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Managed Care and Provider Perspective

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TRANSCRIPT

HEALTH LAW SYMPOSIUM

APRIL 3, 1999

Coral Gables, Florida

I. WELCOME AND INTRODUCTION

[Preliminary remarks]

II. MANAGED CARE AND PROVIDER PERSPECTIVE

TIM RAVICH: [A]llow me to introduce the panelists. I'll start from the audiences' right and work toward the left.

First we have **FRED MESSING**. Mr. Messing is executive Vice President and Chief Operating Officer of Baptist Health Systems of South Florida. Mr. Messing was appointed Chief Operating Officer of Baptist Health Systems in August of 1998. Mr. Messing previously held the position of Chief Executive Officer of Baptist Hospital. He was the Chief Operating Officer of Baptist Hospital from 1986 until his promotion to Chief Executive Officer in 1995. Mr. Messing holds a Master's Degree of Business Administration with specialization in Health Care Administration from the George Washington University in Washington, D.C. He holds also a Bachelor of Business Administration degree from the City College of New York. A fellow of the American College of Health Care Executives, Mr. Messing is currently its regent for Southern Florida. He is on the Board of Directors of the Florida Hospital Association and the South Florida Hospital Association. He has served as chairman of the Florida Hospital Association's "Quality and the Public" Task Force. He was the founding chairman of the Coalition of Miami Dade County Chamber of Commerce and serves as the Chair-Elect at the Beacon Council, which is Miami-Dade County's primary economic development organization. He also serves as a board member of the Sterling Council, the State of Florida's official Quality and Performance Improvement Organization. Mr. Messing, thank you so much for being here; this Symposium is complete with your presence and participation.

The next speaker is **ANN-LYNN DENKER**. Dr. Denker received her B.S.N. and M.N. from the University of Florida and her Ph.D. here at the University of Miami. She is currently the clinical director of the Electronic Medical Record Project of the University of Miami Jackson Memorial Medical Center. She has served as assistant to the chair of the Public Health Trust and clinical nurse specialist for pediatric cardiology. In addition, she was the past president of the Florida Nurses Association and past Chair of Constituent

Assembly of the American Nurses Association. Doctor, thank you for being here.

Next is **KATHY CERMINARA**. Professor Cerminara teaches at the Nova Southeastern University Law Center at Davie, Florida. Professor Cerminara received her J.D. from the University of Pittsburgh School of Law and her L.L.M. from Columbia University School of Law. She chairs a Bio-Ethics Health Law Working Group [. . . which meets monthly]. Professor Cerminara teaches health-law related courses focusing on managed care and ERISA, including ERISA's effect on patient care.

Introductions completed, I turn your attention to our panelists.

FRED MESSING: Great, thank you. Well, good morning. It's a genuine pleasure to be here with you this morning and I appreciate your invitation.

I'd like to start out by telling you a little bit about who we are. We have the University of Miami Jackson Medical Center represented here and I come from Baptist Health Systems. For those of you who are not familiar with Baptist, we include Baptist Hospital, South Miami Hospital, Baptist Children's Hospital, Homestead Hospital, Mariner's Hospital and the Miami Cardiac Vascular Institute. I have responsibility for the operation and coordination of each of these organizations. And so I've got a pretty good sense of what happens in terms of the health care marketplace today, specifically as it relates to the South Florida area and also from some of the linkages that we talked about throughout the state of Florida which we would agree what's happening nationally. But, a lot of my comments are going to be very much focused on what's happening locally because that's my primary area of familiarity.

As we talk this morning, I'd like to provide some insights that will hopefully be meaningful to you and sometimes we end up sort of restating the obvious, and I don't mean to restate the obvious. I came across two quotes that I thought were particularly profound. This is from Calvin Coolidge, "The more and more people are thrown out of work, unemployment results." So keep that one in mind. And the other is actually from Charles Degall, "China is a big country inhabited by many Chinese." We will hopefully keep it a little bit deeper than that.

What do we try to do in the health care industry, or the health care profession? I submit to you that you can slice or dice this thing in one or dozens of different ways, but I'd like to have you think about it from our perspective — what I try to communicate to my folks — and that's our critical success factors. And to me it's clinical excellence first and foremost, service excellence, and fiscal excellence. If I can accomplish those three, I've got a very, very successful organization. And what I would like to discuss with you

a little bit is the impact of managed care and the changing environment on actively accomplishing those.

First thing we talked about was clinical excellence. And when you think about why you go to a health care facility, — I mean it can be real pretty, it can have fancy equipment and everything else, but ultimately when you go there, you go there because you need health care services and the expectation is that they're going to be very, very high quality and very, very well-done.

