What to do about Specialty Services

Philip L. Ronning
Ronning Healthcare Solutions

The specialties have played *the* pivotal role in the evolution of healthcare during the past fifty years. While cardiovascular disease and gastroenterology were first identified as specialties in the 1940's, it wasn't until the 1970's that specialty medicine and surgery became increasingly central to a hospital's identity. As hospital's looked to enhance their image by adding *Medical Center* to their names it seemed to be understood that it would be somehow iniquitous for a hospital to claim itself a medical center if it did not offer heart surgery.

Specialization, Subspecialization, and Subsubspecialization in Internal Medicine

Christine K. Cassel, M.D., and David B. Reuben, M.D.

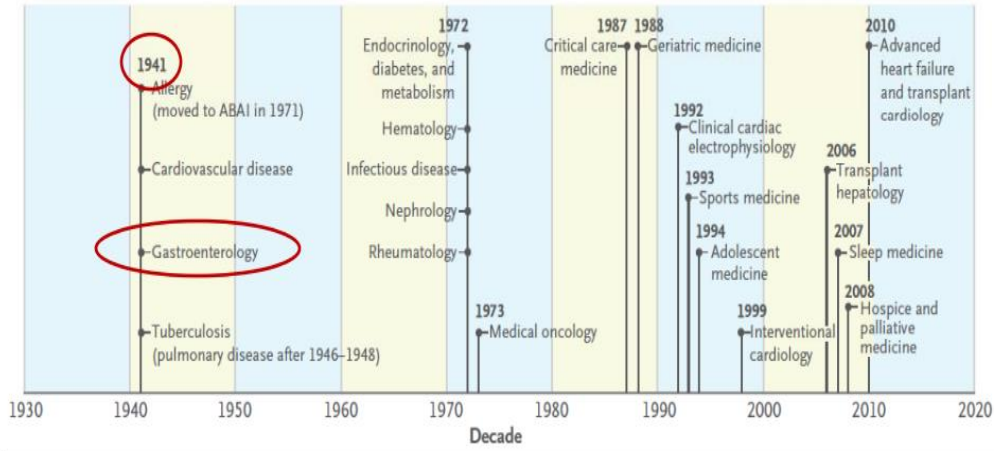


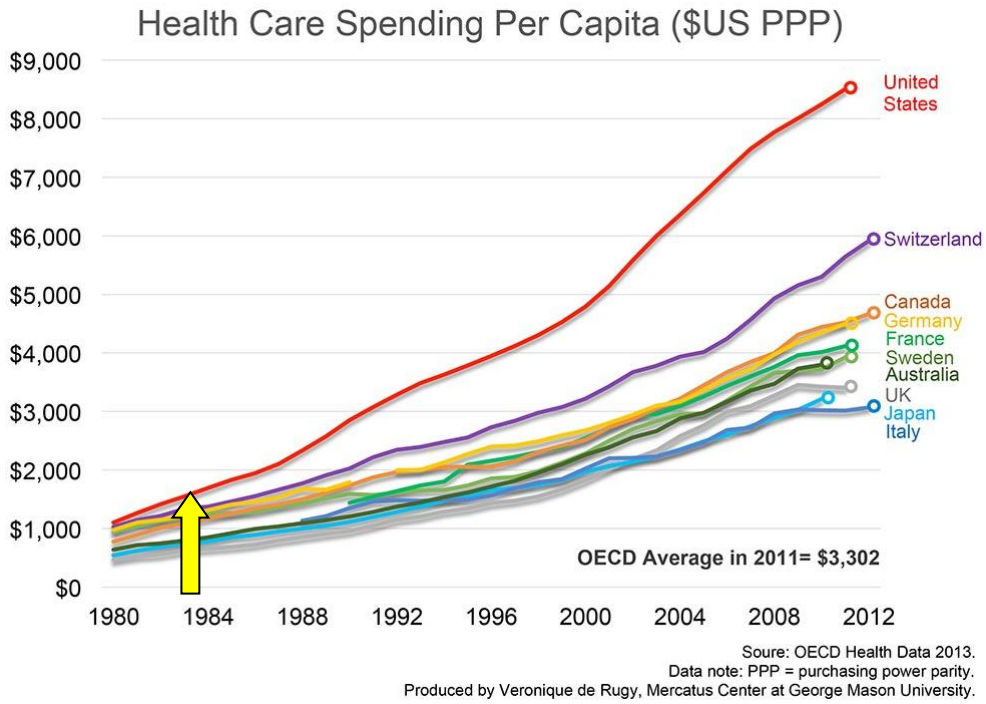
Figure 1. Timeline of Subspecialties Approved by the American Board of Internal Medicine.
The American Board of Allergy and Immunology (ABAI) was founded in 1971.

