

# RECRUIT, REWARD, REENGINEER

Three ways to survive the coming primary care physician shortage

**B**race yourself. Demand for primary care physicians is about to skyrocket at a time when there aren't enough to go around. So hospitals need to make themselves as attractive as possible to maintain this vital link to patient referrals and care management.

What is behind the jump in demand? A number of factors are at play. One of the biggest is that the health reform law passed in March is expected to extend insurance coverage to about 30 million previously uninsured Americans. But the nation already is anticipating a shortage of 35,000 to 44,000 primary care physicians for adults by 2025, according to the American College of Physicians.

"You can empower everyone in the universe to purchase insurance, but without the physicians to provide the care and continuous care then you've got a severe problem," says James J. Dickson, CEO of Copper Queen Community Hospital in Bisbee, Ariz., and an Arizona Hospital and Healthcare Association board member. The law doesn't take enough steps to boost the number of primary care physicians, he and others say.

At the same time, the aging of the population is causing an increase in chronic conditions that need to be managed continuously. The number of people 65 years and older was 39.6 million in 2009, a figure that is expected to increase to 72.1 million by 2030, according to the federal Administration on Aging. In 2002, more than half of the Medicare population was treated for five or more chronic conditions, AARP notes.

The growth in chronic diseases fuels demand for outpatient services. Utilization in this area will grow by 30 percent in the next decade, predicts a recent report by Sg2, a Chicago-area health care information company. By contrast, inpatient discharges are expected to remain flat at best over the coming decade. To tap outpatient growth, hospitals will need strong relationships with primary care physicians, says Jillian V. Addy, director at Sg2. These connections will allow hospitals to capture referrals and the associated downstream revenue.

The increase in chronic diseases, combined with federal efforts to slow health care spending growth, is driving a push toward new delivery models, such as medical homes and accountable care organizations that emphasize care coordination across the continuum of services and settings. Both are to be tested under the health reform law. Under these models, "Who is the ascendant participant in the provision of care? The primary care doctor," says John Peabody, M.D., Sg2 medical director and senior vice president.

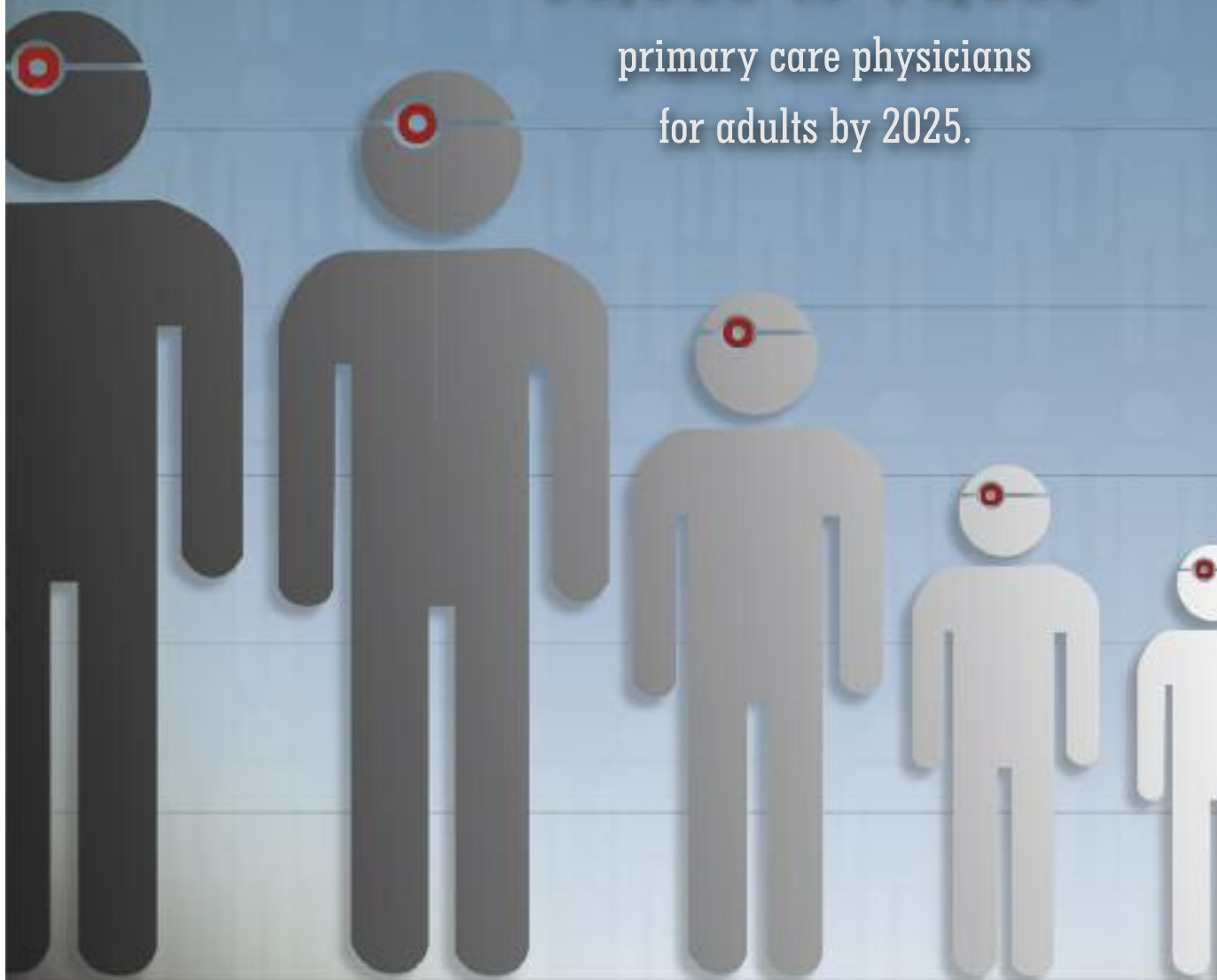
The reform law also includes provisions intended to reduce hospital readmissions. Beginning in October 2012, most types of hospitals will face Medicare payment penalties if they have higher-than-expected readmission rates for heart failure, heart attack and pneumonia. Patients who see their primary care doctors after discharge are less likely to be readmitted, notes Peabody, an internist by training. "So you've got to have that primary care doc," he says.

