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The New Academic Health Center Hybrid
page 5
Why academic health centers need to be part business, part academic.

Making the Journey into the Networked Enterprise

Career Rx 42
Management Grand Rounds 44
Reader Feedback 45
Classified Advertising 46

The Emergence of the Extended Healthcare Enterprise

Lessons, Dangers, and Difficulties for Health Care Integrators from the world of mergers, acquisitions, and alliances

by Robert Porter Lynch & Iain Somerville

First Generation: Vertical Integration

Driven by Cost Cutting Forces

The trend of the 1990s in healthcare has been to jump onto the vertical integration bandwagon, epitomized by a rash of mergers and acquisition in the pursuit of economies of scale and elimination of redundancies. Worshiping at the alter of cost cutting, the focus of first generation vertical integration strategy has been to create delivery systems that contain costs while maintaining quality -- all worthy goals.

Not New to other Industries

Vertical integration, while relatively new to healthcare, is a well-traveled route for other industries. Characterized by its monolithic, hierarchical, centralized control systems, vertical integration has traditionally been the first step in consolidating businesses that have been traditionally fragmented, such as healthcare has been. Examples in other industries include:

Steel: Vertical Integration began in the steel industry in the late 1800's with ownership of every step of production from the mine to the railroads to transport the ore to the smelters to the steel production plants. While highly successful for many years, smaller, more decentralized steel producers virtually wiped out the vertical integrators ten years ago.

Autos: Vertical Integration was how General Motors made its name in the 1920's, and Ford not much later. Ford is beginning to Ade-integrate@ now, and Chrysler did it in the 1980's. Ford is far more profitable than General Motors on a car by car basis, and Chrysler even more so -- making better cars and more money. However, General Motors has been slower to learn, and paying a very high penalty for the lesson -- just barely eking out a profit on autos, while a highly networked competitor such as Chrysler has earned billions.

Computers: IBM succeeded with vertical integration for many years, building to a crescendo in 1989 with $60 billion in sales and 420,000 employees. But IBM got its wings clipped by more agile competitors that were highly networked with strategic alliances focused on providing unique core competencies. After losing billions in the early 90's, IBM has shifted from a command and control vertical integration to a service-based networked integration, shedding employees, and gaining back revenue. As a service based network, their revenues have increased by $10 billion, profits have skyrocketed, while the workforce was cut by a third.

What's Wrong with Vertical Integration?

The problem is not with *integration,* per se, it's with the intersection of the *vertical* aspects with the value chain.

It's important to know how our thoughts have shifted about integration. In heavy capital industries, (steel, autos, electronics, insurance, and health care) the prevailing ideas have been to *control* through command systems that were originally designed for the Roman Legions and the Catholic Church. While these worked well in the past, in a fast moving, technologically driven world, these systems have proved to be inefficient.

