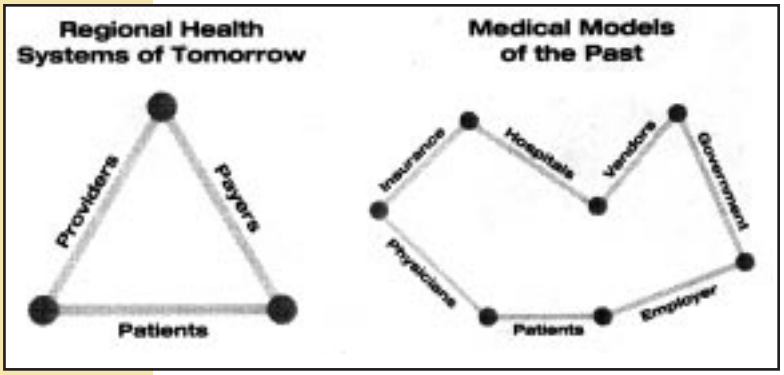
Responding to Healthcare Reform;

Strategic, Operational and Facility Planning Options

On September 22nd, 1993, President Clinton announced to Congress and the nation that, "this healthcare system of ours is badly broken and it's time to fix it". Those words marked the start of a great reformation in American healthcare. Over the next 100 months, the healthcare reform movement will create more structural change and upheaval than the medical care industry has witnessed in the last 100 years. While numerous reform issues are now under debate. the single biggest problem with todays healthcare system, is that we don't have one- an efficient healthcare system that is. Instead of a true, functioning system we've created and inherited a complex assemblage of ill-fitting parts which often fails to serve the collective needs of our patients and healthcare providers. Briefly stated, healthcare has a "systems problem".

Todays non-system of medical care is a problematic and confusing collection of hospitals, nursing homes, physicians, patients, employers, government agencies and insurance companies. The overwhelming complexity of this structure makes it inherently unstable and inefficient. An alternative, offered by certain managed care models, is a simplified three



part structure consisting of provider, patient and payer.

The unified triangular structure allows all elements to share the load (risk and cost) in a more balanced way. No part of a well constructed healthcare system operates in isolation, all the major components should be in direct contact, responding and interacting with one another synergistically. This structure describes a truly integrated svstem of healthcare, a system that many healthcare providers, payers and patients now seek to adopt. The key to creating an integrated regional system of healthcare, is to unite and assemble it's three major component parts.

"The ability to assume risk, provide comprehensive care and remain profitable under capitated payment plans will be easier for systems that control every element- the insurance, hospital and physician components." The Integrated Healthcare Report, Aug.'93.

To a large degree, market forces and federal reforms are doing this in the patient and payer components of the new managed care models. The health education movement, an increase in co-payments and "out of pocket spending" by patients and greater freedom of choice in selecting health plans are creating a more unified group of patient consumers. Payer groups are being reformed as employer health alliances and co-ops. Many employers are now purchasing medical services directly from independent HMO's and Physician/ Hospital Organizations(PHO' s).

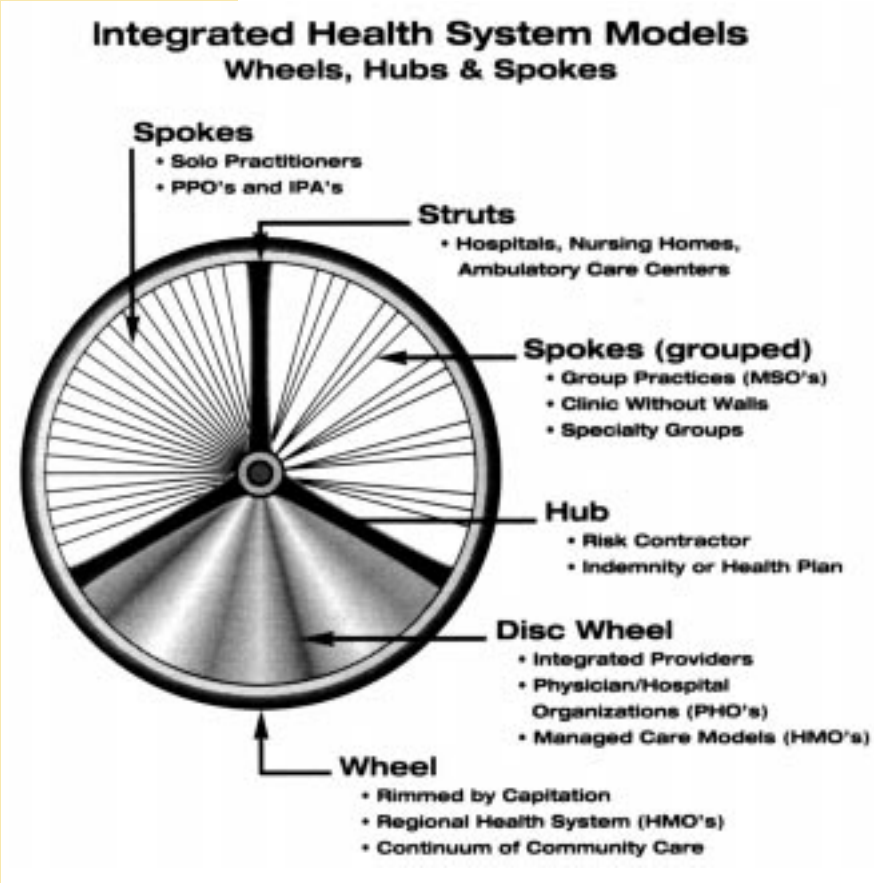
While a larger fraction of provider groups are beginning to offer a managed care product, most medical care services are still being provided by a fragmented system of hospitals and physicians who are unwilling or unable to accept the risk of capitated care agreements

