

PHYSICIAN WORKFORCE SHORTAGE ISSUES IN CALIFORNIA RURAL HOSPITALS



A survey of federally and state designated rural hospitals

*Prepared by National
Health Foundation for
the California Hospital
Association Executive
Management Group*

March 2009



Produced by National Health Foundation for the
California Hospital Association
March 2009

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Physician Workforce Shortage Issues in California Rural Hospitals

ACKNOWLEDGMENTS

The authors wish to thank the rural hospital administrators who participated in this survey. We know that their time is valuable and thank them for working to provide exceptional healthcare to California's rural communities. We would also like to thank the California Hospital Association for encouraging the participation of rural hospital CEOs and supporting this work.

National Health Foundation (NHF) is an independent, charitable, tax-exempt 501(c)(3) public charity dedicated to improving and enhancing the healthcare of the underserved by developing and supporting innovative programs that 1) can become independently viable, 2) provide systemic solutions to gaps in healthcare access and delivery and that 3) have the potential to be replicated nationally.

California Hospital Association (CHA) seeks to develop consensus, establish public policy priorities, and represent and serve hospitals and health systems. In concert with its member organizations, CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals can continue to provide high-quality patient care.

PHYSICIAN WORKFORCE SHORTAGE ISSUES IN CALIFORNIA RURAL HOSPITALS

EXECUTIVE SUMMARY

In this report, results of a survey of federally and state designated rural hospitals regarding physician workforce recruitment issues are presented. National Health Foundation conducted this survey per the request of the Executive Management Group of the California Hospital Association.

In light of current financial stress on California hospitals and the geographic maldistribution of physicians, this survey examines retention and recruitment issues for rural hospitals in order to identify possible solutions.

Eighty-six percent of California's 69 state and federally designated rural hospitals in California participated in the survey.

The survey identified the following key findings:

1. Rural Hospitals do not have sufficient physician coverage; specifically specialists and primary care physicians.
2. Rural location and the lack of spousal job opportunities deter physicians from practicing in rural areas.
3. Access to healthcare in the community is diminished due to the lack of adequate physician coverage.
4. In California, reimbursement from Medi-Cal is not adequate to cover patient care & the payer mix and population size in rural communities cannot support a specialists practice.
5. Competition in the form of large medical groups and urban opportunities divert physicians from rural areas.
6. Rural hospitals use creative approaches to recruit and retain physicians.
7. The inability for rural hospitals to employ physicians serves as a barrier and roadblock that deters physicians from practicing in rural areas.

BACKGROUND

In February 2009, National Health Foundation (NHF) was asked by the Executive Management Group of the California Hospital Association (CHA) to create and administer a survey of all federally and state designated rural hospitals regarding physician workforce shortages. The survey was to specifically examine retention and recruitment issues. To date there has been no systematic study to identify the depth, breadth and magnitude of this problem in California.

The 69 state and federally designated rural hospitals in California strive to serve the health needs of 17% of California's residents who live in rural areas. They not only provide healthcare, but often serve as the largest employer in the region impacting both the healthcare industry and the local economy. The rural healthcare system in California serves more than 800,000 patients in their emergency rooms each year and provides almost 1 million acute and skilled-nursing bed days a year to rural communities¹.

CRITICAL ISSUES

While the need for rural healthcare is significant, the rural healthcare system is faced with several critical challenges. Specifically, rural hospitals are highly vulnerable to 1) Fiscal challenges and 2) Recruitment and retention of an adequate physician workforce.

Fiscal Challenges

There are many fiscal challenges that face California's rural hospitals including California's state economic crisis and the national economic downturn. Rural hospitals are extremely vulnerable to both as they depend greatly on federal and state financing. As is the case with many hospitals statewide, rural hospitals are

greatly dependent on Medicare and Medicaid reimbursements due to their patient demographics. Medicaid reimbursements in California are the lowest in the United States (25% less than the national average²). Therefore rural hospitals are not able to afford operating costs as they are not reimbursed properly for care given.

Additionally, the payer mix in rural communities is suboptimal for the financial success of rural hospitals. The patient bases of rural hospitals tend to be covered by Medi-Cal, Medicare or are uninsured. They are missing a high rate of private and employer based plans which would normally make up for some of the losses with increases in Medi-Cal and uninsured patients.

