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EDITORIAL

Specialized Hospitals Spark Debate on Quality

Whether patients receive better care in acute-care general hospitals or in specialty hospitals is a hotly debated health care issue. The arguments of traditional hospitals convinced Congress to put into the new Medicare reform act an 18-month moratorium on physician self-referrals to certain new specialty hospitals while the government studies the issue. The act grandfathers existing specialty hospitals and those under development before Nov. 18, prevents grandfathered facilities from adding physician investors and from expanding to other specialty categories, and limits the number of new beds grandfathered facilities can add.

Supporters of acute-care general hospitals say that the debate centers on economics, not on quality. Administrators in these hospitals argue that specialty hospitals are picking the healthiest patients, who are at low risk, thus leaving general hospitals to take care of sick, complicated, and expensive patients. State hospital associations are working to maintain strong certificate-of-need laws that can impede the development of new specialty hospitals. At the same time, the American Hospital Association and other groups are promoting the enactment of legislation that would forbid physicians from performing surgery in hospitals in which they have a financial interest.

Specialty physicians believe they can offer better quality in specialized facilities. They argue that performing a high volume of procedures each day produces more consistent results, citing literature that links high volume with high quality. They also contend that a facility with specialized nurses, equipment, and procedures will have fewer complications and infections and will achieve better outcomes. These physicians, however, need definitive quality data showing that specialty hospitals have superior outcomes and lower infection rates. When they have such data, consumers will demand access to such facilities.

Those who run specialty hospitals say there are many reasons these facilities have been growing quickly: They offer a patient-focused environment, with low infection rates, they have no emergencies (so doctors and patients don't get bumped from the schedule), and they have lower costs than general hospitals have. What's more, advances in anesthesia and surgical techniques allow physicians to do more procedures in outpatient settings, which patients prefer.

Does the growth of specialized hospitals mean that savvy consumers will demand access to facilities that concentrate on a narrow range of procedures, offer convenient world-class services, and achieve superior results? If so, which type of hospital wins this economic debate may be irrelevant, since both will have to offer specialized facilities with measurable high-quality results to meet these consumer demands.

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Study: Collaboration Improves Care

Collaboration on care among cardiologists and generalists is associated with higher quality processes and outcomes of heart failure than is care provided by either cardiologists or generalists acting alone, the results of a study done last year show.

According to the National Center for Health Statistics, heart failure is the most common hospital discharge diagnosis for individuals aged 65 or older. The advanced age of these patients is an important factor to consider when assessing who should provide heart failure care, says Ali Ahmed, MD, MPH, a geriatrician who has a special interest as well as training in heart failure in older adults.

"A 45-year-old man with coronary artery disease, a history of a myocardial infarction, and no other medical problem might receive all the care he needs from a cardiologist, so he might not need to see a primary care physician," Ahmed offers. "The profile of patients with heart failure, however, is quite different. More than 80% of these patients are 65 years or older, and most of them have multiple medical problems and take multiple medications."

The lead author of the study published in the June *American Heart Journal,* Ahmed is an assistant professor in the Department of Gerontology and Geriatric Medicine at the University of Alabama in Birmingham (UAB).

Optimal Care

Ahmed asserts that patients who have complex medical problems such as heart failure as well as other conditions and take multiple medications should not see only a primary care physician or only a specialist such as a cardiologist. "For these patients, solo care will not be the best model of care," he says. "While primary care physicians can provide excellent overall care, they are less likely than cardiologists to provide life-saving drugs to patients with systolic heart failure.

"On the other hand," Ahmed continues, "although cardiologists are more likely than primary care physicians to provide better care for heart failure patients, they are less likely to address noncardiac issues. Just as cardiologists are quite capable of ordering a flu shot for a patient, primary care physicians are capable of prescribing an ACE inhibitor, but because of the nature of their training and practice, they often do not."

Although a number of studies have compared the care provided by generalists and cardiologists for patients with heart failure, there have been no published studies to date comparing the quality of heart failure care provided by generalists alone, cardiologists alone, and consultative care, Ahmed notes.

"Heart failure is the one cardiovascular disease that seems to be increasing in incidence in older adults," says Richard Allman, MD, a geriatrician and a co-author of the study. "We are on the verge of a tidal wave of geriatric patients. Even now, heart failure is almost an epidemic, yet we do not know nearly enough about how to care for these particular patients." Allman is director of the Birmingham/Atlanta VA Geriatric Research, Education, and Clinical Center and the UAB Center for Aging.

Currently, generalists provide most care for patients with heart failure in outpatient settings. "These physicians choose whether to treat such patients themselves or to refer them to a cardiologist," Allman says. "We need to know how to maximize the effectiveness and efficiency of heart failure care. In this context, defining appropriate roles for generalists, cardiologists, and collaborative teams is an important issue."

For certain patients, solo care will not be the best model of care, says Ali Ahmed, MD, MPH, of the University of Alabama, Birmingham.

Defining Quality

Ahmed decided to pursue the research after noticing that many of his patients with heart failure were not receiving optimal care. "I have noticed that many patients have not been receiving a formal left ventricular function evaluation, or they may not be given prescriptions for medical therapies that can save their lives upon hospital discharge," he says. "In fact, for many patients with heart failure, we do not know whether they have systolic or diastolic heart failure."

Unfortunately, delivering quality care to patients with heart failure is made more difficult by the nature of the syndrome, Ahmed points out. "Heart failure is a clinical diagnosis," he observes. "Making this diagnosis can be difficult, and even more so in older adults. Unlike a 45-year-old person with heart failure who presents after noticing difficulty in breathing after walking a few blocks, a 75-year-old experiencing the same symptom might decide to walk less, attributing the symptom to old age, and then present at a much later stage. Many older

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adults also suffer from depression and present with fatigue and tiredness, which are also presenting symptoms of heart failure."

