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Healthcare Reform Through Redesign

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Alanna D. Runge, B.S.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Business Administration

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ABSTRACT

This thesis will focus on the study of a complex redesign plan that healthcare organizations can utilize through healthcare reform.

Research has indicated that there are numerous individuals who are uninsured or underinsured. In addition, research has supported the rising costs of healthcare today. Because of these two elements, the federal government has launched a healthcare reform campaign. Therefore, healthcare facilities must be able to reengineer the way they currently conduct business.

There have been several redesign plans developed through research. However, the five common components are the delivery services, financial management and cost containment, marketing development, physician relations, and employee structure. Each of these components need dramatic changes in order for healthcare institutions to survive reform.

The purpose of this study is to apply each of the five basic components in a typical healthcare setting. Each of the areas studied examined typical problems

existing within the components. Specifically, it is hypothesized that by redesigning the five major components the healthcare facility will dramatically improve in performance.

This study consists of secondary data. There were no subjects used in this process. The data collected was analyzed on an independent basis.

Results of the analysis collected demonstrated considerable evidence to support the hypothesis. In conclusion, healthcare insititutions need to redesign their current methodology in order to remain constant in the future.

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INTRODUCTION

Overview

It is virtually impossible to read the newspaper or watch a news program without the discussion of the reform of the current healthcare system. Currently, there is a large amount of the population that is not covered by any form of health insurance. Also, people are requesting a sophisticated system of healthcare which treats patients as customers at a lower cost. In addition to the desires of the general public, Congress is also ordering a healthcare system that can deliver a higher quality of healthcare with a reduced revenue plan. The above factors have caused numerous healthcare facilities to examine their methods of delivering healthcare to individuals. The theory of redesigning the healthcare environment originated from the in-depth examination required to remain in business. This examination process caused facilities to begin to look at each and every process and policy within their walls. The processes under examination

include actual medical procedures or delivery of healthcare, physician relations, financial, managerial and administrative, marketing, and employee structure. Therefore, it is clear that the healthcare industry requires a complex reengineering project which will be completed through healthcare redesign.

Rationale

Today's healthcare environment is marked by increasing unpredictability, instability, and overall change. The mention of the word "change" usually is met with resistance. The need for an integrated delivery system increases by the day. As stated above, there are many factors that have led facilities to the point of redesign. It is important to examine five of the more prominent factors that are essential to survival.

Before one can examine the necessary components for the reform of healthcare through redesign, one must examine the task of redesigning any entity. Reengineering or redesigning a facility is currently looked upon as the only hope for breaking away from the ineffective, antiquated ways of conducting business

that will otherwise inevitably destroy them. It is clear that all organizations are going through changes in order to keep up with the competition as well as international markets, economic hardships, and technology (Hammer and Champy 5).

The theory behind redesign, as stated above, is to maintain an organization through a constantly changing environment. Today, change is a process and not a single event. During the decade of the 80's nearly half of all U.S. companies were restructured, over 80,000 firms were acquired or merged, several hundred thousand companies were downsized, at least 700,000 organizations sought bankruptcy protection in order to continue operating, and over 450,000 others simply failed. It is clear from the above statistics that the hospital industry is slightly behind in the race to redesign. However, that factor should encourage healthcare facilities to launch and implement a successful redesign plan (Pritchett and Pound 2).

A major factor, and perhaps the most popular one, is that there are approximately 35 million uninsured individuals in society. These people, for numerous reasons, do not have any kind of healthcare coverage.

Congress has promoted this fact which has been the primary cause for redesign of the healthcare facilities (Iglehart 962). Congress has put together a universal health plan that will basically dictate how hospitals and healthcare facilities will operate in the future. The plan is to target our dollars in the healthcare system more effectively and more efficiently, so that we will have reduced expenditures for defensive medicine, reduced administrative costs, and achieve savings through greater use of coordinated care. The overall impact of the plan on healthcare facilities is unknown at this point. However, it is clear that this factor has been a driving force for the redesign of the delivery of healthcare in totality (Hagland 44).

The next factor that has an important role in the redesign of healthcare is the overall delivery system. This system refers to the actual delivery of the care to the patients. One may hear the words "delivery of healthcare" and immediately think that those words only pertain to a doctor/patient contact. However, there are numerous processes and procedures that can be examined and changed which fall under the "delivery of healthcare" parameters.

As stated above, there are various processes and procedures within a healthcare facility that relate to the delivery of healthcare. Perhaps the most common viewpoint, although there are many viewpoints to consider, would be that of the patient. The patient, which has now become a customer, is one of the keys to a successful redesign plan. Intensified competition for patients covered under managed-care plans has shocked some hospitals into taking customer satisfaction more seriously. Hospitals and healthcare facilities need customers, both internal and external, to be satisfied in order to stay in business. This concept has evolved from certain factors such as increased competition and reductions in payment. Healthcare facilities used to be able to function due to the nature of their business. However, now it is imperative to satisfy both the internal and external customers (Greene 30).

Further, increased financial management and cost containment will also be included in the redesign formula for a successful healthcare facility. It is understood that those who are charged with the responsibility of the financial management of their

healthcare institution should remember that such a facility needs to be financially healthy in order furnish healthcare to others. For this reason alone, the health of the facility should be placed ahead of the health of the patient. Richard Clarke, President of Healthcare Financial Management Association states that "We are beginning to see a crack in the healthcare industry's financial structure as it relates to hospitals. To be able to survive, the health of the institution is now critical." The above statements should adequately reflect the importance of a solid financial picture for the healthcare facility. It is, however, rather difficult to comprehend the actual truth to the above statements. The basis for which hospitals originated is one that cares for the sick without regard for payment of those services. Nevertheless, a major concern for the redesign efforts of any facility should be the financial stability and cost containment of the institution (Herkimer 4).

There are numerous procedures which create strength around the financial sector of a healthcare facility. Primarily, hospitals function through the reimbursement of charges billed to various third party

payors or governmental entities. The structure of such a billing and reimbursement procedure can be quite complicated. It is important that the account receivables department, or the system described above, is working properly. In addition to a strong receivables department, healthcare facilities are seeking to increase the managed care activities, increase package pricing, capitation plans, and concentrated collection efforts focused on certain payors are other programs that are being developed through the redesign of healthcare (Herkimer 5).

In addition to the increase in financial management, cost containment must be analyzed in order to complete the redesign project. This concept can be quite large in scope ranging from employee suggestions to activities created by administration or accounting departments. It is important to examine the critical aspect of the theory itself. Healthcare reform was brought to light in part of the spending aspect of the current state of the industry. Therefore, it is important that healthcare facilities begin to examine how they are spending their money. For example, the healthcare industry is generating four billion paper

claims annually, and the estimated administrative expenses associated with these claims is in excess of 20 percent of total healthcare expenditures. This statistic illustrates that there is alot of room for improvement in containing the cost of billing claims to third party payors. It is clear, therefore, that cost containment is a major ingredient in a successful redesign plan (Swarzman 27).

Another factor in the successful redesign efforts of a healthcare institution is to focus on the areas that they excel in or the areas that they service the largest percentage of patients within the market. Typically, there may be several large healthcare facilities within one geographical area. Therefore, it is not uncommon for such a facility to service a large majority of the population for a certain type of service such as a cancer center or obstetrical unit. This facility will most likely maintain the market share for this certain type of service. A component of the redesign plan is to focus on those certain areas and seek to expand them. Marketing in the broad sense is programmatic and analytical; it serves a planning function by determining the needs of the market and the

types of services that will meet those needs. It is clear to see the importance of a marketing component in the redesign plan. However, managers who assume that marketing programs themselves will generate tangible business results are wrong. While marketing plays a vital role in promoting the utilization of services, it is only the initial step in securing new business for the healthcare organization. It is imperative that a marketing plan is not only developed through the promotion of certain product lines such as an orthopedic product line, but maintained throughout the redesign plan in order to receive financial rewards (Snow 45).

Continuing through the factors of a successful healthcare redesign plan, one can address the physicians and their role in the overall plan. Physicians have always been considered the life of any hospital or healthcare facility. Any facility can receive referrals through physicians. Therefore, physicians basically dictate where their patients go for their healthcare needs. It is important, then, to consider physicians in the redesign process.

No matter what form healthcare reform takes,

hospitals and physicians will have to work together as partners and align incentives. Not only will the relationship need to be stronger to increase physician commitment to the organization, it must be stronger to survive in the managed care arena. It is the hope of the healthcare facilities that there will be strength created through numbers. A hospital that is closely affiliated with physicians in the delivery of health care, and which has aligned hospital and physician incentives, should be able to offer more attractive prices to managed care plans or third party payors, manage actual care more efficiently, and reduce the number of providers with which the plan needs to contract. The above facts clearly support the need for a closer working relationship with physicians and healthcare institutions. There are extensive plans and processes by which a healthcare facility can begin to create this intimate relationship. Those procedures will be examined later in the text (DeMuro 27).

Finally, the last factor that will be examined is the structure of employees within the facility. This factor contributes significantly to the redesign efforts due to the fact that it is this group actually

running the facility on a day to day basis. It is this group that actually has the ability to come into contact with both internal and external customers. It is important that they understand the mission and foundation of the facility, current policies and procedures, and the future of the institution. There are several items that can be examined in depth which would enhance the employee structure. These include increase employee empowerment, increase cross-training activities, employee suggestions, continuing education programs, and increase benefits to ensure long-term commitment to the facility. The employee structure is evidently very important in the redesign efforts of the management team (Sherman 37).

The above components are certainly necessary for healthcare reform, and it is important to focus on these components as target areas in the redesign process. With a solid idea as to the key areas within a successful redesign plan for the future, it is necessary to examine the historical events leading up to the current situation. The history of the healthcare industry is as important in the redesign efforts of a facility as the key components mentioned

above.

