



MANAGING MANAGED CARE

Managed care—the attempt by insurers and purchasers to control costs by encouraging competition among providers—is fundamentally altering both the healthcare market and the leadership structure of large healthcare systems. In most provider organizations, overseeing managed care has been the responsibility of a single official, either the chief financial officer, a director of managed care, or a senior executive specifically assigned to it. Whatever the title, the official's chief task has been typically narrow: to obtain managed care contracts from purchasers. But all this is changing now.

"MANAGING CARE": A DIFFERENT VISION

In the future, healthcare providers will have to learn the art of "managing care," a concept integral to but broader than managed care.

Managing care goes far beyond obtaining contracts. Indeed, it is the result of providers' recognition that they must improve organizational performance in order to effectively compete for those contracts. The shift to managing care has four dimensions.

Importance of Operations Managing care reaffirms the importance of operations—specifically, the importance of recruiting administrators capable of transforming virtually every system of care delivery. This should come as good news to operations executives, especially those skilled in

The Task Calls for an Integrated Management Team

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reengineering, those who value systems analysts and industrial engineers, and those who can work patiently with hospital teams.

Dangers of Retaining Obsolete Systems Managing care is the solution when providers begin to realize the dangers in trying to live up to a capitation contract with a delivery system designed for fee-for-service care. Providers attempting to manage

Summary Healthcare providers must learn the art of "managing care," a concept integral to but broader than managed care. Managing care has four dimensions: recruiting skilled operations managers; developing systems, procedures, practices, and protocols that meet the demands of capitation and risk management; fully integrating physician leaders; and preserving society's resources by providing care on the wellness, rather than the sickness, model.

Managing managed care, which is now usually the task of a single executive, will tomorrow require a team comprising these four roles:

- The CEO articulates the system's vision, helps develop its strategic plan, and leads the effort to educate all its associates and employees about managed care.

- The operations leader (which may in fact be a group of operations executives) redesigns the system's organizations, redeploys its managers, and dismantles its obsolete methods.

- The physician leader (which may also be a group, rather than an individual) helps retool the system's practices and protocols in a way that enables it to deliver the highest quality of care at the lowest possible cost.

- The managed care executive acts as the broker between the system and insurance firms. In larger systems, this executive designs long-term partnerships between the system and insurers.



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capitation and risk inevitably find that they need fundamentally different systems, procedures, practices, and protocols than they formerly relied on. These new activities include:

- Outcomes research
- Early management of risky populations
- Addition of alternative providers, such as nurse practitioners
- Development of improved information systems

No healthcare provider should, for example, consider offering capitated Medicare services without first establishing a means to prevent overutilization and agreeing with physicians on new ways for patients to gain access to care.

Necessity of Integrating Physician Leaders

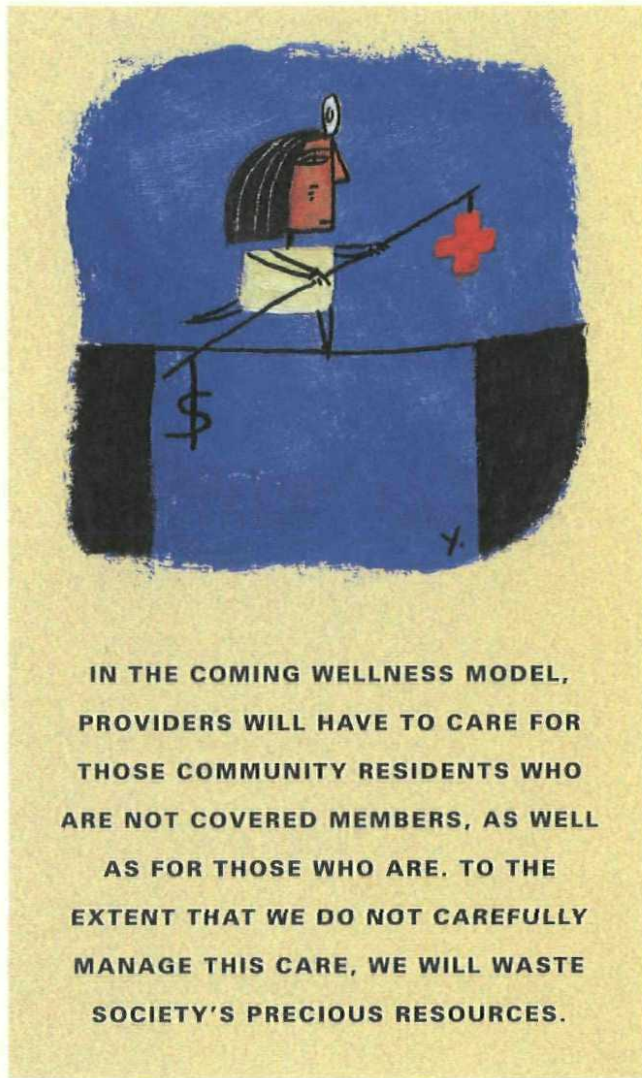
Managing care requires providers to fully integrate physicians into their leadership. What one might call the "partners lite" model of physician integration is insufficient. By its nature, capitation limits the revenue obtainable from healthcare purchasers. These limits force healthcare managers and physicians to reach agreement on redesigning systems for delivering care, retooling protocols, hiring and compensating an adequate number of primary care doctors, installing expensive front-end risk identification mechanisms for the frail elderly, and many other matters. But managers and physicians will not be able to agree on these questions if they see themselves as employers and employees; they must be partners.