Due to these challenges, 6 hospitals have closed in the past 4 years and 75% of remaining hospitals have had to reduce the range of their services.

Recruitment & Retention of a Physician Workforce

In addition to the economic stress of inadequate reimbursement and California's budget crisis, the state is also experiencing issues related to physician workforce recruitment in rural areas. While number of physicians per 100,000 population has increased, there is a wide geographic and demographic distribution of physicians. Specifically, there is a maldistribution of both specialists and primary care physicians in rural areas³.

There are many challenges for physicians when considering practicing rural medicine in California. They include: a high cost of living

¹ California Hospital Association, Rural Hospitals, Background Paper. 2009 Health Policy Legislative Day.

² Henry J. Kaiser Family Foundation, State Fact Sheet. www.statehealthfacts.org.

³ Assessing the status of California's Physician Workforce: Shortage or Surplus, California Health Policy Roundtable, Issue Brief. October 2001.

relative to other states; low reimbursement from Medi-Cal and private health plans in comparison to other states; a poor patient payer mix; an environment dominated by managed care contracting agreements⁴; and the inability to be employed by a hospital.

Physician preference also plays a large role in contributing to workforce shortages. According to a 2008 national survey of medical residents⁵, the majority of respondents state that location was the most important factor in practice opportunities followed by a good financial package and loan forgiveness. Additionally, the majority of residents wanted to practice in a single specialty group, partnership or as a hospital employee and wanted to work in a community with a population between 100,001 and 250,000. Only 4% of respondents ranked communities with less than 25,000 as a top preference. Additionally over 50% of young physicians surveyed in a different survey chose to practice in an area less than 10 miles from their residency program and 81% chose to practice in an area less than 150 miles from their residency program⁶. Additionally, the survey noted that young physicians' family considerations are the most significant factor in determining their practice location as well as having grown up in a rural area.

This survey was inspired by the aforementioned challenges so that possible solutions may be identified.

The goals of this survey are to identify:

- Whether rural hospitals have sufficient physician coverage and in what areas they are in the most need (i.e. specialists, primary care, etc.)
- Whether recruitment or retention is a significant problem.
- Why it is difficult to recruit or retain physicians in rural settings.
- Major barriers hindering the recruitment/retention of an adequate physician workforce.
- Successful models for obtaining and maintaining a proper physician workforce.
- Whether access to care for community residents is impaired due to a lack of physicians.
- Strategies that should be implemented to facilitate the resolution of physician workforce shortage issues.
- How California Hospital Association can be helpful to rural hospitals to ensure that they have adequate physician coverage and how CHA can ensure that rural communities have access to adequate healthcare.

⁴ California Hospital Association, 2009 Health Policy Legislative Days, Background Paper: RURAL HOSPITALS, 2009.

⁵ Merritt Hawkins & Associates, 2008 Survey of Final Year Medical Residents, 2008.
<http://www.merrithawkins.com/pdf/2008-mha-survey-medical-residents.pdf>

⁶ AAMC

METHODOLOGY

Study Design. The study employs an oral survey design.

Timeline. The writing, scheduling and administration of the survey was conducted over a very aggressive 3 week timeline from inception to finish (February 10-March 2, 2009).

Description of the Study. A list of all federally and state designated rural hospitals was generated by the California Hospital Association (CHA). CHA sent an email to all rural hospital CEOs alerting them of the survey. NHF staff members then called every hospital CEO followed by an email to schedule a time to conduct the survey. During this time, it was determined who would be responding to the survey. As respondents were contacted to see if they wanted to participate, many administrators' assistants requested that an additional email be forwarded to remind them and CEOs of the intention of the survey.

Sample. The sample for this survey was all federally and state designated rural hospitals (n=69). A total of 59 surveys were conducted.

Data Collection. The qualitative survey tool was created in Microsoft Access linked to a Sequel database. The survey consisted of 8 parent questions and all were open ended. Interviews were conducted over the telephone during a scheduled 30 minute meeting time. NHF staff members conducted the interviews. Answers were transcribed directly to the database while on the phone with each respondent.

