

# 18 *CASE*

## The Premier Health Care Alliance Emerges

“Significant changes have been occurring for health care alliances,” said Ben Latimer, president and CEO of SunHealth Alliance until November 1995. “Consolidation, integration, and growth and acquisitions by investor-owned health care organizations are all impacting alliances. Take for example, what happened in St. Louis. Barnes Hospital, Jewish Hospital, and Christian Health Services merged to form BJC Health System. Each one of them belonged to a different health care alliance – Barnes was associated with Voluntary Hospitals of America (VHA), Jewish was allied with Premier, and Christian was a member of American Healthcare Systems. After the merger, BJC extensively studied the three different alliances and chose one – VHA.”

In 1995, there were over 700 hospitals involved with mergers or acquisitions and 1996 would probably have more, based on the number that occurred in the first half of the year. Latimer continued, “Although consolidation has occurred somewhat more slowly in the South, we are observing more and more of it. SunHealth had the largest market share in our 15-state area, but we had little room to grow. Consolidation meant that SunHealth was going to

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This case was written by Linda E. Swayne, The University of North Carolina at Charlotte, and Peter M. Ginter, University of Alabama at Birmingham. It is intended as a basis for classroom discussion rather than to illustrate either effective or ineffective handling of an administrative situation. Used with permission from Linda Swayne.

gain some partners and lose some others. It was a real challenge to grow in that kind of environment.”

“In addition, investor-owned health care organizations were acquiring hospitals. Many of those that they purchased were for-profits, but increasingly they were not-for-profits in need of cash. The Columbia/HCAs and Tenets were ready to buy these hospitals and in some instances, after purchasing them, closed them.

“The investor-owned organizations tout their ability to buy at lower prices. They promote this idea to combat the profit-making image and to induce communities to sell the local hospital to them. Because they own the hospital, they can mandate compliance. They also require that all their units buy from a single source in order to obtain those lower prices.

“Integrated networks or health care systems have been formed in many areas of the country. This organizational alternative, if it is of sufficient size, was able to compete with SunHealth if we didn’t continue to grow. We wanted to grow, but not at the cost of sacrificing quality.

“One way we could get larger was to require our partners to belong only to SunHealth Alliance and set a specific amount of purchasing that was required. But then we would have to decide if we would require partners to disassociate if they didn’t meet these requirements and whether we would pay them a ‘market value’ for their shares and how we would determine that market value.

“Another way to grow would have been to acquire another regional alliance in New England or the West, but our partners’ goal was to be a ‘premier’ alliance. They wanted to be part of a strong alliance with a great deal of market power as well as prestige. So we began thinking about becoming much larger and the way to do that was through a merger.

“We began talking with VHA in February 1995 about a possible merger. I signed a nondisclosure and confidentiality agreement but it was not limiting – meaning that I was not prohibited from talking with others. Consultants were hired to determine the interest and compatibility of the two organizations. The consultants and lawyers had been talking for nine months when Robert O’Leary of AmHS contacted me at the American Hospital Association annual meeting with a proposal that SunHealth merge with the very new AmHS/Premier. Those two alliances had merged in August. I owed it to the SunHealth partners to talk with O’Leary.

“We quickly realized that AmHS/Premier had a good geographic fit with SunHealth and there was a good fit with services. We had some overlap with VHA. In addition, there was a difference in the organization of SunHealth and VHA. VHA was organized by regions. SunHealth and AmHS/Premier had similar organizations.

“One month after the contact with O’Leary, our Board approved a merger of equals with AmHS/Premier. We think it was the right choice for us. SunHealth partners liked Rob O’Leary’s vision and the ‘fit’ between the organizations. In the final analysis, the ‘fit’ was the most important variable.”

## History of SunHealth Alliance

In 1969, SunHealth was founded as Carolinas Hospital and Health Services, Inc. (CHHS), by the state hospital associations of North Carolina and South Carolina

as a free-standing, not-for-profit, shared services corporation. The South Carolina Hospital Association (SCHA) had contacted the Duke Endowment, a major foundation in the Carolinas, to determine whether it had any interest in helping SCHA set up something similar to a California program – the Commission for Administrative Services to Hospitals (CASH). In the mid-1960s, hospitals cooperated more than they competed, and CASH and other similar organizations were emerging to assist with planning and applying industrial and management engineering techniques to hospitals for increased efficiencies.

Although receptive, the Duke Endowment leadership was concerned that the 20 or so hospitals in South Carolina were too few to be able to develop such a program. In addition, they knew that a similar group was under way in North Carolina. The Duke Endowment proposed one organization with a board of directors comprising hospital CEOs from both states. The two Carolinas had many commonalities, including culture, social structure, and economy. The hospital communities were similar in philosophy and maintained close ties. In addition, the Duke Endowment was chartered to improve higher education and health care in both North Carolina and South Carolina and saw an opportunity to leverage its grants to benefit more hospitals in the two states.

The two state hospital association CEOs developed the plan and bylaws for the organization. Dr. John Canada, a professor at North Carolina State University, put together a proposal for introducing management engineering and management education for the hospitals. Canada took the responsibility for finding the first staff. According to Latimer, “He considered a number of folks, I understand, but he had some contact with Dr. Harold Smalley at Georgia Tech who suggested that I be considered. I met with the eight-member board and was fortunate to be selected by that group.”

### *Ben Latimer Assumes Leadership of CHHS*

Ben W. Latimer earned a BME degree from Georgia Tech University in 1962 and then worked for somewhat over a year at Procter & Gamble in the Department of Industrial Engineering as a management trainee. He returned to Georgia Tech and studied under Dr. Harold Smalley, one of the pioneers in applying industrial engineering and quantitative analysis techniques to health care. (The term *management engineering* was more acceptable to hospital administrators and physicians and thus was used in health care.) Just before he completed the master of science degree in industrial engineering, Latimer was recommended by Smalley for a position with Methodist Hospital in Memphis, Tennessee. There Latimer worked on improving staffing and scheduling, particularly in the area of nursing. He realized early on that management techniques would be interwoven with the newly developing computer technology and management information systems. Although satisfied with the progress he was making in introducing management engineering at Methodist Hospital, he was intrigued by the opportunity at CHHS.

“Though independent of direct hospital association control or ownership, CHHS did serve *in effect* as the associations’ operational arm for some services developed or wanted by them for hospital members,” wrote Ben Latimer and

Pat Poston in a 1976 *Topics in Health Care Financing* article. As an example, they cited group purchasing that was researched and developed by the South Carolina Hospital Association but operationalized by CHHS. Latimer stated, "However, CHHS was never limited to implementing only those activities assigned it by the associations. In fact, CHHS operated as an expansion-minded company and would assess user needs and organize services to meet those needs.

"This organizational model was especially applicable to states in which size, density, and health care patterns precluded the existence of enough mid-sized hospitals to support shared services economically," commented Ben. "In addition, the separate but 'associated' corporation provided additional benefits – services could cross state lines, we had to be cost effective in order to survive, we had greater flexibility to recruit and pay employees differently than the associations, we could provide some services that associations were not able to provide, and members did not pay 'dues' but rather membership fees plus fees for the services that they selected. . . .

