Hospitalists Win Points For Inpatient Efficiency

BY BRUCE JANCIN
Denver Bureau

DALLAS — Inpatients treated by hospitalists have significantly shorter average lengths of stay than do those with the same conditions treated by office-based general internists or family physicians, according to the largest comparative outcome study to date involving the three physician groups.

The briefer length of stay (LOS) in the hospitalist-treated patients did not come at a cost of increased inpatient mortality or 14-day readmissions, which were similar across all three physician groups, Dr. Peter K. Lindenauer said at the annual meeting of the Society of Hospital Medicine.

BRUCE JANCIN/ELSEVIER GLOBAL MEDICAL NEWS

The study findings suggest that "the hospitalist model of care will continue to be attractive," Dr. Peter K. Lindenauer said.

Hospital costs were lower for hospitalists than for general internists, but similar for hospitalists and family physicians, reported Dr. Lindenauer, a hospitalist at Baystate Medical Center, Springfield, Mass.

"Based on these findings, we believe that the hospitalist model of care will continue to be attractive to hospitals seeking to improve throughput while reducing costs," he said.

Dr. Lindenauer presented an observational retrospective cohort study involving 76,296 adult inpatients at 45 U.S. hospitals. They were cared for by 284 hospitalists, 993 general internists, and 971 family physicians. To facilitate comparisons, patients had to have one of seven common presenting diagnoses: acute MI, chest pain, heart failure, ischemic stroke, urinary tract infection, pneumonia, or acute exacerbation of chronic obstructive pulmonary disease.

The investigators used multivariate regression models to examine the impact of physician specialty on outcomes while controlling for potential confounders including patient age, comorbidities, gender, ethnicity, and hospital size and location.

Mean LOS ranged from 4.7 days for hospitalists to 5.2 days for general internists, with costs ranging from a low of $7,077 for family physicians to $8,078 for hospitalists. The 14-day readmission rate ranged from 6.3% for hospitalists to 6.9% for general internists. Inpatient mortality was the lowest for family physicians at 4.1% and highest for general internists at 4.5%.

After adjustment for potential confounders, the mean LOS for hospitalists was 0.6 and 0.4 days shorter than for general internists and family physicians, respectively. Those differences were significant. Costs averaged $417 less per case for hospitalists versus general internists.

Dr. Lindenauer and his coworkers were particularly interested in learning whether the outcome differences among the three groups of physicians could be explained simply by the substantial differences in patient volume. Hospitalists treated an average of 75 patients per year with one of the seven index diagnoses, compared with 30 for general internists and 20 for family physicians. Three-quarters of all hospitalists cared for 40 or more patients per year with these diagnoses, compared with 23% of internists and 9% of family physicians.

However, when the analyses were restricted to those general internists and family physicians who met the 40-patient-per-year criteria, it was apparent that patient volume explained only a minority of the outcome differences. For example, the difference in average hospital costs between hospitalists and general internists dropped from $417 to $276 when only high-volume internists were considered. LOS was only modestly shorter for high-volume internists than internists overall, and there was no difference at all in length of stay between all family physicians and high-volume family physicians.

Dr. Robert Wachter praised this as "a spectacular study—obviously the largest to date and probably the most persuasive study to date of an efficiency benefit."

The most surprising finding is the lack of a cost difference between family physicians and hospitalists, given the hospitalists' significantly shorter LOS, which is traditionally a major determinant of costs, observed Dr. Wachter, professor and associate chairman of medicine at the University of California, San Francisco.

Dr. Lindenauer replied that he has a couple of theories about that point. One is that the family physicians' prior knowledge of their patients from their office practices led to less redundancy in inpatient test ordering.