Compounding these difficulties, the diagnosis must be made by taking a good patient history and conducting a careful physical examination. "There is no particular diagnostic test or procedure that will definitively establish the diagnosis," Allman explains.

Once the diagnosis is made clinically, an echocardiogram or other type of evaluation of left ventricular function helps physicians determine whether the heart failure is due to systolic or diastolic dysfunction. Such a determination is crucial in determining an optimal treatment plan.

Methodology and Findings

For the study on collaborative care, researchers used data from a project by the federal Centers for Medicare and Medicaid Services (CMS) and implemented by the Alabama Quality Assurance Foundation. In that project, researchers collected data on Medicare beneficiaries aged 65 and older who had been discharged in 1994 from 11 Alabama hospitals with a principal discharge diagnosis of heart failure.

The researchers accessed the database to pursue a retrospective follow-up analysis, which used left ventricular function evaluation via echocardiography, multiple-gated acquisition scan, or contrast left ventriculography, and ACE inhibitor use as indicators for processes of care. In addition, 90-day readmission and 90-day mortality rates were examined as indicators of care outcomes.

These four indicators were analyzed according to the type of care given to each patient with heart failure—generalist care only, cardiologist care only, or consultative care from both a generalist and a cardiologist—and adjusted for other factors that might be related to those outcomes (such as patient demographics, clinical characteristics, and clustering in hospitals).

Of the 1,075 patients with heart failure in the data set, 55% received care from a primary care physician, 13% received care from a cardiologist, and 32% were cared for by both types of physicians.

The analysis revealed that 36% of the patients who were admitted by a primary care physician had documentation of a left ventricular function evaluation. "Therefore, for more than 60% of patients admitted by a primary care physician, there was no documentation as to whether or not they had systolic dysfunction," Ahmed points out.

What's more, only 53% of the patients admitted by a cardiologist had documentation of a left ventricular function evaluation. However, 75% of the patients receiving care by consultation between a generalist and a cardiologist had documentation of a left ventricular function evaluation.

Similarly, only 54% of the patients receiving care from either a generalist or a cardiologist alone received an ACE inhibitor prescription at discharge, while 71% of patients receiving collaborative care received the drug. The analysis for ACE inhibitor use was restricted to patients who were discharged and had no absolute or perceived contraindications to ACE inhibitor use (such as low systolic blood pressure and high serum creatinine and potassium).

Finally, while the category of care was not associated with mortality, patients with heart failure who were cared for by both a generalist and a cardiologist had lower odds of having an admission related to heart failure within 90 days of discharge than were patients receiving solo care.

Ahmed's research team did not study why cardiologists might behave differently when they are acting alone as opposed to when they are consulting with a primary care physician. "One possibility is that when cardiologists are acting as consultants, they know that they may not have an opportunity to follow up with the patient on an outpatient basis," Ahmed explains. "That situation might make a consulting cardiologist more likely to act more aggressively in the treatment of the patient than would an admitting cardiologist."

Study Implications

Part of the gap in care processes is likely explained by imperfect documentation, Ahmed believes. "When a primary care physician calls for a cardiologist consultation, the cardiologist might ask if the patient had an echocardiogram in the past," he says. "In such cases, the primary care physician, who might have obtained an echocardiogram in the past and would not have otherwise documented it, will do so. Working with a con-

"We are on the verge of a tidal wave of geriatric patients. Even now, heart failure is almost an epidemic, yet we do not know nearly enough about how to care for these particular patients."

—Richard M. Allman, MD, UAB Center for Aging

sulting cardiologist requires thorough communication of the patient's condition and care to date, and therefore would prompt such documentation."

Nevertheless, the differences in left ventricular function evaluation and ACE inhibitor use are significant because in most cases, physicians working alone did not provide this care. "Our findings are important because most patients with heart failure in this country receive solo care from either a primary care physician or a cardiologist," Ahmed observes.

"I have no doubt that collaborative care is the best option for achieving good outcomes and good processes of care for heart failure," Ahmed continues. "In my opinion, all generalists are capable of evaluating left ventricular function in a patient with clinically diagnosed heart failure. All they need to do is to order an echocardiogram. The results will be reviewed by a cardiologist and reported back to the generalist physician in understandable language."

All echocardiogram reports describe left ventricular function either as a calculated or an estimated left ventricular ejection fraction in percentage, or as descriptive (such as mild, moderate, or severe) left ventricular dysfunction, Ahmed notes. "All generalist physicians should be able to prescribe ACE inhibitors to all eligible patients with systolic heart failure," says Ahmed. "If they are not comfortable in starting beta blockers for their patients with systolic heart failure, they should refer patients to cardiologists. This is a perfect example of a collaborative relationship that can translate into good quality and outcomes of care."

But managing patients with heart failure is much more complicated than simply evaluating left ventricular function or starting certain medications. Recent research shows, for example, that adding a selective aldosterone blocker in combination with other heart failure medications, such as ACE inhibitors and beta blockers, offers the potential to reduce cardiovascular death in patients following a myocardial infarction, according to a program on CHF presented in December at the midyear clinical meeting of the American Society of Health System Pharmacists.

The study by Ahmed and colleagues was done before the benefit of aldosterone blockers in heart failure was known. "In terms of use, the indications for the use of aldosterone blockers in heart failure are more restricted than those for ACE inhibitors or beta blockers," he explains. "Their use is indicated for certain patients who do not have renal insufficiency or hyperkalemia; in other words, a select group of advanced heart failure patients."

Moreover, many patients with systolic heart failure have coronary artery disease, and a cardiologist can investigate whether these patients are candidates for revascularization. "If patients with heart failure have a history of coronary artery disease or if they have angina, they definitely need to be evaluated by a cardiologist," Ahmed comments.

