

NC IOM Steering Committee on Primary Care and Specialty Supply
Wednesday, April 7, 2006
NC Hospital Association, Cary
10:00-3:00

Meeting Summary

WELCOME

E. Harvey Estes, Jr., MD
Chair, Steering Committee

PROVIDER RECRUITMENT PANEL

The provider recruitment panel focused on an overview of hospital recruitment issues and discussion regarding rural and smaller hospitals' perspectives and physician practices and recruitment.

Jeff Spade, CHE

Executive Director
NC Rural Health Center
NC Hospital Association

Mr. Spade noted that most of North Carolina's hospitals are community-oriented, non-profit facilities. For-profit hospitals are a very small segment of North Carolina hospitals, with less than ten total for-profit facilities. There are a number of federal hospitals as well in the state, but community hospitals predominate. Within North Carolina there also are 20 critical access hospitals. The critical access hospitals are generally rural hospitals that have a lower operating margin and higher percent of gross revenues going to uncompensated care as compared to the average North Carolina hospital. The smaller and more rural the hospital, the higher the percentage of gross revenues that goes towards uncompensated care such that when looking at rural hospitals the patient operating margin drops below the break even point. However, it is very important to protect such hospitals because they are integral to the local economies.

G. Douglas Atkinson

Associate Dean/Vice President of Networks
Wake Forest University Health Sciences and Wake Forest University School of Medicine

Mr. Atkinson described how many hospitals, regardless of their size, are facing similar, critical issues that affect their future:

1. Bottom line performance is not improving; bankruptcy trends accelerated in 2005.
2. Cut-throat competition, including medical tourism, is making it hard for medical centers to survive.
3. The public is losing confidence in US hospitals.
4. Staff satisfaction is low. Shortages of nurses and other allied health professionals continue, which will further exacerbate issues.
5. Lawsuits are on the rise. Medical malpractice has grown.

The number one concern of hospitals is operating margins. North Carolina hospitals have performed pretty well. Between 2003 and 2005 they experienced a decrease in the percentage of hospitals with a negative margin and an increase in the percentage of hospitals with a healthy margin.

From the academic medical center standpoint, North Carolina's five academic medical centers are fortunate to be collaborating together. They discuss observed trends and current problems. By sharing some of these best practices, there is a real opportunity for growth and improvement within the state. Now, these partnerships need address the issues regarding physician and other allied health personnel manpower. There needs to be a mentality of cooperation.

In North Carolina, there are diverse groups of good quality secondary and tertiary hospitals, and approximately five alliances that bring together constituent groups of small to medium hospitals to try to leverage the common entity or need. Thus, there are different models for addressing patient care issues. The old concern regarding not bringing physicians to the table is changing as hospitals become the employer of choice. Academic medical centers and regional hospitals have outreach programs, such as clinic services that go out and act as a referral centers. Referral centers have an obligation to promote the idea that when community hospitals are unable to provide necessary care, tertiary hospitals can treat patients and return them to their community hospitals as soon as possible. We want patients to receive as much care as possible in their community hospitals because it is more cost effective and allows for better care for the whole family.

Many hospitals lack access to capital, which impacts quality, physician recruitment, and the ability to maintain a competitive edge. Many hospitals are opting for sale. North Carolina does not have many proprietary hospitals, but the state is being eyed because the number of hospitals in economic distress is seen as a real opportunity to acquire proprietary hospitals. However, a better option would be for hospitals to partner and form joint ventures because such collaborations are more creative and beneficial for the community. The mentality should not be one of coming in and taking the hospital away from the community; local support of a hospital and its providers is important. Currently, there is a national net loss of 15-20 hospitals per year, mostly in urban and suburban areas.