Analysis. Data from the access database was exported to an excel spreadsheet where quantitative response rates were calculated. In addition, a qualitative analysis was conducted. Open ended question responses were coded so that emerging themes could be identified.

Presentation of Results. Survey results will be presented according to each question. Additionally significant survey findings will be presented as key findings. Characteristics of survey respondents are described in Appendix A and raw data tables of survey results are presented in Appendix B.

RESULTS

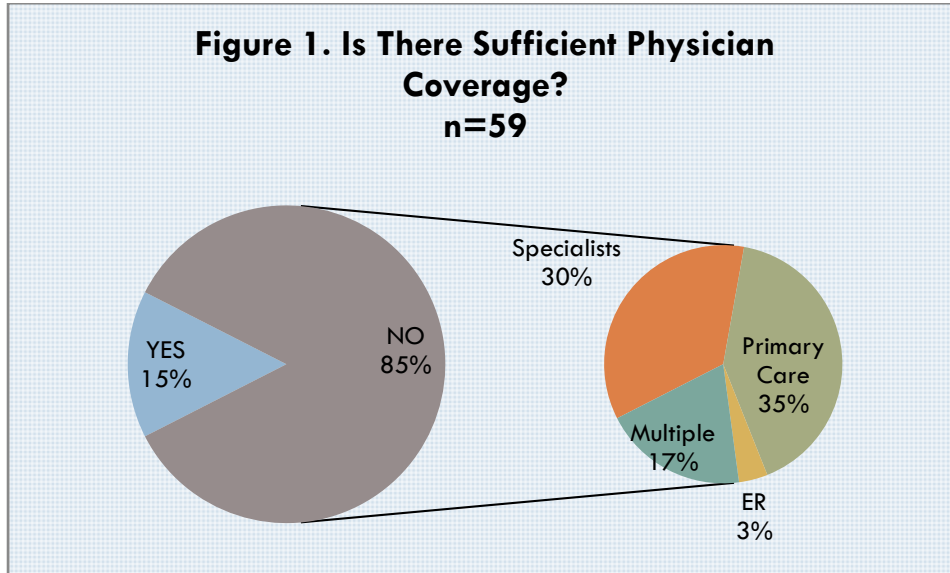
KEY FINDINGS

- 1. Rural Hospitals do not have sufficient physician coverage; specifically specialists and primary care physicians.**
- 2. Rural location and the lack of spousal job opportunities deter physicians from practicing in rural areas.**
- 3. Access to healthcare in rural communities is diminished due to the lack of adequate physician coverage.**
- 4. In California, reimbursement from Medi-Cal is not adequate to cover patient care & the payer mix and population size in rural communities cannot support a specialists practice.**
- 5. Competition in the form of large medical groups and urban opportunities divert physicians from rural areas.**
- 6. Rural hospital use creative approaches to recruit and retain physicians.**
- 7. The inability for rural hospitals to employ physicians serves as a barrier and roadblock that deters physicians from practicing in rural areas.**

1. Rural Hospitals do not have sufficient physician coverage.

Survey respondents overwhelmingly felt that they did not have sufficient physician coverage to serve their communities. Specifically, 85% of respondents emphasized the need for additional physician coverage. Primary care physicians were identified as the area of greatest need followed closely by specialists.

These findings are consistent with national surveys on the physician workforce quoted earlier. According to a recent Physicians' Foundation survey, 78% of physicians surveyed believe there is a shortage of primary care doctors in the United States today, 49% of physicians said that over the next three years they plan on either reducing the number of patients they see or plan on no longer practicing and 60% would not recommend a medical career to young people⁷. This downward trend in the number of practicing physicians threatens the already fragile rural healthcare system.



“We are isolated and we have established physicians, but we need more specialty doctors. Unfortunately we don’t have a large enough patient base to support a specialists salary.”

“We have an aging medical staff and not enough specialists to take call and cover the ER.”

⁷ Conducted on behalf of the Physicians' Foundation by Merritt Hawkins & Associates, “The Physicians' Perspective: Medical Practice in 2008”, October 2008. http://www.physiciansfoundations.org/usr_doc/PF_Survey_Report.pdf

2. Rural location and the lack of spousal job opportunities deter physicians from practicing in rural areas.

While national surveys show that location is the biggest indicator of physician preference, only 10% of respondents in this survey responded that the rural location was the main barrier to securing an adequate physician workforce. However, this 10% were extremely vocal in their beliefs that the rural lifestyle and the barriers involved with it, specifically in terms of spousal satisfaction, were significant.