I participated as a consultant in the mad rush to add cardiovascular surgery and interventional cardiology beginning in the late 1980's, working with some 150 hospitals in the process. While status and community service were certainly a part of the attraction, the reimbursement riches awaiting those treating heart disease was the fundamental driver of the growth of these programs. Hospitals became medical centers as a result of adding a heart program and with cardiologists and cardiac surgeons necessarily came more (and specialized) anesthesiologists, infectious disease specialists, nephrologists, and pulmonologists to provide the necessary support for these critically ill patients. As each specialist developed a practice outside of the cardiac program and volumes grew and the *clinical pitch* of the place jumped. The hospital had, indeed, become a Medical Center.

Gradually, but inevitably, the general practitioner, the family practitioner and the general internist were moved out of the CCU, the ICU, the surgeries, the ER and today, it seems, even out of the Doctors Dining Room.

The proliferation of the specialties is linked closely to the birth of managed care in California during the 1980's. With the implementation of DRG's, insurers were able—for the first time—to compare the costs of similar high-cost inpatient stays at different hospitals. They found in cardiovascular surgery, which represented 30% or more of their claim costs, a 400% charge difference (from $22,000 to $88,000) between hospitals in downtown Los Angeles, where I worked at the time. This led Prudential to imitate industry by anointing low-cost/high quality/high-volume programs Centers of Excellence – in order to channel patients to the low-cost providers. Managed care was and has been largely *managed referrals;* the presumption being low-cost = high-quality and, hence, care is being managed.

The claim that managed care has been a success is dubious. Managed care it seems is not the sole cause, but is related to a growth in per capita spending. Although managed care had been around for more than a decade, it did not grow substantially until the early 1980's.



About that time, costs were beginning to increase more rapidly than in the past. Perhaps coincidentally, hospital and health system integration began at the same time.

Undoubtedly, the rise in healthcare costs is driven principally by the costs of the specialties. It is these specialties that have generated the profits for hospitals and health systems to expand – for healthcare to become a *business*. It is difficult to not recognize the value of applying business principles to healthcare, but the inevitable push for growth and profits that followed is now pushing the specialties into the crosshairs of cost reformers.

With the Accountable Care Revolution, which was growing long before the advent of the Patient Protection and Affordable Care Act, has come a focus on value; make no mistake, value means less volume and less volume means fewer profits.

Given that the *more of the same* option is out, what then should we do about specialty services? The options lie in three inter-related domains: Organization, Innovation and Financial Management.

Organization

At any level of any enterprise, the quality of the organization drives success. Areas in which organizational development can amplify results are many.

- ✓ ***The Service Line***

  The Service Line (or Product Line) was widely applied to healthcare in the 1980's and with great success. The model places organizational emphasis on profit-rich activity centers that benefit financially and demand through focus. This focus remains valid but the changing environment has often invalidated the assumptions underlying the structure of the service line.

  OPPORTUNITY ALERT: ***Reinvent the service line***

- ✓ **The Institute**

  Institutes were widely developed in the 1990's as promotional vehicles and began as the name for the service line or a specialty physician's practice. The name implies a level of research and professional pursuit seldom seen. Institutes are now often bereft of both meaning and benefit.