Larry Chewning, MHA
CEO
Sampson Regional Medical Center

Mr. Chewning began by describing Sampson Regional Medical Center (SRMC) as a hospital serving a rural population in southeastern North Carolina; its primary service area is most of Sampson, Duplin, and Hartland counties, all of which are rural. Approximately 40% of patients from the primary service area are hospitalized at SRMC, and approximately 47% of primary service area residents' ambulatory surgeries are performed at SRMC. Currently, Sampson County's population is growing and about 80% of its population growth is from Hispanic workers, which has very serious impacts on healthcare services. Sampson County

also has a significant portion, higher than North Carolina as a whole, of residents living below the poverty line, and it is well-known that health risks are associated with lower per capita income.

SRMC struggles daily to serve the 80,000 people in its primary service area. It is a classic rural community hospital with 150 beds and an operating margin from +5% to -1% in the past five years. Mr. Chewing spends at least 25% of his time working with medical staff development, especially growth issues, because of the importance of new physicians coming to the community. He also deals with issues such as access to care, financial stability, etc.

Though people ideally want to stay home for healthcare, SRMC realizes that it cannot, and does not, offer some of the needed subspecialty services. However, from a quality standpoint, the things that they do, they do very well. They participate in a number of benchmarking activities and their statistics are good. Regarding specialties, “survivor” specialties are those that make or break them financially, such as general/vascular surgery and cardiology. Though SRMC should be, could be, and is offering all of the “survivor” specialties, they are thin in those areas. One more provider in one of those crucial areas would have a major impact at SRMC as compared to in one of the more populated areas of North Carolina.

Rural community hospitals like SRMC face risks to their survival. They have difficulties recruiting necessary specialists in those areas in which they are thin. They face an eroding payor mix with an increase in the portion of their patients that self-pay and/or are uninsured. They also face reduced payment for services by Medicare compared to facilities in more urban areas. Unfortunately, the financial difficulties in gaining sufficient payment for services makes recruiting healthcare personnel even more difficult because they are attempting to recruit personnel to provide the same care for less than they would make elsewhere.

SRMC looks at several different measurement parameters to determine whether their medical staff is sufficient and/or how many additional providers they need in certain categories to fully address the needs of their patient population. They currently have a shortage of providers. Physicians who come to work at SRMC often have some familiarity with rural areas or small towns; understand there is a good quality of life there and as professionals they can be challenged and have a good career there; are attracted to North Carolina, especially if from the upper Northwest or Northeast; often received some part of their education in North Carolina; want to be in a small group such that they benefit directly from their work; are attracted to the mechanisms to forgive student loans through work in a rural area; appreciate no managed care; enjoy the collegial atmosphere; have overcome the bias they may have encountered previously against coming to a rural hospital.

Rural community hospitals in a defined underserved area can put a lot on the table to attract physicians compared to hospitals in larger areas that are not rural or underserved. Most recently recruited SRMC physicians have received a number of incentives, including signing bonuses, payment of professional liability insurance, income guarantees, relocation expenses, assistance in school loan repayment, and/or assistance in marketing their practice. These benefits are available for a defined period, usually one to two year(s), and are considered a

loan; if the physician does not stay in the area for a certain period of time he/she must pay back the benefit/incentive.

There were comments and questions after Mr. Chewning's talk. Obstetrics was discussed as another "survivor" specialty that also is in trouble because many people are no longer practicing obstetrics. Obstetrics has become very unstable, mainly due to liability insurance. Primary care physicians want hospitalists hired to help alleviate their acute care workload at SRMC, and SRMC is considering going from a weekend hospitalist service to a five-day-a-week hospitalist service. SRMC has no hospital-owned practices and creation of a hospital-owned practice would be a last resort if there were difficulties recruiting certain specialties. If the hospital employed the physicians in a hospital-based facility, they could support them, but physicians under an employment contract in an off-campus setting is a better way to ensure the viability of the practice. The emergency department at SRMC previously had onerous on-call responsibilities, especially for specialties that were few in numbers. However, recent changes have allowed the responsibilities to change to a requirement of ten on-call days a month if the physician is on an active medical staff as a solo practice. Patients go elsewhere on other days.