Research suggests that physicians are not a homogenous group and behavior cannot be predicted uniformly. Rural-intending physicians or those who always intended to work in a rural community, tended to care most about family when considering placement while urban or suburban-intending physicians tended to care most about income when considering a job⁸. Therefore it is possible that CEOs at rural hospitals deal mostly with rural-intending physicians who have already self selected to be in a rural area and therefore no longer see location as a factor.

While many rural areas in California have an exceptional quality of life, they often lack a variety of job opportunities. Many respondents stated that while convincing the physician is an easy task, convincing their spouses is another story. Many respondents stated that because of this issue they look specifically for husband and wife teams.

“Spouses don’t want to live in rural areas....especially wives; they want to live in a metropolitan area.”

Rural areas also lack the conveniences, especially in terms of cultural experiences, shopping and entertainment that larger metropolitan areas possess.

“There is Wal-Mart rural and there is us, we are rural rural.”

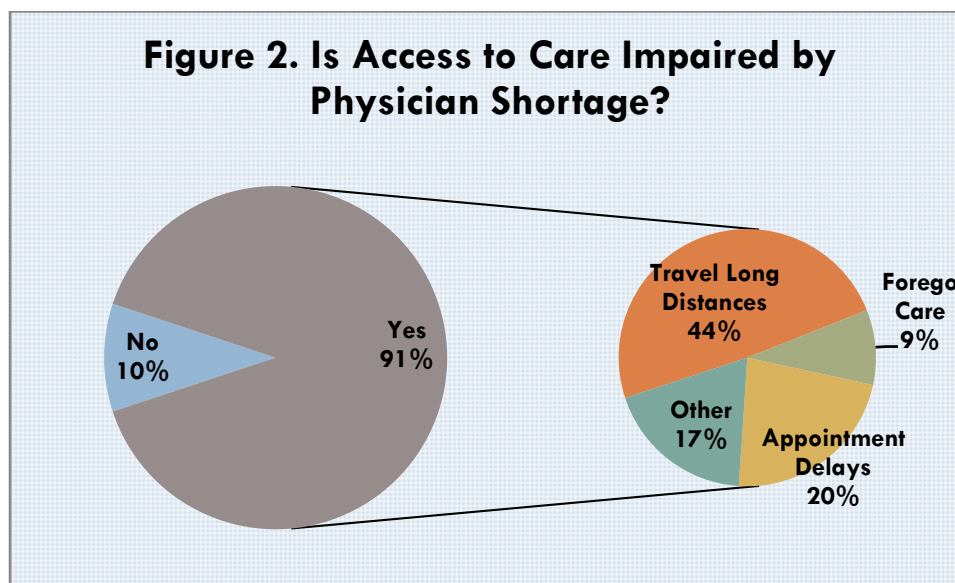
Housing issues are also a large factor in the recruitment of physicians. While rural areas in California tend to have cheaper housing costs than urban centers, this is not always the case. Many rural areas are also vacation destinations in California and consequently have a high cost of living. Additionally, even if housing prices are reasonable for California, they are still more expensive compared to other states. An additional issue in relationship to housing currently is that many prospective physicians have a very difficult time selling the current home in this tough economic market.

“While our hospital is located in a rural area and geographically isolated it is still considered a desirable area to live and is therefore expensive. We find that the difficulty is that physicians feel like they can’t earn enough money in this area to live.”

⁸ Peters TD, Steward TR. Location factor affecting family medicine physician practice setting preferences: application of social judgment theory to rural health policy. AHSR FHSR Annual Meet Abstr Book. 1996; 13:7

3. Access to healthcare in the community is diminished due to the lack of adequate physician coverage.

Rural communities by definition tend to be isolated from other communities and urban centers. Therefore it is imperative that residents of the community have reasonable access to healthcare when necessary. It is assumed however that most rural communities will not have immediate access to certain specialties. Ninety percent of survey respondents stated that access to care was impaired for residents in their communities due to physician workforce shortages. Specifically patients tend to delay their care, travel longer distances, have longer wait times and at times forego care due to the obstacles of finding a doctor. Additionally mental health services tend to be scarcer in rural communities which result in many residents not receiving proper mental health care.