"The first service provided was management engineering known originally as the Carolinas Hospital Improvement Program or CHIP. It was designed to move hospital administration toward developing strategies for quality improvement and cost containment. It included such things as work and cleaning schedules and management education because most hospital administrators were educated in various health professions and had to learn management skills 'on the job.' For the CHIP program, all the development support came from the Duke Endowment. But as that was followed by other programs in the biomedical engineering and clinical engineering areas, the W. K. Kellogg Foundation supported our efforts as did the Kate B. Reynolds Health Care Trust.

"We used foundation support for development funds to establish new programs. However, each service we added was designed to be self-supporting. If the service was not good enough and the member hospitals weren't willing to pay for it, then it was not continued."

### *The Growing Alliance Expanded Beyond the Carolinas*

When CHHS was originally developed, the support from the Duke Endowment and the composition of the governing board dictated that it was a service organization for the two Carolinas. "It never crossed our mind to serve anyone other than North and South Carolina," Latimer said. "In the mid-1970s, the question was first raised about offering services beyond our two states. The board decided that it would not harm the current partners and would allow for a larger staff that would have the opportunity to gain more from a broader representation of health organizations, and there would be broader forums for development and expansion.

"Up until the mid-1970s, CHHS served all sizes of hospitals in the Carolinas. Because of our location and the mix of hospitals in the area, most people probably thought we only served small and medium-sized hospitals. Some of the large hospitals – those with 400-plus beds – thought they had more in common with other large-sized hospitals across a broader region. So we formed

the Sun Alliance, which corresponded loosely with the geographic area of the Southeastern Hospital Conference. We [CHHS] provided services for Sun Alliance.”

### *CHHS Becomes SunHealth Alliance*

“Eventually we determined that having two separate organizations was not beneficial. On the advice of Dr. Howard Zuckerman, a consultant from the University of Michigan, we merged the two organizations into SunHealth Corporation in 1985,” Latimer stated. The planning consultants laid out the concept of a regional health services network and encouraged the development of a network organization that in effect mirrored the composition of the hospital industry in the region – small community hospitals, large hospital systems, university hospitals, public hospitals, and so on. Given that the purpose of SunHealth was to provide health services to a large share of the population in the region, the consultants encouraged alignment of hospitals corresponding to actual patient flow patterns among facilities and physicians.

The board and management of SunHealth did not want the organization to be thought of as an “investment vehicle designed to return earnings,” but rather as a service organization to help partners fulfill their missions. *Partner* was consciously selected to be used when referring to shareholder hospitals to constantly remind all involved parties that SunHealth was a shared alliance where partners worked together to share risk and improve health care.

### *Requirements for SunHealth Membership*

SunHealth Alliance offered membership to hospitals that met the following criteria:

1. A candidate must be a tax-exempt organization engaged principally in the operation, directly or through an affiliated entity, of a not-for-profit hospital with total assets of \$5 million or more.
2. It must not be contract managed by an entity other than one that is controlled by or under common control with the member.
3. It must have approval in accordance with board policies and procedures.

In terms of recruiting for new partners in the Alliance, priority was given to (1) hospital organizations in population areas not served by existing partners, (2) those readily able to hold equity interest, (3) those demonstrating interest in existing alliance activities, and (4) those having commitment to improve region-wide health care delivery.

A new partner was evaluated on the basis of the characteristics it conveyed in its management team, relationships with other providers (competing and cooperative), recommendations from existing members, and the candidate’s objectives in seeking network membership. SunHealth used the term *multihospital system* to refer to partners who operated multiple hospital facilities in different

service areas. The term *emerging integrated health care system* was used to refer to those partners that operated acute care hospitals but had related (diversified and nondiversified) hospital services.

Because of its regional orientation, the SunHealth Alliance (more so than other major alliances in the country) was composed of diverse segments of membership, including public, general, denominational, rural, community, not-for-profit, and regional referral hospitals, plus academic medical centers that served patients from throughout the world. Some of the implications of this diversity among members were reflected in the establishment of membership criteria and requirements. Although members shared some objectives in networking, their local strategies were typically diverse. Some members, constrained by law, organizational relationships, or philosophy, could not make certain types of institutional commitments. For example, public general hospitals and tax-district hospitals were subject to public bidding. Denominational, university, and foundation operated hospitals were subject to systems or organizational investment requirements for purchasing.

A partner's rights might be terminated if that shareholder failed to continue to meet the technical eligibility requirements, such as loss of its tax exemption, being no longer engaged in the operation of a not-for-profit hospital, being acquired or contract managed by a nonrelated organization, or failure to pay its approved assessment.

## SunHealth's Goals and Benefits for Partners

SunHealth's overarching goal was supporting partners to achieve their goals. "I think that our support is one of the things that distinguishes SunHealth from other multihospital organizations and arrangements," said Latimer. "We are so committed to helping our partners reach their goals. We do that through a variety of means:

- collecting and sharing information and experience;
- creating new and better ways through research, development, and testing; and
- supporting the installation and implementation of new and better ways at alliance hospitals."

### *Services Provided for Partner Hospitals*

The impact of the prospective payment system (implemented in 1983) on hospitals caused considerably more concern with improving efficiency. Because hospitals were reimbursed at a predetermined level for each diagnosis related group, those hospitals that could provide the service at a cost below the reimbursement rate had greater revenues over costs and thus greater flexibility. The hospital could choose to spend the money on expansion, development of new services, new technology, and so on. Therefore, CHHS served the hospital members by helping them to increase efficiency.

After CHIP, Carolinas Hospital Engineering Support Services (CHESS) was established to assess and provide feedback on the rapidly emerging new health care technologies. CHIP and CHESS were followed shortly by group purchasing developed in the mid-1970s to offset inflation, the money crunch, and cost-justification requirements. SunHealth did not actually purchase or warehouse items that partners needed. Rather it negotiated terms and conditions to ensure the quality of goods and services, plus sought value added arrangements.

To provide the best in quality and price, SunHealth developed “corporate partnerships” in the mid-1980s with a small number of selected companies. SunHealth Alliance partners purchased approximately \$2 billion annually, encouraging vendors to provide an array of value-added offerings as well as an excellent price. Purchasing included medical and surgical supplies, dietary products, pharmaceuticals, medical imaging products, capital equipment, and laboratory supplies. According to Latimer, “We go beyond trading volume for price. With our corporate partners we want to work closely together for our mutual benefit. Some of our corporate partners are Johnson & Johnson, Abbott Labs, DuPont, Juran, and General Medical.”

### *Consulting and Other Services*

SunHealth’s consulting unit had been in operation for more than 20 years. A variety of consulting services allowed hospitals to increase their efficiency in both administrative and clinical areas. Consulting expertise included nursing management, financial management, cost management, decision support, quality management, telecommunications, materials management, facilities management, human resources management, productivity management, health care planning (both strategic and operational), managed care issues, information systems, and medical staff services.

“Each consulting service provided partners with new techniques or new services not previously employed to maximum benefit in typical hospitals in the region,” Latimer said. As SunHealth was better able than individual hospitals to locate, recruit, and compensate scarce technical and professional personnel, these programs made staff expertise available economically on a shared basis.

Partner hospitals were able to obtain support services that assisted in the planning, development, operation, and management of integrated managed-care programs, including contract evaluation and negotiation. The SunHealth staff provided assistance to hospitals in strategic consulting and health care planning services designed to strengthen alliance members as market leaders and improve interactions among hospitals, physicians, patients, and payors.