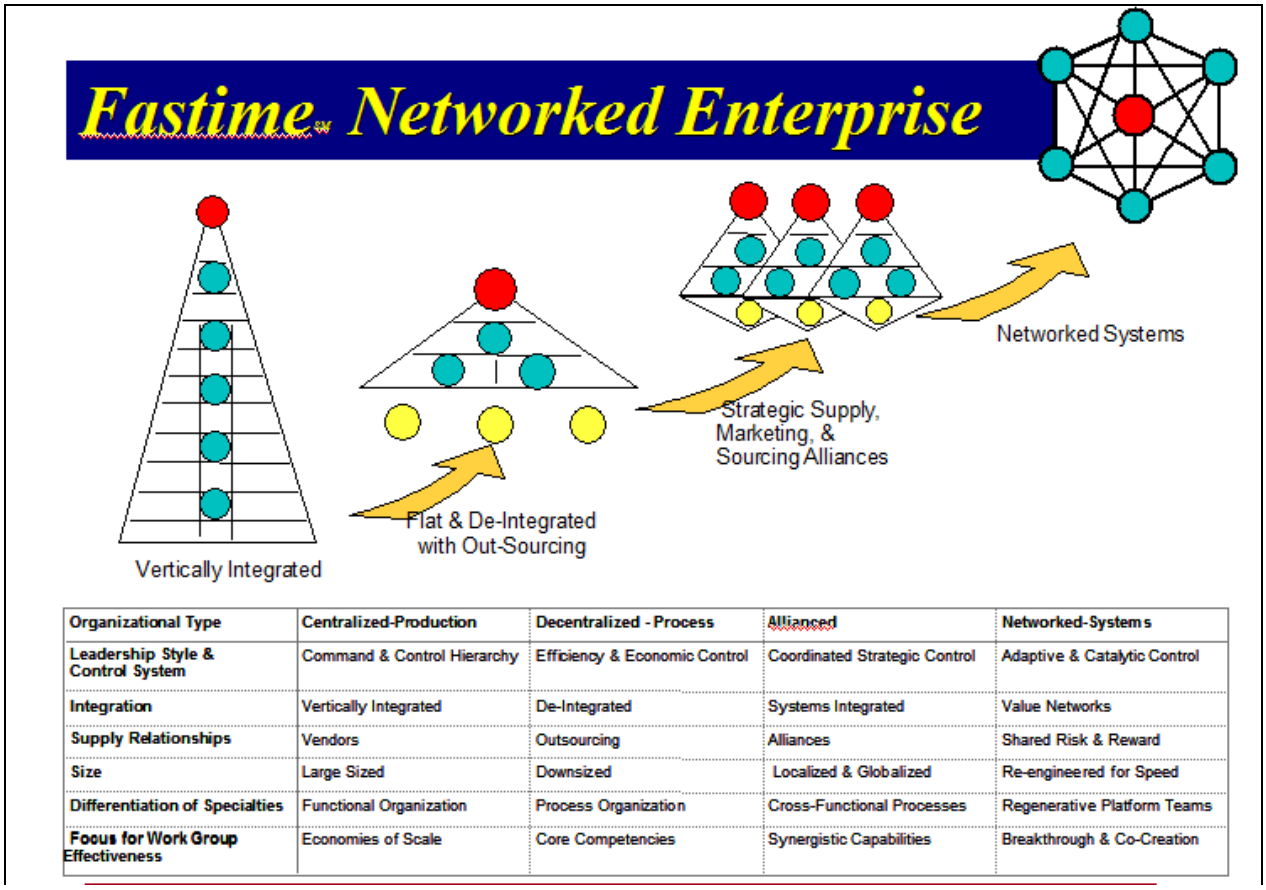
In health care, doctors tended to have their own command and control systems as small independent practices. When scaled to the size of a hospital, the command and control system worked well until too much government bureaucracy, medical control, proliferating insurance red tape, and technology pushed the command and control paradigm to its limits.

Now, looking to gain efficiencies and economies of scale, many of the large health care acquisitions are attempting to squeeze more and more out of a dying paradigm. While broad-based first generation vertical integration with its attendant command and control systems will work for the short term (because of the tremendous inefficiencies and overcapacity in the healthcare system -- some claim 50-60% of all work is non-value added), it is now being shown there are far more efficient and effective methods of delivering health care.

De-integration, Outsourcing, and Networked Integration

As health care is transitioning into this first stage of vertical integration, in industry after industry faced with intense competition, hierarchical vertical integration is being replaced by the next stage of progression: *outsourcing* of core competencies. This process of downsizing and outsourcing is called *de-integration.* (*de-integration* should not be confused with *disintegration*, a totally different process) What's more, de-integration is simply a transition state -- it will not be permanent -- now being replaced by a more advanced phenomenon: *networked integration* -- sometimes referred to as the *virtual* organization or the *extended enterprise*. (see figure 1)

Networked integration is far more efficient and powerful as a generator of value to customers, shareholders, and employees. It rethinks the value chain and embraces *shared risks and rewards* as well as an *alignment of interests* through *strategic alliances*. Networked integration focuses on delivering unique core competencies, some of which are not indigenous to healthcare, such as computing, digital imaging and telecommunications. The result of networked integration has been the achievement of breakthrough strategies that redesign complete delivery processes and value chains.



Organizational Type	Centralized-Production	Decentralized - Process	Alliianced	Networked-Systems
Leadership Style & Control System	Command & Control Hierarchy	Efficiency & Economic Control	Coordinated Strategic Control	Adaptive & Catalytic Control
Integration	Vertically Integrated	De-Integrated	Systems Integrated	Value Networks
Supply Relationships	Vendors	Outsourcing	Alliances	Shared Risk & Reward
Size	Large Sized	Downsized	Localized & Globalized	Re-engineered for Speed
Differentiation of Specialties	Functional Organization	Process Organization	Cross-Functional Processes	Regenerative Platform Teams
Focus for Work Group Effectiveness	Economies of Scale	Core Competencies	Synergistic Capabilities	Breakthrough & Co-Creation

Value Generated by Networked Integration

As industries have transitioned to the networked structures, the results can show significant advantage over the slower, more cumbersome vertically integrated competitors:

Autos: General Motors, using the hierarchical vertically-integrated method takes $5 billion and 5 years to design a new car, whereas the network-integrated competitors such as Chrysler and Toyota can design a car for a third the cost and in less than half the time.

