## POLICY & PRACTICE

### Bill to Thwart Medicare Cuts

A bipartisan bill (H.R. 2356) introduced by Rep. Clay Shaw (R-Fla.) and Rep. Ben Cardin (D-Md.) seeks to halt impending cuts to Medicare physician payments and replace the flawed formula that determines those payments. Following up on a recommendation of the Medicare Payment Advisory Commission, the bill would increase payments by no less than 2.7% in 2006. It would also repeal the sustainable growth rate adjustment, replacing it "with a methodology that assures adequate and appropriate payments as well as stable updates for Medicare providers," Rep. Cardin said in a statement. Physicians face a 4.3% cut in Medicare payments in 2006 and subsequent cuts totaling 30% from 2007 and 2012, if the formula isn't fixed. The bill was referred to the House Ways and Means and Energy and Commerce committees. A similar bill introduced in the Senate (S. 1081) would provide a positive update to Medicare payments for 2 years.

### Few Seeking Quality Improvement

A majority of physicians are not actively engaged in quality improvement practices and are reluctant to share information about the quality of care they provide with the general public, a survey of more than 1,800 physicians revealed. Only one-fourth of the respondents said they were using an electronic medical record routinely or occasionally, and one-third said they were redesigning their systems to improve care. In addition, just one-third said they had access to any data about the quality of their own clinical performance. Although 7 out of 10 thought physicians' clinical information should be shared with leaders of the health care systems at which they work, fewer respondents (55%) thought patients should have access to quality data about their own doctors, and only 29% thought the general public should have access to such data. The survey was conducted by the Commonwealth Fund between March and May 2003 and published in the journal Health Affairs.

### Medicaid Patients and Drug Access

Medicaid patients are finding it just as difficult as the uninsured to get access to prescription drugs. Researchers from the Center for Studying Health System Change found that 22% of Medicaid beneficiaries aged 18 and older could not afford to get at least one prescription filled in the previous year. Although access problems experienced by Medicaid beneficiaries were comparable with those experienced by the uninsured, only 9% of adults with employer-sponsored health coverage said they could not afford a prescribed drug in the previous year. The findings were drawn from HSC's Community Tracking Study Household Survey, a national survey involving 46,600 people in 2003 and 60,000 people in 2001.

### Vaccine Underinsurance

Just because you have insurance does not mean you're covered for immunizations, a survey of 995 Americans conducted by researchers at the University of Michigan, Ann Arbor, indicated. As many as 36 million privately insured adults and 5 million privately insured children are not covered for immunizations, a factor that may be contributing to low immunization rates. "Over the past few years, newly approved vaccines have been increasingly expensive, so insurance plans have been less likely to cover them," said lead study author Matthew Davis. "This means that new vaccines of the future may be available to many people only if they can pay out of pocket." A majority of the respondents said they'd be willing to pay higher premiums for vaccine coverage, and most strongly believed that vaccines were effective and generally safe (Health Affairs 2005;24:770-9).

### Depression and Marijuana Use

The evidence for a link between marijuana use and depression is getting stronger, according to the White House Office for National Drug Control Policy. "There certainly are people who self-medicate, but the danger we're talking about is the growing evidence that use itself may be triggering and may be worsening the onset of mental health problems," ONDCP Director John Walters said at a Washington press conference. "Now would some of those people have mental health problems anyway? That's entirely possible. But it's also entirely possible that some of these people may not subsequently show these mental health problems, and the evidence suggests that the use of marijuana may trigger the onset of problems that would not otherwise be there." The office's National Survey on Drug Use and Health shows that, among persons aged 18 years or older, those who first used marijuana before age 12 were twice as likely to have serious mental illness in the last year as those who first used marijuana at age 18 or older.

### AMA: Ban Booze Ads at NCAA Events

The American Medical Association has asked the National Collegiate Athletic Association to eliminate alcohol advertising associated with NCAA events. "The prevalence of alcohol advertising in college sports sends a damaging message about the core values of the NCAA and higher education," AMA President-elect J. Edward Hill, M.D., said in a statement. In a national poll sponsored by the AMA, 62% of adults said the NCAA should reverse its policy and not allow beer companies to advertise during college sporting events. NCAA spokesman Erik Christianson said the association already limits alcohol ads to 60 seconds per hour of any broadcast NCAA event, and he noted that the NCAA executive committee was already planning to discuss, at an upcoming meeting, the idea of banning the ads completely, in response to a request from one of its divisions.