SunHealth joined with a variety of outside organizations to assist in the planning, development, and management of more specialized areas such as malpractice, general liability and workers’ compensation insurance services, mental health, addictive disease and rehabilitation service, financial management consulting, human resources consulting, executive and physician search, medical claims collection, housekeeping, dietary plan operations and laundry management,

electronic claims processing, employee health benefits, and utilization review services.

“Our services offered to partners must be of sufficient value to be used by the hospitals without resorting to mandates or dues. In essence, we had to be self-sufficient, including generating some surplus so that we could develop new programs or improve existing programs that were of benefit for our partners.”

Partners were charged for the consulting and clinical technology services they used in three different ways. One was the per diem rate, or a fixed amount per “expert day.” Another was a per project charge: “We quote a charge to carry out the project and if the quote is off we have to absorb the loss, or if it comes in under the quote, it is to our advantage,” Latimer explained. The third way was a continuing service arrangement. “We place a full-time industrial engineer in the hospital to manage a department. The hospital reimburses us for the compensation of the individual.

“We use incentives to encourage purchasing from SunHealth vendors,” Latimer stated. “Financial incentives are offered in those situations that are likely to produce financial results. For example, volume purchasing achieves greater savings for the alliance; the savings are returned to partners through rebating of the service fees. Other services, such as consulting, are offered purely on a fee basis as volume usage does not generate discounts.”

### SunHealth in 1995

Approximately 650 employees at SunHealth provided services to its 151 partners. The partners provided nearly \$25 billion worth of health services annually through 350 hospitals that accounted for over 72,000 licensed beds. Located primarily in 15 southeastern and south central states, hospital bed-size of partners varied as illustrated in Exhibit 18/1. SunHealth had clearly stated its mission and vision (see Exhibit 18/2).

SunHealth was extremely successful in serving its partners’ needs and remaining financially strong, as evidenced by its key indicators and comparisons of its hospitals with other hospitals nationally and regionally (see Exhibit 18/3). Purchasing volume was \$1.5 billion for fiscal year 1992 or \$28,253 per adjusted occupied bed.<sup>1</sup> Purchasing incentives of \$1.9 billion and \$16.6 million in vendor dividends were credited to partner organizations in fiscal year 1992.

Exhibit 18/1: SunHealth’s Partners by Bed Size

Number of Adjusted Occupied Beds	Percent of Partners
1–199	34.2
200–299	32.2
300–399	10.7
400–499	12.2
Over 500	10.7

## Exhibit 18/2: SunHealth Mission and Vision

**Vision**

Together, we improve the health status of people in our communities.

**Purpose and Mission**

The SunHealth Alliance is a working partnership committed to improving the health status of people in our communities. The alliance exists to help partners and their allies succeed in carrying out this commitment by:

- Providing sustained leadership for the positive transformation of health services organization and delivery;
- Transferring knowledge and experience relating to health services delivery, and developing new methods and knowledge;
- Supporting the linkage of efforts and integration of services in networks, so as to serve communities better; and
- Providing cost-effective resources for the improvement of health status.

**History of AmHS<sup>2</sup>**

American Healthcare Systems (AmHS), located in San Diego, California, restricted its membership to hospital systems. AmHS was founded in 1984 by merging two previous alliances, Associated Health Systems, headquartered in Phoenix, Arizona, representing 11 systems, and United Health Care Systems, located in Kansas City, Missouri, with 14 systems. By 1995, its board was comprised of 40 CEOs of the shareholder systems that owned, leased, or operated 397 hospitals and had affiliation agreements with 528 other hospitals. AmHS shareholders and affiliates were located in 46 states and the District of Columbia.

Since its founding in 1984, the organization had three different leaders. First was Charles Ewell who left in 1986 to become president of the Governance Institute in La Jolla, California. From 1986 to 1995, Monroe Trout, MD, was president, chief executive officer, and chairman. Robert O'Leary assumed the position in 1995.

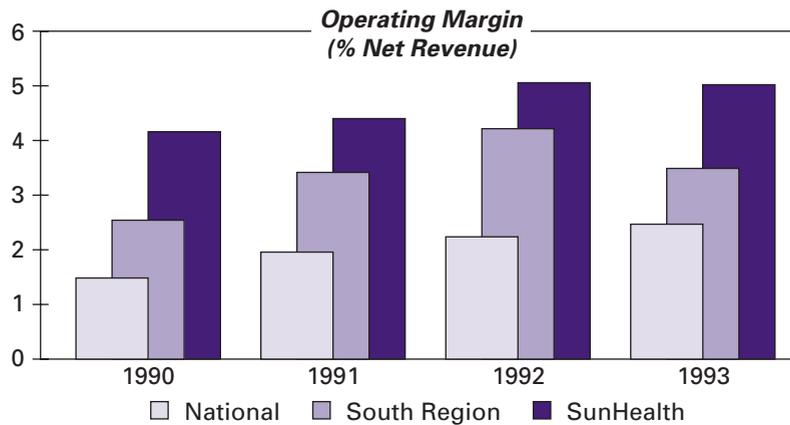
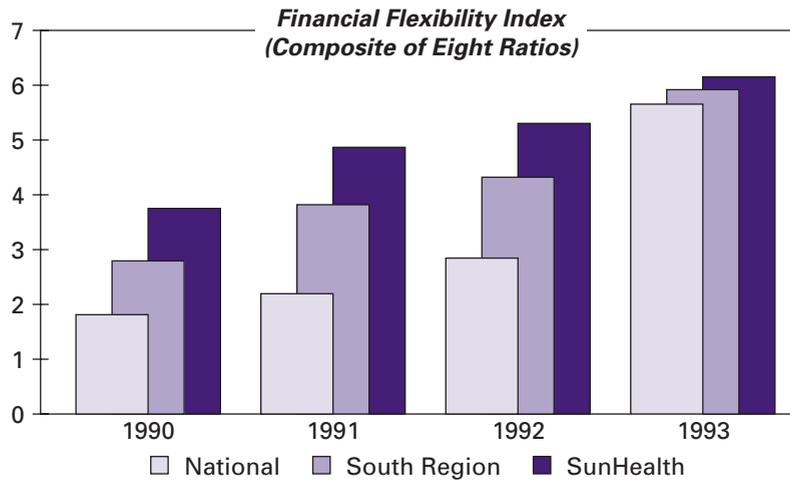
In January 1987, AmHS adopted a strategic plan that called for eliminating programs that directly involved the alliance in health care delivery and expanded services that could best be offered on a national scale.<sup>3</sup> The plan had the following objectives:

- AmHS will develop profit-making ventures that offer high-quality products and services to AmHS shareholders and other health care providers. These ventures will complement rather than compete with AmHS shareholders.
- AmHS will broaden its shareholder base to achieve maximum geographic coverage. This will permit AmHS to take full advantage of economies of scale and mass purchasing, as well as to provide a wide base for distribution of its products.

Exhibit 18/3: SunHealth Key Financial Indicators

Key Indicator	FY 1991	FY 1992	FY 1993	FY 1994
Current ratio	2.4	2.2	1.9	1.6
Total assets	\$14.2 million	\$16.2 million	\$18.3 million	\$20.8 million
Total shareholder equity	\$8.8 million	\$9.5 million	\$9.8 million	\$10.0 million
Book value per share	\$123.98	\$130.68	\$131.00	\$132.00
Enrollment of alliance	141	145	149	155

Comparisons of SunHealth Hospitals with Other Health Care Institutions



Source: HFMA Reports and Company Records.