Encouraging Collaboration

Not only should primary care physicians seek out the assistance of cardiologists, cardiologists can encourage collaborative care as well. "Even though the United States has a large number of cardiologists, there are not enough of them to treat the approximately 5 million patients with heart failure in this country," Ahmed points out. "What's more, it is not appropriate for cardiologists to be managing all the health problems facing 75-year-old patients with heart failure. Cardiologists can have a role in educating generalists about the basic quality indicators for heart failure care and about when to refer patients to a cardiologist."

Indeed, Allman observes, geriatric patients have multiple comorbidities and functional problems. "Furthermore, for these patients, social factors can impact their health status as much as any disease diagnosis," he says. "A cardiologist may not have the time or the interest to focus on those issues. Also, some of the medicines used to treat heart failure may impact other aspects of a patient's care."

While quality of care is obviously the primary motivating factor for such collaboration, solid relationships with primary care physicians also can help cardiologists generate new referrals. "While I do not have any data to support it, I am positive that many patients with systolic heart failure would benefit from a referral to a cardiologist, who can initiate therapy with beta blockers or evaluate the need for revascularization in those patients with coronary artery disease," Ahmed says.

As many physicians are discovering, the care of older patients is challenging and collaboration with colleagues can help address those challenges, Allman concludes. "Even though physicians know how to deliver high-quality care, working with a colleague can prompt them to think about the best treatment plan for a particular patient," he says.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

More than 60% of patients admitted by a PCP had no documentation as to whether they had systolic dysfunction.

Act Will Foster Pay for Performance

Physicians and other providers will benefit under the Medicare reform bill passed in November and signed by President Bush in December. The Medicare Prescription Drug Improvement and Modernization Act rescinded a scheduled cut of 1.6% in reimbursement for rural Medicare providers that was set to become effective this year.

What's more, physicians who were scheduled to get a cut of 4.5% in Medicare payments this year and next will instead receive a 1.5% increase in 2004 and 2005, according to CCH, a publisher in Riverwoods, Ill.

One of the most significant provisions of the act involves a prescription drug benefit scheduled to go into effect in 2006. "All Medicare patients will be eligible for a long-overdue prescription drug benefit, and the neediest patients will receive the most assistance," says AMA President Donald J. Palmisano, MD. "This important legislation also ensures continued access to care by halting planned Medicare physician payment cuts and replacing the cuts with a payment increase of not less than 1.5% over the next two years."

When signing the bill, President Bush said, "Drug coverage under Medicare will allow seniors to replace more expensive surgeries and hospitalizations with less expensive prescription medicine. And even more important, drug coverage under Medicare will save our seniors from a lot of worry. Some older Americans spend much of their Social Security checks just on their medications. Some cut down on the dosage, to make a bottle of pills last longer. Elderly Americans should not have to live with those kinds of fears and hard choices. And this new law will ease the burden on seniors and give them the extra help they need."

Data on Quality

One of the most interesting provisions of the act involves pay for performance, a trend that has been growing among private health plans. Many experts believe that if Medicare paid more money to physicians who deliver high-quality care, it would help to improve the quality of care overall nationwide. The act will allow some physicians to collect bonuses for meeting certain performance standards, and hospitals also can earn higher payments by tracking how quickly and how well they treat patients, according to a report by the Associated Press. Under the law, the Institute of Medicine will develop uniform quality standards and a plan for paying physicians for good performance, and, in trial programs, participating doctors will receive additional Medicare payments for meeting or exceeding performance standards, the AP says.

Hospitals that voluntarily provide data on quality care to the Centers for Medicare and Medicaid Services, which runs the Medicare program, will receive 0.4% higher reimbursements for every Medicare beneficiary they treat, the AP says. Hospitals will need to provide data on the number of heart attack victims who get aspirin therapy and the number of patients with pneumonia who get antibiotic treatment.

Also, the law establishes new Medicare regional PPOs that will begin operating in 2006. In order to participate in Medicare, these PPOs will be required to report on how well they provide care to beneficiaries, the AP says.

Specialty Hospitals

Among the organizations that may suffer financially under the act are specialty hospitals. The law prohibits physicians from making new investments in such hospitals for the next 18 months while federal officials study the effect of these facilities on community hospitals. Under the law, Congress set an 18-month moratorium on physician self-referrals to certain new specialty hospitals while the government studies the effect of specialty hospitals on traditional acute care facilities. The act grandfathers existing specialty hospitals and those under development before Nov. 18, but prevents grandfathered facilities from adding physician investors or from expanding to other specialty categories. The act also limits the number of new beds grandfathered facilities can add.

Physicians serving patients in rural areas may see an increase in reimbursement under the law. Medicare had been scheduled to cut payments to physicians in rural areas this year, next year, and in 2006, according to *AMNews*. By eliminating the cuts, physicians in rural areas will be paid at about the national average rate, the *AMNews* says. What's more, the act aims to help attract physicians to rural and underserved areas by giving

The law establishes new Medicare regional PPOs that will begin operating in 2006.

physicians a 5% bonus for providing care in these regions. CMS will calculate the ratios of primary care and specialty care physicians to Medicare beneficiaries in each county, and physicians providing care to beneficiaries in counties that fall in the bottom 20% of these ratios will qualify for the bonus, *AMNews* says.

To qualify for the bonus, it will not be necessary to locate a practice in those counties but simply to provide services in those areas by holding a clinic in a qualifying county for two afternoons per week, for example, according to *AMNews*.

Preventive Care

Another important provision of the law will reimburse physicians for conducting basic physicals on new Medicare patients. "Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for a complete physical," Bush said. "The Medicare system will now help seniors and their doctors diagnose health problems early, so they can treat them early and our seniors can have a better quality life."

Moreover, all Medicare beneficiaries will be covered for blood tests to diagnose heart disease. "Those at high risk for diabetes will be covered for blood sugar screening tests," Bush noted. Adding coverage for preventive services is a small but important step, observers say.

By coordinating care for patients with chronic illnesses such as diabetes, heart disease, and high blood pressure, the government hopes to contain costs among those patients who account for a large percentage of spending under the program. The law will encourage physicians, pharmacists, and other health care providers to work closely with patients with chronic conditions in an effort to limit costly hospital stays, according to the AP.

