NETWORK UNITES PAYERS, PHYSICIANS, HOSPITALS

System Participants Work Together to Improve Access to Care and to Design Cost-Saving Incentives

Physicians, payers, and hospitals in Lane County, OR, are working together to improve access to care in the community. Through Sacred Heart Health System (SHHS), Eugene, these groups, which previously often competed with each other, are now uniting around a common goal: serving people better.

SHHS, formed in January 1992, has brought all the "players" to the same table as equals to design a network that will integrate care and improve access by reducing healthcare costs. Together, system members design cost-saving incentives and the products the system offers to the community.

The new system's approach has required participants to change their traditional paradigm of healthcare delivery, in which providers and payers protect their individual interests. SHHS members have adopted a new cooperative paradigm that enables them to make collaborative decisions that are guided by the need to provide high-quality, cost-effective care.

SHHS's network of hospitals, payers, and physicians promotes managed care as the most efficient means to coordinate care and reduce costs. All participants share in the risks of a capitated payment system.

FORMING THE INTEGRATED NETWORK

The Sisters of St. Joseph of Peace, Health and Hospital Services (HHS) formed SHHS in January 1992. Two years earlier, HHS's president, Sr. Monica Heeran, CSJP, had become

Summary Through Sacred Heart Health System (SHHS), Eugene, OR, physicians, payers, and hospitals are designing a network that will integrate care and improve access by reducing healthcare costs. Together, system members design cost-saving incentives and the products the system offers the community. They promote managed care as the most efficient means to coordinate care and reduce costs. All participants share in the risks of a capitated payment system.

Since the system pulled together the payers, physician groups, and hospitals, many of these entities' management functions were consolidated at the system level to avoid duplication and reduce administrative costs.

Bringing in physicians was the most difficult yet important aspect of forming a successful network. Working with two physician groups in the community, the system's sponsor—the Sisters of St. Joseph of Peace, Health and Hospital Services—developed the Physician Practice Board. The board, representing 300 physicians, meets weekly and makes recommendations on issues that affect physicians.

SHHS also added innovative new functions such as an integrated medical cost management and continuous quality improvement program. Another key to success is a clinically oriented information system, which will allow the system to track patients once they leave the hospital. It also will provide a better understanding of what things have an impact on outcomes and will reduce paperwork.

A portion of the system's revenue is designated for initiatives to improve access. And the system recently appointed a tack force on access to explore what they can do in cooperation with others in the community.

concerned about the lack of access to care in the county and rising healthcare costs.

To explore options for how the Sisters of St. Joseph of Peace could respond to these problems, Sr. Heeran organized a 1990 corporate planning retreat. "The participants agreed that an integrated arrangement where physicians, hospitals, and payers worked together could better serve the community," Sr. Heeran told *Health Progress.* "We thought a narrow hospital focus would not solve the community's problems."

This belief was confirmed by Mission 2000, a year-long project HHS launched after the retreat to study the community's historical healthcare costs and barriers to access. Some 56,000 of the county's 275,000 residents lacked health insurance, yet 35,000 were employed. Employers were deeply concerned about the cost of providing health insurance to their employees.

"Mission 2000 revealed that cost was the greatest impediment to access in the county, and that problems of cost, access, and quality could best be addressed through an integrated delivery network," said Skip Kriz, SHHS's vice president for planning and product development.

Several factors led HHS to choose Lane County to begin an integrated delivery system. People were familiar with managed care (a health maintenance organization [HMO] began there in the late 1970s), few residents went outside the county for care, and Sacred Heart General Hospital in Eugene—the largest hospital in the county—had good relations with physicians. HHS created SHHS (see **Box**, p. 20), Sr. Heeran said, in order to provide a more effective organizational structure as well as to change the overall organizational mindset. "Managers and employees must move beyond seeing themselves as hospital managers or employees of an insurance company. Our people must begin to view their roles as being part of a larger health delivery system."