I would submit to you that the impact of managed care has been a negative one in large part from a facility perspective. Now where you will hear a lot of managed care companies come back and counter that as saying, "Well because of the protocols that we have, because of the continuity of the care we have, because of a lot of other things, we're able to follow up on patients outside of the facility and, therefore, improve the quality of care. And we can do things like, screening exams and again, making sure that diabetics are cared for, and things of that nature." I think that statistically that has not been proven, but I would also suggest to you that periodically that is exactly the case. There were a number of HMOs and others around the country that are actually doing a pretty good job with protocols like that. But from a facility perspective, — and again, we're going to hear more from what happens in terms of nursing — we are trying to stuff more and more care into a reducing amount of time. There's actually a [. . .] strategy on behalf of managed care, which isn't really a strategy, but it's just the way things work out — where if you do the things that do best with a conventional Medicare program, for example, based upon how we get paid, you absolutely get killed in terms of some of the other payment methodologies. Without getting technical, Medicare pays you a finite number of dollars based upon what's referred to as DRG or Diagnoses Related Group. So if you have a protocol that essentially has a patient who presents with that particular kind of problem being treated in a very efficient way, that's a good thing from a conventional Medicare program. However, probably 50% of all patients on Medicare, for example, are paid for in a *per diem*, — which means we get a fixed number of dollars for every day the patient is there. So what happens is that as you reduce the length of stay, as you do a lot of things you need to do, you absolutely get killed because you need more and more patients in a more compressed time period and you're not getting paid for the extra days. So from an economic perspective, it's a contradictory strategy.

What does that do for the staff? Well from the nursing staff perspective, — we have some sick patients who are being cared for in the inpatient [. . .], right now. Many managed care companies will simply not approve the admission of a patient who's not quite that sick. So the population left within a hospital setting, tends to be a very, very sick patient group; they're a very demanding group. In many cases they're an older group than they were

before. They're older, they're sicker, they're hurting and that puts a tremendous strain. Because now you're talking about not only the economics *per se*, in terms of the demands, you're also talking about a nurse shortage that's happening around the country and is probably going to get worse in terms of experienced nurses. [. . .] It becomes such a frustration from a professional perspective that a lot of nurses who are really the most seasoned people we have are just dropping out of the profession. And that fact, from our perspective, is immensely frustrating — the best care-givers that you might possibly want to see, and they're saying, "You know what, there's an easier way to make a living, I have other things to do with my life. It just doesn't make sense to stay in this kind of environment."

From the facility perspective again, the [. . .] economics have so drastically changed, it makes investments in brand new equipment and new facilities that much tougher also. So again, trying to maintain that clinical edge is a very, very difficult thing to do in an era of diminished reimbursements.

From the service perspective, this is probably the most frustrating for us because we're an organization that really prides itself on service excellence. And I think that there are two perspectives that I will talk about. One is emergency departments ["EDs"]. I don't know how many of you have been to an ER in the past year. Relatively long waits, assuming that you weren't life or death. Waiting times have gone up dramatically. Why? Again, I throw a few factors out there. One is that we are under an obligation, legally, to provide care to every patient that presents an emergency for us. So there is no opportunity, — and I learned a while ago that both Baptist and South Miami Hospitals are part of Baptist Health Systems. [So,] I can be sitting in a situation with a Baptist ER has fifty people waiting and South Miami ER has two people waiting, and I can't suggest to them "Why don't you go to South Miami and get treated more quickly," even though we're the same system, the economics would be identical from our perspective because of COBRA and a number of pieces of legislation out there; we cannot do that. So every patient gets at least screened and in all probability treated. The second thing is — I don't know how many of you even try to get an appointment with the doctor anymore, — but, physician practices are overwhelmed. Physicians, more and more, are paid a flat number of dollars, so there is every incentive in the world to take on larger panels of patients. Well, what's happening, unfortunately, is that in many cases, they can't in fact get those folks into the office in a timely manner. And so what happens is rather than waiting two weeks to get your doctor's appointment, you'll say, "Well O.K., I can wait four hours in the ED, it's easier." So a lot of people are trying to go through EDs because of that.

Last factor is the State of Florida law, — and now federal law will probably follow suit, — says that if a patient presents with five symptoms that they would reasonably believe to be an emergency, the managed company must pay for it. So if you know the right words, like I'm in "severe pain," — and you have to make sure it's documented appropriately — your managed care company will, in fact, have to pay for at least the screening exams, and again, in all probability your treatment. So EDs are getting overwhelmed from the service perspective; that tears my heart out when I think about that. We at Baptist Hospital, specifically, right about the time that Hurricane Andrew hit in mid-1992 — we were seeing about 40,000 patients a year through our ED. Last year it was 82,000. I don't know of any organization today, first of all, that's able to handle that kind of road curve. Secondly, the problem with emergency department, — because a lot of people look at the delays and they say, "Why don't you just make the EDs bigger?" — I keep calling them EDs as opposed to E.R. It's an emergency department rather than a room. — And we have, but the problem is that a lot of the reason that there are delays in the emergency department have to do with the services behind the emergency department. We [may] have a patient who needs to be admitted to a critical care unit or [. . .] get over to surgery or if they don't have [. . .] scanners or whatever, you could only do a certain amount from the emergency department and the rest of what happens, happens behind the scenes. And if you don't have the support capabilities behind the scenes, you end up with that patient being held in the ER and the next patient that's waiting out front ends up waiting for a long period of time, — very, very frustrating.

