

2011

Table of Contents

Annals of Health Law

Follow this and additional works at: <http://lawcommons.luc.edu/annals>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Table of Contents, 20 *Annals Health L.* (2011).

Available at: <http://lawcommons.luc.edu/annals/vol20/iss2/1>

This Prefatory Matter is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in *Annals of Health Law* by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.

ANNALS OF HEALTH LAW

THE HEALTH POLICY AND LAW REVIEW OF
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW

VOLUME 20, ISSUE 2

SUMMER 2011

CONTENTS

Foreword i

ARTICLES

From Clinical Integration to Accountable Care MARK SHIELDS 151

Four key challenges to reforming health care organizations can be addressed by a clinical integration model patterned after Advocate Physician Partners (APP). These challenges are: predominance of small group practices, dominant fee-for-service reimbursement methods, weaknesses of the traditional hospital medical staff structure and a need to partner with commercial insurance companies. APP has demonstrated teamwork between 3800 physicians and hospitals to improve quality, patient safety and cost-effectiveness. Building on this model, an innovative contract with Blue Cross Blue Shield of Illinois serves as a prototype for a commercial Accountable Care Organization. For this contract to succeed, APP must outperform the market competition. To accomplish this, APP has implemented strategies to reduce readmissions, avoid unnecessary admissions and emergency room visits, expand primary care access, and enhance quality and patient safety.

Between the Scylla and Charybdis: Physicians and the Clash of Liability Standards and Cost Cutting Goals within Accountable Care Organizations CHRISTOPHER SMITH 165

This article seeks to examine the conflict between non-cost-conscious medical malpractice liability standards and health care cost cutting measures within the context of Accountable Care Organizations (“ACOs”) under the new health care reform law. This article begins by providing an overview of the high level of health care spending within the United States health care system in order to provide a context for better understanding policymakers’ push for cost cutting measures, including ACOs. This article then examines the tension between cost containment efforts and medical liability standards through an examination of the “stuck in the middle” mentality that physicians face when they are forced to meet both liability standards that do not take into account cost concerns and cost cutting standards imposed by or through managed care organizations, pay-for-performance programs and consumer-driven healthcare. This article then introduces the concept of the ACO and describes elements of the ACOs envisioned under the new health care reform legislation. This article concludes by examining and analyzing whether and how ACOs will exacerbate the cost containment/liability standard tension, and how that tension may impact the effectiveness of ACOs.

The Schizophrenia of Physician Extender Utilization THOMAS R. MCLEAN 205

The Patient Protection and Affordable Care Act of 2010 provides incentives for healthcare to be delivered by Affordable Care Organizations (ACOs). The public face

of many, if not most, ACOs is likely to be the Patient Centered Medical Home (PCMHs), a business structure that evolved from Retail Medical Clinics, which made greater use of physician extenders (PAs). Accordingly, this paper examines the evolution and structure of PCMHs as well as how the PCMH is regulated. As neither legal or market regulatory mechanisms are ideal for policing business structures that employ PAs, this paper concludes that the tort reform most appropriate for PCMHs is the introduction of either no-fault or enterprise liability coverage.

**Using Law to Fight a Silent Epidemic:
The Role of Health Literacy in
Health Care Access, Quality, & Cost BRIETTA CLARK 253**

The dominant rhetoric in the health care policy debate about cost has assumed an inherent tension between access and quality on the one hand, and cost effectiveness on the other; but an emerging discourse has challenged this narrative by presenting a more nuanced relationship between access, quality, and cost. This is reflected in the discourse surrounding health literacy, which is viewed as an important tool for achieving all three goals. Health literacy refers to one's ability to obtain, understand and use health information to make appropriate health decisions. Research shows that improving patients' health literacy can help overcome access barriers and empower patients to be better health care partners, which should lead to better health outcomes. Promoting health literacy can also reduce expenditures for unnecessary or inappropriate treatment. This explains why, as a policy matter, improving health literacy is an objective that has been embraced by almost every sector of the health care system.

As a legal matter, however, the role of health literacy in ensuring quality and access is not as prominent. Although the health literacy movement is relatively young, it has roots in longstanding bioethical principles of patient autonomy, beneficence, and justice as well as the corresponding legal principles of informed consent, the right to quality care, and antidiscrimination. Assumptions and concerns about health literacy seem to do important, yet subtle work in these legal doctrines — influencing conclusions about patient understanding in informed consent cases, animating decisions about patient responsibility in malpractice cases, and underlying regulatory guidance concerning the quality of language assistance services that are necessary for meaningful access to care. Nonetheless, health literacy is not explicitly treated as a legally relevant factor in these doctrines. Moreover, there is no coherent legal framework for incorporating health literacy research that challenges traditional assumptions about patient comprehension and decision-making, and that emphasizes the need for providers to improve communication and take affirmative steps to assess patient understanding.

The absence of a clear and robust consideration of health literacy in these doctrines undermines core access and quality aims, and it means that such laws are of limited efficacy in promoting health literacy. Returning to the theme that the health literacy problem reflects a complementary view of access, quality and cost, it is likely that the cost implications of this problem (and not concerns about quality and access) will motivate the kind of health literacy reform that may ultimately strengthen existing quality and access standards. One recent example of this can be seen in reforms linked to government, insurer and provider attempts to reduce costly medication errors.