

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 843 Patient Access to Primary Care Providers
SPONSOR(S): Health & Human Services Committee, Rodriguez, A.M.
TIED BILLS: IDEN./SIM. **BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|--|---------------------|---------|--|
| 1) Health Market Reform Subcommittee | 13 Y, 0 N | Gilani | Crosier |
| 2) Health Care Appropriations Subcommittee | 9 Y, 0 N | Nobles | Clark |
| 3) Health & Human Services Committee | 14 Y, 0 N, As CS | Gilani | Calamas |

SUMMARY ANALYSIS

'Continuity of care' generally refers to a patient's care over time by a single individual or team of health professionals but can also include effective and timely communication of health information at different levels of care between the patient, the primary care provider, and other treating specialists. This long-term patient-physician relationship in which the physician knows the patient's history from experience allows the physician to integrate new information and decisions efficiently without extensive investigation or record review.

Continuity of care by a primary care provider is associated with greater patient satisfaction and better patient outcomes, especially in the management of chronic conditions, by decreasing hospitalizations and emergency room visits, and improving preventative services. Conversely, fragmented care where a patient's various healthcare providers do not communicate with one another can have an adverse impact on the quality of care, and is associated with increased healthcare costs, medical errors, and risk of re-hospitalization.

The bill requires hospitals to notify a patient's primary care or specialist provider, if any, within 24 hours of the patient's admission to the hospital. Additionally, the bill requires the hospital to inform patients immediately upon admission that they may request to have their primary care or specialist provider consulted during the development of their plan of care. If the patient makes this request, the treating physician at the hospital must make reasonable efforts to consult with the patient's primary care or specialist provider during the patient's admission.

Upon discharge, the bill requires the hospital to notify the patient's primary care or specialist provider, if any, of the discharge within 24 hours and provide the discharge summary and any related information or records to the primary care or specialist provider within 7 days.

The bill may have an indeterminate, but likely insignificant, negative fiscal impact on the Agency for Health Care Administration.

The bill provides an effective date of July 1, 2019.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Continuity of Care

'Continuity of care' generally refers to a patient's care over time by a single individual or team of health professionals but can also include effective and timely communication of health information at different levels of care between the patient, the primary care provider, and other treating specialists.¹ This long-term patient-physician relationship in which the physician knows the patient's history from experience allows the physician to integrate new information and decisions from a holistic perspective efficiently without extensive investigation or record review.²

Studies suggest that continuity of care by a primary care provider is associated with greater patient satisfaction and better patient outcomes, especially in the management of chronic conditions, by decreasing hospitalizations and emergency room visits, and improving preventative services.³ Conversely, fragmented care where a patient's various healthcare providers do not communicate with one another can have an adverse impact on the quality of care, and is associated with increased healthcare costs, medical errors,⁴ and risk of re-hospitalization.⁵

Care Coordination

Health care experts, policy makers, and patient advocacy groups have identified coordination of care as an integral part of improving the current health care system.⁶ In 2010, Congress prioritized improvement of the health care delivery system through integrated care and care coordination, and created incentives for providers who communicate with one another across systems to improve patient

¹ Institute of Medicine Committee on the Future of Primary Care; M.S. Donaldson et. al., PRIMARY CARE: AMERICA'S HEALTH IN A NEW ERA, 27-51 (National Academies Press, 1996), available at: https://www.ncbi.nlm.nih.gov/books/NBK232643/pdf/Bookshelf_NBK232643.pdf (last visited Mar.12, 2019).

² Id. at 52-75; See also, AMERICAN ACADEMY OF FAMILY PHYSICIANS, *Continuity of Care*, <https://www.aafp.org/about/policies/all/definition-care.html> (last visited Mar. 12, 2019).

³ Michael D. Cabana, MD, MPH, and Sandra H. Jee, MD, MPH, *Does Continuity of Care Improve Patient Outcomes?*, 53:12 J. FAM. PRACTICE 974-980 (Dec. 2004), available at: <https://www.mdedge.com/jfonline/article/60297/does-continuity-care-improve-patient-outcomes> (last visited Mar. 12, 2019), a meta-analysis reviewed existing research and narrowed its scope to 8 studies focused on the effect of continuous primary care on quality of patient care; See also, David J. Nyweide, PhD. et. al., *Continuity of Care and the Risk of Preventable Hospitalization in Older Adults*, 173:20 JAMA Intern. Med.1879-85 (2013), available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1738715> (last visited Mar. 12, 2019), a retrospective cohort study of approximately 413,000 FFS Medicare beneficiaries over 65 with at least 4 ambulatory visits in one year observed the patients over a 2-year follow-up period. The study found that among this population, higher continuity of care is associated with lower rates of preventable hospitalizations; Eric A. Colean, M.D., M.P.H., et. al., *The Care Transitions Intervention: Results of a Randomized Controlled Trial*, 166:17 Arch. Intern. Med. 1822-28 (2006), available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410933?version=meter%20at%20null&module=meter-Links&pgtype=Blogs&contentId=&mediald=&referrer=&priority=true&action=click&contentCollection=meter-links-click> (last visited Mar.13, 2019).