- AmHS will remain financially self-sufficient by sustaining a variety of revenue sources.
- AmHS will strengthen its key core services, including marketing and the AmHS Institute's representational and educational endeavors.

AmHS developed a number of ventures to benefit shareholders. AmHS Insurance Management Services (IMS) was designed to improve AmHS shareholders' access to cost-effective liability insurance coverage. It created two insurance companies (AEP and ADRL) to share risk, exerting a measure of stability and control over the market in areas such as excess liability insurance. IMS group purchased insurance from major insurers at substantial discounts, often with profit-sharing provisions.

AmHS Capital Corporation was a financial services company that provided customized programs such as a taxable medium-term rate program (when tax-exempt financing was an issue), a consolidated credit card program to serve hospitals and nonacute care sites such as doctors' offices, and a capital asset protection program to better manage and control capital equipment servicing expenses.

The AmHS Business Group focused on initiating new programs. As an extension of the strategic partnering concept, AmHS Business Group attempted to add value for shareholders by reducing operating costs while maintaining or improving medical efficacy. It purchased equity positions in various manufacturers in exchange for achieving market-share objectives, assessed products and services of health care suppliers (such as those that provided high-technology equipment for potential investment by AmHS), and coordinated two venture capital funds in which AmHS was a special limited partner. By 1995, more than \$45 million had been invested in emerging medical companies.

The AmHS Institute, located in Washington, DC, was the organization's public policy center. The Institute served three functions: advocacy, education, and communication. New initiatives were in the areas of managed care, physician integration, information systems, and alternative care purchasing for nonacute care facilities.

These ventures, and AmHS's corporate partnerships in the purchasing area, were structured to generate capital for the corporation and the systems. AmHS prided itself on its small, highly professional management staff. With a total roster of less than one hundred employees, fewer than any other similar-sized alliance, AmHS made the best possible use of shareholders' assets – maximizing benefits while minimizing overhead expenses. AmHS was able to maintain this staffing level by relying on the talents of its multihospital system shareholders.

In the summer of 1989, AmHS initiated a program to improve member compliance in some group purchasing programs.<sup>4</sup> The compliance improvement program encouraged members to participate at specified levels. Shareholders were rewarded for total compliance in the program with up to 10 percent of annual dividends. Shareholders falling below specified levels were penalized. The eventual goal was 100 percent compliance, which would result in higher returns on investments for members. In 1995, AmHS had accomplished better than

**Exhibit 18/4: AmHS Mission**

AmHS mission is to ensure the availability of high-quality health care services to patients at a reasonable and affordable cost. AmHS supports this mission by linking outstanding multihospital systems that share this goal and recognize the benefit of leveraging their resources through collaboration. It is through the strengthening of its shareholders that the success of AmHS can be measured.

90 percent compliance. If a purchasing group cannot guarantee commitment from its members, it had no bargaining leverage. It was not only the number but the commitment that vendors desired.

AmHS was a shareholder-driven national alliance of 40 distinguished multi-hospital systems working together to improve their competitive positions, realize the economic advantages of size, and create innovative solutions addressing common needs. Its statement of mission is included as Exhibit 18/4.

To be considered as a shareholder in AmHS, an applicant should:

- be a not-for-profit health care corporation;
- be a high-quality prestigious health care organization;
- have a mission consistent with that of AmHS;
- complement the operations of existing shareholders;
- have a sizable market share within its major markets;
- have a strong financial position and be large enough to participate fully;
- have a well-respected management team;
- be able to fulfill certain AmHS program commitments, such as a requirement to participate in the AmHS purchasing program; and
- not participate in any other national alliance.

In July 1995, Quorum Health Group became a corporate affiliate of AmHS. Quorum was a for-profit corporation but its 105 affiliated hospitals were not-for-profit organizations.

## History of Premier Health Alliance<sup>5</sup>

Based in Westchester, Illinois, Premier Health Alliance began in 1983 as a consortium of 16 Jewish hospitals that agreed to develop a formal arrangement to handle common concerns. Originally the organization limited its membership to community teaching hospitals. The leadership did not plan for growth because of its focus on community teaching hospitals.

Alan Weinstein became the first president. Two years later the organization changed its name to Premier Hospitals Alliance to reflect the admission of non-Jewish members. It changed names again in 1993 to Premier Health Alliance as many of its members became health care systems rather than single hospitals.

Premier offered a wider range of services to its members than other broader-based alliances. This was because its member hospitals had similar needs and

wants and the group was small enough so that the staff maintained personal contact with each hospital. Premier services fell into three areas: services that saved hospitals money directly, such as group purchasing and investment programs; services that enhanced the member's market share, such as home care, imaging, and physician bonding; and information sharing services.<sup>6</sup> Premier had 70 programs that were evaluated continuously. A program that did not meet its expectations was marked and studied to see if it should be dropped. Between 7 and 12 programs were dropped in a year, but at least that many were added. Premier was expanding its managed care consulting and management services for its members.<sup>7</sup>

In 1995, 55 hospitals and health systems owned Premier, representing 280 hospitals. Together the hospitals accounted for nearly \$2 billion in purchasing. Premier developed a committed buying program that was designed to reward the hospitals that bought more of their products and services from vendors that Premier had under contract. Hospitals that agreed to buy 80 percent of applicable products under five national contracts earned 12 percent lower prices, on average, than other Premier contracts.

According to Weinstein, president of Premier Health Alliance, "Our commitment to being a member-driven organization is the cornerstone to our success. No alliance offers more to its members in program depth and breadth, quality, or service. We have high expectations of those we work with and serve. Premier boasts a proud heritage that will carry us well into the future, side by side with our membership." Premier's mission statement is included as Exhibit 18/5.

Premier's operating philosophy incorporated the following:

- Premier provides programs and services that support members as they pursue cost savings, management efficiencies, medical excellence, and the integration of health services in their communities.
- Premier delivers meaningful, strategic solutions to the management, clinical, and operating issues facing members during an era of unprecedented health reform.
- Premier programs are tailored to serve members in their individual environments and foster collaboration with other local health organizations. Programs must provide immediate financial value, long-term strategic value, or both.
- Premier is governed by its owners, yet is responsive to the needs of its member organizations.

#### Exhibit 18/5: Premier Health Alliance Mission

Premier Health Alliance is a national alliance owned by preeminent hospitals, systems, and provider networks that are responsible for improving the health of the people who live in their communities.

Premier provides hospitals, systems, and provider networks strategic advantages to improve health – through collaborating with other organizations, sharing meaningful information, pursuing economies of scale, and preserving community resources. Premier provides member hospitals, systems and provider networks the strategies and services they need to sustain a leadership role in health care excellence, community service, education, and research.

- While voluntary in nature, Premier strives to build compliance in and, thereby, increase the success of its programs.
- Premier members' staffs participate in Premier projects at every step, lending their expertise and ensuring relevance and appropriateness. Premier's own employees are an equally valuable asset, and the alliance is committed to their ongoing training, development, and recognition.
- All Premier relationships – with owners, members, business partners, and employees – are characterized by personal service, mutual respect, integrity, and the highest ethical standards.

