



# NETWORKING FOR RURAL HEALTH

SHARED SERVICES: THE FOUNDATION OF COLLABORATION

Anthony Wellever

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by

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This project is a three-year initiative of the Academy, with support from The Robert Wood Johnson Foundation. Its purpose is to strengthen the rural health care infrastructure by fostering the development of rural health networks.

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### **A** bout the Author

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# INTRODUCTION

**S**haring and collaboration are what rural health networks are all about. Networks bring together rural providers—and possibly other agencies, employers, or community organizations—to address health care problems that could not be solved by any single entity working alone. It's not surprising, then, that many networks choose shared services as the first—and sometimes the only—activity that they engage in. Indeed, early findings from a study conducted by the University of Minnesota's Rural Health Research Center indicated that 92 percent of rural health networks with 20 or fewer members participate in a shared-service arrangement.

Shared services are medical or administrative services for which two or more hospitals or health care organizations agree to share responsibility. The most pervasive shared service in health care is group purchasing, in which multiple organizations leverage their combined buying power to negotiate with vendors for affordable services or supplies. Other common shared services include specialty services, laboratories or pharmacies, bill collections, laundries, continuing education programs, and transcription services.

In a 1995 study of 300 hospitals in rural health networks, the number one reason hospital administrators cited for joining a network was to promote cost-efficiency. Shared services provide an excellent opportunity to do that: they can maximize each member's resources, create economies of scale, reduce costs, and ultimately improve patient care.

Moreover, sharing services lets networks reap the benefits of collaboration without threatening the independence of their members. Unlike institutional mergers, which force freestanding hospitals or clinics to consolidate their systems and operations, network shared-service arrangements allow members to choose the activities that would be most advantageous to them and their patients. For instance, a shared recruiting service may not be an attractive opportunity for a hospital that doesn't suffer from frequent staff shortages.

Most examples of shared services occur in horizontal networks—that is, networks that are composed of similar types of entities (e.g., an all-hospital or all-nursing home network) that serve different geographic markets. Because the members serve different markets and do not usually directly compete, they are ideal candidates for sharing.



Vertical networks also sometimes share services when there is a sufficient number of like partners to make sharing beneficial. For example, three clinics in a network composed of clinics, hospitals, public health agencies, and nursing homes may agree to share dental services.

This report focuses on shared services in the context of rural health networks. It discusses the types of shared ventures that networks typically engage in, the role network leaders can play to coordinate and broker shared services, and the issues that leaders should consider when deciding to share services.

This report and other technical assistance materials for rural health networks are available on the *Networking for Rural Health* Website: <http://www.ahsrhp.org/ruralhealth/rural.html>. For further discussion about the nature of rural health networks, see “Principles of Rural Health Network Development and Management,” by Gregory Bonk. For more on business planning, see “The Art and Science of Business Planning for Rural Health Networks,” by Anthony Wellever and Robert Cameron.

**RURAL HEALTH NETWORK:** a formal organizational arrangement among rural health care providers (and possibly others) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved.

Source: University of Minnesota, Rural Health Research Center, 1997

**SHARED SERVICES:** the coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or non-medical services on the part of two or more otherwise independent hospitals or other health programs.

Source: National Rural Health Association, 1997

**COLLABORATION:** a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to: a definition of mutual relationship and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.

Source: Amherst H. Wilder Foundation, 1992



# WHY SHARE?

**F**or many providers and hospitals in rural communities, sharing is more than just a good idea: it is an imperative to survival. Often, rural hospitals are able to stay afloat only by weaving complex webs of affiliations. A hospital may get its information systems, phone services, and specialist services through a large urban hospital, its group-purchasing discounts through the state hospital association, and a tele-medicine link to the state academic medical center through a rural health network.

From a network's perspective, sharing is a strategy for meeting the needs of member organizations or the community. Network members tend to be interested in shared services because they implicitly recognize the shortage of health care resources in rural communities and the need to join forces in order to accomplish their goals. By pooling resources, organizations can create economies of scale and overcome capital constraints.

Cost savings are often the leading incentive driving networks to share services, but many networks base the decision on non-economic or tangentially economic grounds as well. Sometimes, a network will decide to engage in a shared service because doing so may lead to a more meaningful future relationship

with another participant—whether it be a large, urban medical center or the state rural health association.

In other instances, a network or member institution may participate because it doesn't want to be left out of a deal-making process that could yield valuable contacts or networking opportunities (in other words, buying a service is the price of being at the bargaining table).

Another reason hospitals may engage in shared activities through their network is simply to support the concept of the network and ensure that it remains viable. Political considerations may also drive the decision. For example, hospital administrators may be willing to pay more for a network service if it means the network can offset the power of a regional hospital.

In many cases, it is not the specific shared service that brings participating organizations the most value; it is the shared service's collateral value. This is particularly true with clinical services. For example, a hospital might lose money on a shared computed tomography (CT) scanning service, but gain overall revenue because the CT program enables the development of other, more profitable clinical programs.



# HOW CAN NETWORKS FACILITATE SHARING?

**T**here are a variety of roles that networks can play to facilitate shared services in their organizations. They can offer services directly to their members; they can coordinate services provided by a single member or group of members; or they can contract for services with an outside vendor.

