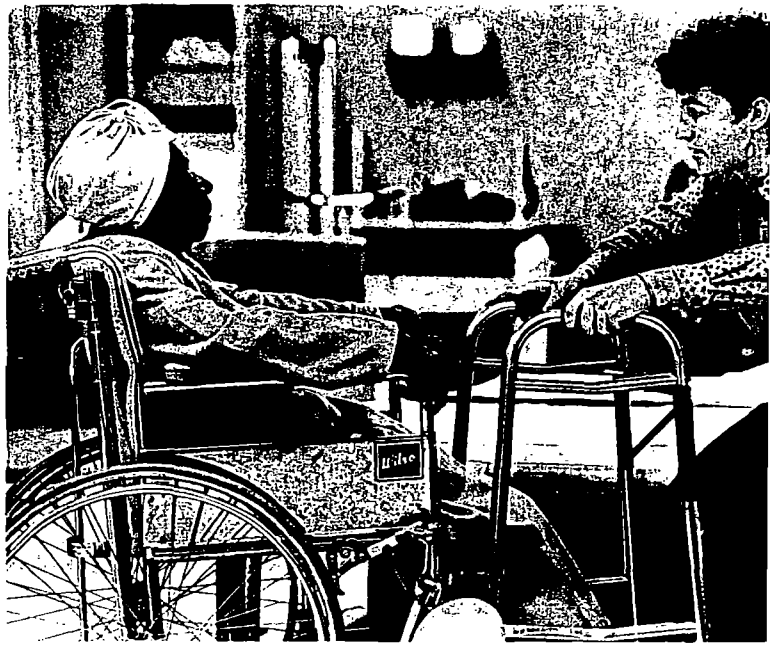
Group Health Cooperative of Puget Sound

Seattle, Washington

One of every 11 residents in Washington state and north Idaho, close t
a million people, belongs to Group Health Cooperative of Puget S
(GHC), making it the fifth largest nonprofit HMO in the nation— an
largest consumer-governed health care organization. Enrollees who p
extra $25 lifetime membership fee are eligible to elect the all-cons
Board of Trustees. Consumer committees regularly review quality mea
and consumer advisory councils monitor operations. All of which ha
Dr. Arnold Relman, retired editor of the *New England Journal of Me*
to call GHC "my model of the future...With patients right on the
of directors monitoring them, doctors are committed to the highest q
of care."

All of the enrollees—whether employer-paid, individual, Medica
Medicaid—receive comprehensive coordinated medical care for a fixed
paid fee with minimal copayments and deductibles. This includes a
range of preventive care and community health services. GHC offer
vices through its own facilities—including 29 primary care or family me
centers, two hospitals, an inpatient center, a skilled nursing facility, an
specialty medical centers—as well as 30 other major institutions with
it contracts for other services.

Because Group Health Cooperative of Puget Sound is
an insurer and a provider, its incentives are to provide the most appro
cost-effective care: if patients get sick, GHC must pay. In 1991, the o



zation had earnings of $25.4 million on revenue of $704 million. One other sign of its success: turnover among its medical staff of almost 1,000 is just 4–5 percent a year, compared with a national average for large group practices of 5–12 percent.

Southwest Catholic Health Network

Phoenix, Arizona

A 50-50 joint venture formed in 1985 by two Catholic health care systems (St. Joseph's Hospital and Medical Center in Phoenix, and Carondelet Health Care Corporation in Tucson), SCHN offers two managed care plans, both of which are subsidiaries. Pascua Yaqui Health Plan, with some 3,300 members, has a contract with the Indian Health Service. Mercy Care Plan, with 68,000 potential enrollees, is one of 14 capitated plans serving Arizona's Medicaid population.

Mercy provides full-spectrum care on a prepaid capitated basis. The plan is at financial risk for its enrollees' health care costs. However, there are a limited number of stop-loss measures if Mercy exceeds reinsurance thresholds, as might happen with members in special catastrophic categories such as AIDS patients.

Within the network, primary care providers are also paid on a capitated basis, but specialists are reimbursed on a discounted fee-for-service basis and hospitals are reimbursed on a discounted charge basis according to a state formula. As for co-payments, patients are charged $1 for each office visit and $5 for each visit to an emergency department.

Contra Costa Health Plan

Contra Costa County, California

This county-based HMO serves a diverse cross-section of the San Francisco Bay community: county employees and their families, the medically indigent, the elderly, and small-business employees in the private sector—some 23,000 in all.

Contra Costa Health Plan is one of eight operating divisions of the county's health services department, and most of its medical services are provided by county facilities. But CCHP also contracts with private hospitals for some emergency care and for some specialty care. It has established satellite geriatric clinics with the help of businesses, cities, and John Muir Hospital; and it is talking with school districts about starting school-based family practice community clinics, which also would serve as vocational training sites.

CCHP is a prepaid health plan, with discounts for non-smoking group members, single parents, and children-only coverage. Physicians are salaried county employees, but outside providers are paid using the Medi-Cal rate schedule on a per-diem/per-case basis.

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America's Hospitals and AHA:

The work we do together...

American Hospital Association

Report to Members

1991–1992

American Hospital Association

It's been a privilege over the past year to help shape hospitals' response to the many challenges that face us—legal, regulatory, legislative—and it's a privilege to work with each of you. My experience since joining the AHA has reinforced something I've believed for a long time: there are no finer people than the people who work in hospitals. My AHA duties give me wide scope to collect the evidence to prove that this is so, from coast to coast and border to border. In these travels, I have been singularly struck by the dedication, caring, and resourcefulness that you bring to your work.