The other thing is, again, as the economics change, the ability to provide enough support staff really gets crunched because people keep saying, "O.K., we're going to cut staff, but we're not going to cut the front line nursing staff." Well, that sounds great but the strange thing is that when you reduce the runners who run pharmaceuticals from the pharmacy to the nursing floor — if that's the first thing you've eliminated — the reality is that the nurse now has to go off the floor, down to the pharmacy to pick up that particular prescription change. If you cut your billing staff, if you cut your maintenance staff, whatever, you find yourself actually impacting patient care, even though it's not directly, it is indirectly because it puts an extra strain on the nursing staff.

Last category that I wanted to talk about goes to what I call, "Fiscal Excellence." What we're having around the country now, — this is not unique to South Florida — is downgradings by bond agencies of health care providers. And that's a difficult situation because what it says is that, number one, [not only are we] going to have a lot more difficulty accessing capital, but number two, when we can, we are going to pay more for it. That then turns around and feeds back into cost of health care services, which is already too

high, but that continues to put pressure on the operating margins, and you end up a little bit with a vicious cycle. There have been people who have talked about the advantages of having a single-payor health care system, and I think organized medicine and the insurance companies and everyone has just said, "I think that's the worst thing you can possibly do." And I would suggest to you that there is a growing number of people in our country who now say, "You know, what? It's not the worst!" [. . .] But unfortunately, we have always had vested interests right now in the form of the insurance companies. And the managed care companies themselves have a very, very substantial income stream, which is coming into their organizations, who have no interest at all in seeing that income stream diverted or changed. So we're going to be going through some very interesting discussions. As a matter of fact, the Medicare Commission, which was just disbanded, I guess within the last couple of weeks, is trying to come up with a uniform approach towards the next generation of the Medicare program, and essentially was unable to reach a resolution on the best way of doing this. And again, a lot of it came down to some departmental issues, on whether you end up with a defined benefit approach where the government would pay X number of dollars towards an insurance package or whether you would, in fact, have the package pretty much parallel to what's in place right now [. . .].

I wanted to touch on three or four other things very, very quickly. I know you all are primarily focusing on the legal side of things, but the management science perspective, the first thing I want to talk about is employees, — employees, in general, — going beyond nursing staff.

If I use the term "strategical alignment," "management and staff," that again is something that is very, very fundamental to the way that we manage. And probably one of the great management scientists of our day, is the guy who writes Dilbert. And he's got a couple that I think are extremely profound. [Displaying overhead of cartoon] This one is going to be impossible to read, so I'll read it for you. I apologize for that. But essentially, you've got a fellow speaking to his manager and it says, "Please make your report consistent with our strategic plan." And you've got the employee saying, "What's our strategic plan?" The manager says, "It's a secret." "Are you saying you don't trust me?" The manager: "I don't think it's a coincidence that most employee sabotage is done by employees." Dilbert: "How can I do my report if I don't know the strategy?" The manager says, "O.K., O.K., I'll let you glance at it." Then he says, "Times up, times up, that's long enough." At which point, Dilbert says, "That's the warranty for your chair." And the manager says, "Really, I've been managing this for years." There is a real craziness that goes on in businesses where you're not communicating to people who work with and for you. It doesn't matter really whether it's

employees, or physicians, or board members, but the reality is that there's not great communication.

I think that there are some wonderful strategic plans out there, but people aren't taking the time to really communicate them adequately with the people that work with and for them. Same thing with employees. You can look around the country time after time in terms of major re-engineering efforts and there's an absolute breakdown in communication and linkage to what's happening around you. We're going through some very difficult times in the health care environment right now and I thought it was particularly interesting. — We did an employee survey; I think it was around 1994. The first one we got in a formal way in a number of years. And we asked people about positive and negatives in organization and their work environment and so on. Anybody know what the single largest dissatisfier was? I know a lot of things come from salaries, working hours, number of staff, whatever. One word: stress. People were so stressed out. It genuinely surprised me. And when you start looking at the reasons why people are stressed out, they're multiple. In some cases it's because, you know, "I've got too many patients and I don't have enough staff, or I've got real problems trying to run my home life or my kids, or it's getting to work everyday, or it's whatever it is." And what we concluded was that we could not fix the causes of stress. We could treat some of them, we genuinely could. We couldn't fix the reason that people get stressed. About the best we could do was fix what we could fix, but then try to help people learn how to deal with stress. And I would submit to you right now that stress continues to be, probably, one of the major problems. And I think unfortunately undiscovered problems can be much of our work environment, and I can tell you its rampant in the health care field.

Next we're going to talk about, and I know you're going to hear a lot more about, later today and this afternoon, that's physicians. We routinely go on scraping doctors off the walls, and they're bouncing off the walls, left and right. It is a very difficult time for most doctors out there. They are seeing their incomes diminish, not only substantially, but radically. Those of you who are married, or something, [. . .] you go home to your spouse, and you try to explain that some of the things that you've become used to doing in your family life, it doesn't matter what your economic level is, — are no longer going to be sustainable. And whether it's your kids going to private school, whether it's the size of the house, whether it's money going to the retirement plan, or whatever — that's a very difficult message to convey to anybody. And some of the solutions that doctors are coming back with, — we occasionally hear about dishonest physicians and I would suggest to you that that's a microscopic number, just like it is with health care managers —, but I don't think that's really a reasonable reaction, — or we continue to see this proliferation of physicians doing partnerships or doing joint ventures, or