Since the system pulled together the payers (through SelectCare, a not-for-profit HMO), physician groups, and hospitals, many of these entities' management functions were consolidated at the system level to avoid duplication and reduce administrative costs. Most staff reductions occurred through attrition. Also, innovative new functions such as an integrated medical cost management and continuous quality improvement (CQI) program were added. The **Box** on p. 21 lists the members of SHHS's management team.

Physician Participation Key

Bringing in physicians was the most difficult, yet most important, aspect of forming a successful network. Physicians invited to participate had to belong to groups large enough to accept the financial risks of capitation. In addition, the groups had to be capable of funding increased utilization review activities, developing quality assurance and peer review systems for outpatients, and monitoring clinical outcomes. Because these criteria required professional management and sophisticated information systems, it was not possible for solo practitioners, small groups, or loosely structured independent practice associations to participate.

The exclusion of some physicians from the panel generated controversy within the medical community. While all medical staff members remain as panel members serving the system's general HMO product, the selection criteria for the select panel product have been a focal point for discussion between the system and physicians who do not fit the criteria.

Physician Practice Board "The underpinning of our thinking was, you can't do reform without the active participation of physicians because they control so many of the resources," explained Wes Jacobs, MD, a member of the SHHS management team. "We wanted the hospital, health plan, and physicians to sit at the same table with the same information," he said.

HHS worked with two physician groups in the community, a primary care group and a multispecialty group, to figure out how physicians could be represented at the table—what kind of structure they would accept to represent the physicians' perspective in the management of the system.

The groups developed the Physician Practice Board (PPB), which actually functions "halfway between a board and a management team,"

"Our people must begin to view their roles as being part of a larger health delivery system," noted Sr. Monica Heeran, HHS's president.

according to Jacobs, who is now chief executive officer of the PPB. "The PPB is actively involved in management—more than a board usually is," he said. The PPB meets for three to six hours a week and makes recommendations about issues that affect physicians, such as risk-sharing arrangements, subscriber benefit packages, and physician payment structures. Jacobs noted that it has been a problem for doctors, who have a full-time job taking care of patients, to commit the time.

The Physician Practice Board is actively involved in management.

The PPB represents the panel of more than 300 physicians who contract with SelectCare. The composition of the six-person board initially sparked controversy among the physicians because doctors' organizations traditionally include representatives of all subgroups, Jacobs said. "In selecting the physicians for the PPB, we tried to balance primary care and specialists," he explained, "but a larger board could not have functioned in a business. The concept was to represent the broad interests of physicians."

Although many doctors felt uncomfortable at first with delegating to a nonrepresentative board the authority to speak on their behalf, the PPB is gaining credibility, Jacobs said. The system board can reject a PPB recommendation, but it cannot impose anything on the physicians without the PPB's approval. This rule fosters collaborative problem solving and physician trust, according to Jacobs.

SHHS physicians agree that trust is essential if SHHS is to control costs by aligning the incentives of all the providers in the system. "Doctors would not want a system that creates a financial incentive to withhold needed, appropriate care, and we are continually looking to make sure we do not set up such a system," said Paul Panum, MD, who is medical director of the Eugene Clinic, a multispecialty group practice affiliated with SHHS, and a member of the PPB. Like the hospitals, he explained, primary care physicians are paid on a capitated basis, receiving a certain amount per month to provide a specified list of services. Providers of radiology, pathology, physical therapy, mental health, and chemical dependency services are also capitated. Other specialists are paid on a fee-for-service basis according to a fee schedule that includes incentives to reduce costs.

Continuous Quality Improvement SHHS sees its medical cost management efforts as inextricably linked with CQI, said Tom Lawry, SHHS vice president for external affairs. The system recently hired a vice president of CQI/medical cost management "to ensure that the persons responsible for cost management are also the ones driving CQI," he explained.

Panum said that SHHS physicians, who have been involved from the beginning in planning the system, realize that the goal of CQI is to improve the quality of healthcare. Both Panum and Jacobs agree that physicians willingly participate in CQI efforts when such efforts are relevant to what the physicians were trained to do, that is, take care of people.