The number of Medicare beneficiaries with chronic conditions is large and growing, says Mark Miller, executive director of the federal Medicare Payment Advisory Commission. "Typically, the costliest 5% of beneficiaries account for about half of all Medicare spending each year," Miller told Congress last year. "These beneficiaries often suffer from one or more chronic illnesses and require repeated costly hospitalizations. Health care for beneficiaries with chronic conditions has often been fragmented and poorly coordinated. Evidence-based practice guidelines are not always followed, nor are patients taught how best to care for themselves. Experts contend that effective management of beneficiaries with chronic conditions requires ongoing, coordinated care across health care settings and among various service providers."

What's more, Miller continued, "Experts predict that the number of Americans living with at least one chronic condition will rise from 125 million in 2000 to 157 million by 2020, and many of these individuals will be Medicare beneficiaries. Currently, more than three quarters of all Medicare beneficiaries have at least one chronic condition, and almost one third have four or more conditions. Beneficiaries with chronic conditions account for about 80% of program spending."

Another important new provision lets all Americans, even those who are not enrolled in Medicare, pay for out-of-pocket health care expenses through new health savings accounts. "Every year, the money not spent would stay in the account and gain interest tax-free, just like an IRA," Bush said. "And people will have an incentive to live more healthy lifestyles because they want to see their health savings account grow."

But not all observers are pleased with the new law. "What has been touted as the greatest expansion of Medicare in the history of the program is actually a tremendous bait and switch," says Judith Stein, executive director of the Center for Medicare Advocacy, in Mansfield, Conn. "The elderly will gain a very limited prescription drug benefit in return for the greatest restructuring of Medicare. This restructuring will eventually destroy a system that is beloved by 40 million people for whom it provides health insurance."

But Peter D. Haytaian, vice president of government programs and specialty businesses at Oxford Health Plans, in Trumbull Conn., believes that the law offers important reforms. "The legislation is one step toward giving seniors more choices in Medicare by providing reimbursement relief to Medicare+Choice plans so they can continue to serve 5 million seniors today and add a prescription drug benefit," he comments. "By increasing reimbursement levels, the bill will make the innovations of private plans, such as disease management and ancillary benefits like dental or vision, available at a lower overall cost. As a result, Oxford will expand its offerings in the metro New York region, and we support the test program to introduce PPO options to Medicare as it also provides more choice to seniors."

—Reported and written by editor Joseph Burns. More information on quality improvement is available on our Web site *(see page 16)*.

Currently, more than three quarters of all Medicare beneficiaries have at least one chronic condition.

Reports Raise Concerns About Physician-Owned Specialty Hospitals

The growth of physician-owned specialty hospitals and ambulatory surgery centers is causing concern among hospital administrators and health policy planners, according to a recent report. Those concerns include whether specialty hospitals and ASCs provide the cost and quality benefits their proponents claim they provide, whether these facilities have a negative financial effect on general hospitals, and whether they increase or decrease access to care.

In most of the specialty hospitals and ASCs that physicians own, doctors work in partnership with other physicians, with a local hospital, or with a national firm that specializes in such facilities. One such firm is MedCath, in Charlotte, N.C., which works with cardiologists to deliver cardiac care in specialty hospitals nationwide. Physician ownership in such facilities means the physician owners can take patients away from other hospitals, the report says, and offers financial rewards to the participating doctors.

The report, titled "Focused Factories? Physician-Owned Specialty Facilities," was published in the November/ December issue of *Health Affairs*.

Policy experts and hospital administrators say that specialty facilities could lead to excess capacity, provide unnecessary services, and lower quality because of decreased volume at traditional hospitals, the report says. It also suggests that these facilities could reduce community hospitals' net revenue and thus their ability to subsidize services that are usually unprofitable but are socially necessary.

Capacity and Quality

Specialty hospitals is the topic of another report; this one by the General Accounting Office. It states that advocates of specialty hospitals contend that the focused mission and dedicated resources of these hospitals both improve quality and reduce costs. Critics contend that specialty hospitals siphon off the most profitable procedures and patient cases, thus eroding the financial health of neighboring general hospitals and impairing their ability to provide emergency care and other essential community services. Critics also contend that physician ownership of specialty hospitals creates financial incentives that may inappropriately affect physicians' clinical and referral behavior.

The GAO report, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance* (GAO-04-167), was issued in October and is available online (at www.GAO.gov).

For now, the authors of the *Health Affairs* report caution health policy regulators to be careful about making any regulatory interventions involving specialty facilities, in part because data on the effect of specialty hospitals and ASCs are inconclusive, and these facilities could have the potential to function as "focused factories" that improve quality and reduce costs.

Because general hospitals provide a broad range of services, they lack the advantages of specialization long recognized by economists and are vulnerable to smaller, more specialized facilities, such as ASCs, say the authors of the *Health Affairs* report. "By dedicating staff, equipment, and management attention to the treatment of one specific type of disease, both inpatient (specialty hospitals) and outpatient (ambulatory surgery centers) focused factories could provide better-quality health care, at lower cost, and with higher patient satisfaction," the report says.

Focus and Location

There are 100 specialty hospitals that focus on cardiac, orthopedic, or women's medicine or on surgical procedures, the GAO says. These specialty hospitals are concentrated in areas where state policy facilitates hospital growth, meaning there are no certificates-of-need requirements. Many states require a CON before a new hospital can be built.

In fact, specialty hospitals are

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Advocates of specialty hospitals contend that the focused mission and dedicated resources of these hospitals both improve quality and reduce costs, while critics contend that specialty hospitals siphon off the most profitable procedures and patient cases, says the GAO report.