This report is different from the annual reports of the past. Rather than a list of accomplishments, it focuses on a few issues that made a difference for us all. It highlights the work we do together in creating the best possible environment for patient care. I'm proud of our joint efforts to define and to solve problems. As we've worked together, we've gotten to know one another better; we've fashioned a health reform banner we can march under; and, we've begun to nurture a sense of hope and optimism for the future.

These are the pre-eminent accomplishments of the past year. They are the foundation on which all others will rest. Given the strength of our reciprocal relationship, I feel certain those accomplishments will be many.

Dick Davidson

Richard J. Davidson
President

Health Care Reform: Those marble steps are getting crowded...

A funny thing happened on the way to reform. We used to be climbing those marble steps in Washington pretty much by ourselves to talk to lawmakers about delivery system gaps and government payment inadequacies. Now the path to lawmakers' doors is downright crowded with folks concerned about health care for the American people. When AHA members talk to their elected representatives, they no longer have 10-minute courtesy calls. Instead they often have half-hour or longer sessions with representatives who are eager for information, looking for ideas on how to make the health care system work better.

All of us, AHA members and staff, have devoted a tremendous amount of thought and energy to just that task—defining an improved health care system. We started at the very beginning, asking, "What are the fundamental characteristics that we think our health care system should have?" We agreed on universal access to a basic set of benefits as a foundation. Then we asked, "How can we structure the system to deliver these qualities, also keeping in mind cost containment?"—because the political discussion makes clear that health care reform is not going to happen absent cost containment.

We have shaped the answers to these questions into a plan we can be proud of. Unlike virtually every other proposal on the table, our reform plan allows us to increase access *and* restrain costs. Our plan also returns a large measure of responsibility for our communities' health back to where it belongs, to the local level. It challenges hospitals, in cooperation with other providers, social service agencies, schools, and other community organizations, to work

The issue is no longer whether *reform will occur, but rather* what *and* when. *AHA's position in the debate is strong. It is carefully thought out and has societal benefit, not simply the self-interest of hospitals, as its aim. To remain credible in the process, however, we must consistently demonstrate hospitals' community benefit. That is the way to earn—and to keep—the public's trust.*

C. Thomas Smith
President and
Chief Executive Officer
Voluntary Hospitals of America
Irving, Texas

together to shape a delivery system matched to local needs.

We're not naive about this process. It can't be accomplished overnight and without some sacrifice and some dislocation. But the potential benefits are greater than the negatives. Our colleagues who have already moved toward collaboration and networking show it can be done and that the rewards for doing it are significant.

Any of us inclined to stick with the status quo should give some serious thought to what today's trends mean for hospitals tomorrow.

Hospitals as Advocates: Illuminating the achievements and the problems

"When hospitals bring an elected official into their facility, it can change that person's whole perspective," says John Russell, president of The Hospital Association of Pennsylvania. "He or she sees both unbelievable achievements and serious problems. That's what is getting the attention of the lawmakers we deal with."

Pennsylvania has been in the vanguard of developing an organized effort to tell the local hospital story to elected representatives through hospital visits and other direct contacts. AHA listened to Pennsylvania's experience and that of other states with similar grassroots efforts when we developed our national grassroots advocacy program—WHIP—Working with Hospitals to Influence Policy.

AHA WHIP has a number of initiatives, some already implemented, some still in the planning stages. An early success has been Legislative Advocacy Workshop Sessions, or LAWS—three were held in 1991. Hospital leaders from com-

munities represented by especially influential Members of Congress in the areas of health policy and funding were brought together for two-day training programs. Sessions covered the nuts and bolts of political advocacy as well as the latest legislative developments in relevant health care issues. LAWS participants drew up "tactical action plans" as part of a coordinated national strategy to advance AHA's legislative agenda.

This targeted approach, drawing on the strengths of members and allieds, paid tangible dividends. Thanks in part to participants' contacts with key lawmakers, final Medicare capital PPS regulations were markedly improved. (Other AHA members were able to influence the process as well, through special briefings on the proposed regulations and AHA-crafted software that allowed members to estimate impact on their institutions.)

We worked hard to advance hospital—and by extension, patient—interests in other areas as well, with Medicaid adequacy a particular target. We argued that while a long-term solution to the medical indigency problem is needed, Medicaid reform is essential in the near term. At the federal level we worked for improvement in Medicaid coverage, and, at the state level, supported court challenges to redress state underpayment. And, when hospitals were threatened on the federal level with an abrupt cutoff of Medicaid payments raised through state donation and assessment programs, we successfully fought for a transition period. Ultimately, however, we believe that care for the poor is a broad social responsibility and that programs to finance such care should spread the obligation as widely and equitably as possible.

To further strengthen hospitals' voice in federal policymaking, we have increased our visibility in the presidential campaign. AHA spoke for hospitals in several health care forums and candidate debates in primary states, and we continue to convey the hospital viewpoint to the nominees' campaigns. Members presented AHA's reform plan to the platform committees

The LAWS workshops are an excellent method of educating "grassroots" hospital advocates, allowing us, in turn, to better educate "the Hill." The final Medicare capital regulations are just one example of LAWS' success. The impact on our hospital was significant—$10 million or more in reimbursement due to the expansion of the "old capital" definition. As a sole community provider, we also do better with new capital. The field's grassroots lobbying effort on capital meant a big difference to our hospital.

Philip H. Fisher
President
Valley View Regional Hospital
Ada, Oklahoma

of both major political parties. And, we had a presence at both political conventions, through messages in convention periodicals and through special high-visibility activities. In addition, convention delegates with a special interest in health care received a light-hearted convention "survival kit" containing over-the-counter remedies for headache and heartburn. It was designed to increase exposure for AHA's health care reform plan, which was described in a brochure in the kit. A similar kit was sent to national political reporters covering the campaign and to presidential campaign staffs.

