Single Specialty Medical Centers in the Context of Healthcare Reform

Much debate is currently focused on healthcare reform, with emphasis on imaging onrushing costs, increasing access, while maintaining quality.

The following points run contrary to current goals yet seem to work on a small scale.

Why not expand this to a national, or even global, level?

For starters, the recent focus on increasing primary care medicine may actually be more costly. While a necessary part of our medical infrastructure, the primary medical specialist needs to work more closely with their subspecialized colleagues. This will paradoxically increase health costs in the long run.

The exponential explosion of medical knowledge has clearly made it impossible for a physician to have even a cursory knowledge of all specialties, let alone subspecialties. The result is that a general physician will often miss the diagnosis, and currently more relevant, will expend much greater resources in order to arrive at the diagnosis, let alone formulate the appropriate treatment plan.

For example, it is not uncommon that a patient presents to me, a hand specialist, with wide pain. While my experience and clinical acumen, will often lead me to the diagnosis immediately by just listening to the patient’s complaints, the patient who comes from a primary care doctor may see me with an MRI already performed. A battery of blood tests, and perhaps even a course of physical therapy already in progress. The problem is that this patient may simply be suffering from DeQuervain’s tenosynovitis, a very common condition responding to a single corticosteroid injection in 80% of cases per the scientific literature. I am so confident about the result that these patients are typically not even given a follow-up appointment. Hence, the difference is clear: the subspecialist makes the diagnosis much faster, with superior resolution of the clinical problem and at much less cost, utilizing less testing and imaging provoking costs, increasing access, while maintaining quality.

The issue is that this same scenario applies in nearly all fields of medicine. Even in other orthopedic areas, as a hand surgeon, would be completely out of my league if evaluating a patient presenting with something as common as intractable low back pain. This diagnosis alone occurs in 65 million Americans and costs our society more than 100 billion a year! If I feel ill prepared to manage this problem as an orthopedist, how can a general internist, or perhaps even a chiropractor be sufficiently qualified to ensure that they are not missing spinal stenosis, a merrily herniated disc, or perhaps a scoliosis which requires surgery and not diagnosis, whether glaucoma, lymphoma or renal hypertension, should be managed by the appropriate specialist, from the outset and till symptoms resolve/massages.

A further problem is the instruction of non-trained, essentially hypnoses, into the fabric of American medicine. This means that non-medical personnel are frequently interfering with care, or serving as “cost-controllers” when they are really superfluous. Do physicians really need a pencil-pusher “authorizing” care when their staff calls the insurance carrier to essentially ask permission to perform a procedure or order a test? This layer of bureaucracy is redundant and not cost-effective. It slows the process and adds cost to the system. Are MDs not the best barometer of whether a test is needed?

An physicians not subjected to the most arduous training and education of most any profession while, in most cases, maintaining a certain ethical standard dictated by a professional code of conduct and enforced by medical societies. The amount of money, and time, saved by avoiding this validation step would greatly offset the occasional physician overutilizer, or even uncounselable provider.

A major cost issue remains the overtly prominent central role that the hospital systems continue to assume. This is very likely due to the powerful hospital lobby and is something that needs to be gradually scaled down. The issue is not only to move possible services into the outpatient care realm, but also to make them increasingly specialized. A major hospital system in Miami area has long recognized this fact and already formed a large network of efficient and accessible outpatient urgent care and diagnostic centers. Ophthalmology and endoscopy centers long ago have realized this gain, and furthermore, free market forces have actually driven down costs in many scenarios. A multi-disciplinary team can most effectively, and prudently, address clinical problems.

KNG Health Consulting found in a seven year study that moving a variety of surgical procedures into ambulatory surgical centers (ASCs) away from hospital corners, greatly decreased the cost of treatments. Despite concerns to the contrary, there was no overutilization, or even greater self-referral of patients, even when physician-owned.

Over-burdening government regulations, such as Stark I and II laws, have unfortunately inhibited this growth not allowing potential cost savings to be realized. Further expansion of government bureaucratic control would be even more detrimental.

The current hypothesis suggests that specialized centers contain not only ASCs, but also the necessary diagnostic, consultation, and rehabilitation services under one roof in order to promote efficiency, while delivering the most optimal care possible. Clinical studies can also be performed optimally in this environment, where large cohorts of patients with similar diagnoses can be studied, and patient outcomes can be more over successful, as well as cost efficient. Patients would have the opportunity to select these centers of their own accord, and be treated if appropriate, or referred by a panel of less specialized physicians, or even clinical nurse practitioners, who could best determine what venue the patient should pursue. This “one stop shopping” concept represents a common sense approach to health care.

Referring to our previous example, a middle aged labor complaining of low back pain would be seen, perhaps even without an appointment, in an orthopedic urgent care center. An orthopedic physician assistant, or preferably, a family practice physician with training in musculoskeletal medicine would do a cursory physical exam, order appropriate tests such as an X-ray, and have the spinal orthopedic surgeon see the patient in follow-up if initial anesthetics, NSAIDs and bedrest do not resolve the problem within several days. That specialist would then determine if further testing is truly necessary, such as an MRI to look for a disc herniation or other problem. He may be referred to a chiropractor for manipulation, a physiatrist or perhaps a physical therapist if appropriate. If surgical microdiscectomy is indicated, that too can be done in the same facility. All this would likely be done within several visits, if the patient is not discharged earlier, and the multitude of patients with similar conditions would sharpen each practitioner’s clinical skills.

All one has to do is ask a patient who has been seen in this type of facility what their opinion is. Patient satisfaction tends to be high. This approach can be used for many different types of medicine. We have seen the advent of orthopedic urgent care centers around the country in select markets. We have recently seen OrbusNOW open in the Doral area, blazing the trail for this concept in South Florida. We simply need to expand on what we already know…

Alejandro Badia, MD, FACS
Badia Hand to Shoulder Center
Hand & Upper Limb Consultant, OrbusNOW
www.orbusnow-fl.com