Will Hospital-Employed Docs Raise Costs?

BY MARY ELLEN SCHNEIDER

AN ANALYSIS FROM THE CENTER FOR STUDYING HEALTH SYSTEM CHANGE

Hospital employment of physicians continues to rise rapidly around the country, but the trend could drive up costs at least in the short term, according to a report from the Center for Studying Health System Change.

Physicians who are employed by hospitals are often paid based on their productivity, which is an incentive to increase the volume of services. In some cases, physicians are under pressure from their hospitals to order more expensive tests, according to the report released in August.

Researchers from the CSHSC based their analysis on interviews with nearly 550 physicians, hospital executives, health plan officials, and others, in 12 nationally representative metropolitan communities (Findings From HSC 2011 August [Issue Brief No. 13]). The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y.

In one area, at least two cardiologists said they declined job offers from a local hospital because they believed the pressure to drive up volume would be stronger there than in their independent cardiology practices, according to the report.

"The acceleration in hospital employment of physicians risks raising costs and not improving quality of care unless payment reforms shift provider incentives away from volume toward higher quality and efficiency," said Dr. Ann S. O'Malley, a senior health researcher at the CSHSC and a coauthor of the study.

The trend toward hospitals' employing more physicians can also drive up costs for the health system because hospitals are able to charge hospital facility fees for office visits and procedures, even when those services are administered in a physician's office. That means that Medicare – and in some cases private insurers – are paying significantly more for the same services simply because the physician is employed by the hospital.

Hospital employment of physicians does have the potential to improve quality through better integration of care and communication between physicians. But the researchers noted that integration and communication can be slow to improve just because physicians get their paychecks from the hospital. respondents from the 12 communities said that the hospital employment model is generally helpful in coordinating care for a single diagnosis, such as heart failure. But integration across all of a patient's medical needs requires more time and effort, they said.

The research was funded by the Robert Wood Johnson Foundation and the National Institute for Health Care Reform. ■

Top-Notch Hospitals Often Have Physicians at Top

BY FRANCES CORREA

In a time when hospitals are looking for ways to optimize their performance, a recent study suggests an association between physician-led hospitals and high performance ratings.

Among 1,859 hospitals that were analyzed in the specialties of cancer, digestive disorders, and heart surgery, physician-led hospitals scored more than 25% higher than did those with nonphysicians managers, averaging 8-9 points more in their hospital quality ratings, according to Amanda Goodall, Ph.D., a senior research fellow at the Institute for the Study of Labor, Bonn, Germany. She analyzed data from performance ratings for the top 100 hospitals as ranked by U.S. News and World Report in 2009.

Hospital quality points were awarded based on quality measures including mortality rates, nurse staffing, physician decision making, the number of discharges, and availability of necessary technologies.

The fact that the number of physician-led hospitals has declined by 90% (from 35% in 1935 to 4% today) has contributed to the ailing U.S. health care system, according to Dr. Richard Gunderman of Indiana University, Indianapolis, who has written about physicians as hospital leaders (Acad. Med. 2009;84:1348-51). One of the reasons our health care system "is in such sorry shape" is the fact that many of the chief executives of our hospitals and health care corporations see the hospital primarily as a business whose product happens to be health care, Dr. Gunderman said.

He added that the qualities of a good doctor and a good manager are closely linked. "Studying structure and function and using it to improve coordination and performance is second nature to physicians. We need to provide physicians opportunities to better understand the structure and function of hospitals and [other health care organizations], so that they can use that understanding to help hospitals perform better."

The change, Dr. Gunderman said, needs to come from within the medical school curriculum.

"The organizational dimension of medicine (as opposed to the molecular, cellular, and other dimensions) has been crowded out of the curricula of medical schools and residency programs," he said. ■

Big Names Missing From List of Best Hospitals

BY ALICIA AULT

The Joint Commission issued a list of what it is designating as the top-performing hospitals in America, and the facilities that are not listed may be somewhat surprising.

The Commission, which accredits some 4,000 hospitals in the United States, created a new designation for hospitals last year, to recognize the ones that are "the best of the best" in terms of quality, said Dr. Mark R. Chassin, president of the Joint Commission.

Out of the 3,000 hospitals for which the Joint Commission has been collecting performance data on for the last decade, 405 met the top performance criteria for data reported in 2010. They represent only 14% of the universe of facilities that the Joint Commission accredits.

These hospitals had a 95% score on a composite measure for all 22 performance measures for heart attack, heart failure, pneumonia, surgical care, and children's asthma care. The hospitals also met a second 95% target for each individual measure, which means "a hospital provided an evidence-based practice 95 times out of 100 opportunities to provide the practice," according to the Joint Commission.

The 405 that made the cut were primarily small and rural, leading to questions from reporters as to why some of the bigger and better-known academic and urban medical centers, all having stellar reputations, did not achieve the ranking of a top performer. Dr. Chassin replied, "Reputation and performance on important measures of quality don't often go together."

Missing from the list are such well-known facilities as Johns Hopkins, Duke, the Cleveland Clinic, the Mayo Clinic, M.D. Anderson, and even the Geisinger Health System, which has been hailed as a quality pioneer.

Dr. Chassin said that the Commission's use of process measures, instead of outcomes measures, was the best way to determine quality of care.

Overall, hospitals are doing much better at meeting these measures, said Dr. Chassin. But he added, "Hospitals can and should do better."

Among the improvements tallied by the Joint Commission in its annual report on quality:

- Hospitals provided an evidence-based heart attack treatment 984 times for every 1,000 opportunities to do so, for a composite score of 98.4%. That's up from 86.9% in 2002.
- The surgical care score improved from 82.1% in 2005 (when it was added) to 96.4%.
- A total of 91.7% of hospitals achieved 90% or better on the overall composite score, up from just 26.2% in 2002.

Hospitals are still lagging in two areas. Only 60% are hitting the 90% target for providing fibrinolytic therapy for acute MI within a half hour of arrival. And 77% are reaching the 90% compliance goal for administering antibiotics to ICU pneumonia patients who are immunocompetent.

Starting in 2012, hospitals seeking accreditation will be required to hit 85% or better on a new composite measurement for performance on accountability measures. Dr. Chassin estimated that currently, 121 hospitals would not hit that target. ■

VIEW ON THE NEWS

Quality's in Outcomes, Not Process

Given that the "quality" we are talking about here is measured by process documentation (not actual outcomes), the smaller the hospital and number of documenting physicians, the more likely you are to see percentages of "quality" in the upper echelons. In other words, the process may be occurring in the larger hospitals, it is just not getting documented as such. ... Smaller hospitals can create uniform documentation standards a lot faster than larger hospitals.

It is a bit disingenuous for Dr. Chassin to suggest that reputation and performance do not often go together. In the case of the Cleveland Clinic, Johns Hopkins, Duke, and other similar centers, it most certainly does and has been shown in direct outcomes measurement.

You will notice that Lakewood Hospital in Lakewood, Ohio, is the only Cleveland-area hospital that is in the upper echelon in process measurement for acute MI as listed by the Joint Commission (as it is, Lakewood Hospital is owned by the Cleveland Clinic and is a member of the Cleveland Clinic Health System), but if, because of this "best of the best" list, a complicated patient with an acute MI chooses to go to Lakewood Hospital over going to a tertiary center with outcomes reported as good as the Cleveland Clinic main campus, then the Joint Commission should be ashamed of itself.

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