As our members increase their political activity, those from tax-exempt institutions wanted to be sure they complied with federal law. To answer their questions, we developed a straightforward summary of federal guidelines covering political activity, including lobbying and PAC fundraising and disbursement issues.

LAWS workshops and other grassroots advocacy efforts will continue this year. As more and more members take part in them, our advocacy effectiveness will continue to grow.

Advance Directives: Not just another regulation

Late in 1991, the Patient Self-Determination Act went into effect. The legislation requires hospitals to develop policies and educational programs on advance directives—documents such as living wills and durable powers of attorney for health care—that set out individuals' wishes concerning future medical treatment if they are unable to express them when seriously ill.

The act could have been just another regulation to comply with, just another administrative headache. But AHA and its member hospitals saw it as an opportunity for members to demon-

strate community leadership on an important issue, one that touches many families, and has multifaceted implications for hospitals, too. So we prepared an information packet giving hospitals ideas on how to educate staff, first, on the requirements of the law, and then on how to go out into the community and talk about advance directives and the difficult issues surrounding care at the end of life.

Hospitals took this community service opportunity and ran with it. The response to these award-winning materials, titled "Put It In Writing," was tremendous. In addition to complimentary copies sent to every AHA member and members of the American Society for Health Care Marketing and Public Relations, 3,500 more packets were ordered—by hospital attorneys, members of ethics committees, social workers, and by a wide variety of community organizations as well. And hospitals have ordered more than half a *million* copies of the public education brochure.

AHA provided members with other help in complying with the law, too. We aired two teleconferences, one five months before the regulations went into effect, and the other just after the implementation date, addressing some of the specific operational problems the requirements were generating. We also produced a video for hospitals to use in helping patients understand the value of executing advance directives. And, we worked with the Hastings Center, Briarcliff, NY, and the Education Development Center, Newton, MA, to distribute "Decisions Near the End of Life." This intensive on-site training program is designed to improve the way caregivers help patients and their families make end-of-life ethical decisions.

AHA's "Put It In Writing" was designed to do what all our communications materials and educational programs are designed to do—to put practical tools in your hands to help you better serve your patients and communities. To help you get through challenging days in the most effective and efficient way possible, and still

As usual, the AHA gave us a head start in dealing with a new regulation and helped us turn it around to an advantage for the hospital. The material on advance directives made a complex and sensitive subject very understandable, and the fact that we got it eight months in advance of the law's implementation date helped us be proactive in training our staff and starting to educate our patients and community.

Nancy Brooks
Director, Social Services
Palos Community Hospital
Palos Heights, Illinois

keep abreast of new trends, ideas, requirements. And when we can help you transform a potential administrative headache into an opportunity for community service, as we did with advance directives, that's best of all.

It has long been the philosophy at Franklin Regional Hospital to be more than just an institution where people come when they are ill. From the calls and letters we receive from hospitals nationwide, wanting to know more about our programs, I feel that there is a renewed awareness and a strong commitment by hospitals across the country to take a leadership position in community service. That we have been a part of this process is not only extremely gratifying to the board, medical staff, and employees at Franklin Regional Hospital, but is a real source of pride for those who live in the communities we serve.

Harry Shanelaris
President, Board of Trustees
Franklin Regional Hospital
Franklin, New Hampshire

Hospitals and Community Service: A whole lot is happening

What happens when a 49-bed hospital serving a three-county-wide economically depressed area decides to tackle a higher-than-average cancer rate, a 50 percent low-birth-weight rate, the complex issues surrounding child abuse, the needs of the 15 percent of its service area population 65 years or older? A lot can happen. A *whole* lot, as New Hampshire's Franklin Regional Hospital proves. For example:

- A cancer screening program to educate a predominantly blue-collar community about the benefits of early detection can be established. A Women's Health Clinic can be founded. And, there can be tangible results: Six hundred and seventy-one women can receive free PAP smears in one year, uncovering four cases of early-stage cervical cancer. Free breast exams and subsidized mammograms can be given, uncovering four cases of breast cancer. And, all cancers can be treated successfully.
- A prenatal clinic with a caring and supportive atmosphere can be founded to provide complete medical services to women who could not afford private medical care. Courses in pregnancy and childbirth can be taught. The head of the prenatal clinic can visit new mothers at home. The result? A dramatic increase in the number of women served who seek pre-

natal care in the first trimester, from one-quarter to three-quarters, in just four years.

- A comprehensive multi-disciplinary plan can be drawn up to deal with child abuse. The plan can train emergency department personnel, school nurses, teachers, police, and social service professionals to identify and intervene in child abuse cases. A "Kids and Company" curriculum for grades K-6 can be developed to provide personal safety training for children and educational workshops for parents and teachers.

- A series of preventive health classes can be offered, starting with 15 the first year and growing to 67 classes in three years. Course content can expand from the traditional classes in childbirth, parenting, and substance abuse, to women and self-esteem, addictive personalities, and yoga.
- A program for seniors can be founded and given a snappy title—"HOP for Life" (HOP=Healthy Older People). The program can change senior attitudes from "We have no skills. We couldn't teach each other about physical fitness and health," to "We can be a success," and "I don't have to be perfect." A Kitchen Band—instruments compliments of the kitchen drawer—can become such a success it needs a booking agent.

Franklin Regional Hospital does even more. It brought all community health and social service agencies, civic groups, and churches together in a network to eliminate duplication of services and make sure individuals are efficiently and effectively served. It set up a system of host families and trained them to provide emergency temporary shelter for children taken into protective custody. It developed a school wellness program. It became a regional resource center for social services.