Wheels, Spokes and Hubs

In the post-reform era, it will be necessary for all medical care providers to choose a specific role in the newly evolved, integrated systems of healthcare. Will your rnedical care organization choose to be a wheel, a spoke or a hub?

Hubs are risk contractors (health plans and indemnity policies), absorbing the financial pressures and insuring that coverage remains intact for patient subscriber groups. Spokes can be single solo practitioners or more likely, a bundle of spokes (group practice models such as IPA' s, MSO' s or the new Clinics without Walls). Hospitals, nursing homes and ambulatory care centers are larger struts supporting the system. Hubs and spokes may come together in a limited fashion to attract capitated contracts or spokes and struts may merge to form larger PHO's.

The ultimate extension of this integrated structure is the wheel or HMO. It is rimmed and contained by capitation and is capable of providing it's patient subscribers with a lifetime package of integrated healthcare services.



The quicker a healthcare provider selects and takes their position in the wheel, the sooner other component parts will begin connecting and interacting, (referring) to that provider in a positive way. Indecisive healthcare providers may be ignored or denied a useful position in the integrated health systems of tomorrow.

Managed Competition does not wait for healthcare reform. Price wars are now breaking out between California HMO's. The Blue Cross HMO, California Care, recently announced new subscriber rate reductions of 20% to 25%.

Everyone's a Specialist

While physician salaries currently constitute only 20% of total healthcare costs, physician practice patterns and referrals to other medical services determines almost 70% of our $900 billion annual healthcare bill. Many of these referrals for consultation, diagnosis and treatment are to other medical specialists. In marked contrast to HMO's which have almost equal numbers of primary care and specialty care physicians, today's medical practice features 70% subspecialists with only 30% primary care physicians (PCPs). The use of PCP's as the patient's initial point of contact and "gatekeepers" in managed care models, has shown to be an effective tool in curtailing the inappropriate use of specialist services and related costly technologies. Primary care is now viewed as the "value added" branch of medicine, controlling the cost of healthcare and encouraging more disease preventiveservices.

