The Transition to Regional Networks

Changes in Reimbursement and Approaches to Care Favor Cooperative Arrangements among Providers

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The healthcare field is entering an era of dramatic change. As costs escalate, the delivery system grows more fragmented, and the number of uninsured and underinsured Americans increases, organizations throughout the United States have begun to call for basic reform of the healthcare system.

Several national organizations, including the American Hospital Association (AHA) and the Catholic Health Association (CHA), have presented working reform proposals advocating coordinated regional healthcare delivery systems (see also "Organized Systems of Care," *Health Progress*, October 1992, pp. 22-28). AHA refers to these as community networks, while CHA refers to them as integrated delivery networks (IDNs).

INTEGRATED DELIVERY NETWORKS

Under such systems, a number of healthcare organizations would be linked or affiliated with each other to provide efficient, high-quality care. Generally, persons in a given area would enroll in one of several competing networks that serve their region. In certain cases, such as in rural areas, only one network may be available.

One of the major differences between these networks and current multi-institutional systems is that the latter are actually often chains rather than genuine systems. In a chain, each component delivers the same product or service. The proposed regional networks, on the other hand, would provide a full continuum of services and programs from prevention through aftercare and long-term care, and from primary through tertiary care. Each network would coordinate

Summary As costs escalate and the delivery system becomes more fragmented, organizations throughout the United States have begun to call for basic reform of the healthcare system. Several national organizations, including the American Hospital Association and the Catholic Health Association, have presented working proposals advocating coordinated regional healthcare delivery systems. The proposed networks would provide a full continuum of services from prevention through aftercare and long-term care, and from primary through tertiary care.

In the past few years, providers themselves have begun to see the value of cooperative efforts. Collaborative ventures such as group purchasing and sharing mobile equipment have increased as hospitals look for ways to reduce costs and control overhead. Mergers and affiliations are also becoming more common.

As they develop, different networks will allow for various kinds of interrelationships among components. In general, these systems will provide high-volume, low-cost services at a number of sites and low-volume, high-cost services at a central location. Secondary and tertiary campuses will focus increasingly on specialty care, and as volume increases at primary campuses, secondary and tertiary organizations will establish more primary affiliations.

To make the transition from a competitive to a cooperative healthcare delivery system, providers will have to reexamine their mission and values and, in many cases, refocus their vision of the future.

relations among hospitals, physicians, home healthcare agencies, nursing homes, public health departments, voluntary agencies, wellness programs, hospices, schools, and clinics.

> The focus is shifting to a model that emphasizes full-spectrum healthcare.

Cooperation Versus Competition

One of the purposes of creating these networks will be to promote cooperation among providers and thus reduce costly and unnecessary duplication of services. Such systems will be mission driven and provide high-quality, outcome-oriented continuum of care services. Universal coverage will open access to everyone in the community, which is the essential goal of the CHA proposal.

During the 1970s and the 1980s, economists, the major proponents of a competitive healthcare marketplace, assumed that competition would keep prices and charges low. However, unlike in the general marketplace, where those who pay for a service also use it, healthcare consumers rarely pay directly for the services they receive. This—along with the increased cost of technology, poor design, overutilization, profit incentives, and the "sweepstakes" awards for malpractice suits—has caused healthcare costs to skyrocket from 7 percent of the gross national product in 1970 to an estimated 13.4 percent in 1992.

Not only has competition failed to hold down costs; it has reduced, if not eliminated, communication and cooperation between providers in an already fragmented marketplace. By forcing most providers to operate independently—and thus duplicate services, equipment, overhead, and facilities—competition and profit incentives have reduced efficiency, increased costs, and sometimes even lowered the quality of care.

By 1990 many had come to see that only through cooperative effort—in which providers share incentives, rewards, and risk—could healthcare costs be controlled. And in the past few years, the value of collaboration has become increasingly evident. Collaborative ventures such as group purchasing and sharing mobile equipment, which have paid dividends to both providers and the general public, have increased as providers look for ways to reduce costs and control overhead. Mergers and affiliations are also becoming more common.