BY GERI ASTON

The American College of Physicians  
projects a shortage of

**35,000 to 44,000**

primary care physicians  
for adults by 2025.



If these combined factors are raising primary care's star at a time of shortage, what should a hospital's strategy be and how can it compete? The answer depends on your mission and your market.

For example, a hospital in a competitive, crowded market might adopt a strategy to employ primary care physicians to drive business to the hospital, says Steve Messinger, managing partner at the health care consulting firm ECG. A rural, sole community hospital might look at creating an economic relationship—employment or otherwise—with primary care physicians to stop an exodus from the area and stabilize the primary care community. “The fundamental thing that every hospital needs to think about is: What's my primary care strategy as a component of my larger physician strategy, and is that the appropriate strategy for our circumstance and our market?” he says.

Many hospitals are going the employment route because it makes sense and it's increasingly attractive to physicians, he notes. Primary care doctors want two basic things: fair compensation and some control over both their practice and their lifestyle. In this time of economic insecurity, many more primary care physicians see hospital employment as a path to both. “[They are saying], ‘I'm not interested in the practice lifestyle of the grizzled veteran. I want some security in my job. I don't want to take the risk of hanging out a shingle. I want to have a life. I don't want to be on call all the time. Therefore, I'm going to go to a place where I can have economic stability and lifestyle stability,’” he notes.

The shortage of primary care doctors is forcing hospitals interested in hiring them to compete. They're doing it by offering good salaries, little or no call duty, regular work hours and, in some cases, signing bonuses, several consultants say.

Copper Queen Community Hospital used these and other techniques when its primary care market began “imploding” due to physician departures, CEO Dickson says. In 2004, the hospital absorbed Copper Cities Physicians Practice and established federally recognized rural health clinics in Bisbee and Douglas, Ariz. Then, in 2007, it opened another in Palominas. The clinics offer adult and child primary care, physical therapy and on-site lab services.

The clinic physicians, part of Copper Queen Medical Associates, are employed by the hospital. To attract primary care doctors, the hospital offers a competitive salary. Dickson says a current internist opening pays \$175,000 a year. In addition, the physicians who exceed a productivity target receive a payment bonus. The competitive package is possible because of enhanced Medicare and Medicaid reimbursement at rural health clinics.

The primary care doctors work regular hours, are on call only every seven weeks, are covered under the hospital's medical malpractice policy, and are plugged into the facility's electronic health record system, Dickson says. Copper Queen, a 14-bed acute care, critical access hospital, also has a telemedicine arrangement with a Tucson hospital so that its physicians can get their continuing medical education. “We've taken away the major inertia to physicians practicing in rural areas by having a good support system,” Dickson says. “They can watch University of Arizona grand rounds in their clinics.”

