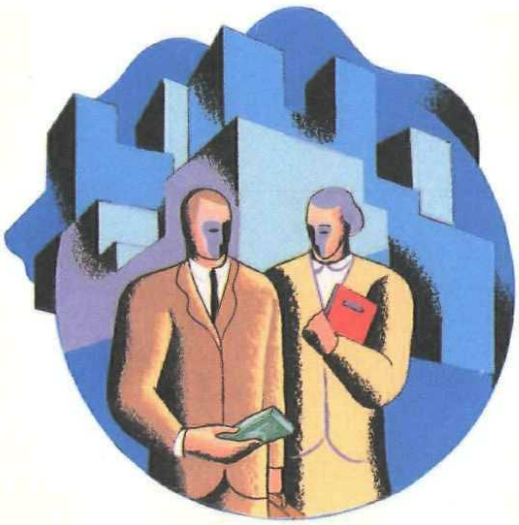
versities of Michigan and Iowa, as well as with the Henry Ford Health System.

Integrated healthcare systems will also need information systems that provide easy access to patient care information in outpatient, inpatient, ancillary, and nursing home settings, Collins states. And without aggregate data on quality of care, outcomes, appropriateness, and costs of care, he adds, the system will not be able to make necessary improvements. "An extensive information system in the integrated healthcare system is equivalent to the human central nervous system—without it the body won't work," he says.

Cooperation Essential

Collins urges hospitals and physicians not to get into a "war" with each other; he makes the same plea to primary care and specialty physicians. "Ultimately we are all trying to build efficient services for the community," he says, "and that will take the participation of everyone."

—Judy Cassidy



Relationships with Payers

Sisters of Providence Health System, Portland, OR
Mercy Healthcare Sacramento, CA

As the shift toward capitated payment accelerates, hospitals and systems seeking to form integrated delivery networks will be faced with strategic choices about their relationships to payers. Providers must be flexible enough to adapt to different market conditions and take advantage of potential new relationships, but they must also be sure the arrangements they enter into are consistent with their goals and capabilities.

Sisters of Providence's Health Maintenance Organization

Provider networks considering ownership of a health maintenance organization (HMO) should take a careful look at the market they are entering and ask whether they have the resources to manage the payer's side of managed care, warns John P. Lee, vice president for operations, Sisters of Providence Health System (SPHS), Portland, OR.

Early Presence The system, which includes three large hospitals, has owned an HMO for more than 10 years now. It began by offering health plans for employees within the system.

"We entered the market early enough to establish a presence," Lee explains, "and we have gone through the process of moving from fee-for-service forms of reimbursement to capitated payments." The system's HMO now has close to 100,000 enrollees, and nearly 150,000 people are

eligible to participate in SPHS's preferred provider organization (PPO). Its hospitals account for approximately 30 percent of the inpatient volume in Portland.

Because it owns an HMO and also contracts with organizations that offer managed care products, SPHS is sometimes in the uneasy position of pursuing business relationships with competitors. "We find there's a price to pay for moving into a more fully integrated system," Lee notes. "As we evolve, we will have to figure out how to continue to work with existing insurance companies that our own HMO competes with." For example, SPHS is currently in the local Blue Cross's PPO, and the system is open to the possibility of developing further relationships with the insurer. "If they wanted to offer our system as an HMO, we'd go along with it," Lee says. "But they're reluctant to do it when we have our own plan."

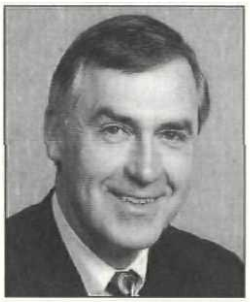
Integrated Management Teams To strengthen its integrated delivery system, SPHS recently placed all its acute care hospitals under a single management team. A former chief executive officer of one of the system's tertiary hospitals is now in charge of regional development, with all SPHS programs reporting to him. One goal of the reorganization is to develop the capability to track outcomes and monitor processes at all system delivery points.

Lee stresses the growing role primary care providers will play as integrated delivery networks become more prevalent. "In many instances they will in effect become gatekeepers and patient managers. As a result, their income is going to go up, and the reality is the extra dollars they receive will come from decreased hospital utilization and possibly some containment of reimbursement to specialists."

Like many other providers, SPHS has made a strong effort to increase the range of its primary care services. The system has created a statewide home care network with a local component that serves about 1,000 persons per week. In addition, a recently created primary care division now employs 60 primary care physicians.

SPHS is also working to form strategic alliances with local clinics, many of which are owned by physician groups. But as was the case with other managed care organizations, the system sometimes finds it difficult to forge cooperative arrangements in this area, since many clinics are themselves interested in enrolling clients directly and are thus potential competitors.

Aligning Interests Lee believes that such clashes of interest need to be resolved to ensure that communities receive optimal healthcare. "The best care in the future will occur when physicians, hospitals, and insurers come together and arrive at some kind of common vision. They have to sit together at the table to figure out how they can, working together, improve the community's health status."



"As we evolve, we will have to figure out how to continue to work with existing insurance companies that our own HMO competes with," Lee notes.

Mercy Healthcare's Delivery Network

Although ownership of an HMO can give a system or network a measure of control over its destiny by enabling it to contract directly with large employers, the resources required to operate such an organization successfully rules out this option for many providers. In most cases, a more realistic approach is to concentrate on developing a comprehensive healthcare delivery network.

Mature Market This is especially true in areas where the HMO market is already heavily penetrated, advises John Chambers, vice president of operations at Mercy Healthcare Sacramento. A five-hospital network serving the Sacramento, CA, area, Mercy is a member of the San Francisco–based Catholic Healthcare West.