And, Franklin Regional Hospital does more than serve its community with these programs. It offers "train the trainers" courses in many of

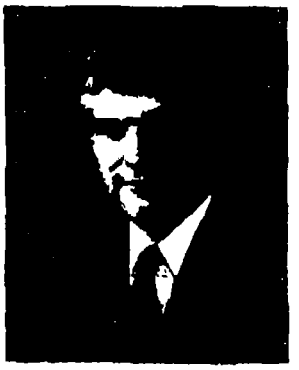
We find that by expanding our vision and our programs out into the community; by educating ourselves and other policymakers, both public and private, in matters of public policy, health policy, community needs and effective use of resources; and by forming partnerships—with community groups, churches, schools, businesses, government, other non-profits, and other providers—we are able to make a measurable difference. In an environment with the odds stacked against us, we are turning obstacles into opportunities—we are building a healthier, more productive community. That is, after all, the fundamental purpose for which hospitals exist.

Carolyn B. Lewis
Chairman, Board of Trustees
Greater Southeast
Healthcare System
Washington, D.C.
(Greater Southeast was the 1989 McGaw Prize recipient)

these areas to other hospitals, schools, and agencies across the state. No wonder its nominating letters for the Foster G. McGaw Prize used phrases like "known statewide as 'The Caring Hospital'"; "has a vision of health and wellness for all citizens"; and, "a remarkable achievement in a short period of time in an economic climate not at all favorable to hospital outreach."

And, no wonder Franklin Regional Hospital won the 1991 Foster G. McGaw Prize, presented by the American Hospital Association and the Baxter Foundation to recognize excellence in community service.

AHA salutes Franklin Regional Hospital, the 1991 Foster G. McGaw runners-up (St. Joseph's Hospital and Medical Center, Paterson, New Jersey; St. Luke's Hospital, Cedar Rapids, Iowa; and Kootenai Medical Center, Coeur D'Alene, Idaho), as well as hospitals everywhere that are going beyond providing excellence in acute and outpatient care to reach out into their communities and address broader needs. We encourage you to capture all you do for your community for the official record—in your annual report and on IRS Form 990, for example. Such documentation can be an important communications tool today, and it may be a crucial factor tomorrow in affirming hospitals' community value to cities, states, and the federal government.



The increased cooperation in data gathering and analysis will enormously enhance our ability to serve our common membership. The easier it is for us to access and compare national and state data, the more effective we can be in dealing with both the federal and state legislatures. Right now, the situation is so fragmented that if we in Florida have a particular concern—with Medicare, for example—we have no way of knowing what other states may already have done on that issue. A²IRNET, with new resources such as the planned directory, will provide a means of tapping into all that expertise and experience out there, so that we don't have to start at square one.

Charles Pierce, Jr.
President
Florida Hospital Association
Orlando, Florida

The New Paradigm: Sharing, data and more...

The Allied Associations Information Resource Network, known as *A²IRNET*, shifted into high gear in 1991, revving up with a set of principles and three goals to enhance data sharing between and among AHA and the allieds: to strengthen communications; to initi-

ate a strategic planning process; and to provide increased support for day-to-day operations.

AHA and allied data directors and staff formed seven work groups to collaborate on the development of an electronic bulletin board, new resource directories, and a confidentiality policy, among other ventures; they'll be working closely with the new allied CEO panel on data. You can read all about it in a new quarterly, *AHAIRNET NEWS*, designed to keep everyone up to date on individual and joint data projects.

In the same spirit, the number of cooperative agreements governing the joint collection and processing of AHA Annual and Panel Survey data continued to grow, reaching a new high of 36 states.

Data sharing is just one example of the renewed spirit of cooperation between AHA and its allied state and metropolitan hospital associations. AHA recognizes and supports the special local and regional relationship between the allieds and their members.

And, we recognize that creative problem solving is happening not only at 840 N. Lake Shore Drive, Chicago, and 50 F Street, N.W., in Washington, not only in academia and public policy centers, but where you are, on the front lines of health care delivery. A big part of AHA's job is keeping in close touch with the field so we hear about these innovative ideas and new initiatives—and so we can share what we learn with all AHA members so you can benefit from and build on your colleagues' ingenuity.

This renewed cooperative spirit extends beyond AHA and the allieds—to Capitol Hill, the executive branch, the federal agencies, and other health care organizations—wherever there's a concern for excellence in health care delivery. We need every single brain cell and every ounce of creative energy available to solve the complex problems facing us today. That's why we listen, and we share.

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1. Meeghan/ MANDY talking points
Jason/ updated ones

2. check/ MISSION STMT

3. Meeghan — AHA folders —

4. Kelly — Drew

5. ACH — • How long they've been a member

July 27, 1993

MEMORANDUM

• community

Audience:

Approximately 2000; Hospital administrators (ceo's, presidents, etc), senior management, VPs of nursing, nurse managers, supply and purchasing managers, hospital social workers and pharmacists, and venders, etc.

correct what's wrong

Items to be included in AHA speech:

courage // mission

- Recognize the problems they face and why health care reform is absolutely necessary (Use example of what she saw at MLK Hospital if AHA member or D.C. hospital)//Possibly incorporate what she saw and learned through her involvement at Arkansas Children's Hospital;
walk w/ us because for 2 long have walked alone
- Commend the AHA on its health care reform positions and emphasize our common ground;
- Been guilty when felt being shit on // you had 2 choices - complain or work w/ you
- Commend the AHA leadership for their valuable contributions to the Administrations' health reform efforts. (Use language comparable to that in the AMA speech where we stroked leadership. Need to provide some cover for the Washington leadership that is evidently way out ahead of its members.);
collaborative
in areas do use info will we have what high cost technology
- "community care networks" -- AHA want antitrust clarification to collaborate -- clearly know the rules .... Put in a direct statement about changing the antitrust rules; // pioneer - early on, pooling
- Address the Medicare issue by comparing it to the overall need for health care reform (i.e., We need to systematically address the problems running rampant in health care -- and not in a piecemeal fashion such as was necessary for the Medicare cuts.); MIDWAY //
- Incorporate the themes from the CHA speech

Recon
MEDICAID — "Dish" payments

Greg Lawlor
Rm 219

• U.S. hospital
ANTITRUST — we recognize your need clarification of the antitrust laws //

- Comm. Care Network
- UNIV. COV – hit 1st
  - cost ctrl
  - less paper & micromgmt
  - increased

focus in bkf

emph on Rural care & infrastructure

Tension b/t non & for profit; more rural members than URBAN;

ENDORSED Elders → AHA

– Seek better ways to make it easier to work together to reduce costs –

memories of

- Light — 1st BOARDS Mtg -- being last

Roger Berkley – Res ARK. Hosp. Assn.