Consumers to Benefit

Physician-owned specialty hospitals and ambulatory surgery centers are designed to attract business from consumers. Some experts believe this strategy is an important step as the health care system evolves into a consumer-driven system, and that the evolution will include the development of focused factories.

"Focused factories provide specialized services that are packaged from the consumer's point of view," says Regina Herzlinger, a business professor at Harvard Business School. "A consumer with a medical problem is interested in getting the solution for that medical problem. Health care today is not organized by provider. It's like a department store that's organized by what buyers are expert in buying. So, a department store might have one department with towels, one with hardware, and another with bathroom fixtures because those departments have buyers who are specialists in those different areas. But what consumers want is a department that enables them to fix up their bathroom, bedroom, or living room, and they're not interested in the expertise of the buyers. They want the store to combine that expertise in a way that enables them to get what they need."

Focused factories are a form of horizontal integration that involves determining how to do something and then replicating it, Herzlinger adds. "So, while it's not trivial, it's not as difficult as running a vertically integrated system that involves running four to 15 different businesses simultaneously. Horizontal integration leads to economies of scale in purchasing and economies of scale in administration."

—JB

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much more likely to be found in states where hospitals are permitted to add beds or build new facilities without first obtaining state approval for such health care capacity increases, the GAO report says. Twenty-eight states have at least one specialty hospital, and about two thirds of the 100 specialty hospitals are located in seven states: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas, according to the GAO. Last year, at least an additional 26 specialty hospitals were under development, and about 60% of these facilities were being built in California, Louisiana, and Texas, reinforcing the existing pattern of geographic concentration, the GAO notes.

Although general hospitals typically have more beds than specialty hospitals, specialty hospitals often treat more patients in their given fields of specialization, the GAO says. Financially, specialty hospitals have tended to perform about as well as general hospitals in terms of Medicare inpatient business, but have tended to outperform general hospitals when the costs from all lines of business and the revenue from all payers were considered, the GAO report shows.

Physicians who have an ownership interest in a specialized facility can collect fees for their own professional services as well as share in any profit generated from the facility fee paid to the organization that operates the facility. In a traditional hospital, the facility fee goes to the hospital.

Market Considerations

It is not unusual for large single-specialty groups to establish specialty hospitals. The *Health Affairs* report cites Orthopedics Indianapolis, a 64-member physician group in Indianapolis that is developing an orthopedics hospital, as one example.

Specialty hospitals appear less likely to be created in markets with dominant hospitals, whose brand name and large market share might enable them to induce health plans to refuse to contract with such facilities and to persuade physicians not to invest in or cooperate with them, the *Health Affairs* report says.

ASCs are less complex than specialty hospitals to develop, according to the report. Compared with specialty hospitals, the report notes, ASCs require less capital and are less likely to be subject to CON regulations. Most ASCs have two to four operating rooms and are dedicated to providing a particular service, the report says.

Physicians are whole or part owners of almost all ASCs, the report shows. It found that although ASCs have traditionally been created by an entrepreneurial physician or a national firm recruiting physician-investors from many small practices, during the past few years large single-specialty groups have been involved in developing ASCs. Orthopedic ASCs are particularly threatening to general hospitals, since orthopedic procedures are the most profitable services a general hospital offers, the report adds.

As is the case with specialty hospitals, the absence of CON requirements for ASCs and the presence of large single-specialty groups are key factors associated with the development of ASCs, the report says.

Cost Implications

Physicians and health plan executives who were interviewed for the *Health Affairs* report said specialized

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Group Offers Response

The Medicare Prescription Drug Improvement and Modernization Act of 2003 puts a moratorium on physician self-referrals to certain new specialty hospitals while the government studies the issue.

The 18-month moratorium will negatively affect physician investment in specialty hospitals, says the American Surgical Hospital Association in San Diego (at www.surgicalhospital.org). The ASHA explains that the Stark Act prohibits physicians from referring Medicare or Medicaid patients to an entity if the referring physicians have a financial or ownership interest in the entity.

In the past, physicians have structured their ownership of specialty hospitals to avoid Stark liability concerns by relying on the Stark exception (the "whole hospital exception"), the ASHA says. In essence, this exception means that a physician's ownership in a hospital will not create a financial relationship with that hospital for purposes of the Stark Act if the referring physician is authorized to perform services at the hospital and the ownership or investment interest is in the hospital itself and not merely in a subdivision of the hospital, the ASHA explains.

This exception allows physicians to refer patients to a hospital in which they have an ownership interest if that interest is in the entire entity as opposed to an interest in a hospital department or in a joint venture. The effect of this exception has been to permit physician ownership in specialty and whole hospitals if the ownership interest is in the entire entity and the physicians are on staff at the hospital.

The new Medicare act severely limits this exception. For physicians concerned about the effects of the new act on their ownership interests in a specialty hospital, a number of options are available, and physicians should consider the advantages and disadvantages of each one, the ASHA says. Physicians could, for example, broaden the service range of the facility to avoid the definition of a specialty hospital, the association says. Physicians should be aware, however, that as of late December, it was unclear how the government would define a specialty hospital under the law.

Physicians also could divide the project into an ambulatory surgery center and spin off an imaging facility, because the law does not affect the ability of physicians to own an ASC, nor does it affect the ability of a group practice or a hospital to own an imaging facility, the ASHA says. In this way, a specialty hospital could be operated as an ASC, and the imaging portion of the project could be purchased by a single group practice or a hospital, the ASHA points out.

Physicians also could stop providing care for Medicare and Medicaid patients, the ASHA says. Such a modification in operations may not be economically feasible and state regulations may restrict physician ownership of hospitals that could apply to referrals of all patients and not just patients insured by a federal health care program, according to the ASHA.

Another option is for physicians to sell the specialty hospital to a third party or to merge or combine with other specialty hospitals or ASCs to create a publicly traded company. —JB

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facilities could provide services at a lower unit cost than those provided by outpatient or inpatient units in general hospitals. When physicians have an ownership interest in a facility designed specifically for their needs, they can increase their productivity, decrease costs, and increase quality, the physicians said.