Indeed, it may turn out that only physicians truly know how to hold healthcare costs down. If that is so, some system leaders may decide to design governance and organizational structures in a way that puts physicians at the helm of the managed care process.

Social Imperative for Managed Care America's defini-

tion of healthcare is being broadened. We are beginning to understand that care based on the traditional sickness model devours an ever-increasing portion of our gross national product.

It is much less expensive to manage care for specific illnesses (asthma in children, for example) than it is to treat acute episodes of such illnesses in emergency rooms. In the coming wellness model, providers will have to care for those community residents who are not covered members, as well as for those who are. To the extent that we do not carefully manage this care, we will waste society's precious resources.



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James Yang

IMPLICATIONS FOR THE MANAGED CARE FUNCTION

Tomorrow the task of managing managed care will be too large to be the responsibility of a single executive. It should be the work of a team. The ideal team will have at least four roles represented on it:

- The chief executive officer (CEO)
- The operations leader
- The physician leader
- The managed care executive

Please note that these are functions, not necessarily persons. For example, the executives of a healthcare system's acute care and long-term care facilities could act together as the system's "operations leader." A "physician leader"

might be a group made up of the system's medical director, its medical staff leaders, and the CEO of its associated physician-hospital organization. The point is, by bringing representatives of these functions together, the team can develop and implement a unified vision of managing care.

The CEO The healthcare CEO's role is changing. Whereas the CEO formerly oversaw the operations of a single acute care hospital, today he or



she is likely to be the chief strategist of a multi-institutional system—a much more complicated organization. As chief strategist, the CEO must watch an ever-changing market and make decisions about it with the same skill and urgency he or she once applied to the operations of that single hospital.

The CEO of a Catholic healthcare system has three primary tasks. First, he or she must articulate a vision of managed care as it has been shaped by the Catholic health ministry. The task is particularly important because many people tend to have a negative view of managed care. Some equate it with job layoffs, cut-backs in other resources, and mergers with unfamiliar organizations. Others, perhaps misled by the media, understand it as huge corporate profits, on one hand, and the denial of healthcare services, on the other. And still others, including some associated with Catholic healthcare, see managed care as a threat to ministry values.

To counter such views, the CEO must show that managed care is in fact an *improved* method of providing the best possible care at the least possible expense. The CEO must demonstrate that reinventing healthcare by improving its coordination and reducing its redundancy and confusion is *also* a way of expressing ministry values.

Second, the CEO must, with support from the board and the system's physicians, help the managed care team develop a strategic plan. The plan should address the critical factors in managing care—for example, a system for analyzing costs and setting prices, a system for identifying high-risk Medicare patients in selected disease categories, and a system for managing such high-risk clinical categories as congestive heart failure or predicted prenatal risk. With a strategic plan, the healthcare system's leaders will be able to coordinate all the other plans necessary to move the organization forward. Without it, the organization will only lurch and jerk toward change, with much confusion.

Third, the CEO must forcefully lead the effort to educate all those associated with the system—board members, physicians, nurses, and other employees—to prepare them for managed care.

This transformation will require monumental changes in the thinking processes of each of the organization's participants.

The Operations Leader As noted earlier, the operations leader may in fact be a group composed of operations executives from each section of the healthcare system's continuum of services, such as primary care, acute care, long-term care, and home health.

Reengineering is the operations executives' primary task. They must be skilled at redesigning organizations, redeploying managers, and dismantling obsolete methods—for example, an admitting

process focused on patients' ability to pay rather than on their illnesses. Operations executives must know how to create critical delivery capacities, especially those central to newly organized systems (e.g., a program to identify pregnancy early in Medicaid enrollees). And, in pursuit of these objectives, the executives must value organizational change over "business as usual" and make tough decisions that put the patient first.