Mercy Sacramento had attempted to set up an HMO in a joint venture with another health system about six years ago, but the system and its physicians soon realized they were not yet in a position to deal with a capitated environment. Since then, Mercy leaders have decided that the system should adopt a different strategic direction.

"In our situation," Chambers explains, "probably 80 percent of the area population is in some kind of care plan. In addition, in California a lot of these organizations are planning to put together statewide plans, which would have been beyond Mercy Sacramento's capabilities."

Mercy also benefits from its affiliation with Catholic Healthcare West, Chambers emphasizes. "We are actually a system within a system, and membership in CHW has given us access to important legal, financial, risk management, and insurance resources," he points out. The affiliation enables Mercy to focus its efforts on healthcare delivery.

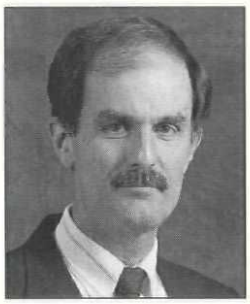
Comprehensive Services Because Mercy could not fill any market niche not already filled by other organizations, the system decided it could best use its capital resources to develop a comprehensive package of services that are accessible to the majority of people in the system's service area. The recent inclusion of Methodist Hospital in Sacramento in the Mercy system was an important addition. "Part of our overall strategy has been to create a network that put 80 percent of the population within 15 to 20 minutes driving time of one of our facilities," Chambers says. "Methodist gave us a presence in the southern part of Sacramento."

Mercy is also investigating the possibility of

collaborating with other facilities in nearby markets, although planners do not anticipate that these facilities would join the system. "Our expectation is that they would remain autonomous and that we would have a business relationship rather than a governance relationship with them," says Chambers.

Flexible Relationships In pursuing relationships with payers, Mercy planners have sought to be open and flexible. The system has contracts with a number of HMOs, and it does not demand exclusive contracts with any payer. "Our strategy has been to develop a portfolio of managed care plans and try to enter into agreements with the largest players in Sacramento," Chamber says.

Chambers notes that the system's relationship with payers has changed with the maturing of the area's managed care market. At first, contracts between providers and HMOs were typically renegotiated year to year. But as the parties involved developed a better understanding of the risks and responsibilities capitated agreements entail, multiple-year contracts became more prevalent.



Mercy planners have sought to be open and flexible, Chambers says.

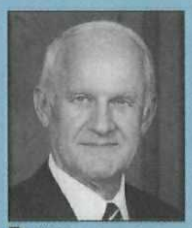
Mercy leaders are pleased that the system can make longer-term commitments. "It's something we want and something the market wants," Chambers says. "The biggest advantage is that it provides stability for beneficiaries, who don't have to worry that in the next open enrollment they will have to choose from a new group of physicians and hospitals."

In establishing relationships with HMOs or similar organizations, providers should look at who the successful payers are now and who they are likely to be in the future, Chambers advises. He says providers should also seek assurances that payers can arrange contracts to fit their needs. "If you want to do capitated agreements, make sure they are open to that. If you are interested in longer-term arrangements, check to see if they will consider multiyear agreements," he suggests.

The experience and financial strength of an HMO are also important considerations, Chambers concluded. "Make sure they know what they are doing and that they have the resources to weather tough times."

—Phil Rheinecker

HEALTHSOURCE ARKANSAS: A MANAGED CARE PARTNERSHIP



Bowen

For providers with a strong presence in a relatively underdeveloped managed care market, sometimes the best approach is to match strength with strength.

This past spring St. Vincent Infirmary Medical Center conducted a nationwide market search of organizations with experience in managed care to find a partner in developing an integrated delivery network in Little Rock, AR. After considering a number of potential candidates, St. Vincent leaders decided to approach Healthsource, Inc., Concord, NH. St. Vincent and Healthsource eventually agreed to form a new company, Healthsource Arkansas, which will offer a full array of managed healthcare products. The agreement is subject to approval and licensing by the state insurance commissioner.

William H. Bowen, former chief of staff for then-Governor Bill Clinton, recently joined Healthsource Arkansas as its president and chief executive officer. He explains that a number of factors made Healthsource an attractive partner for St. Vincent. "The founders and current leaders of the organization are entirely doctors," Bowen says. "Their familiarity with the provider side of the healthcare system, including hospitals, made them an ideal choice."

Healthsource is also a proven success. Founded in 1985 by physicians in Concord, NH, the organization now has a presence in 12 states. "They have a marvelous information system that keeps them in touch with developments throughout the organization. And their knowledge of managed care products, which we will depend on very much, is remarkable."

Another factor drawing St. Vincent to Healthsource was the organization's experience in small, usually rural markets. "They have done what a company like Wal-Mart did," says Bowen. "They have for the most part avoided the larger cities and sought to establish themselves in smaller communities."

For its part, St. Vincent brings to the partnership a well-established provider network offering a full continuum of services. Bowen expects that Healthsource Arkansas will at first be granted authority and licensure to serve only counties close to Little Rock. But St. Vincent's affiliations with other providers give Healthsource Arkansas the prospect of statewide outreach.

According to Bowen, one of the primary advantages of shared ownership of a managed care organization is that it sharpens both parties' interest in making the arrangement succeed.

Bowen adds that partnerships like Healthsource Arkansas, because they combine the strengths of providers and insurers, are in a good position to attack many of the hurdles integrated delivery networks face in establishing themselves in a particular market. "You have a number of parties to deal with—providers, physicians, gatekeepers, hospitals—and none is incidental. Thus there are a lot of opportunities to drop the ball if you don't work at it carefully, which is why it is so helpful to have a skilled joint venturer at your side."