ACP AMERICAN COLLEGE OF PHYSICIANS INTERNAL MEDICINE | Doctors for Adults

Changes afoot at physician-owned specialty hospitals

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By Jessica Berthold

When Oklahoma Heart Hospital opened in August 2002 in Oklahoma City, it didn't take long for nearby community hospital Baptist Medical Center to realize it needed to make some changes.

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New developments

"We saw an immediate decline in patient volume," said Stanley Hupfeld, CEO of Integris Health, which owns Baptist Medical Center and 13 other hospitals in the state. "For the most part, we've been able to build back and offset the loss, but we definitely felt an impact."

Similar scenarios are playing out around the country, as new specialty hospitals stake claims in markets once served exclusively by full-service hospitals. Owned by physicians and focused on a specific type of care like orthopedics or cardiology, these hospitals number around 140, experts say, despite the fact that Congress effectively banned their construction between 2003 and mid-2006 (see specialty hospitals by state).

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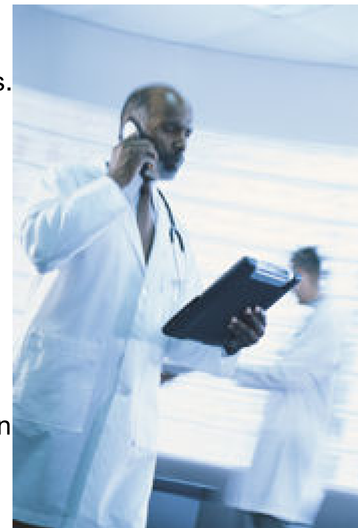
The great debate



Specialty hospitals are controversial, with detractors saying they promote overutilization of costly medical procedures (see sidebar) and encourage doctor-owners to refer patients to their own facilities. The most common accusation is that specialty hospitals "cherry-pick" the highest-paying patients—those who have elective surgery—and leave community hospitals with the lowest-paying ones, such as the uninsured in emergency departments. Several studies seem to back these claims.

"There is no question that some patients get transferred to our hospitals from specialty hospitals either when their insurance runs out or when they get into financial problems," said Mr. Hupfeld. "In some cases, the selection occurs before admission, where all of a sudden the only patients we see referred from a particular physician are the low-pays or no-pays."

Supporters of specialty hospitals, like the American Medical Association, say their focus on high-quality, specialized care raises the bar for all hospitals and gives doctors more control over their craft. They point to research indicating lower mortality rates and higher patient satisfaction rates at specialty facilities, as well as a 2005 Medicare study that found that the financial impact of specialty hospitals on community hospitals is limited.

"I think the efficiency a specialty hospital can provide does offer some benefit to the patient," said Anne Borik, DO, a hospitalist at the Arizona Heart Hospital in Phoenix who formerly worked at a general hospital (see sidebar). "With cardiac care, it's just the nature of the disease that treatment is dependent on time."

Controversy on the topic flared anew in January, when a man developed problems after having elective spinal surgery at the small, doctor-owned West Texas Hospital in Abilene. Unable to deal with the 44-year-old's respiratory complications, hospital workers had to call 911 and have the patient transferred to a larger hospital, where he later died.

Specialty hospital defenders say the incident was isolated and rare. Still, congressional leaders took notice, calling for changes in the way specialty hospitals operate, such as more disclosure of emergency capability and physician ownership. CMS, meanwhile, is revising its payment system to discourage hospitals from picking healthier patients over sicker ones.

Whether these measures will be enough to allay concern about the impact of physician-owned hospitals on the health care system remains to be seen. Either way, hospitalists can expect changes in the specialty hospital workplace in the coming months and years.

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Changes in emergency care

By October, CMS is likely to require specialty hospitals to notify patients in writing if there isn't a doctor present at all times, as well as explain how they plan to meet emergency medical needs when no doctor is on site. The agency may also require specialty hospitals to divulge physician ownership, according to proposed rules that CMS issued in April.

Molly Sandvig, executive director of Physician Hospitals of America, an advocacy group for physician-owned hospitals, said she doesn't think these changes will have a large impact on specialty hospitals. She noted that CMS already requires most hospitals to provide some level of continuous emergency care.

"We're already doing most of these things. We may not be disclosing 24-7 emergency coverage in the manner that CMS is proposing, but it certainly will not be hard to do," Ms. Sandvig said.

Efforts by individual states may have more of an impact, however. Washington state recently passed a law saying that specialty hospitals have to provide 24-hour emergency care, while an Ohio bill would require all hospitals to have designated space for a round-the-clock emergency department, as well as an "adequate" number of doctors and nurses working at all times.

Beefing up emergency services will benefit hospitalists, said Adam Singer, ACP Member, chairman and CEO of IPC-The Hospitalist Company.

"One solution that specialty hospitals have been pursuing has been hiring or contracting with a hospitalist to provide 24-7 on-site emergency coverage," Dr. Singer said. "So these changes are further fuel for the hospitalist movement."

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Changes in payment

Another development that may affect specialty hospitals is CMS' ongoing revision of its reimbursement structure, a process that's expected to be completed in 2009. Instead of paying a

set amount for a given procedure, the new reimbursement system will pay more when that procedure is done on a severely ill patient with comorbidities and less when it's done on a healthier patient. The revisions are, in part, a response to government studies showing that specialty hospitals had lower percentages of major or extreme cases than community hospitals.

Alwyn Cassil, spokeswoman for the Center for Studying Health System Change, a nonpartisan research organization, said the new payment structure will finally give specialty hospitals the chance to prove their claims that they perform with higher quality and greater efficiency.

