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Integrating Success

Top-performing health networks offer lessons in using efficiencies, expertise to improve patient care

By Joe Carlson

Posted: January 25, 2010 - 5:59 am ET

Last year, when St. John's Mercy Health Care in St. Louis became one of the largest systems in the U.S. to go live all at once with one of the major electronic health-record systems, it was easy to hold down all the hourly consultants' fees.

Easy, that is, because there weren't any consultants involved.

Administrators deployed the EHR system in four hospitals and more than 60 clinical sites using an all-in-house staff that was trained on similar rollouts that took place in the other integrated systems owned by St. John's Mercy's sponsor, the Sisters of Mercy Health System.

"It was a \$450 million project for us across all markets," says Sisters of Mercy President and CEO Lynn Britton. "It would have been an \$800 million project if we hadn't used our resources wisely."

That kind of strategy—using the system's scale and internal knowledge base to increase efficiency while implementing an initiative to improve patient safety—was a major reason why the Sisters of Mercy system saw not one but two of its regional health systems finish in the elite top three of the 2010 IHN 100 compiled by healthcare data firm SDI.

As new and existing integrated healthcare networks look ahead to the second major wave of expansion in the past 20 years, many experts will be looking for success stories, wary to avoid the mistakes that led to the unraveling of so many of the complex integrated delivery schemes that were formed in the early 1990s.

For SDI's 2010 list of the top 100 best-performing integrated delivery networks, St. John's Mercy Health Care landed in the second position overall after ranking No. 28 the year before. Meanwhile, St. John's Health System, Springfield, Mo., maintained its perennial position in the list's upper echelons for a fourth straight year, landing its second No. 3 ranking in that time after coming in first in 2007 and 2009.

Sentara Healthcare, Norfolk, Va., took top honors in the 2010 list, and has finished in the top five in all of the past five years. MultiCare Health System, Tacoma, Wash., holds the No. 4 spot on the 2010 list after landing in the top 10 in 2009 and 2008. Intermountain Healthcare, Salt Lake City, placed fifth after landing in third place last year and second place for the three years before that.

The annual SDI IHN 100 ranks integrated healthcare networks based on eight performance metrics using information submitted voluntarily by the systems, including measures of clinical

integration, technology integration, utilization and services offered.

However, it was the financial stability metric that mattered most for this year's list, the 13th annual produced by Plymouth Meeting, Pa.-based SDI. Overall, performance scores were lower than in years past because of tepid financial performance, says Pat Witman, associate director of acute care and contract administration profiles for SDI.

Conversely, the systems that landed in the top 10 did so primarily because of their financial performance, as measured by operating and profit margins, and by the systems' ratios of long-term debt to capitalization.

"For me, that was the story this year—the financial," Witman says. "Many of them talked about the fact that they either have investment losses, losses on their swap agreements, losses on their capital and properties, and bad debt. They have a lot more uninsured people coming through their ER and clinics."

Ahead of the pack

Yet despite those challenges, some integrated networks still outperformed their peers. Observers say more integrated delivery networks are likely to come into being in the next several years, and those that already exist are likely to grow as they try to emulate the successes demonstrated by top players on the SDI list.

As is happening today, experts say, the last great boom in integrated delivery corresponded with the election of a president focused on healthcare reform.

The years immediately before and during the healthcare reform debate during the Clinton administration saw the rapid formation of new integration models between hospitals and physicians that included diversification into outpatient and ambulatory clinics, creation of new physician-hospital organizations known as PHOs, entry into insurance markets through HMOs, and rapid growth in the size of chains and not-for-profit hospital systems, academic and industry experts say.

In public, the proponents of such integration often said their goals were to create a "continuum of care" for patients to improve safety, cut costs and increase efficiency, observers say. In the boardroom, however, executives talked more about the financial goals of achieving market dominance, eliminating competition, and gaining more leverage over commercial payers, according to insiders and academics like the authors of a 2002 Health Affairs article titled "Integrated delivery networks: A detour on the road to integrated health care?"

While none of those were new goals, many hospitals found a new urgency in achieving them—and physicians showed more willingness to cooperate, experts say—because of the widespread uncertainty in the market over proposed payment reforms. Sound familiar?