## Shared-Service Arrangements in Networks

- n **Network can contract with a vendor to provide a shared service.**
- n **Network can create a joint venture among some or all members that allows for the sharing of services and/or equipment.**
- n **Network can coordinate a shared service that is owned and operated by a member or members.**
- n **Network can negotiate terms of a master contract with vendors for members to sign bilaterally with vendors.**

When a network functions as a coordinator, it takes the lead role in scheduling and organizing for the provision of a service to members and other parties who may be involved in the deal. For example, network staff might assign personnel in a float pool or schedule times for area clinics to use a shared mobile technology service. An advantage of this approach is that it puts the network in a position of control: By

coordinating the service themselves, network staff can ensure that it is used equitably and efficiently by members. On the other hand, small networks that don't employ many people may find they can offer the network more by working with the staff of a large member institution to coordinate the service. Services coordinated by a network may be developed and owned by the network or made available to it by a member or vendor.

Networks also frequently serve as brokers of shared services. Broker networks link one or more members with an outside vendor, so they can work out a shared-services arrangement. To do this, a network might seek out potential partners on behalf of a member, convene initial meetings between the two groups, and help negotiate agreements among the parties.

As with coordinating shared services, serving as a broker gives networks a measure of control over the decision-making process. It allows networks to investigate possible linkages with vendors anonymously before committing to one or involving members in the deal.

Other key advantages of brokerage deals are that they don't require networks to make capital expenditures and they usually allow services to be provided at low costs. That's because the vendor assumes responsibility



for the capital and operating costs of the service. Although members pay usage fees, they can in turn charge patients for the service, therefore assuming virtually no financial risk. This may be a particularly attractive option for newer networks that do not yet have established records of achievement, and those whose leaders may be hesitant to ask members for help raising capital.

Networks that serve as innovators encourage their organizations to seek creative solutions to problems that individual members might consider risky. Innovative networks “push the envelope” by introducing a shared service that may be expensive to develop or arouse political concerns but that also has the potential to substantially improve members’ operations. For example, the Panhandle Area Health Network, which is

profiled on p. 14 of this report, developed a shared credentialing program that greatly enhanced the quality of physician credentialing in its community, cut down doctors’ paperwork (through the creation of an electronic database), and generated a significant revenue stream for the network.

At first the program wasn’t an easy sell to local physicians and hospitals, many of whom were accustomed to their own organizations’ credentialing methods and had apprehensions about centralizing the function. But the network worked hard to get all five of its member hospitals on board—using face-to-face contact to make the case that the service could benefit the institutions—and the decision paid off for all involved.



# PLANNING TO SHARE SERVICES

**A**s with all network activities, network leaders should base their decision to share services on the results of careful planning. During planning, network leaders weigh all the benefits and drawbacks of participating in a shared service and try to balance the network's interests against those of individual member organizations.

The process usually begins by identifying potential projects that are important to members and the community through strategic planning. The goal of strategic planning is to develop a portfolio of network goals and proposed initiatives for reaching them; it is typically done by a committee of key stakeholders who meet regularly over a period of weeks or months. (For further discussion of strategic planning, see "Strategic Planning for Rural Health Networks," by Katherine Browne, Daniel Champion, and Robert Stenger; it is available free of charge at [www.ahsrhp.org](http://www.ahsrhp.org).)

The next step is to further assess a potential shared venture identified during strategic planning by doing a business plan. Business planning involves making in-depth customer and market analyses and designing detailed organizational and management models by which a business will operate within a specified time frame. The decision to proceed with implementation of a service rests on the

results of business planning. See box on p. 8 for an overview of issues networks should consider when developing a business plan. (For more on business planning, see "The Art and Science of Business Planning for Rural Health Networks," by Anthony Wellever and Robert Cameron at [www.ahsrhp.org](http://www.ahsrhp.org).)

One of the most common business decisions networks have to make about shared services is whether to "make" or "buy" the service they're developing. There are pros and cons to both approaches, and the choice of which way to go will vary from network to network. Making a service means that the network owns and operates it; it does not

## ASK YOURSELF

- n **What are the key areas that determine our success?**
- n **How attractive is the opportunity?**
- n **What is the payoff for the community, the network, the members, etc.?**
- n **What is the time frame?**
- n **What are the chances of successful implementation?**
- n **What are the risks? Are they acceptable?**



Source: Academy for Health Services Research and Health Policy, 2000 (Adapted from Charles Seashore, Consultant, Columbia, MD)



necessarily mean that it has created it from the ground up. For example, if a network purchases an existing service from a member, expands it, and makes it available to other members (e.g., physical therapy services), the organization is still considered to have “made” the service because it has sole control over it. Buying, on the other hand, means that the service is provided through an outsourcing arrangement with a member or vendor that controls its production.

Networks often opt to buy a service if doing so allows them to acquire technical and managerial expertise that isn’t present in the network, reduce their capital investment in the project, or to fast-track implementation. By contrast, making the product may make more sense for networks that employ skilled personnel who are qualified to create a service at a lower cost or of a better quality than is available elsewhere. Indeed, being able to

ensure a product’s quality is a key reason why many networks make their own services.