Historical Perspective

Healthcare today is now one of the largest and most complex industries in the United States in both cost and employment. Healthcare expends more than 11% of the gross national product, and cost increases have consistently exceeded rates of inflation for the total economy. In other words, the health system has a major impact on the rest of society, just as society has a major influence over health services (Schulz and Johnson 3). Clearly, the industry has a long and colorful history. The foundations of the healthcare industry were not built on gross national product and expenses. The industry was built on caring individuals who were dedicated to the science of medicine and the well-being of other people. There are many different historical approaches one can take when examining the healthcare industry. However, the focal points for this text will concentrate on the events and problems that has led up to the current need for reform.

Perhaps the largest problem facing the reform effort is the fact that more than 35 million Americans

are estimated to be without health insurance and few of these have the means to pay for their hospital care, or to pay a physician except for the most routine care. Countless other millions are inadequately insured and will face burdensome costs should they become seriously ill. At this point, the individuals who do have insurance may also face the cancellation of that policy during a serious illness. Also, technology is constantly enhancing the development of new drugs and new equipment which generates new costs. Further, total expenditures are also rising as a result of an aging population, people who require more healthcare because the conditions that afflict the elderly tend to require more frequent and longer hospital treatments. All of the above increased costs are borne primarily by employers and government, but ultimately they are passed on to the public through increased taxes and the increased cost of services and manufactured good. These rising costs have prompted government officials to look at the overall healthcare system and initiate a reform package (Raffel 273).

Financing the health system has thus become a major problem and the obvious reason for reform.

Government, insurers, and employers are unhappy with the present situation. Numerous citizens who are uninsured would like to secure health insurance but find it too expensive. Also, hospitals and nursing homes are unhappy about inadequate payments, and about the growing number of people without any means to pay for their care. Physicians are unhappy about the unwanted criticism about their incomes and the increased amount of regulation imposed by insurers and the government. They feel that these regulations will inhibit their ability to treat their patients. All of the involved individuals agree that their must be a new system that allows to control costs and yet ensure access for all to needed health services of high quality (Raffel 274). It is at this point that the current government administration decided to actually tackle the enormous problem at hand and bring about healthcare reform.

Summary

It is evident that one cannot get away from the constant discussion of healthcare reform. Every individual seems to have their own perception of how

the reform should occur. However, one needs to approach the matter of reform through the concept of redesign. There are several key factors in the redesign plan. Those factors are: individuals without healthcare coverage, the delivery system, financial management and cost containment, marketing product lines, physician relations, and employee structure. There must be a new way of "seeing how things can be done." The rules of the healthcare delivery game are changing. As the healthcare industry undergoes these major changes, only those healthcare providers that react quickly will survive. This ability to react will require considerable flexibility and an openness to an entirely new set of ideas. The bottom line: There must be a reengineering of the healthcare delivery system in America. Therefore, the purpose of this paper is to examine healthcare reform through the redesign process (Zimmerman and Skalko 7).

Chapter II

LITERATURE REVIEW

In the last year, the concept of reengineering has bombarded the U.S. healthcare industry much like the Allied invasion of Normandy more than fifty years ago according to David Zimmerman, author and healthcare consultant. Also, some of the results have been similar: major victories that required a great deal of courage and hope, planning, and the sacrifice for a greater good for the greatest of reasons - survival (Zimmerman and Skalko 9).

Healthcare reform is currently being orchestrated by the government. It is obvious that providers of healthcare, those being hospitals and healthcare clinics, must accommodate those coming changes in order to survive. The ticket for the future of the industry remains at the hands of each facility. These facilities must redesign their organizations in some manner. The point of this study will focus on healthcare reform through a complex redesign process. Although there are numerous components that can be examined in a redesign project, this paper will focus

on five major components. They are medical services and the delivery of healthcare, financial management and cost containment, marketing product lines, physician relations, and employee structure. At this point, one needs to examine the driving factors that have led the government and medical community to reform through redesign.

For more than twenty years the U.S. federal government has expressed official discontent over the rising healthcare costs and has responded mainly by launching a great debate between competitive and regulatory solutions. Competitive theorists would have government reorganize or reengineer the system to give more opportunity for market forces. Regulatory proponents urge government to issue established rules that constrain the behavior of the system's players. Both groups have attracted faithful followers, but neither has been strong enough to eliminate the other. The 1990s finds a healthcare system that has numerous problems that neither of the above entities have been able to cure (Brown 18).

The current driving force for healthcare reform from both the competitive and regulatory groups is the

amount of uninsured individuals in the country. Today, there are more then 35 million Americans without health insurance. This staggering number creates a major burden on employers, government, and eventually the public through higher taxes and costs of goods. This fact alone has attracted the attention of the federal government which, in turn, has been called upon to reform the current healthcare system (Raffel 273).

Over the past two centuries, the provision of medical care in the United States has been shaped by several factors, including educational philosophy, political power, periodic health crises, the exercise of power by private entities, and a strong belief in limited, contained government, individual choices, and science and technology. At certain times, Americans have sought to establish a universal program of healthcare that would be available to all people regardless of their economic situation. These efforts can be traced from the presidency of Theodore Roosevelt. He originated the idea of a universal plan; however, the idea failed due to the lack of public trust in the government. Also, in 1917 the American Medical Association proposed a national health

insurance plan, but shortly thereafter it reversed its position and has remained opposed to a such a plan ever since (Iglehart 963).

Caught in the middle of the conflict is the practicing physician, the chief link between patients and society. Their primary concern goes far beyond the economics of the healthcare industry. They have remained so closely involved in treating their patients correctly, they have subsequently contributed to the rising healthcare costs. Consistently physicians have not paid any attention to the costs of the medical care that they order for a patient. Their primary concern is to adequately treat and diagnosis the patient. Due to the cost factor, several parties are trying to intervene in the treatment of their patients. They are now extremely concerned about their loss of control and the regulations imposed by third-party payors (Iglehart 963).

It is apparent that government officials and strong medical organizations have been seeking a better healthcare system for some period of time. However, the primary concern was the cost of the healthcare and the financing efforts. Today, hospitals and payors are

shifting uninsured patients' hospital costs to paying clients, avoiding insuring high-risk patients altogether, constructing a utilization-control structure that reviews physicians' clinical decisions in minute detail, and engaging in a variety of entrepreneurial ventures that are changing the nature and image of medicine. It is apparent that changes need to occur (Iglehart 964).

Further, some of the major findings by a recent survey conducted by Deloitte & Touche and Hospitals & Health Networks stated that out of the 1,143 hospitals and 41 health systems that responded 53% are redesigning or reengineering their organizations. This behavior is directly related to the healthcare reform package that will be coming from the federal government. In addition, 81% of those hospitals say their institutions will not operate as stand-alone facilities within five years. Finally, 48% of those surveyed stated they are instituting customer satisfaction and quality management programs (Cerne 30).

The historical background mentioned above can certainly lead one to recognize the fact that there is

a need to control rising healthcare costs. The federal government is going to produce a healthcare package. All parties involved in healthcare are going to have to adapt to those changes. The transition can be quite easy through the redesign process. Healthcare facilities must reengineer or focus on five key components which are the actual delivery of services, financial management and cost containment, marketing product lines, physician relations, and employee structure. Healthcare facilities will be able to interweave the reform package that arrives from Congress with the above components to create healthcare reform through redesign (Zimmerman and Skalko 36).

Before analyzing the five components in depth, one must consider an essential factor in the redesign process which is support from upper management. According to Edwin Moldof, author, he states that,

> Strategic planning is a systematic activity that allows an organization to anticipate future changes and the effects those changes will have on the organization. Most successful redesign efforts or strategic plans are those that are created by the organization's own staff. These plans are most likely less expensive than consultants and are better suited for the individual facility. However in order for any redesign effort to work, top management must be

> totally committed to the institution. This commitment is the essential ingredient in a redesign plan. All redesign efforts will eventually fail without this level of dedication from top management. (27)

Clearly, upper management must be in favor of the redesign efforts and support those efforts in order to succeed.

Further, Gail Larsen, Manager of Hospital and Professional Affairs at Blue Cross of Chicago states, "the support of a hospital leader is vital to creating a positive climate for the solutions the team proposes and a belief that change can and will occur" (Larsen 75).

The first area of examination is the actual delivery of health services at a healthcare facility. As implemented in most healthcare organizations, total quality management (TQM) and continuous quality improvement (CQI) will at best provide only marginal improvements. Also, these tools produce results at a rather slow pace. What is required is a redesign of fundamental organizational structure and patient care processes (Wakefield 152).

The modern hospital's departmental and compartmental organizational formats were basically

established early in the twentieth century. Following the advance in the technology of medicine, the organization of the healthcare industry has been driven by the specialization of knowledge, skills, and technologies employed to provide individualized patient-care services. Over time, individual health provider groups established certain aspects of the traditional nursing care process and promoted profession-based patient-service differentiation. With each profession-based differentiation, new supervisory and departmental structures came into being. Hospitals then came to be organized around the provision of a growing array of their separate, specialized patient-care services, rather than around the best methods of meeting patients' healthcare needs. As a result, hospitals have become highly bureaucratic and inefficient organizations typified by extensive vertical management structures that support a highly compartmentalized organizational structure (Wakefield 153).

Recent changes in the expectations and the demands of hospital customers (for example, patients, physicians, and insurance companies or third party-

payors), along with high costs, have resulted in a need for greater operational efficiencies while maintaining or improving overall quality. Further, certain experts agree that implementation of a redesign plan is critical to the future of the healthcare institutions. Douglas S. Wakefield, graduate professor and author, states that,

> Today we are faced with the uncomfortable realization that healthcare specialization and compartmentalization may be working at cross-purposes with the customer's expectations. A critical challenge, not only for healthcare but for all businesses, is making the decision to reinvent or redesign what is being done today to better ensure an organization's long-term viability. (153)

The goal for redesigning the actual delivery systems is complete customer satisfaction as well as improved performance. As stated, the three basic customers of a healthcare facility are patients, physicians, and third-party providers/vendors. The actual delivery of services can range from outpatient registration to a transplant operation. According to Arthur Sturm, President and Chief Executive Officer of Sturm Rosenberg Cafferata, "service standards now cover everything from waiting times to accuracy of billing to

clinical performance" (Sturm 25). In either instance, all customers involved need to be considered. Common themes in healthcare redesign applications include a mechanism for developing interventions that meet patient needs as perceived by the patient rather than by the provider. These themes change how the work gets done, organize diagnostic processes, and implement care protocols around individual patient needs.

