

# MODEL FOR THE INTEGRATED NETWORK?

## *Rehabilitation Makes a Good Candidate*

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If the 1980s were years of dramatic change in healthcare, the nineties will come to be known as an era of revolution.

Most experts now agree that the engine of this revolution will be the integrated delivery network (IDN). But the changes involved in creating such a network are enormous—so enormous, in fact, that few genuine IDNs are yet operational, especially at the clinical level. This is true even of Catholic hospitals, which, compared with non-Catholic institutions, often have more experience functioning as part of multifacility systems. Building IDNs is complicated by the fact that the task is unprecedented. There are no prototypes.

There is, however, one existing healthcare service that may be a good model for constructing an IDN. That service is rehabilitation.

**Summary** Rehabilitation is a good model for an integrated delivery network (IDN). Because it is an integral part of the treatment plans of a diverse group of medical specialties, rehab often plays a pivotal role in patients' recovery. Since its focus is on functional outcomes, rehab is compatible with a capitated payment system.

In addition, rehab entered the managed care arena before other "product lines," so rehab providers have experience with diverse reimbursement conditions. And although rehab encompasses all levels of care, it is not too large to function as a model for a full-scale IDN.

There are four key stages in the development of a rehab IDN:

- A strong leader with a clear vision organizes a



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### THE "PRODUCT LINE FOCUS"

Providers increasingly use what they call a "product line focus" as a starting point for vertically integrating IDN components. In effect, integration of one or more product lines provides the IDN with a "micro" model that can be the basis for network wide integration. Rehabilitation is a good product line to start with for the following reasons.

**Major Need of Population** Rehab often plays a pivotal role in patients' recovery. It is closely aligned with all

aspects of medical care and is an integral part of the treatment plans of a diverse group of medical specialties, from orthopedics to neurology. Rehab thus has great value for a large segment of the network's providers.

**An Outcome Focus** Valuable too is rehab's focus on functional outcomes and documentation—key features of the new delivery system. Because its

working committee composed of the key leaders of each entity involved in rehab: hospitals, nursing homes, home health, and others.

- The committee begins to design the proposed network. Though the committee may study other IDNs, its focus is on its own organization's needs and objectives.

- A master plan addressing systems gaps and opportunities throughout the IDN is drawn up. Integral to the plan is a schedule according to which each of the network's components will be integrated.

- The master plan is implemented. The working committee determines the IDN's final structure and names the members of the management team.

results are so often quantifiable, rehab will have an increasingly important role in healthcare.

**Experience with Diverse Payers** The rehab patient mix represents a full spectrum of payer sources, from managed care to Medicare. In addition, rehab entered the managed care arena before other product lines did, so rehab providers are experienced in operating under more diverse and restrictive reimbursement conditions. As various other acute care product lines come under managed care, they will be facing the same issues already addressed by rehab providers.

**Full Continuum of Care** Rehab is a multifaceted product line that encompasses all levels of care: acute, subacute, ambulatory, home health, and others. As a result, rehab has already addressed the full range of issues that will be seen in any IDN at the macro system level.

**Long-term Value to Systems** Rehab increasingly is seen as pivotal to an IDN's survival under a capitated payment system. Producing strong functional outcomes will be essential for an IDN,

both in controlling utilization and in fostering the community's health. Rehab will be especially important in controlling the utilization pattern of chronic patients—who, though they constitute only 16 percent of the U.S. population, account for 41 percent of healthcare expenditures.

**A Manageable Size** A rehab unit, though usually sizable, is not too large a product line to make a good model for a full-scale IDN. Medical staff involvement tends to be limited to a few specialties, which makes integration easier.

#### FOUR KEY STEPS IN DEVELOPMENT

Even for a single product line, the movement toward integrated delivery is complex. Contrary to popular belief, it is significantly more complicated than creating an organizational structure. Creating the structure is, in fact, only a small part of the process, and one that comes relatively late in the game.

The process for integrating delivery for rehab services will vary from provider to provider. All,

## SSM CREATES A MODEL IDN

SSM Rehabilitation Institute (SSMRI), based in St. Louis, was one of the first system providers to develop an integrated delivery network. SSMRI is a multilevel rehabilitation provider, part of the central region of the 17-hospital SSM Healthcare System.