When sketching out a business plan for a shared service, network leaders should calculate the “real dollar” return-on-investment associated with both making and buying. The calculation should take into account the projected capital, operating costs, and revenues for each option, as well as the less obvious “opportunity costs;” these reflect the value of opportunities foregone or actions not taken as a result of a decision, such as the prestige a network might lose if it bought rather than made its product. It’s also important to consider whether specialized expertise is available to the network, whether the network has the potential to recruit needed talent, and whether making the service would be overwhelming to already busy network executives or members.

### **ASSESSING THE EFFECTIVENESS OF SHARED SERVICES**

How network leaders evaluate the effectiveness of a shared service depends on what they had hoped it would accomplish. Many networks share because they believe doing so will create efficiencies—either by lowering costs or increasing productivity.

A shared service’s financial impact on a network can be measured fairly easily: Did the enterprise make a profit? What was the return on investment? From the members’ perspective, the service’s economic effect is measured in terms of whether it reduced operating or transaction costs at their organization. Does sharing make it less expensive to provide the service or function than it would be otherwise?

Efficiency may also be assessed by productivity, which measures the relationship between inputs to a business (costs) and outputs (services). If the network can produce more services at the same cost by sharing (or higher quality services at the same cost), then the service has increased productivity.

In other cases, a network will use non-economic criteria to assess its shared service. Did the network provide previously unavailable clinical services to the community? Did it improve the services or the image of the member or the network? For members, a shared service should be considered fair. In other words, the parties involved in the service should receive benefits in proportion to their investment.



## AN OVERVIEW OF BUSINESS PLANNING

- Step 1: Define the business: The first step is to describe what the business or cooperative enterprise is, what it will do, and who will use it. Be specific: list products and services to be offered; explain why they are needed; tell who the customers will be. Explain why the network should be involved in this line. Ask yourself:
- w Why should I start this service?
  - w What is the product or service?
  - w What are the business's objectives?
  - w Who are the customers for this business?
- Step 2: Analyze the market: Defining the market for a business plan begins with identifying attributes of the business's potential customers. The next task is to estimate the number of potential customers in the market. The final step is to identify and apply an appropriate use rate for target market segments. Use rates are expressed in an element of time and a unit of measurement—for example, births per 1,000 females, aged 18 to 44. Ask yourself:
- w How large is the market geographically?
  - w What volume of services (or income) will these customers generate?
  - w Is the market growing or shrinking?
  - w Should I sell to network members only?
- Step 3: Project demand; target market share; and develop marketing strategy: After identifying and considering factors that influence demand, estimate how much of the market potential can realistically be captured by the proposed business venture. Ask yourself:
- w Who are my current (and potential) competitors?
  - w What are their strengths and weaknesses?
  - w What share of the market could I expect in one year? After three years?
- Step 4: Develop organizational management and staffing models: This step of the business plan describes the nuts-and-bolts of the business from an operating perspective. The description specifies the resources needed in terms of facilities, equipment, and staff. Ask yourself:
- w Where will the business be located?
  - w What facilities and equipment are needed?
  - w What types of human resources are needed? Are they available?
  - w Who will manage the business? What is their experience? What should it be?
- Step 5: Assess the financial and mission implications of the business: The assumptions made in the earlier part of the business plan about sales volume, pricing, facilities, supplies, equipment, and human resources are quantified in this step in terms of dollars. Ask yourself:
- w How much capital is needed to start the business or service?
  - w Where will the capital come from?
  - w How much revenue (net of allowances) will be generated at a given volume?
  - w What will it cost to produce products/services at a given volume?
  - w How much profit is estimated at a given volume?
  - w How will profits be used (e.g., distributed to members or reinvested)?
  - w Does the project fit with the mission of the network?



# DECIDING TO SHARE: THE MEMBERS' PERSPECTIVE

 Once a network has developed a shared service, its members must decide whether—and to what extent—they wish to participate. Each organization must weigh how much a service will cost them (in dollars or loss of autonomy, for example) against how much it will benefit them (in revenue, prestige, and organizational stability). Answering the following questions can help network members decide whether sharing is right for them.

## **WHAT ARE THE BENEFITS OF COOPERATION?**

Would the shared service give the organization access to resources that they lack the cost or expertise to develop themselves? Would it be the quickest and easiest way to achieve desired ends?

Some shared services benefit members by producing revenue and others by lowering the cost of services. A service sold to members at one price and to non-members at another may produce revenue and reduce costs at the same time.

Not all benefits of cooperation are monetary. Participation in a shared service may improve the image of an institution, possibly giving it a competitive edge against other area hospitals or helping to prevent outmigration to urban centers. For example, a

hospital may lose money on an MRI service offered through the network, but the availability of the service may help some patients and create a perception in the community that the hospital is an up-to-date provider of quality services.

## **WHAT ARE THE COSTS OF COOPERATION?**

What are the fees associated with consuming the service? What will it cost the member to coordinate the service in its institution? Will the member have to lend any expertise to the development and management of the service?

In networks with multiple products and services, a member may be willing to pay more for one service than it would pay on the open market—if the entire package of network products and services cost less, or if the network produces other intangible benefits.

Sometimes, sharing services can diminish a member's competitive advantage by reducing its autonomy. Some group purchasing plans, for example, require that products be standardized in order to obtain the best prices. Standardization limits the freedom of the member to choose its own vendors and products and can compromise the member's uniqueness or perceived quality.