According to Jay Greene, author for Modern Healthcare magazine, there are six keys to patient satisfaction. They are as follows:

1. Quality of nursing care
2. Ability of physicians, nurses and staff to work together in an organized manner to serve the patient better
3. Care and concern shown to patients by hospital employees
4. Discharge instructions
5. Available technology and equipment
6. Pain management

This list represents patient response to a telephone survey. In that survey, patients have placed the quality of their care before the technological advances of medicine. Clearly, the quality that flows through the delivery systems is essential to the institution

(Greene 30).

It is important at this point to identify and define what delivering quality means. Quality in healthcare can be defined as the effective and appropriate use of resources to maximize the possibility of positive outcomes, while limiting the probability of negative outcomes. This definition of quality is more focused than the standard definition of TQM - simply meeting or exceeding customer expectations. Clinical quality improvement is more limited than TQM with since the primary focus towards the patient care process. Clinical quality improvement includes the ongoing analysis of the delivery services or process of providing care, establishes rules, and monitors behaviors that deviate from those rules. While TQM involves all areas of a healthcare institution, clinical quality improvement concentrates on directly improving the health status of an individual or the health of a community (Dieter 38).

The main problem with healthcare delivery systems is that they do not serve the customer. As stated above, customer satisfaction is now necessary in the healthcare industry. The delivery systems must be

reinvented in order to be able to adapt to any customer's needs (Sturm 25).

In addition to the above, Fred Brown, president of Barnes Jewish Christian Organization, states that,

> There needs to be a redesign or reegineering in our healthcare facilities in such a way that focuses on the delivery of the actual care being provided. The focus is on the customer now. (Brown)

An example of the importance of delivery systems in a facility would be the outpatient registration process. Any individual who visits a healthcare facility must go through outpatient registration. Although the area is a non-clinical area, quality can still be measured. Patients normally give standard demographic information, physician information, and insurance information upon each visit. Regardless of their current health, most patients must go through this sometimes lengthy process. Several problems exist with this process. There are extensive waiting periods, lack of courtesy from admitting staff, inadequate hours of business operation, incomplete collection of insurance information, and difficulty in the admission office by telephone. This scenario is

just an example of one healthcare delivery system currently in place in some form or another in most hospitals. Obviously, improvements can be made with this system by redesigning the entire process. The redesign process begins with inadequate procedures much like the one above. At this time, a redesign team, made up of individuals from various management levels and departments, will evaluate the process to determine what can be done to change it to make it easier on the customer (Larsen 76).

Further, Bill Schoenhard, executive vice president of SSM Healthcare System, illustrates that the delivery of care is essential to the facility. He states,

> There needs to be a balance with technology and reality. Healthcare facilities need to modernize to meet the customer's needs. This modernization needs to be maintained to be able to survive the future. (Schoenhard)

In summary, the redesign of the healthcare delivery systems should be patient-care focused. The main problem with the delivery systems currently in place is that they are not centered around the customer. Each delivery system needs to be broken down into small steps to evaluate each one. Upon

evaluation, the facilities need to make changes in order to accommodate the customer. The need for quality improvement is an issue of economic survival. The cost of poor quality is estimated to be as high as 40% of revenues in service organizations such as hospitals. Competitions within the healthcare industry will cause the market to move toward those healthcare providers with reputations as high-quality providers. Improving the quality of the healthcare delivery systems of an organization may generate the greatest financial return (Dieter 44).

The next component to be examined is financial management and cost containment. Although these two entities are separate in many ways, they need to compliment one another in a healthcare facility.

Before examining the history of hospital financial management, it is necessary to examine the evolution of third-party payors. Medicare was inaugurated in 1966 as part of the Social Security system to provide health insurance for persons over age 65. Benefits have since been extended to include disabled persons and their dependents and those individuals suffering from chronic kidney disease. Part A of the program, financed by

payroll taxes collected under the Social Security system, provides a portion of hospitalization expenses and some nursing and home care costs. Part B is a voluntary enrollment supplemental program that pays certain costs of physicians' services and other medical expenses. It is supported in part by general tax revenues and by contributions paid by the elderly (Schulz 36).

Medicaid was inaugurated in 1967 also as part of the Social Security Amendments. However, Medicaid is a program run jointly by federal and state governments. It was created to provide financing for the poor and medically indigent who required medical treatment. Initially it was a one-class health service for all citizens. However, today it is primarily for the indigent. Medicaid covers hospital, physician, and skilled nursing home services. The federal government supports approximately 29% of the total healthcare system costs. In addition, state and local governments account for about 13% of public expenditures for healthcare. Typically, the state governments, in addition to their portion of Medicaid, support public health services and public hospitals to the poor who

are not covered by Medicaid. Finally, the private sector covers approximately 58% of healthcare costs. Private health insurance, such as Blue Cross and Blue Shield, account for 32% with premiums paid by employers and individual subscribers. The remaining balance, about 26%, is not covered by third-party payors and therefore is paid either by individuals at the time of service or provided without reimbursement to those providing the care. It is the remaining group of uninsured and the underinsured individuals that has prompted the attention of the federal government (Schulz 38).

Actual hospital financial management began at the turn of the century. During the first half of the twentieth century, the accounting systems were simple bookkeeping systems. The records were maintained on a strict cash basis with little concern for costs, as long as there was enough money available either from gifts, donations, or actual charges to patients. Third party guarantors were few and far between. There was little need or even concern for any advanced management reporting and cash control system. The primary concern was the patient and patient healthcare with disregard

for the health of the facility. However, by mid-century the accrual accounting system was being installed in most healthcare facilities, and the bookkeepers had to become accountants. It was in 1966, when Medicare was introduced into the nation's healthcare facilities, that the accountant's role and the accounting system needed rapid expansion and sophistication. The accountant became a controller. For the first time in many healthcare facilities, as a result of the Medicare-mandated cost finding process, healthcare facilities were able to calculate the total costs for a specific revenue generating department. Prior to Medicare, the majority of the healthcare facilities were concerned only with direct departmental costs, and the rates for charges were frequently set based not on actual cost but in correlation to charges of the neighboring hospitals. Internal management has found many benefits as a result of the mandated requirements such as cost finding, budgeting, and departmental need assessments (Herkimer 2).

Today, the key focus in financial management within a healthcare facility is the receivables department. According to David Zimmerman, author and

healthcare consultant,

> More focus is aimed at managing receivables than at any other time in the history of hospitals. More responsibility has been added to receivable managers and more demands are being made on receivable managers. (1)

The role of the accounts receivable department is crucial to any healthcare facility. This department is charged with the management of cash flow. The amount of cash a facility has is dependent upon how well they bill for their services and collect on those services. Although there are other departments that conduct important financial management activities, such as financial planning, budgeting, and accounting, those departments cannot function without cash flow that the accounts receivable department generates (Zimmerman 1).

Further, Tommy L. Ladewig, director of corporate finance at Sisters of Charity, states,

> Accounts receivable management is one of the most important activities in the operation of a hospital. The financial obligations of the hospital can be properly discharged only when the cash receipts and accounts receivable procedures are correctly established and supervised. (25)

Finally, the bills and collection efforts that

emerge from a patient accounts department are often treated as insignificant by many hospital administrators because they are not a part of the care-giving mission. However, without those bills and the cash they generate, the hospital will close (Markesich 23).

Healthcare financial managers are faced with numerous problems ranging from sharp turns in profitability, increasing competition for capital, a greater need for debt financing, and a greater demand for quality healthcare at more affordable prices. The main problem boils down to the shortage of cash flow. This problem is due to a number of reasons, primarily the change in the focus of cost reimbursement (Daniels 48).

Managed care originated in the 1980s with the sudden change from a cost-based reimbursement to prospective payment and capitation systems. An example of such a system would be payments made by diagnostic related groups (DRGs). Managed care is a concept that originates from the hospitals negotiating contracts with exclusive insurance companies such as a Health Maintenance Organization (HMO) or a Preferred Provider

Organization (PPO). The members of these insurance companies can only go to the contracted hospitals for services. In turn, the hospitals discount the charges to the insurance companies. This type of reimbursement has increased in recent years. Although there have been numerous other factors that have chipped away at the bottom line, the main cause in cash shortage is the amount of managed care activity. Healthcare institutions need to redesign their financial structure and focus in order to be able to have a bottom line in the future (Schulz 8).

In accordance with the cash shrinkage, healthcare facilities have been struggling for ways to contain costs. Due to the increase in managed care activity and economic situations, facilities must monitor every cost that the institution incurs. U.S. health spending is the highest in the world and continues to increase more rapidly than in virtually all other countries. Gross outcome measures are not good. In 1970, health spending was $346 per person in the United States. In 1989, health spending was $2,354 per person. The average for the international healthcare spending was $1,094 per person (Schieber 113).

Further, today national healthcare expenditures in the United States are projected to rise by the turn of the century to 1.6 trillion, an amount equal to 16.4 percent of that year's gross domestic product (GDP). These numbers reflect the extreme need to control the rising costs of healthcare through redesign (Weil 27).

Slowing down the rapid growth of healthcare costs is a key issue in healthcare reform. On one side of the cost containment debate are those individuals who argue that eliminating inefficiency, such as unnecessary care and administrative costs, can more than effectively control healthcare costs without sacrificing medical benefits or the patient. On the other side are those individuals who argue that the forces driving costs upward will certainly overwhelm any potential efficiency savings. These widely differing opinions have not been supported by a solid analytic framework designed to estimate the potential savings nor and substantial documentation as to where the potential savings will originate. There are two basic sectors in cost control within the healthcare environment. They are the physician sector and the hospital sector. This study will highlight problems

within the hospital sector (Schwartz 225).