whatever, — trying to get part of the ancillary dollars, because there's recognition on their part that says, "Wait a minute, why are those patients and those dollars going to the hospitals, we're the ones who are referring the patients out; we ought to at least have a fair share or at least have a crack at doing that." We're beginning to see some of those start to surface again. There's been a real rampant phase and then the Stark Laws¹ came out and they kind of diminished to a large degree and you started to see a resurgence. As a matter of fact, a major piece of legislation that's going to be in Florida, the legislature this year is [. . .] an effort to overturn the *Wingo* decision legislatively.² That's something I hope you all will be talking about later. That can have a pretty profound impact because something will probably move on that this year. This is a major effort and it looks like it's got the votes to pass.

The other thing is physicians are taking on larger panels of patients and that again, leads back to what I was saying earlier because that goes back to the difficulties of getting into the doctor's office. That again is a major frustration in terms of people's interaction with their physicians.

The last thing, information systems and communications. Right now everybody is focusing on the infamous Y2K and the cost of doing it is mindboggling. We don't know, quite honestly, whether in [. . .] we are going to end up with major issues or whether they're going to be minor glitches and nobody knows. But, I've got to tell you that from a legal perspective, from a potential liability perspective, I've got to be damn sure that I'm doing everything I can possibly do to provide the safety of the patients who are going to come in contact with us. — Very, very complex, multi, multi, multi-million dollar endeavor for us and I will guarantee you it is for virtually every other hospital in the country. I don't know how many billions or hundreds of billions of dollars will be spent on this by the time we're done.

We see tremendous opportunities in the technology that's occurring right now, whether it's the internet or other type of communication techniques. The opportunities are tremendous. The reality is that, up to now, the results have been microscopic. We have not seen anything really exciting and one of the problems is that the methodologies and mechanisms we have right now are not particularly user friendly. Particularly when you think about the highest risk group of folks, — when you're talking about older Americans. You've just got a lot of people who are sitting down and in many cases can use computer terminals in very sophisticated kind of ways. Over probably the next decade, as the technology improves, as we get interactive voice, as we get into more

¹ 42 U.S.C. § 1395nn (1999).

² *Agency for Health Care Administration v. Wingo*, 697 So.2d 1231 (Fla. 1st DCA 1997).

television-based rather than PC-based kinds of communication methodologies, I think we have a tremendous, tremendous opportunity to improve preventive and follow-up care, to take chronic patients and really do the kind of follow-up we talked about [. . .] on the HMO side. Again, tremendous opportunity and marginal performance as of right now. That's a very, very exciting opportunity.

Having said that, I'm going to turn it back over and be happy to address any questions . . .

ANN-LYNN DENKER: Thank you. I'm going to stay seated because I already ran ten miles this morning, so . . . I'm Ann-Lynn Denker and I'm a nurse, and . . . I come from the University of Miami Jackson Memorial Medical Center. [That facility is] an academic teaching hospital; it is a public facility and it has a private partnership with the University of Miami School of Medicine. It is actually the only partnership like that in the country and it's very unique. In other words, the University utilizes Jackson as its teaching facility, and in turn the doctors from the University care for the patients at Jackson Memorial Hospital. And we've had a long history in this community and in the early 1970s, when we were what was termed a "County Hospital" and the vision that you might have about thinking about county hospitals around the country. Clearly we've worked really hard to make Jackson have a different image. We became, through an ordinance with the county, governed by a group called the Public Health Trust and its group of voluntary citizens that are appointed by the county commission who actually are responsible for running the hospital.

. . . When I first went to work at Jackson, early in the 1970s, we were in a situation where we had very poor facilities, we had very limited resources, patients had to wait a long time for services and generally, people really didn't find it a place they would really want to come to. The problem is that if you're a teaching facility and an academic center, you want to be excellent, you can't only be taking care of poor people. And so, we were threatened with loss of our accreditation, and had some very serious problems there. And we have worked very hard over the years to up-grade that care — do a kind of single standard of care, that not only people that have nowhere else to go, but that other people would actually choose to go to such a facility. In order to do that, we depend very much on paying patients that include not only private insurance, which is virtually non-existent now, but Medicaid, Medicare, which has always been our lifeline and we have a dedicated funding source that this community, the voters, actually approved. That's a half a penny; that's why we have 6.5% sales tax right now that helps fund the medical center, [. . .] which . . . [is] sometimes very controversial in this community. Because we are a public hospital, we do everything in the sunshine, which sometimes puts

us at a disadvantage, to compete with our competitors. People scrutinize all of our pennies that we spend often because they are public pennies and they should be scrutinized.

The Public Health Trust was developed to try to get Jackson and its functioning out of the county commission's politics. It has made our functioning less bureaucratic because we actually make decisions there at the Public Health Trust; however, it has never taken away the politics and we were talking about politics and that's the way it is, it is there in health care and its grown much more every day. Because I've always worked in a public setting, and I was brought up in this system where you provide care to everybody regardless of their ability to pay, watching the times change and managed care develop and medicine for profit [become] a very strong part of our economy and our culture, I've seen changes that I just thought I would never see and you have lots of mergers, alliances, partnerships, all kinds of things happening. I remember the first time they told us at Jackson that we would have some relationships with Columbia and most of us thought that was horrible. How could you have a partner? And there are still people that think that, actually, it is a business; well, it's all a business and we have to watch our dollars also.