"There hasn't been a real true test of this, because there hasn't been a level playing field," said Ms. Cassil, a self-described "agnostic" about specialty hospitals. "What CMS is proposing looks pretty substantive as far as moving to make the payment system more accurate."

Yet others, like Mr. Hupfeld and the American Hospital Association (AHA), feel the payment changes don't go to the root of the problem: doctors' incentive and ability to refer their most lucrative patients to their own hospitals for procedures, and their disincentive to do the same for low-paying patients. The best solution is banning physician self-referral, they said.

"If we don't pull the fangs on self-referral and financial imperative, and get focused back on making sure we pay doctors appropriately for professional services, there could be way too much damage done before things get under control," said Ellen Pryga, AHA director of policy.

Indeed, said Mr. Hupfeld, Medicare's changes to its reimbursement structure will hurt some community hospitals that have struggled to adapt to the presence of specialty hospitals.

"What's happened is that general acute care hospitals have, for example, developed heart programs, so now if they tinker with [reimbursement] to get at the specialty hospitals, it's going to be several years before the general acute care hospitals can also make that shift," said Mr. Hupfeld.

Yet restructuring the payment system is good news for hospitalists, according to Dr. Singer, since the new system will require doctors to be more thorough with diagnoses and documentation—a skill most hospitalists have already honed.

"The job of a hospitalist is to better communicate and coordinate the team, and documenting is part of that communication," Dr. Singer said. "Under the new system, it's going to be very important for hospitals to have better documentation so they can code better, and that should lead more hospitals to contract with hospitalists."

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Do procedures increase when specialty hospitals move in?

One charge against specialty hospitals is that they promote overutilization of certain procedures, thus driving up health care costs in general. Critics point to an August 2006 analysis of Medicare discharge data which found that opening a doctor-owned heart hospital was associated with a significant increase in the rate of cardiac surgeries in a given market area. Further, there were more surgeries in that market than would have been expected given national trends and the market's historical experience, the Medicare Payment Advisory Commission report said.

More recently, a study in the March 7, 2007, *Journal of the American Medical Association* found that opening a cardiac hospital in a given region increased the rates of coronary revascularization

there compared to other regions that either had no heart hospital or had a cardiac wing of a general hospital.

The study didn't measure whether those revascularizations were appropriate or not. While few would argue that doctors are performing procedures that are completely unnecessary, they may be opting more for surgery in cases where its use is discretionary, said John D. Birkmeyer, MD, coauthor of the *JAMA* study and professor of surgery at the University of Michigan in Ann Arbor.

"It's unlikely that inappropriate surgery is what accounts for the greater use of interventions in markets with specialty hospitals," Dr. Birkmeyer said. "I suspect that a higher proportion of those procedures would fall into an intermediate zone, where it isn't totally clear from the medical evidence whether a [surgical procedure] is indicated or not."

The most direct concern of the research findings is that, in an era of rapidly rising health care costs, resources aren't being used effectively, Dr. Birkmeyer added.

"A bigger issue than the redistribution of patients from community to specialty hospitals, from the perspective of society, is how the opening of specialty hospitals is changing the threshold for intervention and the global cost associated with treatment," Dr. Birkmeyer said.

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One hospitalist's perspective

Anne Borik, DO

After spending several years at general hospitals, Anne Borik, DO, went to work at Arizona Heart Hospital as a contracted hospitalist with IPC-The Hospitalist Company nearly six years ago. (Arizona Heart Hospital is 30% owned by physicians and 70% owned by MedCath Corporation.) Dr. Borik spoke with ACP Hospitalist about her experience working at both kinds of hospitals.

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Q: What's the difference between working at a specialty hospital and a general hospital?

A: In a non-specialty hospital, you have a role to play, and that role may be specific. At a specialty hospital, you are available to the specialist in an unconditional way because there may not be the staff available to do things separately. For example, at my hospital, I may fulfill the endocrinology role for our diabetic patients while also helping to expedite discharge planning.

Q: Do you think working at a cardiac hospital is different than another kind of specialty hospital?

A: A lot of surgeons and cardiologists are really busy in procedures and interventions, so cardiac hospitalists really have to stand firm and be grounded, and make sure we are clearly available to the patient. We become educators in a general sense. We fulfill the need for patients to

understand the technical terms that the surgeons aren't going to spend time to sit down and explain.

Q: Why do you like working at a specialty hospital?

A: For one, I really enjoy cardiovascular medicine. Also, the hospital is a smaller physical area to cover—it's not a huge 10-story building—and it allows you to develop an intimacy with staff that you can't in a bigger facility.

Q: Are your hours different at a specialty hospital?

A: The hours are more predictable at a specialty hospital. There is a high turnover of patients, but they are mostly scheduled cases.

Q: Does the pace of the work differ?

A: A specialty hospital is fast-moving. You don't sit around and waste time during the day. I happen to be one that moves fast, so I am really cognizant of getting the patients in, getting the job done and getting them out.

Q: Do you think the pace is fast at most specialty hospitals?

A: Yes. If you look at a spine hospital, those patients are going to come in, get their procedure and get out. They aren't going to lie around for long. At mine, people come in with a heart attack, they go to the cath lab and on day 2 they are up and out.

Q: Do you ever miss the clinical variety of working at a general hospital?

A: At times I do miss the challenge of some of the newer, odder diagnoses and differential diagnoses. What offsets this is a greater sense of confidence. After a while you become very confident in dealing with some of the problems you might see at a heart hospital, like different cardiomyopathies, arrhythmias and post-op patients. I like the feeling that I have a good handle on what I do, and that I do it well and in a timely manner. I think the outcome is the patients get more efficient, timely care.