The Florida Senate

Interim Project Report 2000-56 *September 1999*

Committee on Health, Aging and Long-Term Care Senator Charlie Clary, Chairman

STUDY OF THE EMERGING PHYSICIAN SPECIALTY "HOSPITALISTS"

SUMMARY

"Hospitalists" are licensed physicians who practice exclusively in the hospital setting and specialize in the care of adult hospital inpatients. At this time, the only public policy issue that has crystallized relating to hospitalists is how managed care organizations are implementing hospitalist requirements. The issue is whether or not a hospitalist program is being implemented on a mandatory basis or a voluntary basis.

Hospitalists are not a creation of managed care. Hospitalists are creatures of modern medical economics. Since 1997, growth in the number of hospitalists and the use of hospitalists has escalated rapidly.

There is no single model for implementing a hospitalist program and there are no definitive studies of the effects of the use of hospitalists on health care quality and costs. Because hospitalist programs are evolving in the health care market and because the effects are not yet clear, staff recommends no legislation at this time.

BACKGROUND

This report examines *who decides which* physicians admit and manage adult patients in the hospital (inpatient) setting. Since the mid-1980s, primary care physicians have been arranging with other physicians, who specialize in the care of inpatients, to manage or coordinate the care of their patients during the patient's hospitalization. In reaction to a managed care company *unilaterally requiring* that its subscribers be admitted by and managed by physicians with whom it had contracted for care during hospitalization, some affected parties have sought legislation to prohibit such a requirement.

Legislative Action

During the final few days of the 1999 legislative Session, language that purported to prohibit health maintenance organizations (HMOs) from mandating the use of hospitalists was amended onto Committee Substitute for Senate Bill 2554, relating to insurance contracts. The adopted language states *[n]o health maintenance organization's contract shall prevent a subscriber from continuing to receive services from the subscriber's contracted primary care physician or contracted admitting physician during an inpatient stay*. Another related provision states *a health maintenance organization shall not deny payment to a contract primary care physician or contract admitting physician for inpatient hospital services provided by the contracted physician to the subscriber.* The language was amended out of the bill by the House of Representatives and, therefore, did not become law.

This legislative language was in reaction to an effort to require use of hospitalists for the delivery of adult inpatient hospital care, except obstetrics and gynecology, as announced in a letter dated February 12, 1999, from Prudential HealthCare-South Florida to its physician providers. In a letter addressed to "Dear Colleague," the company's medical director for South Florida notified the plan's network of physicians " . . . that beginning March 15, 1999, IntensiCare Corporation, a hospital management company, will begin a transition towards principal responsibility for all PHC members during the time of confinement in an acute or sub-acute setting." The transition was to proceed in two phases. Phase One starting on March 15th at nine named facilities and "all sub-acute facilities," and Phase Two starting on June 15th "at all other PHC contracted hospitals and will continue at all sub-acute facilities." Plan providers were instructed that "[a]ccording to the above-noted schedule, when a PHC member needs inpatient or sub-acute care, the medically necessary admissions will be approved to the appropriate facility by one of our participating 'Hospitalists.'" The letter goes on to state three anticipated benefits to result from this change and then: "We will be communicating this information of enhanced acute care to our members, through our customary publications, as well as our Member Services. Please join us in optimizing the benefits of this program by sharing this information with your Prudential patients."

The apparently unilateral and mandatory approach employed by the company catapulted a legislatively "invisible" issue, up to that point, into the legislative deliberations during the final days of the 1999 legislative Session that ended April 30. The company's actions seem to have solidified opposition to the mandatory use of hospitalists. To date, while other HMOs in Florida have announced plans to implement a hospitalist program, no others are known to be pursuing a mandatory policy. The only other reported instance of mandatory use of hospitalists by a managed care company that staff has been able to confirm is by Cigna Healthcare of Texas.

Evolutionary Nature of American Health Care

It is often said of the practice of medicine that it is more an art than a science. So, too, can the broader health care system be understood as a combination of the practice of medicine *with* the application of contemporary social policy that prescribes how to finance the services and products delivered through the system. Social policy is a constant factor influencing the American health care system for two important reasons: (1) the inflationary tendencies of the health care sector of the economy and (2) the role of all levels of government as a sizeable purchaser of health care services using tax dollars.