I'd like to give you a little perspective of health care from the perspective of nursing and, of course, I'm very biased and I'm an advocate for nursing and if you know about health care mostly from T.V., you probably don't have a very good vision of what health care is about. Let's put it this way, the purpose of a hospital is for people to receive nursing care, and so nursing plays a very significant role. And as health care has moved out of hospitals and to other kinds of facilities, the primary purpose of most health care is to receive nursing care in many different forms, from very primary care to very acute care.

Nursing has had a lot of its own problems over time. It's been primarily a female profession. Some would say it's had its problems in competing with other specialties including physicians. My first nursing job, I'll never forget, actually, — nurses would stand up when a physician walked into the room, and so [today] we have a very different kind of health care system. We have everybody competing. If you think back to the last presidential election, when health care reform was the big topic: Do you remember the people we saw on T.V., it was the advertising from the insurance industries and they said, "You know, the government wants to get into health care and that's the most horrible thing" because they showed this couple, Harry and Louise that said, "I like my health care. I have insurance. I like my health care." How many of you have had a negative experience with health care in the last year in terms of accessing it for you or your family? Just one person? Everybody! It is not an easy experience. When we were talking, — even for those of us that have

deep connections into health care, it's a very difficult system to maneuver nowadays. You have to be tough and smart and very demanding. Anyway, at that time, physicians were kind of on the side of Harry and Louise because they kind of liked the way it was too.

. . . Health care reform really didn't go anywhere in terms of a big plan. We've had what we've called "incremental reform" and that has just been piece-meal things — mostly directed by insurance companies and so it hasn't been, I may be biased, but it hasn't been to the benefit of patients and I don't even think that at many times it has been to the benefit of providers as Mr. [Fred] Messing was saying. I consider him a hero. He talked very positively about nursing and the importance of it. Around the country, unfortunately, not all administrators have been like that and they have seen one of the easiest ways to decrease costs has been to get rid of many of those very expensive nurses and replace them with other kinds of unlicensed, less-skilled people. So much so that there are facilities in this country where the typical name tags that providers would wear with their name and their title and their identification were not including those credentials on people's nametags. So everybody's nametag looked the same. So if you were a patient in the hospital, you may not have even known who was taking care of you and who's a nurse, and who's not a nurse.

One of the things that the American Nurses Association has really worked very hard at is trying to educate the public on what they should expect when they access health care and they have a pamphlet that's called, "Every Patient Deserves a Nurse." And that does not mean that in a hospital every patient has an individual nurse. But what we're saying is that every patient's care should be directed by a nurse and that every patient should have a plan of care, know who their nurse is, know what's in their plan of care, and expect certain amounts of teaching, education, and so on. There's a lot of people called nurses. If you call a physician's office to make an appointment, sometimes they say, "I'm the nurse," and you often don't know who that is. Currently, there is some legislation in Tallahassee that is tied to some other kinds of activities, particularly, Tele-Health, that we have been trying to get through, in terms of who can use the title of nurse because it's very confusing to the public and to the community. There are skills that professional nurses have that less costly providers frequently do not have.

One of the other things that we've been very concerned about is the "Patient Bill of Rights." And during the health care reform movement that we had a couple of years ago, the American Nurses Association had an agenda for health care reform. And it was actually seen very favorably by both parties, by both sides; it was bipartisan — because it primarily looked at issues of access and people having choice and being able to have quality care and to have primary health care. And it was really not much oriented towards

money, income, that type of thing, and maybe that was why nurses don't make a lot of money. They do O.K., but in terms of some of the other providers, they don't, but nursing traditionally tends to be a very caring profession.

There have been many different models for providing care over the years. And I would watch the nursing shortages come and go and it's very interesting because it is cyclic. For a period of time we had glut of nurses and now we're getting ready to head on into a shortage, which is all over the country. There are a lot of reasons for that. One is a lot of women have found that they can access other professions easily. At one time there were not a lot of opportunities and choices for women. Nursing is a hard profession. You work really hard. Patient care is really difficult. Also, there's also a "glass ceiling" in terms of advancement. The only way that many nurses can advance, — what happens is that the really skilled clinical nurses, — is that in order for them to advance, they need to move away from patient care into administration. And nursing is tough, it's hard. It's hard physical work and it's hard emotional work. I've seen all kinds of models of care come and go and right now we're at the time, where, as Mr. Messing said, . . . patients in the hospitals are sick, they're really sick. Nobody gets to go in the hospital anymore unless you're really sick. We envision down the road that hospitals will be much more intensive care centers and a lot more of the care will be on the outside in outpatient settings. So you have fewer nurses, sicker patients, and less time in which to take care of them. You know that if you're going to have surgery, you don't get to come the day before anymore, — and they bring you in really early in the morning and before you can have any teaching, or education about your condition and how to care for yourself, you're shipped out and on your way home. So it does make it very frustrating for nurses.