The American Hospital Association Vision For Health Care Reform:

A Summary

The American Hospital Association's health reform vision addresses the fundamental flaw in almost every other reform plan: failure to reconcile increased access and restrained costs. Our plan is centered on "community care networks." Although the form networks take would differ according to local needs, their basic premise would be the same: each would offer a seamless health care system, from preventive care to long-term care, so patients would no longer be left to patch together their own health care services from a multitude of unconnected providers. Community care networks bring a more rational set of incentives to our current delivery system by:

- *Promoting the health of patients and preventing future, more costly illnesses.*
- *Encouraging collaboration among health care providers to avoid duplication of services.*
- *Conserving health care resources by providing only appropriate and necessary care.*

AHA'S PLAN:

Provides Universal Access to Health Benefit Coverage

All Americans will have coverage for a basic set of services from preventive care through long-term care. Those who don't have employer-sponsored coverage or an individual policy will be covered through an expanded public program replacing Medicare and Medicaid. A phase-in period and strong financial incentives will help make employers able and willing to provide coverage.

Is Patient-Centered and Focuses on Keeping People Healthy

As enrollees in local community care networks, patients will no longer have to wander unguided through a fragmented system, but will have a single entry point for all services needed. Precious resources now spent on excessive paperwork, unnecessary competition, and the administrative demands of multiple payers can be dedicated to improving patient care. All incentives will be geared to keeping patients as healthy as possible, emphasizing prevention, primary care, and wellness, and to improving the entire community's health status.

Provides Integrated Care

Services of hospitals, physicians, and other providers will be offered as a package. Government, businesses, and individuals will contract with community care networks to provide care for enrollees, and the network will be paid a set annual fee for each enrollee's health care.

Exactly how a network will be organized and what role hospitals play will depend on what best suits the needs of the community the network serves. Hospitals, physician groups, and private insurers could own and operate networks or co-own them with other providers. Or they could serve as providers of services under contract with a network.

Contains Costs

Community care networks will help to reduce the rate of health care cost increases. When providers are paid as a group, they will act as a group to monitor the use of health care resources and avoid unnecessary care. Over time, excess capacity and duplication of services and technology will be eliminated, bringing the "medical arms race" to an end.

The AHA proposal calls for an independent national commission that would determine a comprehensive set of basic health care benefits. With the commission's advice, Congress would set a target figure for public program expenses. The commission would translate this figure into a set of services that the money would cover, taking patients' and providers' needs into account. The decision-making would be open to public scrutiny and would make plain the trade-offs that budget decisions require. The set of services covered under the public program would be the minimum that must be covered in the private sector.

Can Be Phased In

AHA's vision builds on what is familiar — health coverage through employers for those who are employed, and government coverage as a safety net for those who are not or who cannot afford private coverage. It would preserve what is best about our system, and, in an orderly, step-by-step fashion, fix what needs fixing. As interim steps, AHA encourages federal legislation to implement antitrust, insurance, and malpractice reform; reforms at the state level; and the development of provider networks at the community level.

Christine McEntee
Vice President and Deputy
Director for Federal Relations

American Hospital Association
Capitol Place, Building #3
50 F Street, N.W., Suite 1100
Washington, D.C. 20001
Telephone 202.638.1100

AMERICAN HOSPITAL ASSOCIATION

DATE: July 23, 1993

TO: Washington Office Staff

URGENT

FROM: Rick Pollack

SUBJECT: Letter to OMB Director Panetta

ATTENTION: EXECUTIVE BRANCH NETWORK CONTACTS

Please make sure that the attached letter is provided to all of your Washington-based executive branch contacts.

Thanks very much.

American Hospital Association

AHA

Richard J. Davidson
President

July 22, 1993

The Honorable Leon Panetta
Director
Office of Management & Budget
The White House
Washington, DC 20550

Dear Mr. Panetta:

We are deeply disappointed by reports that suggest the Administration may support Medicare savings that are beyond those contained in the House version ($50 billion) of budget reconciliation. As you know, that level of savings is generally reflective of the President's budget request.

When the President's budget was proposed in late February, the American Hospital Association accepted the President's call for "shared sacrifice" by all, including hospitals, in order to rebuild our economy. And we agreed to respond to that challenge, provided that the approach stood the test of fairness and was linked to real health care reform.

Be certain, the $50 billion in proposed Medicare savings will create genuine hardship, particularly for many rural and urban hospitals in financial peril. Let me remind you that two thirds of the nation's hospitals must subsidize the cost of treating Medicare patients every day. And increases above this $50 billion level will clearly make it more difficult for these institutions to keep their doors open and their services available to their communities.

50 F Street, N.W., Suite 1100
Washington, D.C. 20001
202.638.1100

840 North Lake Shore Drive
Chicago, Illinois 60611
312.280.6000

Given our willingness to work in a responsible manner to achieve a fair and balanced response to the President's call for "shared sacrifice", it is disturbing that the Administration appears ready to abandon its own budget. This lack of commitment by the Administration to its own position raises serious concerns about our ability to forge a reliable partnership to win health reform in the months ahead.

