



# SERVING OUR COMMUNITIES BETTER

**T**hroughout the United States, healthcare organizations are forming networks capable of providing an integrated continuum of healthcare services to large population groups. The Catholic Health Association (CHA) and the American Hospital Association both advocate restructuring the healthcare delivery system as a fundamental and essential element of healthcare reform in our nation.<sup>1</sup>

The terms that describe the new networks include "integrated delivery networks," "community care networks," and "accountable health plans." Although the terminology and definitions vary somewhat, most leaders advocating reform agree on the importance of certain key features:

- Close linkages among physicians, hospitals, and other providers to build a comprehensive spectrum of coordinated services
- An organizational structure that enables the vertical and horizontal integration of services
- A strong focus on assessing and improving the health status of the community, in addition to caring for individual patients
- The capacity to assume financial risk for providing care to a defined population group or groups



*Mr. Prybil is regional executive and chief executive officer, Daughters of Charity National Health System-East Central, Evansville, IN; Fr. Golden is senior executive for university mission, DePaul University, Chicago, and canonical adviser to DCNHS-East Central; and Sr. Ballance is chair, DCNHS-East Central Board of Directors.*

## *Guidelines For Planning And Developing Integrated Delivery Networks*

**BY LAWRENCE  
PRYBIL; REV. PAUL  
GOLDEN, CM, JCD;  
& SR. XAVIER  
BALLANCE, DC**

### **MISSION FOUNDATION**

The Daughters of Charity National Health System (DCNHS) mission statement proclaims that the fundamental purpose of the system, its regional organizations, and its local healthcare institutions is "to contribute toward improving the health sta-

### **Summary**

In 1994 the Daughters of Charity National Health System-East Central (DCNHS-East Central) adopted 11 guidelines to help corporate staff and local leaders plan and develop integrated networks.

Guideline 1 emphasizes needs-based strategic planning.

Guideline 2 focuses on the community-based network planning process, recommending a team approach and ongoing communication with the local ordinary.

In guidelines 3 through 5, the DCNHS-East Central Board of Directors spells out key issues that must be covered in proposals ultimately presented for governance action.

Guideline 6 presents three core elements that should characterize all CBNs in which DCNHS-East Central institutions participate.

Guideline 7 emphasizes that all CBN proposals and agreements must be clear with respect to the Catholic identity of DCNHS-East Central institutions.

Guidelines 8 and 9 require that proposed changes to traditional policies and management practices be explicit in CBN proposals.

The tenth guideline requires that all CBN proposals indicate an explicit evaluation function.

The final guideline underscores that regardless of the strategic fit or how well a CBN is designed, it is unlikely to succeed unless both internal and external relationships are based on a solid foundation of honesty, mutual respect, and trust.



tus of individuals and the communities we serve by providing patient-centered, economical health services, with a special concern for the sick and the poor." The statement also calls for all system leaders to "promote a healthy and just society through community-based networks, and collaboration with those who share our values."

Since this mission statement was adopted in 1992, DCNHS has encouraged its entities to forge strong "community-based networks" (CBNs) capable of providing an integrated continuum of services to large population groups.<sup>2</sup> This priority flows from the conviction that forming integrated networks with partners who share a common vision and compatible values will serve community needs more effectively and efficiently than the fragmented delivery system that has prevailed in the past.

The Daughters of Charity National Health System—East Central (DCNHS—East Central) created 11 guidelines in 1994 to help corporate staff and local leaders plan and develop community-based networks (CBNs). DCNHS—East Central, one of four regional organizations that make up the national system, comprises 21 inpatient facilities and a range of related programs and services in a six-state region.

## GUIDELINES

While crafting the guidelines, the board obtained input from local governance and management leaders, CHA and DCNHS staff, and corporate and canonical legal advisers. The board's intent was to provide parameters that would be clear and helpful, but allow appropriate flexibility at the local level. Following are the guidelines with brief explanations:

**1. Community Needs Assessment** Community needs and an up-to-date strategic plan should provide the foundation for a DCNHS—East Central institution to initiate or participate in a CBN planning process. The nature and focus of these efforts should be consistent with the overall goals and strategies set forth in the institution's strategic plan.

Just as DCNHS and DCNHS—East Central policies stress the importance of ongoing assessment of community needs as a foundation for local strategic plans, this guideline emphasizes needs-based strategic planning as the basis for planning and developing CBNs.

**2. CBN Planning Process** The planning process for forming or joining a CBN ordinari-

In crafting the guidelines, the board's intent was to provide clear, helpful parameters that allowed flexibility at the local level.

ly should follow the general steps outlined in the **Box**. A team approach involving local and regional representatives will be used to ensure good coordination. Providing regular reports to local, regional, and DCNHS leadership, routinely seeking their advice, and ongoing communication with the local ordinary are key elements in the planning process.