## WHAT ARE THE ALTERNATIVES TO SHARING SERVICES?

Are other services available for supplying the needed or desired resources? Are they less expensive? Do they better meet the organization's particular needs?

Some potential alternatives to sharing network services are for member organizations to develop services themselves, to acquire them by joining a hospital system, or to develop an exclusive agreement with a larger hospital that provides the services. If resources are available from multiple sources, a network member may participate in some shared services provided by the network, but may also use services provided outside the network. This strategy reduces dependence on a single source and improves the probability that resources will always be available.

## IS THERE A NEED TO COOPERATE?

How central is the desired resource to the member's operation? Services that are essential to members' ability to operate are more attractive than those that are merely peripheral to their core business. For example, a hospital may be more interested in providing a diagnostic service such as CT scanning—which furthers its mission of improving patient care—than in a shared laundry or administrative service.

## SHOULD LINKAGES BE INFORMAL OR FORMAL?

Informal business arrangements are common in rural areas, and health care is no exception. Many sharing arrangements among rural providers are simple, informal, bi-lateral agreements based on trust. Health care leaders interact with one another at trade associations, planning councils, and professional society meetings, where they

establish social connections that promote sharing. Organizations that have similar management and staffs, serve similar patients, and share similar values find it easy to join together in common interest.

However, as the number of sharing partners increases, so too does the potential complexity of business arrangements. Although it may be relatively straightforward for two parties to informally negotiate and monitor a shared service, it becomes difficult for three or four organizations to do so, particularly if they are not geographically close to one another. Thus, in most cases, it makes sense to formalize the agreement by having all parties sign a contract that lays out the terms of the deal. Other key reasons to make a formal business arrangement include:

### w **To solidify organizational commitment.**

When managers negotiate deals, they are merely acting as agents for their organizations. Shared-service arrangements are based not on personal relationships, but on interorganizational relationships in which the assets and resources of one organization are used by others. The terms of these relationships should be clearly spelled out so that owners and trustees can understand the consequences of sharing.

### w **To create institutional memory.**

Formal codification creates "institutional memory" for the project that will exist beyond the tenure of the individuals who negotiated the agreement. This is particularly important in rural health care settings, where turnover among staff and administrators can be high. Formal documents should spell out costs and benefits in detail, list fees, specify schedules, and outline policies and procedures.



# CASE STUDIES

**T**he two case studies that follow are intended to illustrate different ways that networks can develop shared services.

**w Medi-Sota, Inc. (Dawson, MN)**

Medi-Sota functioned in the role of broker, contracting on behalf of its members through preferred vendor relationships for diagnostic imaging services. The operation and scheduling of mobile diagnostic imaging services was outsourced to vendors.

**w Panhandle Area Health Network (Marianna, FL)**

The Panhandle Area Health Network played the role of innovator in creating a credentials verification organization (CVO) within the network. The network created the CVO from the ground up, with the primary purpose of creating a revenue-generating product.

## **CASE STUDY # 1**

Medi-Sota, Inc.

Medi-Sota, Inc. is a consortium of 24 rural hospitals and nursing homes located in southwest and central Minnesota. It was formed in 1976 to foster physician recruitment to the area. In 1984, the network was incorporated as a nonprofit organization. Its

membership includes the board chairs, chiefs of staff, and CEOs of each facility; the CEOs act as board of directors and meet once a month. The network is financed through member dues, small grants, grant writing fees, and rebates on some purchasing contracts. The network's leaders describe the organization as "an alliance of rural health care organizations working together to effectively provide value to members and strengthen the delivery of health care in the Medi-Sota service area."

One of the network's initial accomplishments was to coordinate an affiliation with the University of Minnesota to develop specialty outreach services. Today, in addition to physician recruitment services, Medi-Sota provides continuing education programs for its staff and trustees, an annual wage and benefit survey to members, and a number of preferred vendor contracts, including mobile bone densitometry, long-distance phone services, and medical waste disposal.

In 1992, Medi-Sota began to consider developing shared mobile imaging services, beginning with computerized tomography (CT). The network had initially hoped to own and operate its own CT service, but decided instead to negotiate a contract with a mobile CT vendor because the cost of



providing the service was too high. Thus, Medi-Sota functioned in a brokerage role, contracting on behalf of its members through preferred vendor relationships.

After sending a request for proposal (RFP) to several regional mobile imaging technology vendors, the network selected one and negotiated a three-year master contract. Executives from hospitals that chose to participate in the service signed the contract as a bilateral agreement between their organization and the vendor. (A sample RFP is contained in the appendix.)

Since then, the network has re-bid the contract twice when it came up for renewal; it currently has a vendor that provides complete service to the network and is responsible for staff, equipment, supplies, and maintenance. To follow are the network's leaders' answers to questions about why they decided to pursue a shared-service arrangement and what they learned from doing so.

**Q: Why did your network decide to share services?**

**A:** In recent years, it has become increasingly difficult for small rural hospitals to compete in the health care market. With reduced reimbursement rates being mandated and a large percentage of elderly citizens living in rural areas, it is imperative for our hospitals to work together to obtain shared services at the best possible price.

Obviously, a large group of health care providers has more bargaining power than each would have alone, and together we can obtain more affordable pricing. Collaboration also enables members to offer more of the services their patients desire in their service area.