Sincerely,

Dick Gephardt

COPY

July 23, 1993

President Bill Clinton
The White House
Washington, DC 20500

Dear Mr. President:

As you and your administration work with the conferees on the Omnibus Budget Reconciliation Act of 1993, an overriding question for the American public is whether the conference agreement meets your own standard of shared sacrifice in its goal of deficit reduction. Reducing the deficit is always a painful process, but older Americans, hospitals and physicians are willing to do their share if the pain is equitably distributed. In this regard, the proposed Medicare reductions are of central concern to our organizations.

Unfortunately, much of the debate around this deficit reduction package has focused on the ratio of direct spending cuts to tax increases, rather than on meeting a standard of shared sacrifice for all Americans. In fact, many Americans receive benefits through direct spending programs while others benefit from indirect spending through a myriad of tax preferences designed to promote certain economic and/or social outcomes. Regardless of which type of spending, the burden of paying for these benefits is borne by all of us as taxpayers. Ultimately, Americans will judge this package based not on whether some arbitrary ratio has been achieved but rather on whether the burden of deficit reduction is fairly distributed.

Earlier this year, you proposed $46 billion in Medicare cuts -- an unprecedented proposal. In making this proposal, you urged all Americans to share in the sacrifice needed to reduce the deficit. As you know, our organizations demonstrated that we -- and our memberships -- were willing to do our part. The Medicare provisions included in the House-passed bill, comparable to your proposal, would cut $48 billion from Medicare over five years -- the largest single reduction in the program's history. Unfortunately, the Senate increased the cut to $58 billion. Reductions of this magnitude: 1) threaten beneficiary access to needed care; 2) promote increased cost-shifting to the private sector; and 3) pose barriers to the reform of our health care system. The added Medicare cuts in the Senate did not occur in order to reduce the deficit but rather to offset the loss of revenue due to the efforts by energy interests to exempt themselves from the shared sacrifice which you called for in your proposal. We are disappointed by remarks attributed to you and those of your administration supporting the higher Senate Medicare cuts.

You have frequently noted that we cannot achieve real, long-term deficit reduction by simply continuing what we have been doing for over a decade: cutting Medicare and shifting costs to beneficiaries and the private sector. While Medicare and Medicaid costs may be driving much of the growth in our deficit in recent years, we will not make real progress against those increases until we take on the underlying system-wide problems which drive up health care costs. As you know, comprehensive reform of our health care system can accomplish this task.

Because of these concerns, our organizations strongly recommend that you urge the conferees to be guided by the House provision in establishing the level of Medicare cuts, not the Senate's.

Like most Americans, older Americans, hospitals and physicians are willing to do their part to reduce the deficit. They ask only that the burden of deficit reduction be fairly shared.

Sincerely,

Horace B. Deets
American Association
of Retired Persons

Richard Davidson
American Hospital Association

James S. Todd, M.D.
American Medical Association

American Hospital Association

AHA

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
FAX NO. 202 626-2345

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To Marilyn Yager	From Rick Pollack
Co. White House	Co. AHA
Dept. Chief of Staff's Off	Phone # 626-2311
Fax # 456-1121	Fax # 626 2355

February 16, 1993

Dear Chief Executive Officer:

I wanted to share with you in advance what we're hearing and our best reading of how health care providers will be affected when President Clinton unveils his economic package in his Wednesday, February 17 address to Congress.

Few details were out over the long weekend and the President's Monday night speech made only a brief reference to health care. Press reports have been sketchy and no official documents have surfaced. But here's what we've been able to learn: President Clinton's economic plan will include substantial Medicare budget savings over the next four years. It is possible that a freeze on the Medicare prospective payment system update factor will be included for between one and two years.

We also understand that the President is likely to "signal" that there will be a second stage of his economic plan -- in the context of either his budget, to be released in March, or the announcement of his health reform plan, probably in May or June. It will contain two parts. First, increased taxes, presumably emphasizing "sin" taxes -- to pay for expanded access. And second, private sector health care cost containment that could be in the form of insurance premium increase limits.

How should hospitals respond? First, it is in the best interest of the communities which hospitals serve that the nation's economy gets back on track. A strong economy generates job growth and health coverage in the private sector. To achieve deficit reduction and economic growth, the President has asked for shared sacrifice from the American people. His Medicare actions are certain to be part of a wide-ranging set of spending cuts and tax hikes with no one sector being singled-out. We expect him to frame the Medicare constraints as a first step in cost containment while Mrs. Clinton's task force puts together the comprehensive reform plan.

It is essential that we not overreact. Hospitals must not be isolated from their communities, appearing to want more when everyone else is being asked to accept less in a national effort to repair the economy. We must remain focused on the most important goal: real health care reform.

By the same token, the Administration and the public must understand how the actions will affect hospitals and communities. We will analyze the new proposals in the context of other federal cutbacks and the current, serious shortfall in Medicare payments. With 20 percent of the nation's hospitals in financial peril and nearly two-thirds of all hospitals subsidizing the cost of treating Medicare patients, the action could have a serious, harmful impact in some communities, including hospital closures, job losses and further erosion of already vulnerable rural and urban institutions.

And we will analyze the details of the President's proposal thoroughly to determine if we are being treated fairly in the context of the President's overall plan.

It will be critical to know how the Medicare action deals with wages and salaries, whether or not it penalizes hospitals for changes in the general economy, volume shifts or case mix, and if there is a limited exceptions process to address special situations. These and other issues will be thoroughly debated in the Congress and hospitals will participate vigorously.