## AmHS and Premier Merge

In July 1995, AmHS and Premier agreed to merge. In August, the organization formally became AmHS/Premier – the largest hospital alliance representing over one-quarter of all community hospitals in the United States and \$8 billion in purchasing. Robert O'Leary, CEO of AmHS, became CEO of the new organization, and Alan Weinstein, president of Premier, became president and chief operating officer. AmHS brought shareholders experience in systems and competing in managed care environments. Premier had developed expertise in technology assessment, information systems, and quality measurement.

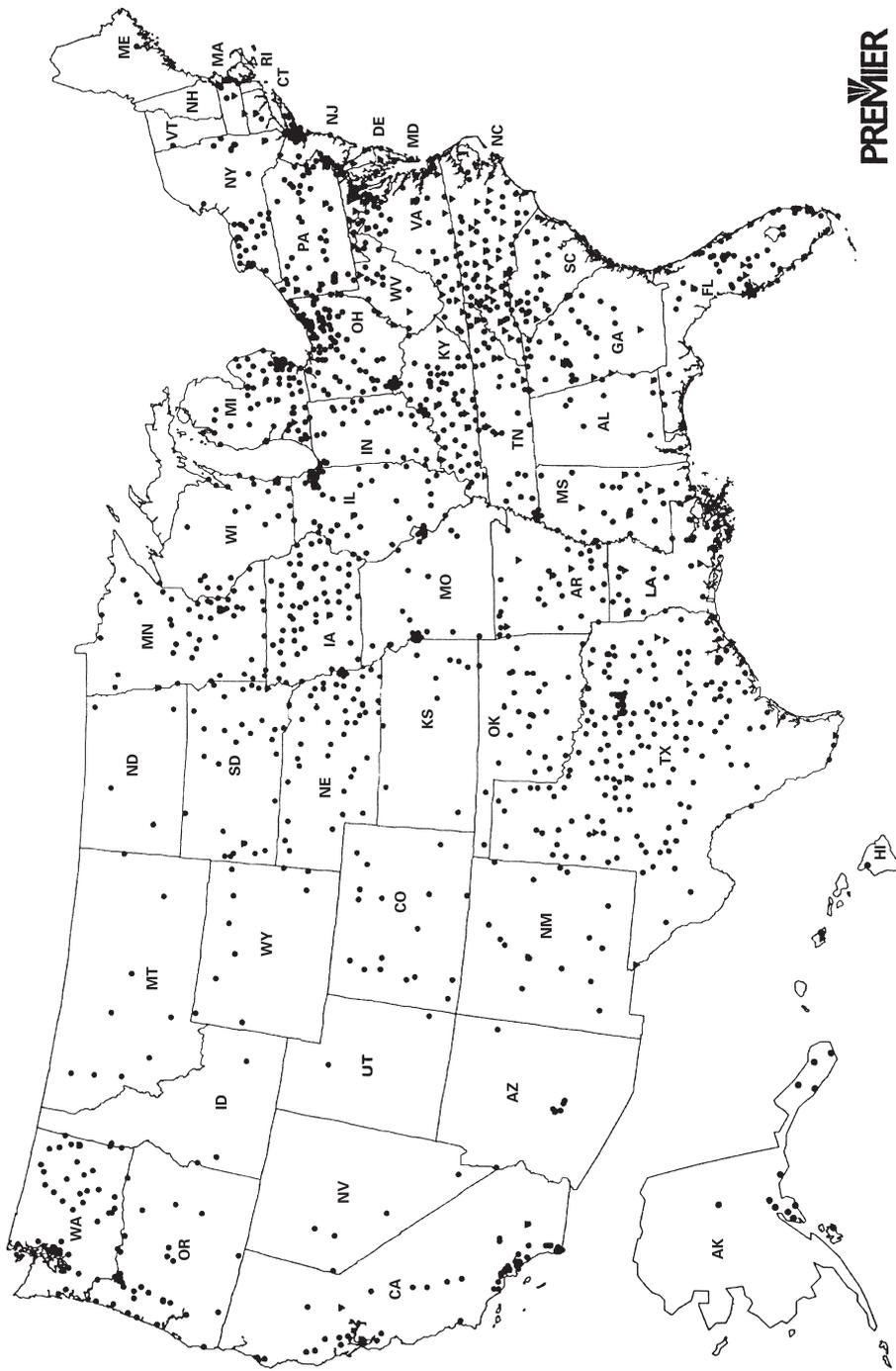
AmHS/Premier had 95 shareholders operating 400 facilities representing 1,400 hospitals with 240,000 licensed beds in 49 states. They operated in most major metropolitan areas providing the potential for the development of regional networks. The new company was less well represented in the Southeast and the Rocky Mountain areas. It represented \$45 billion in revenues making it three times larger than Columbia/HCA and 30 percent larger than the next largest alliance, VHA.

A 13-member board was to govern the organization – four members from AmHS, four from Premier, three outside members, and O'Leary and Weinstein. Joint committees were expected to draft new policies for the merged organization; a high level of compliance was a priority. AmHS required that 90 percent of eligible goods be bought under its corporate contracts, and Premier guaranteed 80 percent compliance under selected contracts.

## AmHS/Premier and SunHealth Agree to Merge

Four months later in November 1995, the recently merged AmHS/Premier formally merged with SunHealth. The new alliance had 240 shareholders with 650 facilities and 1,700 hospitals in 50 states. It represented over 30 percent of the community hospitals in the United States and was five times larger than Columbia/HCA in terms of members and purchasing volume. Annual purchases would be \$10 billion, making it a formidable customer and competitor. SunHealth provided geographic coverage in the Southeast, added buying clout, and enhanced services including technology assessment, benchmarking, and physician integration. Exhibit 18/6 provides a map of the location of the new organization's hospitals.

Exhibit 18/6: Geographic Location of AmHS/Premier/SunHealth Hospitals



PREMIER

“There was a time in the mid-1980s that we actually became a shareholder in AmHS.” Latimer explained, “VHA and Aetna were having conversations about joining together to create a national HMO brand name. AmHS wanted to counter-balance that strong association with one of its own. AmHS offered SunHealth Alliance, Yankee Alliance, Adventists System, and several others an opportunity to develop a national brand name approach to the market through Provident Insurance Company. They only required that SunHealth buy one share of AmHS stock to be a part of the enterprise. We purchased a share as it seemed to be a low-risk opportunity. However, we decided fairly quickly it was not for us. Subsequently, AmHS decided that members of its alliance should be required to do all their purchasing through AmHS and the deal with Provident fell through. We withdrew, as did the Adventists who decided to join with us.”

### Characteristics of the Three New Partners

Each of the new partners had similarities and differences. Exhibit 18/7 summarizes the general characteristics of the organizations before the mergers.

The new leadership team became Robert O’Leary as chairman of the board and chief executive officer, Ben Latimer as vice chairman of the board, and Alan Weinstein as president and chief operating officer. The first board of directors

Exhibit 18/7: Comparison of AmHS, Premier, and SunHealth

<i>Founded</i>	<b>AmHS 1984</b>	<b>PHA 1983</b>	<b>SunHealth 1969</b>
Leadership	1984–1986, Charles Ewell 1986–1995, M. Trout, MD 1995– Robert O’Leary	1983– Alan Weinstein	1969– Ben Latimer
Stakeholder Terminology	Shareholder	Owner	Partner
Geographic Strength	Northeast, Midwest, Northwest	Major metropolitan markets	Southeast
Number of Stakeholders	40 Shareholders	55 Owners	152 Partners
Number of Owner and Affiliate Hospital Units	925	280	355
Orientation Toward Fee-for-Service	Low	Medium	High
Number of Employees	100	130	650
Purchasing Compliance	100% required, but dual source	Moving toward 80% required	Sole source with incentives
Corporate Structure	Parent corporation and LLP	Cooperative corporation C(6)	Cooperative corporation C(6)
Revenues of Stakeholders	\$36 billion	n/a	\$24.8 billion
Collected Revenues of Division	\$78.6 million	\$28 million	\$61.5 million

meeting was held in February 1996. Each of the organizations provided five members to the board that also included O'Leary, Latimer, and Weinstein for a total of 18 members. The organization used AmHS/Premier/SunHealth until March 1996 when the name Premier and the corporate logo were adopted.