Evolution of the Practice of Medicine

The practice of medicine is continually evolving, and has seen its more rapid development during the later half of the 20th century. There has been an explosion of medical knowledge during this period that includes a growing recognition of the distinctness of hospital practice from office practice. Patient care during earlier eras was basically "seamless," but varied, in terms of the physician-patient *relationship* as such care moved from the office to the hospital treatment setting. Now, inpatient care is allocated only for the sickest patients and, due to technologic advances and advances in treatment therapies, outpatient hospital care or outpatient office care is available to many patients who previously would have had to be hospitalized. The medical community seems to be moving toward separating the practice skills applicable to the illnesses that require inpatient care from those that can be treated with outpatient hospital or office care.

Physician practice patterns have changed substantially from the time, approximately 20 years ago, when a physician's office was located next door or across the street from the hospital in which his or her patients were being treated. Back then, primary care physicians (PCP) cared for an estimated average of 15 to 20 hospitalized patients *per day*. Now, most PCPs care for an estimated average of only one or two hospitalized patients per day, if any, and those patients may be located in two or three different hospitals around a city or county. Now, due to a variety of factors, including the development of outpatient care for conditions that previously required inpatient hospitalization, many physicians are no longer located next door to, or across the street from, the hospital in which they have privileges. Furthermore, today a managed care company, more often than not, may decide from which hospital a subscriber/patient must seek services, as controlled by its contractual arrangements. Therefore, making hospital rounds more commonly, nowadays, involves a car commute, which may directly impact the frequency and spontaneity of visits to confer with hospitalized patients, or the physicians who are treating them, that is, if the PCP is maintaining an office practice as well.

The evolution of medical practice into the distinct realms of inpatient and outpatient care, generated by the explosion of medical knowledge was preceded by medical practice evolving through trends of specialization and subspecialization. As a result, after finishing basic medical education, including an internship, medical students more often than not pursue resident training so that they may acquire additional, yet more specialized, medical skills in a more narrowly focused aspect of medical practice. Examples of such specialties include dermatology, internal medicine, surgery, pediatrics, radiology, pathology, or emergency medicine. Further specialized training may result in subspecializations such as, (1) under pediatrics: neonatology, pediatric cardiology, pediatric surgery, intensive medicine; (2) under internal medicine: psychiatry, cardiology, gastroenterology, pulmonology, urology, obstetrics and gynecology, or oncology; and (3) under surgery: cardiovascular surgery, neurosurgery, and orthopedics.

Of all the specialties and subspecialties that have emerged, the specialty of general internist appears to be sort of lost in the rapid rush to subspecialization. It seems that increasingly there is less demand for the services of a general internist in the hospital setting due to the number of subspecialties of internal medicine that focus expertise more narrowly on specific systems or organs of the human body. However, there seems to be a growing appreciation for general internists with significant practice time in the hospital setting as

invaluable managers/coordinators of specialists and subspecialists in the care and treatment of inpatients.

Over the years, numerous physician specialties have emerged for the care and treatment of hospitalized patients. One of the more visible specialties to which the hospitalist specialty can be most readily compared is that of specialization in emergency medicine. No longer do PCPs direct their patients to meet them at the emergency room when the patient calls to complain about an urgent health-related problem. For the most part, PCPs instruct their patients to go the emergency room, if determined necessary, and to call the managed care provider or other appropriate entity for authorization to receive services from the emergency room physician and staff. The emergency medicine specialty seems to have been widely accepted across all sectors of the health care community for at least the past 20 years.

"Hospitalist" Defined and Professional Training
According to the National Association of Inpatient Physicians (NAIP), an organization that represents the interests of hospitalists, the term "hospitalist" is merely "a job description." Hospitalists may be allopathic or osteopathic physicians. Approximately 55 percent of hospitalists are trained in general internal medicine; 35 percent are trained in an internal medicine subspecialty, most commonly pulmonary or critical care medicine; about six percent are trained in family practice; and the remainder are mostly pediatric hospitalists trained as pediatricians. There is no separate specialty board certification currently available for hospitalists.

