If You Build It, Will They Come?

The healthcare industry of the 70's and 80's grew and prospered in a virtual "field of dreams". Hospitals and medical centers expanded at exponential rates financed by the fee-for-service ethic of, "the more you do, the more you earn." Every new medical enterprise flourished, the supply of patients was abundant and it was common knowledge that, "if you build it, they will come".

The arrival of managed care and capitated reimbursement presents us with a new idiom, "if you build it, will it pay?" The newly emerging integrated health systems have little interest in creating fee-for-service, profit centers. Their world is focused on patient outcomes, exploring new clinical pathways and reducing costs without sacrificing quality . Managed care enrollment is the source of all revenues and facilities are often seen as just another expense, a drain of valuable capital. What follows is a collection of recent statistics, facts and phenomena that will reshape hospitals and healthcare facilities in the new medical marketplace of the future.

Location, location, location

Delivering the right health services at the right location is essential for proper market penetration and the ability to successfully position specialist and primary care physicians. Preventive medical care, primary care and related ambulatory services will be decentralized throughout the community, making them as convenient and accessible as possible. Specialty group practices will often cluster around hospitals, sharing technologies and maximizing the value of those costly acute care settings. Many specialist groups will be housed in offices created from low census bed wings in the hospital.

Look for community based primary care offices to house 5 to 10 physicians with hospital based multi-specialty groups ranging from 10 to 25 doctors.

(Source: AMA study, 1993)

End of the Line

Much of the duplication and wasteful departmentalization in hospitals today can be traced to the arrival of "product line medicine". Except for a limited few large tertiary centers, the concept of medical product lines and specialty centers will end. Hospitalized patients will often be grouped by acuity rather than diagnosis. This will improve staff and facility utilization with a better distribution of patients throughout the hospital.

Typical Planning Profiles	Indemnity Plans (Fee-for-Service)	Managed Care Plans (Capitated)
Covered Lives	100,000	100,000
Primary Care Physicians	40	60
Specialist Physicians	160	60
% Physicians in Group Practice	15%	85%
Hospital Beds (Acute)	280	130
Average Length of Stay	6.0 days	4.5 days
Ambulatory Care Sites	Minimal	Extensive
Average Annual Premium	$3,000	$1,600

Sources: Integrated Healthcare Report, Sokolov & Ottensmeyer

The Feminization of Medical Care

The number of female physicians continues to grow. Over 50% of all primary care residents in medical school today are women. (Remember that PCP's are now the most sought after practitioners in healthcare today.) This gender shift in hospitals will do much more than reapportion the number of toilets in the physicians lounge. It will cause a welcome shift in the culture and consciousness of the organization. Employee benefits such as child care centers and secured, dedicated parking spaces for night shift employees will become high priority issues. Sensitivity toward design quality in the healthcare environment will also grow over time.

HOT Links

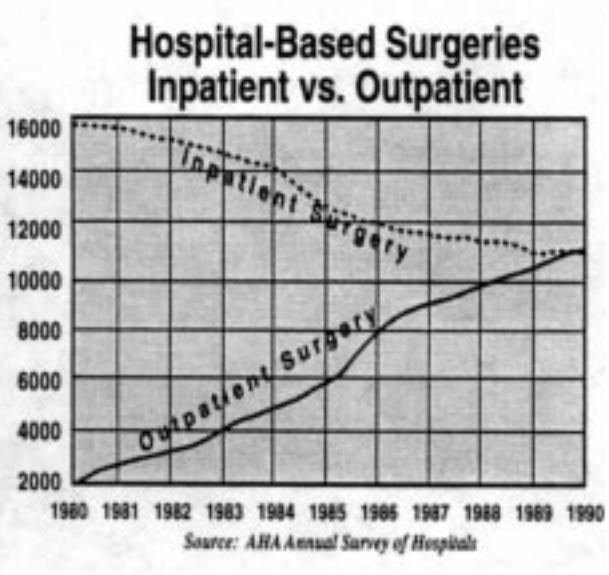
Healthcare no longer needs to be a "place centered" service. Regional healthcare systems such as Harvard Community Health Plan are beginning to deliver health services on the information superhighway, using H.O.T.S. Health Oriented Telecommunication Systems.

50 to 80% of all patients who initially seek medical care do not really need to see a doctor. 70% of a good diagnosis depends on what the patient tells the doctor. 60% of all patients who need serious medical care, see a physician only after it's too late to treat their problem inexpensively.