Analyses of hospital costs indicate that technological development has been the most important cause of increased hospital costs, accounting for roughly half of the rise over the past decade. Hospital spending on labor and other inputs and demographic changes account for the remainder. As stated before, during the 1980s diagnosis related groups (DRGs) and the increase or managed care activity resulted in a one-time reduction in the use of hospital days of some 30 percent. This factor did not keep pace with the rising costs of technology, demography, and other factors. Today, the projected increase in hospital costs will be 6.8 percent between 1994 and 2000. This growth is due to the aging population. The costs will continue to rise and the profits will continue to decrease with more managed care activity. Therefore, cost containment is a definite key in the redesign arena (Schwartz 226).

The next component in the redesign plan is the increase in marketing efforts. In order to remain competitive, healthcare institutions are now promoting their services. This school of thought is relatively

new in the healthcare industry. In fact, health services are no longer service-driven, they are market-driven organizations. A market-driven organization is one that focuses on the needs and demands of the target markets and provides the products that they need. Healthcare facilities will need to either redesign or create a marketing department within their institution to cater to the customer's needs (Schulz 231).

Philip Kotler, a leader in the marketing industry, states that,

> In the past many hospitals were faced with the burden of too many patients. But during the past decade, hospitals began to face falling admissions and low occupancy. In the scramble to pull in new patients, many hospitals turned to marketing. The more they looked at the problem, the more complex the marketing challenges appeared. Most hospitals realized that they could not be all things to all people. Some began to focus on offering certain specialties, such as heart care, pediatrics, burn treatment, and psychiatry and others focused on demographic segments. (644)

In addition, most healthcare institutions were originally established by a religious or community group, philanthropists, or by physicians to serve the needs of the sick and injured. This service approach was supported by post World War II payment incentives

that rewarded healthcare facilities by paying higher costs for the amount of services they offered people. This process increased the provider's income, size of facilities, and the overall quality of service. In the civil rights era of the 1960s and 1970s, healthcare was considered a freedom or right of all people and certain programs were started to increase the access to medical care. However, in the 1980s managed care evolved which allowed healthcare providers to serve a multitude of people but at a severe reduction in their reimbursement. Marketing, as a science in healthcare, began to evolve due to the increased competition resulting from the managed care activities (Schulz 231).

Marketing the products of a healthcare facility has become one of the most important managerial functions in the healthcare industry. Patients are the primary element that produces revenue in a healthcare facility. This environment has become very competitive. The health service facilities feel they must sell their services directly to patients, as well as to physicians, just as any other consumer product industry. Focus on market management in the 1980s

resulted in the application of "product line management." This concept allows certain hospitals services to be treated as separate revenue centers that have organized market plans attached to them. Women and children's health, cardiology, and oncology are examples of product lines. However, product line management has faded in a number of hospitals because of problems that arise while trying to implement the matrix organizational structure in which product line management usually falls. In order to stay competitive, the marketing aspects of the healthcare facility must be reengineered or redesigned to maximize the benefits that the healthcare facility has to offer the public (Schulz 232).

The main problem within the marketing departments of healthcare facilities is the inability to identify their products. Healthcare facilities are just now discovering that they have products that are actually for sale. The product, in this sense, is the actual care. In the past, hospitals did not identify with any product. Now, it is critical to market their products for survival.

The second problem within the marketing

departments of the healthcare facilities is that they do not identify the customers and they do not meet those needs of their customers. As stated, there are three basic customers of a healthcare facility. They are patients, physicians, and third-party entities. Rockwell Schulz, graduate professor and author, illustrates that,

> Other publics, or people or organizations that have an actual or potential interest or impact on the hospital, that should be identified include the community where the hospital is located. Relatives and friends of patients constitute another public of hospitals. In many communities, other hospitals are in this group. (235)

Clearly, Schulz points out that there are other "customers" of a healthcare facility other than the three basic entities mentioned above. However, because each of the above-mentioned customers serves a different function, it is important to identify the normal or usual function of the basic customers and how the hospital can better serve the needs of those main customers. The secondary or ancillary customers mentioned by Schulz will be addressed through meeting the needs of the basic customers. In conclusion, by not identifying the proper customers, the hospital is

not in a position to identify the needs of the community. Again, there needs to be adjustments in the marketing scheme of healthcare facilities (Schulz 235).

An example of the above concept is marketing to ethnic communities. For years, makers of consumer products have tailored their advertising campaigns to reach ethnic groups. Now the healthcare industry must learn how to market their services to an ethnic population. In competitive markets, cultural specialization is a way for providers to distinguish themselves from the rest of the pack. Currently, there are nearly 8% of U.S. residents who are foreign born. After all, patients do not follow instructions they do not understand. From a cost standpoint, physicians might order tests when they can not identify the chief complaint from the patient. This creates unnecessary costs to the system. In short, identifying the customer and attempting to service those needs are a must in the redesign efforts of a marketing department. (Jaklevic 32).

In addition to the three components previously mentioned, physician relations is also very important to any redesign plan. As previously stated, one of the

most important customers to a healthcare facility is the physician. The physician can send their patients to virtually any facility within a community. There are certain exceptions where patients must go to the facilities that their managed care plan includes. In either case, there is a definite need for a strong physician/hospital relationship. Therefore, it is essential for upper management to maintain a solid relationship with the medical staff in order to receive patients to their facility. Although relations among healthcare providers have been in existence for several years, today hospitals and physicians are seeking to link together to a greater extent than in past years. While recent emphasis on healthcare reform may be a factor contributing to this increased rate of hospital-physician integration, healthcare providers were developing such relationships before healthcare reform became an issue. In either situation, physician alliances are a key in the redesign formula (DeMuro 27).

In the beginning years of medicine, people with little or no training that could treat the sick could be regarded as physicians. Most "physicians" were

educated under an apprenticeship system, and there was no formal organized method for testing the competence of those practitioners. In addition, there were no effective licensing bodies that could validate, by the granting of a license, to the physician's competence. Today's medical practitioner is very different than from the practitioner mentioned above. The current medical physician must pursue a difficult course of study and clinical practice under the close supervision of faculty. This faculty is usually at the upper level of their profession. In addition to courses in a premedical curriculum at a college or university, they must undertake at least three years of additional supervised specialty training in a nationally accredited residency training program upon the completion of medical school. The end result is an individual licensed by the state government to practice medicine. This type of education produces a physician who is competent to diagnose and treat most illnesses and to know when to refer the patient for specialist care (Raffel 1).

Extraordinary changes are occurring in the medical practices within the United States. After several

decades of typical practices or standards of medicine, physicians are now faced with several problems. Some of those problems are a decline of professional autonomy, increased competition among themselves, and changes in the methods of payment for their services. A majority of these changes can be attributed to reform and efforts at cost containment. In fact, the physician of today is quite fearful of what the future will bring (Raffel 61).

There has been a lot of interest in physician-hospital relationships over the last few years due to the changes that have occurred. Surveys have been conducted by the industry professionals, universities, and consultants to measure the attitudinal climate, governmental involvement, and employment relationship. All of these studies have focused on the internal relationships between a hospital and the members of its medical staff. The physicians are reaching out for these alliances to create stability within their practice. They are uncertain of the changes that reform will bring. In addition, the government regulations of recent years has created a feeling that they cannot truly treat their patients and still abide

by the mandated rules. Again, today's physician is fearful of the future. It is the responsibility of the healthcare facility to establish strong physician relationships in order to thrive in the healthcare industry in the future (Burns 7).

Peter Reticker, manager and consultant, states that,

> Universal access to primary care will reverse the hierarchical importance of providers and the setting in which healthcare is provided. The emphasis will likely be on the general and family practice 'gatekeeping', the management of health services by a primary care physician. This change represents a shift away from specialist and subspecialist healthcare managers. (94)

Also, the physician of the future will need to be a manager and negotiator. Large medical institutions are likely to increase formation of horizontal relationships with physicians in the efforts of cost containment and stability.

A hospital that is closely affiliated with physicians in the delivery of healthcare, and which has aligned hospital and physician incentives, should be able to offer and obtain more attractive prices to managed care plans, manage the delivery of the actual

care more efficiently, and reduce the number of providers with which the plan needs to contract. Such an affiliation is known as a total integrated delivery system (DeMuro 27).

The main problem with the relationship between the healthcare provider and the practicing physician is lack of cooperation. This problem stems from the control that the physician maintains through the patient flow. Physicians control the number of patients that the facility receives. Due to their fear, physicians are holding on to this element of control. Providers need to begin to work with the physician and create a safe environment with which they can practice medicine. It is apparent that the growing interest in hospital-physician alliances can promise both parties a better chance at stability and survival into the future (Manecke 33).

According to David Zimmerman, author and healthcare consultant, "physician backlash could pose a major obstacle to any hospital redesign effort." Getting physicians involved and maintaining a solid relationship with them in redesign efforts is a major component to the success of the project. Considering

their vital role in the overall healthcare process, physicians should play an equally important role in any redesign program. The hospitals need to recognize the need for a solid relationship and cooperation from the physicians. This can be accomplished through redesign efforts. (Zimmerman and Skalko 66).

The last component of a successful redesign plan is employee structure. The employees of any organization are a very important element. In a healthcare setting, the employees are even more important since they are selling such a delicate product. That product is the actual care that the organization manufactures or delivers. Due to the nature of the industry, these employees require continuing education, cross-training, and empowerment. The healthcare employee of today will not be the same for the future. The redesign of the employee structure is necessary to the future of the facility.

Organizations in general currently operate in an era of doing more, with fewer resources, for less cost, with greater efficiency, and in less time. In this stressful climate, most organizations still do very little to reward and secure their employees for taking

care of business.

The cornerstone of the healthcare industry is care. This care can be found in the culture of most healthcare facilities. Healthcare employees function in that special culture. Culture has to do with the people in the healthcare organization and the unique quality of character of the facility. Most healthcare organizations have personalities in the same way as people do. Their personality is not something tangible; it is composed of many sensations and impressions of those who make up with work force of the healthcare organization. Such impressions are generated by the values held by those who are high executives who manage the organization, the physicians who utilize the facility, and the providers of patient care. It is this unique, caring culture that the healthcare industry is typically known. Healthcare organizations must seek to maintain the above autonomous culture through the employees. This culture will enhance the environment which will attract patients, physicians, and vendors. It is important to seek to protect this culture through the redesign process (Schulz 102).

