

Dear Alumni and Friends,

ANYONE FAMILIAR WITH HEALTH CARE IN BUFFALO knows that fundamental changes are under way following legislation that was passed last year mandating the restructuring of area hospitals. The legislation, which was based on recommendations made by the state Commission on Health Care Facilities in the 21st Century, required, among other things, that Kaleida Health System and Erie County Medical Center consolidate their operations and form a new nonprofit corporation that is aligned with UB.

The goal of the new law is to improve the delivery of health care in our region by creating a more integrated and efficient hospital system that is focused on providing quality care rather than on fueling competition between unaffiliated entities.

Many cities, including Pittsburgh, St. Louis and Cleveland, implemented similar measures over a decade ago in response to the same outside forces Buffalo can no longer afford to ignore. These forces include (1) an excessive number of inpatient beds and the inefficient utilization of facilities that house these beds; (2) reduced reimbursements to hospitals and providers, which undermine the long-term financial stability of systems; (3) the negative consequences of competition, such as the purchase of duplicative technologies; and (4) improvements in medicine that have led to a shift away from inpatient facilities and a greater emphasis toward outpatient-care delivery.

Once the new hospital corporation board's charter is finalized (which I'm anticipating will have happened by the time you receive this issue of *Buffalo Physician*), efforts to reengineer our area's health-care system will then focus on the important task of clinical-service line strategic planning. This task will be mandated by the new corporation's board of directors and driven by UB's Academic Health Center and hospital and physician leaders. Its success requires active participation of teams of physicians, other care providers



and hospital administrators having expertise in each of the identified clinical-service lines.

By identifying and putting in place carefully planned multidisciplinary clinical-service lines, we will be establishing system-wide operations that will integrate care, improve efficiency and provide the structure needed to provide a consistent standard for quality assurance. I am confident that, in the long term, these changes will drive the revitalization of health care in Buffalo.

The first step in the planning process will be identifying what the clinical-service lines will be and how

many. There is no preset number, as this is something that is determined by the needs of a community—some university hospital systems have as many as 18; others as few as 12.

In this phase of planning, we will not only discuss how best to integrate existing services in Buffalo, but we will also identify critical gaps in services. This latter exercise will present us with an opportunity to ensure that Buffalo has the same services available to its residents as do cities of comparable size, thereby assuring that patients no longer have to leave our region to obtain the treatments they need.

By organizing the delivery of health care around proactively planned clinical services—new or existing—we will be forming centralized, core groups of expert providers who in turn will have the “critical mass” to draw sufficient patients through referral networks. With a revenue

stream assured in this way, hospitals and providers will be able to reinvest in further improvements of facilities and services. Fortifying service lines is a magnet for new faculty, strengthens graduate medical education programs and attracts and retains community physicians.

Decisions regarding the location of these services, personnel hiring and equipment purchases would then be determined in a coordinated, system-wide manner. This in turn makes it possible to take into consideration a community's demographic and epidemiologic profile. For example, do we need special services that accommodate the needs of an elderly population, or that address the realities of high rates of obesity, stroke and heart disease? In designing inpatient and outpatient floor space, do we include endocrinology in the cardiovascular service line and co-locate it next to the pulmonary service line because many patients with heart disease have diabetes and emphysema? If an outpatient with heart disease needs a pulmonary function test, can we have this capability down the hall as opposed to down the street?

When organized in this way, clinical services have the potential to represent “centers of excellence.” A recent development that further supports this potential is the formation of UBMD, the university's single-practice plan. When you align such a plan with highly integrated clinical-service lines, you are then in a position to develop metrics of quality assurance and “user-friendliness” because you have two powerful groups that can demand of themselves a certain level of quality.

Related to this is the concept of reciprocity of services among physicians. For example, if I am a cardiologist who has a patient who develops diabetes and I request a consultant from endocrinology, what are the expectations? How long do I have to wait for the consultant to see my patient: two hours? twenty-four hours? one week? What will the standard be for

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this? Once this is determined, then everyone is held to the standard.

I don't need to detail the economic advantages of such a coordinated and cooperative system. Suffice it to say that hospitals and physicians will be able to respond to needs with thoughtful analysis. They won't be compelled to fund two underutilized cardiac catheterization suites for the sole purpose of maintaining a presence at two locations for competitive reasons.

Increased profits derived from efficiency make it possible to fund state-of-the-art facilities that in turn

can attract and enhance the university's clinical research efforts. If we have a new, integrated pulmonary-allergy-immunology service, for example, it only makes sense that space be allocated on this service for related clinical research.

The same holds true for undergraduate medical education, graduate medical education and continuing medical education. Well-integrated, multidisciplinary clinical services are ideal settings for teaching. Conference rooms can be located on service floors, providing private space specifically designed to facilitate learning.

Having taken part in similar planning strategies prior to coming to UB, I know the value of being able to actualize change of this magnitude, especially when the “status quo” is no longer an alternative.

I am confident that changes, such as I describe here, can take place in Buffalo, and I look forward to the opportunity to work with you to help drive these needed changes.

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