Margaret C. Merrick, MD

President, CEO, and Co-Founder
A+ Medical Business Services, Inc.

Dr. Merrick noted that physician recruitment has changed. Hospital administrators have a better handle on recruitment than many physicians who have been practicing. Dr. Merrick's experience is based on community practices that typically have between one and three physicians. Community practices are struggling with increased patient volume and complex patients with greater needs. There is a consistent trend in decreased practice profits for these community practices. Also, the primary care physicians are covering the needed specialty services, but they are still being reimbursed at the lower primary care fee schedule rate rather than the higher specialist fee schedule rate.

Practices recruit new providers to help with increased patient volume, on-call needs, and community needs. However, they are not recruiting to make money for the practice because a new physician actually decreases profits; hiring a physician assistant or nurse practitioner is more cost effective. In actuality, the average practice cannot afford to hire a new physician because new physicians often expect a sign-on bonus, repayment of at least part of their large student loan debt, relocation expenses, and a salary guarantee, as well as clearly defined work hours and limited call. The total cost of hiring a new physician can exceed \$250,000 before the break-even point. If the practice can afford a new physician, they cannot recoup the cost because reimbursement is fixed, they cannot raise fees, and if the hospital provides the salary guarantee any profits from the new physician go to the hospital and the new physician cannot assist with practice overhead until the guarantee ends. Also, even after the salary guarantee ends, new physicians often cannot generate the work to maintain their salaries since the guarantee often exceeds what they reasonably can make. Hospitals can help though; they need to maintain the competitive advantage for the community at large to attract and retain physicians who have been identified as a community need. Business and civic leaders should

also be involved. The hospital can help an established practice with recruitment fees, sign on bonuses, and student loan repayment. The doctor does get the 1099 as the loan is forgiven. However, the hospital only can give incremental salary guarantees and the new doctor cannot share the profits with the established practices. An experienced practice management team is needed to compile all of this to help practices understand physician recruitment, but this often is beyond the scope of the staff in the average community practice. Further, for the new physician to stay, his/her spouse must like the area and have his/her own career opportunity and job satisfaction, and there must be a reasonable compensation package, equitable distribution/ownership, and an experienced, knowledgeable practice management team to help bring in his/her money.

Short-term solutions: collaboration between practices and hospitals; accurate physician compensation data; a practice management course in residency programs covering the basics of medical business operations; student loan repayment options, including on community, regional, and state levels; an understanding by practices that they have to compete with other practices in the community and that patients expect to receive services that they can get if they go to urban areas; collaboration between practices and colleagues in hospitals; and an understanding by hospitals that they are the ones who can recoup the costs of recruitment incentives.

Long-term solutions: exorbitant recruitment packages need to end because cannot be justified in the long-term, and base salary should be realistic; increased awareness of and utilization of AHEC; initiatives to assist community practices and hospitals with Information Technology and Practice Management Resources; and subspecialty support via telemedicine with regional tertiary care/AHEC centers, especially since the technology is here for telemedicine to work but is not set up in most hospitals.

At the end of Dr. Merrick's presentation there were several comments and questions. One issue discussed was the interoperability of information technology systems and how there is a need to resolve this issue in partnership with the federal government. It was mentioned that one of the greatest sources of physician interest in North Carolina communities is low liability. The perception of North Carolina is that it is still a good place to practice medicine, but some are nervous about where the state as a whole is going, especially in light of the ineffective measures to pass prospective liability relief legislation. The importance of communication was also discussed regarding the need to rebuild public confidence with public disclosure through open meetings as one means of improving communication. Another discussion surrounded the need for more team practice training in medical schools and continuing medical education. Academic medical centers should adopt a team approach and the team approach should also be present in residency programs. Another highlighted need for continuing medical education was training to help doctors that are struggling to adapt to performance metrics while also struggling to make ends meet.