## Competition

Alliances were created to offer independent members the same buying clout and economies of scale enjoyed by national investor-owned systems plus the opportunity to contract with employers as part of a national health care delivery network.<sup>8</sup> For a variety of reasons many independent hospitals belonged to more than one alliance or purchasing group. Nationally hospitals belonged to an average of 2.8 purchasing groups, although in New York and Pennsylvania, they averaged belonging to four buying organizations.<sup>9</sup>

### *Industry Competitors*

Within the industry there were over 200 purchasing groups. The undercutting of prices led some industry analysts to comment that group purchasing was turning into a commodity industry.<sup>10</sup> However, a purchasing group differed from an alliance in that there was usually no financial or leadership commitment to the purchasing group. An alliance expected member organizations to participate in its governance, sharing of information, and assisting other members as well as paying membership fees.

Many hospital systems and networks were large enough to obtain their own volume buying discounts. Some questioned whether there was still a need for alliances.

There were five major alliances in the United States: AmHS, Premier, SunHealth, University Hospital Consortium (UHC), and VHA. After the merger, Premier became the largest, followed by VHA. UHC was the smallest. Exhibit 18/8 provides a comparison of Premier with its two major competitors.

### *University HealthSystem Consortium*

University HealthSystem Consortium, located in Oakbrook, Illinois, was started as University Hospital Consortium in 1980 by several CEOs of university hospitals. UHC targeted a specific group of hospitals, those owned by universities and whose staffs were controlled by medical schools. It began a group purchasing program in 1984 to provide university institutions with increased clout in purchasing pharmaceuticals, insurance, supplies, and services. In 1993 UHC surpassed \$1 billion in group purchases on behalf of its members. Sixty-five university hospitals in the United States were members of UHC.<sup>11</sup> According to Samuel Schultz II, PhD, vice president for information services at UHC, the organization had grown so much

## Exhibit 18/8: Competitive Organizational Comparison

	Premier	Columbia/HCA	VHA
Total number of acute care hospitals	1,757	307	1,136
Total membership	1,757	363	1,332
Shareholders	131	n/a	97
States	50	36	47
Beds	276,000	61,400	253,000
Admissions	9.3 million	1.9 million	7.8 million
Surgical operations	6.8 million	0.6 million	5.7 million
Emergency visits	26.8 million	0.5 million	21.8 million
Percentage of community hospital beds	30.5%	6.8%	28.0%
Estimated purchasing volume 1996	\$6–10 billion	\$2.5 billion	\$7 billion

**Source:** "The New Premier: One Year After the Merger," *IN VIVO The Business and Medicine Report* (July/August 1996), p. 25.

because its member hospitals were "in dire straits."<sup>12</sup> General university funding was severely restricted across the United States during this period of a weakened economy. University hospitals, as part of the university, were affected as well.

University hospitals tended to see their mission in terms of being on the cutting edge of health care as they saw patients, gathered data, and performed research. Thus, they had specific needs for the very newest technology and in fact were often involved with developing that technology. Many academic health centers faced the dilemma of being the site not only where new drugs and technologies were first used but also where the cost ramifications first emerged. Therefore UHC was very involved in cost and reimbursement assessments. UHC did not offer consulting services for investments in technology or services designed to acquire patients. Services included group purchasing, materials management, a national traveling nurse placement service, a nurse recruiting service, risk-management insurance services, advice on winning contracts for clinical research with pharmaceutical companies, managed care planning, and information-sharing services.<sup>13</sup>

Strategic goals recently formulated for UHC included an aggressive quality agenda, with a dozen programs in management reengineering and quality of care, plus development of tools for members to perform market assessments.<sup>14</sup> A major growth area was development of information services for clinical and technology assessment. UHC served as a clearing house for information on new technology and was setting up information-sharing systems that would assist member hospitals in clinical research by sharing outcomes information. UHC was developing a clinical information network – a vehicle for collecting members' clinical, financial, and administrative data to investigate quality of care and resource management issues.<sup>15</sup> The ability to share data among academic centers, whose information system architecture varied from archaic paper systems to PC LANs to minis to mainframes to client-server setups, was a challenging task but one that was being tackled at UHC.

## *Voluntary Hospitals of America*

Voluntary Hospitals of America, located in Irving, Texas, was the nation's largest hospital alliance in number of beds prior to the Premier merger. It was founded by 30 hospitals in 1977 and grew to include 97 shareholders and more than 1,300 members at the end of 1995.<sup>16</sup> In 1989, VHA Enterprises divested a variety of business activities that were considered strategically less valuable: VHA Physician Services that offered physician bonding products; VHA Capital; VHA Consulting Services, sold to Arthur Andersen and Co., Chicago; VHA Long-Term Care and VHA Physician Placement Services to their respective managements; and VHA Diagnostic Services to a group of outside investors.<sup>17</sup>

At that time, VHA renewed its emphasis on managed care. "We're probably the only alliance that is appropriately in the managed-care business on a national level, because we have the broadest national presence," according to Bruce Brennen, VHA's vice president for communication.<sup>18</sup> VHA retained a 50 per-cent stake in Partners National Health Plans, a joint venture with Aetna Life Insurance Company of Hartford, Connecticut. With substantially over 2 million members enrolled in 33 states, Partners was the third-largest managed-care program in the United States (Kaiser Permanente was the largest). Brennen said that VHA was keeping its managed-care operations because it helped hospitals in local markets and would be strategically important in the future. About 90 percent of VHA members were involved with Partners, which operated a number of PPOs and HMOs.<sup>19</sup> However, by the end of 1993, VHA sold its 50 percent share to Aetna.<sup>20</sup>

New initiatives for VHA included an in-house educational program on implementing best practices, a separate satellite network program for educating top executives, a program to help its members choose and implement information technologies, and a joint program with the Catholic Health Association to market a software program that measured the benefits that hospitals provided for their communities.

VHA was not pleased with SunHealth's decision to merge with Premier. It released a statement that read, "Over the past year, VHA initiated a relationship with SunHealth by participating in task forces and jointly developing a community-ownership advocacy initiative. These joint activities led to further discussions of how a merger might bring value to our members. VHA did not view a potential merger as crucial to its long-term success and acknowledged that several local market conflicts presented potential roadblocks. Despite these challenges, our conversations with SunHealth focused on the potential benefits of bringing our organizations together. During our discussions, SunHealth, without prior notification, began exclusive negotiations with AmHS/Premier that resulted in their recent decision to merge."

## *The Future of Alliances*

Not all hospital CEOs are satisfied with alliances. The primary disadvantage reported is that programs did not meet the needs of individual hospitals.<sup>21</sup> The

larger the alliance, which was good for purchasing volume, the more challenging it became to tailor services that met the needs of individual partners.