**Q: What value did the product (mobile CT services) add to the network? Was the market ripe for this product line? Did it fit in with your network's long-term strategy?**

**A:**

- w For many members, savings on this service alone (for a small, low-volume hospital) justified their membership dues to the network.
- w There was enough competition in this market to drive lower pricing for a large group.
- w Our mission is to work together to effectively provide value to members and strengthen the delivery of health care in the Medi-Sota service area. This has been one way of working toward this goal.

**Q: Who was involved in planning the venture? What legal issues did you have to consider?**

**A:**

- w The Medi-Sota Planning and Development Coordinator, along with the Board of Directors, drafted an RFP that was sent to potential vendors in the region.
- w Because we contracted our mobile CT service, much of the liability was the responsibility of the vendor. Also, the network was not responsible for employing the technologist or other costs (taxes, social security, unemployment, and workers compensation) associated with owning this type of service.

**Q: What were some of the challenges you encountered when contracting for diagnostic imaging services? How can they be addressed?**

**A:** The biggest challenge was scheduling. The RFP should include a list of participat-



ing members and a desired schedule, or at least the number of visits required to handle the volume at each of the facilities in your network. Of course, the larger your membership becomes, the greater this challenge is.

It is important that the mobile CT provider have the resources to provide necessary coverage for your group, and that the network consider ways to make the service available to new members who may want to use it after the initial contract has been executed. Other issues, such as the availability of shore power or the type of scanners used, must be researched. By including all the necessary specs in your RFP, you can better evaluate the proposals you receive.

**Q: Conversely, what were some of the approaches that worked well in planning or coordinating the shared venture?**

**A:** We found that it works best for the network director and a small task force of board members to meet and go over all specifications required for the desired service.

Once the specs are agreed upon, the RFP should be drawn up by the network's director and distributed to all potential vendors. The task force should meet to review the proposals on the provided deadline. In addition to the cost of service, the membership needs to evaluate coverage availability, experience, and quality.

When a preferred vendor has been selected, your representative group may want to designate an individual to negotiate the specific terms of the contract with the preferred provider. The vendor should then furnish your group with a master contract

identifying all terms that can be reviewed and approved by board members.

**Q: How did you decide whether to make or buy the service you provided?**

**A:** Some issues to consider are:

- w Anticipated volume (Making a service can be difficult for high-volume services, which require a good deal of time, money, and energy to develop.)
- w Cost to provide the service (Buying the service can minimize capital expenditures.)
- w Liability (When a network buys a service, the vendor usually assumes some liability.)
- w Available resources and expertise (Making may make more sense if the network has the resources and expertise to develop the service; buying if it doesn't.)
- w Potential revenue for your consortium (This should be factored into return-on-investment calculations for both options.)

**Q: What advice can you offer other network leaders considering a shared-service venture?**

**A:** Research your needs, so that all issues are addressed in the RFP process. In addition to pricing, the network must review the vendor's capability of providing the coverage necessary for your members. If the service is not adequate, the venture will not be a success.

**Q: Do you consider the venture a success? Why? Looking back, is there anything you would have done differently?**

**A:** Group contracting of services, primarily for mobile CT and MRI, has proven to be successful for our network. With the increased bargaining power we achieved



through the network, our members were able to save money and continue to provide the desired services at their facilities.

Group contracting is a constant learning experience. As each contract comes up for renewal, and as each new service is considered, past experience will dictate your approach. Overall, the network has been happy with its results.

## CASE STUDY # 2

### Panhandle Area Health Network

The Panhandle Area Health Network (PAHN) was created in 1993 to improve

community access to the health care system and keep health care as local as possible. The network is a nonprofit organization whose membership includes 85 members that represent area physicians, hospitals, and public and allied health providers. Its service area includes five counties in the Florida panhandle. PAHN's board of directors, which are elected by its members, are comprised of administrators of hospitals and public health departments, physician leaders, and representatives from local businesses and governments. The network is supported by member dues, federal and state grants, and revenue-generating activities.

#### About the Service

**When Medi-Sota's initial three-year contract expired with its mobile CT vendor, the network decided to re-bid the contract in collaboration with another rural health network, the nine-member Rural Health Alliance. Five members of that network, and nine of Medi-Sota's 24 members, signed agreements to participate.**

**Under the current agreement, the vendor serves participating hospitals with two mobile CT units stationed in the area. The units remain in each location for a portion of the day, according to the needs of each hospital and the terms of the bilateral agreement between the hospital and the vendor. The vendor provides a complete service and is responsible for staff, equipment, supplies, maintenance, and quality assurance. The vendor bills hospitals on a per-scan basis, according to a master fee schedule that has been agreed upon in advance. Hospitals charge patients according to their own fee schedule.**

Throughout its history, PAHN has pursued a number of shared ventures, including joint contracting for collection agency services, group purchasing of insurance and laboratory services, shared biomedical engineering services, and mobile dental services. Among its other activities, the network runs a pharmacy assistance program for clients with chronic diseases and sponsors community health education programs and Children's Health Insurance Program outreach.