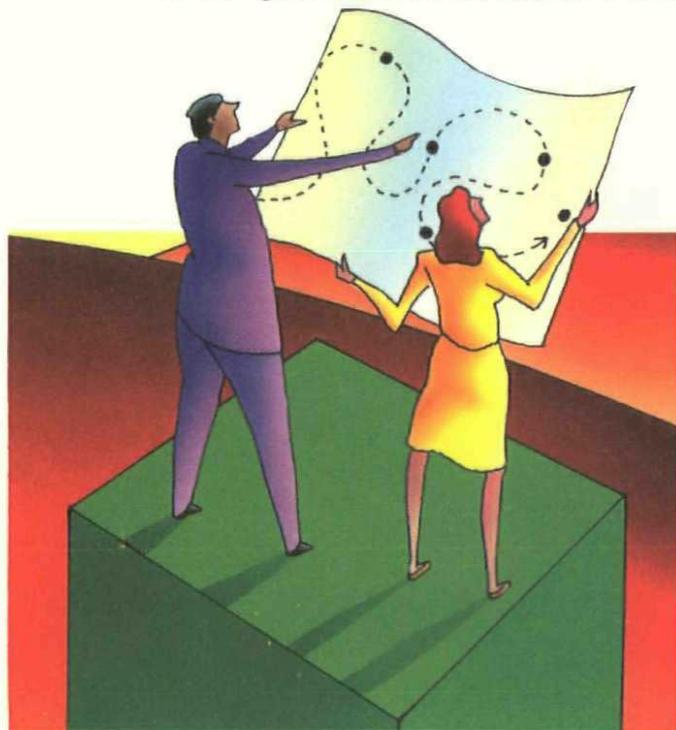
Each community and the manner in which CBNs develop within them are somewhat unique. In general, however, DCNHS—East Central experience suggests that successful planning processes include three major and distinct phases:

- First, potential CBN partners must be identified. Through open dialogue the entities must gain a reasonable degree of mutual assurance that they share compatible visions, values, and principles.

- Second, network partners need to develop an overall plan for a CBN and assess its desirability and feasibility in relation to established criteria.

- Third, if desirability and feasibility have been adequately demonstrated and the respective governance bodies and sponsors approve of the affiliation, implementation planning and due diligence must be completed to provide a solid basis for final approvals before the CBN begins operation.

The general steps outlined in the **Box** would be modified when a DCNHS—East Central institution is assessing the possibility of affiliating with an existing network. However, most of the same



Michael McGurt



issues must be addressed and resolved in a satisfactory manner.

**3. Improved Services** Any proposal to form or join a CBN should document how it would enable healthcare needs to be met more effectively and provide improvements in services to the community, particularly the poor and underserved.

**4. Mission, Goals, and Structure** Any proposal to form or join a CBN should provide a

## Networks

will vary substantially in both form and function.

clear statement of the CBN's mission, goals, and functions, set forth an organizational plan and the rationale for it, and demonstrate that the proposed network is both desirable and feasible.

**5. Common Vision and Values** Any proposal to form or join a CBN should provide solid evidence that the CBN partners share a common strategic vision, compatible values, and strong commitment to collaboration in serving the community. CBN partners must be comfortable with shared responsibility for setting the CBN's mission/vision, goals and policies, rather than exercising unilateral or dominant control over them.

## GENERAL STEPS IN MAJOR COLLABORATIVE STUDIES\*

1. Identify potential partner(s) for collaboration. Some key questions include: Are their missions compatible with ours? Are their values compatible with ours? Would some form of collaboration be likely to serve the community better and make long-term strategic sense?

2. In concert with the potential partner(s), define the basic premises and principles on which a study of collaboration would be based. Ensure that the other organization(s) is represented by persons who can speak authoritatively for it and that they are truly in accord with these premises and principles.

3. Develop a clear statement of the mission/vision, goals, and functions for a collaborative effort. The intent is to define why we might collaborate and what we would aim to accomplish.

4. Define the plausible alternative structures that might be used to accomplish the defined mission/vision, goals, and functions. (Remember: Form follows function.)

5. Assess the respective advantages and disadvantages of each alternative structure; determine which structure, on balance, appears to be the best.

6. Assess both the desirability and feasibility of a collaboration plan that is based on the defined mission/vision, goals, and functions and the organizational structure that has been determined to be the most appropriate.

7. Provide complete report and recommendations for consideration by the parent organizations and sponsors.

8. If the recommendation is to proceed and this recommendation is adopted by the parent organizations and sponsors, then move into the "implementation planning and due diligence" phase, which will produce detailed operational plans, management team arrangements, budgets, etc.