Retailing: Similar results prevail in other industries. In retailing, the network-integrated companies such as WalMart or the many retail franchises (e.g. McDonalds, Radio Shack, etc) are growing at a galloping rate, while their more traditionally vertically-integrated and de-integrated competitors such as Sears and K-Mart can't keep pace.

Insurance: Similar results have been achieved by shifting from a bureaucratic command and control hierarchy to a networked integration structure, with 30% reduction in non-value added work, boosting profits and customer satisfaction by an similar amount.

The Difficulty is AControl@

Command and control hierarchies become overburdened with too much inappropriate or non-value added control. GM's Oldsmobile General Manager John Rock stated the difficulty in shifting from a hierarchical system to a team-oriented organization when he said: Awe still are working to change the attitude of many middle managers...many of them are from the old command and control school" who are unwilling to give up their traditional areas of power within the corporation.

Cost Squeezing

Cost squeezing is the usual tactic of the command and control vertically integrated corporation. The classic example is General Motor's former chief of procurement who was notable for squeezing his vendors unmercifully. While credited for saving $2 billion in supplier costs, his actions so fouled up the supply chain in the new Cavalier plant that it cost GM over $2 billion in lost revenues due to delivery delays, poor quality, and inabilities of the new suppliers to produce components necessary to run the operations.

Vertical behemoths operate at a higher-cost level than the more streamlined networked organizations. In the mega-acquisition of HCA by Columbia Healthcare, the goal is to cut out over $100 million in operating costs by slicing out duplicative administration, facilities, and services. However, this will take a lot of squeezing. For example, the HCA hospital in Atlanta charged 41% above the national average. (Sommers, 1994)

Justification of Capital Investment

Through massive acquisitions, first generation vertical integration carries along a heavy burden of capital expenses, which require heavy cost cutting to feed investors hungry for their returns. In a race to cut costs, the verticals engage in squeezing vendors harder and harder, thereby commoditizing the supply base. When one considers that the Avendors@ are now doctors, it is easy to understand the physician's general dissatisfaction with the state of the industry. Capital investment causes justification of itself, not reform, re-engineering, or regeneration.

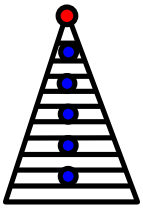
Excessive Reporting Systems

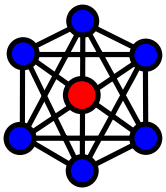
In a further effort to control costs, vertically integrated command and control bureaucracies are also noted for excessive reporting systems. The emphasis by healthcare to engage in external utilization review (UR) is an effort to wring out excesses in the system. But it hasn't produced much benefit to the overall system, adding significant extra time to primary care provider's already pressured schedules and adding millions in costs to maintain the control systems in place. (Goldstein, 1994). When the draconian controls do not cut costs sufficiently, the natural reactions are to put in more controls, send in the auditing team, and tighten the reins.

The Growth Rate

The trend toward de-integration is already evident. Kaiser Permanente, a vertical organization, is growing at only 2-3% annually. Others verticals, such as Columbia can maintain high growth rates only through acquisition. Contrast this with the 20-30% growth rates of the de-integrated competitors such as United and Pacificare.

COMPARISON OF VERTICAL INTEGRATION & NETWORKED INTEGRATION





	Vertical Integration	Networked Integration
Organizational Structure	Hierarchical	Interconnected
Ownership	Monolithic Single Ownership	Shared Risks & Rewards
Strategy is formed	At Top	At Outside and in Middle
Strategy is carried out by	Top Management	All Employees
Leadership Style	Command & Control	Coordination & Teamwork
Leader is	Ranking Authority	Catalyst, Empowerer, Coach
Decision Making done by	Upwards to the Top Echelons	Outwards, to the field at site of customer interface
Organizational Center	Top	Integrated Delivery Teams
Work is delivered by	Specialized Functionalities	Cross Functional Teams
Work Group Organization	Leader Directed from Above	Interactive Self-Directed
Workers Regarded as	Replaceable Commodities	Value Creators
Control Systems	Extensive, Time Consuming	Focus on Leading Indicators
Culture is	Mandated by Policies & Procedures	Responsive to Customer Requirements
Adaptability to Change	Rigid	Flexible & Resilient
Speed of Responsiveness	Very Slow and Cumbersome	Very Fast and Agile
Rewards accrue to	Top Management & Shareholders	Customers, Shareholders, All employees & Alliance Partners
Risk is assumed by	Outside Investors	Numerous Internal Stake-holders & Alliance Partners
Perspective on Value Chain	Component View, Price Driven	Systems View, Value Driven
Suppliers are seen as	Vendors	Alliance Partners

