



RELATIONSHIPS WITH OTHER PROVIDERS

INTEGRATED DELIVERY NETWORK, ST. LOUIS
SYNERGON HEALTH SYSTEM, CHICAGO

To Bill Schoenhard of SSM Health Care System, St. Louis, one of the most important factors in choosing partners for an integrated delivery network was a common vision of the future.

"We don't have any magic crystal ball," says Schoenhard, who is executive vice president and chief operating officer of SSM, as well as a key player in a recently formed integrated delivery network in the St. Louis area. "There's so much uncertainty with the Clinton proposal, but there are certain parts of the vision that we think are important for everyone to share."

Schoenhard says the new network's vision includes a commitment to moving away from a sickness model, which has a fee-for-service, acute care orientation, to a wellness model with capitation and financial incentives that emphasize prevention and primary care.

The network (as yet unnamed) includes five members of SSM Health Care System: St. Mary's Health Center, Richmond Heights, MO; St. Joseph Health Center, St. Charles, MO; St. Joseph Hospital West, Lake St. Louis, MO; Cardinal Glennon Children's Hospital, St. Louis; and SSM Rehabilitation Institute, St. Louis. Other network participants are DePaul Health Center, Bridgeton, MO (a member of the Daughters of Charity National Health System);

Saint Louis University Health Sciences Center, St. Louis; and Missouri Baptist Healthcare System, St. Louis.

CHOOSING PARTNERS

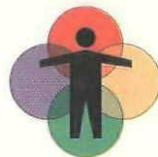
From the beginning, SSM had determined it did not want to join an exclusively Catholic network, Schoenhard emphasizes. "We saw value in the mission and philosophy of the non-Catholic providers," he says. "There's a common commitment to the ministry, to serving the needs of the community."

In addition to a compatible mission and vision of the future, Missouri Baptist makes a good partner because of its location in an area not covered by any SSM facilities and its strong rural outreach program, Schoenhard says.

An additional criterion in choosing partners was to complete the continuum of care necessary for a fully integrated network. To that end, network leaders are holding discussions with other hospitals in the area, including some in Illinois, as well as non-hospital providers such as long-term care and home care providers, he says.

The current participants envision a seamless delivery system offering a full continuum of care. This would require a common registration number and medical record for patients, using primary care physicians as points of entry, Schoenhard

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explains. Then patients would be able to move through a network of services at the appropriate level, with convenience, low cost, good access, and coordination. He noted that such a system is not available in the St. Louis market at this time, but is present in some more mature markets.

THE MOVE TO GREATER INTEGRATION

Last August, when SSM and its partners announced their plans to form an integrated delivery network, they reported that all participating institutions would retain their own identities and sponsorship. Now, several months later, Schoenhard says they are working toward greater integration.

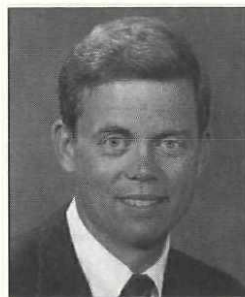
"We don't think that a loose hospital alliance—just a cooperative of some kind—can work," says Schoenhard. "While we may not have a merger of assets, we're going to need an operating company that has the capacity to pool revenues, to work at consolidation of services, and to have the financial incentives aligned such that we can really do meaningful reduction of services, measurement of quality, and transfer of patients in a continuum of care across the network."

Ultimately, he says, establishing such a holding company or other entity will prepare the network to receive capitated reimbursement—which is increasingly important as managed care spreads throughout the area and healthcare reform approaches.

To manage the transformation from individual organizations to a network, the participants are forming a steering committee, which will include physician representatives. Seven subcommittees are already at work, focusing on:

- The form and structure of the network
- Criteria and membership for metropolitan providers
- Criteria and membership for rural providers
- The primary care distribution system
- Managed care
- Education, particularly graduate medical education and residency sites, as well as allied health education
- Program services to see where network members can cooperate and consolidate work and services within the current loose affiliation model

For shared services to really work, "we're going to have to have our financial incentives aligned as an operating entity, as a network," Schoenhard says. Already the SSM Rehabilitation Institute has begun discussions with some network participants about provision of rehabilitation services. And network members are starting to talk about cooperating in such areas as workers' compensation and occupational medicine.



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MOVING AHEAD

To determine how the network members can accomplish their vision of integrated delivery, Schoenhard says they have talked with a number of consultants about various models and their experiences in other markets. Since the network members "had a pretty good sense of what we wanted to be," they decided to make some decisions up front and then engage specific experts to implement them.