9. Submit final report and proposed implementation plan to parent organizations and sponsors for final action; if approval is granted, implement the plan and move into a unified mode of operation.

\*Continuing communications at appropriate intervals with the local ordinary or his designee and a canon law advisor is vital in all studies of major collaboration. Good communications with the DCNHS national office also are necessary to ensure awareness, coordination, and support (e.g., DCNHS staff involvement in certain "due diligence" activities).

Guidelines 3 through 5 identify important expectations that must be addressed thoroughly in developing a CBN plan and assessing its desirability and feasibility. Through these guidelines, the DCNHS-East Central Board of Directors, acting on behalf of the canonical sponsor, spells out some matters regarding key issues that must be covered in the proposals that ultimately are presented for governance action.

**6. Essential Elements** It is recognized that the mission, goals, functions, and organizational structures of CBNs will vary significantly from community to community; however, all CBNs in which DCNHS-East Central institutions participate should (a) embody commitment to improving the health status of the individuals and communities served though providing a comprehensive spectrum of holistic services rather than focusing only on acute care, (b) provide for physician integration and leadership, and (c) enable effective participation in risk-sharing and capitated payment systems.

DCNHS and DCNHS-East Central leaders recognize that networks will vary substantially in both form and function, depending on local needs and circumstances. However, three core elements should characterize all CBNs in which DCNHS-East Central institutions participate. The exact nature of these elements will vary from setting to setting, but the board believes that the long-term success of a CBN will require continual attention to these three elements.

**7. Catholic Identity and Sponsorship** All CBNs in which DCNHS-East Central institutions



participate should reflect the DCNHS mission and values and preserve, protect, and strengthen the Catholic health ministry.<sup>3</sup> In this context, any proposal to form or join a CBN should address the traditions of Catholic healthcare and Church teachings, especially as these are expressed in the *Ethical and Religious Directives for Catholic Health Care Services* and canon law. When DCNHS-East Central institutions become part of a CBN, they will continue to abide by these teachings and directives. Ethical and canonical consultation should be sought in applying the Church's principles of cooperation in relation to any activities of CBN partners that may be proscribed by the directives.

Guideline 7 emphasizes that all CBN proposals and agreements must be clear with respect to the Catholic identity of DCNHS-East Central institutions and their compliance with Catholic teachings and norms. In many communities, the CBNs with which DCNHS-East Central institutions affiliate will include some non-Catholic partners, but the guidelines spell out the expectation that the CBN partners will share compatible strategic vision, values, and principles and have mutual respect for each other's philosophy and heritage. To recognize and underscore these understandings, DCNHS-East Central leaders sought the counsel of CHA staff and canonical advice in formulating this important guideline for planning and developing CBNs.

**8. Reserve Powers** Any proposal to form or join a CBN and the CBN's actual governing documents must maintain appropriate reserved powers for the DCNHS-East Central Board of Directors acting on behalf of the canonical sponsor, and provide appropriate mechanisms to enable the board to carry out these reserved powers.

**9. Roles and Responsibilities** It is recognized that, when a DCNHS-East Central institution affiliates with a CBN, the role and responsibilities of local governance and administration will be altered, in some instances substantially. Similarly, CBN linkages sometimes will require adjustments in the application of DCNHS-East Central Policy AL-1, "Levels of Authority and Regional Approval Processes," and/or other system policies and procedures.

When a DCNHS-East Central institution

becomes part of a CBN, it must to some extent alter its traditional policies and management practices. Guidelines 8 and 9 recognize this and require that the proposed changes be explicit in CBN proposals presented to the DCNHS-East Central Board of Directors for approval. The exact nature of the changes will vary depending on the structure of the CBN, its role and functions, and the other partners involved. The general principle is that, when a DCNHS-East Central institution affiliates with a CBN, its power shifts from full control of a particular institution to influence over a larger and more complex network.

**10. Evaluation** Any proposal to form or join a CBN must outline processes for ongoing evaluation and continuous improvement in the CBN's performance to ensure it remains true to its stated mission/vision and goals.

DCNHS-East Central policies embody a commitment to ongoing, objective evaluation and continuous improvement of organizational structures, policies, performance, and partnerships.<sup>4</sup> Guideline 10 reflects that commitment by requiring that all CBN proposals indicate an explicit evaluation function.

**11. Relationships** In all aspects of planning, developing, and implementing CBNs, high priority must be devoted to building understanding, commitment, respect, and trust among key constituencies, including employees, local governance and management teams, physicians, parent organizations and sponsors of CBN partners, and community leadership.

Guideline 11 underscores that regardless of the strategic fit or how well a CBN is designed, it is unlikely to succeed unless both internal relationships and relationships with key external constituencies are based on a solid foundation of honesty, mutual respect, and trust.

