INTEGRATED DELIVERY NETWORKS

Research Guides System’s Vision Of Redesigned Care Delivery

Wheaton Franciscan Services (WFS), Wheaton, IL, did not start out three years ago to redesign the way it delivers care, but that was the result when WFS introduced continuous quality improvement (CQI) training. As part of its CQI process, the organization answered three questions: Why do we exist? What do we want to become? What will guide us along the way? The result was a mission statement with broad implications for how the system should organize itself: “The Wheaton Franciscan System is committed to human and community development in ourselves and in health and shelter services.”

“We asked, What would our health system look like if we were committed to human and community development?” explains WFS’s Larry Pheifer. Referring to the mission statement, the system determined that its services should be community based, focused on the individual, and coordinated in a seamless continuum. In a nutshell, that meant identifying needs and providing the services to meet those needs. “That’s how we developed our concept of integrated delivery, which we call ‘Community Based Individually Coordinated Care.’ CBICC is driven by our mission, independent of healthcare reform,” Pheifer explains.

COMMITMENT TO INTEGRATED DELIVERY
WFS’s president, Wilfred Loebig, decided to allocate sufficient resources and personnel to fulfill the system’s commitment to the concept of CBICC. He appointed Pheifer (who was then president of Franciscan Home Health in Milwaukee) leader of CBICC development and charged him with making the system’s concept of integrated delivery a reality.

WFS defined integrated delivery as a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is both clinically and financially at risk for the health status of that population. Essential to the concept was the notion that WFS would need to form network partnerships in order to achieve its vision, but the system did not need to own or control its partners.

Pheifer identified major systemwide initiatives for achieving WFS’s vision of integrated care:

- Form closer relationships with physicians.
- Determine governance structures that facilitate relationships among partners.
- Develop human resources policies for integrated delivery—for example, by considering alternatives to pay-for-performance and other compensation issues.
- Design what WFS calls “the system of care,” a detailed plan to integrate clinical care for covered individuals in WFS integrated delivery networks (see Box on p. 15). The system of care will offer a coordinated continuum of health and related shelter services and will include a process for matching services with individual needs across multiple providers in a geographic market.

COMMUNICATING REDESIGN
These initiatives had to be communicated to the system’s five regions. Realizing that capitation “is
now more than a reimbursement mechanism but a way of delivering care differently," Pheifer
dezigned system members in dialogue during the
last six months of 1993 on the need to move
away from the fee-for-service paradigm that
focuses on treating illness and, instead, embrace a
new paradigm focused on improving the individu-
als' and the community's health status.
He initially concentrated on the system's
regional executives, who will be responsible for
creating regional integrated delivery networks
that include physicians, institutional providers,
and insurance companies. Later, he involved
boards, middle managers, and physicians.
Pheifer is using several media to explain
CBICC. He has made more than 50 presenta-
tions to various groups. He regularly distributes a
question-and-answer sheet that clarifies terms and
imparts basic information. A quarterly newsletter
explains CBICC concepts, the current healthcare
environment, the system of care, and WFS's plans
and activities.

**Learnings for the Future**
WFS has learned much from the redesign process
that began almost accidentally. In the future, the
system will communicate more often with its
constituents. WFS realized early on that it needed
to use terms such as "system of care" consistently
in all its communications, Pheifer says, but more
frequent communications would have helped
people grasp difficult concepts more quickly.
"One year into the process, there is still a lack of
understanding of the system of care and why we
must focus on the health status of communities,"
says Pheifer, "but understanding is growing as
the components of the system of care become
clearer."
The system will also do a better job of involv-
ing physicians in designing the system of care,
Pheifer says.

By the end of 1996 WFS will be ready to mar-
ket its system of care to insurers and managed
care organizations, Pheifer says. He believes the
system of care will be sensitive to environmental
factors and transferable to any of the system's
geographic markets. Most important, the system
of care will fulfill the system's mission of human
and community development by matching indi-
vidual, family, and community needs with the ser-
dices of the network.

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**Designing the "System of Care"**

WFS is proactively designing a system
care that will be used for all clients in
the WFS healthcare system. "The sys-
tem of care will answer the question,
How will we manage the care of a cov-
ered life in an integrated network?
explains Larry Pheifer, who oversees
the design process.

With external pressures such as com-
petition and capitation forcing rapid
restructuring of healthcare delivery,
Pheifer describes the task as "redesign-
ing the car as it's going 65 miles per
hour down the freeway." His job, he
says, is to lead the system's research
work "so we don't test door handles
while someone else is planning to
replace the door."

WFS has three tiers—the corporation,
the regions, and the individual sub-
sidiaries within each region. "The trick
becomes, How does work done at tier 1
relate to tier 2 and to tier 3?" Pheifer
says.

To make the systemwide task man-
ageable, a design team is working to
develop a prototype system of care to
be pilot tested in 1996 in each region.
The five-member team—consisting of
Pheifer, a physician, a clinical nurse
specialist, a research assistant, and an
external consultant—will also consult
with other clinicians.

The prototype the team designs will
feature components, or "major process
variables." These might include, for
example, coordinated scheduling, a
central records repository, nurse case
managers assigned to primary care
physicians, and comprehensive health
status assessments for each covered
individual. Some components will be
uniform for all regions; others will vary
according to regional needs.

Research studies, recommended by
the prototype design team, will answer
questions that arise as each compo-
nent is articulated and will validate
assumptions about the need for particu-
lar components. In each region a core
team of senior leaders will assess
resources for this research, and teams
of clinicians will conduct the research.

Research efforts will piggyback on
activities already going on in WFS facili-
ties to match services and needs. For
example, groups are currently working
on a central records repository and clin-
ical pathways.

Getting feedback from customers is
another piece of the research effort.
The design team will convene panels of
individuals and purchasers to learn
what "quality characteristics" (e.g.,
access to clinical information) they
want the system of care to include.