

Health Policy Newsletter

Volume 12 Number 1

January, 1999

Article 2

The Implications of "Hospitalist" Medicine

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Suggested Citation:

Lenow JL. The implications of "hospitalist" medicine. *Health Policy Newsletter* 1999; 12(1): Article 2. Retrieved [date] from <http://jdc.jefferson.edu/hpn/vol12/iss1/2>.

The Implications of "Hospitalist" Medicine

In 1996 Wachter and Goldman formally heralded the emergence of what may well become a defining influence in the management of acute inpatient care, the role of the "hospitalist."¹ Robert M. Wachter, MD, Associate Chair, Department of Medicine at the University of California, San Francisco (UCSF) School of Medicine, defines the hospitalist as a physician who spends at least 25% of his/her time acting as the physician-of-record for patients admitted or transferred by that patient's primary care physician. The hospitalist concept has been in force since the early 1990's with programs existing in some form at Henry Ford Health System, Penn State/Geisinger Medical Center, Park Nicollet, and Emory University Crawford Long Hospital as examples.² Clearly, the concept has significant implications for physicians of all training persuasions as well as for integrated delivery systems. Proponents of hospitalist medicine suggest that the demand for outcomes accountability from the marketplace creates new demands on health care systems and third party payers to demonstrate more efficient models of care delivery. In a recent JAMA publication, Wachter provides evidence that reorganizing an academic medical center's service orientation in order to concentrate faculty time and early case intervention led to improve cost savings without a negative impact on quality outcomes as measured by readmission rate, mortality rate and functional status--and no change in patient satisfaction levels.³ Advocates also argue that use of a hospitalist allows the primary care physician more time in the Department with concomitant opportunity to enhance patient-physician relationships and availability. The pro-hospitalist camp suggests that the primary care physician will still have a critical role in the management of the hospitalized patient through ongoing family dialogue and coordination of discharge matters.

There is an equally vocal contingent that is very much opposed to this compartmentalization of the patient-physician nexus. Among the concerns raised are that primary care physicians will be sacrificing critical acute care skill and training for the sake of "cost savings,"⁴ and the potential specter of the degradation of the physician-patient relationship. Many physicians feel that drawing a line between ambulatory and inpatient care for the primary care physician is an artificial and inappropriate separation of roles. There is also concern about how a high-powered hospitalist environment might impact the education of residents, i.e., many Family Practice and Internal Medicine educators are fearful about diluting the overall training and autonomy of the primary care physician-resident experience. The potential of new tort liability issues is also cited as a cause for concern regarding attendant foreseeable breaks in communication between the primary care physician, the patient and patient's family, and the hospitalist. This is especially likely where certain third party payers have shown the proclivity to enforce involuntary hospitalist programs on primary care physicians for their enrolled membership. Such a scenario manifested in Philadelphia earlier this year by a local Medicaid HMO, but was successfully stopped through the combined efforts of the Department of Public Welfare for the state of Pennsylvania, the Delaware Valley Hospital Council, several interested medical leaders, the Pennsylvania Health Law Coalition and a sizeable complement of interested lay consumers.

What lies ahead? Only a few reports thus far tend to support pro-hospitalist claims of improved care quality and cost-efficiency. It is still too soon to label the movement an unqualified success, but it is also clear that many systems are taking a much

harder look at the viability of such a strategy where risk-bearing is a component part of their business. Both third party payors as well as integrated hospital systems bearing risk are viewing hospitalist medicine as a method for reducing excess bed day utilization and also as a method for improving consistency of care delivery in the inpatient setting. For example, in 1993, US Healthcare, now Aetna US Healthcare (AUSHC) developed the "Physician Liaison" program, which offers physicians the option of using designated hospital-based practices for their patients rather than admitting the patients themselves. This occurred without any financial implications to a physician's bonus compensation. More recently, AUSHC has modified the process to encourage primary care physicians to admit patients themselves while still offering the liaison option for those who want it. AUSHC had originally intended their program to support the needs of patients in facilities where their primary physician was not available. It was not intended to be a tacit endorsement of the hospitalist movement.

The Jefferson Health System (JHS) has a few examples of hospitalist-styled practices (Bryn Mawr Hospital, Thomas Jefferson University Hospital, in response to certain insurance company requests, and Partners in Primary Care) which have worked very efficiently thus far and without any bothersome breaches of the primary care physician-patient relationships. While JHS has maintained an open-minded approach to the development of the hospitalist movement, it will always maintain the strongest commitment to the integrity of the primary physician-patient relationship, especially given Thomas Jefferson University's national stature in the development of Family Medicine residency and practice development. Such flexible and creative options are needed in the face of pressure to reduce costs in a very competitive market environment. A hospitalist "team" approach (i.e., the multidisciplinary approach utilizing physician, case manager, social worker) may be a viable model of care for the future.

Perhaps the greatest strength of the JHS is the commitment to the importance of the physician-patient relationship and the fact that the system represents the most "physician-friendly" environment in which to practice, as compared to competing health systems in our region. Physicians are encouraged to actively participate in case management activities with system care management staff as well as key care management committees. Any adoption of hospitalist-based thinking must be subordinate to these principles. Certainly, a cautious approach to today's "trendy" strategies is prudent. After all, the "ambulist" may be the next rage.

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