Some of the issues that nurses have to deal with in terms of legal matters have to do with licensure. And each state varies. Nurses are licensed by the state. When we talk about Tele-Health, it's a whole new idea that people can be in one state and practicing in any other state. So there's a lot of legislation looking at some kind of single licensure that would allow people . . . so that there would be some regulation if you're living in this state, and you're practicing here, but you're giving care in another state, where would you be disciplined if you have licensure problems?

The other thing is, — how many of you are familiar with the term "Advanced Registered Nurse Practitioners?" These are nurses that have additional training in primary care and physical assessment, and it's been a long battle for the nursing profession. There [are] studies that show that nurse practitioners can provide approximately 80% of all the primary care that's needed in this country. Well that's very threatening to our physician colleagues. But the idea is that physicians whose training and schooling is much longer and much more expensive should be doing more complex,

difficult kinds of activities, whereas nurses can be doing primary care. And we've been in turf wars and constant battles with our physician colleagues over these licensure issues. In rural states, advanced practiced nurses can practice independent of a physician. Now the reason for that is because nobody wants to practice in those areas. So what we say is "If nurses can practice effectively in those areas, why shouldn't they be able to provide that same kind of care in other areas?" — very strong physician lobbies from the American Medical Association and the Florida Medical Association every year in Tallahassee — we get *that* very much. In Florida, the way nurse practitioners function [is] under the supervision of a physician. Now it doesn't mean that the physician is standing there supervising you but you have to have some kind of arrangement and agreement with a physician when you work under protocols. We have been working very hard for many years to try to take those supervision items away. Part of the reason is what it does in terms of adding to the cost of health care. If I have to, say I am a mid-wife and I have a practice and I see patients. And I will refer my most difficult patients, the patients that have either high risk and have complications back to a physician. But, in order to have a supervising physician I'll probably have to pay that person for every patient that I see and manage. So, it adds a cost to health.

There are many studies that show nurses utilize fewer tests, patients have less surgery, have shorter lengths of stays, recover quicker just because of their approach to care. So that's been a big controversial situation throughout the country and in this state. Nurses have had to fight for Medicaid and Medicare reimbursement and we recently have gotten that in the past. What would happen is the physician would get the reimbursement and give some to the nurse. [. . .].

I mentioned the title "Prescriptive Authority" — is another issue. In this state nurse practitioners have prescriptive authority but not for controlled substances. So if I'm a nurse practitioner and I'm managing a patient and they need a controlled substance I have to go to one of my physician colleagues and either borrow their DEA number or have them write that prescription. In many states nurses do have prescriptive authority. The federal government [which] issues the DEA numbers has no problem with nurses having these numbers. I have had the opportunity and the horror to testify before the Florida legislature about the need for nurses to have access to prescriptive authority and I've had physician colleagues say, "Are you going to let these nurses have the ability to prescribe dangerous, life-threatening drugs?" Well, the truth of the matter is that nurses prescribe life-threatening drugs of all sorts everyday. And its just another, what we see, is another turf war and opportunity to try to keep nursing down or in its place. But if we're really going to provide enough primary care to all the people in this country, if we

were to have universal health care today, and those forty-one or forty-two million people that don't have insurance were finally in the system and had the opportunity to have a primary care provider, we would not have enough physician primary care providers today. So those are all some of the issues about economics.

I'd just like to mention one other thing, a little bit about the labor work force. It's clear nurses are being utilized more and more in terms of — for primary care. Many hospitals that have internship and residency programs, where those programs are being decreased, in terms of the number of residents that they have, — and you know interns or residents have always been used as cheap labor for health care facilities. Many places are utilizing nurse practitioners in their stead to do much of that type of work. There are a lot of opportunities, I think, in health care and managed care in many ways now that nurses have begun to understand and accept the fact that all the care will not be provided in hospitals. So there's a lot of opportunity in terms of managed care for nurses in terms of being primary care providers.

Nurses have always been integral parts of hospitals, in the administration of hospitals and there's no reason why they can't be integral parts of managed care. [. . .]

KATHY CERMINARA: As Tim mentioned I'm Kathy Cerminara and I teach at Nova Southeastern University School of Law. I'd like to pull some points — legal, political, socio-economic points out of what we've heard from our two providers today. Lengthened with a few of a things we on the outside see or read about or hear or fear are happening — and just quickly make a bullet-list of points, ways in which it seems that the advent of managed care has affected provision of health care in this country. And then I'd like to open things up to questions either from you or to allow either of the panelists to respond to the things on the list or the things they've heard each other say.

Very, very quickly, I think we've heard from Fred [Messing] and Ann-Lynn [Denker] today that we do see, no big surprise, an increased emphasis on cost cutting, on business, both not-for-profit and for profit health care. Institutions, of course, operate to earn money. But I think we see a shifting emphasis as more institutions take on for profit status, or more for-profits look at their books. We see capitation and *per diem* measures, putting the time crunch on individual practitioners and on institutions. We see the high-tech end of health care of electronic health care, telemedicine, things as simple as voicemail and messaging, — allowing people to leave messages and to have the physicians reply for them. My physician allows you to call in for your confidential test results, so that you never need to speak to a person, never need to take up anyone's precious time but still knowing the results of your care! I think these things add distance between patients and caregivers

certainly affects the landscape. We see increasing use of alternative, well not alternative medicine, but caregivers other than MDs, — nurses practitioners. We see use of physician assistants. We see use of other people certainly aside from the primary care physicians and the admitting physician in an institution.