Although the final form of the network is still up in the air, Schoenhard says their initial plans call for the formation of a managed care company. "Our interest is not in competing with managed care companies in town but in looking for new and creative relationships with them," Schoenhard says. He thinks the initial step of working as a network in managed care will lead to a more mature organization with an operating company that can pool revenues and work to rationalize the system, since the St. Louis market has a significant oversupply of services, Schoenhard says.

He also emphasizes that their plans include collaborating with as many parties as possible. By the end of the year, the first new partner is expected to join the network, when St. Joseph Hospital of Kirkwood becomes an SSM member and, by virtue of that, a network member. St. Joseph's sponsor, the Sisters of St. Joseph of Carondelet, is currently completing an agreement with the Franciscan Sisters of St. Mary (SSM's sponsor) to transfer sponsorship of St. Joseph in exchange for that of St. Mary's Hospital in Blue Springs, MO.

In addition to an openness to new members, Schoenhard says the network is working to help any institutions adversely affected by the network to "manage the transition of their ministries in a way that would be beneficial to them and to the community." Such discussions, already underway, he says, are important to the sponsoring congregations and to Catholic collaborative efforts.

SYNERGON HEALTH SYSTEM

For Leonard Muller, president and chief executive officer of Synergon Health System, Oak Park, IL, forming an integrated network was a question of survival.

"The collaborative model, versus the competitive model, is a lot more inexpensive for the provider *and* the community," he says. "The more you compete, the more you raise prices."

Synergon was formed in 1990 but added a new partner in July 1993 when Rush-Presbyterian-St. Luke's Medical Center, Chicago, joined the network. Other Synergon participants are Oak Park



Hospital, Oak Park (a member of the Wheaton Franciscan Services, Inc.); Westlake Community Hospital, Melrose Park, IL; Westlake Pavilion, Franklin Park, IL; and Community Nursing Service West, Oak Park.

Muller said that the economies of scale have been much more than Westlake and Oak Park hospitals expected when they formed the network. "We expected to eliminate a half a million to a million dollars in redundancies," Muller says, "but the savings have approximated more than \$2 million and are still growing."

He notes that staff have suggested many of the ways to consolidate and eliminate redundancies. "Once you start breaking down the barriers and people start seeing it's not 'we' versus 'they,' there are unlimited things you can do—things we never even thought of initially," Muller says. For example, Oak Park and Westlake had not planned to integrate in the areas of materials management, computer systems, laboratories, and security programs, but have since done so.

Muller, who was the president of Oak Park Hospital before it entered the joint venture, noted the integration and savings are largely occurring in shared services and operations between Oak Park and Westlake hospitals. He

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does not expect Rush to become as integrated as the two other facilities.

PRINCIPLES FOR COLLABORATION

All situations are different and require different degrees and models of integration, Muller stresses. "There's no cookie cutter way of doing it. You have to develop a process that you think would work under the local conditions." But he does have some principles that he thinks will stand the test of time in any situation.

Be Certain You Have a Similar Vision First, the collaborating partners must be certain that their visions are similar, Muller advises. For example, Oak Park talked at length with another Catholic healthcare organization about the possibility of integrating. But after 8 to 10 months of discussions, he says, they called a halt because negotiations were going nowhere: The other organization was more interested in acquiring a facility than collaborating with one.

With Rush, by contrast, Muller said they had a conversation, discussed their visions, and struck a deal within four months. "Within seven months we signed an agreement, and not one legal dollar was spent." The shared vision, he says, involves forming a metropolitan-wide system to contract

PROVENANT HEALTH PARTNERS: INTEGRATING ELDERCARE DELIVERY

Healthcare providers involved in integrated care networks not only have to build strong relationships with others, they must focus on meeting the needs of their communities. Provenant Health Partners, Denver, is doing just that by offering a full continuum of care to elderly persons in its service area.



Rockers

seniors in that one building," says Provenant Health Partners Chief Executive Officer Tom Rockers. Senior Life Center has 38 short-stay, teaching-model nursing home beds; 32 extended care facility beds; 24 rehabilitation beds; and 16 geriatric psychiatric beds.

Using a five-person geriatric practice it purchased in 1990 as its base, Provenant has built the practice up to 14 geriatricians. Along with nurse practitioners and social workers, Provenant geriatricians staff four senior health clinics in Denver. These clinics provide ambulatory services for 5,000 Medicare patients. In addition, Provenant offers home healthcare, senior housing, and senior day care. "In our Senior Care Division we offer the full continuum of care—all the way from physicians through home healthcare," explains Rockers.

Provenant is currently negotiating its first managed health organization product—a senior care product, notes

Rockers. "We will be taking on the risk within our corporation, where we have the physicians and other services, and doing the full capitation for a Medicare health maintenance organization product that will be offered by one of our insurance partners."