Figure 2

Dying Paradigm:

The fundamental problem is that healthcare system is misaligned: doctors, hospitals, insurers, patients are not pulling in the same direction. Vertical integration fails to solve the basic problem: Purchasers want to pay less, and providers have excess capacity to provide more. Once the redundancies and overcapacities are driven out of healthcare, there is nowhere else to go except squeeze vendors, insurers, and customer. Organizations in this situation fail to heed the signs of a dying paradigm:

> *When great intentions yield mediocre results, when the tried-and-true ceases to work, when every attempt to fix things is met with frustration and failure.... then perhaps the design has reached its limits, and the paradigm is ready to shift. Opportunity is present; creative vision is called for, and bold action in new dimensions is the nature of things.....*

Making the Shift to Networked integration

While healthcare is experiencing the next wave of de-integration with a re-alignment of risks based on capitation, it is only a transitionary step to what lies beyond -- the more synergistic, systems-oriented networked integration. We need to create a system that is market driven, medically directed, patient centered, payer friendly, simple to operate, interconnected, cross functionally delivered, and aligned for the same Awin.@

The Obstacles to the Networked Integration

Achieving this goal will require overcoming a number of shibboleths, including the fear of losing control, accountability, overhauling the entire value chain, and a redesign of the system of incentives appear to be a daunting task to many. However, as evidenced by Mullikin Medical Centers, Cascade Healthcare Alliance, and St. Vincent's in Australia, this shift is very possible, and can produce outstanding results.

At the core of the shift, however, will be a clear transition away from a hospital centered delivery system. Our heavy capital investments in hospitals creates an Aedifice@ complex that keeps us trapped in the old paradigm.

Much of the difficulty in making the shift also lies in our lack of understanding of what networked integration means. First, what networked integration is not: it is not hierarchical,@ not Aunilateral,@ not fragmented, not Acomponent focused,@ nor is it centrally owned and controlled. (see figure 2)

In a network, each Apartner@ aligns on a common value proposition, shares risks and rewards, and aims at satisfying not an intermediate customer (e.g. laboratory satisfying physician) but *looking through the value chain to the ultimate customer* -- the patient -- and flexibly teaming with various other specialists to deliver the most potent, curative-preventative mix of desired products, services, and systems in the right order, fast, and as inexpensively as possible.

Healthcare management will be challenged to shift its thinking dramatically. When top management in a vertically oriented company looks at the networked organization, to

them it seems chaotic or political, with no one in control. While this is not the case, the feeling of loss of command and control causes an uneasiness that holds back many executives and physicians from making the move. In contrast, the networked organization is not led by command and control, but a more coordinative, strategic, and visionary form of leadership that represents coaching more than leading an army in combat.

What's Needed to be Successful

As the networked delivery system emerge in healthcare, it will have a number of characteristics that give its cooperative nature a powerful competitive edge:

- Powerful Strategic Vision & Value Propositions which create real benchmarked breakthroughs in performance by all the participants in the network.
- Value Chain Redesign which *eliminates non-value added work, out sources non-core competencies,* and *creates alliances* for essential core processes. (see figure 3)
- Flexibility to shift with changing needs without oppressive hierarchies and vertical structures.
- Services provided by *cross-functional* teams (physicians first, then eventually jointed by professionals from nutrition, mental health, dentistry, physical therapy, etc.) addressing root systemic causes of ill health and aiming at wellness.
- Enabling Architectures for *information, organization,* and *human resources* which encourage paperless record-keeping, team coordination, and broad job descriptions focused on team performance.
- System-Wide Reward Structures that give all the participants -- medical professionals, payers, and patients -- incentives to work together to focus on wellness not illness. Similarly, sharing of risk by each of the parties is equally important to make sure everyone has some Askin in the game.@
- Shared Decision Making and Control, which comes from the realization that extraordinary value can be created not by unilateral control nor by giving up control, but by enjoined and aligned control.

While capitation has initiated the shift from vertical integration to deintegration, the endgame is not capitation, but rather a further stage of networked integration with a true alignment of interests across the spectrum from client through provider to payer.

