IMPLEMENTING HEALTH REFORM

Physician-Owned Specialty Hospitals

The criticisms of physician-owned specialty hospitals are chiefly that they receive the same tax breaks and insurance payments as do traditional hospitals, but don't provide the same breadth of care (no labor and delivery, no emergency care), and that they are rife with conflicts of interest. Periodically, the federal government has imposed moratoriums on physician ownership, but even so, the number of facilities has grown.

Now, a provision of the Affordable Care Act bans the construction of new physician-owned hospitals that do not receive Medicare certification before Dec. 31; existing physician-owned facilities have been prohibited from expanding since the law was enacted on March 23.

Dr. Jack Lewin, CEO of the American College of Cardiology, talks about the upcoming ban on physician-owned specialty hospitals.

Cardiology News: What finally moved Congress to approve permanent restrictions on physician ownership?

Dr. Lewin: Strong opposition from hospitals was very effective in protecting their interest. There are legitimate concerns related to specialty hospitals in some communities – for example, where services for low-income patients may be jeopardized by the shifting of high-revenue patients from public and community hospitals to specialty hospitals. This is certainly not a phenomenon everywhere specialty hospitals exist.

The ban notwithstanding, the way care is provided will change due to public and market pressures.

DR. LEWIN

The contrary position is that specialty hospitals provide services at a higher quality and a competitive cost, which benefit patients. If legitimate problems were caused by the introduction of a hospital into a community, it would be better to address the concern in approving the new facility rather than to create an outright ban, which is all too often simply an anticompetitive effort of the existing traditional hospital.

CN: Critics cite improper referrals and higher procedure rates among their reasons to ban physician-owned hospitals. The ACC is against a ban. What is the argument for physician ownership?

Dr. Lewin: The ACC supports a policy that promotes better medical and clinical quality outcomes and patient satisfaction. There are a number of ways to protect against physician self-interest, self-referral, and overuse of services. The use of ACC registries could readily identify such problems. In many instances, physician investors in these facilities are limited to less than 1% of overall ownership. It is hard to argue that this in itself is an unfair self-interest, in particular when there is no source of funding available to improve the situation in communities where operating rooms are overbooked, understaffed, and ill equipped. In other words, the ACC supports assurances that physician self-interest is not the key factor behind a specialty hospital, but rather that the central issues are the best interests of the patient and community, and the quality of care.

CN: How can physicians ensure that appropriate and high-quality care is being delivered at specialty hospitals?

Dr. Lewin: More than 2,400 hospitals participate in the ACC's NCDR (National Cardiovascular Data Registry) programs, but by using just a few specialty-hospital registries, we could provide objective feedback and comparisons based on clinical data, rather than on claims data that insurance companies and the government use. Our registries provide access to data and feedback on quality outcomes, system problems, and rates of complications. If specialty hospitals were required to participate in these registries, most of the concerns could be mediated.

CN: Does the ACC support legal challenges to the coming ban on physician ownership?

Dr. Lewin: The ACC believes that the ban should be lifted and replaced with thoughtful policies that allow for specialty hospitals to improve access, quality, patient satisfaction, and efficiency. These policies could address concerns about self-referral, self-interest, or adverse impacts on other needed community-based hospital services.

CN: What would the ACC propose as an alternative to the ban?

Dr. Lewin: The ban notwithstanding, the way care is provided in the United States will change due to public and market pressures. Community hospitals will continue to need to provide emergency surgeries, general intensive care, and other services as currently provided in the traditional model, but the ACC believes that the best care and services will evolve into specialty units that focus on increased volume and increased quality in cardiology, orthopedics, gynecology, trauma, neurosciences, oncology, and other specialized areas. This will include pediatric as well as inpatient services. If we are serious about promoting the best outcomes, best quality, and patient and physician satisfaction, then this is where we are headed, regardless of the politically inspired ban. ■

Education Reforms Needed to Implement Medical Home

BY JANE ANDERSON

FROM A HEALTH EDUCATION SUMMIT SPONSORED BY THE CARTER CENTER

Implementing the patient-centered medical home is not enough to improve health care quality – physician education also needs to change, emphasizing team-based approaches to medical care, participants said at a summit to discuss training gaps in primary care, behavioral health care, and health promotion.

The summit, held at The Carter Center in Atlanta Oct. 5-6, examined whether medical students are being trained appropriately to function efficiently and effectively in the newly reformed health care environment.

"Purchasers are actively choosing to buy different kinds of care" because they can't find the types of health care they need in the current system, said Dr. John Bartlett, senior adviser for the Primary Care Initiative at The Carter Center.

IBM, for example, is actively searching out communities that offer patient-centered medical homes, and is moving away from communities where it cannot purchase this type of care, he said.

"Private purchasers are getting tired of paying the price of poor-quality medical education," Dr. Bartlett told reporters in a conference call convened Oct. 6 to discuss the meeting's conclusions.

Meeting participants identified several key deficits in the U.S. medical education system, according to Dr. Michael Barr, senior vice president for medical practice, professionalism, and quality at the American College of Physicians.

"We train people separately and expect them to work together," Dr. Barr said. "The current education system doesn't seem to value that type of training environment."

In many programs, physicians-in-training don't meet actual patients until relatively late in their training, and many curricula don't emphasize the types of mental health issues that primary care physicians will need to practice, he added.

Some medical schools have implemented educational programs worth emulating, although implementing those programs on a large-scale basis might require changes in medical school accreditation requirements and regulatory requirements, Dr. Barr said.

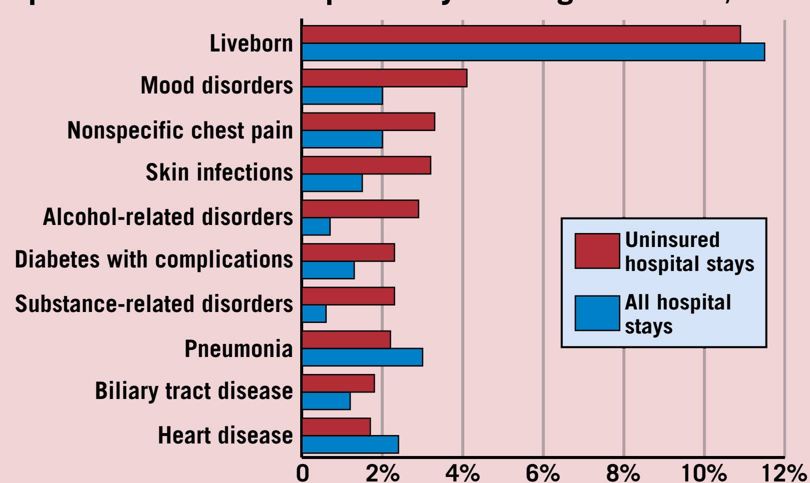
For example, the University of Wisconsin, which uses patients as educators, introduces medical students to patients on their first day in class, Dr. Barr said. This helps to sensitize medical students very early in their careers to issues that will arise in primary care.

Dr. Barr pointed out several changes in medical education that could be implemented relatively quickly:

- ► Providing more training for medical students with nonphysician mental health professionals.
- ► Emphasizing wellness and prevention.
- ► Developing faculty members who can teach within the patient-centered medical home model of care.

Dr. Bartlett added that medical schools also need to focus on ambulatory mental health issues, such as mild to moderate depression, that primary care physicians are most likely to encounter in practice, as opposed to providing only experience on the psychiatric ward. ■

DATA WATCH



Note: Based on data from the Nationwide Inpatient Sample.
Source: Agency for Healthcare Research and Quality

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