TOWARD IMPLEMENTATION: MANAGED CARE AND DELIVERY SYSTEMS

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Managed-care organizations can and should play a role in promoting the development and implementation of programs designed to enhance the health of urban populations, particularly the inner-city poor. Managed care is here to stay. While managed care remains very much a work in progress, it must be recognized as one of the major stakeholders in the development of solutions to the health care problems of the urban poor.

In many respects, managed care is simply the messenger carrying the conclusion, unhappy as it may be for many, that the perceived quality of health care is too low and the cost too high for too many health care consumers. You will often hear this imbalance in quality and cost expressed as the low perceived value of health care. While many feel that we have the best health care system in the world, I need not point out the many significant deficiencies in American health care, especially as they relate to the cities.

A NEW PARADIGM

In many respects, managed care is the architect creating a new health care paradigm that must include three principal components:

1. A change in health care financing that incorporates new approaches to reimbursement, resulting in an alignment of financial incentives and a rationalization of financial reward.
2. A change in the organizational structure of health care (or, some might say, a lack of organization) that incorporates the concept of integrated and coordinated systems of care.
3. The imposition of accountability by ensuring the availability of information,

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the utilization of evidence-based medicine, and the application of continuous quality improvement.

All three components are necessary for managed care to achieve its full potential and become a sustainable system for health care delivery. To put this another way, short-term cost reduction alone should be viewed as an abject failure.

Unfortunately, too many view managed care as the enemy because it has resulted in:

- a dramatic change from what had been three comfortable decades of financial abundance;
- a significant change in the revenue stream for all providers;
- a shift in the balance of power, authority, and responsibility from the physician to the managed-care organizations;
- a loss of job security and significant changes in the physician workforce;
- a perception that managed care is blurring or infringing on the traditional boundaries of public health.

These changes are unsettling at best, but conferences such as the New York Academy of Medicine's Sesquicentennial Symposium allow a dialogue that should facilitate the identification of solutions to problems, old and new, that will meet the needs of all stakeholders.

This paper cannot discuss the entire spectrum of diversity in the managed-care industry, such as plan structure, tax status, benefit design, mission, and values. It should be noted, however, that many health plans are beginning to demonstrate improved health care outcomes. Many of the successful programs have embraced and adopted the principles of public health, including an emphasis on prevention and wellness and a population focus. This outcome may be forcing a change in the traditional roles, but it provides, to all who are concerned with urban health, an opportunity to achieve traditional goals if we adhere to our traditional principles. The proponents of managed care believe that it is creating a health care infrastructure that will enhance the health status of the community. However, it is a different community than the one served by many in public health because it is a community defined largely by membership in a plan. To be sure, no plan alone can effectively address all of the determinants of health status: some can be addressed by individual plans, some can be addressed by coalitions of plans, but most will require collaboration among several stakeholders to achieve optimal health status.

Another principle that is driving managed care is a belief that the public is best served by a competitive, pluralistic, market-driven system of care, with

success determined primarily by creativity, innovation, market sensitivity, and performance. The scope of expertise and resources necessary to address such complex issues as domestic violence, teen pregnancy, drug-resistant tuberculosis, substance abuse, smoking, and many others requires a much broader effort than can be generated by any single organization. Collaboration is a necessary requirement to achieve the outcomes that we all desire.

The many health care services and programs that have generally been provided by safety net institutions, and that have been described as public goods, must be acknowledged. These services and programs have generally not been addressed by managed-care plans and include:

- uncompensated care
- the growing population of uninsured
- community service functions
- medical education
- medical research

Changes in reimbursement have begun to limit the ability of the safety net institutions to cross subsidize these programs from the excess revenue generated from other clinical services. This is an important first step in rationalizing the health care system and ensuring that the same standards of demonstrable efficacy, effectiveness, and accountability get applied to the safety net providers and academic institutions that we now require of all health care providers. In addition, many health plans have begun to demonstrate an expanded commitment to the communities in which they operate and support such activities as medical education, research, and broader community services. These actions do not mean that a solution to the safety net issues and public goods has been found, however; the issues remain extremely complex and the entry of managed care has not simplified the task.

The boundary between public health and managed care is a dynamic one, and both the need for competitive markets and concerns about safety net issues are real. Reform of the health care delivery system is needed, but, to paraphrase a remark made by Dr. Anderson,¹ one of the presenters at the symposium, it should not be left entirely to the invisible hand of the marketplace.

NEW RELATIONSHIPS

Timely identification and implementation of solutions to the priorities identified in the New York Academy of Medicine symposium will require new relationships between and among the major health care stakeholders. These relationships should be characterized by collaboration, partnership, and coalition building.

Oxford Health Plans has undertaken several initiatives that address some of

the issues discussed at the symposium. These initiatives reflect the efforts of only one plan in one region, but suggest that the aggregate potential across the country must be enormous. Each of the initiatives discussed in this presentation represents a partnership with other stakeholders. Space does not permit an additional discussion of the internal, population-based initiatives being undertaken at Oxford, such as the plans' Asthma Disease Management Program, which has reduced emergency room visits and admissions for asthma among plan Medicaid members by 35% to 45%, respectively.