"It's also possible that FPs have a less intense practice style than hospitalists or general internists, perhaps not pursuing the zebras or carrying out the work-up to the nth degree. But those are just hypotheses. We haven't had time to drill down into the data yet to understand whether, for example, in the setting of stroke they're not ordering the MRA and MRI and instead are just stopping at the CT," he said. ■

POLICY & PRACTICE

Costs Grow for Medicare Drugs

Prices for 10 of the most prescribed brand-name medications have risen nearly 7% since December under Medicare Part D insurance plans, while wholesale prices for the same drugs have risen just 3%, investigators from the House Oversight and Government Reform Committee reported. The increases could indicate that despite initial success in containing drug prices, Part D plans may be losing some leverage over drug makers and drug prices, according to the investigators, who added that Part D premiums have jumped 13% over the past year. Meanwhile, the rebates insurers are getting from drug manufacturers are less than expected. The committee looked at prices for the top 10 drugs of 2004, most of which have no generic alternatives. For example, they found that the cost of a month's supply of Lipitor (atorvastatin) had climbed nearly 10% to more than $84 in mid-April, from about $77 in mid-December. Wholesale prices climbed 5% in that time. Pharmaceutical industry representatives disputed the panel's conclusions. "There is one big glaring omission in the Government Reform Committee's report: The Medicare prescription drug program continues to provide large cost savings to tens of millions of seniors and disabled Americans," PhRMA Senior Vice President Ken Johnson said in a statement. "Unfortunately, the committee's report focuses on just a handful of medicines and tries to draw sweeping conclusions."

Hospital CEOs See MD Shortage

More than two-thirds of hospital CEOs responding to a survey identified physician shortages as a serious problem that must be addressed soon, while more than three-quarters said that the nurse shortage is a serious problem, according to the Council on Physician and Nurse Supply, which commissioned the survey from health care staffing company AMN Healthcare. Almost all of the 400 CEOs responding said recruiting physicians was difficult or challenging, and almost all favored an expansion of physician training. Overall, 86% said they are currently recruiting physicians; 80% of those are looking for primary care physicians, and 74% are seeking specialists.

Washington, Kansas Pass Reforms

Governors in two states last month signed legislation aimed at expanding access to health coverage. In Washington, Gov. Chris Gregoire (D) gave final approval to a new law that includes a plan for covering more children and young adults by requiring that insurance carriers and state employee programs offer enrollees the opportunity to extend coverage for unmarried children up to age 25. The legislation also creates health record banks to improve provider-patient connectivity, and includes measures aimed at managing chronic illness better. In Kansas, Gov. Kathleen Sebelius (D) signed into law a bipartisan measure that falls short of her goal of providing coverage for all state residents, but nonetheless puts the state "on a path toward coverage for all," she said. The new law provides assistance to low-income uninsured families to help them buy private coverage, and includes grants to small businesses and loan guarantees to clinics that serve the uninsured. The measure also requires the state to develop a plan for full coverage by next year's legislative session.

Gender Differences in Care

Women with heart disease and diabetes are less likely to receive several types of routine outpatient care than are men with similar health problems, according to a Rand Corp. study published in the May/June edition of the journal Women's Health Issues. Researchers studied more than 50,000 patients, examining 11 different screening tests, treatments, or measurements of health status. Among people in commercial plans, women were significantly less likely than were men to receive the care evaluated in 6 of the 11 measures, while women enrolled in Medicare managed care plans were less likely to receive the care evaluated in 4 of the 11 measures. The largest disparity found by researchers was that women were less likely to lower their cholesterol to recommended levels after suffering an acute cardiac event, or if they had diabetes.

OxyContin Maker Pays Fine

Purdue Pharma and three current and former executives pleaded guilty last month in federal court to criminal charges that they misbranded the company's product, OxyContin (oxycodone). The company agreed to pay about $600 million in fines and other payments, while three top executives, including the company's president and its top attorney, agreed to pay a total of $34.5 million in fines. Misbranding involves promoting a drug in unauthorized ways, potentially for unapproved uses. U.S. Attorney John Brownlee said that Purdue and its executives had deliberately downplayed OxyContin's potential for addiction when promoting it and therefore persuaded physicians to prescribe it.

U.S. Scores Last on Health Care

The United States again ranked last among six nations studied by the Commonwealth Fund on access, safety, efficiency, and equity measures of health care, the Washington think tank reported. The study, "Mirror, Mirror," draws on survey responses from primary care physicians and data from a Commonwealth Fund scorecard, and compares the U.S. health system with those in Australia, Canada, Germany, New Zealand, and the United Kingdom. The United States outperformed all other nations on preventive care delivery but lagged behind on health care information technology and on coordinating chronic disease care. In addition, U.S. patients were more likely than were their peers to forgo treatment because of high costs, the study found.

—Jane Anderson

Pages 42a—42b