Finally, I must emphasize again the need to look at these proposals in relationship to achieving our vision of health care reform. We must not look at this action too narrowly. We must assess the extent to which we are moving toward universal access and the restructuring of the delivery system around community care networks.

Hospitals are for reform. We will be skeptical of any actions that continue the arbitrary ratcheting-down of today's badly-broken Medicare payment system. They would be in no one's best interest.

We will be communicating with you again directly when more is known and we've had an opportunity to analyze the President's actions. Please read AHA News for coverage of the Administration's actions on the economy, the budget and health reform and for specific news on AHA's course in the days ahead.

Sincerely,

Richard J. Davidson
President
American Hospital Association

American Hospital Association
AHA

Rick Pollack
Executive Vice President
Federal Relations

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To Marilyn Yager	From Rick Pollack
Co.	Co.
Dept.	Phone #
Fax #	Fax #

July 23

Marilyn -

Looks like we've
Kout to be thrown
Overboard.

Rick

WEDNESDAY, JULY 21, 1993

The CQ FaxReport

The Afternoon Fax-Daily from Congressional Quarterly Inc.

Bentsen, Panetta Talk Energy Tax With Conferees

Work on crafting a final budget reconciliation package continued this morning as top administration officials met with House Democratic conferees.

Although Treasury Secretary Lloyd Bentsen and Office of Management and Budget Director Leon E. Panetta both stated that an energy tax would be in the final package, its shape was still not clear.

Bentsen and Panetta said that the energy component would likely follow the Senate proposal of a 4.3-cents-per-gallon tax on gasoline, and would raise $23 billion to $34 billion. President Clinton wants to cut $500 billion from the deficit over five years.

But Jim Slattery, D-Kan., said many Democrats would rather scrap an energy tax altogether. Even Majority Leader Richard A. Gephardt, Mo., left open the possibility that the final package would not include an energy tax component.

"It's conceivable," he said.

Panetta also said that the administration was moving in the direction of the Senate position of $58 billion in Medicare cuts. That could take some selling with the Congressional Black Caucus, which has drawn the line at $50 billion.

Speaker Thomas S. Foley, Wash., said if the cuts are crafted the right way they could pass. "As long as these cuts don't intrude on beneficiaries, they can be considered," he said.

(Background, CQ Weekly Report, p. 1853)

Other Hill Action Today

House Moves to Uphold China MFN Status

The House today rejected, 105-318, a resolution (H J Res 208) that would have revoked extension of most-favored-nation (MFN) trade status to China.

President Clinton in July extended MFN status to China for one year, conditioning future extensions on improved human rights conditions in that country, which has been criticized for abuses since the communist government's 1989 crackdown on pro-democracy demonstrators.

Some lawmakers wanted to require a conditional MFN extension this year; others wanted to revoke MFN altogether because of continued evidence of nuclear weapons proliferation by the Chinese government.

(Background, CQ Weekly Report, p. 1722)

Hearings Continue on Gays in Military

Under close questioning by Senate Armed Services Committee Chairman Sam Nunn, D-Ga., Pentagon General Counsel Jamie Gorelick this morning acknowledged that President Clinton's new policy on homosexuals in the military would not allow gay soldiers to engage in any conduct barred by the Pentagon's pre-Clinton policy.

And on the other side of the Capitol this morning, Defense Secretary Les Aspin told a House Armed Services panel that the new policy's chief benefits for gay soldiers were that they no longer would be asked if they were homosexual and that Pentagon investigators no longer would conduct free-wheeling witch hunts to ferret out homosexuals trying to keep their sexual orientation secret.

"If you are gay and mind your own business and keep your private life private, you can serve," Aspin told the Military Forces and Personnel Subcommittee.

(Background, CQ Weekly Report, p. 1889)

Black Caucus, Clinton Meet to Mend Fences

Black lawmakers met with President Clinton this morning in a fence-mending session that touched on spending for social programs, congressional redistricting, and the withdrawal of Lani Guinier's nomination as head of the Justice Department's Civil Rights Division.

Congressional Black Caucus Chairman Kweisi Mfume, D-Md., told reporters after this morning's meeting that the session was triggered by the "Lani Guinier episode," in

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NATIONAL JOURNAL'S
CongressDaily
Pg. 1 of 5 3:05 PM • Wednesday, July 21, 1993

BUDGET

Senate Democrats Seek More Spending Cuts In Package

Senate Finance Committee Democrats met this afternoon to try to find ways to remove as many GOP objections as possible to the reconciliation package — including an effort to include more spending cuts, **Sen. Max Baucus**, D-Mont., told *CongressDaily*. "We want to cut back as many reasons as possible for the Republicans to castigate us," Baucus said after a private session of Senate Democratic tax conferees. The group was scheduled to meet again late this afternoon to craft a counter-proposal to an offer sent over Tuesday night from their House counterparts. According to Baucus, the senators discussed proposing additional spending cuts, including reductions in discretionary programs. Several senators also called for the elimination of the gasoline tax altogether, or at least to not increase it beyond the Senate-passed bill. Baucus, who opposes the gas tax, said many senators believe it will lose votes in both the House and Senate, and could "jeopardize" the entire package.

Meanwhile, Treasury Secretary Bentsen earlier said it is "important to have an energy tax" in the budget reconciliation bill, and suggested the administration may embrace a gas tax somewhat larger than the Senate provision. "I think what we'll see primarily is a gasoline tax" coming from motor fuels, Bentsen said after a meeting with the House Democratic Caucus. He speculated the final gas tax provision would raise between $22 billion and $32 billion, but added it could go as high as $34 billion — depending on whether it is structured on a year by year or accelerated basis. While **House Speaker Foley** said he thinks the final conference product would contain an energy tax, **Majority Leader Gephardt** said it was "conceivable" that the package would not include any energy tax at all.