Operations executives are better placed than other managers to perceive such organizational anomalies as misaligned reward structures or cultural symbols that are inconsistent with the new vision. Incongruent elements like these can act as a brake on the healthcare system's progress toward success. By working closely with the system's human relations specialists, operations executives can help retool the pay and reward systems for the new world of managed care.

The Physician Leader Physicians are increasingly aware that they are reinventing medical science. This is especially true of physician executives in large systems, whose work may involve management, outcomes research, ethics, economics, and cost-benefit analysis, as well as the direct care of patients. Of course, the medical profession, feeling an obligation to improve the human condition, has always demanded creativity. Nevertheless, today's physician executive is a pioneer whose most important task is to inspire other pioneers in their construction of a less confused, seamless system of care. It is vital that physician leaders be represented on the managed care team.

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MANAGING CARE

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The managed care executive serves as the voice of the market.

The Managed Care Executive As a team member, the managed care executive continues to act in part as a broker between the delivery system and insurance firms.

However, as large healthcare purchasers seek higher quality at lower cost, competition is growing sharper among insurers, on one hand, and among providers, on the other. As a result, some providers and insurers are attempting to cut *their* costs by merging some of their functions—for example, member enrollment, member risk identification, claims and utilization review management, and credentialing and quality review. In these cases, the managed care executive's chief role is not to broker contracts, but to design long-term partnerships between the organizations.

An essential role for the managed care executive is to work with the physician leader to design improved systems of care for enrolled populations. In this key role, the managed care executive serves as the voice of the market, guiding the organization toward success in the new world of capitation and risk.

MANAGING CARE AS A WAY OF LIFE

In the end, the entire managed care team must help the CEO educate the delivery system's other participants. To this end, a passion for bringing the system to a new level of excellence must be kindled in the hearts of team members. They must come to see managing care as—not a sideline activity—but new behavior, new disciplines, new concerns, and new enthusiasms. □

SPIRITUALITY IN MANAGED CARE

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example, held five one-hour small-group sessions for participants to discuss their physical, emotional, and educational well-being and their history of relating to a religion and to transcendent forces. They later reported expanded understanding of one another and greater energy for collaborative efforts.

Managed care structures should include incentives for individuals to avail themselves of similar educational opportunities. Spiritual caregivers, who are appropriate leaders in this work, must be capable of facilitating such group sharing and individual self-exploration.

Healthcare costs could be reduced by attending to individuals' unresolved grief and degree of acceptance of their own mortality. Experienced helpers in many disciplines know that the art of teasing out the specific feelings, memories, and meanings associated with a major life loss—that is, facilitating the grieving process—frees energy in a person. Healthcare clinicians in general, however, may not attend as carefully to the process of grief. A nurse educator once told me that she had taught about the grieving process for years, but only when her own baby died did she begin to understand grief on any useful level. Loss and grief are universal experiences that give us the opportunity to emerge with enhanced wisdom, but the process of grief requires time and active sharing with empathic and patient people.⁷

Most healthcare structures, policies, procedures, and workloads are not set up to foster such care or even tolerate it to any great degree. Professional staff members share their own losses among themselves only briefly, if at all. As managed care structures come to value total well-being more, their convictions must be strong enough to invest in structures that will help patients and staff deal healthfully with their losses.

Our acceptance of our own mortality comes from how we deal with personal experiences of loss, and from open conversations about what has meaning for us in life. Managed care systems would benefit by fostering the spiritual health of all their workers. Clinical practitioners dealing

with patients who are terminally ill are often upset or burdened by instructions from the family to "do everything possible." Yet in-house ethics committees generally focus on decisions regarding treatment, not on allowing staff members to express their own feelings. The opportunity to speak with neutral counselors is all too rare. The space and time to talk about their own feelings of loss would help healthcare professionals care more compassionately and effectively for the dying and their families.

Healing is a communal, as well as a personal, phenomenon. Optimum healing requires a collaboration of professions, systems, agencies, and congregations. The reason helping professions are needed at all is that a combination of efforts can achieve more healing than individual attempts. The success of communal healing phenomena such as Alcoholics Anonymous and its dozens of clones demonstrates that healing happens when people overcome the barriers to addressing personal issues with others. Both administrative and spiritual care professionals need to conceive of healing as community wide and deeply personal at the same time. □

NOTES

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