**—Jennifer Silverman**

# Hospitalists Have Minimal Effect on Patient Outcomes

BY BRUCE DIXON
*Contributing Writer*

CHICAGO — The largest-ever study of the influence of hospital-based physicians on outcomes and costs has failed to show significant benefits, David Meltzer, M.D., reported at the annual meeting of the Society of Hospital Medicine.

"There was a slight trend toward lowering hospital mortality. Otherwise, we found no difference in outcomes between hospitalists and nonhospitalists," said Dr. Meltzer of the University of Chicago.

"I was somewhat surprised. We began the study expecting we'd see a larger difference," he told this newspaper.

The multicenter study involved 31,013 admissions at six academic centers over a 2-year period. The goal was to compare costs and outcomes of hospitalized general medical patients treated by hospitalists or by nonhospitalist physicians. The researchers used administrative data, patient surveys (including both inpatient interviews and a 1-month follow-up survey), a chart review looking at process of care variables, data from the National Death Index, and surveys of attending physicians, staff, and primary care physicians.

The investigators concluded that hospitalists did not affect the average length of stay, costs, or outcomes of care across all sites. "Length of stay and cost fell with increasing disease-specific experience, but hospitalist experience may have been offset by higher initial resource use," Dr. Meltzer said during a plenary presentation of the study, which was also presented in a poster session.

Hospitalist care was associated with significant reductions in mean length of stay at two of the six sites, and further analysis of physician factors may improve outcome profiles across all sites, Dr. Meltzer said.

Earlier, single-center studies of the effects of hospitalists have produced mixed results. A 2002 review led by Robert M. Wachter, M.D., at the University of California, San Francisco, concluded, "Empirical research supports the premise that hospitalists improve inpatient efficiency without harmful effects on quality or patient satisfaction" (JAMA 2002;287:487-94).

Dr. Meltzer's own earlier study of over 6,500 patients at the University of Chicago showed that "hospitalist care was associated with lower costs and short-term mortality in the second but not the first year of hospitalists' experience."

During a later session at the SHM meeting, Dr. Wachter said that the latest study by Dr. Meltzer is not totally relevant to nonacademic hospitals. "It's a different kind of environment. The evidence for improvement resulting from the use of hospitalists remains robust with more than 20 published studies showing average cost and length-of-stay reductions of about 15%."

Dr. Meltzer cited several caveats that may take some sting out of the findings.

One study limitation is the "spillover effect," he explained, which may help to raise the quality of the nonhospitalist comparison group and lead to underestimation of the value of hospitalists.

"Interns and residents work with hospitalists and learn new ways of doing things that may be more efficient and lead to better outcomes, and they remember [these new ways] at the end of the month and then go work with and teach other attendings. So we're used to thinking that teaching is from the attending to the resident to the intern, when in fact there's teaching within those levels and even up the levels," Dr. Meltzer told this newspaper.

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Another equalizer is "a sort of selective attrition effect where, because the hospitalists are taking up more ward months, the department or section can be more selective in whom they put on the wards, so you get only the best attendings on the wards and, not surprisingly, they do a little better than the group as a whole would have done if you had not been able to sort of weed out those who might not do such a good job," he said.

Dr. Meltzer's third caveat is that, as earlier studies show, hospitalists improve over time. "I think our data are consistent with the hypothesis that hospitalists have real effects, but that those effects don't appear so immediately in the data that we see for all these reasons."

Finally, Dr. Meltzer was impressed by the finding that the average hospitalist in the study cared for 134 patients, compared with a 46-patient case volume for the average nonhospitalist.

"What's even more striking," he said, "is that when we go to disease-specific experience, the average hospitalist cared for two-and-a-half patients with that same diagnosis, and the average nonhospitalist cared for less than one (0.93). We found that every doubling of disease-specific experience decreases length of stay and cost by about 3%."

The next step, he added, is for someone to conduct a similar multicenter comparison study in community hospitals. And "further work is needed to assess physician factors, site factors, and spillover effects that could influence comparisons between hospitalists and nonhospitalists."

In addition to the University of Chicago, study centers included the University of California, San Francisco; the University of New Mexico; the University of Iowa; the University of Wisconsin; and Brigham and Women's Hospital, Boston. ■