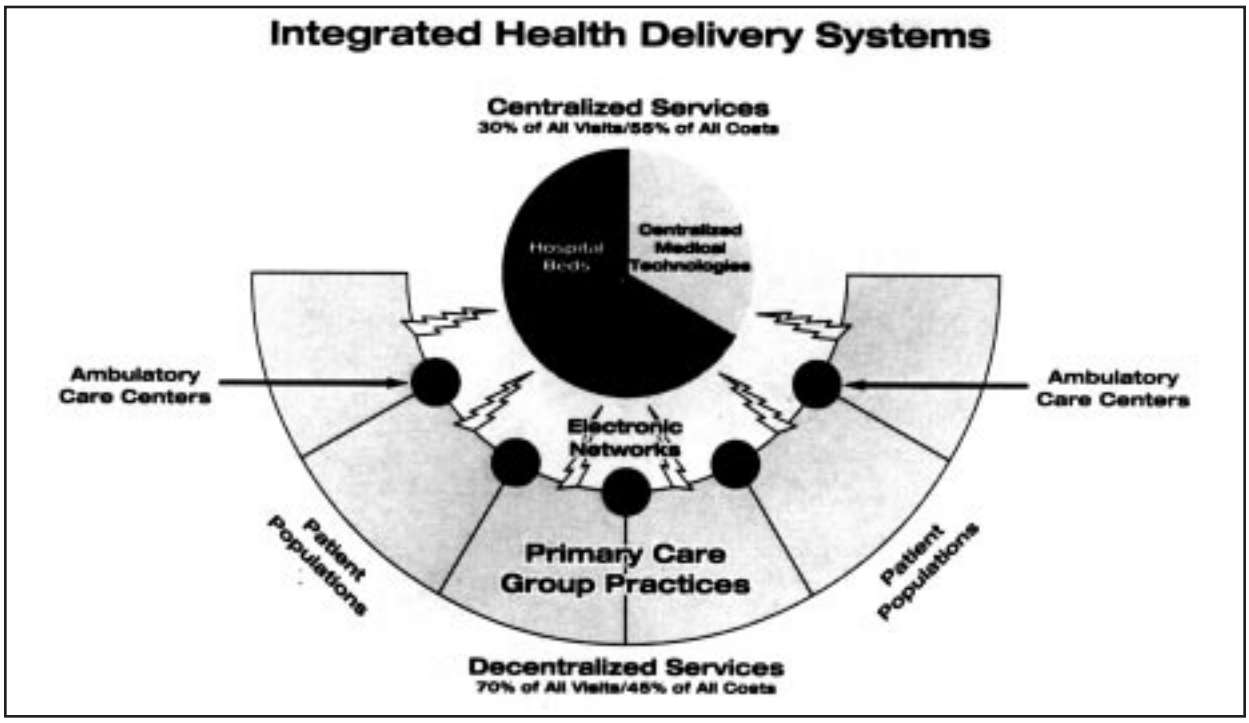
The integrated health system of tomorrow will have two distinctly different roles for primary and specialty physician groups. With new medical technologies and an increase in multiskilled practitioners, 70% of all patient visits in the year 2000 will be to PCP group practices. Many of these primary care services may also be delivered by school nurses, midwives, med-techs and other physician extenders. The foundation for any successful program of primary and preventive care, is local availability and convenience. Basic healthcare services will no longer be "place centered". Primary care and related ambulatory services will be decentralized throughout the community making them as accessible as possible.

The other 30% of patient visits will come by referral to single specialty group practices. These subspecialists will cluster around hospitals, sharing medical technology and maximizing the value of those costly acute care settings. These groups will often merge into PHO's with the hospital, doing larger volumes of specialty diagnostics and surgical cases, improving the quality and reducing the cost per case.

Tomorrow.

Physician practice patterns are a major determinant in the cost and quality of patient care. Reforming the healthcare system begins with a restructuring of those medical practice paterns.

"To succeed in the 90's, we must align our facilities for health care with the new philosophies of health reform." Don McKahan



Although specialists and PCP's will be located in distinctly different service settings, their connectivity will be improved as fiber optic data networks and the "information superhighways" begin to expand. All clinical information will be electronic and this data will serve as the foundation for new systems of quality control, outcomes management and telemedicine.

Responding to Health Reform

The creation of a responsive and integrated system of healthcare, requires new thinking on three major fronts. First, restructuring the practice of medicine. Second, revising the role of hospitals and third, expanding our vision of community healthcare.

1. Restructuring for medical practice of

While solo practitioners may survive, the ability to thrive in the future is dependent on successful partnering and contracting in a group practice setting.
The formation of successful group practices can be assisted by the following:

• Educating and assisting key physician leaders in the creation of groups. This may include bringing in group practice consultants, attending symposiums, case study practices and group practice newsletters .

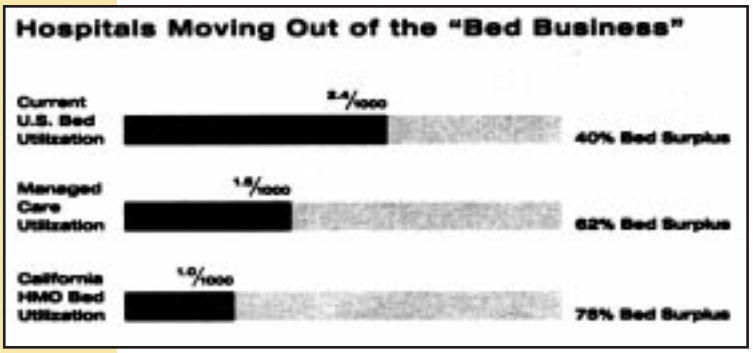
• Explore HMO contracting possibilities for integrated group practice models. Begin modeling your groups and hospital to accept the challenge of capitated contracts.

