TASK FORCE UPDATE: PART I

# The Challenge of Cost Shifting

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The members of the SGIM Academic Hospitalist Taskforce (AHTF) read with extreme interest a recent article in the *Annals of Internal Medicine*, titled "Association of Hospitalist Care with Medical Utilization After Discharge: Evidence of Cost Shift From a Cohort Study" (Ann Intern Med 2011;155:152). This research has broad and important consequences for hospitalists and generalists alike.

Researchers from the University of Texas Medical Branch in Galveston, Texas, analyzed a large Medicare database from 2001 to 2006, comparing hospitalized patients who were cared for by a hospitalist (a generalist with more than 90% of E&M codes from inpatients) to those who were cared for by a known primary care physician (PCP) (a physician the patient had seen two or more times in the last year). The study examined outcomes and costs associated with the hospitalization and the 30 days following discharge. The researchers performed sophisticated analyses including propensity scoring and conditional logistic regression.

In this database, patients cared for by a hospitalist had a *shorter* length of stay (LOS) (0.64 days shorter) and had *lower hospital charges* (- $282) compared to those cared for by their PCP. But during the 30 days following discharge, Medicare costs were *higher* (+ $332) for those patients cared for by hospitalists. In addition, those under hospitalist care were *less likely to be discharged home, more likely to visit the emergency department (ED), less likely to see their PCP, and more likely to be readmitted within 30 days*. In fact, 60% of the increased cost after hospitalization was attributable to readmissions.

While most previous studies of the hospitalist model have shown shorter length of stay and cost, those findings were limited solely to the hospitalization. This is the first study to show that the inpatient cost savings may be shifted to the post-discharge phase of care.

This striking result surprised many and certainly made for easy headlines and sound bites in the medical news and the lay press. (For example, the *New York Times* published an article, titled "The New Old Age: Do Hospitalists Save Money," on August 12, 2011.) Are the results a valid and true indictment of the hospitalist model? Has the rapid expansion of hospital medicine been bad for patients and the health care system? Should we return to the "old days" when there was a single provider across the care continuum? The SGIM Academic Hospitalist Taskforce thinks absolutely not.

Notably, there have been many criticisms of the study in letters to the editor and health care blogs, including: 1) the patients were hospitalized five to 10 years ago, so this study may not represent current standards of practice; 2) the patient population was limited to Medicare fee-for-service and did not consider younger patients or other insurance models; 3) the study did not consider quality of care provided by either hospitalists or PCPs; 4) the cost data for the hospitalizations may not reflect true cost savings with hospitalists—the LOS was decreased by 11%, but the cost decrease was only 2%—suggesting that hospitalists spend at least $300 more per day than PCPs (a finding not reported in previous research); 5) the plausibility of the findings regarding discharge disposition is questionable—the odds of discharge home under hospitalist care was 0.82, which would imply that one fifth of patients have a different discharge destination when comparing hospitalists and PCPs (a finding not validated in prior studies or in general practice); and 6) the potential impact of multiple unmeasured confounders has not been addressed.

Based on these concerns, should we reject the results outright and refuse to consider the implications? We think absolutely not.

We applaud the authors for asking an important question and for their large sample size, reasonable assumptions, and rigorous analysis. The research, while flawed, should force us to consider: If the results are valid, *why do the differences exist, and what are the implications for hospitalists and generalists*?

There are many theories as to why hospitalist care could result in shorter length of stay and inpatient cost savings, higher readmission rates and ED visits, and higher costs after discharge. One easy possibility is that hospitalists discharge patients "quicker and sicker" and that the shorter LOS results in higher readmissions and ED visits. Unfortunately, as an accompanying editorial points out, previous research doesn't support this connection. It is possible that hospitalists are less aware or comfortable with outpatient resources or networks and thus are more likely to discharge patients to a nursing facility or leave them without an adequate safety net after discharge. Conversely, PCPs might be more likely to readmit a patient discharged by a hospitalist because of uncertainty about the clinical course.

If this result is valid and real, there are many other possible ex-

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planations, but all of them focus a lens on the transition of care. Since the early days of the hospitalist movement, providers recognized that it is essential to get this right. Yet, in practice, it feels like we haven't quite figured out how to best admit patients, care for them, and then safely and effectively transition them back to outpatient care.

The AHTF views this paper as a call to action—a loud call not just for hospitalists but for generalists and the broader health care system. The coordination of an efficient, effective, high-quality, high-value transition from the hospital to the clinic is not a one-way street. To get this right, all of us will need to be engaged, keeping the patient at the center. In the era of the advancing patient-centered medical home and bundled payments, we look forward to working with SGIM and SGIM members to get this right. We look forward to engaging in rigorous research and thoughtful, multi-center, collaborative sharing of best practices. Let's get started.

*SGIM*