The hospitalist "specialty" is simultaneously an old and a new health care delivery concept. The term "hospitalist," according to NAIP, is a physician dedicated to the care of hospitalized patients. They coordinate all aspects of an inpatient's care, including regular visits to the bedside, ordering tests and medications, integrating recommendations from specialists, and updating the family until the patient is discharged, when care is transferred to the patient's PCP. Generally, throughout the literature, others describe hospitalists as licensed physicians who devote a minimum of 25 per cent of their practice to *management or coordination* of *adult* hospital inpatient care, nursing home care, or rehabilitative care. The concept is old in the sense that for more than 20 years pediatric practice in the United States has involved consultation with physicians specializing in hospital-based care of children, referred to as "intensivists" rather than "hospitalists." It is a, relatively, new concept when applied to adult health care.

The National Association of Inpatient Physicians estimates that there are, nationally, 5,000 physicians currently practicing as hospitalists, an increase from an estimated 300 in 1995. The estimated number practicing in Florida is 300, and they are located in all regions of the state.

Health Care Financing and Hospitalists
The financing mechanisms in the American health care system are characterized by dysfunctional markets that are perpetuated by huge federal government purchasing programs, mainly Medicare and Medicaid, employer-sponsored health plans that are self-funded or purchased, and a sizeable group of people who have no health insurance and who may, or may not, be able to pay for needed health care services. Meanwhile, those parties responsible for paying for services provided through the health care system, have a desire to maximize efficiencies and are always seeking means of building in predictability of costs.

As the desire to control health care costs (largely through the managed-care approach to health care delivery) has increased, physicians and hospitals are increasingly experiencing changes in how they function in the health care system. Payment for health care services is more often than not structured to cover a bundle of services for a specified period of time on a per patient basis. Unlike fee-for-service reimbursement that allows physicians and hospitals to directly influence the amount they earn based on the services they provide, managed care reimbursement has significantly constrained the earnings flexibility of physicians and hospitals.

Also, managed care has affected the ability of physicians to handle an office practice along with a hospital practice. Under capitated payments, most physicians participating in managed care plans accept, or must be willing to accept, a large number of subscribers to achieve a level of compensation that is sufficient to meet their needs and expectations. The large number of subscribers to which a PCP must be available contributes another significant factor to practice logistics. While the volume of office visits per day has substantially increased, the number of hospitalized patients continues to decrease, albeit such patients are much sicker than the average hospitalized patient of earlier times.

For several years HMOs and other managed care organizations produced quantifiable and predictable savings relating to health care costs. Such has not been the result for the past two years, at least, for most HMOs. In a story from the Associated Press published in the *Orlando Sentinel* on August 10, 1999, the majority, 56 percent, of HMOs are characterized as having lost money "for the second year in a row in 1998, prompting many plans to raise premiums and cut benefits." In fact, according to this report, HMOs lost a national aggregate of $490 million in 1998 and $768 million in 1997, based on findings of a study by Weiss Ratings, an independent rating service. The narrower loss reported for 1998 relative to the 1997 reported loss, according to Weiss Ratings, is directly attributable to increased premiums and reduced coverage of Medicare beneficiaries.

The adverse financial developments impacting HMOs may reasonably be expected to affect service delivery and availability, because of the large proportion of people who receive their health care through such organizations. Certainly, HMOs have incentives to reduce costs and improve efficiencies in order to minimize financial losses. However, they are just as certain to understand that they cannot survive if they compromise the quality of care they provide to their subscribers. Consequently, HMOs may view hospitalists as offering "salvation," particularly if they believe the claims of substantial savings--some claims of as much as 30 percent--on hospital costs. This could mean a savings of almost $400 per day per patient, or more, in Florida where it is reported that hospital stays can cost $1,300 per day per patient. A representative of hospitalists believes hospitalist care may save an indemnity insurer paying on a *per diem* basis from 10 to 20 percent for the patients that a hospitalist manages. If payment is on a capitated basis or by diagnosis-related group (DRG), that savings would be realized by the hospital providing services to the patient.