⁴ "Medical error" generally refers to failure of a planned action to be completed as intended or a preventable adverse effect of care, and can range from documentation errors to improper diagnosis or failure to test or treat as required.

⁵ Study of 86 patients seen by their PCPs 2 months after hospital discharge found 49% experienced medical errors and patients with a work-up error were 6.2 times more likely to be re-hospitalized within 3 months after the first outpatient visit. Carlton Moore et. al., *Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting*, 18:8 J. GEN. INTERNAL MED. 646-51 (Aug. 2013), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494907/> (last visited Mar. 12, 2019).

⁶ See generally, THE AMERICAN COLLEGE OF PHYSICIANS, *The Patient Centered Medical Home & Specialty Physicians*, <https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home/understanding-the-patient-centered-medical-home/the-patient-centered-medical-home-specialty-physicians> (last visited Mar. 12, 2019); THE JOINT COMMISSION CENTER FOR TRANSFORMING HEALTHCARE, *Hot Topics in Health Care, Issue #2: Transitions of Care: The need for collaboration across entire care continuum* (Feb. 2013), available at: https://www.jointcommission.org/assets/1/6/TOC_Hot_Topics.pdf (last visited Mar. 12, 2019); THE COMMONWEALTH FUND, COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM, *Organizing the U.S. Health Care Delivery System for High Performance*, Aug. 2008, available at: https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2008_aug_organizing_the_u_s_h_ealth_care_delivery_system_for_high_performance_shih_organizingushltcaredeliverysys_1155_pdf.pdf (last visited Mar. 12, 2019).

outcomes.⁷ The American Academy of Family Physicians supports continuity of care and recommends the primary care provider play a role in the patient's care across all settings, directly and by coordination of care with other health care professionals.⁸ In an effort to better coordinate care, some hospitals have implemented continuity visits or increased communication procedures so that the patient's provider can be consulted in the patient's care.⁹

Physicians who practice a medical specialty have extensive education and training in a specific field of medicine, such as cardiology, endocrinology, orthopedics, or rheumatology. Due to their specialized skills, specialist providers are often consulted on or co-manage a patient's chronic condition.¹⁰ Specialty care is critical because it provides effective diagnoses and treatment to reduce clinical uncertainty and can be effective in the treatment and management of chronic conditions.¹¹ Studies show that the best patient outcomes result from co-management of conditions between specialist and primary care providers.¹²

Patient Handoff

A critical moment in the continuum of care is during patient handoff, when the patient care responsibility is transferred from one healthcare professional to another. This is especially significant during transition from an inpatient to an outpatient setting. Based on reports and studies, it does not appear to be common practice for a hospital to communicate with the patient's providers during a patient's admission or even at discharge.¹³ Often, the patient's providers are wholly unaware of the hospitalization or do not receive a discharge summary or information from the hospital.

There is evidence to suggest that when hospitals fail to communicate with the patient's providers during a patient's admission or discharge, there is an increased rate of medical errors and risk of re-hospitalization.¹⁴ A growing body of research and articles recommend that a patient's provider be informed of the patient's admission to or discharge from a hospital, with most effective care being provided when information is shared between the provider and treating physician throughout the course of the admission.¹⁵

⁷ The Patient Protection and Affordable Care Act, [Pub. L. No. 111-148](#), H.R. 3590, 111th Cong. (Mar. 23, 2010).

⁸ AMERICAN ACADEMY OF FAMILY PHYSICIANS, *Continuity of Care*, <https://www.aafp.org/about/policies/all/definition-care.html> (last visited Mar. 12, 2019).

⁹ Allan H. Goroll, M.D. and Daniel P. Hunt, M.D., *Bridging the Hospitalist-Primary Care Divide Through Collaborative Care*, 372:4 N. ENGL. J. MED. 308-309 (Jan. 2015), available at: https://www.researchgate.net/publication/271222735_Bridging_the_Hospitalist-Primary_Care_Divide_through_Collaborative_Care (last visited Mar. 13, 2019); See also, Larry Beresford, *Continuity Visits by Primary Care Physicians Could Benefit Inpatients*, THE HOSPITALIST (Apr. 2015), <https://www.the-hospitalist.org/hospitalist/article/122479/continuity-visits-primary-care-physicians-could-benefit-inpatients> (last visited Mar. 13, 2019).

¹⁰ Christopher Forrest, M.D., Ph.D., *A Typology of Specialists' Clinical Roles*, 169(11) ARCHIVE OF INTERN. MED. 1062-8 (2009), available at: <https://static1.squarespace.com/static/52d9c6c5e4b021f2d93416db/t/53a1f295e4b0b7f569f7e388/140312325699/Arch+Intern+Med+2009+Forrest.pdf> (last visited Apr. 4, 2019).

