Review the Southeast Medical Center case study found on page 92 of the course text.  Of the recommendations found on pages 100-101, select the three which you consider to be the highest priority/most important to the case.  Justify your reasoning.  Support your opinion with a minimum of two outside scholarly resources.  Write a three- to five-page paper (excluding title and reference pages) with your selected recommendations and justifications. The paper must be in APA format.

Southeast Medical Center Case Study Review the Southeast Medical Center case study found on page 92 of the course text. Of the recommendations found on pages 100-101, select the three which you consider to be the highest priority/most important to the case. Justify your reasoning. Support your opinion with a minimum of two outside scholarly resources

In-Depth Case Study: Southeast Medical Center

The following case study involving a large organized delivery system exemplifies many of the issues described earlier in this chapter.

History and Evolution

Southeast Medical Center (SMC; a pseudonym) was established as a public hospital in the 1920s, just before the Depression. Located in the Southeast, a $1 million bond financed the 250-bed facility. Major expansion projects in the 1950s increased the hospital’s size to 600 beds. Formal affiliation with the local university’s College of Medicine residency program in the 1970s further expanded capacity. Thus, SMC became a public academic health center and subsequently assumed multiple missions of patient care, teaching, and research. Capital improvement programs were conducted during the 1970s, and in 1982, a massive renovation and construction project ($160 million) added 550 beds to the facility. In the 1980s, a 59-bed freestanding rehabilitation center was opened adjacent to the hospital, and a physicians’ office building was constructed next to the hospital. Medical helicopters were also acquired in 1989, expanding SMC’s trauma services. In addition to serving as a regional provider for trauma, SMC also furnishes burn, neonatal, and transplant care for the region.

Responsibility for governance of SMC has shifted over the years. In the early years of operation, a hospital board ran SMC. In the 1940s, the city was given direct control over the hospital. In the 1980s, the state legislature created a public hospital authority (to be appointed by the county commission) to govern the hospital. In the 1990s, the hospital’s board of trustees voted to turn operations of the hospital over to a private, not-for-profit corporation (501c-3), the SMC Corporation. However, oversight for charity care remained with the county’s hospital authority. The SMC Corporation is directed by a 15-member board of directors and essentially manages the organized delivery system through a lease arrangement with the county hospital authority.

Today, SMC is a private, not-for-profit academic health center that is accredited by JCAHO. It also serves as the primary teaching hospital for the local university. Approximately 1100 private and university-affiliated attending physicians and more than 400 resident physicians in the university’s College of Medicine residency program serve the community’s medical needs. SMC also serves as the clinical site for associate, baccalaureate, and graduate nursing programs for the university and community colleges.

SMC serves as a regional and international referral service with more than 800 acute care beds. SMC has established community centers in a variety of locations, which has created increased access. In addition to specialized medical services, SMC is committed to providing community resources for education, information, and programs aimed at helping residents stay fit and healthy. Four out of ten patients that passed through the SMC’s door came from outside the county.

SMC also operates an HMO health plan for charity care patients. In 1991, the County Commission established the SMC Health Plan to operate as a Medicaid HMO or insurance healthcare plan for the poor. The plan reimburses SMC on a case-by-case basis for medical services, but it also negotiates discounted rates and costs with the hospital. During the early 1990s SMC’s payment from the health plan dropped substantially. In 1996, the program was under a freeze by the state and could not enroll participants for more than a year.

Thus, SMC is not just the hospital—it is a comprehensive organized delivery system that also includes facilities distinct from the hospital (i.e., SMC Health Plan). In addition, SMC ambulatory care centers are located throughout the county. SMC was the only public hospital in a metropolitan area with a population of one million or more that received no public subsidy. Most citizens believe that SMC was subsidized by their taxes. In 1971, the County Commission agreed to supplement hospital revenues with property taxes. In 1985, the county commissioners passed a quarter-percent sales tax to fund indigent care. The tax was repealed in 1987. In 1991, the county instituted a one-half percent sales tax to fund indigent care at all hospitals in the county, including SMC.

In sum, while SMC receives no public subsidy, it does receive a portion of the half-cent sales tax which depends on the preferences of the county commissioners each year. Unlike a direct subsidy, no public money is ever guaranteed.

As an academic health center (AHC) SMC has multiple, conjoined missions of teaching, research, and patient care. While providing patient care for approximately 40% of the nation’s poor, AHCs are struggling to find a competitive position in today’s rapidly changing healthcare environment. Until recently, they have enjoyed a privileged position atop the healthcare pyramid as a niche provider of tertiary services. With the growth of managed care and reductions in government funding, the ability of AHCs to compete is being drastically undercut.