In May of 1999, PAHN began planning for a new shared service: a credential verification organization (CVO). A CVO is a business that conducts primary source identification of physicians and other health care providers and reports their findings to the governing bodies of hospitals, managed care organizations, the state Department of Health, and other health care facilities. CVOs assist in the process of awarding medical staff membership and delineating privileges. Some of PAHN's reasons for creating a CVO were to:



w **Attract more competitive health plans with a panel of credentialed physicians.** During the market research phase of planning, PAHN learned that health plans wanted to contract with a panel of physicians in the area that could be certified by the National Committee on Quality Assurance (NCQA). If a health plan uses a CVO that is NCQA accredited, it does not have to do an NCQA survey of its own credentialing procedures. PAHN viewed the creation of the CVO as both a revenue-producing service (charging health plans and others for NCQA-accredited credentialing) and a managed-care positioning strategy (allowing local physicians credentialed by the CVO to be eligible for health plans' provider networks).

w **Improve quality and reduce costs of credentialing for member hospitals.** The CVO was intended to cost member hospitals less per unit of service and be of higher quality than it would be if each organization provided credentialing independently. This is a vital function of innovative networks: they attempt to substantially improve a crucial function in the operation of member facilities.

w **Develop a revenue source.** PAHN is developing a plan for its self-sufficiency. Integral to that strategy is the development of revenue-producing services that can be sold to members and non-members in the area.

To follow are the network's leaders' answers to questions about this shared service.

**Q: Why did your network decide to share services?**

**A:** It was part of our commitment to work with rural hospitals. The network hired a consultant to study the markets and finances

of five of its member hospitals and to help them decide to partner with one another to accomplish their goals. As a result, executives from each of the five hospitals signed a cooperative agreement. The CEOs and the chairs of the hospitals' boards of trustees met quarterly to find ways to work together to cut costs and improve the quality of care. Shared services are a good way to do that, so the group developed a list of potential shared ventures to explore. Physician credentialing was one of the first things they mentioned.

**Q: What value did the product (physician credentialing) add to the network?**

**A:** One of the main benefits was that it brought uncommitted revenue into the network. The network made a profit on the service by selling it to hospitals outside the organization.

For member hospitals, who got the service for free, the service lowered their operational costs and freed up staff time because the CVO's electronic database dramatically cut down physicians' paperwork. The service also gave the network prestige. The CVO is accredited by the NCQA. Health plans know what that means and respect it.

**Q: Was the market ripe for this product line? Did it fit in with your network's long-term strategy?**

**A:** We decided to launch our product at a time when the Florida legislature was developing state-wide credentialing requirements for physicians. In 1999, the Florida Department of Health created an online credentialing database called CoreSTAT. Physicians were required to fill out an application reporting any changes to their information and send it to the state within 45 days. Because the network's CVO enabled



physicians to store their information electronically and print applications, the service made it easier for doctors to comply with CoreSTAT requirements.

By creating a revenue stream, the service helped our network move closer to its long-term goal of becoming financially self-sufficient.

It also fit with the network's goal of developing services that are of practical value to our members. In recent years, the network provided services that are more practical and customer-focused. (In the past, we were more focused on creating new ways of financing health care, such as creating our own health plan. While the CVO does help attract more competitive health plans to the area, it also fills a very practical need.)

**Q: What legal issues did you have to consider?**

**A:** The network hired an attorney to draft contracts for all the hospitals, health plans, and physicians involved. We also had to upgrade our insurance to cover the liability involved in representations about physicians' credentials. This resulted in an additional cost of \$2,500 to \$3,000 for start-up and \$1,500 to \$2,000 per year in ongoing costs.

**Q: What were some of the challenges you encountered as you developed the CVO? How can they be addressed?**

**A:** One of the biggest challenges was trying to educate physicians and hospitals about what the network could offer them. They didn't understand how our service worked, or how it could help them meet the new state rules. We had to keep reminding them to call on us for help.

Eventually, we found it easier to bypass doctors and go right to office staff with our educational efforts. Office staff were more tuned in to informational systems and the required paperwork; they were able to pass along to physicians what they needed to know.

Another challenge was learning how to market our service. When we began selling the CVO outside of the network, we had to learn to see ourselves from a customer's point of view—which meant preparing marketing materials with short, to-the-point “bites” of information.

**Q: Conversely, what were some of the approaches that worked well in planning or coordinating the shared venture?**

**A:** Taking as many opportunities as possible to have face-to-face discussions with all stakeholders, through meetings and visits with customers.

**Q: How did you decide whether to make or buy the service you provided?**

**A:** We decided to make the service largely because we wanted to ensure its quality. With something like physician credentialing—where doctors entrust you with their personal information—the network wanted customers to feel safe that they were getting a high-quality product from someone they knew. We also had a qualified staff person in-house, with a degree in health information management and medical records experience. She took the lead on developing the CVO.

**Q: What advice can you offer other network leaders considering a shared-service venture?**

**A:** Networks are more likely to succeed if they ask hospitals to work with them rather



than directly with one another. There is a sense of competition among hospitals. Although it isn't something that is openly spoken about, it's always there. Our network has learned to recognize this and we now emphasize services that we can coordinate for them—such as administrative services.

**Q: Do you consider the venture a success? Why? Looking back, is there anything you would have done differently?**

A: Our venture is definitely a success. It has lowered costs at participating hospitals, given the network uncommitted revenue and prestige, and is of practical value to our members.

If we could do anything differently, it would be to start the marketing of the product sooner. We are currently marketing our CVO to preferred provider organizations, rural hospitals, and critical access hospitals state-wide.