Before integration, SSMRI managed 80 acute rehab beds, as well as a growing ambulatory population. Each hospital maintained a separate rehab presence. Consequently, the system had much fragmentation in the rehab product line and little opportunity for further development.

In 1989 SSMRI began experimenting with the idea of regionalization, which is often considered the precursor of the integration concept. Regionalization involves centralizing product lines both geographically and organizationally.

Because rehab integration requires a different way of thinking, progress toward it was slow and sporadic. In November 1992 SSMRI and three of its SSM sister providers began developing an integrated rehab network. Central to their efforts

was a systemwide strategic analysis of rehab that quantified the benefits of an integrated system as opposed to independent units.

In September 1993 SSMRI implemented its integration model. The process went so smoothly that it was completed three months ahead of schedule. SSMRI is now responsible for managing rehab services at all SSM facilities and is accountable for both financial performance and client/host facility satisfaction.

**Staffing** SSMRI has consolidated staff, so staff can move around to handle fluctuating workloads at the 11 sites. Because staff can now try different settings, they are more interested in their work and less likely to leave.

The number of full-time employees (FTEs) has decreased through attrition. Because staffing has become more efficient, there has been no need to fill those positions.

**Patient Volume** Because it now has 11 sites and an increased market presence, SSMRI is more seriously involved in nego-

tiating with managed care companies. Its single, strong voice also helps SSMRI capture more of the market and deal with case managers and payers. Inpatient volume has increased 10 percent; outpatient business is also growing.

**Costs** Because the sites were so diverse before integration, comparing costs was like comparing apples and oranges. During its first year, however, SSMRI developed a baseline to set standards for costs.

Costs have been reduced by reducing the number of FTEs, intervening earlier in rehab cases, cutting the length of patient stays, eliminating duplicative services, and implementing an aggressive case management throughout the entire rehab network.

**Quality** SSMRI has standardized outcome measures, productivity standards, and treatment protocols throughout the sites. These changes have given the network consistency and a common strategic direction, which is especially important for managed care.

however, will go through four stages:

1. Clarification and expectation
2. Conceptual design
3. Implementation planning
4. Implementation

The goal is to create a new corporate culture, enabling the organization to do business in a new way. Each stage will require the involvement and skills of key parties.

Central to success are the support of the IDN's top leaders; visionary leadership at the rehab helm; "buy-in" from managers at each level of care; and the cooperation of other players, including physicians and managers of finance, planning, and communications departments.

**Clarification and Expectation** At this stage, senior managers set the direction for the network's development. They define integration, clear up misperceptions, quantify the expected benefits, and secure buy-in from influential parties.

Once these basic tasks have been accomplished, rehab leaders must organize a working committee of key managers representing all of the IDN's entities involved in rehab: hospitals, nursing homes, home health and ambulatory care departments, and others. And committee members must do more than merely attend meetings; they must actively participate for a consensus to be built.

The committee's chances of success will be enhanced if it has a strong leader. This leader must be a person with sufficient authority to make the necessary connections with the larger organization.

The committee's members will be interested in the project, but they will also probably be mistrustful, at least at first. They may fear layoffs and loss of control as their facilities and departments become components of a larger network. The committee should discuss these worries openly, just as it discusses the project's expected benefits.

As for the benefits, most committee members will recognize them readily. But decisions should not be made on the basis of feelings. Committee members should make decisions

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with the aid of market audits, internal audits, and financial analyses.

Analyses that quantify needs and opportunities from an IDN perspective will add a new dimension to the committee's thinking. These "big picture" analyses should identify gaps in the care continuum, spell out the impact of managed care and subsequent development needs, and profile operating deficits or overlaps that

must be addressed if the IDN is to function as a single entity. From these conclusions will emerge the network's strategic underpinnings.

Before the committee moves into the design phase, it should first settle financial accountability and control issues. The most successful IDNs are those developed as a single budget, with full financial accountability at the product-line level for each of the network's entities. Some of the IDN's providers may balk at this, because they fear losing revenue.