OMB Director Panetta said the administration will "move more toward the Senate on energy and more toward the House on investments." And while he said the administration is "moving toward" the Senate position on Medicare cuts, he added that it "depends on what else is on the table." The Senate bill provided for larger savings in Medicare spending than did the House version. Bentsen also re-emphasized the administration's support for an increase in the corporate rate to 35 percent, which was agreed to Tuesday by conferees on a preliminary basis. Regarding changes in the personal rate, Bentsen said, "I think you would see it delayed somewhat." Gephardt said he hopes to see a quick conclusion to the conference, adding, "Hopefully, we can get the conference finished the early part of next week." Sources said Democrats want as much time as possible to sell the package to their members and the public.

HOUSE ADMINISTRATION

Democrats, GOP At Odds Over Post Office Disclosure

House Republican and Democratic leaders today clashed over when and how documents related to last year's House Post Office scandal should be disclosed. Top House Democratic sources said this morning that the leaders strongly favor disclosure of documents from a House Administration task force investigation of the scandal. But a key Democratic aide said the leaders also want a bipartisan resolution that would allow Attorney General Reno up to 10 calendar days to review the documents. **House Speaker Foley** said this morning that the Justice Department should be provided the review to ensure that release of the documents would not compromise its

Marilyn –

When you have a minute

I need to speak w/ you

Re: ~~Ken~~ American Hospital

Association.

Thanks

Kim Tilley

X2131

Mike | AHA folder

- Give them cover -

- Critical to include what we've listened to them & include these specific areas

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

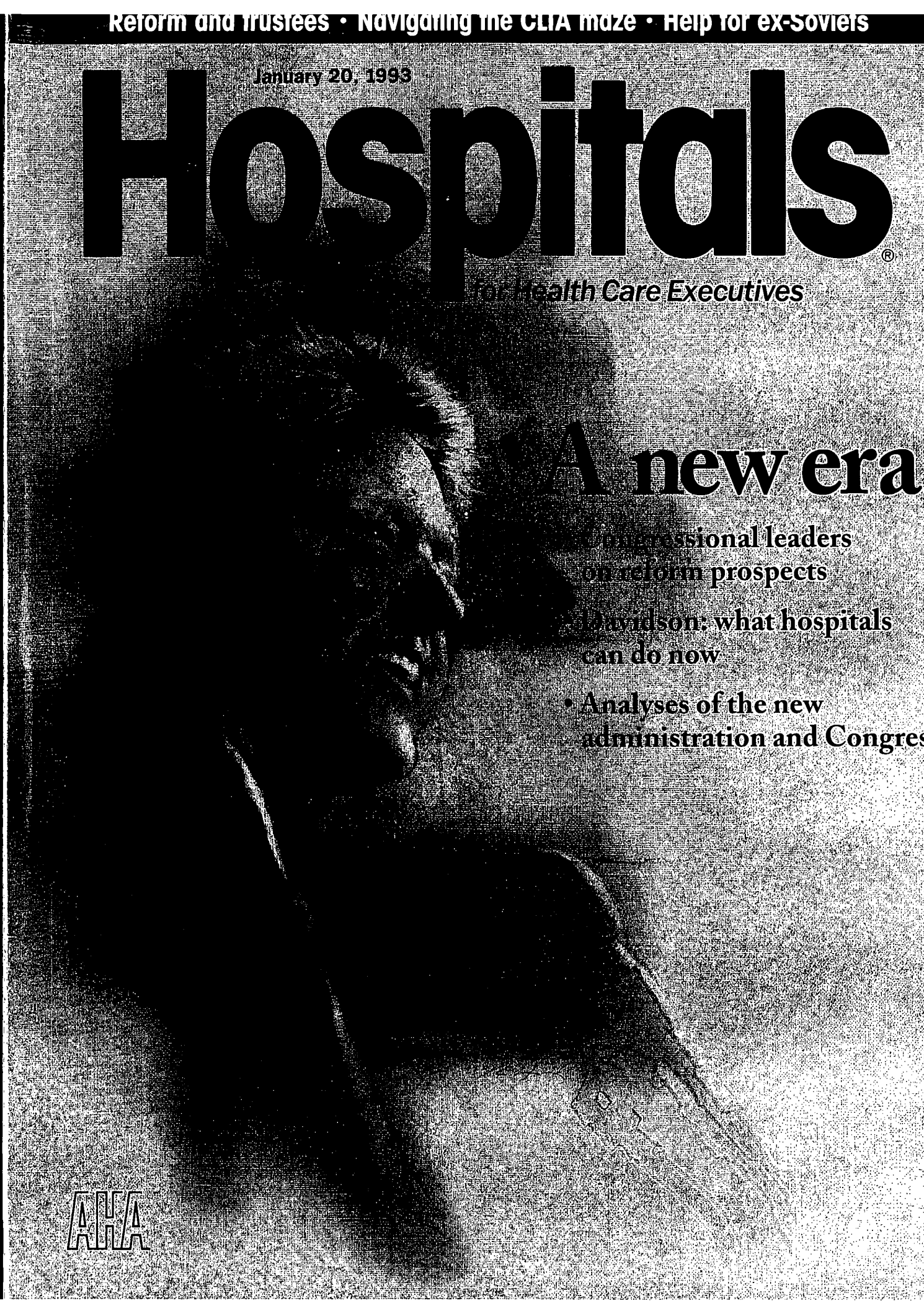
Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

Reform and trustees • Navigating the CLIA maze • Help for ex-Soviets

January 20, 1993

Hospitals®

for Health Care Executives



A new era

- Congressional leaders on reform prospects
- Davidson: what hospitals can do now
- Analyses of the new administration and Congress

AHA