“Without specialists, patients have to travel long distance, and it's possible that they go without care, especially with the economy- and especially if they are on Medi-Cal. They have to drive 50-100 miles to seek care, so many specialists aren't even taking Medi-Cal clients -- so just to find a specialist is difficult – Medi-Cal is a pathetic payer and most docs, specialist in particular, won't take it.”

“Primary care physicians are operating at full capacity and are double and triple booking patients. This backlog prevents the opportunity for patients to be seen in a timely matter. Providing medical homes are not always possible because there are operating at such high capacity, physicians are overworked; they are working at 110-120% just to stay afloat financially.”

“Access isn't impossible, it is just more difficult because patients have to travel to Reno, Carson City or San Francisco to receive some specialty care, the hospital has a telemedicine program effort underway, and particularly for mental health / psychiatry because it's a huge problem; mental health needs are greater than what they can provide”

“There is a 20-25% out migration because of wait times; it’s now approaching four months to see a physician.”

“Lack of having physicians, quantity wise is a huge barrier...many physicians have closed their practices...if it wasn’t for 4 primary care medical clinics, we wouldn’t have a safety net. Currently we have a good 40% out migration. This is due to a lack of having access to primary care and subspecialties on a timely basis. People would rather drive an hour to neighboring areas.”

4. In California, reimbursement from Medi-Cal is not adequate to cover patient care and the payer mix and population size in rural communities cannot support a specialist’s practice.

Medi-Cal (California’s Medicaid program) is underfunded and ranks last in the nation’s payments to providers. This is problematic as California has the highest number of people enrolled in Medi-Cal. Compared to other states, California reimburses at rates that are significantly less than other states. According to 2005 data, the United States spends \$4,662 on average per enrollee annually while in California; only \$2,701 is spent per enrollee. This discrepancy grows when only looking at adults (\$2,102 in the U.S. versus \$813 in California)⁹. This is problematic as operating costs of hospitals in California are higher.

Table 1. Per Enrollee Medicaid Spending in California, 2005¹⁰

| | # | | % | | |
|----------|------------|----------|------------|------|---------------------|
| | California | U.S. | California | U.S. | |
| Total | \$2,701 | \$4,662 | - | - | |
| Children | \$1,142 | \$1,509 | 17.3 | 17.3 | % of total spending |
| Adults | \$813 | \$2,102 | 12.5 | 11.6 | % of total spending |
| Elderly | \$8,750 | \$11,839 | 28.2 | 26.1 | % of total spending |
| Disabled | \$12,265 | \$13,524 | 40.2 | 40.8 | % of total spending |

Respondents of the survey believe that reimbursement rates are not adequate to pay for the care that is necessary. As mentioned previously, 31% of respondents saw reimbursement issues as the largest barrier for ensuring adequate physician coverage.

“We need to advocate for a federal mandate of cost-based reimbursements from Medicaid, because payments are too low for hospitals (rural in particular) to survive. Rural hospitals have no place to shifts costs and they cannot operate on such low payments.”

Respondents also recognize that as economic issues plague the nation, unemployment rates are increasing. With unemployment comes the loss of employer provided health insurance which then puts additional strain on hospitals especially when available health plans such as Medi-Cal do not reimburse the hospitals adequately for care.

“Supply of doctors and payer mix are a huge issue for us...the number of uninsured is rising, it’s at 15.5% in our county right now, the highest in California. We won’t have enough health coverage to pay for care. Emergency department visits have seen a significant growth.”

⁹ State Medicaid Fact Sheets, California & United States, 2005. <http://www.statehealthfacts.org/>

¹⁰ State Medicaid Fact Sheets, Kaiser Family Foundation, 2005 <http://www.statehealthfacts.org/mfs.jsp?rgn=6&rgn=1&x=15&y=10>.