For alliances to survive, they had to think strategically for their members, be financially sound, and provide the desired services. Specific factors that appeared to be important for alliances to survive included:

- the ability to drive compliance;
- the ability to provide successful, comprehensive services beyond purchasing;
- the willingness to take risks and be creative in finding solutions for their members;
- homogeneity in alliance members;
- the ability to provide value added services to both members and vendors;
- the ability to focus on the “top-down sell” (meaning hospital CEO involvement); and
- ability to implement at the local level.<sup>22</sup>

Because of the complexity of current agreements, it was becoming increasingly difficult for hospitals to determine the real value of individual contracts. Hospitals more often were finding that their best strategy was to make a commitment to the group that they believed could best meet their needs on an overall basis – price was not the only criterion. Hospitals might not be able to assess the actual value of group purchasing contracts because they had to weigh the value of available services such as inventory management, electronic data interchange, in-service programs, and remote order entry.

Manufacturers’ attitudes toward groups were changing, as well.<sup>23</sup> Vendors were becoming more selective in their dealings. They were targeting groups that could best deliver compliance and market share. This selectivity prompted some manufacturers to refuse to sign contracts with certain groups if they could not deliver the business in return for price concessions. As a result, some groups might have closed. This made it even more important for hospitals to develop an understanding of which groups could best serve their needs. The consequence of not understanding a group’s direction was that a hospital paid higher prices for the products and services it purchased, which could mean clinical and competitive obsolescence.<sup>24</sup>

Sandwiched between trade associations and multihospital systems, facing aggressive competition from the proliferation of shared service and group purchasing, not-for-profit alliances were searching for unique identities and strategies that provided a sustainable competitive advantage for their members. The diversity of needs and interests among members of an alliance made consensus building, setting priorities, and strategic planning efforts very difficult. The alliances that survived would be those that achieved value for member organizations.

Gerald McManis believed that successful alliances would:

- develop and communicate a concise vision for the future and clearly state long-term strategy and objectives;

- establish a member network that shared the vision and had a good structural fit with the alliance's strategy;
- implement programs and services that capitalized on the unique competence of the organization and its membership;
- operate a lean, professionally managed organization, concentrating on adding real value for members, not simply its own growth and self-perpetuation; and
- build long-term relationships with members based on trust, commitment, and value.<sup>25</sup>

Network growth might eliminate the need for purchasing alliances. Some networks grew large enough to buy on their own or at least became a different type customer. Alliances might need to add alternative-site members to grow – clinics, long-term care facilities, and so on. Among purchasing groups, alternative-site members increased 27.5 percent, but hospital membership only grew 1.2 percent.<sup>26</sup>

## Looking Toward the Future of the Premier Alliance

At the first major meeting of the newly merged organization, Rob O'Leary "vowed the giant group would produce the best prices and the most innovative programs. Our role and our responsibility now is to help reshape the American delivery system."<sup>27</sup> He predicted that Premier would launch a physician equity company – Premier Practice Management – that would go public, a similar company that would be an alternative to selling to a for-profit chain, and use the organization's tremendous leverage to reduce prices to member organizations. In addition, Premier offered a full complement of services for its shareholders and affiliates (see Exhibit 18/9).

The first renegotiated contracts were signed in June 1996. DuPont offered a 30 percent lower price to be the sole supplier of film. Glaxo Wellcome agreed to use the same pricing for acute care drugs and outpatient care drugs, something the pharmaceutical industry had been resisting. This was an important breakthrough for those organizations that managed care.

In October 1996, Premier announced agreements with Alliant Foodservice, Inc., and Cerner Corporation. Alliant won the sole-source contract valued at approximately \$1 billion. Premier agreed to exclusively endorse Cerner as the preferred supplier of clinical data repository systems. Cerner provided Premier members a package named "Premier Foundations," an open clinical data foundation that supported a desktop management information system for clinicians as well as support applications. The use of this architecture by over 30 percent of US hospitals had far-reaching implications.

Things were happening rapidly within Premier, but the melding of the organizations would take some time. As a first step in integrating the three different organizations, each one appointed committee members to tackle important issues in merging the organizations. One of the first outcomes was a statement

## Exhibit 18/9: Premier's Products and Services

### **Cost Reduction Tools**

#### ***Purchasing program***

- Supplies group purchasing for medical/surgical, laboratory, operating room, food service, cardiology, and support services
- Materials management consulting
- Support services including contract management consulting and operations improvement consulting
- Pharmacy group purchasing
- Pharmacy benefit management services
- Pharmaceutical biotechnology information program
- Drug Intelligence Center
- Regional clinical pharmacy coordinators

#### ***Clinical and operational design***

- Benchmarking (clinical and operational)
- Process design and reengineering consulting
- Clinical operations consulting
- Premier CareLinks (clinical resource management)
- On-site management engineering and consulting (community-based performance services)
- Emergency room design using simulation software
- Care management/clinical pathways programs
- Collaborative groups consulting

#### ***Insurance management services***

##### ***Risk bearing***

- Excess liability
- Directors and officers liability
- Excess workers' compensation

##### ***Group sponsored***

- Property
- Managed care liability
- Employee medical benefit stop loss
- Long-term disability
- Group life and accidental death and dismemberment insurance
- Payroll deduction universal life insurance
- Group self-insured workers' compensation
- Universal life insurance program

#### ***Financial resources***

- Business office management services
- Consulting and analysis for ambulatory patient groupings classification
- GE medical tax-exempt financing

### **System Development and Integration Strategies**

#### ***Strategic planning, managed-care, and operations services***

- Strategy and business planning
- Managed care consulting
- Integrated delivery system development
- Government contracting
- Managed care organization development
- Implementation management
- Medical management
- Physician practice management
- *Integrated HealthCare Report*

#### **Technology Management Resources**

##### ***Clinical equipment management***

- Biomedical equipment repair
- Imaging equipment repair
- Technology assessment
- Technology life cycle management
- Buying, selling, upgrading, de-installation, and disposal of preowned equipment
- Network Technologies biomedical and imaging equipment accessories and parts dealership
- Clinical engineering department support and management
- Capital Asset Protection Program for lower capital equipment maintenance costs
- Capital equipment purchase negotiations and group buys

##### ***Clinical research***

##### ***Facilities management***

- Facilities consulting
- Cable Healthcare
- Energy monitoring and conservation

##### ***Information technology resources and management***

- Support materials – a health information network white paper, readiness assessment tool kit, planning and deployment methodology, and a managed-care information technology white paper
- An alliance information technology directory and vendor catalog
- Information system strategic planning
- Information technology network consulting
- Vendor selection and contract negotiation assistance
- Information technology system integration and implementation
- Operations redesign following systems implementation
- Telecommunications consulting

## Exhibit 18/9: (cont'd)

**Networking and Knowledge Transfer Opportunities****Advocacy**

- Grassroots program initiation
- Policy development
- Advocacy publications

**Education and experience sharing**

- Continuing medical education
- Customized workshops, seminars, and retreats
- Managed care and IDS education
- Nurse leadership courses
- Physician education
- Physician practice manager training
- Technology Futures Panel conference
- Research and library services
- Peer group networking meetings

**Human resources management**

- Custom local and regional wage and salary surveys
- Human resources reference desk
- Annual wage and salary surveys
- Physician incentive program design