It is widely recognized that multiple missions of teaching, research, and patient care contribute to the production of costly clinical services that are inconsistent with the demand for less expensive services in today’s healthcare environment. The majority of the services that AHCs provide are now available elsewhere, such as local community hospitals and specialty private medical practices. Furthermore, it is estimated that roughly 70% of their clinical services can be provided elsewhere at a lower cost. It is believed, for example, that AHCs are approximately 30% more expensive, on a case-mix-adjusted basis, than their nonteach-ing competitors.

As a result, AHCs are losing ground to other hospitals and medical practices. They have become providers of a small number of expensive high-tech services involving unique and complex care. However, they continue to be the predominant providers of the nation’s charitable care. As an AHC, SMC reflects these trends. For example, SMC’s organ transplant center and burn unit are unique high-cost services that account for fewer than 2% of the patients treated at SMC each year.

(Wolper pages 92-94)

Wolper, Lawrence F.. HEALTH CARE ADMINISTRATION 5E VITALBOOKS, 5th Edition. Jones & Bartlett Publishers, pg.100-101

Managerial Implications and Recommendations

The jury is still out on the future of organized delivery systems. It is unclear whether the many problems and issues identified here and elsewhere are due to a flawed strategy, flawed implementation (leadership), or both. Clearly, multiprovider integration has not worked well either in American industry or in health care. The point is not to lay blame when systems struggle or collapse. Rather, we need to identify managerial processes or methods that will enhance the probability that systems will survive and prosper. The overriding goal of systems should be to provide maximum value to the healthcare customer.145

The fundamental question is, What types of systems, networks, and alliances are best able to compete effectively and deliver cost-effective care? At this time, however, there is no definitive answer to this question, because there is almost no evidence associating different types of organized arrangements with successful performance or failure.

The future of healthcare systems is highly speculative, given the volatility of markets and future initiatives for healthcare reform. As the governments role in health care expands, these systems become more vulnerable to shifts in government policy.

It seems likely that most multiprovider healthcare systems will emerge successfully from their “growing pains” and continue to solidify their position in the healthcare market as long as they are virtually integrated rather than vertically integrated.

Health care will be purchased primarily on a local or regional basis. Quality and value will be increasingly important to patients who once again have a choice of provider. Fewer resources will be available to deliver care, and the delivery of health care will continue to shift from acute care to ambulatory settings. Barry noted the importance of a system CEO being a “change agent” in this future environment:

Those who can understand and embrace change; those who can transform traditional but key values to tomorrow’s environment; those who can educate their boards of trustees, medical communities, and the community at large; and those who can “right size” the production activities of their organizations, and provide both high quality and cost-effective services will be the winners of tomorrow.146

Recommendations

Healthcare executives in multiprovider healthcare systems need to allow flexibility for member institutions to respond to specific local markets while providing a clearly articulated and well understood vision for the system.

Each system should develop a detailed mission statement and set of behavioral norms (i.e., culture) shared by each facility within the system in order to enhance cohesiveness.

Each system should develop a formal strategic plan for the system with input and a high degree of interaction among the corporate office and institutions in all geographic regions.

Each system should develop and implement explicit measures for quality of care, patient satisfaction, efficiency, and community benefit, and then provide these data to purchasers and other key stakeholders.

Each system should develop and organizational structure that is simple, lean, flat, responsive, customer-driven, risk-taking, and focused.

Governance at the corporate level should be strategic in nature, whereas governance at the institutional level should be operational in nature and focused on local community/region needs and concerns.

Systems should provide formal and informal education for those responsible for governance at all levels in the system.

Systems should provide a clear definition of governance roles, responsibilities, and authority among the system and institutional boards of its component parts.

Systems should provide the leadership required for the individual units of a system to think in terms of overall system performance rather than just in terms of the particular unit’s performance.

Only institutions that fit a particular culture and strategy should be invited to join or remain a member of the system.

Systems should align physician incentives and achieve clinical integration.

Systems should develop information systems to support the integration of clinical and managerial information.

Systems should use their mission and values as a guide in making difficult trade-off decisions.

Systems should change their incentive structures to reflect concern for performance of the system as a whole, not just the individual components.

Systems should own fewer facilities and contract for most services so that they are virtually integrated rather that vertically integrated.

Systems should buy or contract for services only if the additions will add value to the systems’ customers and are compatible with the existing mission, values, goals, and culture.

Systems should allow the individual operating units within the system to have sufficient autonomy to be responsive to the needs of their local customers.

Systems should focus on core competencies rather than trying to be all things to all system components.

Systems should not allow success to breed complacency.  Each integrative step must be evaluated for system wide effects.

Systems should focus on quality rather than the size of the program or system being integrated.

Systems should focus on quality rather than quantity of physician integration.

Systems should place high-performing executives in key positions to implement their integration plan.

Systems should target selected patient populations and payers.

(Wolper 100-102)

Wolper, L.F. Healthcare Adminstration 5E Vitalbooks, 5th Edition. Jones & Bartlett Publishers.