Physician Professional Lifestyle Transformations

Though earnings are more predetermined under managed care contracts than under the fee-for-service reimbursement system, it seems that the predetermined character of these earnings have added an element of predictability that has enabled physicians to pursue certain lifestyle changes relating to their professional practice patterns. For example, some physician group practices assign, on a rotating basis, one of the group members, or contract for a physician, to cover all inpatient care for the adult patients of the group. Numerous physician practice management companies seem to be very instrumental in driving the growing demand for hospitalists by marketing this as a readily available option that allows for physician professional lifestyle change. Such an arrangement permits those physicians who want to concentrate their attention on an office-based practice to do so while accommodating those who choose to focus on a hospital-based practice. Furthermore, under managed care contracts, PCP payment may be capitated on a per-person or fixed-sum basis that does not provide additional compensation for inpatient hospital care so that there is no additional financial reward resulting from caring for inpatients.

Hospital Patient Management Issues

Many hospitals provide uncompensated care to indigent, uninsured, and underinsured patients. Care of such patients is generally provided by a salaried hospital physician, often a medical graduate known as a resident. Under a fee-for-service system of reimbursement, hospitals were able to cover some of the expense of uncompensated care by assigning charges for services provided to paying patients sufficient enough to off-set some of the cost of uncompensated care. Managed care reimbursement has made cost shifting far more difficult because the revenue base on which to cost shift has been substantially reduced due to the proportionately fewer patients whose care is paid for by fee-for-service insurers and because of the pre-negotiated fees of managed care organizations and self-insured employers for hospital services. To better manage their costs and the provision of uncompensated care, some hospitals have hired hospitalists to *coordinate* services provided to indigent, uninsured, or underinsured adult inpatients by resident physicians and other licensed physicians, and may also use them to assist with coverage of patients of physicians who have been granted practice privileges at the hospital.

METHODOLOGY

Since the hospitalist concept is relatively new, staff has proceeded with this project relying primarily on discussions with and interviews of representatives of family practice physicians, the managed care industry, the hospital industry, and representatives of hospitalists. Additionally, staff has requested representatives of managed care organizations to inquire of their membership about their intent to implement hospitalist services as a feature of their health care service delivery. Hospitalists publish information about issues of professional interest on the Internet. Staff has utilized some of these Internet sites in developing an understanding of hospitalists within the context of this project.

FINDINGS

The hospitalist concept is, relatively, so new that more questions arise than answers exist about how PCPs and hospitalists will interact in meeting the total health care needs of adult patients. In effect, introduction of a hospitalist into the care of a patient results in two distinct "realms" of care, particularly under a managed care system--inpatient hospital care and outpatient in-office care.

Research on the hospitalist issue for this project has "uncovered" seven major findings. These findings follow with explanatory comments.

***Mandating* that a hospitalist deliver all adult inpatient hospital care *is* universally opposed by representatives of all physician organizations, including the representatives of hospitalists, as well as other participants in the health care system such as patients and hospitals.**

Mandatory hospitalist programs, so far, have been imposed by at least two national HMOs, though only one such program has been initiated in Florida. In the article, "A New Doctor in the House: Ethical Issues in Hospitalist Systems," *Journal of the American Medical Association*, July 14, 1999, the authors make several salient points about the use of hospitalists in general and about mandatory *versus* voluntary hospitalist programs. They note:

- Use of hospitalists *deliberately disrupts* continuity of patient care. Consequently, this "discontinuity raises several ethical concerns, primarily because it may compromise the relationship between PCP and patient . . . [p]atients can no longer rely on agreements reached in the office following them to the hospital. Nonetheless, the hospitalist shares the PCP's obligations to respect the ethical principles that agreements about preferences for care or individual values often represent.
- The PCP no longer has a formal role in the delivery of inpatient care " . . . because the hospitalist replaces rather than complements the PCP in inpatient care . . . thus institutionaliz[ing] complete discontinuity [of care]."
- The patient-PCP relationship is based on trust that develops over a period of time. A hospitalist, on the other hand, is "unlikely to develop a long-term relationship with a patient," and may consequently "undervalue the importance of working" with a patient to gain trust.