In addition to culture, the healthcare industry maintains an overall positive attitude simply by the nature of the business. Hospitals and healthcare institutions are dedicated to serving individuals who are in need of medical assistance. The environment produces an attitude that is of a positive nature. It is the employees of the institution that pass this attitude around. Attitude is the way that one looks at things mentally. In some instances, attitude can make the difference between life or death. Therefore, it is important, sometimes critical, for the employees to have a positive attitude towards their job and the institution. Through the redesign process, the employee structure can be altered in order to foster a continuous positive attitude among the employees (Chapman 8).

Further, V. Clayton Sherman, management development specialist and author, states "winners make winners and losers make losers (44)." He suggests that a positive attitude among employees is crucial to the success of the organization.

As stated, the change that a redesign project can bring is quite scary for employees. Today,

corporations are downsizing daily. The main problem with the employee structure is the level of fear that accompanies major changes. Healthcare employees are fearful for their jobs during a redesign project. However, the facilities wish to maintain the positive attitude required for the industry and the unique culture that can be found within the institutions.

David Zimmerman and John Skalko state that,

> Most hospitals that are implementing redesign projects do not have huge layoffs. Even hospitals that have been in a redesign project for more than three years reported very little in the way of layoffs. Further, 71% of the hospitals studied reported little or no difference in the number of full-time employees (FTEs) before and after their projects were launched. Fewer than 30% showed a relatively large number of layoffs, but nowhere near the amount within corporate America. Therefore, while some hospitals may indeed be cutting staff in an effort to reduce costs, this is not the case among facilities that are in redesign programs. A superior redesign project will focus on the employee structure and address the fear of the future. (52)

The Health Security Act of 1993 was formally introduced in Congress in November of 1993. It will undergo certain modification before it becomes a law; if it is even passed by Congress. Healthcare

facilities must be ready to act upon these changes in order to stay in business. The five target areas facilities should focus on are the delivery systems, financial management and costs, marketing, physician relations, and employee relations. It is these areas that facilities can begin to redesign (Peterson 44).

After careful examination of the five major components, one can visualize the existing problems within those components. Also, one can visualize the importance of improving those areas in order to remain a productive healthcare facility of the future. The current crisis in the U.S. healthcare industry is a common fact. It is probable that the Clinton plan or a modified version of that plan for healthcare reform will eventually be passed by Congress. Many changes are needed in the current healthcare structure. The system needs to become more effective overall, physicians and hospitals need to become cost conscious and competitive in pricing, duplication of efforts regarding services needs to be eliminated, and hospitals need to focus on assuring the quality of the actual care rather than filling beds. Therefore, it is hypothesized that healthcare institutions need to

redesign their facilities in order to survive reform and the future (Kalkhof 34).

Chapter III

SELECTIVE REVIEW AND EVALUATION OF RESEARCH

As past chapters have illustrated, the current healthcare system is in a state of trouble. The system in existence is extremely costly, highly inefficient, and organizationally inept. In addition, the current system does not provide an outlet for cost relief to those healthcare facilities that render care to the people who cannot afford that care. The government has developed a healthcare reform package which will require healthcare providers to adapt to this package. In order to continue to be in business and exist through this reform, the healthcare providers must change or redesign their existing organizational structures. The five major components that the facilities need to focus on are as follows: delivery of services, financial management and cost containment, marketing, physician relations, and employee structure.

In previous chapters, each of the five components above has been examined in depth. In addition, there has been attention drawn to the main problems existing with each component. This chapter will analyze the

potential solutions for those existing problems.

The first component presented for review was the delivery of the care within the facility. The delivery of services is an important factor in the overall presentation of a healthcare facility. The current methods for evaluating the quality that exists in those delivery systems do not truly measure the quality. The true measure of quality comes from customer satisfaction. The main problem with the current healthcare delivery systems is the lack of customer service required to function in the future. Each delivery system must be redesigned from the customer's viewpoint in order to become more customer orientated.

Each healthcare facility needs to began to closely examine their delivery systems. The current systems need to be broken down in order to eliminate any unnecessary steps in the process. The main goal in redesigning the delivery of healthcare is to better serve the customer. As pointed out previously, there are three basic customers in a healthcare facility; however, the main customer focus in the delivery systems process is the patient. The other customers, such as physicians and third-party payors, are

certainly involved in the delivery process, but they are not the main ingredient.

The example illustrated previously concentrates on the admissions process. The current admissions process for most healthcare facilities is quite lengthy. In addition to the actual time spent in the admitting department, there are restricted hours of business, numerous mistakes by registrars, and lack of courtesy shown by the admitting staff. Finally, the health of the patient is not a concern through the admissions process. It is evident that this process needs to be redesigned to better suit the needs of the patient.

Since the admissions process is the first opportunity for a patient to develop an overall impression of the facility, the entire admissions process should be centered around the patient and not the facility. Healthcare facilities need to assign certain individual teams to analyze each of the delivery systems and began to redesign the existing system. There are many opportunities for redesign in the above admissions process.

The first element to consider is the time factor of the entire process. The length of the entire

process needs to be shorter in order to exipedite the process. Time can certainly be saved between the patient arriving at the facility, visiting with a registrar, and proceeding to the testing area. In fact, the focus has shifted to the registrar's coming to the patients while they are in the outpatient testing area. Bedside admissions or outpatient registration is a method which combines the function of the registrar or admissions office and the financial counselors into a patient-centered process with one individual completing all of the duties in one setting. The patient is assigned one representative and that person takes the patient to the testing area or to the floor while completing the registration process on a laptop computer. This person continues to maintain contact with the patient until discharge. Further, there are certain representatives assigned to certain floors in the facility and representatives assigned to outpatient testing areas.

The redesign efforts of the admissions process has solved a majority of the problems with the old system. The personal attention from the representatives to the patients will increase the customer service issue.

Also, the patients will feel that there is an individual at their disposal. In addition, the time saved by completing the process in transit to the floor or the testing area will eliminate long waiting periods. Finally, the health of the patient will be top priority with the new process. The priority is to get the patient to the testing area or the floor as fast as possible, not to register the patient first. The majority of the delivery systems in healthcare facilities can be improved by applying the same procedures (Catino 12).

The research methods used to evaluate the delivery systems within a healthcare organization were exceptionally detailed and supportive of the conclusion. The delivery systems do not cater to the customers; therefore, the delivery systems must be repaired. The sampling technique used by the authors was unbiased and done on a random basis. There was the constant limitation that most of the delivery system studies pertained only to clinical areas. However, the customer visits non-clinical areas as well.

The next components are financial management and cost containment. Due to their close relation, these

entities will be treated as one unit. Both financial management and cost containment have individual existing problems to overcome. The main problem for financial management is the shortage of cash flow. The main problem for cost containment is to control the rising costs of healthcare. Healthcare facilities of the future must be able to increase their cash flow and still control their costs for operation.

As stated, the main problem with the financial management of a healthcare facility is the shortage of cash flow. The primary reason for this reduction is the changes in the cost reimbursement. The most prevelent change in cost reimbursement has been the rapid growth of managed care. As stated, managed care is the process by which healthcare facilities contract with certain third-party payors and discount their services in return for a certain number of members or patients. The discount process of managed care has put a damper on the cash flow of the facilities. However, the facilities must contract with the third-party payors in order to stay in operation.

As cash flow continues to shrink, more attention must be focused on the accounts receivable department.

In accordance with billing, collecting, and maintaining the cash flow, this department is responsible for managing the contracts made with the third-party payors. Therefore, this department is essential to healthcare financial management.

The problem of decreasing cash flow through an increase of managed care activity can be addressed by redesigning several business office processes. It is crucial that each accounts receivable department have at least one individual assigned to monitoring the managed care contracts to insure proper payment. In addition, the majority of information needs to be electronically transferred, such as electronic remittance advices and cash posting. Further, medical records must code the diagnosis within five days in order for proper billing and collection time of approximately thirty days. Finally, additional follow-up required on unpaid claims must be completed through an on-line system. The installation of these methods will increase the cash flow of a healthcare facility.

However, the cost reimbursement through managed care is going to change. This change is known as capitation. Capitation means a payment or charge per

member or head. This is drastically different from being paid from a DRG or per diem. Capitation contracts will pay providers a fixed amount a month before any services are rendered. This payment method requires a great deal of planning in order to manage the fixed amount of cash. The redesign efforts could be executed by carefully estimating the cost of caring for plan members or patients and altering the revenue-enhancing behaviors which could squander potential profits. Certainly, capitation will mandate the redesign of the financial management of healthcare facilities (Pallarito 94).

In addition to financial management, cost containment must be redesigned. The main problem with the cost factor is that the costs continue to rise. In association with capitation, cost containment can benefit with the careful estimation of the care per patient. This estimation will hopefully eliminate hidden costs. Also with capitation, administrative costs and expenses must be carefully budgeted and monitored. Cash flow will no longer be fluctuating on a montly basis; therefore, expenses must be maintained. Finally, technological costs could possibly be

distributed throughout a healthcare delivery system. One of the primary reasons integrated or healthcare delivery systems began was to share and control costs. These systems usually contain several facilities. To contain and share costs, these facilities should not duplicate services. Therefore, one of the facilities within the network should eliminate their oncology center while moving those existing patients to another facility within the system. This practice is quite common in other healthcare systems across the country.

Both financial management and cost containment need to be redesigned in order to benefit the healthcare facility in the future. The main goal of the reengineering efforts should be on maximizing cash flow while reducing costs.

Authors and consultants used in acquiring financial management and cost containment data all used appropriate sampling techniques. The authors chose hospitals in sound financial shape and hospitals that were not in sound financial shape. This range allowed numerous examples to be available. In addition, the statistical methods used were basic computations used to analyze financial data. The standard formula used

to calculate days in accounts receivable was gross days in accounts receivable divided by gross revenue for the period by the number of days within the period. The limitations perceived with the research was the extent to which it projected the future. After capitation, there does not seem to be an answer that has yet been proposed. However, the data unquestionably supported the conclusion. There needs to be increased cash flow within the facility and a strong effort made for containing the costs of the organization.

