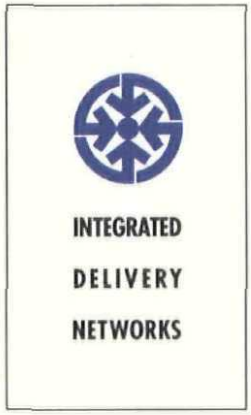
System Analyzes Readiness For Integrated Delivery



Organizations developing integrated delivery networks (IDNs) find the process much like choosing team members to play with them in an upcoming game. But the rules of the game are not fully defined, so it is difficult to know the attributes the team members should have and who the best players will be.

St. Louis–based SSM Health Care System (SSMHCS), sponsored by the Franciscan Sisters of Mary, confronted these circumstances in late 1992, when its board decided to conduct a ministry effectiveness analysis (MEA). The MEA was designed to assess the readiness of the individual SSMHCS entities, located in six states, for participation in IDNs. SSMHCS had set a strategic goal of having each of its entities (14 acute care hospitals, 3 nursing homes, and a rehabilitation facility) participate in a network in some way by the end of 1994.

According to Sr. Mary Jean Ryan, FSM, president of SSMHCS, the goal was to prepare for an environment in which reform is occurring market by market, even in the absence of federally mandated reform. SSMHCS leaders believe that reform means healthcare will be delivered through networks of local providers, governed locally (five SSMHCS hospitals formed an IDN with three other hospitals in the St. Louis area last summer). Inpatient care and assets will shrink. The dominant payment method will be capitation, and new levels of collaboration will exist among providers, especially physicians and local ministries.

In March 1993 SSMHCS began work with the Cambridge Management Group, Cambridge, MA, to develop the MEA plan. William P. Thompson, SSMHCS's senior vice president for strategic development, headed the effort, begun by his predecessor, Gayle L. Capozzalo. Through the plan, each of the system's local ministries assessed the role it might play in a specific IDN. (The system defined a "ministry" according to geographic location, so some ministries consisted of more than one entity in a geographic area.)

"We take a flexible approach to address local needs, which differ dramatically across the system," explains William P. Thompson.

To use personnel time effectively, the MEA process was initiated at a different ministry about every three weeks. Approximately 90 days thereafter, each local ministry developed a recommendation for its participation in a network in its market, according to James L. Dorsey, a member of the Cambridge Management Group's team for the project. The ministries then submitted their recommendations to the system, which is developing a systemwide plan. The ministries' recommendations included the following elements:

- Size of the population to be served
- Network's service area
- Type of network organization
- Potential partners (hospital, physician, payer)
- Services to be provided by the ministry
- Financing mechanisms
- Capital requirements
- Probability of the network coming together and, if it does, probability of its success

Ministry Criteria for Assessing Readiness

The ministries used 13 essential criteria in developing their recommendations (see **Box**). Cambridge Management's Suzanne M. Kearney says these criteria relate to six key factors: the organization's position in its local market, the organization's readiness for IDN participation, the readiness of the organization's physicians for IDNs, the organization's capability for financial self-sufficiency, the organization's capacity for change, and the readiness of the market area for network development.

Teams from the local ministries evaluated their readiness by using these criteria. Representatives of the system's corporate staff—the regional president, the system's director of planning, and Thompson—also served on each local ministry team.

MINISTRIES' CRITERIA FOR EVALUATING NETWORK READINESS

SSMHCS ministries used the following criteria, developed with Cambridge Management Group, to assess their readiness to develop and participate in integrated delivery networks (IDNs). Under each criterion is a list of factors considered as part of that criterion.

Criterion 1 The organization is an important contributor to its community.

- Services to employers, schools, and social service agencies, as well as healthcare providers
- Significance as an employer in the community
- Source of primary training for the major allied health professions
- Site for the undergraduate and graduate training of physicians
- Impact on the economic health of the community

Criterion 2 The organization is an important contributor to meeting the health needs of its community.

- Knowledge of the current health status of the market area's population
- Program alignment with known community need
- Services and programs that are not available from other providers
- Service to the uninsured and underinsured population
- Uncompensated care for the uninsured and underinsured population
- Source of community health education
- Patient satisfaction with services
- Understanding of the healthcare needs of the business community

Criterion 3 The organization is a dominant provider in its market area.

- Dominant provider of services (from preventive to hospice) in its market area
- Dominance of three major service lines

Criterion 4 The organization can be a key provider of a full continuum of care with geographically dispersed delivery capability that ensures ready access to service in the least costly site.

- Provider of multiple levels of care
- Price-competitive acute care services
- Dispersed primary care services
- Quality of patient care outcomes and lower costs through continuous quality improvement
- Cross-functional team approach

Criterion 5 The organization has a committed and aligned cadre, appropriate in number, of primary care and specialist physicians.

- Owner/manager of primary care practices
- Average age of organization's primary care physicians
- Number of primary care physicians in the area
- Mix of specialists to match the "disease profile" of the population served
- Physician satisfaction with the organization

Criterion 6 The organization's physicians are sufficiently organized among themselves and aligned with the organization to share risk with the organization in the provision of services to a defined population.

- Existence of physician-hospital organization
- Existence of management service organization (MSO)
- Existence of single specialty and multispecialty groups

Criterion 7 Physician leaders associated with the organization are ready, willing, and able to take a leadership role in forming or helping to form an IDN.

- Physician experience in working cooperatively with other providers
- Physician experience in practicing under risk-sharing arrangements with managed care providers

Criterion 8 The organization and its physicians are involved in, and committed to, improvement of clinical outcomes through the development and implementation of clinical pathways, monitoring outcomes, etc.