As these cooperative ventures increase, however, several drawbacks will become apparent. Individuals and specific facilities will have less independence, control, and power over operations, and some successful independent facilities will become less attractive. However, the advantages will far outweigh the disadvantages. Networks will increase efficiency, improve overall quality of care, and afford patients better access to care. Networks will also facilitate care management throughout the continuum of care and between levels of care.

Another factor motivating providers to pursue cooperative efforts is the anticipation that the government will at some point force, through incentive and risk changes, movement to integrated networks, a direction in which Canada is also headed. The potential for mandated changes in the payment system favoring managed care on a capitated basis, along with the possible creation of a preferred model for community networks, will prompt existing providers to move to new levels of regional systems. The rapid grassroots development of regional systems in local areas throughout the United States is another sign that our healthcare system is moving in this direction.

Regional Network Models

Regional systems will share some basic characteristics but will evolve initially into several alternative models. The focus in healthcare is shifting from an emphasis on treating illness and disease to a model that emphasizes *full-spectrum healthcare.* Thus hospitals will usually be at the center of the new networks, but they will not necessarily control them nor be the major component.

AHA has suggested that regional networks:

- Provide comprehensive services from primary through tertiary care
- Offer a full continuum of services from prevention through aftercare and long-term care
- Charge persons enrolled a single annual fee

In addition, AHA has proposed that persons be free to choose from among available networks (except in rural areas) and to change or reenroll in networks annually. CHA has proposed similar criteria for IDNs.

Different networks will have various kinds of interrelationships among components. Network executives will ensure that all components function as part of the system, and a network-level coordinating body will make strategic and operational decisions, including decisions on pricing, protocols, quality assurance, and audits.

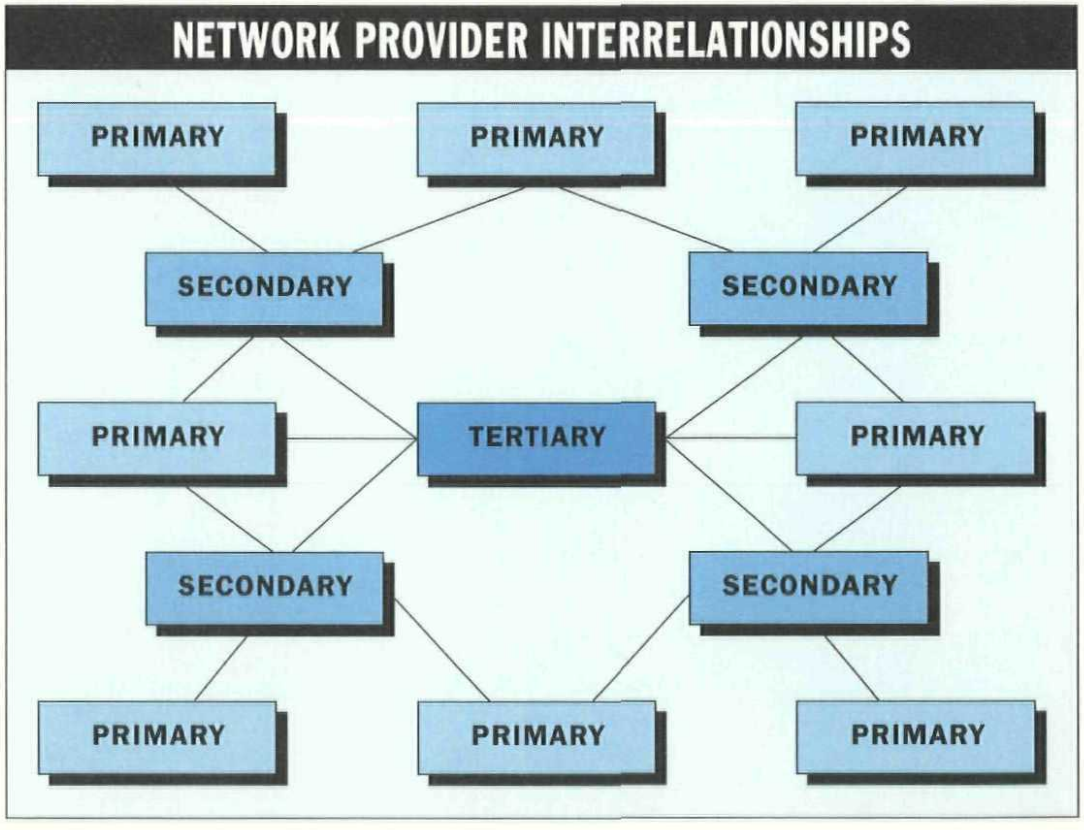
A number of steps are critical to the success of the cooperative process necessary to form a viable network. Providers involved should ensure that they:

- Educate boards, administration, and medical staff
- Define the rules of the game
- Define levels of cooperation
- Outline options and alternatives
- Outline risks and implications
- Outline benefits
- Outline options for community networks
- Perform fact-finding tasks
- Define who directs the process, and to whom the outcomes and the recommendations are presented

Deciding which services and technologies to duplicate and which to centralize will be a key operational decision for network executives. In general, systems will provide high-volume, low-cost services at a number of different sites and provide low-volume, high-cost services at a central location (see **Figure** below). Primary care makes up at least 80 percent of all healthcare services, so a number of primary care centers will be located throughout the network's area. Secondary and tertiary campuses will focus increasingly on specialty care, and as volume increases at primary campuses, secondary and tertiary organizations will develop more primary affiliations. To reduce costs, networks may contract (or outsource) for such services as housekeeping, security, pharmacy, and even computer and certain high-cost testing services. Therefore certain tertiary components, such as transplant services, will be able to serve more than one system.

Regional networks will require centralized planning and coordination, but all involved parties will have a voice in system operations. Refocusing on the persons being served will reorient planning from market share strategies to more complete analyses of user health and human service needs.

Physicians will be viewed as partners in the overall enterprise and integrated to ensure smooth referral within the network. Networks



will also establish clear criteria for entering and leaving the system, as well as for replacing components that have left. A variety of organizational structures will be used (see **Box**).

Organizational and corporate structures will vary from modest agreements to formal affiliations and mergers. A coordination board including board members, administrators, and physicians might oversee the entire network with separate executive bodies managing the network's primary, secondary, and tertiary services. Incorporating physicians into executive bodies at every level of the organization will be critical to ensuring smooth referral among system components.

New Incentives

The present system is geared to a "The more you do, the more you get" philosophy. Under the new system, the incentive will be to intervene early to prevent illness and disease—a strategy for financial solvency that almost totally reverses current arrangements. This approach also incorpo-

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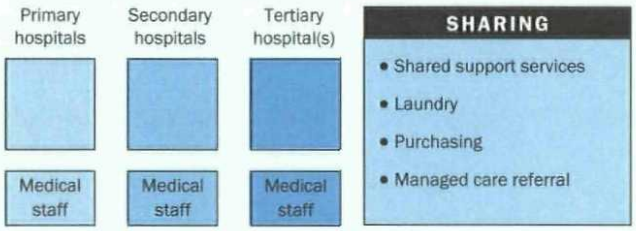
ALTERNATIVE CORPORATE STRUCTURES

The organizational and corporate structures of networks will vary widely from loose agreements to formal affiliations and mergers. In many cases, which structures to use will depend on the degree of trust, familiarity, and cooperation the involved parties have established. As these relationships mature, the components of the organization can become more completely integrated.

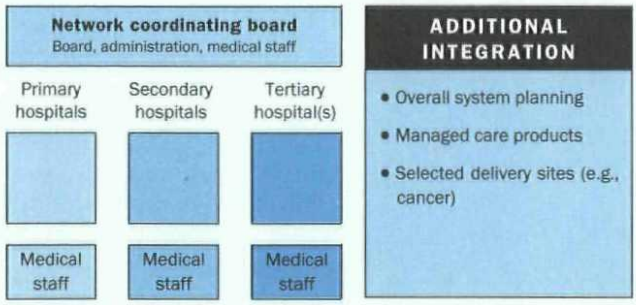
The **Level I** figure displays a possible structure for providers just beginning to pursue collaborative ventures—a network in which primary, secondary, and tertiary organizations share services.