5. Competition in the form of large medical groups and urban opportunities divert physicians from rural areas.

While rural hospitals compared to urban hospitals tend to be at a recruitment disadvantage due to their isolated locations, they are also affected by the competition of nearby larger physician groups and systems. In rural areas, there tends to be fewer doctors to create a large physician practice or groups that allow for reduced administrative costs. The lack of physicians and the outside competing forces of large systems make it extremely difficult for rural hospitals to compete. For example, the Kaiser Hospital system now serves over 6.5 million Californians with 16 hospitals throughout California. The Kaiser Foundation Model essentially is able to hire doctors by working with their own large medical group which ensures salaries for Kaiser physicians. Sutter Health is an additional system that works as a foundation model with both hospitals and physician practice groups. They currently serve Northern California and have contractual agreements with 3,500 physicians. Therefore, a physician is likely to be enticed by the larger systems where they will have an salary, benefits and less administrative headaches.

“Shortage of specialty physicians results in competition to recruit them.”Rural America” is a barrier, most physicians train in urban medical centers and want to work in urban medical centers where they can ensure their salaries -- for them to strike out in rural America it is a practice and lifestyle change.”

“Sutter is working diligently to set up a private hospital close to here, if that happens we will have fewer doctors to choose from. Kaiser is in our market. We can't compete with the big guys, one or two will win and we won't be able to maintain coverage for the doctors we work with.”

6. Rural hospitals use creative approaches to recruit and retain physicians.

Rural hospitals are consistently challenged to provide adequate care for their patients. They are faced with geographic, financial and recruitment challenges different than urban hospitals and therefore must come up with creative solutions to facilitate an adequate physician workforce.

Specialized Recruitment

In terms of recruitment, respondents overwhelmingly stated that they have learned to focus their recruiting efforts to physicians who are seeking the rural lifestyle or “rural intending physicians.” Recruiters tend to spend most of their time making sure that the physician is a good fit for the community to ensure both recruitment and retention. No physician is hired prior to him or her visiting the hospital usually accompanied by their spouse.

Telemedicine

Due to the lack of specialists and the reality that many rural hospitals may never maintain an adequate amount of specialists regardless of recruitment efforts, many rural hospitals are beginning to use telemedicine.

“We have internal medicine, family practice, general and orthopedic surgery covered by on call agreements; we also participate in a telemedicine program that has allowed some access to other specialties; by building up consultants in this telemedicine program patients can have access to top quality specialists.”

“We need to use telemedicine to help us fill gaps of subspecialties. We need to find a way to get these physicians reimbursed properly. Some physicians get scared because they are afraid of getting sued. Just like a “stethoscope around my neck” telemedicine is a tool! This is being held up by money and malpractice.”

Not all respondents however think that telemedicine is an answer to recruitment issues.

“Telemedicine can only help to a certain respect. When patients are connected to larger hospitals they have difficulty paying for services--Medicaid reimbursement is poor, so often telemedicine specialists are not willing to see our patients. And then people get tired of waiting and then get worse.”

Collaboration

Many rural hospitals see the benefit in working together to share administrative costs especially when it comes to physician practice groups. Additionally, rural hospitals will commonly have agreements with larger hospitals in their vicinity to help fill specialty and subspecialty gaps.

In other instances, whole communities have worked together to create a healthier rural environment. This is evidenced in the Mustard Seed Coalition in Mendocino County which is a coalition of local professionals in

health, education, social services and law enforcement who have come together to address the long term needs of their community. The coalition is founded on the principal that external financial dependency is not sustainable and that they must focus on integration and efficiency of local services instead. Specifically in terms of hospitals, the objective is to maximize cost sharing amongst hospitals, clinics, laboratories and mental health services within the county.

“Workarounds”

Potential rural doctors fear that they will not have an adequate income if they come to a rural area because they are not salaried and their income depends on the amount of paying or adequately covered patients. Therefore rural hospitals have been creative in “workarounds” that help to essentially hire physicians or give them the same assurances as hiring without violating the ban on the corporate practice of medicine. The **California Foundation Model** usually involves a parent holding company which is a nonprofit corporation with tax exempt status. This holding company will then have two subsidiaries; one that is the medical group or practice and one that operates the hospital. The hospital does not hire the physicians directly but rather enters into a professional services agreement with the physician group. This essentially allows an agreement of employment to the physicians. The foundation model is effective in areas where there are enough doctors to form the practice group however in regions where specialists and primary care doctors are severely scarce, this model is not possible.