Hospital administrators who were interviewed for the report recognized these advantages but were concerned that specialty hospitals and ASCs might have unfair cost advantages over traditional hospitals because they care for healthier patients, need not provide unprofitable services, and are subject to less regulation. The administrators also were concerned that the creation of specialty hospitals and ASCs could raise total health care costs by creating excess capacity and by providing services that may not be necessary.

On the issue of quality of care, the administrators suggested that quality could be a concern in ASCs because, compared with hospitals, they are subject to less regulation. On the other hand, the physicians who run specialty facilities argued that in such facilities they can implement processes to improve care and that Medicare and commercial health plans fail to give physicians an incentive to make such an investment.

On the issue of the severity of illness of the patients being treated, the GAO report says specialty hospitals treat a lower percentage of severely ill patients than general hospitals treat. But according to the *Health Affairs* report, an analysis by other experts shows that some specialty hospitals treat patients who have a higher case-mix severity than patients at community hospitals.

—Reported and written by editor Joseph Burns. More information on physician practice strategies is available on our Web site (see page 16).

Steps for Improving Health Literacy

By Gloria Mayer, RN, EdD, and Michael Villaire

Medical practices spend considerable time and resources developing materials about specific health issues, treatment options, and step-by-step instructions in order to educate patients about how they can aid in their own recovery. Unfortunately, patients often don't understand these materials, partly because they are generally written at an eighth-to-eleventh-grade reading level, while 90 million Americans are either functionally illiterate or have reading skills at or below the fifth-grade-reading level. The reality is that patients with low-literacy skills have significant problems understanding and effectively using the health care information available to them.

Failing to communicate clearly costs $73 billion annually in unnecessary health care expenses, according to the National Academy on an Aging Society (at www.agingsociety.org). These wasted resources are the result of patients misreading prescription instructions, lacking knowledge to identify the signs of progression of chronic diseases, not understanding how to prepare properly for diagnostic tests, and not following diet regimen materials that contain complex and unfamiliar words or concepts.

__Gloria Mayer, RN, EdD__, is president of the Institute for Healthcare Advancement, in La Habra, Calif. __Michael Villaire__ is a director at IHA, a nonprofit organization (at www.iha4health.org) that provides solutions and tools for low health literacy and educational and community health services.

Three Solutions

Some forward-looking organizations are attacking this problem from different areas of need. Among their targets are communication difficulties (such as the problems patients have understanding directions and assessing questions during a medical visit), problems caused by the low-literacy skills among patients for whom English is a second language, and problems caused by hampered access to consumer medical reference materials when most books and pamphlets are written at an eleventh-grade reading level.

After analyzing what can and does go wrong with follow-up care when patients have trouble understanding what their doctor or nurse said to them during a medical appointment, Pfizer Inc. saw an opportunity to make patient education materials culturally relevant, age-appropriate, and accessible to those with different literacy levels. In addition, Pfizer launched a multiphased program that includes an annual health literacy conference, sponsoring grants, and supporting research.

One of these efforts involves the Partnership for Clear Health Communication (at www.AskMe3.org), a coalition of 19 of the nation's top health and civic organizations. The coalition, with its aggressive agenda to address the growing public health problem of low health literacy, has developed a patient care program that can help the communication process. The program, called Ask Me 3, is a tool to help improve health communication among patients and providers through the use of educational materials developed by health literacy experts.

Ask Me 3 promotes three simple but essential questions patients can ask a doctor or nurse during a medical appointment:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

The communication program includes posters for medical offices and leaflet materials that are handed out to patients. These materials are designed to ensure that patients leave a medical appointment aware of their medical status and are able to act on their follow-up care needs.

Using Technology

Technology is also being used to address the significant problems that language barriers present for health literacy. For example, technology is being used by researchers at the University of California-San Francisco Medical Center in a study on the IDEALL project (Improving Diabetes Efforts Across Language and Literacy), which is designed to help patients who have a chronic disease and experience communication barriers.

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Failing to communicate clearly with patients who have low-literacy skills costs $73 billion annually in unnecessary health care expenses, according to a survey conducted by the National Academy on an Aging Society.

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Because disease management depends on interactive communication at the provider-patient and system-patient levels, barriers to communication can impede successful DM. In fact, research has shown that the likelihood of patients who have inadequate functional health literacy keeping their diabetes under control is less than half the likelihood of patients who have adequate functional health literacy. As a result, the patients with inadequate health literacy have an increased likelihood of developing retinopathy and other long-term complications. Clinical research studies at San Francisco General Hospital Medical Center have shown that even when physicians and other providers consider race, socioeconomic status, and other factors, these communication barriers are among the biggest factors affecting patients' ability to manage their chronic condition effectively.

According to study information presented at the second annual IHA low health literacy conference in 2003, researchers at the UCSF Medical Center are conducting a clinical trial to compare "usual care" with an automated telephone DM system that delivers tailored health education via touchtone or voice recognition to patients in their primary language. The patients are being treated in a multidisciplinary, cooperative clinic model of care in which groups of patients meet monthly with a team of providers for one year. The clinical trial, which is facilitated by both a health educator and a primary care provider, is conducted in English, Spanish, and Cantonese. In the program, an automated telephone message asks the patient sample questions, such as how often he or she had eaten sweets or desserts in the last week.

Researchers hope to enroll 400 patients in the study and will measure the effect of health communication-intensive interventions on the health status of those who have a chronic disease and communication barriers. The researchers hope the project could serve as a model for disease management, help to incorporate new measures to address health disparities, and increase awareness of special barriers to quality care that minorities face.