"The system rewards providers for providing appropriate levels of care, rather than doing more procedures," said Lawry. In the past providers had little reason to avoid practice variations, he said. Now they have the incentive to use peer review, outcomes measurement, and practice guidelines to ensure they are practicing as cost-effectively as possible.

Information Systems "One of the keys to our success will be a clinically oriented information system," said Jacobs. "Fundamental to outcomes research is a data base that includes outpatients

NETWORK COMPONENTS

Sacred Heart Health System (SHHS), Eugene, OR, is an operating unit of the Sisters of St. Joseph of Peace, Health and Hospital Services (HHS), Bellevue, WA, which has health ministries in Alaska, Oregon, and Washington.

Components of SHHS are:

- Sacred Heart General Hospital, Eugene
- Peace Harbor Hospital, Florence, OR
- Cottage Grove Hospital, Cottage Grove, OR
- SelectCare, Eugene
- Physician Practice Board

and that allows us to track patients once they leave the hospital. If we can integrate information from the hospitals, SelectCare, and individual physician offices into a composite patient record, then we can get a better understanding of what things have an impact on outcomes," he said. It will take a few years before the data base is an effective tool. A total redesign of information systems, from staffing to technology, is being undertaken. Physicians and other end users have been heavily involved in the planning process.

> One of the keys to success will be clinically oriented information systems.

Another major goal of the information system is "to reduce the paperwork and bureaucracy that's overwhelming physicians—not only in terms of time but in distracting them from the excitement of practicing medicine," Jacobs said. "We've got to make the interaction between physician, patient, hospital, and system simpler."

Tapping the potential of specialists to control costs also requires information, Jacobs added. Without data, he said, "it's hard for primary care doctors or specialists to know how they compare to their peers." Jacobs thinks measuring the results of all providers and obtaining benchmarks from outstanding organizations and groups are essential to help providers. "If they have to work in a vacuum, there's no way to get the best results."

Improving Access

Physicians are "holding the system's feet to the fire" to demonstrate improved access, said Jacobs. "They are really interested in seeing something that clearly breaks down some of the barriers to access." The PPB has called on SHHS to devise a method to determine over the next few years how its products are increasing access.

A portion of the system's revenue is formally designated for initiatives to improve access, Lawry said, so SHHS will be able to go beyond merely providing charity care. Sr. Heeran recently appointed a task force on access. "It will ask, What should we be doing beyond the walls of this organization? How do we become a catalyst within the community to improve the health of the community?" she explained. For example, SHHS is beginning to explore ideas such as subsidizing insurance premiums for low-income people as an alternative to charity care.

Success: Keeping the Focus on Needs

Most providers are concerned that the healthcare system excludes many Americans and realize that the United States cannot continue to spend 14 percent of gross national product on healthcare. Yet many fear changes such as SHHS's integrated approach because they do not know where they will fit in a redesigned system, noted John Haughom, MD, a member of the PPB. He predicted it will take five to seven years for the nation to reform its healthcare system.

"Our challenge at SHHS is to create working relationships that allow us to adapt to what happens nationally," said Haughom, who is a board member of a newly formed group of medical and surgical specialists. "Our project depends on acceptance by the physician community and the community as a whole. If we can show our goals are achievable, then negative reaction will disappear."

SHHS's participants agree on the key to success: keeping focused on the system's overall goal of serving people. "You have to decide what it is you want to do—run a hospital, run a clinic, run an insurance plan, or provide healthcare to the community," insisted Jacobs. By not losing sight of that latter goal, participants believe, they will be able to continue the century-old ministry of the Sisters of St. Joseph of Peace in the Pacific Northwest.

—Judy Cassidy

SACRED HEART SYSTEM MANAGEMENT TEAM

- President of SHHS
- Administrator and associate administrator of Sacred Heart General Hospital
- President of SelectCare
- Chief executive officer of Physician Practice Board
- SHHS vice presidents for human resources, information systems, CQI/medical cost management, finance, planning and product development, and external affairs