IMPLEMENTING HEALTH REFORM

The Ban on Physician-Owned Hospitals

The criticisms of physician-owned specialty hospitals are chiefly that they receive the same tax breaks and insurance payments as do traditional hospitals, but don't provide the same breadth of care (no labor and delivery, no emergency care), and that they are rife with conflicts of interest. Periodically, the federal government has imposed moratoriums on physician ownership, but even so, the number of facilities has grown. Now, a provision of the Affordable Care Act bans the construction of new physician-owned hospitals that do not receive Medicare certification before Dec. 31; existing physician-owned facilities have been prohibited from expanding since the law was enacted on March 23.

The American College of Cardiology believes the ban should be lifted and replaced with thoughtful policies.

DR. LEWIN

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

CLINICAL PSYCHIATRY NEWS: What finally moved Congress to approve permanent restrictions on physician ownership?

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

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

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

Dr. Lewin: The ACC supports a policy that promotes better medical and clinical quality outcomes and patient satisfaction. There are a number of ways to protect against physician self-interest, self-referral, and overuse of services. The use of ACC registries could readily identify such problems. In many instances, physician investors in these facilities are limited to less than 1% of overall ownership. It is hard to argue that this in itself is an unfair self-interest, in particular when there is no source of funding available to improve the situation in communities where operating rooms are overbooked, understaffed, and ill equipped.

In other words, the ACC supports assurances that physician self-interest is not the key factor behind a specialty hospital, but rather that the central issues are the best interests of the patient and community, and the quality of care.

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

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

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

Dr. Lewin: The ACC believes that the ban should be lifted and replaced with thoughtful policies that allow for specialty hospitals to improve access, quality, patient satisfaction, and efficiency.

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

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

Marketing Your Practice? Make Social Media Work for You

BY SALLY KOCH KUBETIN

FROM A SEMINAR ON RHEUMATOLOGY

SANTA MONICA, CALIF. – Social media provides a way for you to engage with your patients and the community, whether you practice in an HMO or privately, according to Dr. Jeffrey Benabio, a dermatologist at Kaiser Permanente in San Diego.

No matter what your specialty, the principles of using social media such as blogs, Facebook, and Twitter as tools for improving patient care will apply. "Online patient communities are an ascendant means for patients to learn about their disease, and seek advice and comfort from [other] patients like them," Dr. Benabio said in an interview. "Physicians can be part of this conversation and contribute to it. Who better to [advise] patients [on] how to live with pain, live with deformity, deal with insurance companies, than physicians?"

It takes no money but lots of time to build online networks. So why bother? "Patients are going online to interact with their physicians, and we are not there. Whereas patients always had to come to us to learn about disease and health, now they get most of their information online. Our absence online perpetuates a trend of diminishing importance of our profession," he said.

As with much in life, the secret to being effective online comes down to showing up. "A physician becomes a trusted member of the community by being present. Over time, regular blog posts, Facebook updates, and Tweets allow the audience to become familiar with you.

If you decide to post, focus on information that is helpful and informative to your audience. You can discuss medications and non–Food and Drug Administration uses of medications – as long as you do not give actual medical advice, and are clear about any disclosures and disclaimers, Dr. Benabio said.

Google yourself and see what you find."It is as important to be a trusted member of the online community as it is to be a trusted member of your actual community," Dr. Benabio said.

Despite the opportunities offered by establishing an online presence, keep in mind that you are on a slippery slope, he said. "This is a critical time when we are trying to demonstrate our value as practitioners. The more comfortable people are with nonphysicians, the more difficult it will be for us to fight nonphysicians' expansion of their scope of practice."

The seminar was sponsored by RHEUMATOLOGY NEWS – a sister publication of CLINICAL PSYCHIATRY NEWS – and the Skin Disease Education Foundation.

SDEF and this news organization are owned by Elsevier. Dr. Benabio disclosed that he is a consultant for Livestrong.com and a full-time employee of the Southern California Permanente Medical Group. ■