The strategy has put the breaks on physician departures, Dickson says. The unfilled internist position is a new slot. “We're growing,” he says.

### **Employment Makes Sense**

Some hospitals are reluctant to employ physicians after the experiences in the 1990s when the pressure of gatekeeper managed care plans spurred hospitals to buy primary care practices as a way to get referrals and provide leverage against HMOs. When tight managed care waned, hospitals struggled to manage physician practices, and as the practices ran into financial trouble, hospitals began to divest.

As the new set of forces renews interest in the purchase of primary care practices, hospitals can guard against some of the problems that beset earlier efforts, Addy of Sg2 says. For example, to attract physicians, the hospital may want to start with a guaranteed salary for year or so while the doctor establishes his or her practice but then move to a productivity-based compensation model.

In the 1990s, many physicians were given a set salary, regardless of how many patients they saw, Addy says. “There weren't as many incentives to really produce and make sure that the practice is profitable. You have to make sure the incentives are still there to produce.”

Despite the shortage of primary care physicians in the face of increased demand, hospitals looking to go the employment route should be careful who they hire, Addy says. Having rigorous physician selection criteria, based on productivity and the quality of care, is crucial.

Still, hospital trustees should be prepared to see some red ink if the organization gets into the primary care business, Messinger says. It's difficult for a hospital to generate any kind of margin on employing primary care physicians because, relative to their revenue base, primary care physicians have the highest expense base of just about any physician due to the overhead associated with office-based practice. Trustees have to adopt a “systems perspective” when looking at the primary care business line.

“You're just not going to generate the profitability off of a primary care business,” Messinger says. “You're doing it to stabilize the medical community or to make sure there are enough primary care physicians who are going to refer to the specialists in the community.”

### **Relationships Matter**

Once a hospital recruits the right primary care talent, the trick is to keep the doctors at a time when competition is fierce, Addy says. Hospitals should have an on-boarding team that provides physicians with mentors and helps them understand the organizational culture, expectations and core values. The goal is to make the physician's transition as smooth as possible. “This isn't just for new docs, but for ones in the market who suddenly have to get used to being employed,” Addy says. Other steps include providing social engagements, scheduling events to introduce the new physician to the community, arranging meetings with high-level management personnel, and having a team that serves as a liaison between physicians and the hospital.

Even though interest in employment is growing among hos-

## REFORM CAN HELP. HERE'S HOW

The health reform legislation contains several provisions aimed at addressing the primary care physician shortage. They include:

- Creation of a National Health Care Workforce Commission, which will evaluate whether demand for health professionals is being met and make recommendations to Congress, including suggestions on how to eliminate the barriers to entering and staying in primary care.
- Redistribution of 65 percent of unused, Medicare-supported residency slots. Of these, 75 percent must be for primary care or general surgery. The priority goes to teaching hospitals in states with low medical resident to population ratios and to states with high numbers of people in health professional shortage areas.
- 10 percent Medicare bonus payment for primary care services for five years, beginning in 2011.
- Two-year experiment beginning in 2013 that will guarantee that Medicaid pays primary care physicians at least as much as Medicare pays for primary care services.
- Increased funding for the nation's community health centers and the National Health Service Corps, which provides scholarships and loan repayment for primary care physicians who agree to work in medically underserved areas.
- Establishment of "teaching health centers" and grants to develop them. Teaching health centers are defined as community-based, ambulatory patient care centers that operate a primary care residency program.
- Reauthorization of Section 747 of Title VII of the Public Health Service Act, the federal program that provides funds to academic departments of family medicine and family medicine residency programs to increase family physician training.
- Creation of the Primary Care Extension Program, which would help to educate and provide technical assistance to primary care physicians and other health professionals about evidence-based therapies, preventive medicine, health promotion, chronic disease management and mental health, and in developing the capabilities to become patient-centered medical homes.—G.A.

*Sources: The American Academy of Family Physicians, the Association of American Medical Colleges and the American College of Physicians*

pitals and primary care physicians, this strategy doesn't work in every market, and plenty of physicians still have no interest in being employed, several consultants say. Hospitals can strengthen their ties to the primary care community without hiring doctors, Sg2's Peabody says. "You don't need to own all the houses on the block, but you need to know your neighbors and be able to talk to them."