Rockers maintains that the eldercare market is "a market everyone should pay attention to because it's the only growth market in healthcare." He advised that any provider wanting to offer an integrated network of care for the elderly to do the following:

- View each market as unique.
- Be prepared to provide care in an extended care facility and at seniors' homes.

- Know that eldercare "has to be managed differently under managed care. Providers have to provide low-cost, high-quality services at the appropriate time so that elderly patients move through the continuum at the proper rate."

—Michelle Hey



for managed care.

Put Your Deal Breakers Up Front By accident or dumb luck, Muller reports, Oak Park Hospital did the right thing: "You can't waltz and dance and hold back on your deal breakers. Get them up front, and if you can clear those, then the rest of it falls in place lickety-split."

The nonnegotiables for Oak Park included that it would remain Catholic and that it wanted a cooperative model rather than a control model. This means, Muller explains, that the two entities are willing to share governance, finances, and management. Also, Oak Park wanted to merge income statements but not assets, so what belongs to its sponsor (the Wheaton Franciscan sisters) would remain theirs.

Do Not Negotiate in a Fishbowl "You can't negotiate by committee," Muller advises. "You have to send an emissary, like what's going on in the Middle East." For the negotiations between Oak Park and Westlake, only two parties were involved; with Rush, it was three parties. "Of course, everybody had their key people they were keeping informed back at the ranch."

He warns that when everyone knows the facilities' leaders are at the negotiating table and the process is taking a long time, "it allows the negative parties to build up strength."

"There will always be nay-sayers," Muller says. "But if you feel it's the right thing to do, that's what leadership is all about. We're not talking about democracy." Muller jokes that he does not wear a bullet-proof vest but an arrow-proof back-guard, because when a leader is out in front, the arrows come from behind.

The Board Has to Provide a Parachute The person negotiating must have a parachute, Muller advises—such as 24 months' pay guaranteed if he or she is out of a job as a result of the deal that is made. "The board has to protect that person out there in front so that they're working to do the best thing without worrying about their own fanny."

Be Flexible Even though participants in an integration activity have to know their "deal breakers," their limits, they also have to be flexible. "If you go in there with 20 different requirements, it won't go anywhere," Muller warns.

Develop Trust between the Leaders Trust—and hence collaborative relationships—will come easier between persons who know each other, Muller says. "But if the individual isn't well known to you, you have to get some stock in the trust bank, so that you don't have to take a major leap of faith that is unreasonable for the size of the deal."

With both Westlake and Rush, Muller says, he did not know the leaders previously. "But seasoned executives can size up other executives



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pretty well, and our reputations in the community were established. If you can articulate what you want out of the deal, then it goes quickly."

Give It Time Once an integration agreement has been signed, the implementation is "a whole other thing," Muller says. Like a marriage, there may be surprises after the deal is made. "The next thing you find out is, 'You mean you open your gifts on Christmas Eve?'"

The first few years involve working out the details—the differing traditions and practices—as well as gaining the confidence, respect, and trust of employees. "Time is the best thing that you've got going for you," Muller says. "It doesn't happen with the stroke of a pen; you're not integrated right away."

Muller warns that it also might take time to find the best way to integrate the various parties. For example, after Synergon's formation, Muller became the chief executive over both Westlake and Oak Park, but he hired a chief operating officer for each facility. They ended up competing against each other, and eventually he replaced them with executive vice presidents who worked in both facilities—one in charge of nursing and professional services, the other over administration and facility services. Even though in hindsight he sees the error, Muller thinks this change probably could not have been done on day one of the reorganization. In the future, though, he would watch for the opportunity to consolidate executive positions from the start.

Be Clear about When You Want to Involve the Medical Staff To make the integration more acceptable to physicians, Oak Park and Westlake agreed initially that their medical staffs would not be integrated. Now, three years later, Muller reports that the officers of both medical staffs are initiating discussions about integrating their staffs.

THE BENEFITS OF NETWORKS

Muller notes that the collateral benefits of forming an integrated network can be greater than the initial benefits envisioned. Like a marriage, forming a network can bring good and bad surprises. "But you have to put the negatives in the context of the overall vision that you have and not get dissuaded by them," he says.

Schoenhard underlines the positive aspects of a network: increased efficiency, reduced duplication of services, enhanced quality, and lowered costs. And he points out that network membership gives an individual facility increased leverage to influence the future of healthcare delivery—"not in an adversarial role with the insurance community, but more in a way that can help us provide network-type, high-quality, seamless care to the community." —Susan K. Hume