COLLABORATIVE PROGRAMS

Seven initiatives are surveyed in this paper. Each is presented in the context of the issue that had to be addressed and the partners with whom it was implemented.

1. Shortage of adequate facilities and qualified providers in selected areas of New York City. *Partner:* The community itself, because a strong relationship with community leaders was necessary to secure access and gain trust. *Initiative:* Oxford has now developed three ambulatory health centers. The facilities in the South Bronx and Brownsville are fully operational; the facility in Jamaica opened recently. Enrollment is growing, and we are confident that we have made a significant contribution to the health of these underserved communities.
2. Perceived need to enhance community-based resources to complement some of our own Medicaid and Medicare initiatives. *Partners:* Selected community-based organizations. *Initiative:* Oxford directs most of its charitable contributions to those community-based organizations that attract Oxford employees as volunteers. Two notable examples are the Arthur Ashe Institute for Urban Health and the Council of Jewish Organizations (COJO) of Flatbush. Both of these organizations have developed creative programs that should have a positive impact on the health status of their respective communities. The Arthur Ashe Institute has developed a patient education program based in hair salons. The program, called Black Pearls, has been extremely successful in reaching the African American women in the communities served. COJO of Flatbush has developed a program called Friendly Visits for the Homebound: high school students are trained to assist the elderly and infirm following hospitalization. These programs complement Oxford's own programs and include the communities in solutions to their health care needs.
3. Domestic violence. *Partners:* Westchester County League of Women's Voters, New York State Department of Health, and the US Department of Health and Human Services. *Initiative:* We have developed a pilot program

in collaboration with our partners to educate and raise awareness among Oxford physicians about domestic violence. The program includes seminars by regional and national leaders and material for office distribution. A patient tracking system is being developed, and enhanced reimbursement for counseling associated with domestic violence is being considered. In addition, a mechanism for reimbursing nurses who examine victims of sexual assault is under development. The Westchester effort has been developed as a pilot program with the expectation that it will be adapted to all Oxford service areas in due time.

4. Tuberculosis treatment. *Partner:* New York City Department of Health. *Initiative:* Rather than duplicate the resources and expertise of the New York City Department of Health, Oxford is negotiating an arrangement to include the New York City tuberculosis program in its provider network. Such collaboration benefits the local health department, the health plan, and the public because it effectively uses scarce resources and directs patients to the most effective providers.
5. Medical education. *Partners:* Columbia University and Cornell University. *Initiative:* As a network model, Oxford does not have clinical sites to utilize for clinical rotations. The health centers do not yet have sufficient volume to serve as teaching sites. However, we have developed a core curriculum that serves as the basis for a seminar series and an administrative rotation for medical students from both of these New York City medical schools. The Columbia program is offered as a summer elective for students at the end of their first year and as a one-month elective during their fourth year; the Cornell program is limited to a seminar as part of the public health curriculum. Resident rotations are currently being considered based, in part, on the work that is being done by the Partnerships for Quality Education, which is supported by the Pew Charitable Trust.
6. Collaborative medical research. *Partners:* Several academic medical centers. *Initiative:* Because of Oxford's large and growing membership and clinical database, which is referred to by Mr. Wiggins, Oxford's chairman of the board, as the Oxford biosphere, we feel an obligation to utilize our resources to identify ways to improve health status. One of the ways in which we meet this obligation is to participate in collaborative research. Some examples of these collaborations include a study of smoking cessation in adolescents with Columbia University; a study of the early diagnosis of lung cancer with Johns Hopkins University and the University of Cincinnati; a study of barriers to colorectal cancer screening with the Mount Sinai School of Medicine; and a study of smoking cessation in adults with the Mount

Sinai School of Medicine. These are intensely rewarding from a scientific perspective and serve as a reminder of the professional skills resident in at least one managed-care organization.

7. Medical research support. *Partners:* The academic medical community. *Initiative:* In addition to collaborating with several institutions and investigators, Oxford recently created and launched the Oxford Health Plans Foundation. This 501(c)3 organization was created with operating revenue from Oxford Health Plans to serve as a catalyst for change. This vision supports our belief that research must drive change. The foundation will fund a broad range of research with a focus on improvement and creation of better health care systems, outcomes that drive creative solutions, an expanded range of health care options, and enlightenment of the public regarding creative solutions to prevention, wellness, and health. Oxford has a special interest in pursuing studies that focus on the needs of at-risk populations, including those on Medicare and Medicaid, the uninsured, and the chronically ill, and that promote the evaluation, application, and integration of complementary medicine practices.

SUMMARY

The Oxford Health Plans Foundation seeks to create an environment that fosters innovation and encourages new solutions to old problems. That philosophy drives all of the initiatives discussed in this paper. Oxford is optimistic and enthusiastic regarding the potential of many of these collaborative relationships and believes that they can dramatically improve the health status of inner-city populations.

REFERENCE

1. Anderson RJ, Boumbulian PJ. Beyond the safety net in Dallas. *Health Aff (Millwood)*. 1997;16(4):27-29.