"I really think that what's going on today with the Obama administration is similar to that, because they were both serving as the catalyst for change, and everyone was anxious and trying to prepare for change without really knowing what the outcome would be," says Douglas Chaet, founder and chairman emeritus of the American Association of Integrated Healthcare Delivery Systems, or AAIHDS.

As evidence, Chaet—who is also a senior vice president at Independence Blue Cross in Philadelphia—noted that last year's annual AAIHDS conference at the Bellagio hotel in Las Vegas attracted a near-record number of attendees. The only other conference by the association that attracted more attendees was in 1993.

Learning from failures

But as is now clear, many of the experiments in integration from the 1990s were failures. The 2002 Health Affairs article offered this blunt critique: “While the forms of integration varied across hospitals and markets, their economic performance, after a decade of experience, was generally uniform: Nothing worked.”

While some systems worked to undo their integration strategies when things didn't work out as was hoped, others stayed loyal to the concept and continued to experiment, and many have found success, judging by the results of the IHN 100 rankings.

“When everybody else was divesting those things because they couldn't dominate the market, we stuck with it,” Britton says of Sisters of Mercy's physician-alignment integration strategies. “We made some mistakes; we didn't do it all right the first time. But today we are very focused on it. If it's all about market dominance, then I think your priority is misplaced,” he says.

At Banner Health, operating efficiencies have been the goal.

When the two-hospital Sun Health system was bought by Phoenix-based Banner Health for \$316 million in 2008, Banner took \$20 million of annual overhead expense off the Sun City hospitals' books, which was equivalent to about 4% of the former system's operating revenue, says Dennis Dahlen, Banner's senior vice president and chief financial officer.

The savings were accomplished by centralizing common functions into the corporate offices, including departments like financial accounting, accounts payable and receivable, legal, human resources, strategic planning and information technology.

“My general sense is that we are better-positioned to do these kinds of things because we can do them across the board,” Dahlen says, echoing the classic definition of horizontal integration.

Banner, which owns or leases 21 hospitals, placed 10th in this year's SDI IHN 100, after placing No. 22 last year and No. 54 the previous year. It was an interesting turn for a system that faced steep-enough financial difficulties that in addition to staff cuts and other cost-saving steps, the system delayed opening a newly built hospital—Banner Ironwood, which was featured on the cover of *Modern Healthcare* on Nov. 24, 2008, as an example of how the financial downturn was halting building projects across the country.

Peter Fine, Banner's president and CEO, says the financial results that landed the system in the top 10 of the SDI list prove that integration can provide real value in exchange for the additional layers of corporate structure that hospitals and physicians must help support. For example, Fine says, Banner operated its delivery system with an overhead equal to 7% of revenue.

“I would challenge a lot of organizations to tell me they can operate their delivery system with an overhead cost of 7%,” Fine says. “We think we bring real value because we bring financial stability and we manage our overhead.”

Fine says Banner's success rests partly on its ability to focus on “the small details” as it has grown larger. Many large networks struggle for results because they create huge bureaucracies that can't respond to small details at the local level. “Financial stability is driven by focusing on the small things, not the large things,” he says.

Banner also lacks one of the key vertical-integration components that dragged down many of the networks formed in the 1990s—an ownership stake in a health plan. The 2002 Health Affairs article noted that a great many of the hospital-based provider networks that gambled in the insurance world by owning an HMO did poorly because they didn't understand the fundamentals of marketing and risk accounting.

Another realm where vertical integration bogged down many providers in the 1990s was physician alignment—another area that is expected to grow rapidly in the next several years.

“If you can't really bring the physicians into it, it can hardly be called an integrated delivery system,” says Eric Canter, senior consulting manager with IMA Consulting. “There's more push on the physicians with reimbursements, and more of them are seeking to be employed, whether they want to or not.”

Although hospitals have been willing to employ doctors, physicians have resisted the idea because of reimbursement issues. However as happened in the early 1990s, some physicians are warming to idea again.

St. John's Mercy Health Care in St. Louis found organizational and financial success in employing physicians by making it clear at the outset that the hospital does not directly employ the doctors. Rather, the physicians work for one of the system's two medical groups, who have seats at the administration table along with hospital executives. “We certainly feel that the integrated model will enable us to deal with the realities of the future,” says Keith Starke, a physician and chairman of the department of medicine at 915-bed St. John's Mercy Medical Center in St. Louis.