Level I



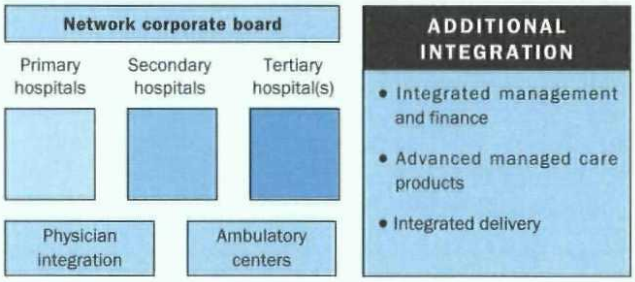
At a more advanced level of integration (**Level II**), a network coordinating board would represent all components, or at least the primary, secondary, and tertiary facilities. This arrangement would allow for more networkwide planning and collaboration, facilitating collaborative efforts among network components.

Level II



A more fully integrated structure (**Level III**) would incorporate physicians into the network at every corporate level and allow integration of freestanding ambulatory clinics. Organizations using such a model would be well prepared to administer capitated managed care plans and control costs of care.

Level III



An **Alternative Level III** model is an approach currently being used by five Ohio hospitals, each of which owns 20 percent of the network corporate office. This consortium is moving into a planned network system with each hospital, regardless of size, having equal power and representation.

Level III (alternative)

For a network to develop effectively, multidirectional relationships must evolve among primary, secondary, and tertiary providers; physicians; and other system components. The ability to effectively integrate, coordinate, and apportion services, programs, technology, and strategies will be critical in a system where reimbursement is capitated.

Successful cooperation will also require skillful negotiation, mediation, and consultation. These organizational structures will be viable only if all parties involved strive to develop a common vision and mission.

REGIONAL NETWORKS

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rates an attitude more compatible with the goal of providing the best possible care using available funds and resources. This mandates a cooperative network of providers with a focus on prevention and alternatives to costly intervention.

The movement toward cooperative ventures will have a significant impact on all involved in healthcare. In the long run, it should be beneficial to those who use and provide health services, as well as to those who pay for them. But in the near term, the changes will often create difficulties—particularly for organizations that are unprepared.

To make the transition from a competitive to a cooperative healthcare delivery system, providers will have to reexamine their mission and values and, in many cases, refocus their vision of the future. They must also be prepared to address possible legal and policy barriers (e.g., antitrust) to collaborative venture. Executives must become aware of the organizational and corporate structures best suited to the new realities within healthcare and learn the negotiation, mediation, and consultation skills that will enable them to work effectively with others. At the same time, healthcare employees must be given the kind of training and education necessary to adapt to the new corporate cultures and organizational structures. Forced integration will not succeed.

The question is no longer whether to develop regional systems but which model to use and how quickly it should be implemented. Missions of service will once again be the priority in the new era of delivery. Many have finally realized that competition, profitability, and market share are results of a mission-driven vision and commitment, not the goal. An organization's mission, vision, and faith in its delivery design will be its bridge to success. □

FINANCIAL MANAGEMENT

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Overall, 198 respondents reported they did have an operating policy requiring that cash discounts be taken, and 77 reported they did not. (Six participants did not answer the question.) Thus, although most hospitals consider the availability of cash discounts to be relatively unimportant in the vendor selection process, many still view it as significant enough to merit routinization once a vendor has been chosen.

Of the 77 hospitals with no routine policy for taking vendor cash discounts, only 11 reported that they use a formula, such as the one presented earlier in this article, to determine whether a particular discount is worth taking.

A SIGNIFICANT OPPORTUNITY

The fact that most hospitals do not consider the availability of cash discounts to be an important factor in vendor selection suggests that many of them are overlooking a significant opportunity to minimize routine operating costs and expenses. The tendency to give more weight to certain other considerations indicates that hospitals may overvalue nonfinancial, subjective factors in dealing with vendors. Perhaps it would be more productive for hospitals to emphasize cost containment, an essential ingredient of which would be to use cash discounts.

The efficient use of resources requires that hospitals, regardless of size or profit orientation, take advantage of financial concessions that facilitate operations and ultimately improve the ability to serve the public. Unless conditions make it impossible to do so, hospitals should strive to take advantage of this concession. □