The next element in the redesign scheme is marketing. Healthcare facilities have found it necessary to market their individual services in order to stay competitive. The healthcare system does include marketing efforts; however, the current marketing efforts do not truly identify their cash cows nor to they identify their customers. These problems can be rectified by reengineering the marketing efforts of healthcare providers.

The first problem identified is the inability of the healthcare institution to establish the product for sale or their cash cow. Healthcare institutions need to begin to promote the services in which they excel at

or those services for which they are known. Certain facilities may be known for their research in cancer. Therefore, this facility could market their cancer center and research center. This would attract patients that desired a facility that was breaking ground in the fight against cancer and that specialized in treatment for the disease. Also, well-being programs are the future product. A main focus of capitation is maintaining the health of the members. The attention will shift from treating the sick patients to health maintainence. Healthcare providers should capitalize on this and begin to redesign their marketing product lines to include community wellness programs.

The other problem mentioned previously is the failure to identify the customers and the inability to meet the needs of those customers. Healthcare providers need to determine their customers and begin to adapt to those customers. This can also be completed by changing or redesigning the marketing departments within the institutions.

Identifying the customer is one essential key in any marketing program. The customer will be able to

assess the strengths and weaknesses of the current programs and services that the facility offers. The organization can use this information to make improvements to accommodate the needs and wants of the major market segment for which it serves. Providers should begin by collecting data on the patients over a few years and then tie this data to the financial data on those patients. This will give certain information regarding the type of services used over the past few years. This survey should enable top management to assess their major market segment.

In addition to the above survey, the providers should gather a list of patients that left for various reasons. These patients should be contacted and their situations need to be reviewed. The hospital should gain valuable information on why these patients were not satisfied and seek corrective measures. Through the above-mentioned methods, healthcare providers could began to identify their customers and seek to serve those customers in the best manner available (Schulz 236).

The research that was employed for the marketing segment of a redesign project undoubtedly supports the

fact that the providers need to develop strong product lines and that the customer needs to be identified. The sampling technique could possibly be somewhat general in the fact that it includes all healthcare providers. This paper is focused around hospitals and not all healthcare providers as the marketing research suggests. All healthcare providers would include independent clinics, physician offices, health departments, etc. However, the research conclusions are supported by the data. The possible limitations detected within the marketing research would surround the issue of generality.

The next component in the redesign plan is physician relations. While discussed earlier, the role of the physician today is ever changing. In the past, the physician need only concern themselves with the health and welfare of their patients. Today, the physician must be a healthcare provider, contract negotiator, and practice manager. These changes, as well as proposed reform regulations, have physicians seeking stronger relations with healthcare providers. The healthcare providers, in turn, are providing such strength to physicians through alliances and networks.

However, the main problem with the physician relations is the lack of cooperation on the part of the physician. This problem can be tackled by redesign of the physician relation infrastructure.

Provider alliances are certainly a key in the reform package. However, there must be cooperation from both entities in order for survival. This cooperation could be enhanced if healthcare providers would involve the physicians in administrative decisions. Physicians input can be utilized not just in clinical decisions but in both financial and administrative decisions. The medical staff should be included on all major financial activities. Since the establishment of the physician-hospital alliance, most physicians on staff should be "contractors" of the hospitals. Therefore, they should understand that they play a major part in the future of the organization. There are various ways to include physicians in the financial decisions. Some of them are as follows: distribute financial statements at medical staff meetings, provide point of service education, include audit procedures in staff physician meetings, and form a value analysis committee (West 47).

Further, physicians should be included as members of the redesign teams. Their input is essential in the delivery systems analysis. Also, physicians can aide in cost containment as well as employee moral and structure. The healthcare providers need to establish a safe haven for physicians to practice medicine. This haven can be created by redesigning the current situation.

The research presented for physician relations was certainly adequate. The majority of the research examined was completed by physicians and extremely detailed. The sampling techniques employed were done on a random basis in some instances, and others were based upon the type of practice. The researcher's conclusions are definitely supported by their findings. There needs to be a stronger, more cooperative relationship between facilities and the physicians that practice within the institution. The research clearly honors that statement.

The final element in the redesign blueprint is the employee structure. It has been established that the healthcare industry fosters a positive culture and attitude. Since one's attitude can greatly affect

one's health, the industry seeks to promote a healthy attitude among the employees of the institution. The patients can then benefit from this attitude. However, the main problem with the employee structure and the current healthcare system is the fear that change creates. Redesign efforts, as stated, bring certain changes for a healthcare provider. It is important to address the fear of the employees and alter their structure in order to adapt to the changes.

There are several steps that executive management can do to reassure the employees of the facility. The first step is interaction with executive management. The employees need to be included in the long term plans of the organization. They need to be aware of the vision and mission of the facility. They will be more supportive of the organization if they are informed of the long range plans. As one is aware, redesign efforts include alot of changes. The employees need to be kept informed of the changes as they occur. Employees need to hear the results of certain situations from top management before reading about it in the newspaper or hearing about it on a television news station. The fear that overall change

brings will be reduced if the employees are kept informed regarding the upcoming events. Also, their loyalty will increase if they feel that they are being included in the future of the organization in such an uncertain period in healthcare (Zimmerman and Skalko 53).

Further, the healthcare facility should establish redesign teams to begin the total process. These teams should include employees that have a strong positive attitude regarding the facility. These employees will continue to support the necessary changes that the future will bring.

In addition to the redesign teams and including the employees on future plans, executive management should begin cross-training programs for all employees. The primary concern for employees going through major facility changes is the security associated with their job. Therefore, top management should begin to train employees to do other jobs associated with their current position. This results in highly-skilled employees who are better trained for the changes in job structures. The popular misconception regarding this factor is that if the employees can not learn the new

skills, then they are out of a job. On the contrary, the employees need to be encouraged to learn other skills to adapt to the changes in the current job.

Finally, performance appraisals can certainly boost employee moral and reduce the present fear. Employees need to be evaluated yearly on a system that measures their true performance while on the job. This type of merit increase, as opposed to a standard cost of living increase, will assure the employee that they are being judged on their individual performance. Therefore, if an employee performs at their highest level, then they will be rewarded on that basis. Also, this allows employees to get feedback on their roles and day-to-day activities. This feedback can assist the employees and their input on the redesign teams. In totality, executive management can do numerous things to reduce the fear factor that is accompanied with a redesign project (Zimmerman and Skalko 62).

The research methods used by Zimmerman and Skalko were mainly based upon several healthcare facilities and their redesign projects. The sample facilities all were approximately the same size with approximately the same number of employees. The suggestions rendered by

the authors had positive results within the test facilities. However, in regards to employee structure the limitations perceived by Zimmerman and Skalko are understated. There are several factors that affect the employee structure that were not considered such as attrition, maturation, and disciplinary action against certain employees. The last factor, disciplinary action, can cause damage to the employee structure while going through a redesign project. This factor was not addressed in the research but does need to be considered.

In totality, the research presented does support the hypothesis that in order to survive healthcare reform, healthcare facilities must launch a redesign project.

Chapter IV

RESULTS

An indepth analysis of a redesign project for a healthcare facility has been completed thus far. The redesign project consists of five major components to which the healthcare facilities should focus. Again, the five major components are the delivery services, financial management and cost containment, marketing, physician relations, and employee structure. This chapter will supply the pertinent research data to support the answers to the problems presented with each component.

The first component is the delivery systems. The delivery systems are those systems which deliver the care to the patient. These systems could range from any laboratory visit to a lengthy inpatient visit. However, not all delivery systems need to be clinical in nature. The admissions process was such a system that illustrated the main problem in the delivery systems. The main problem recognized in prior chapters is the failure to service the customer. Table 1 demonstrates the positive effects of improving customer

service. Clearly, healthcare facilities can see the percentage of profit margin increase with a customer service plan in process.

Table 1

Effect of Customer-Service Programs on Hospital Profitability

	Number	Profit Margin
System hospitals with customer-service plan	29	4.9%
System hospitals without plan	3	4.8
Freestanding hospitals with plan	16	1.8
Freestanding hospitals without plan	12	0.7
For-profit hospitals with plan	21	6.2
For-profit hospitals without plan	2	5.8
Not-for-profit hospitals with plan	24	1.7
Not-for-profit hospitals without plan	13	0.7
Hospitals with more than 150 beds with plan	35	4.9
Hospitals with more than 150 beds without plan	6	4.8
Hospitals with fewer than 150 beds with plan	10	2.0
Hospitals with fewer than 150 beds without plan	9	2.0

Total with plan	45	3.8
Total without plan	15	3.6

SOURCE: As cited from survey by Mishalanie Layton & associates (1990). Modern Healthcare. Exhibit from "Competition for Patients Spurs Hospitals' Concern for Serving the Customer," by Jay Greene (1994).

The above table provides evidence that changes occur with modifications in the customer-service area. Therefore, in the redesign of the delivery systems, healthcare organizations need to address the customer's needs and seek measures to meet those needs. This action will not only enhance the public relations of the facility, but it will increase the profits at the same time.

The next component is financial management and cost containment. As stated, these two entities will be treated independently. The current problem with financial management is the shortage of cash flow. The focus needs to be placed on creating a strong accounts receivable department in order to make the most of the cash available. Table 2 highlights the importance of keeping the days in accounts receivable at a low rate. In turn, this will increase cash flow.

Table 2

Hospital Comparisons - High Days to Lower Days

	Hospitals with the lowest days	Hospitals with the highest days
Average Gross Days Revenue Outstanding	54	98
Percentage of Bad Debt	3.5%	7.5%
Number of Collectors to Beds	1 per 70	1 per 171
Number of Collectors to Open Accounts	1 per 4,750	1 per 8,800
Aging on accounts after billing over 90 days	20%	42%

SOURCE: As cited by a survey by Zimmerman & Associates (1988). Winning at Receivables. Exhibit from "Run it Like a Business," by David Zimmerman (1988).

Clearly, a promising redesign plan should include measures to strengthen the accounts receivable department. In addition, the future of financial management will certainly include capitation. As mentioned previously, there will be a change from fee-for-service to capitation. This method of reimbursement is a certain amount of payment for a certain amount of time. This amount of payment will not fluctuate; however, the patient volume and costs

are free to change. Therefore, it is even more important to have a solid financial picture. Table 3 measures the division of the dollar before and after capitation for certain departments of a healthcare facility.