• Campaign to bring new group practice Medical Directors into your health system.

• Move freestanding ambulatory care centers along with Primary Care office buildings out into the community.

• Create specialty clinics and office space adjacent to the existing hospital. Plan PHO ventures to share the cost of these programs and equipment with subspecialty groups.

• Plan for a data network connecting primary care sites to subspecialist groups and the hospital.



2. Revising the Role of the Hospital

Hospitalization and the cost of related subspecialty physicians, accounts for almost one half of today's healthcare expenditures. When these hi-tech, highly skilled services are required, they must be delivered in the most cost effective and efficient manner possible. The activities of hospital based nurses and physicians needs to be supported by the proper operational systems, facilities and medical equipment. In the hospital, the choreography of care must be well planned and rehearsed, to optimize the performance of all it' s players. Planning for the hospital of the future means:

• Operational restructuring and streamlining the system, cross training of caregivers, redeployment of medical technologies, providing more care with fewer handoffs in the system

• Computerization and integration of all institutional and clinical records.

• Outsourcing for less costly, "stockless" systems of supply, food services, laundry and security. (New safe harbors now exist for hospital joint ventures in shared service organizations .)

• Reallocation of excess bed space in the hospital. (Long term skilled nursing care, rehabilitation units, new ambulatory care programs and hospital based physicians of fices.)

• Creation of co-owned, hospital and physician based specialty centers. (Laser centers, endoscopy, laparascopy and specialty diagnostics.)

• Bringing more specialty group practices into joint ventures with the hospital, for cost sharing and risk sharing under capitated care agreements.

• Creating patient centered, family focussed hospital care models.

Case Study

Dr. Jerry Kay operates a successful, single specialty group practice in cardiac surgery. Offering contract services in the Los Angeles marketplace, Dr. Kay's group has developed a strong reputation for their clinical expertise and cost efficient delivery of surgical services. The operational efficiency of his surgical system, combined with the groups high volume caseload, allows them to perform a cardiac by-pass for $12,000 to $15,000 a case, where other surgeons are charging over $30,000.
Single specialty groups such as this, will continue to flourish as they allow physicians to cut administrative costs, achieve higher and more efficient case volumes, and better share the risk of new capitated care contracts.

3. Expanding our model of healthcare

Good medical care is only one dimension of true healthcare. 80% of what most people die from is preventable and has nothing to do with medical care. The quality of our health is ultimately linked to lifestyle, educational status, housing, nutrition, genetics and our psychological health. To address these issues effectively, our health systems model must expand to include:

• Disease prevention, health education and wellness in schools, churches, clubs and the workplace.

• Creation of more community based selfcare medical malls, mobile-care vans, birthing centers, home hospice programs, ambulatory surgical, diagnostic and screening centers.

• Ambulatory care, primary care and home care will account for almost 80% of all healthcare services by the year 2000. Hospitalization will be seen as the "last resort" with inpatient census dropping another 50% over the next decade.

• Improved health information and access to medical services through local healthcare guides. (Retired physicians, paramedics and nurses)

• Greater utilization of alternative therapies and caregivers.

• The ultimate outcome of a successful regional health system, is a "healthy community" .

Integrated healthcare delivery systems will dominate the medical marketplace by the year 2000. A recent survey shows that 45% of medical group practices and over 60% of surveyed hospitals, plan to have integrated delivery systems in place within the next 12 months. (Source: Survey by Witt/ Keiffer, Ford, Hadelman & Lloyd)

Conclusion

The driving force behind today' s health reforrn movement is evolution. As explained by Dr. Randolph Nesse of the University of Michigan, "advances in medicine would be even more rapid if medical professionals were as attuned to Darwin as they have been to Pasteur." Todays hospitals and healthcare providers have been held hostage, bound up by out dated attitudes and paralyzed by prospect of change. Those who are unwilling to respond to healthcares' evolutionary shifts, run the risk of extinction. Those who ride with the waves of change, will move forward with healthcare, on to its next horizon. The most essential component of this transformational process is education.

(1) Educating our physicians and staff on the new "megatrends" of medical care.

(2) Educating our patient populations to make healthier life choices.

(3) Restructuring our hospitals and retooling our healthcare facilities for the next generation of regionally integrated health systems.

Knowledge and understanding are the ultimate responses to healthcare reform.

McKahan Planning Group

This monograph was created by McKahan Planning Group (1994).
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