Research Guides System's Vision Of Redesigned Care Delivery

INTEGRATED DELIVERY NETWORKS

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.

Larry Pheifer describes the task as "redesigning the car as it's going 65 miles per hour down the freeway."

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

WHEATON FRANCISCAN SERVICES, INC., WHEATON, IL

Sponsor: Franciscan Sisters, Daughters of the Sacred Hearts of Jesus & Mary (OSF), Wheaton, IL
Regions: Racine, WI; Appleton, WI; Milwaukee; Chicago; Waterloo, IA
Facilities: 9 hospitals, 3 long-term care facilities, a rehabilitation center, and 32 other subsidiaries
Employees: 16,000

now more than a reimbursement mechanism but a way of delivering care differently," Pheifer engaged 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 individual's 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 presentations 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."

Wilfred Loebig, WFS's president, allocated sufficient resources and personnel to fulfill the system's commitment to integrated delivery.

The system will also do a better job of involving physicians in designing the system of care, Pheifer says.

By the end of 1996 WFS will be ready to market 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 individual, family, and community needs with the services of the network. *—Judy Cassidy*

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DESIGNING THE "SYSTEM OF CARE"

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

With external pressures such as competition and capitation forcing rapid restructuring of healthcare delivery, Pheifer describes the task as "redesigning 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 subsidiaries 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 manageable, 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 component is articulated and will validate assumptions about the need for particular 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 facilities to match services and needs. For example, groups are currently working on a central records repository and clinical 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.