Today’s Agenda

Rural Primary Care Supply
• Mark Doescher, MD

Albemarle Health Physician Recruitment Methodologies
• Scott Helt, VP Operations

Scotland County Hospital Physician Recruitment Efforts
• Marcia Dial, CEO
Rural primary care supply: are we up to the challenge?

Mark Doescher, MD, MSPH, Director, WWAMI Rural Health Research Center and Center for Health Workforce Studies University of Washington School of Medicine
Background

• Continuing need for physicians in rural areas
• Majority of rural physicians are primary care physicians, especially family physicians
• Interest in primary care careers has declined among medical, PA and NP students
Rural Residents Rely More on Family Medicine Physicians

- Urban: 26.4 (Total) / 209.6 (Total + Family Medicine)
- Total Rural: 33.3 (Total) / 113.2 (Total + Family Medicine)
- Large Rural: 32.4 (Total) / 146.9 (Total + Family Medicine)
- Small Rural: 40.1 (Total) / 99.2 (Total + Family Medicine)
- Isolated Small Rural: 26.6 (Total) / 52.3 (Total + Family Medicine)
Family Medicine Positions Offered & Filled with US Seniors in March (2000-2011)
Key Characteristics Affecting the Rural Primary Care Workforce, 2005

- Urban: % Female 32, % age>55 24
- Large Rural: % Female 23, % age>55 25
- Small Rural: % Female 22, % age>55 27
- Isolated Rural: % Female 24, % age>55 28
Will Increasing reliance on DOs and IMGs translate to rural primary care?

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<tr>
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<th>All Physicians</th>
<th>Primary Care Physicians</th>
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<tr>
<td>DOs</td>
<td>5%</td>
<td>8%</td>
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<tr>
<td>IMGs</td>
<td>22%</td>
<td>25%</td>
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Rural v. Non-rural IMGs in the U.S. Using Conrad 30 J-1 Waivers, FY2004-FY2009 as Reported by State Health Departments*

* Rural/non-rural defined by state government offices requesting waivers; number of states with data missing: 4 in FY04, 8 in FY05, 5 in FY06, 8 in FY07, 5 in FY08, 2 in FY09

Source: Data collected by Connie Berry from state health departments
Primary Care v. Specialty Care IMGs in the U.S. Using Conrad 30 J-1 Waivers FY2001-FY2009, as Reported by State Health Departments*

* Primary care/specialty care defined by state government offices requesting waivers; number of states with missing data: 7 in FY05, 3 in FY06, 6 in FY07, 5 in FY08; 2 in FY09
Source: Data collected by Connie Berry from state health departments
Increasing reliance on NPs and PAs may not translate to rural primary care

Perri A. Morgan and Roderick S. Hooker,
Choice Of Specialties Among Physician Assistants In The United States,
Health Affairs, Vol 29, Issue 5, 887-892
• 30% or greater increase in workload by 2025
• Shortfall of 35,000 to 44,000 primary care providers nationally who treat adults
• Shortfall of over 100,000 total physicians

Source: AAMC
Solutions

• Encourage those raised in rural areas to enter primary care
• Change health professions school curriculum and admission policies
• Support rural training track residency programs
• Provide financial and lifestyle incentives for entering rural primary care practice
Questions?

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Center for Health Workforce Studies
University of Washington

http://depts.washington.edu/uwchws/
ALBEMARLE HEALTH
PHYSICIAN RECRUITMENT
METHODOLOGIES

Primary Care Webinar
June 6, 2011
Located in Elizabeth City, Pasquotank County, NC,

Serves a seven county area including Pasquotank, Camden, Currituck, Gates, Dare, Perquimans, Chowan Counties

During the fiscal year ending September 30, 2010, Albemarle Hospital experienced:

- 6,426 annual admissions
- 8,475 Surgeries
- 759 births
- 33,368 emergency department visits
- 135,823 outpatient visits
Albemarle Health:
Causes of Difficulty Recruiting & Retaining Physicians

Physician recruitment for our community has been particularly difficult due to:

- Median annual household income in Pasquotank County of $38,127.
- County unemployment rate of app. 9%.
- 18.4% of residents living below the poverty level
- More than 25,000 residents of Albemarle Health’s service area are indigent, uninsured, and underinsured

This results in below median potential earnings for physicians
We have traditionally used income guarantee/practice support contracts for recruiting physicians as independent practitioners to:

- Practice as an employee and future partner of an existing independent physician or practice
- Practice sharing office space, overhead and call with an existing physician or practice
- Practice as a solo physician
Income Guarantee/Practice Support
Physician Recruitment Agreement: Pros & Cons

Pros

- Accommodates physicians desiring practice ownership
- In most cases builds on existing physician practices
- Amount of support is capped
- Hospital’s financial exposure & expenditures are limited by contract
- Does not add to hospital’s direct overhead, e.g. staff costs, practice operating costs, etc. (as opposed to an “owned” practice)

Cons

- Does not meet needs of younger physicians desiring employed/limited risk arrangements
- Payments to physician cannot be based on productivity
- Physicians/Practices can try to “game” the system for financial gain
- Significant criminal/legal & resulting financial exposure for the hospital if regulatory guidelines are not followed
Pros of income guarantee/practice support strategy outweighed by the cons.

We were unable to meet our physician recruitment needs through traditional means.