Enterprise transformation is an essential healthcare priority. Designing the networked organization begins with a total reassessment of how *value* must be created in the health care and a commitment to achieve real strategic breakthroughs for the future .

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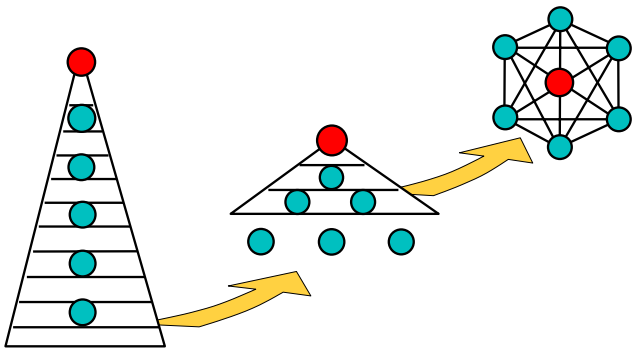
Robert Porter Lynch is President of The Warren Company, and Iain Somerville heads the Organization Strategy Practice of Andersen Consulting. Acknowledgments: James Hudak of Andersen Consulting and Stephen Gomes of The Warren Company for their assistance.

HOW SUPPLIERS ARE VIEWED IN THE DIFFERENT ORGANIZATIONAL SYSTEMS



	VENDOR	OUTSOURCING	ALLIANCE
Viewed As:	Replaceable Commodity	Unique Specialty	Integrated, Customized Specialty
Level of Integration	Low/Not Integrated	Loosely Integrated	Highly Integrated or Inseparable
Number of Suppliers	Many Suppliers	Several Suppliers	Very Few Suppliers
Distinguishing Features	Mainly Price Driven within minimum quality standards	Price plus unique offering (i.e. technology, service, etc)	Synergistic Value Proposition (i.e. mutual growth, etc)
Style of Interaction	Tactical Transaction	Preferred and/or Tactical Relationship	Strategic Synergy
Duration of Term	Short Term	Medium Term	Long Term
Value Proposition	Price and acceptable quality	Price, superior quality, and excellent service	Strategy, Cost, Quality, Reliability, Speed, Innovation, and more
Framework for Winning	Winning is essential for me, What happens to you is your business	A Win is essential for me, and I know I should let you win too if the relationship is to survive	A Win/Win is essential for both of us and is critical if the relationship is to thrive continually
Competitive Advantage	Low Competitive Advantage	Moderate Competitive Advantage	High Competitive Advantage
Make, Buy, or Ally Decision	Seldom produced internally (not a core competency)	Often Produced Internally (debatable core competency)	Frequently has been an integral part of the internal value chain
Trust Level	Distrust Prevalent (caveat emptor)	Trust is important to managing the relationship	Trust essential to generating a continuous stream of new value
Difficulty of Exit	Low Impact, Excellent Ability to Switch Vendors quickly	Moderate Impact	High Impact, Switching may have detrimental impact due to disintegration of systems

Figure 3

Part II: Making the Journey into the Networked Enterprise

by Robert Porter Lynch and Iain Somerville

In the May edition, the authors described the difficulties other industries have had with vertical integration and why so many corporations have abandoned it for other organizational structures.

In this second part of the series they explore the ways health care organizations can make the shift into integrated delivery systems, avoiding the trap of the hierarchical, vertically integrated monolithic structures that will become the dinosaurs of the future.

So many options....

Today the health care landscape is strewn with an almost Byzantine set of structural choices for the organization of the future -- MSOs, IPAs, PHOs, IGPs, HMOs -- an alphabet soup of options, decisions, and trade-offs. Today's health care strategist is more than likely confused and bewildered by the possibilities. And, to make matters worse, the wrong choice in this highly competitive environment may mean the loss of strategic position, competitive advantage, or, worse, the closing of a medical practice or facility.

It is all too easy to make the false assumption that if one chooses the right structure, all will be fine, the delivery of health care will escalate, and a profit will ensure future stability. All these alphabet soup options are really just traps which obscure the real issues confronting health care today.

Rather than focus primarily on the issues of organizational *structure*, it is far more important to understand both the key *strategic* issues and the *architectural design* characteristics (see figure 1) that enable the networked enterprise to outperform its vertically integrated competitors.

Characteristics of Networked Enterprises

1) **Powerful Strategic Vision & Value Propositions** which guides breakthroughs in performance.

2) **Value Chain Redesign** which *eliminates non-value added work, out sources non-core process,* and *creates alliances* for essential core processes.

