

THE FUTURE IS LOCAL

An Interview with Stephen M. Shortell, PhD

In the future the “real payoff in healthcare will be in action occurring in local communities,” says Stephen M. Shortell, PhD. Economic incentives to improve communities’ health and provide care in the most cost-effective manner are driving healthcare organizations in many parts of the country to develop what he calls “community care management systems.”

Shortell says such systems are based on the concept of assessing a local area’s needs and then “right sizing” the healthcare system so the number of primary care providers, acute care beds, home health agencies, and other services is appropriate to meet the needs. To reduce costs and fragmentation in the delivery of care services, clinical service lines in a community care management system will cut across sites of care—hospital, primary care clinic, home, hospice.

“The challenge for Catholic health systems will be to work with local non-Catholic providers. At the local level often there are not

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enough Catholic organizations to meet all the needs,” Shortell notes. “Tremendous leadership skills will be needed to develop community care management systems across sponsorship lines.”

GOVERNANCE AND MANAGEMENT CHANGES

With the new focus on improving health in the local community, practices in clinical care are changing. “You can’t ask physicians and nurses to use protocols, care management systems, and outcomes data and then support them with the old silo-based governance and management structures,” Shortell warns.

New Management Roles He sees many healthcare executives’ roles changing dramatically. Some healthcare systems have made their hospital administrators part of systemwide management teams. Administrators who were formerly responsible for a hospital are now responsible for a function—for example, primary care—across the entire system. Compensation is linked to the performance of that function rather than to hospital performance. Midlevel management is changing, too, Shortell observes, as department heads become clinical service line managers across the community care management system.

Shortell advocates education—particularly in epidemiology, disease prevention, and local health promotion—for managers and trustees as they assume responsibility for the health of their communities. “With greater knowledge of the causes, incidence, and prevalence of diseases and of factors that promote community health, they can appreciate how clinical and health promotion processes can be reengineered to most effectively serve a defined population.”

Innovative Governance Structures “If serving the local area is the name of the game, then accountability and decision making need to be at the community or regional level,” Shortell points out. “You



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in healthcare organizations. He is a principal investigator of the Health Systems Integration Study, a study funded by nine healthcare systems, including Franciscan Health System, Aston, PA; Mercy Health Services, Farmington Hills, MI; and Sisters of Providence Health System, Seattle. The study analyzed the characteristics of systems and the challenges they face in achieving integration.

can't call people to cooperate across institutions and then have individual institutional management boards."

He sees a trend toward hospital boards becoming advisory boards to local or regional boards, which have the ability to make decisions quickly. In governance, as in management, education is critical so that board members understand the change and their new roles, he says.

Shortell describes another innovation: the governance advisory council based on service lines. In this arrangement, three or four board members from each of a system's hospitals make up an advisory board for a particular service, such as cardiovascular care, across the system's service area. He says some trustees are excited about this role because they now have the chance to advise systems about community needs and monitor service line performance, rather than just rubber-stamp decisions.

DEPLOYING HUMAN RESOURCES IN NEW WAYS

As executives, managers, and trustees take on more flexible roles, so will healthcare professionals. Shortell predicts that by the year 2000, more care givers will have multiple skills so they can be deployed as needed to fill out healthcare teams throughout the community care management system.

He foresees more cross-training, accompanied by more flexible state and national certification requirements, so that professionals can perform a variety of tasks without fear of litigation. For example, a nurse might perform some procedures generally done by perfusionists, and vice versa. As one example, New England Medical Center in Boston uses home health nurses to do some inpatient care and prepare patients for post-acute care, resulting in improved continuity of care.

INNOVATIONS IN APPRAISING PERFORMANCE

Shortell says several healthcare systems are revising how they evaluate employees' performance. In the future, performance appraisals will recognize continuous quality improvement efforts that save costs and improve efficiency and quality. They will stress team achievement in quality improvement over individual accomplishment.

PHYSICIANS' PARTICIPATION

Systems are investing in physician leadership as they learn they cannot achieve clinical integration in local communities without first bringing doctors into the system of care. Shortell believes hybrid system models that link physicians with

health systems that have shared physician and nonphysician executive leadership will tend to prevail. Physicians organize around processes of care and opportunities for continuous improvement, making obsolete the traditional medical staff organization structure.

THE LONG ROAD TO INTEGRATED INFORMATION

Management executives have been slow to recognize information technology (IT) as central to the integration of services across the continuum of care. Healthcare organizations have generally put only 2 percent of expenditures into information systems, while other businesses typically spend 7 percent.

The problem, according to Shortell, is that "IT is coming up against a fragmented delivery system." The most pressing need is for IT that provides clinical information across the continuum. However, "until systems develop integrated clinical service lines and understand the needs of the populations they serve," Shortell points out, "they cannot define common information needs, and too many systems are not yet at that point."

IT is receiving increased attention, with some systems spending up to \$150 million over three years to develop the information systems they need. Shortell thinks external pressures for outcome measures and quality "report cards" will drive continued investment.

FUTURE OF ACUTE CARE

Shortell predicts a "tremendous downsizing" in acute care in the next few years. "In some communities, 50 percent of acute care capacity will be taken out. For example, there are parts of Chicago that now have 6,500 beds but by the year 2000 will need only 900 to 1,000 beds."

"Acute care units will be smaller and more focused on intensive care," he says. "There are only three reasons we need acute care—for intensive and coronary care, maternity care, and emergency care. Almost everything else can be done on an outpatient basis, in the physician office or clinic, or in the home."

Discarding the "acute care mentality" is often a painful process. But strategies that stress population-based wellness hold promise for many Catholic providers. With the better-coordinated care, professional collaboration, and efficient management and governance that Shortell foresees in the next few years, the pain may be the catalyst for healthcare systems that more firmly than ever support their mission of holistic service.

—Judy Cassidy

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