**Legal, regulatory, and JCAHO compliance**

- JCAHO/NCQA accreditation preparation services are available and JCAHO decision grid score reports are prepared and compared with those of other organizations, mock surveys and staff training also can be arranged
- Employment, labor law, and other specialized services can be accessed through discounted arrangements negotiated by Premier staff

**Market and customer research**

- A comprehensive, modular health assessment involving quantitative and qualitative evaluation of health needs, risks, behaviors, and existing community resources
- Research services focusing on customer perceptions including community psychographics, focus group facilitation, moderator training, and patient, physician, and employer survey tools

**Measuring and comparing performance**

- Comparing clinical and financial data with that of other health care facilities
- Critical care decision support (APACHE)
- Decision support and cost accounting system assistance
- A functional assessment tool to measure a patient's physical and mental well-being
- A quality indicator comparative database
- A service quality satisfaction survey

**Organizational effectiveness**

- Organizational effectiveness training
- Change management consultation
- Self-managed team development
- Organizational diagnosis
- Mission, vision, and values development
- Executive team building
- Health care organizational performance self-assessment
- Strategic visioning conferences

of values developed by the employees of the new Premier and adopted by the board in April 1996 (see Exhibit 18/10).

Each of the former CEOs knew that merging the three separate organizations to accomplish the synergy they wanted was going to be a real challenge. Using Jim Collins and Jerry Porras's "core ideology" and "envisioned future" framework, Premier was developing a draft of its foundation statements.<sup>28</sup> The organizational leadership had a draft of core values, core purpose, and core roles (see Exhibit 18/11). Using these as a point of departure, they were working on refining and gaining consensus on the core ideology and the development of Premier's "envisioned future."

"For us to focus on survival of the acute-care hospital is wrong," Ben Latimer emphatically stated. "Success will be increasing the health status of our partners' communities without acute care. It is our task to help our partners achieve this paradigm shift and deliver care – wellness promotion as well as illness care – in new ways that lead to improved health status."

## Exhibit 18/10: Premier Values Statement

Premier consists of leading systems and networks of healthcare organizations that have created this enterprise to further their responsibility for improving the health of communities. *Premier exists to bring value to its owners and affiliates.* We provide value through quantifiable economic advantage and meaningful strategic solutions to the management and clinical issues facing our constituency. Premier's strength comes from its ability to provide leveraged solutions while recognizing the need for market flexibility.

**Values**

We believe our success is dependent on creating partnerships that bring value. We think of every encounter as an opportunity for a partner relationship. This includes encounters with our owners, affiliates, business partners, and employees. We are a responsible and accountable organization within the healthcare industry and the larger society. We work together to achieve our mission through the following core values:

***We act ethically***

- We are honest and fair
- We treat individuals with equality and respect
- We are accountable, both individually and corporately, for our actions
- We use our influence responsibly
- We actively embrace our fiduciary responsibility

***We deliver exemplary and customized service***

- We ask and listen to our partners
- We provide meaningful and timely products and services to meet our partners' needs
- We work as a team to provide coordinated services
- We openly communicate meaningful and timely information
- We empower employees to make decisions

***We enhance value***

- We optimize revenue growth and owner return on investment
- We deliver cost-effective performance improvement in our operations and our business solutions
- We are committed to maximizing profitability
- We develop strategic solutions through knowledge transfer

***We lead and embrace change***

- We are visionary, yet respectful of our heritage
- We deliver innovative solutions
- We reward creative thinking and responsible risk taking
- We actively challenge our assumptions and the way we conduct business
- We work beyond traditional norms and practices
- We commit to personal and organizational development, recognizing individual accountability for our own growth
- We commit to transforming the industry to benefit the broader society

***We Commit to be The Best***

- We attract and retain the best partners
- We deliver the best products and services
- We create the best work environment and support the balance between work and personal life
- We continually raise our standards as we try for new levels of excellence
- We invest in developing leadership expertise throughout the organization

We celebrate our accomplishments and have fun in what we do while serving our communities and patients.

April 4, 1996

## Exhibit 18/11: Premier Core Ideology (Draft)

## Foundation Statements

## Core Ideology

## Core Values

- Integrity that shines in the individual and the enterprise
- Enduring respect for others' worth and for the principles that uphold our communities
- A passion for performance and a bias for action: creating real value, engaging change, leading the pace

## Core Purpose

- To improve the health of communities

## Core Roles of the Enterprise

- Producing cost savings and quality improvements
- Providing alternative revenue sources
- Providing strategic vehicles
- Facilitating the rapid transfer of knowledge and experience

## NOTES

1. Adjusted occupied bed (AOB) is computed by multiplying total annual patient care revenues by the average 12-month census and dividing by total annual inpatient revenues:  $AOB = \text{total annual patient care revenues} \times \text{average 12-month census} \div \text{total annual inpatient revenues}$ .
2. Much of the information for this section was taken from *Building Value for Our Systems*, an American Healthcare Systems brochure.
3. Howard Larkin, "Alliances: Changing Focus for Changing Times," *Hospitals* 63 (December 20, 1989), pp. 34–35.
4. Howard Larkin, "Alliances Argue Merits of Compliance Incentives," *Hospitals* 63 (December 20, 1989), p. 37.
5. Much of the information for this section was taken from a Premier Health Alliance brochure.
6. Larkin, "Alliances: Changing Focus for Changing Times," pp. 34–35.
7. "Collaborative Efforts Enhance Program Development," *Health Care Strategic Management* 11, no. 2 (February 1993), p. 23.
8. Gerald L. McManis, "Not-for-Profit Alliances Need to Focus on Value," *Modern Healthcare* (October 15, 1989), p. 20; and Larkin, "Alliances: Changing Focus for Changing Times," pp. 34–38.
9. Lisa Scott, "Group Purchasing Evolution," *Modern Healthcare* (September 27, 1993), p. 52.
10. Jim Montague, "Can Purchasing Alliances Adapt?" *Hospitals and Health Networks* 69, no. 16 (August 20, 1995), pp. 30–34.
11. Membership information was provided by University Hospital Consortium corporate offices in a telephone interview.
12. Carolyn Dunbar, "A New Era Dawns for the University Hospital Consortium," *Computers in Healthcare* 13, no. 13 (December 1992), p. 32.
13. *Ibid.*, p. 34.
14. *Ibid.*
15. *Ibid.*
16. Current membership information was supplied by VHA corporate offices in a telephone interview.
17. Larkin, "Alliances: Changing Focus for Changing Times," p. 35.
18. *Ibid.*
19. *Ibid.*
20. Information supplied in a telephone interview.
21. Larkin, "Alliances: Changing Focus for Changing Times," p. 35.
22. John A. Henderson, "Hospitals Should Reassess Group Purchasing," *Modern Healthcare* (March 10, 1989), p. 80.
23. *Ibid.*
24. *Ibid.*
25. McManis, "Not-for-Profit Alliances," p. 20.
26. Scott, "Group Purchasing Evolution," p. 58.
27. Lisa Scott, "Giant Alliance Shares New Name, Bold Plans with Hospital Members," *Modern Healthcare* (March 18, 1996), p. 5.
28. For a complete discussion see James C. Collins and Jerry I. Porras, "Building Your Company's Vision," *Harvard Business Review* 88, no. 5 (September/October 1996), pp. 65–77.