3) **System-Wide Rewards** for teamwork, along with sharing of risks and rewards.

4) **Shared Decision Making** which creates extra-ordinary value through enjoined and aligned control.

5) **Flexible Structures** to shift with changing needs without oppressive hierarchical structures.

6) **Services provided by *cross-functional* teams** addressing root systemic causes of ill health and aiming at wellness.

7) **Enabling Architectures** for *information, organi-zation,* and *human resources*

Figure 1--Characteristics of a Value Network

Begin with a Strategic Value Proposition

A powerful strategic vision and value proposition is essential for beginning the transformation process from traditional, fragmented and hierarchical systems into fast-response, efficient networks. Take, for example, the vision of Dr. David Campbell, CEO of St. Vincent's Hospital in Melbourne, Australia. When constructing a new hospital, Dr. Campbell was concerned that the new building would be nothing more than a

modern version of what he already had.

Dr. Campbell and his team set forth a bold new future at the outset: A*to be the best hospital in the state in three years, the best in the country in 5 years, and among the 10 best in the world in 10 years as measured by standard industry benchmarks*.@ An organization mobilizes around a strong and measurable vision, people become passionately committed to it, and it becomes the Asoul@ of the organization itself.

To further empower the vision, Dr. Campbell ensured that the value proposition was clear, specific, and measurable. He was emphatic about benchmarked breakthroughs in performance being embraced by all the participants. He knew that he had to create a quantum jump for the future, and that to achieve this goal, he would have to create a clear measurement that stretched each and every one of the team. Measurability motivates the mind to creative action.

Value Chain Redesign

St. Vincent's was also faced with multiple problems, including:

a) Inefficient Care Delivery Processes: An analysis revealed that health care professionals were spending only 53% of their time on patient care and 10% of staff time was wasted on logistical problems.

b) Fragmented Structures: With over 500 basic job descriptions and 7 levels of management, along with highly specialized departments, there were very serious coordination and communications problems.

This situation called for a serious look at how the hospital's value chain produced results. As Sister Claire Nolan explained it: " *We were building a new hospital, but it started looking like every other hospital. We realized we had to look at everything as a system -- the ward structure, the patient, the community, the family."*

After an overhaul of both processes and delivery systems, sixteen existing care processes became five patient care and six support processes, with considerable cost reduction and time savings. Wards and specialized departments vanished, replaced by eight Patient Care Units (PCUs) dedicated to specific ailments and staffed by cross-functional care teams.

After eliminating non-value added work, outsourcing of non-core competencies was examined. Central services (e.g. X-Ray, Accounting) that could not cut costs through reengineering were contracted out.

Redesign of the value chain does not have to be contained only *within* the organization's boundaries, however. In the case of Cascade Healthcare Alliance in Bellevue, Washington, value chain reengineering spans an entire range of activities *between* a number of health care providers. Cascade aims at creating a collaborative health care delivery system where all the providers are aligned on the same objectives and share risks and rewards (as illustrated in figure 2).

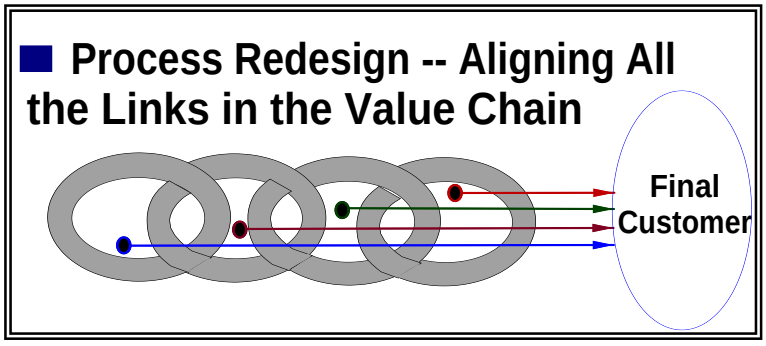


Figure 2 -- Aligning Risks & Rewards

Cascade first addressed the issue of non-alignment between primary care physicians and specialists. In the words of Dr. Greg Aeschliman, one of Cascade's cofounders:

"*The current system is rife with conflict between primary care & specialists. We wanted to ensure that, from day-one, Cascade was collaborative. We consider primary care physicians and specialists to be equal partners in this system so it is a win-win for both."*

Composed at this time only of medical doctors, Cascade decided early on to *outsource* its hospital requirements, rather than acquire a hospital, as most vertical integrators typically chose to do. In this way Cascade keeps its capital investment low, while maintaining its focus on the core strategy -- patients and wellness -- rather than emphasizing structures such as buildings and bureaucratic organizational hierarchies. It currently has alliance relationships with Overlake and Evergreen Hospitals. But these are more than vendor relationships. Cascade rewards the hospitals for quick turnover and lower price of entry. In addition, Dr. Aeschliman states: "*We reward the low-bidders with higher revenue streams and other benefits*."