Something [the other] speakers didn't mention but is beginning to surface, I'm not sure how common it is in South Florida yet, is managed care companies that put hospitalists in place, once a patient is admitted to the hospital, to coordinate care within the hospital setting rather than allowing the admitting physician or the primary care physician to do so. We see mergers and acquisitions, until, for example, major entities such as Aetna have a presence in all or nearly all the U.S. health care markets. In fact, we don't have a single payor system, but what we may end up with, some health care economists would say, is something that looks an awful like the Clinton Health Care Plan [i.e.,] one major provider in each region of the country. It just would come about privately through mergers, acquisitions, and perhaps resulting bankruptcies of those entities that are squeezed out of practice. Because we have seen some bankruptcies and we may see more in some instance such as that of Allegheny Hospital in Pittsburgh. You see large entities with academic health care components and major research facilities that have filed for protection under the Bankruptcy Code. You see the government attempt to encourage, if not require, Medicare and Medicaid patients to engage in managed care rather than traditional Medicare and Medicaid coverage. And we see the government increase its efforts to police fraud and abuse, both among individual practitioners and among entities of institutional caregivers including, once again, the academic medical center. I think a lot of these things many of which were touched on by our speakers certainly are indications of the changing health care landscape, — much of which have been brought about or at least highlighted by the event of managed care. I guess first of all I'll invite either of the panelists to respond to any of the things I just brought up. And then also, please, we would love to have, I'm sure, questions from the audience.

ANN-LYNN DENKER: There are so many areas. We could sit here all day. I thought of a couple of things. One is the area of corporate compliance — [. . .] that is an area that I think most hospitals, or all hospitals, should be working on very diligently. The government [has] lost a lot of money in Medicare *per se* and they're out there to get it whether you have fraudulent intent to scam and steal from the government or whether it's just because your systems are not in place. So I think that's one area that has come about in this environment and we really are working on.

FRED MESSING: I . . . make a few points . . . One is, you know what, people need hugs. There is a holistic side of medicine that unfortunately, as we get more into the scientific bases of medicine, gets short-circuited and your [Prof. Cerminara] example [of] not having to come into contact with a human being to get a result., — now you get a number back, [. . .] you get a result back — it could scare the hell out of you and what do you do with it? There needs to be a certain amount of human interaction. Again when I talked about service excellence — that to me is a part of service excellence but it's also a part of clinical excellence. And that's, I think, one of the reasons that alternative medicine or collaborative medicine has caught on because I think one thing that sector does magnificently, in large part, is it communicates, it feels, and it interacts with people. That's a scary part of what we are losing, I think, in our health care system. As more people come into emergency departments for care, that's not the way you create a warm relationship.

The hospitalist issue that [Kathy Cerminara] touched upon is one, it's of concern. I don't look upon hospitalists as being good or bad inherently, for 15 years we have had intensivists. These are people who basically run intensive care units. It's so complex that we recognize its being on the scope of many of the private physicians but again, it's up to the individual physician to determine whether or not an intensivist will be involved. I think it ought to be up to the individual as to whether a hospitalist would be involved. It's a lot more efficient way of dealing with inpatient care. But again you're down to the same problems of it breaks the continuity of care.

The last thing I wanted to touch upon, when you talk about the stresses and the strains of the system, there's one concept we haven't gone into, that's the entire issue of pharmaceuticals. When you look at the biggest driver of patients into Medicare and other kinds of HMOs it's because you've got this huge actual, and [in] many cases potential, expense that people are going to be going through that's really not picked up under the conventional Medicare program. There's at least one prediction that says that by the year 2005 the pharmaceutical expense part of the equation will equal the hospital part of the equation. And when you take a look at some of the break through drugs and some of the approaches being used right now I think you can really kind of envision that.

The other thing which has had, I think, a little bit of an unexpected result has been this advertising kick. Because now that pharmaceutical companies can advertise directly to the public we've now got patients coming into doctors offices saying "I want a prescription for this" and the doctor says "You don't have that problem." [The patient] would say "it doesn't make a difference, I want a prescription for it." You know what, it's going to take the doctor 20 minutes to talk you out of it. It's going to take 30 seconds to right the script; it doesn't make sense not to write the prescription — you got a

happier patient and you have more time on your hands, so it works out great. The pharmaceutical industry is one that is going to need a great deal of attention from a regulatory perspective. It is very frightening because that's a totally uncontrolled piece of the equation right now.