Also, in the face of a national and state manpower shortage, in the long-term there will be a need for behavior change in the area of preventive health and wellness, as citizens take responsibility to change their own unhealthy behaviors. Another idea put forth was providing support for non healthcare personnel that help make a practice viable. Someone also

suggested looking at the selection process of medical students and modifying it to select for people who have the altruistic attitudes for the work. Regarding specialists, someone noted that it can be hard to recruit specialists; community doctors are congealing into large aggregate groups where meeting the needs and expectations of the population is a real problem. Further, the economics have fundamentally changed the relationship between hospitals and physicians because now in some arenas they are competitors. However, there is an advantage in looking at the idea of the benterprise where hospitals can help physicians looking at that business line in total, rather than focusing on isolated economic exchanges. Finally, it was commented that the typical tertiary centers where patients go are at capacity and the excess capacity is in the rural community hospital but the key is getting the physicians there in those rural communities.

SMALL PROVIDER PRACTICE ISSUES

Steve Crane, MD

Family Practice Program Director
Hendersonville Residency Program

Dr. Crane began by noting that 24% of Americans live in non-metro areas. Rural healthcare is characterized by a physician shortage that will increase as physicians retire. Rural areas also have reduced insurance coverage largely because the employer-based insurance on which most working people depend is nonexistent.

Rural practices are more likely to be providing obstetrics care, are more likely to perform a wider range of procedures, are more likely to accept Medicaid, and spend more time in direct patient care with a median of 32-35 patients seen per day. Rural physicians tend to refer the same amount and type of patients as their metropolitan counterparts. However, there are quality and safety concerns with rural practices because of the large number of patients they must see per day, which limits their time with patients and potentially increases the possibility of an error due to oversight. The rising cost of care also is a concern.

Regarding satisfaction with rural practice, there are both positive and negative factors. Positive factors associated with rural practice are that patient relationships tend to be deeper and more sustained, physicians tend to be part of a community and play a bigger role in the community, there is more clinical autonomy, there is care provided to medically needy, and the quality of life in a small community is often better. Negative factors associated with rural practice include reduced access to urban centers, more limited employment opportunities, and limited time away from the practice because time away burdens those, often few, left behind. From Dr. Crane's personal experience, the key factors in deciding on rural practice are: the lifestyle, as many want to go back to small town roots and values though they do worry about call, professional isolation, and the daily grind; economics because they worry about how to repay educational loans; family issues, especially schools for their children and spouse employment; and community service because many rural medicine providers enjoy being a health leader in their community.

There are two main options to consider for improving rural physician recruitment and retention: there could be a more focused strategy to recruit rural medicine candidates or there could be design and development of a better system of rural medicine. Dr. Crane's personal feeling is that even if you get all of the best candidates, unless you fix the system, you will not get and keep the physicians in the rural areas. To better recruit rural medicine candidates, programs should be strengthened and established to identify and nurture students likely to practice in rural areas. Nurturing includes providing additional training/support in "entrepreneurial" practice management and additional training/support in community leadership. A better system ideally would involve reducing overhead costs, redirecting money to primary care/innovative health financing, and primary care case management networks. The goals of a reformed rural health model would be more primary care providers to serve isolated populations, improved retention, lower out of pocket cost of primary care, open access to reduce barriers to care, and better, safer care. One way to develop this new model is by promoting low-overhead practice models, which would improve access to care, preserve provider income at lower volumes of care, and improve quality. Another way to develop a new model is through creating a franchise-like model for primary care case management networks through which a network of practices could be created. The networks can provide economies of scale, which would help in making items such as electronic health records more affordable, and there also is a lot of power in networks, including administrative and peer support. A third way to develop a new model is through creation of innovative financing techniques. Of note, malpractice is not a key issue; it is not the crisis in primary care that it is in other places or specialties.