**Conceptual Design** At this stage, the committee begins to outline an organizational model for the integrated rehab network. Issues to be decided include legal structuring among nonrelated parties, management control, and facility-related questions. Committee members will set up the elements that constitute a seamless system of healthcare, one that has continuity of medical leadership and provides local controls.

Committee members may want to study other IDNs and perhaps use one or more of them as organizational models. The best model, however, is one based on their own network's needs and objectives.

In its conceptual design the committee should describe organizational features, objectives, key management roles, and the qualifications of management team members. Though the committee will be drawing up an organizational chart, it should not yet write names in the chart's boxes. In this way, committee members will avoid tailoring a job to a particular person's talents, rather than finding the best person for the job.

**Implementation Planning** At this stage, the IDN's master plan is developed. The network's leaders will use this plan to ensure that all facets of the integration



process are dealt with. The plan must address operating systems gaps and opportunities, information systems, human resources, marketing, communications, implementation stages, medical staff relations, managed care, final financial arrangements, and further definition of management roles and responsibilities. Integral to the plan is a time line designating the dates by which various components of the network should be integrated.

The drafting of the master plan is, unlike the other stages of the IDN-building process, usually most successful when done by the rehab leadership. The network's working committee, which has hitherto performed most of the labor, serves best here by reviewing the leaders' plan.

**Implementation** In this stage, the committee determines the IDN's final structure, picks the members of its management team and assigns their various responsibilities, coordinates the flow and interfacing of many different sets of tasks, and works to inspire confidence in the project at all levels of the organization.

### MAKING IT WORK

Successful integration is an enormous task requiring the input and support of many people. The leaders of such a project may find the following guidelines helpful:

- Create a "win-win" environment from the first stage through the last. This involves assuring participants that their services or programs will be enhanced at the end of the journey. It also means keeping your word—on this and everything else.
- Do not use integration as a disguise for downsizing or consolidation. Do not integrate while in the midst of downsizing. Trust plays an important part in this process.
- Designate one person as the leader for the entire process.
- Involve key managers at all levels of the system throughout the process. Do not contact them only when there is a problem. Work hard to maintain communication among top leaders of all the entities involved.
- Use a two-tiered approach for managing implementation: a management team and working groups. Delegate aspects of the implementation process to both the managers and the working groups.
- Create specialized working groups to oversee the analyses and integration of different aspects of the process, such as information systems, human resources, and communications. Have three to five specialized working groups active at one time.

- Allow for significant differences among the operating, management, and information staffs of the various providers. During implementation, address only the critical differences. Save the others until later.

- Have a contingency plan in case a key member or members of your team must resign.

- Hold all parties accountable for completing their responsibilities in a timely manner.

- Develop and stick to a reasonable time line for plan development and implementation—typically six to nine months.

- Communicate, communicate, communicate. Communication must be open to all staff members at all levels of all facilities. Use a multifaceted approach, from "town hall" meetings with staff to ongoing updates for facility management. And have in place a structured communication plan from the very beginning of the process, to help reduce staff anxiety over change.

- Be sure the IDN's and its entities' top leaders believe in the desired outcome of integrated rehab service and are committed to the project. Although there probably will be rough times, do not let these derail the effort or undermine the leaders' trust in the project. Without their trust, you cannot successfully build a new corporate culture.

- Conclude financial arrangements among the entities early in the process. This will motivate parties to invest in the success of the process.


- Address organizational structure issues—including who performs what role—late in the process. Fine-tuning the structure occurs at every stage. However, be prepared for some impatience from the management team.

- Get input and feedback from physicians from all entities and at all levels. Repeatedly reassure them that integration will be positive and will not interrupt their work or lower its quality.

- Outline the guiding principles for integration, which should include no layoffs, no salary cuts, and decentralization of therapists. This will help staff deal with change.

- Be sure you choose a qualified consultant, if you use one. The consultant should be able to provide technical assistance, help create win-win outcomes, and help ensure that the needs of all players are met effectively.

- Expect great results. The new culture will address difficult issues and offer new, creative solutions. □

 For more information on creating networks, call Frances Fowler, 404-955-5957.