

EDITORIAL

Are Hospitalists Part of the Health Care Solution?

Michele Fang, MD

Dr. Fang is clinical assistant professor at the University of Iowa.

More than 30,000 doctors, nurses, and other care providers make up the hospitalist movement. A major driving force behind this growth is the purported savings in hospital costs and reduction in length of stay. Hospitalists have expanded their breadth from not only taking care of patients without physicians but also to expanding services to pediatric hospital medicine and neurosurgery co-management.

However, health care costs do not end with a patient's hospital discharge. A retrospective study of 60,000 Medicare patients from 2001-2006 showed that although hospitalist care yielded an average inpatient savings of \$282 per Medicare beneficiary, there was a higher readmission rate, more emergency department visits, and more patients discharged to skilled nursing facilities than their own homes. This led to an extra \$332 in the month after discharge—mostly from an increase in readmissions. One can make excuses and say it is because hospitalist patients, compared to patients followed by primary care physicians (PCPs), have more medical comorbidities. One might also argue that 30-day readmissions were not a primary goal during the study or that two times as many hospitalist patients came from skilled nursing facilities than from home. The finding that hospitalist care costs more, however, should be a wake-up call to all hospitalists.

Yet several studies have not found a strong association between length of stay (LOS) and readmission. It is more likely that the fragmented hospital care problems result from transitions of care, especially going from hospitalist to PCP. A hospitalist may "forget" to tell the PCP that a patient is being discharged from the hospital so that when the PCP gets a call from the patient about post-discharge problems the PCP instinctively tells the patient to go to the emergency department because he/she doesn't know the details of the hospital stay. In contrast, a PCP following a patient post-discharge may choose to have the patient come to the office for reevaluation rather than directly sending him/her to emergency. Hospitalists also tend to routinely use post-discharge services to nursing facilities when they feel a medically complex but stable patient could crash later; at least at a facility, nurses and physicians will "watch" over the patient.

The *Annals* article did not measure the intangible pieces of hospital medicine such as improved patient mortality and morbidity gained from quality improvement (QI) and process improvement. This is probably worth more than the additional \$50 associated with the hospitalist model. Although the length-of-stay reduction—especially when there is fixed reimbursement—can have a large financial impact, hospitalists

also may be better at decreasing hospital-acquired conditions such as catheter-related infections, deep venous thrombosis prophylaxis, and decubitus ulcers. Also, hospitalists have kept the hospitals running when the residency work-hour limits imposed by the Accreditation Council for Graduate Medical Education had reduced the number of inpatients a resident could admit. Hospitalists are often hired to cover the remainder of the patients both night and day.

Hospitalists have the opportunity to reduce costs for care by more than \$282 by ordering fewer tests, teaching our new physicians quality and process improvement, and performing QI projects. With the focus over the last 15 years on LOS, efforts in QI have only recently been emphasized. Yet physician compensation for performing QI is often not rewarded in academic medicine because there are no RVUs for research, it is difficult to get QI published as "original research," and often QI studies are time consuming to perform. Until hospital medicine puts these issues ahead of LOS or RVUs, we will fail to show our true value to hospitals and our patients.

Reference

Kuo YF, Goodwin JS. Association of hospitalist care with medical utilization after discharge: evidence of cost shift from a cohort study. *Ann Intern Med* 2011; 155(3):152-9." **SGIM**