### Shared Credentialing by the Numbers

**COSTS:** PAHN estimates the CVO's start-up costs at \$40,000, not including staff time, rent, equipment, and overhead. The primary expenditure was for software, which cost \$15,000. (Price quotes from several vendors were between \$10,000 and \$50,000. With the help of skilled computer personnel, the network purchased good software at a low price.) The remaining \$25,000 was spent on: consultants (including a computer consultant and a health care quality expert to help prepare the CVO to meet NCQA requirements); NCQA accreditation, which cost \$14,000; legal fees; liability insurance; credentialing and NCQA training; computer upgrades; registration with national primary source verification databases (e.g., National Practitioner Data Bank); and supplies.

The CVO was projected to incur \$50,000 in operating costs per year, based on a volume of 200 credentialing files and 500 physician applications to managed care organizations. Staffing included 0.4 full-time equivalents (FTEs) for professional staff and 0.25 FTEs for clerical staff.

**REVENUES:** PAHN charges hospitals a one-time registration fee of \$1,000 to use the CVO, and a credentialing fee of \$60 to \$85 per physician, depending on whether their medical staffs also use the CVO. Physicians are charged \$200 the first year they use the service and \$130 per year thereafter. For the annual fee, the CVO will complete up to eight managed care organization applications for physicians, update their CoreSTAT profiles, and notify their offices when documents in the CoreSTAT file need to be renewed. Health plans are charged \$45 per inquiry.

After eight months in operation, the network had 60 physician credentialing files—which put it somewhat below its planned break-even point. One reason for the delay in breaking even was the time required to set up and market the operation. Eight months later, PAHN has covered all costs. It has redirected its marketing plans to accommodate the Florida Department of Health's objective to upgrade credentialing in rural hospitals statewide. The PAHN CVO is receiving state critical access hospital grant funds as an incentive to deeply discount credentialing services to Florida's 28 rural hospitals.



# CONCLUSION AND FURTHER READING

**S**haring services can help networks meet their goals and is an excellent way to build trust and morale. But in order for shared services to be successful, network leaders need to put some time and thought into their decision to offer them—and members need to carefully weigh whether to participate. When networks work together to ensure these ventures meet everyone's expectations, shared services can truly form the foundation for collaboration.

## CONCLUDING OBSERVATIONS

1. The goals of networks are frequently satisfied by sharing services.
2. To be successful, shared services must produce real benefits for members.
3. The perspectives of members and the network in regard to sharing services may differ.
4. Shared services are shaped by their environments (e.g., market conditions, technology, proximity of members).
5. Shared services can build trust in networks.
6. The decision to offer a shared service and the decision to use a shared service are determined by financial and nonfinancial (i.e., strategic and political) criteria.
7. As the complexity of shared services increases, so does the need for greater organizational structure at the network

level (e.g., corporate organization, staff, accounting).

8. Sharing services makes members more dependent on the network, thereby increasing network cohesion.

## RELATED RESOURCES FOR RURAL HEALTH NETWORKS

The following technical assistance documents have been produced under the *Networking for Rural Health* project. They are available at [www.ahsrhp.org](http://www.ahsrhp.org).

Strategic Planning for Rural Health Networks, by Katherine Browne, Daniel Champion, and Robert Stenger. Washington, DC: Academy for Health Services Research and Health Policy; March 2001.

Principles of Rural Health Network Development and Management, by Gregory Bonk. Washington, DC: Alpha Center; January 2000.

The Science and Art of Business Planning for Rural Health Networks, by Anthony Wellever and Robert Cameron. Washington, DC: Academy for Health Services Research and Health Policy; December 2000.

Forming Rural Health Networks: A Legal Primer, by James W. Teevans. Washington, DC: Alpha Center; October 1999.



# APPENDIX

## SAMPLE REQUEST FOR PROPOSAL

**XYZ RURAL HEALTH NETWORK  
P.O. BOX 3  
TINYTOWN, US 59111**

## REQUEST FOR PROPOSAL

### I. OVERVIEW

#### A. Purpose

XYZ Rural Health Network is seeking a preferred vendor to provide *Mobile CT Scanning Services* to its 15 member hospitals. The vendor selected by XYZ Rural Health Network will contract with and be paid fees by the individual hospitals in the network that choose to use the services of the preferred vendor.

Contracts developed pursuant to the RFP will be available to all present and future members of XYZ Rural Health Network.

#### Description of Network

XYZ Rural Health Network is a tax-exempt corporation composed of 15 rural hospitals located in 12 rural counties of the southwest United States.

XYZ Rural Health Network was formed in 1993 and engages in numerous clinical and administrative services, including specialty outreach services, group purchasing of supplies and material not available from larger buying groups, staff continuing education, physician recruitment, medical waste disposal, and mobile MRI scanning. XYZ Rural Health Network's mission is to provide value to its members and improve the delivery of health care services to the residents of the service area through effective collaboration.

#### Network Contact

Any inquiries concerning this RFP should be made in writing to \_\_\_\_\_, Executive Director of XYZ Rural Health Network at the address below. Interested firms will be provided



with written response to all questions. Questions should be submitted on or before April 20, 2001. Responses to questions will be mailed to all vendors on May 1, 2001.