We added physician employment as a key physician recruitment/retention strategy.
Hospital Employment Model: Provisions of Physician Employment Agreement

Used to recruit physicians when:

- There is no opportunity to build on an existing practice
- Physician does not want the financial risk of practice ownership
- There is a need to bring greater stability to a specific medical specialty at Albemarle Hospital (ex. Anesthesia, Surgery, Neurology, OB/GYN)
- There is a need and/or desire to financially incentivize physician productivity and quality
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<th><strong>PROS</strong></th>
<th><strong>CONS</strong></th>
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<td>Is a more effective way to recruit young physicians</td>
<td>Hospital bears ongoing cost of the physician</td>
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<td>Provides incentives for increased production</td>
<td>Hospital bears the risk &amp; associated operating &amp; capital costs of practice ownership</td>
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<td>Is a better means of stabilizing a service</td>
<td>Can contribute to polarization of the medical staff between employed and independent physicians</td>
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<td>Offers the hospital better control over supply &amp; demand</td>
<td>Can create the perception (as well as the reality) of competition between the hospital and independent practices</td>
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<td>Allows the hospital to better attract solo specialty physicians to the community</td>
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<td>Hospital costs may be offset by practice revenues</td>
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<td>Offers opportunities to share some overhead expenses with other owned practices (e.g. billing, collections, personnel management)</td>
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Hospital Employment Model: Provisions of Physician Employment Agreement

- Contract term: usually 2-year initial term with additional 2-year renewal terms
- Contract provides salary, benefits, incentive compensation. Base salary usually set at MGMA median or slightly below. Incentive compensation offers opportunity for $20k-$40k additional earnings/year
- Incentive compensation based on attaining productivity, quality and customer satisfaction targets
- Other provisions: e.g. sign on bonus ($15k - $45k), relocation costs at $12,500, 3-month temporary housing reimbursement at $1,200/month, full range of benefits (health, life, long-term disability, retirement, etc.).
Both physician recruitment modalities have their place in today’s competitive marketplace. Albemarle Health will need to employ both strategies to ensure physician recruitment efforts are successful. Employment has proven to be our most successful strategy, netting us new providers in internal medicine, neurology, orthopedics, anesthesiology, OB/GYN, and currently being used to recruit pediatricians. Stabilizing key services such as general & vascular surgery, Gynecology as independent physicians become hospital employees. Employment will become an increasingly important physician retention tool.
Physician Recruitment and Retention is Perpetual

Marcia R. Dial, CEO
Scotland County Hospital
Memphis, MO
Scotland County Hospital’s Background

- 25 bed, not-for-profit, Critical Access Hospital in Memphis, Missouri
- Established in 1970 and continually provided healthcare services for extreme northeast Missouri.
- Primarily serves Scotland, Schuyler, Clark and Knox Counties, as well as other surrounding areas.
- Only hospital in a 10,000 square mile area, SCH provides essential medical care to nearly 21,000 residents.

Case Mix Percentage
- Medicare 25%
- Medicaid 21%
- Uninsured 13%
- Insured 41%
- *Estimate of 50% of insured are underinsured*
Federally Qualified Health Clinic (FQHC) verses Rural Health Clinic (RHC)

FQHC
- Late 1980’s we began our first working relationship with a Federally Qualified Health Clinic (FQHC).
- At that time, SCH had the equivalent of 1.5 F.T.E. physicians.
- With joint effort and resources a physician was recruited into our community.
- The FQHC was established.

RHC
- In 1997, SCH opened our first Hospital Based Rural Health Clinic (RHC).
- We now have three RHC’s in three rural counties.
- RHC’s stabilized the medical staff.
- RHC’s physicians also staff our Critical Access Hospital’s (CAH) emergency room, hospital in-patients and provide obstetrical services.

Summary
Since 1997, an RHC has operated side by side with the FQHC at Scotland County Hospital. Each bringing needed resources, as physicians were scant then and still are presently.
Barriers

- Isolation
  - Serve many small communities that span a large geographic area
  - Transports to tertiary care
    - Helicopters fly only about 50% of the time
    - Ground ambulances must travel 2 ½ hours on secondary roads with many one lane bridges for the first hour.
- Staff must be highly skilled - Overwhelming Responsibility
  - Limited resources & specialist to fall back on.
- Amenities
  - Major airport 3 hours away
  - Shopping mall 2 hours away
  - Wal-Mart is a 1 hour drive
- Grueling hours
  - Always seem to be on-call

“Must love hunting, fishing and internet shopping”
Successes

- Model
  - Committed to skills, training and certifications
    - ACLS, ATLS, PHILS, ALSO, PALS, NEONATE, TNCC, STABLE, etc.
  - Aggressive in the technology deemed important to our doctors.
    - Lab, chemistry analyzer
    - C-T 32 scanner
    - Ultrasound
    - Tele-Radiology
    - EMR
  - Facility and services that accommodate their practice needs
    - OR, OB, ICU, etc.
- Academic culture
  - Journal Club and Case Presentations
- Teaching exposure
  - Teaching agreement with four medical schools that have a rural rotation for medical students and residents.
- Rural practice exposure
- Economic engine
  - Engage young people in elementary and high school to encourage them to pursue a healthcare career
- Compatible and complementary
- Practice model
- Planning partners with the Board of Directors and Administration
Summary

However, given all of the effort, and planning, and trying to do everything right, for a physician providing rural healthcare, life is hard therefore; *recruitment is and always will be perpetual*”
Questions
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