#### UNDERSTANDING, ACCEPTANCE

Consultation with local governance and management leaders, when formulating the guidelines, paid off because leaders have reported that they understand and accept them. The guidelines have been communicated within each DCNHS-East Central organization through educational sessions and a variety of other channels. Whenever a DCNHS-East Central entity initiates CBN dis-

*Continued on page 48*

Network  
partners will  
share vision,  
values, and  
principles and  
have mutual  
respect for  
each other's  
philosophy and  
heritage.

## SERVING OUR COMMUNITIES

Continued from page 37

cussions, the guidelines are shared with the potential partners. This communicates—up front—to potential partners the parameters within which DCNHS—East Central will operate. For both internal and external constituencies, the guidelines are proving to be helpful because they identify the overall expectations of the DCNHS—East Central Board of Directors, acting on behalf of the canonical sponsor, and outline a set of general steps to be followed when forming or joining a network.

As DCNHS—East Central institutions affiliate with CBNs and gain additional experience, the DCNHS—East Central Board of Directors will modify the guidelines from time to time to reflect the lessons our institutions have learned. In the year since the guidelines have been introduced, response has been positive. □

 For more information about the DCNHS—East Central guidelines for planning and developing integrated networks, contact Lawrence Prybil or Ronald Mead, 812-963-3301.

### NOTES

1. See, for example, Catholic Health Association, "Setting Relationships Right: A Proposal for Systemic Healthcare Reform," St. Louis, 1993, Chapter 3; and American Hospital Association, "National Health Care Reform: Refining and Advancing the Vision," Chicago, 1992.
2. Daughters of Charity National Health System, "Community-Based Networks," St. Louis, 1993; and "Community-Based Networks II," St. Louis, 1994.
3. For a useful source document, see Catholic Health Association, "How to Approach Catholic Identity in Changing Times," St. Louis, (a reprint from *Health Progress*, April 1994).
4. DCNHS—East Central Policy AF-1, "Formal Continuous Improvement Processes," 1992; and DCNHS—East Central Policy AR-2, "Principles and Key Components of Regional Evaluation," 1993.

## GETTING IT ALL TOGETHER

Continued from page 40

financial terms for the rest of the organization.

**How Comfortable Are You that Your Strategic and Financial Plans Are in Sync?** Each organization must answer this for itself. Our answer, in the early days, was: "Not too comfortable!" It took time for us to assure ourselves that if we had clearly inserted an item in our strategic plan, it would turn up in the financial plan as well.

**How Comfortable Are You that You Are Making Strategic and Financial Plans Effectively** Again, our answer at first was: "Not comfortable." We began to see some interesting differences between the two kinds of plan:

- Our traditional financial plan was about incremental changes, whereas the strategic plan was about *fundamental* change.

- The financial plan contained core business activities, whereas the strategic plan contained the vision, the "new frontier."

- Financial plan targets tended to be used to constrain, rather than complement, strategic initiatives.

- The financial plan was based on projected revenue increases, but the strategic plan forecast a drop in revenue.

**Will Short-Term Trade-Offs in the Financial Plan Impair Longer-Term Strategic Direction?**

They certainly can; short-term trade-offs are very real. At FHS, we believe the solution lies in how you manage the trade-offs and how flexible you are in striking a balance. We have tried to move systematically from concept (the strategic plan) to reality (the financial plan).

**Can Successful Strategic Plans and Successful Financial Plans Peacefully Coexist?**

Absolutely. They can flourish and become a force in moving your organization forward if:

- All parties involved understand the rapidly changing nature of the health-care business.

- Planners stay focused on the market-based, economic reality of the organization, rather than looking at specific projects in isolation.

- Planners are willing to challenge their mental models of investment. (Making a 30-year investment in a business with a shelf life of fewer than five years does not make sense.)

### TOWARD MORE CONTROL

FHS's development of its strategic/financial planning process has been a complex one. It has been complex not only because it has required balancing strategic and financial choices and constraints, but because it has also required balancing a mix of different roles and personalities. The new process forces us planners and CFOs to work together closely—and to do it continuously, not just twice a year.

Today there is a compelling need to have plans that support the most likely scenarios for the future. We discovered we could no longer afford to plan in the traditional manner, basing our budget on incremental volumes and adjusting after the first six months. If we had continued things in the old way, we might have found ourselves in serious trouble by the end of the *next* six months.

We believe we are creating a process that is ultimately going to give FHS leaders much firmer control of the system's future. It is true that, in today's healthcare market, payers strongly influence a system's income. If the system's leaders are wise, however, they can continue to determine the balance-sheet side. To the extent that they allocate their capital resources well, they wind up with more control, a greater sense of stability, and the knowledge that they are doing everything possible to increase the strategic value of their investments. And that will be a necessity for all healthcare providers as we move into a very demanding era. □