Easy-to-Read Books

A problem prevalent within the medical community is the general belief among providers that low-literate patients will not read reference materials under any circumstances. However, a study measuring the effectiveness of a health reference book written at a third-to-fifth-grade reading level found a high readership level and usage by its recipients over six months. A total of 92.2% of those surveyed said they sought medical help from the book, *What to Do When Your Child Gets Sick* (IHA Publishing, La Habra, Calif., 2000) at least once when a medical issue arose. A total of 98.4% referred to the book three or more times over six months. Findings from the study, conducted by the Institute for Healthcare Advancement, refute a common assumption by medical professionals that the reading-challenged will not use health reference books for their own health care at home.

Among those surveyed, 99.2% found the health reference book easy to follow when trying to locate a particular medical problem, and 91.4% found the book completely answered any health questions they had. Moreover, 98% understood the overall medical information completely. The top six topics that participants researched were fever; cold and flu; ear, nose, and throat ailments; stomach problems; allergies; and the care of infants.

The results of this study provide important evidence that more books should be written at this basic reading level. *What to Do When Your Child Gets Sick* is one of a series of five books in the "What to Do" health series written at the third-to-fifth grade reading level. It covers 100 common health problems, including childhood ailments (such as earaches, vomiting, and colic) and information on how to handle pressing problems (such as burns, diarrhea, and broken bones). The narrative is supported with 161 illustrations allowing readers, and even nonreaders, to understand the information quickly and to take action.

Recognizing that medical practices often feel stretched in their operational efforts to deliver all appropriate care to their patients, much could be said for the need to look inward on what does and doesn't work. If patients aren't following the instructions that their physicians give to them, perhaps low literacy is playing a role. Among the vital dollars this country spends on delivering health care, providing funding for easy-to-access and easily comprehendible patient medical information would be money well spent.

—More information on physician practice strategies is available on our Web site (see page 16).

Researchers at the UCSF Medical Center are using an automated telephone system that delivers tailored health education via touchtone or voice recognition to patients in each patient's primary language.

Five Developing Trends Offer Physicians More Options in 2004

By Richard L. Reece, MD, editor in chief

Five trends that are developing this year will affect physicians by increasing their practice options. The first two trends relate to hospital care: As baby boomers grow old and as physicians who develop specialty care centers take market share from acute-care general hospitals, hospital capacity will expand. The third trend relates to consumers, who are becoming more health care savvy and are being given more choices in how they can use the health care system. The fourth trend involves technology, which physicians are using to improve productivity. The fifth trend relates to the shortage of both physicians and nurses, a trend that may help boost their salaries.

These trends are offering physicians many options, with more to come, especially as many areas of the country experience physician shortages. By 2010, there may be a shortage of 50,000 physicians, according to some estimates. Currently, specialists, for example, are becoming increasingly in demand by hospitals seeking to serve the elderly and aging baby boomers; and some patients also are seeking primary care physicians, because more PCPs (between 25% and 50% of PCPs, depending on the region of the country) are no longer accepting Medicare patients.

Hospital Capacity

During the 1980s and 1990s, the number of U.S. hospitals declined from a high of about 7,000 to the current number of about 4,900. But as the population ages and as physicians and entrepreneurs seek to profit by providing high technology services that only hospitals can offer, new hospital construction is booming. These new hospitals, however, are unlike those previously built: The new ones are offering private rooms, luxury units, and various specialized services. Seeking to provide cardiac bypass and angioplasty services in local markets, new heart hospitals also are being built.

As the market for hospital services expands, many hospitals are finding they cannot recruit enough physicians or nurses to staff the new facilities. To address this problem, hospitals are offering record-setting starting salaries and other bonuses in their efforts to recruit anesthesiologists, cardiologists, radiologists, orthopedic surgeons, as well as other specialists.

Hospitals are offering record-setting starting salaries and bonuses in an effort to recruit anesthesiologists, cardiologists, radiologists, orthopedic surgeons, and other specialists.

This trend offers attractive options for physicians: A specialist in a high-demand specialty can pick the hospital or region of the country in which to practice; a PCP has the option of becoming a hospitalist, since hospitals are hiring hospitalists and intensivists at an unprecedented rate.

Consumer-Driven Care

A consumer-driven health care system is inevitable, experts say, in order to control costs. Other experts counter that such a system would be unfair to sick and vulnerable patients who may not have the necessary means to choose their health care wisely.

Some employers favor consumer empowerment as a way to address escalating health care costs. As employers shift costs to employees and their families, they are also giving their employees more choice in their health care options (based on the theory that consumers will spend their own money wisely and will become discerning buyers of care). Also, many major health plans are offering consumer-driven health programs to their participants.

As consumers become more savvy about health care, they are also becoming more informed, more willing to bargain, more expectant of higher levels of service, and less willing to wait for care. They also want more electronic communication with their physicians, as well as more procedures performed in customized, personalized settings outside of traditional hospitals.

Specialty Care

Seeking to respond to consumers' demands for more specialized care, physicians have been developing "focused factories." In these facilities,

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Five Trends to Watch in 2004

The following trends are likely to expand practice options or offer new practice opportunities for physicians this year and over the next few years:

1. Hospitals will expand capacity.
2. Consumer-driven health systems will continue to grow.
3. Focused factories will take market share from acute-care general hospitals.
4. Physicians will continue to install new technology to boost productivity.
5. The shortage of nurses and physicians will drive up salaries.

—RLR

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specialty physicians offer specific kinds of care to specific patients. Heart hospitals are a good example.

In heart hospitals, where cardiologists offer highly efficient care for a specific population, physicians have found they can see more patients, stay on schedule, and control the quality of care. Also, if they have an ownership interest in the facility, they can increase revenue by collecting facility fees from payers. These fees, which used to go to local hospitals, can total about two to four times the surgical fees that the physicians collect.

Owning such a facility is appealing to physicians, so much so that the number of specialty hospitals, including those that specialize in orthopedic and cardiac care, has doubled in the last three years to about 100. Also, the number of physician-owned outpatient surgery units is expanding by about 20% a year. Some of these new facilities are developed through partnerships or joint ventures with hospitals. Most are partially or wholly physician-owned freestanding enterprises.