Hospitals are taking a variety of steps to foster loyalty among primary care physicians as competition for them grows. One way is by subsidizing their electronic health record system purchase, Addy notes. Under a 2006 change to the Stark laws, hospitals can donate up to 85 percent of the expense, with the exception of hardware. "Definitely there is a lot of interest in an EHR strategy and IT subsidies with primary care practices as a way to strengthen alignment," she says.

Other hospitals are tapping local primary care physicians' expertise by involving them in the development and adoption of best practices for treating conditions for which there is a lot of variability in quality and costs, Messinger says. "So you're getting the physicians together to say, 'If we would standardize this, there is a huge benefit to the community.'" It ties doctors into the organization from the perspective of giving them some psychic ownership over the program."

### Extending Physicians' Reach

The shortage, combined with the growing emphasis on care management, also means hospitals should explore new ways of providing primary care more efficiently, several consultants say.

One option is electronic patient visits for routine or nonurgent care, Peabody says. These appeal both to tech-savvy physicians and busy patients. The patient doesn't have to take the time to go to the office and the physician can attend to more patients. "More and more payers are willing to enter into these arrangements or try them out on a trial basis," he says.

Another way to better leverage primary care physicians' time is through the use of mid-level providers, such as nurse practitioners and physician assistants, several consultants say. For example, an advanced-practice nurse could conduct follow-up visits with patients who have such chronic diseases as diabetes or congestive heart failure, Peabody says. Or a nurse practitioner could handle cold and flu cases, referring patients with more worrisome symptoms to the doctor.

Leading group visits to educate patients on chronic disease management is another option. Using health professionals to support primary care physicians in these ways not only eases doctors' work burden, but allows them to focus on complex cases and new diagnoses, which are most likely to generate hospital referrals, Peabody says.

Some of the new models of care being tested also could reduce the need for primary care physicians, says Christiane Mitchell, director of federal affairs for the Association of American Medical Colleges. For example, under the medical home concept, primary care physicians work as the manager of a team of nonphysician practitioners.

"The medical home model could help reduce the pressure related to the shortage of physicians," she says.

As the physician shortage increases demand for mid-level practitioners to fill the gaps, hospitals will have to compete for these professionals as well. Physician-extenders' salaries already are going up, Messinger notes.

To ensure access to mid-level practitioners, hospitals should make sure they have good relationships with nursing and physician assistant schools, Addy says. Some organizations have created affiliations with these schools that allow trainees to work within a clinic setting in the hope that, when they graduate, they'll stay with the hospital. "Others have created their own schools and started grooming their own talent," she adds.

Despite the help mid-level practitioners can provide, "there's never going to be enough nurse practitioners to take care of the primary care physician shortage," Peabody says. And although the health system reform law took some steps to increase the number of primary care doctors, it didn't go far enough, many consultants and hospital officials say.

The biggest problem is the law didn't expand the number of Medicare-supported medical residency slots, which was capped in 1997, Mitchell says. Instead, the law reallocates 65 percent of unused positions at teaching hospitals mostly to primary care and general surgery training programs at other teaching hospitals. The AAMC estimates that the law puts about 1,000 slots in play. The measure stipulates that in redistributing the positions, the priority goes to teaching hospitals in such states as Florida, which doesn't have enough medical residents to serve the population,

or New Mexico, which has a large percentage of people living in health professional shortage areas, she notes.

The AAMC had pressed for the reallocated slots to be spread more broadly, Mitchell says. "There are pockets of need all across the country."

The health reform measure also includes new funding for primary care training in its prevention and wellness section. Under this provision, Department of Health & Human Services Secretary Kathleen Sebelius in June announced an investment of \$250 million to increase the number of health care providers and strengthen the primary care workforce. Included in that amount is \$168 million to train more than 500 new primary care physicians by 2015. Other funds go toward nurse and physician assistant training. While the new funds are welcome, they are temporary appropriations, Mitchell notes.

The increase in insured patients expected to result from health reform and the aging of the baby boom generation into Medicare starting next year means the federal government has to do more to address the primary care shortage, consultants and hospital officials say.

"Unless we see an expansion of graduate medical education, an expansion of the number of residency slots and expansion of the number of medical schools, we are basically stimulating demand and not doing anything for supply," Messinger says. **T**

.....  
GERI ASTON is a freelance writer in Chicago.