ANN-LYNN DENKER: I have one comment and that's the area of bioethics. [. . .] I have been a long-term member of our bioethics committees; we have a child and an adult committee. It's going to be playing more and more of a role as these difficult decisions have to be made. I just, real briefly, want to share a case we had this week. A woman that's Jehovah's Witness, 24 years old, due in about three weeks. She also has a genetic-type of blood disease where she does not produce platelets. It's such a disease it's not amenable to any kind of medications. So regularly a person with this kind disease could live a pretty normal life by getting blood transfusions or platelet transfusions. And because this woman [is a] Jehovah's Witness she will not do that. And now that she is pregnant and near term, and her blood levels are very low, — and there's very big concerns about her hemorrhaging, bleeding before delivery or during delivery and the possibility of the [effect] on the baby, — and even the concern about having the baby to be transfused. We have protocols and procedures and things that we usually approach. People have a right to make their own decisions in health care. And we always try to respect those rights. So if the woman does not want a transfusion, she will not get one. But it's complicated by the viability of the baby. We would also, clearly, when we have a baby that needs to be transfused, we will, in an emergency situation, transfuse the baby based on the idea that the baby has not had the opportunity to make choices about their religion and/or go to court if there was time. So we had these two situations and we had like a two hour deliberation. Also you have the concern of the physician being sued if he does transfuse the woman, he's going to get sued; and if he doesn't transfuse the woman he's going to get sued. It's a very difficult situation. We came up with something that would help the situation. [. . .] This woman lives in Homestead, [Florida], which is a ways from our facility, so we decided the best thing would be to hospitalize her right now at this moment because the physicians can take that baby from her in the time period of about three minutes. Even if it would mean she might not survive, the baby would. Well what do you think happened? Medicaid surely was not going to approve this little three week stay at Jackson Memorial Hospital. But we went ahead to make a decision to do what we thought was right and in the best interest. But somebody has to pay for that three week stay at Jackson Memorial Hospital. So that's another instance how managed care can affect so many parts of a person's care, — not only the medical parts but the psychological parts — and for all the providers and the torment that they have to go through in terms

of how to deal with this. So, it's very complex and very interesting. I think that the questions and concerns are going to become more and more complex.

(From the Audience): Yes. Let me ask you a question and this is purely informational. I hear Ms. Denker say that patients that are going into hospitals are really sick and they have to be tough, smart and very demanding in order to get what they are there for. I think Mr. Messing said the same thing. My question is, O.K., so everyone is looking out for the dollar, who is looking out for these patients? Obviously, if they are that weak they can't be tough, smart and that demanding. Do we have an ombudsman system [. . .].

FRED MESSING: Let me start out by commenting on that. I wouldn't phrase it exactly as you did in terms of looking out for the dollars. I think what is happening is we are trying to do a lot for these patients in very limited amount of time. The sophistication of what we are doing is very high. And you know, when you think about *that* much being done to someone whether it's the medication, whether it's a test or whether it's whatever, it really is very comforting having somebody looking over your shoulder. Because one of the things that happens is you're pretty much out of it for a period of time, — again because you are that sick when you're there — at about the time when you're now lucid enough and attuned enough to know what's going, [you're] on your way out the door. O.K., so it's a matter of, I think, — and in many cases, people actually suggest having a family member, if that's at all possible, as kind of like your advocate or your ombudsman or whatever, — but having some kind of linkage to you during your hospital stay. We've got a lot of checks and balances built into the system, but I think that in a lot of places around the country, — and I'm not going to focus on mine, because I think we do things and others do things that are maybe a little bit more supportive and protective — but I think it's always a good idea to try to keep a family member or trusted individual real close by and have them kind of keep an eye out for you. I think it's just a good thing to have if you can.

ANN-LYNN DENKER: You would hope that your health care providers would be your advocate and sometimes they may and sometimes they may not. But that's one of the reasons that we are so insistent that the public be educated on what they should expect and how they can go about it. And I know that at both Baptist and at Jackson we have bioethics committees, we have patient representative services. And my dad was a patient at Baptist and those people worked very closely with me. But you do have to be aggressive enough to know what you are not getting. Unfortunately, that's where the system has gone. I think all of us would like to improve it to a greater extent but I think anybody in my family that's in the hospital, I'm going to be there with them.

(From the Audience): And I appreciate what you are saying but I think a family member may not be adequate in these situations unless somebody is there to explain the legal rights and what the medical possibilities are.

ANN-LYNN DENKER: Well all hospitals have risk management departments. They have bioethics committees that people can access both patients and families or anybody else. There are state regulatory agencies that you can access if you really feel, — and I tell you, if you contact them they will be at the door of the hospital the very next morning. So there are mechanisms, but people have to be knowledgeable about them.

FRED MESSING: Yeah, I'm also not at all suggesting that there are rampant errors or intentional errors or anything else going on. The point being: it is a very intensive period of time. A lot is happening to the individual and you, as a patient, are kind of out of the loop in many cases just because of, again, — whether it be physical condition, pharmaceuticals or whatever, having somebody else that's also watching out for you is just a good thing to do. Again, it's not a matter, I don't think, that there are rampant errors being made with great frequency. I think it's just another safety level. I think we got a lot of checks and balances in place. That's just another one we would suggest.

ANN-LYNN DENKER: And consumers need to play a bigger role. I mean consumers really need to, — if they feel that their providers and the facilities that they go to aren't adequate or meeting their needs they need to be making enough noise and going to places to get care where their needs are met.

TIM RAVICH: At this point, I'll have to close the discussion. [. . .].