A mandatory hospitalist program imposed by an HMO or a managed care company may result in a situation in which a patient receives hospital care from a physician whom he or she has not chosen and, therefore, has not given informed consent for treatment. Furthermore, selection of a hospitalist at the time of hospitalization would not be ideal, especially when the patient may be learning of such an arrangement for the first time.

It seems that *voluntary* hospitalist programs implemented by HMOs are based on the demonstrated ability of their physicians to *reasonably manage hospital utilization*. Most of the HMOs operating in Florida seem to have implementation of a hospitalist program under consideration, to varying degrees. Relying on internal hospital utilization data, some HMOs are encouraging their physicians to participate in a hospitalist program or, alternately, HMOs may be contracting with physician group practices that utilize hospitalists.

The National Association of Inpatient Physicians, founded in 1997, has published a position statement strongly opposing mandatory implementation of hospitalist programs. In addition to its position statement, NAIP's co-presidents John Nelson, M.D. and Winthrop Whitcomb, M.D., on behalf of the board of directors, on May 3, 1999, sent a letter to the American Association of Health Plans and the Health Insurance Association of America to oppose, "in the strongest terms possible, the imposition of mandatory hospitalist programs by [managed care] organizations on patients and primary care physicians." They sent the same letter, on June 9, 1999, to the Blue Cross and Blue Shield Association and, on July 21, 1999, to Prudential HealthCare-South Florida and Cigna Healthcare of Texas. The stated basis of their opposition was, " . . . we believe that the success of the hospitalist model fundamentally depends on the ability of the primary physician, with whom the patient has a long-standing and trusting relationship, to endorse both the individual hospitalist and the hospitalist model of care to a patient."

John R. Nelson, M.D., Co-president of the National Association of Inpatient Physicians advocates voluntary use of hospitalists by the primary care physician. He believes that "hospitalists need to earn referrals not be assured of them through managed care mandates." [Telephone interview, August 12, 1999]

Use of hospitalists in the delivery of adult inpatient hospital, nursing home, and subacute care services is *anticipated* to result in significant efficiencies and *cost savings*, and early results when examined by interested parties, seem to indicate that such anticipation may be correct; however, while use of hospitalists is growing rapidly, the experience is so limited and the time frame so short that no meaningful determination about cost trends can be made at this time.

This is the conclusion of Kaiser Permanente in a study that it conducted between 1994 and 1997, as reported in "Implementation of a Hospitalist System in a Large Health Maintenance Organization: The Kaiser Permanente Experience," *Annals of Internal Medicine Supplement*, February 16, 1999. Following development of its best practices hospitalist model, Kaiser Permanente implemented a hospitalist program in January 1996. As a result of its study, subject to several research design limitations, the HMO reported finding " . . . no striking changes in utilization or quality outcomes in facilities that adopted a hospitalist model for inpatient care." Noting that its inpatient utilization had been declining since 1990, the HMO did find that "[f]acilities that implemented hospitalist programs have seen a trend toward lower mean lengths of stay for adult medicine inpatients. . . . [w]e have not seen the same type of decrease in admission rates, which have remained fairly stable since the implementation of hospitalist programs."

A multi-specialty group practice, Park Nicolett in St. Louis Park, Minnesota, that implemented its own hospitalist program in January 1994 did report decreased hospital charges due to the decrease in length of stay. The study was performed by the group practice that later merged with Methodist Hospital in Minneapolis to form HealthSystem Minnesota in 1995. Because of the different organizational structure between the group practice and the HealthSystem, the study findings are not applicable to the hospitalist program implemented by the HealthSystem. *See* "The Park Nicollet Experience in Establishing a Hospitalist System," *Annals of Internal Medicine Supplement*, February 16, 1999.