System-Wide Risk & Reward Structures

One of the most frustrating aspects of the health care delivery system is the highly fragmented nature of how risk and reward is spread across the participants in the system -- medical providers, payers, businesses, and patients have all pulled in different directions. Historically, physicians have been paid on a fee for service basis, with the heavy consequence of escalating costs. While managed care has begun to curb rising costs, it often pits provider against payer, catching the patient in the middle of a tug-of-war.

Cascade aims to create an aligned risk and reward system that promotes incentives to work together on wellness, using a "co-capitation" model that splits the budgeted pool of money 50-50 between primary care and specialists. According to Dr. Aeschliman: "*Co-capitation is a risk stratification strategy. It tells everyone what fees they are going to get ahead of time. In co-capitation the way to make money is not by doing more procedures, but from increased enrollment and greater system efficiency. Low enrollment means the risk pools become more volatile, therefore patient satisfaction is a high priority*."

Value is generated for doctors on a long-term basis. Unlike the fee-based models, wealth is not created by fee-for-services activities (the more you do, the more money the physician receives), but rather from the equity in the risk pool -- the more healthy the patients, the greater the equity build-up.

Shared Decision Making and Control

Networked enterprises realize that extraordinary value can be created not by unilateral control nor by giving up control, but by enjoined and aligned control. At Cascade, Dr. Aeschliman "*knew that the monolithic, command and control model simply couldn't provide the variety of services the community needed."* Similarly, at St. Vincent's Dr. Campbell eliminated the command and control hierarchy by giving decision making and budgetary authority to PCU leaders, putting them in charge of day-to-day staffing and other basic decisions.

Flexible Structures

Inherent in any organization today is the need to be able to change and adapt in the rapidly shifting environment. This is an area where the networked enterprise excels beyond the more oppressive centralized systems of the monolithic, vertically integrated organization.

At Cascade, community interests require a variety of delivery systems and adaptations. For example, in the more industrialized community of Everett, where the paper mills are located, patients have a different set of medical requirements, such as labor injuries. However, in Bellevue where Microsoft is located, software programmers encounter carpal tunnel and stress-related problems. A community based model has a far higher likelihood of providing high levels of patient (and provider) satisfaction.

Flexibility requires a stability of culture and an emphasis on critical values and principles. Without this alignment of cultures, it is difficult to push the decision making out to the periphery of the organization where the patient-provider decisions must be made. At St. Vincent's, several value-based principles prevailed which would always remain constant when everything else was in turmoil:

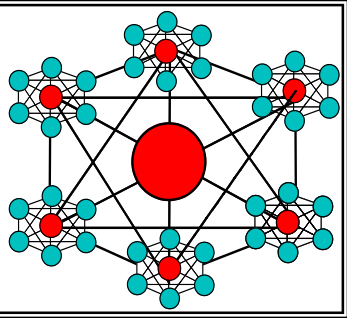
1) Patients are central to the hospital's operating processes. They were no longer to be treated as objects in processes optimized for others (namely doctors, nurses, and administrators).
2) Services are to be brought as close to the patients as possible. This resulted in a systematic development of distributed services -- for example, patient gurney rides were eliminated to the greatest extent possible.
3) Various care providers were "integrated" into teams to raise the service quality. If the team concept meant that nursing administrators would sometimes have to supervise doctors in patient care units, then so be it.

A solid set of value-based principles is essential because it builds trust, which, in turn, lowers transaction costs, increases creative forces, and builds power into the integration process. Without trust, interrelationships are forced into mechanistic tactical transactions. Only with trust can the networked organization truly become a streamlined and productive entity.

Services provided by Cross-Functional Teams

Unlike the functional specialization of the centralized command and control system that delivers care through transactional "silos" with cursory hand-offs between nurses and doctors, labs and hospitals, primary care and specialists, the networked enterprise emphasizes cross-functional teamwork. In this way, essential processes which cut across traditional boundaries of specialization are better integrated, thereby creating greater value in the system. (see figure 3)

The Networked Organization is highly inter-connected and resembles the advanced information technology system that forms the foundation of its communications network.
Figure 3



Cross-functional teams provide an additional benefit -- they enable the team to address root systemic causes of ill health and focus their energies on achieving wellness -- important factors of success in a capitated delivery model.