\_\_\_\_\_, Executive Director  
XYZ Rural Health Network  
P.O. Box 3  
Tinytown, US 59111

### **B. Proposal Format and Submission**

Vendors must respond to all items and follow the order of presentation set forth in section III-A. Failure on the part of the vendor to respond to specific requirements of the RFP may be a basis for disqualification of the proposal.

Each proposal must be submitted with one (1) original, signed proposal and \_\_\_ (x) copies to the address of the *Network Contact* listed on the first page of this RFP.

All proposals must be received at the address listed on page 1 by 4:30 p.m. (CDT) June 1, 2001. No corrections or re-submissions shall be accepted after the proposal admission deadline. Proposals received after the proposal submission deadline will not be considered.

### **C. Contract Period**

The initial contract resulting from this RFP will be for three years. All contracts entered into by the preferred vendor and member hospitals will terminate on August 31, 2004, regardless of the date the agreement was entered into.

## **II. SPECIFICATIONS OF THE SCOPE OF SERVICES TO BE PROVIDED**

### **A. Services to be Provided**

The successful vendor will have the capability to provide mobile CT services for all of the member hospitals. In addition, they will have the capacity and capability to provide the following services according to the needs of individual members. Include desired specifications of the service, including:

- w Type of equipment (e.g., spiral or non-spiral CT)
- w Identify who supplies the technologist to operate the scanner
- w Identify who supplies the disposables, minor equipment, and other supplies used in making the scans
- w Liability coverage required
- w Hard copy of films
- w Generator required
- w Power linkages required
- w Identify who will interpret scans
- w Identify acceptable time-frame for reporting interpretations
- w Specify provisions for providing emergency or off-schedule scans



**B. Scope of Service**

Members of XYZ Rural Health Network will contract with the preferred vendor according to their needs. Exhibit 1 displays the results of a survey of XYZ Rural Health Network member. It lists the volume of CT services in the most recent 12-month period, whether they will or will not participate in the joint contract, and the date at which they might start.

<b>EXHIBIT 1 XYZ RURAL HEALTH NETWORK CT SURVEY</b>					Participant in Joint Contract?	
Member	Current CT Provider	Date of Contract Expiration	Number of Scans per Year	Yes	No	

**C. Responsibilities of Network**

XYZ Rural Health Network may select a preferred vendor and will facilitate the development of individual contracts between the selected preferred vendor and individual members. XYZ Rural Health Network reserves the right to reject any or all proposals as determined to be in the best interest of its members.

**III. VENDOR PROPOSALS**

**A. Vendor Proposal Format**

The prospective vendor should provide a concise narrative that addresses each of the issues listed below. Failure to address each issue may result in disqualification.

1. Provide a summary of history and experience of the company with regard to the provision of mobile CT services
2. Describe the following characteristics of the firm:
  - w Ownership
  - w Organizational structure specifying where responsibility lies for the delivery of mobile CT services
  - w Legal action and outcome of legal action taken against the firm in the past five years



- w Evidence of liability protection
- w Evidence of financial stability of the firm
- 3. Provide a list of rural health references for whom similar services have been provided within the last three years.
- 4. Provide a detailed description of the equipment to be used, the frequency of scheduled services, criteria for image quality, and the types of diagnostic studies of which the system is capable.
- 5. Provide a list of CPT codes, a procedure description, and price to the hospital per billed scan. Include in the billing price film, contrast media, and other supplies, and all technical costs necessary to complete the examination. There should be no additional charges for performing additional slices of any single scan. Specify if there is a charge for using the generator.
- 6. Describe how requests for emergency services or requests for changes in schedules will be handled, specifying the time frame required for complying with requests.
- 7. Provide a copy of the uniform contract that would be made available to each present and future member of XYZ Rural Health Network.
- 8. Provide explanation of why the services of the firm are superior to those of competitors (e.g., training, billing, cost).

### **B. Evaluation Criteria**

Each proposal received on or before 4:30 p.m. (CDT), June 1, 2001, will be reviewed and evaluated. Proposals received after the deadline will not be considered. The criteria for evaluating the proposals will be:

1. Experience of the firm in similar rural facilities.
2. Scope of services that will be provided within the proposed fee structure.
3. Quality, timeliness, and frequency of services.
4. Demonstrated ability to meet the needs of XYZ Rural Health Network members.
5. Total cost of services. (The goal of the network is to have the prices for each procedure be less than amount paid by Medicare for the same procedure.)

XYZ Rural Health Network may contact each vendor's references. XYZ Rural Health Network will conduct a scored evaluation of the proposals. If the highest scoring vendor is minimally acceptable to the network, XYZ Rural Health Network will advise its members of its selection of the preferred vendor. The bidder selected as the preferred vendor will also be notified and a date will be scheduled to begin master contract negotiation.

### **C. Contract Negotiation**

After the selection of the preferred provider, XYZ Rural Health Network will coordinate negotiations concerning specific terms of the contract between the preferred provider and the individual XYZ members who choose to contract. The same contract will be presented to all XYZ Rural Health Network members.

XYZ Rural Health Network members that decide during the term of the agreement with the preferred vendor to install an in-house CT scanner or a full-time on-site CT scanner shall be allowed to discontinue the contract with no penalty. Contracts developed pursuant to the RFP will be available to all present and future members of XYZ Rural Health Network.