  OPPORTUNITY ALERT: ***Revitalize and Renew The Institute***

- ✓ ***The Center of Excellence becomes the Center of Value***

  Center of Excellence has long been a hackneyed term but the organizing concept is as vital as "building a winning team." All are drawn by the notions of achieving excellence, realizing success and winning something. The term may be dead, but creating a team dedicated to accomplishing a goal, tangible or intangible, is not. Clinical excellence has come to be expected, value not so much. Like excellence before it, value is largely intangible and needs to be defined *in* your organization *by* your specialists *for* your market. Remember, value is not simply about data; many clients (referring physicians and patients) put service first in their definition of value.

  OPPORTUNITY ALERT: ***Convene a New Ambition Integrated with Value***

- ✓ ***The Affiliated or Owned Practice***

  Changes in reimbursement have led to significant growth in the number of employed physicians and owned or affiliated medical groups. Along with this shift has come a changing dynamic in the psychological make-up of the medical community. More recent graduates and an increasing number of women physicians have less desire for the autonomy and professional dominance so highly valued by the previous generation of doctors. This changes the character of the medical community and the competitive environment.

  OPPORTUNITY ALERT: ***Redefine the Cultural Expectations of the Medical Staff***

Innovation

Creativity is an essential ingredient for any company to be successful in the long-run, yet we spend very little time providing the environment for it to occur. Ted Leavitt of Harvard said, "Managers (and physicians) spend too much time doing and too little time thinking." With all the patients, all the meetings, who has the time? There are plenty of opportunities for innovation even in smaller programs.

- ✓ ***Clinical Innovation***

  Physicians as scientists are inquirers who are not provided the luxury of inquiry. Perhaps we can learn from Google and Linux by giving physicians time to think, to dream.

  OPPORTUNITY ALERT: ***Build Think Labs, not Sleep Labs***

- ✓ ***Technological Innovation***

  Technology continues to fuel the specialties but rarely does a technology replace its predecessor. Technology adoption strategies are seldom planned; rather, technology adoption is a reaction rather than a response.

  OPPORTUNITY ALERT: ***Become active in Technology Scanning***

- ✓ ***Comparative Effectiveness Research and Application***

  The ACA provides millions of dollars in funding each year to the Patient-Center Outcomes Research Institute (PCORI). The current call for proposals from PCORI has a funding budget for projects totaling $76 million; 313 projects have been funded since its inception in 2013. Comparative Effectiveness Research is generally important to referring physicians and will become of increasing interest in the future.

  OPPORTUNITY ALERT: ***Challenge physicians to do funded research***

- ✓ ***Analytics***

  Healthcare generates a wealth of information for each patient encounter and only recently has this information been made more accessible. Electronic medical records and claims data now make it possible for specialists to add value by managing both quality and cost together and to determine how one impacts the other.

  Opportunity Alert: ***Use analytics to paint an accurate clinical/financial picture***

Financial Management

- ✓ ***Focused Managerial Accounting***

  Competitive industries focus increasing attention to cost accounting as margins shrink. While not as exciting as generating new revenue sources, reducing costs does increase margins. The specialists have a role in the analysis but more importantly in the implementation of cost management. This is an old topic, like standardization, that must be constantly revisited.

OPPORTUNITY ALERT: ***Do old fashioned cost-accounting***

- ✓ ***Bundled Payment Strategies***

Arguably, bundled payment is the future for all high-cost and procedure-based services. The program must have a strategy for aggressively participating in not only the CMS program but also generating interest in the commercial market. First entries in the market have more risk but history shows they have sustainable market advantage.

OPPORTUNITY ALERT: ***Grow the bundled payment market***

- ✓ ***Readmission Reductions***

Reducing readmission is not a revenue source for specialty physicians but as the CMS focus will include more specialties in their readmissions net, reducing readmissions is certainly a priority for the program and a target for gain-sharing.

OPPORTUNITY ALERT: ***Add readmission reduction to physician incentives***

The future of the specialties is not bleak, unless you sit idly by.

> *"Mark this well, you proud men of action! You are, after all, nothing but unconscious instruments of the men of thought."*
>
> Hegel

For more information on Philip Ronning and bringing him in to speak at your organization, please contact Innovative Healthcare Speakers at info@InnovativeHealthcareSpeakers.com or (406) 586-8775.