Domingo Rodriguez-Cue, MD

Family Medicine

Martin General Hospital

Dr. Rodriguez-Cue described the challenges he faces on a daily basis, which include devaluation of services such that physicians are working harder and making less, large amounts of paperwork, decrease in the joy factor for providing medicine, payment only for fixing something and not for quality or prevention, more difficulty with collections, increasing practice overhead, difficulty in recruiting residents, and rising malpractice where people sue for bad outcomes instead of true malpractice. To optimally train physicians for rural care, rural residency programs are the best. Efficiency also is important to learn because it is very important in a rural practice.

Dr. Rodriguez-Cue's suggestions are to change the method of training to better prepare doctors for: dealing with patients; creating bonds; improving informatics capabilities and efficient use of information software; being aggressive with practice management (PM), collections, low overhead, and management; creating a life-long support network; and looking at prevention.

At the end of the presentation, there were several comments and questions. Regarding interoperability, several commercial based electronic medical records (EMR) provide physicians with more interoperability. In general, an electronic structure for medical records and information is what some feel should be offered instead of guaranteed incomes because of

the efficiencies gained through using EMR. However, another person commented that EMR do not always work because medicine does not have standards for exchanging data, which makes it difficult to develop a system to work for larger groups. There need to be standards set so data are interchangeable; this needs to be high on the list of what is coming at the state level. Another comment also revealed that the net benefit of EMR in primary care was found to go to the payers, not the providers, so that the investment is not clear-cut when it comes to primary care EMR use. One person responded that EMR have increased their patient volume. However, they said that they have a difficult case to make with residents to encourage them to be efficient, so they tell them that if they become more efficient they will have a better quality of life. EMR improve life for the staff and the physicians, but the difficulty is implementing it. Academic medicine and Area Health Education Center programs can take the leadership role in educating practitioners on how to improve efficiency. Not everyone agreed that EMR increase the number of patients seen, and suggest that it can have the opposite impact. Dr. Rodriguez-Cue noted that EMR are not customizable to patient/provider needs, rather physicians must learn to work with the EMR to develop the efficiency that they allow. Regarding the low overhead issue, it was noted that there are a couple of models for reducing overhead, such as a group practice where the physicians have a central area where all overhead is paid by lab revenue or EMR, and the \$30 visit no insurance model with one support staff person and no paperwork. In response to a comment about how much overhead has increased and the difficulty of designing an EMR system, it was pointed out that providers have the ability to put pressure on these companies to sell these products for less. Also, regardless we will have to find ways to lower overhead and be more efficient, such as through integrating more care with nurse midwives, behavioral health specialists, and other allied health professionals, towards an outcome of more efficient physicians and better patient care.

POTENTIAL RECOMMENDATIONS

Pam Silberman, JD, DrPH

Dr. Silberman began by reminding everyone that the next meeting will most likely be in July and will focus on the recommendations. She then asked if we were missing any recommendations. There was a comment that EMR should be built into the recommendations, possibly in terms of Area Health Education Center training or regional health information organizations. In terms of mental health, it was commented that there is not a lot in the recommendations on the use of mid-levels and other providers like social workers and the need for change in policy in order to integrate those providers. Another comment was that there are recommendations to increase supply but that does not make sense if people are having difficulty finding jobs. However, the response was that, for the most part, nurse practitioners (NPs) and physician assistants (PAs) are not having trouble finding jobs in North Carolina, though certified nurse midwives (CNMs) do have difficulty. There also was a comment regarding the worldwide shortage of physicians and clinical personnel. Worldwide efforts will be to not have physicians and international medical graduates come to the US and western Europe, but will strengthen attempts to keep practitioners in other areas. Finally, someone commented that there are a lot of recommendations and asked whether any would be removed. The response was that priority recommendations may be highlighted in the issue briefs while other recommendations may be included in an appendix. Also, a recommendation can be removed from the list if there is agreement that it is not a good idea.