¹¹ *Id.*

¹² *Id.* See also, D. J. Willison, et al., *Consultation between Cardiologists and Generalists in the Management of Acute Myocardial Infarction: Implications for Quality Care*, 158(16) ARCHIVES OF INTERN. MED. 1778-83 (1998); J.E. Lafata et al., *Provider Type and Receipt of General and Diabetes-Related Preventive Health Services Among Patients with Diabetes*, 39(5) MED. CARE 491-99 (2001); J.Z. Ayanian, *Specialty of Ambulatory Care Physicians and Mortality among Elderly Patients after Myocardial Infarction*, 347(21) N. ENGL. J. MED. 1678-86 (2002).

¹³ Sunil Kripalani, M.D., M.Sc., et. al., *Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care*, 297:8 JAMA 831-41 (Feb. 2007), available at: <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.522.2320&rep=rep1&type=pdf> (last visited Mar. 13, 2019); extracted and synthesized data from existing body of research and found that direct communication between the hospital and primary care physician occurred less than 20% of the time, the availability of the discharge summary at the first post-discharge visit was less than 34% and remained poor even 4 weeks after discharge and affected the quality of care in 25% of follow-up visits.

¹⁴ *Id.* See also, *supra* fn. 5.

¹⁵ Diane Shannon, M.D., M.P.H., *Effective Physician-to-Physician Communication: An Essential Ingredient for Care Coordination*, 38(1) PHYSICIAN EXEC. J. 16-21 (Jan-Feb 2012), available at: http://www.mdwriter.com/uploads/1/8/0/3/18033585/md_to_md_communication_pej.pdf (last visited Mar. 12, 2019); See also, Stacey S. Brener, M.Sc., *Association Between In-Hospital Supportive Visits by Primary Care Physicians and Patient Outcomes: A Population-Based Cohort Study*, 11:6 J. HOSP. MED. 418-24 (June 2016), a retrospective cohort study of 164,059 patients, the 12% of patients who received visits from their primary care physicians had lower risks of adverse patient outcomes, fewer ER visits, and increased utilization of community health services; Carl van Walraven, M.D., M.Sc., *Effect of Discharge Summary Availability During Post-Discharge Visits on Hospital Readmission*, 17:3 J. GEN. INTERN. MED. 186-92 (Mar. 2002), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495026/> (last visited Mar. 13, 2019), studied 888 patients discharged from a single hospital after treatment for an acute illness and found that the discharge summary was only given to the primary physician in 25% of cases and in those

Hospital Regulation

In Florida, the Agency for Health Care Administration (AHCA) regulates hospitals under ch. 395, F.S. Current law does not require Florida hospitals to coordinate care with primary care providers or authorize patients to request such coordination.

Effect of the Bill

The bill requires each hospital in the state to notify a patient's primary care or specialist provider, if any, within 24 hours of the patient's admission to the hospital.

Currently, there is no statutory requirement that a treating physician at a hospital consult with a patient's primary care or specialist provider during the admission. The bill requires the hospital to inform patients immediately upon admission that they may request to have the treating physician consult with the patient's primary care or specialist provider, if any, when developing the patient's plan of care. If the patient makes this request, then the treating physician must make reasonable efforts to consult with the primary care or specialist provider during the patient's admission.

Currently, there is no statutory requirement that a hospital notify the primary care or specialist provider of a patient's discharge from the hospital. The bill requires each hospital in the state to notify a patient's primary care or specialist provider, if any, within 24 hours of the patient's discharge from the hospital and provide the discharge summary and any related information or records to the primary care or specialist provider within 7 days of the discharge.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Creates s. 395.1052, F.S., relating to patient access to primary care provider.

Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

AHCA may experience an insignificant negative fiscal impact for rulemaking, which it can absorb within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

cases, the patients had a decreased risk of re-hospitalization compared to their counterparts; See generally, Gregory A. Harlan, et. al., *Improving Transitions of Care at Hospital Discharge—Implications for Pediatric Hospitalists and Primary Care Providers*, 32:5 J. HEALTHCARE QUALITY 51-60 (Sept.-Oct. 2010); Vicenza Snow, M.D., et. al., *Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine*, 4:6 J. HOSP. MED. 364-70 (July-Aug. 2009), available at: <https://pdfs.semanticscholar.org/4d62/22d8eadfdb0e3dc7edad34cc86b1290afbd5.pdf> (last visited Mar. 13, 2019).

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DATE: 4/4/2019

PAGE: 4

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill's requirements for hospitals to provide patient notices, facilitate consultations between providers, and transfer discharge information to the providers may increase hospital workload, and may reduce hospital costs by reducing readmissions and other adverse incidents.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority in current law to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 3, 2019, the Health and Human Services Committee adopted a strike-all amendment that adds a patient's specialist provider, if any, to the bill's requirements for notification, consultation, and transfer of information and records transfer.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.