Entities such as insurers, HMOs, and hospitals that pay for, or are otherwise responsible for, inpatient services clearly anticipate significant savings from hospitalist practice efficiencies. There have been reports of payers allocating as much as 40% of their revenue to inpatient care. It seems reasonable that hospitals would consider a hospitalist program as a possible solution to the delivery of quality, cost-effective care for uninsured or underinsured patients. Projected savings estimates as high as 30% seem doubtful, but the development of other medical specialties offer some evidence that focused specialization in hospital care may reasonably be expected to yield improvements in quality and efficiency in service delivery. Conversely, medical specialization has sometimes contributed to health care inflation due to higher reimbursement levels for specialists and the tendency of specialists to accelerate use of cutting edge technology.

In a related development, the federal government has issued an advisory bulletin that prohibits certain cost savings incentive arrangements between hospitals and physicians. The Office of the Inspector General (OIG) of the Department of Health and Human Services announced in July 1999, as guidance to the health care industry to prevent fraud and abuse and to promote lawful and ethical conduct, that it had determined so-called gainsharing arrangements should be prohibited when involving care provided to Medicare or Medicaid patients. Gainsharing arrangements are direct or indirect payments to physicians from hospitals "as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's care." Such arrangements provided for the hospital to split the savings created by a physician and may have been used as a part of hospitalist compensation or as incentives to any physician having privileges to practice in a hospital with such arrangements. Reportedly, some of the independent hospitalist companies have negotiated contractual terms with HMOs of 50% of savings. It is unclear whether the OIG position will affect any such arrangement, if Medicare or Medicaid patients are not involved.

Hospitalist proponents insist that hospitalists improve the *quality of care* of hospital, nursing home, and subacute care services because of their focused expertise; more immediate availability to the patient and staff; higher volume of setting-specific experience; and greater familiarity with the institutional personnel and settings in which they practice, relative to physicians caring for few patients on an infrequent basis in, generally speaking, unfamiliar settings.

While there are considerable expectations and anecdotal accounts of quality improvement resulting from the expertise of hospitalists, sufficient time has not elapsed to yield data adequate for evaluation of the impact of such a program. Some preliminary studies have found the potential for such quality improvements as:

(1) managing physician availability for provider consultations and patient or family consultations--improved communications; (2) efficient test ordering and use; and (3) outpatient enhancements due to increased PCP availability in the office for, possibly, longer office visits for outpatients.

Use of hospitalists may exacerbate the *communication* problems that already exist between PCPs and the specialists who provide most adult inpatient hospital treatment.

Communication deficiencies currently exist between PCPs and specialists because of the discontinuity of care as a patient obtains services in the different settings of the health care system. Hospitalist programs, if not carefully designed, could exacerbate these deficiencies. Instead of a seamless continuum of care, a patient's care is "segmented" as a result of where the record of care resides after services have been rendered. Hospital records remain with the hospital, outpatient PCP in-office records remain with the PCP, payment records remain with the insurer or managed care company, and there is currently no mechanism that brings all of the patient data together into one document file.

Because of the fragmented records system, problems may arise around certain patient sensitivities known to the patient's PCP, such as a female rape victim's refusal to be treated by a male physician, an AIDS patient who may not want information about his or her health disclosed to certain family members, or instructions about end-of-life care. If the PCP is not involved in selecting the hospitalist or is not allowed a formal role in the patient's care, the PCP is incapable of avoiding possible patient emotional traumas, breaches of confidentiality, or facilitating honoring of expressed patient wishes documented in the PCP's patient record in an advance directive.

Use of hospitalists may force patients to take on a more formal responsibility in coordinating their health care between hospital services received and physician office services received to ensure *continuity of care*. This may be necessary because, if the patient's PCP is not the admitting physician, such physician may not have the ability to access the patient's hospital record, which is the hospital's property, leaving PCPs to rely on the patient care summaries provided by the hospitalists attending to the patient.

A hospitalist system may result in the insurer or managed care company having a "complete" patient file for each patient. Yet such a system may preclude the PCP or the hospitalist from having the ability to factor in other information known about the patient, but housed in a file to which the provider may not be authorized access. Therefore, either payers will need to institute information technology that allows for the authorized, controlled, and shared access to patient records maintained by all care providers or patients will need to arrange to maintain a complete medical file of all care they have received.