HOTS systems can provide patients with timely information and improved access to health providers with a direct link from home to healthcenter. Subscribers can have 24 hr. access to "ask a nurse" services, appointment scheduling, wellness programs and health education. These systems may soon expand to include home diagnostic services, sending real time patient data, heart rates, blood chemistries etc., to centralized medical monitoring stations.

What's the Alternative?

Managed Care systems are constantly seeking the best quality care, delivered in the lowest cost setting. Hospitals are seen as the last resort, accounting for a 60% drop in hospitalizations by California managed care patients over the last 5 years. Alternative delivery sites will continue to proliferate with almost 60% of all surgery now being performed on an outpatient basis. Recovery Centers are now being licensed in 16 states with an explosive growth in home care nursing and subacute nursing centers built to SNF standards.



Compared to new less costly options Ambulatory Care, Home Care and Sub Acute Care, Tertiary Care Hospital looks like a *sumo wrestler in a chorus line*.

The Lite Hospital

The, once highly prized, acute care hospital is viewed within the new managed care marketplace, like a *sumo wrestler in a chorus line.* Despite their costly overhead and inherent inefficiencies, hospitals will remain as an important component of any full service health plan. To survive in a capitated marketplace, hospitals will continue to reshape themselves, dropping a great deal of excess baggage along the way. Expect hospitals to dispose of almost 1/3 of their current medical technologies (equipment acquired during the medical arms race of the 80's).

Nursing units will be combined or converted to clinical specialist offices, outpatient programs or subacute care. Health plans will replace many of the hospitals departments including billing, collections, Q/A & U/R, information management and purchasing functions with regionally based Management Service Organizations (MSO's). In an effort to raise much needed capital, some hospitals will sell off their facilities which will be leased back from medical development corporations.

Managed Care Environments

In an effort to promote prevention, managed health plans will begin reshaping the environments of their patient/ subscribers. Some HMO's are now installing handrails and slip resistant surfaces in the homes of seniors, building ramps in the schools of their handicapped patients and adding physical therapy gyms to their existing nursing home projects.

"Infomatics"
Health systems will be investing $15 billion over the next decade on integrated clinical information systems. Expenditures for patient centered computing will increase 22% annually through the year 2000. These systems will drive new programs of telemedicine, clinical decision making, outcomes management, computer based patient records and the electronic integration of all care givers in the system. Look for these new computer systems to drain large amounts of capital from proposed building projects and simultaneously require more resources in the form of new communication closets, cable trays in the ceilings and sophisticated uninterrupted, clean electrical systems.
(Source: Volpe, Welte & Co., 1994)

The New Clients
The cost of creating a new integrated health system is staggering, oftentimes in the billions of dollars. With their debt capacity already exhausted, hospitals and physicians will seek new partners with fresh sources of capital. The new partners will be insurers such as CIGNA and Aetna or investor owned management service organizations like Phycor, Summit and Heritage Health Systems. New physician "supergroups" such as Fallon, Park Nicollet and Mulliken Medical are also positioned to "buy in" as the healthcare clients of the future.

The new owners are extremely cost conscious, with high expectations for the efficiency and productivity of their healthcare facilities. They will seek innovative, low cost concepts for the reuse and recycling of existing buildings, assistance in facility utilization audits and services for restructuring and resizing their existing medical campus.

Family Focused Healthcare
Here is a suggestion for restructuring low census, semi-private patient rooms. Consider moving a hotel bed into the space and encouraging a friend or family member to assist in the patient care process. Shorter lengths of stay means patient care must be carefully transitioned from the hospital to the home. Patients are discharged "quicker and sicker" these days and family care givers need to receive *on the job training* before the patient arrives back home. Nursing units should be equipped with home care classrooms, family consult areas, kitchenettes and storage space for family focused healthcare.

Hot Potato
Risk, in the form of capitation, is the "hot potato" that all healthcare systems are now learning to handle. Healthcare architects will be sharing that risk in the form of "capitated" GMP's for all projects along with guaranteed performance standard for each building system. New healthcare development teams will spring up as joint ventures between planners, designers and contractors. Sorry, fee-for-service architects and planners need not apply.

Conclusion
Over the last 50 years we have rebuilt and quadrupled the size of healthcare's physical infrastructure. There is no question that the United States now has the very best healthcare facilities in the world. Unfortunately, our high-tech and high cost system of medical care has not produced an equally high health status for many Americans. Our challenge for the future is clear. We must now provide more than the biggest and best medical facilities, we must provide the healthcare facilities that our patients require.

"The hospital is human invention, and as such can be reinvented at any time"

Leland Kaiser

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