

Hospital Groups Optimistic About Health Reform

The economy is one reason that health reform may have a greater chance for success in Congress.

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Many physician and hospital groups are feeling optimistic about the chances for comprehensive health reform, in response to early signals from the incoming Obama administration.

Laura Allendorf, Washington representative for the Society of Hospital Medicine (SHM), expressed similar sentiments. "Health reform was a top priority for [then-Sen.] Obama during the campaign, and many members of Congress also made health care a key message in their campaigns," said Laura Allendorf, Washington representative for the Society of Hospital Medicine (SHM). "Consequently, lawmakers are expected to move quickly on a health care bill when the new Congress convenes."

The economy is one reason that health reform may have a greater chance for success now than it did during the Clinton administration, said Dr. Nancy H. Nielsen, president of the American Medical Association. As more Americans lose their jobs, they are also losing their health insurance, she said, driving policy makers to address the issue of the uninsured. "There may be more tension

for change now than there has been in the past," she said.

Mr. Obama addressed that tension head-on during a press briefing last month to announce former Sen. Tom Daschle (D-S.D.) as his choice for Health and Human Services secretary.

In a move that many agree signals how serious Mr. Obama is about health reform, he tapped Sen. Daschle for not one, but two posts. In addition to serving as HHS secretary, Sen. Daschle is slated to serve as director for a new White House Office on Health Care Reform. Sen. Daschle's HHS position must be confirmed by the Senate; however, the health care czar position does not.

Hospital-related societies also have other legislative priorities for the 2009. For example, the SHM is planning to advocate for changes in Medicare and other payment systems to reward quality and promote better outcomes. "The federal government needs to get better value for the substantial dollars it spends on health care," Ms. Allendorf said. "SHM will advocate for new reimbursement models that align incentives across providers to improve patient care. We will support [Medicare] demonstrations that test bundling of Part A and B payments for episodes of care, [and] urge

Congress to ease legal barriers that hamper the ability of hospitals and physicians to share savings from improved efficiency and quality."

The SHM also will advocate for improved care coordination, particularly as patients transition from the hospital to the home. The SHM is urging that components of its Project BOOST (Better Outcomes for Older Adults Through Safe Transitions)—a program that uses a team approach to assess patients and develop a plan for safe hospital discharge—be incorporated into congressional health reform plans as a way to improve care transitions and reduce readmission rates, Ms. Allendorf said. Increased funding for comparative effectiveness research is another priority for SHM, she added.

The Federation for American Hospitals has its own health care reform proposal, known as Health Coverage Passport. A health reform white paper written by Sen. Max Baucus (D-Mont.) includes many elements similar to those found in the federation's plan. "Once the new administration comes in, there is going to be a lot of movement" on health reform, said Jeff Cohen, executive vice president for advocacy and political affairs.

The FAH also would like Congress to pass a law barring physicians from referring patients to hospitals in which the physician has a financial interest. The House of Representatives has passed such a ban twice and the Senate has

passed it once, but the proposal has yet to become law, Cohen said.

Other legislative priorities for the federation include ensuring that hospitals receive their usual "market basket" payment increase in the Medicare program—based on the price increases for a standard list of goods and services—and pushing for rural hospitals to get their fair share of the "disproportionate share hospital" money that is given to facilities who serve a large number of low-income and uninsured patients.

Meanwhile, the AMA is pushing Congress and the administration to enact permanent Medicare physician payment reform by eliminating the sustainable growth rate formula, which ties physician payments to the gross domestic product. Without congressional action on the payment formula within the next year, physicians will be faced with a projected 21% cut in Medicare payments starting in 2010, Dr. Nielsen said.

If Congress chooses to throw out the SGR formula, legislators likely will need to authorize some fast-track pilot projects to test some of the most promising models for new payment systems such as global and bundled payments, said Robert Doherty, senior vice president of governmental affairs and public policy at the American College of Physicians. ■

Senior editor Joyce Frieden contributed to this report.

Work-Hour Rules

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patients and 6 hours for transitional and educational activities. In contrast, the Institute of Medicine (IOM) recommends that the 30 hours include 16 hours for admitting patients, followed by a 5-hour protected period for sleep sometime between 10 p.m. and 8 a.m. The remaining 9 hours may be used for transitional and educational activities. A simpler, second option is a 16-hour shift with no protected sleep time.