Table 3

Dividing Up the Premium Dollar

Department	Current	Capitation
Hospital Inpatient and Outpatient Services	41 cents	30 cents
Physician Services	33	37
Outpatient Drugs	8	9
Nursing home care	1	5
Administration	14	12

SOURCE: As cited by Stanford University Hospital; J.P. Morgan; Source Book of Health Insurance Data (1992). Modern Healthcare. Exhibit from "Gatekeepers of Capitation," by Karen Pallarito (1994).

The above table demonstrates that capitation will bring changes in the reimbursement structure. This activity will need to be addressed with the financial management staff. In addition, cost containment will be a factor with capitation. This element compliments

strong financial management. Financial managers will need to cut costs in order to exist under capitation. The above table, again, illustrates that capitation will most likely change the financial structure of the organization. In conclusion, both cost containment and financial management are extremely important in any redesign project.

The next component in a successful redesign plan is the marketing services. The marketing of healthcare services is a new area to the standard healthcare facility. These facilities are having to develop new ways to promote their services in order to compete in today's marketplace. The two problems recognized with the current marketing efforts within facilities are the inability to properly identify the customer and what products to market to the public. Table 4 highlights a guide to adapting a marketing program that suits a healthcare institution. This table provides several steps to obtain the maximum level of performance from the hospital's marketing department. As previously stated, developing product lines are crucial for survival.

Table 4

Epidemiology of Marketing Plan

* Develop a tool to better equate resources and services with the population's health needs
* Develop a framework for a more global understanding of the health of the patients
* Develop a guide to the development and provision of comprehensive community services
* Develop an objective basis for communication between management and employees
* Develop a method for reconciling organizational interests with the community's growing needs for change

SOURCE: Epidemiology in Health Services Management. Exhibit by A. Denver (1984). Management of Hospitals and Health Services. Exhibit by Rockwell Schulz and Alton C. Johnson (1990).

The table above provides marketing policies that should be considered in a redesign project. It is important to identify the customer and the product. Once identified, both of these entities should be addressed in proper fashion. An innovative redesign plan would encompass marketing strategies for a healthcare organization well into the future.

In addition to the above-mentioned components in a redesign format, physician relations requires change.

The existing relation between the healthcare institution and the physicians is under a great strain. These relations need to be improved and the amount of cooperation between the two entities needs to increase. Physicians are a crucial part of a healthcare facility. In addition, they are very important to a redesign plan. Therefore, executive management should seek measures to increase the physician activity and strengthen the existing relationship. Table 5 measures several factors regarding physicians before and after a redesign program. This table analyzes the overall physician behavior regarding several general factors in their daily routine.

Table 5

Physician Satisfaction Ratings

	Before Redesign	After Redesign
Nurse Relations	5.1%	6.4%
Finding Information	2.8	5.6
Information Quality	4.3	5.6
Care Processes	3.3	5.3
Quality of Care	3.6	6.2

SOURCE: As cited by a survey from The Sibson, Inc. (1988). Reegineering Healthcare. Exhibit from

"Benchmarking and Performance Tracking", by David Zimmerman and John Skalko (1994).

It is evident that there were changes in physician attitude after a redesign project in the various categories. A redesign project could certainly improve physician relations in a healthcare environment. Finally, management needs to focus on physician involvement in the entire redesign process to ensure physician cooperation.

The last component in a redesign effort is employee structure. As mentioned previously, the employees of a healthcare facility present the facility. In addition, they send their attitude to the patient. Therefore, it is important that their attitude be supportive of the institution and the redesign project. Since redesign projects bring a lot of changes, it is imperative that the employees remain fearless of the future. Management can address this fear through numerous avenues. Table 6 illustrates employee satisfaction before and after a redesign project.

Table 6

Mean Job Satisfaction Ratings

	Before Redesign	After Redesign
Efficiency of Work	3.4%	4.6%
Physical Layout	3.7	6.4
Daily Workload	3.0	4.7
Patient Care Quality	3.9	4.9

SOURCE: As cited by a survey from The Sibson, Inc. (1988). Reengineering Healthcare. Exhibit from "Benchmarking and Performance Tracking," by David Zimmerman and John Skalko (1994).

The employee structure was altered after a redesign project was implemented in the hospitals surveyed. It is important that the employees support the facilities in this endeavor. Again, a solid redesign plan would include changes in the employee structure to improve working conditions and reduce the level of fear.

In summary, the tables presented substantiate that a redesign project will cause variations in the basic components within current healthcare institutions.

Chapter V

DISCUSSION

The previous chapters have examined the structure of a complete redesign project for a healthcare institution. A successful effort at the redesign or reengineering of a healthcare facility would include five major components. Those components are the delivery systems, financial management and cost containment, marketing procedures, physician relations, and employee structure. The financial institution should prosper into the future if these components are properly redesigned to certain specifications. The specific issues with each component was presented in chapter three with potential solutions. In addition, chapter four supplied data to support those solutions. This chapter will focus on the interpretation of that statistical data.

The delivery systems include every aspect of care dispersion within the facility. The system presented for example was the admission process. The main issue with the delivery systems in totality is the lack of customer service. The admission process, as an

example, does not service the customer. The customer must go through several processes, somewhat difficult people, and inconvenient hours of operation. It is apparent that immediate results could be identified in the admissions process if it were redesigned to service the customer. Table 1 presented in chapter four analyzes the difference in profit margins between facilities that have instituted customer service programs, and those that have not instituted customer service programs. All of the profit margins had increased with the facilities that had a customer service plan implemented. The total growth overall was 0.2 percent. However, the most growth occurred in the freestanding hospitals. The freestanding hospitals without a plan experienced a profit margin of 0.7 percent. The freestanding hospitals with a plan experienced a profit margin of 1.8 percent. That is approximately 1.1 percent in profit margin growth for simply implementing a customer service program in the facility. A successful redesign plan will modify all the delivery systems to change the focus from convenience to the facility to convenience to the customer.

The problem area with financial management is the shortage of the cash flow. The health of the organization is extremely important for the future. The healthcare facility must generate as much cash as possible. In addition, the cash generated must be monitored correctly. Therefore, the increased focus on the accounts receivable department is the potential solution to cash flow shortage. Table 2 illustrates the various elements that fluctuate with high days in accounts receivable versus lower days in accounts receivable. The higher day hospitals experience a larger percentage of aging accounts, a larger amount of bad debt, and more full time employees in order to maintain the accounts. Clearly, the lower the accounts receivable days, the better off the facility. The redesign plan for healthcare institutions should include measures to improve the performance of the accounts receivable department.

In addition to financial management, cost containment requires attention in any redesign project. This factor is the driving force that gained the attention of the federal government. The method of reimbursement is currently fee for service. However,

capitation, or bulk payment per month for each member, will cause changes. It will be extremely important that hospital management monitor the cost factor for each department due to the reduction in reimbursement that capitation will bring. Table 3 illustrates the current division of a typical dollar within a healthcare facility and the estimated division under capitation. The estimated hospital dollar will decrease by 11 cents. This number does not appear to be a great amount; however, when multiplied by the number of patients a facility services within a year, it becomes a great amount. In addition, the administrative costs also decrease by 2 cents. This activity substantiates the fact that capitation will result in changes in the management of cash flow. The proposed redesign plan includes cost containment. The costs need to be examined carefully since the cash will simply not be available as it is currently.

A successful redesign effort would include radical changes in the marketing department. The current problem presented in previous chapters has two elements: the institution needs to identify the customer and identify the products that the facility

could market to the public. These issues, when reengineered, will increase profits and add stability to the institution for future years. Table 4 examines the epidemiology of a marketing plan. This plan states several procedures and ideas to implement. The first procedure emphasizes the need for a tool that identifies the population's health needs. This is certainly a method that can be used to identify the customer of the facility. In addition, this plan includes the development of products that support the community and serve the needs of the community. Clearly, this part of the plan would assist healthcare management in selecting which products to market to the community. The facility needs stand out as much as possible in the community. The marketing services of the healthcare organization can propel the facility's image in the community. A redesign plan, created for healthcare organizations, should certainly examine the marketing departments. These departments should resolve the above-mentioned problems in order to survive healthcare reform. The table also supports evidence that marketing plans can increase the activity of the facility in the community.

Physicians are a crucial piece in the healthcare structure. Healthcare facilities depend upon physicians to send them patients. However, the relationship between physicians and facilities is experiencing difficulties. Physicians need to increase their level of cooperation with the facility. In turn, the facility needs to create stability in the physician practices. The solutions proposed to this problem can be implemented through a redesign plan. Table 5 examines the physician satisfaction rate before redesign and after redesign. The satisfaction was measured in regards to several factors that are included in a physician's daily routine. All of the areas experienced a growth in satisfaction after redesign. The largest growth area was in finding information. Physicians reported that the level of finding information prior to redesign was at 2.8 percent. The level after a redesign plan was implemented was 5.6 percent. Also, the overall quality of care issue went up from 3.6 percent to 6.2 percent. It is apparent that physicians surveyed felt an increase in all areas after a redesign plan was implemented. In addition, the customer service

component was measured. According to the physicians, the overall quality of care went up through a redesign program. Further, nurse and physician relations experienced a growth of 1.3 percent. The quality of the information requested also went up 1.3 percent. In totality, the results were all positive. This supports the fact that physician relations can be improved through a redesign program. Finally, the redesign program should focus on the relationship and seek measures to improve the quality of that relationship. Healthcare reform will certainly change the course of business for today's practicing physician. However, that transition can be a smooth process with the support of the healthcare organization.

The employees of the healthcare facility are very important. These individuals directly care for the patient. Also, their attitudes are passed on to each patient. The maintenance of a healthy attitude within each employee is necessary for the future of the institution. The changes that a redesign plan creates is quite fearful for the employees. The management of the facility needs to address this fear and seek opportunities and methods to eliminate that fear.