At St. Vincent's, allied health workers, including nutritionists, physiotherapists, mental health professionals, and social workers join nurses and doctors at the patient bedside as full members of care teams. The charge nurse now works in a care team. Support staff such as receptionists, file clerks, and records managers are dispersed from their centralized and specialized department to the PCUs. As Sister Nolan explains: "*We even put a pharmacist at the ward level -- then the pharmacist becomes a key player in the health of the patient on an on-going basis, rather than an distant disburser of drugs."*

With the shift to cross functional teams comes a major change in the environment of the care centers (formerly called wards). Now the St. Vincent's environment is more like a home. Sister Nolan relates:

> "*We are here for the patient, their family and their loved ones. This takes the fear away from being in the hospital. The family and loved ones are enabled to focus on the recovery of the patient -- they are no longer just considered 'visitors.' In many ways, our hospital looks more like a hotel. The family can even cook for the patient on site. This is what the patient wants -- to feel like they are loved and at home."*

Enabling Architectures

Crucial to the effectiveness of the networked enterprise are a set of enabling systems architectures which give the health care teams a trusting and coordinated team environment, a set of broad job descriptions focused on high levels of team performance, and accurate, real-time information.

At St. Vincent's, job descriptions were consolidated from 500 to 13; an action which the union leaders accepted because these new jobs were slotted into the old wage agreements and because the union was involved in the process of re-writing the new descriptions. Union members did not see the changes as threats for several reasons. First, job security was protected by making staff cuts only through attrition. Second, the changes were initiated on a ward-by-ward basis, and those wanting changes the most volunteered to go first. With each new initiative, the learnings of the predecessors were embraced by the next wave. And third, the principle "people support what they help create" was a fundamental to the process.

Antiquated information systems had also plagued St. Vincent's. The hospital had an inordinate number of non-integrated information systems; managers were not getting the information they needed to make clinical or administrative decisions in a timely fashion. The information system was then designed to "wrap around the patient" looking at key issues such as communications, medical technologies, and information. Clinical interviews were conducted to identify problems and support services were clustered according to the types of patient needs.

Cascade recognized a similar need. Dr. Aeschliman states: *"We knew the information system we were designing required a high capacity to flow data in real time throughout a community and measure changes. It needed to link us with the police -- car wrecks for example. It had to be more than just data, it needed to be solid, usable information that allowed us to make important medical judgments. Careful coordination is essential to link data flows with work flows and dollar flows."*

Initiating the Change

Making a shift as dramatic as these two organizations have tackled is indeed a massive task and should not be engaged in without considerable thought, analysis, and planning. Throughout the process it is essential to have extensive involvement of the staff in the effort. The best redesign of value chains comes from those who see failings every day. People support what they help create. In the words of Cascade's Dr. Aeschliman:

> "*Doctors, in the end, are the ones who can substantially influence the outcomes -- their buy-in is essential*." And from Sister Nolan: *"We felt we were part of creating the future. We felt so good about it*."

Pilot projects are also an important element in making the change. St. Vincent's made extensive use of pilots to test the viability of proposed changes and to make change more palatable. Only twenty doctors (less than 10% of the medical staff) were asked to volunteer to develop the initial pilot trial runs to prove efficacy. At Cascade, doctors are required to put only their capitated patients through the new system --other fee-for-service patients can be billed through traditional systems, thus reducing the sense of risk during a time of great change.

The Results

Are the results worth the effort? Is the networked enterprise is more effective, efficient, or profitable? Let's examine the results:

At St. Vincent's, costs have been slashed dramatically by $7 million (US), the staff was cut by 600,

and the number of beds as been reduced 11% from 450 to, while throughput has increased.

Cascade is less than 2 years old, and the results are still being compiled. But early indications are very positive. They currently have 12,000 covered lives and are growing rapidly. Doctors have been flocking to the new system, with membership now greater than 150. And investment by these doctors has totaled nearly $2 million in two equity offerings made during the last 18 months.

These networked enterprises demonstrate that it is very possible to create health care organizations that are market-driven, medically-directed, patient-centered, strategically-focused, cross-functional, and inter-connected, while aligned on the same "win." As Dr. Aeschliman states: "*We have established a huge dynamic equilibrium, where every activity in the system is linked and defined by market pressure."*

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