"The 80-hour workweek is reasonable, but [increased] restriction of the number of hours on call and for naps at night will be a challenge for everybody," Dr. Daniel J. Brotman said in an interview. The recommendation to limit on-call shifts to 16 hours "is absolutely too restrictive." Patient care may become more fragmented as a result, he said. "I worry the patient is going to be adversely affected by increasing the number of handoffs."

There is a love-hate relationship with residency work-hour reform, Dr. Brotman said. "For hospitalists, there are more job openings when residency work-hours rules restrict the number of hours residents can do. The downside is that hospitalists who work in academic institutions with house staff end up shouldering more of the clinical burden."

"Residency programs will be limited in their ability to retool their schedules and coverage schemes to fill these gaps, so hospitalist programs will need to help pick up this workload," said Dr. Michael J. Pistoria, associate general internal medicine section chief for inpatient medicine and associate director of the internal medicine residency program, Lehigh Valley Hospital, Allentown, Pa.

The Society of Hospital Medicine does not have an official stance on restriction of residency hours, according to a spokesperson.

The "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety" report, which is more than 300 pages long, estimates an additional \$1.7 billion is needed to comply fully with all of the recommendations, including the cost of additional staff to cover reduced residency hours. "Hospitalists are potentially the beneficiaries. That adds to our job security, but it will not be the type of work most hospitalists get excited about. For example, they may not be keen about covering a resident's patients at night while they sleep," said Dr. Brotman, director of the hospitalist program at Johns Hopkins Hospital in Baltimore.

Instead of this cross-coverage, a more likely scenario is a limitation on the number of patients admitted to a residency program, with hospitalists seeing their own patients separately, Dr. Brotman said. He has no affiliation with the Institute of Medicine or the ACGME.

Regarding the potential cost, "my first thought is: Where is that money going to come from? Hospitals and health networks are being squeezed in every way possible already," Dr. Pistoria said. "This will only add to the strain by essentially necessitating alternative means of in-house admission and patient coverage—i.e., hospitalist programs."

Although the IOM work-hour recommendations apply to all specialties (except the aforementioned tighter restriction for emergency department residents), there are differences in job function between residents. It makes less sense to restrict residents in a cognitive specialty, such as internal medicine, because it will mean a quicker dismissal of the physician who knows the patient best, Dr. Brotman said. In contrast, fatigue could be a greater concern among surgical residents. "You don't want someone dozing off in the operating room, so the residency work-hour rules may make sense for a surgical resident—you don't want them to start a case when they are fatigued."

Responding to the report in a media release, the American College of Surgeons stated concerns about

the shorter shifts. "The IOM recommendation regarding 16-hour shifts could compromise the education of the residents and possibly affect the continuity of patient care that is essential to ensuring that all surgical patients receive safe, effective, and high-quality care before, during, and after surgical procedures."

Noncompliance with the 2003 ACGME limits was an impetus for the IOM report. "A lack of adherence to current limits on duty hours is common and underreported," committee authors wrote in an IOM Report Brief (www.iom.edu/CMS/3809/48553/60449/60469.aspx). "Therefore, the committee recommends changes to ACGME monitoring practices, including unannounced visits and strengthened whistleblower processes to encourage resident reporting of violations of limits and undue pressure to work too long."

"Programs have been struggling to comply" with the ACGME limits, Dr. Brotman said. But "making the rules more draconian and enforcing them more is not the solution."

Other recommendations in the report include confining in-house call to every third night without averaging (the ACGME limits permit averaging); limiting the frequency of in-hospital night shifts to 4 consecutive nights a week, followed by 48 hours off; and specifying mandatory time off as 5 days per month, 1 day per week, and at least one 48-hour period per month. In addition, all moonlighting now counts toward the 80-hour per week average maximum for residents.

"Our residency program takes these limits very seriously and overhauled our schedule to allow us to be compliant with the 2003 rules," Dr. Pistoria said. He added that if any or all of the IOM recommendations are adopted, "it will force us and every other residency to again make some major changes." ■

The full report costs about \$50 and can be downloaded at www.nap.edu or requested by calling 800-624-6242.