- Use of clinical pathways
- Counseling of outliers
- Concern for the organization's financial success

Criterion 9 If no significant changes from the current environment take place, the organization will be able to generate sufficient cash flow over the next five to seven years to maintain its healthcare and other social obligations to the community.

- Acceptable financial measures and ratios
- Percentage of year-end revenue derived from outpatient activity
- Condition of physician facilities
- Financial resources to absorb any start-up losses due to undertaking innovative contractual arrangements
- Strong capital structure

Criterion 10 The organization is more able than other providers in the area to manage a dispersed, multilevel delivery system.

- Integrated clinical administrative, financial, and information and telecommunications systems

Criterion 11 Many acceptable providers are available to cooperate in developing an IDN.

- Value compatibility of potential partners
- Comparability of pricing and cost structures
- Compatibility of medical staffs

Criterion 12 The organization's market falls within a geographic area where the formation of IDNs is under way or openly discussed.

- Inclusion of the organization in discussions
- Involvement of the organization in IDN formation
- Ownership of a financing mechanism
- Necessity of organization to any network formed in the area
- State initiatives

Criterion 13 Within the geographic bounds of the organization's market area, there is a sufficient population that could be enrolled in a capitated IDN.

- Area population
- Age cohorts
- Number of major providers in the area
- Number of staffed acute medical/surgical beds in the area

System Criteria

After the local ministries submitted their written recommendation for IDN participation, system managers used four criteria, each defined by detailed factors, for evaluating the local ministries' recommendations (see **Box**, below). Dorsey explains that the criteria, which are closely interconnected, were each weighted after considerable deliberation.

Specific Learnings

"As the local teams developed their scenarios," Thompson says, "they recognized that the system's influence would be proportionate to the local ministry's presence in the community." Rural ministries, for example, would probably be smaller participants in a network that would include larger entities in a nearby urban area.

"As a system with a presence in the Southeast, Midwest, Upper Midwest, and Southwest, we saw significant variance in communities' readiness for managed care and in the readiness of physicians to accept different organizational structures," Thompson notes. "We *did* find uniform readiness on the part of other providers to begin exploring networks." He cautions, however, that providers' concepts of a network vary from area to area. In some markets, providers view a network as a "sellers cooperative"—a loose affiliation to deal with managed care. "In others, like St. Louis," Thompson says, "providers are more ready to look at significant rationalization and consolidation of services."

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Developing a common vision among staff was not difficult because as part of the MEA process, they discussed the elements of success in a future healthcare system driven by capitated payments. "Many people initially said, 'If reform happens, we can see the value of networks, but we don't know how reform will go,'" Thompson recalls. "But the realization that changes are occurring regardless of Washington overcame this resistance." The system has also identified key "nonnegotiable" issues of Catholic identity and values to guide ministries considering ventures with non-Catholic organizations.

Thompson says the system is developing closer relationships with physicians. Almost all SSMHCS facilities have begun physician-hospital organizations and management services organizations. The system is also helping physicians to

Continued on page 22

SYSTEM'S CRITERIA FOR EVALUATING MINISTRIES' RECOMMENDATIONS

Criterion 1 Mission

- Enhancement of services to those less fortunate
- Enhancement of the ministry's contribution to provision of optimal healthcare services
- Recommended integrated delivery network's (IDN's) ability to influence community health status
- Recommended IDN's ability to influence state and national policy regarding healthcare delivery
- Ministry's ability to influence the IDN regarding policy changes in healthcare directed at improving health status on local, state, and national levels
- Maintenance of a Catholic presence in the delivery of healthcare services
- Avoidance of alienation of Church property

Criterion 2 Achievability

- Readiness of the ministry, including its physicians, for participation in an IDN
- Readiness of the market for IDN development
- Competitive position of recommended IDN in its marketplace as it is being developed
- Existence of managerial resources required by the ministry and by the IDN in the development phase of the IDN
- Resulting position of the ministry if the effort to develop the IDN fails
- Acceptability of the ministry's recommended plan to the local ordinary

Criterion 3 Long-Term Success

- Competitive position of recommended IDN in its marketplace when it is operational
- Probability that the recommended IDN will enroll more than 400,000 covered lives
- Financial success of the ministry as a healthcare provider within the recommended IDN
- Financial success of the recommended IDN's financing mechanism if the ministry participates in that mechanism
- Contribution to maintenance of a bond rating acceptable to the system
- Resulting position of the ministry if the IDN fails operationally or financially after several years

Criterion 4 Strengthening of the System

- Synergy with other system ministries
- Ability of the IDN to strengthen system identity

Continued from page 20

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come together into multispecialty groups. "It may be a group practice without walls to allow physicians to remain in their current location but have backup and coverage. We take a flexible approach to address local needs, which differ dramatically across the system," Thompson explains.

Benefits to the System

Thompson believes the MEA project has benefited the system in several ways:

- Local entities have used the analysis in their own strategic planning. "The project has been an opportunity to ask serious questions about how their role will change in the next five years," Thompson says.
- Communications between the corporate office and the entities have improved greatly, with each gaining understanding of the other's roles. Corporate staff in particular have learned about the issues and needs of the local entities.

"The MEA has been well received by the local ministries," Thompson says. "Many found it was not a mandate from corporate as much as it was a chance to take time off from daily pressures to try to understand and prepare for the future."

The project's best outcome, Thompson says, is a vision for the system. "We now have a much greater appreciation for what the system can be in the future."

—Judy Cassidy