Table 6 evaluates the job satisfaction ratings before a redesign project and after a redesign project. In all areas surveyed which included efficiency of work, physical layout, daily workload, and patient care quality, there was evidence of growth. The largest growth resulted from the physical layout of the organization. The overall growth was 2.7 percent. Also, the efficiency of their work went up 2.2 percent. Overall, the employees surveyed felt that their jobs became more efficient after a redesign project. Further, the patient care quality also went up 1 percent. Again, the customer service aspect experienced growth. Finally, the daily workload also went up by 1.7 percent. As stated in previous chapters, the employees will need to be able to handle more responsibilities. Hence, cross training is a positive force in a redesign plan. It is evident that Table 6 supports the fact that the overall employee structure is improved upon through a redesign project. The healthcare institution needs to continue to seek creative avenues to strengthen the employee structure within the facility. It is the employees, not executive management, that has the most contact with

the patient. Therefore, it is important to retain and motivate positive employees through a redesign plan.

Summary

As pointed out, all of the evidence has been presented to support a redesign of the current healthcare system. Healthcare reform will bring certain changes to which the industry must adapt. Further, the changes are still unknown. Therefore, a redesign of the current system in place at healthcare organizations is most appropriate.

Due to the complexity of the current healthcare system, the proposed redesign program must contain certain elements. Those five main elements are the delivery systems, financial management and cost containment, marketing services, physician relations, and employee structure. These areas include a vast number of services and departments. The redesign plan presented includes all of the components.

There are two main reasons for the attention on the current healthcare system. They are the amount of uninsured individuals and the high costs of healthcare. The federal government has tackled the problem and

promised a reform package with drastic changes. However, the healthcare providers will need to accommodate those changes for survival in the future years. Therefore, the proposed redesign plan should be accepted and implemented in healthcare facilities.

It is important to summarize the problems and solutions identified thus far in previous chapters. The first component is the delivery systems. The primary problem, lack of customer service, was presented. It has been proven in healthcare facilities a growth in their profit margin upon the implementation of a customer service program. The next component is financial management and cost containment. The problems in these components are cash flow shortage and rising costs. Again, it has been established that lower days in accounts receivable reduces costs through fewer employees. In addition, capitation will force executive management to analyze their costs in association with operation. Further, the marketing component could greatly enhance the productivity of the facility. However, the problem with this component is the inability to identify the customer and which product to market to the public. The suggested

procedures will certainly stimulate community activity enabling the facility to identify the customer. In addition, the facility can then decide which product to market. The next component is physician relations. The problem with this element is the lack of strength and cooperation from either side. The evidence presented proves that the overall physician attitude did improve after redesign methods were implemented. Finally, the employee structure was examined. The main problem with this component is controlling the level of fear that accompanies a redesign program. The data has supported the fact that employee workload and efficiency improved after a redesign project was implemented.

In conclusion, the research supports the fact that changes need to be made in the current healthcare organizations. In addition, these changes need to be focused on certain areas. Further, these changes need to focus more on the customer and less on the facility. Also, the federal government has developed a plan to make changes in the current system. Therefore, the hypothesis that redesign will occur through healthcare reform should be accepted.

Limitations

There were several problems encountered while completing this research project. Aside from slight problems with data collection and some inconsistent studies, the main problem with this research study was some of the redesign plans had flaws in their design. The majority of the plans studied examined the five basic components of redesign. However, some of the plans only examined certain aspects that were specific to one healthcare organization. As stated before, there needs to be a plan that services all the healthcare facilities and not just one in particular. This factor put a hinderance on the data analysis. It was difficult to locate redesign plans that would facilitate all healthcare institutions. The redesign plan examined in this research effort would support any healthcare facility.

Suggestions for Future Research

The suggestions for research in the future would contain the healthcare plan that Congress will introduce to the public. This plan will most certainly cause changes in the current healthcare industry. It

is this plan that will outline how the hospitals and healthcare facilities will operate in the future. In addition, there are some factors of this project that could be altered if this project were to be re-examined. The supportive data available for current assessments is very limited. This is due to the rapid changes that have occurred in the industry. Also, it would be appropriate to study several facilities that have all applied the same redesign plan and measure their outcomes. Again, facilities in the research all applied different variations of redesign plans. Finally, in my personal opinion, each healthcare facility needs to implement a redesign program of some degree. The current systems in operation do not service the customer. Further, these systems are costly, inefficient, and slow in process time. The future will bring a facility that only services critical care patients and every other service will be on an outpatient basis. The current systems in place are not equipped to handle those radical changes. As stated by Rich Grisham, president of Unity Healthcare Organization, "the best competitor is a dead one." This statement holds true to the healthcare industry.

The competition is very strong in the industry. Therefore, the facilities need to set themselves apart from the other organizations in the geographical area. A solid redesign program will implement changes to close the gap between healthcare organizations. Therefore, the healthcare institutions need to redesign their current methods in order to survive healthcare reform and the future.

Works Cited

Brown, Fred. Personal interview. 19 October 1994.

Brown, Lawrence D. "Political Evolution of Federal Healthcare Regulation." Health Affairs 11 (1992): 18.

Burns, Lawton R. and Darrell P. Thorpe. "Trends and Models in Physician-Hospital Organization." Healthcare Management Review Fall 1993: 7.

Catino, Linda. "Paradigm Shift." The Journal of Patient Account Management July 1994: 12.

Cerne, Frank. "The Fading Stand-Alone Hospital." Hospitals and Health Networks 20 June 1994: 30.

Chapman, Elwood N. The Fifty-Minute Supervisor. California: Crisp Publications, Inc. 1988.

Daniels, Gregory and Patrick M. Lynch. "Determining Optimal Risk Retention in the Healthcare Industry." Healthcare Financial Management April 1994: 48.

DeMuro, Paul R. "Provider Alliances: Key to Healthcare Reform." Healthcare Financial Management January 1994: 27.

Dieter, Bryan and Doug Gentile. "Improving Clinical Practices can Boost the Bottom Line." Healthcare Financial Management September 1993: 38 & 44.

Greene, Jay. "Competition for Patients Spurs Hospitals' Concern for Serving the Customer." Modern Healthcare 18 July 1994: 30 & 31.

Grisham, Rich. Personal interview. 19 October 1994.

Hagland, Mark. "Sullivan: White House Moving Ahead on Reform." Hospitals 20 October 1992: 44.

Hammer, Michael and James Champy. Reengineering the Corporation. New York: Harper Collins Publishers, Inc., 1993.

Herkimer, Allen G. Understanding Hospital Financial Management. Germantown: Aspen Systems Corporation, 1978.

Iglehart, John K. "The American Healthcare System." The New England Journal of Medicine 2 April 1992: 962, 963, & 964.

Jaklevic, Mary C. "Programs, Ad Campaigns Reach Out to Members of Ethnic Communities." Modern Healthcare 1 August 1994: 32.

Kalkhof, Christopher J. "Alternatives to Federal Regulatory Realignment of Healthcare." Healthcare Financial Management January 1994: 34.

Kotler, Philip and Gary Armstrong. Principles of Marketing. New Jersey: Prentice-Hall, Inc. 1994.

Ladewig, Tommy L. and Bill A. Hecht. "Achieving Excellence in the Management of Accounts Receivable." Healthcare Financial Management September 1993: 25.

Larsen, Gail. "Improving Outpatient Registration with TQM." Healthcare Financial Management August 1993: 75 & 76.

Manecke, Stephen R. "Practice Acquisition: Buy or Build." Healthcare Financial Management December 1993: 33.

Markesich, Steve. "The Anatomy of Bill Production." The Journal of Patient Accounts July 1994: 23.

Matejka, Ken. Why This Horse Won't Drink. New York: American Management Association 1990.

Moldof, Edwin P. "Do-it-Yourself Strategic Planning Provides Map to the Future." Healthcare Financial Management February 1994: 27.

Pallarito, Karen. "Managed-care Markets Teach CFOs the Secrets of Capitation." Modern Healthcare 27 June 1994: 94.

Peterson, Dan M. "A Review of the Health Security Act of 1993." Healthcare Financial Management January 1994: 44.

Pritchett, Price and Ron Pound. The Employee Handbook for Organizational Change. 2nd ed. Dallas: Pritchett and Associates, Inc., 1994.

Raffel, Marshall W. and Norma K. Raffel. The U.S. Health System. New York: Delmar Publishers Inc., 1994.

Reticker, Peter. "Healthcare Reform and Emerging Employment Trends." Healthcare Financial Management January 1994: 94.

Schieber, George J. and Jean-Pierre Poullier. "International Health Spending: Issues and Trends." Health Affairs Spring 1994: 113 & 116.

Schoenhard, Bill. Personal interview. 19 October 1994.

Schulz, Rockwell and Alton C. Johnson. Management of Hospitals and Health Services. St. Louis: The C.V. Mosby Company, 1990.

Schwartz, William B. and Daniel N. Mendelson. "Eliminating Waste and Inefficiency can do Little to Contain Costs." Health Affairs Spring 1994: 225.

Sherman, V. Clayton. From Losers to Winners. New York: American Management Association, 1987. 37 & 44.

Snow, Janet L. "Sales: Evaluating the Return on Investment." Healthcare Financial Management May 1994: 45.

Sturm, Arthur. "Build Network Properly and Customers will come." Modern Healthcare 19 September 1994: 25.

Swarzman, Gerald F. "Does Your Patient Accounting Process Pass the System Test?" Healthcare Financial Management July 1994: 27.

Wakefield, Douglas, Cyphert, Stacey, and James Murray. "Understanding Patient-Centered Care in the Context of Total Quality Management and Continuous Quality Improvement." The Joint Commission March 1994: 153.

Weil, Thomas P. "Use Rates Under President Clinton's Health Reform Plan." Healthcare Management Review Spring 1993: 27.

West, Daniel J. "Involving Physicians in Cost Reduction Strategies." Healthcare Financial Management April 1994: 46.

Zimmerman, David and John J. Skalko. Reengineering Healthcare: A Vision for the Future. Wisconsin: Eagle Press, 1994.

Zimmerman, David. Winning at Receivables. Wisconsin: Eagle Press, 1988.