To the extent that PCPs limit, or are limited in, hospital, nursing home, or subacute care experience, they may find it increasingly difficult to resume such practices and may be limiting their *future ability to be credentialed* to work in such settings due to the loss of skills necessary for working in such environments.

It is unclear whether diminished hospital practice will automatically result in loss of the ability to be credentialed for hospital privileges; there may be other means such as continuing medical educations courses that may accommodate such abilities. However, the impact of a hospitalist program on credentialing should be considered by licensed physicians and those in training to ensure that such skills continue at an adequate level for support of a community's needs during times of extraordinary demand for hospital care.

Apparently, HMOs have been increasingly polling their PCPs (and evaluating through other means) for their rate of hospital admissions. The majority of PCPs seem to be reporting an estimated average of 1 to 2 inpatients per month. If such an estimate is near to the actual number of inpatients attended by PCPs, it would seem to suggest that PCP hospital-based skills could be "eroding." Such erosion may occur due to the relatively limited amount of time spent on patient management in the hospital setting, limited time spent in different hospitals, the on-going responsibilities of the PCPs office practice, the limited amount of time available for updating credentials that pertain to inpatient care needs, and the limited role that a PCP plays in the hospital because of the availability of specialty services.

The catalysts for launching hospitalist programs are prompted by a *variety of motivations* and business arrangements.

The hospitalist issue should not be misconstrued to be a managed care issue just because of its introduction into the legislative realm as an HMO issue. It is not. Managed care organizations are considering and examining the potential of hospitalist programs, but have only slowly proceeded since the early 1990s. Physician group practices appear to have been the first entities to use hospitalists, who may have been members of the group or contractually affiliated with the group. Now hospitals are employing or contracting with hospitalists as well.

Managed care companies are using hospitalists as "gatekeepers" on hospital admissions, to avoid unnecessary and costly hospitalizations as well as for improved quality and efficiency during the hospital stay. Insufficient data exist to determine the affect of such programs on overall patient care. It is clear that Prudential-South Florida anticipates cost improvements as a result of its program. The *Palm Beach Post* reported in an article published February 19, 1999, entitled "HMO to Place Its Own Doctors in Hospitals," "Prudential, the county's fifth largest HMO, lost $34 million in the third-quarter of 1998, and [Dr.] De Leon [medical director] acknowledged the change is partly an effort to cut costs. 'It saves money,' he explained, 'because if hospitalists are as experienced as we believe them to be in moving the patient through the intricacies of the hospital system, they can get things done more timely than other physicians not involved in hospital work.' Does that mean patients will be discharged sooner? 'Yes.' De Leon said emphatically. 'But not before it's time. Never before it's time.'"

Other health care providers have their differing motivations for using hospitalists. Hospitals, for example, may employ hospitalists to care for uninsured, underinsured, and out-of-pocket paying patients. Additionally, a hospital's hospitalist may be made available to care for patients of physicians having privileges to practice at the hospital, at the request of the physician, in lieu of the physician caring for his or her patient while the patient receives inpatient hospital services during late-night hours, vacation time, or under all circumstances. A group practice may contract with hospitalists to care for their hospitalized patients. Whether a sole practitioner or a group practice, it appears that physicians have been entering into arrangements with hospitalists for some time now. These arrangements allow physicians who choose to practice exclusively in their private offices the flexibility to do so, allowing them to pursue a desired professional lifestyle.

RECOMMENDATIONS

It may be premature for government to become involved in "resolving" how the use of hospitalists should proceed. Given the visible nature of such services to consumers, practitioners, and payers, there is a better chance, than in many other situations, that the marketplace will settle the issue of under what circumstances such a service may be acceptable. Therefore, at this time, staff recommends no legislation.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
Committee on Health, Aging and Long-Term Care, 404 South Monroe Street, Tallahassee, FL 32399-1100, (850) 487-5824
SunCom 277-5824

MEMBER OVERSIGHT
Senators Burt Saunders and Ron Klein