There are some downsides for the orthopedists, cardiologists, heart surgeons, radiologists, neurosurgeons, and urologists who own these focused factories. For one: The physicians may need to spend considerable time on management and thus have less time for patient care. There also is the risk of a financial loss.

What's more, local hospitals may revoke the medical staff privileges of the physician entrepreneurs involved in these focused factories and choose to compete with them by hiring their own specialists. After all, hospital administrators recognize that cardiovascular services, orthopedic surgery, and general surgery contribute 60% to 70% to the hospital's bottom line. For physicians concerned about the disadvantages of owning focused factories, a partnership or a joint venture with a hospital may help to minimize the risks.

Technological Solutions

Americans believe that technology can solve almost any problem, particularly problems in health care, and it is this thinking that helps drive up health care costs. In fact, new technology accounts for about half of health care inflation.

New technological devices include defibrillators and pacemakers, robotic surgical tools, insulin delivery systems, electronic systems for measuring physiologic changes, ultrasound technologies, and sophisticated imaging machines.

Such new electronic technologies are offering many options for physicians seeking to increase revenue by improving productivity. For example, an increasing number of physician practices are installing electronic medical record systems and other systems to facilitate patient communication online and by e-mail.

Having sophisticated computer software allows patients to generate their own medical histories before seeing a physician, as well as enabling physicians to document their findings electronically and then bill payers automatically. Recognizing that patients will pay for online consultations, physicians are marketing their practices on the Web and are developing their own websites.

Staff Shortages

The shortage of physicians and nurses will continue to plague hospitals, particularly in fast-growing cities in the West. Phoenix, for example, has grown by 40% in the last decade and its population is increasing by 100,000 residents annually. After building new hospitals to accommodate the growing population, administrators have found that they cannot find adequate personnel to staff these facilities.

As consumers become more savvy about health care, they are also becoming more informed, more willing to bargain, more expectant of higher levels of service, and less willing to wait for care.

Changes Coming Under the Medicare Reform Act

One of the most significant developments in 2004 will involve Medicare. Under the bill Congress passed late last year, the government will reform Medicare and provide beneficiaries with coverage for prescription drugs.

One of the most significant aspects of the law calls for the government to provide a prescription drug card to the elderly, but this part of the law will not go into effect until June 8, 2004, and the new drug benefit itself will not go into effect until Jan. 1, 2006.

But beginning this month, physicians will start to see changes as a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003. As of the first of the month, for example, changes to provider reimbursement will begin, including a reduction in payments based on the average wholesale price (AWP) of prescription medications, according to Epstein, Becker & Green PC, a law firm in Washington, D.C. Changes in reimbursement based on AWP will affect physicians who have been getting reimbursed for dispensing or administering medications in their offices.

By the middle of this month, the law calls for the federal Centers for Medicare and Medicaid Services to publish new rates for the Medicare Advantage plan (formerly known as Medicare+Choice), EBG says. The rates will go into effect on March 1 and will apply retroactively to Jan. 1.

On Jan. 1, 2005, reimbursement for most drugs covered under Medicare Part B will change from pricing based on AWP to pricing based on the average sales price (ASP), EBG says.

On June 8, 2005, the moratorium on the use of the "whole hospital exception" under the Stark Act will end for physicians who have an ownership interest in a specialty hospital. Also, by this time, the government's study on the effect of specialty hospitals should be completed.

On Jan. 1, 2006, regional PPOs for Medicare Advantage will begin operating and a competitive acquisition process for drugs dispensed under Medicare Part B will begin, according to EBG.

In Arizona, hospitals have a ratio of 1.9 nurses in acute care settings for every 1,000 residents (compared with 3.3 per 1,000 nationwide). With 1.4 physicians per 1,000 residents (compared with 1.9 physicians per 1,000 in other cities), Phoenix has 26% fewer physicians than cities of comparable size in other states. In response, hospitals are hiring more hospitalists and intensivists and are paying specialists to provide on-call coverage and for emergency services provided to uninsured patients.

Looking Forward

Underlying these five trends is another trend that has been gathering momentum over the past several years; it involves the cost of health services, which is now rising about six times as fast as the domestic inflation rate. Many parties—including employers, employees, the uninsured, Medicare and Medicaid recipients, health plans, hospitals, federal and state governments, and physicians and other health care providers—are being negatively affected by these high costs.

To control health inflation and to preserve the health system, several steps must be taken: Reforms must be implemented to provide universal coverage of basic care; rewards for medical injuries must be restructured so that more money goes to injured patients and less to lawyers and the court system; and health care delivery, which should be based on evidence and publicly disclosed data about hospital and physician performance, will require improvements in information technology and a consensus on how to use the data that are collected.

All of these trends will change the health system and the ways that physicians practice. But the most significant change may come from the federal government, as it tries to reform the Medicare system. As Congress considers how best to change the manner in which the federal government (the largest payer in the U.S. health system) manages care for the nation's elderly, it has plenty of examples to follow.

The Veterans Health Administration, for example, has had a quality improvement program in place since 1994 and is using electronic medical records widely; this program has reduced costs while improving the quality of care that the VA delivers. Kaiser Permanente of California is investing heavily in an information system that will deliver patient information to physicians at the point of care. Some health plans (such as Tufts, Harvard Pilgrim, and HealthPartners) are paying physicians for meeting certain quality targets based on patient satisfaction and outcomes.

While none of these new systems are perfect, each offers lessons that the federal government could follow as it seeks to reshape Medicare.

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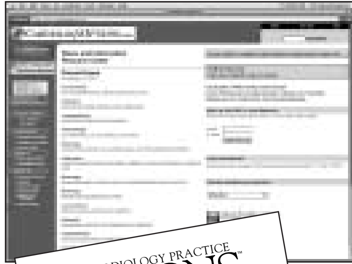

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