Hospitals have also been exploring the creation of the **1206D clinic model**. A 1206D clinic is formed when a region is identified as being underserved. The creation of such a clinic allows for the limited hiring of physicians. However, some respondents felt that this model did not allow for quality control.

“1206d model is a headache because of compensating physicians and not being able to monitor performance and compliance issues.”

In addition to the 1206D clinic model, hospitals have been instituting **hospitalist programs**. The hospitalist program consists of using doctors who specialize in treating patients who are admitted after being seen in the emergency room. Usually, these physicians are trained in internal medicine and allow the hospital to reduce issues related to shortage of doctors on call. Hospitalists are not hired by the hospital but are contracted through large and often national physician groups that specialize in hospitalist programs.

“We operate more clinics out of necessity and contract with physicians for specialty services. We have to offer some sort of stability with an income guarantee. However we are unable to provide benefits because it’s difficult to acquire health insurance in rural area for single provider. We also use hospitalists who are contracted with an outside vendor. Potential physicians are excited by the hospitalist program as it provides relief to private practice physicians and reduces call time. It also allows for our clinic based providers to spend more time on outpatient care than being on call.”

Locum Tenens

Rural hospitals will also use locum tenens¹¹. This model consists of essentially contracting with a physician staffing group for temporary physicians. Many hospitals are forced to hire temporary physicians especially when short staffed in their emergency rooms. This practice however is not preferred due to the expense.

Financial Incentives

Rural hospitals also offer income guarantees, extensions of the J1 Visa¹² and medical school loan reimbursement programs to attract physicians to their region. If qualified, certain rural areas also receive loan reimbursement from the federal government. While these are all attractive to new physicians the fear of the rural hospital is that physicians will not stay in the region once their loans have been forgiven, their income guarantee runs out or they become a citizen or return to their country of origin. Most rural hospitals see these solutions as short term.

“We can’t get anything without income guarantees. Typically we have a 1 year loan and 2 year payback...guarantee income for loan period...Docs stay in area for 2 years and have loan forgiven and then leave.”

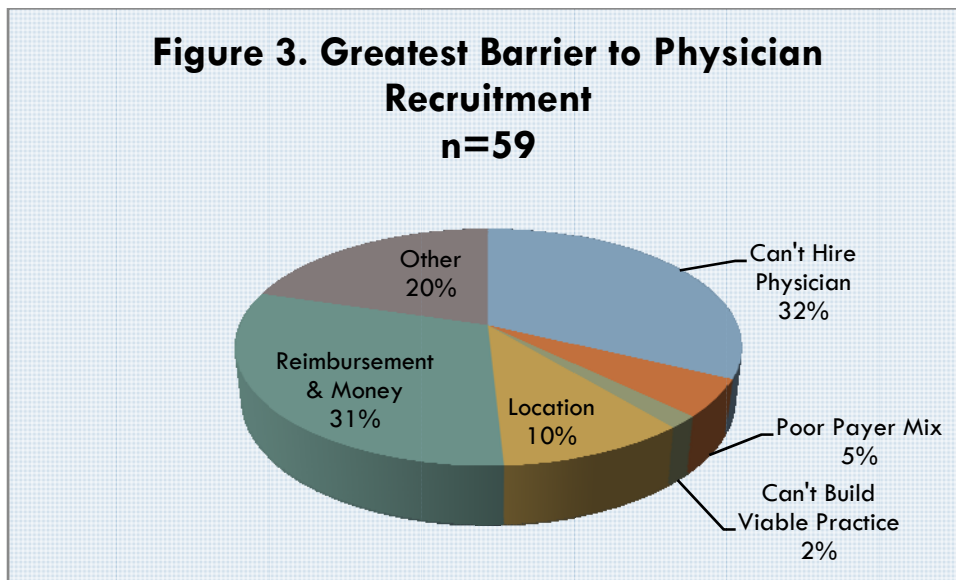
¹¹ Latin for place holder.

¹² A temporary nonimmigrant visa reserved for participants in the exchange visitor program. The visa has a 2 year limit.

7. The inability for rural hospitals to employ physicians serves as a barrier and roadblock that deters physicians from practicing in rural areas.

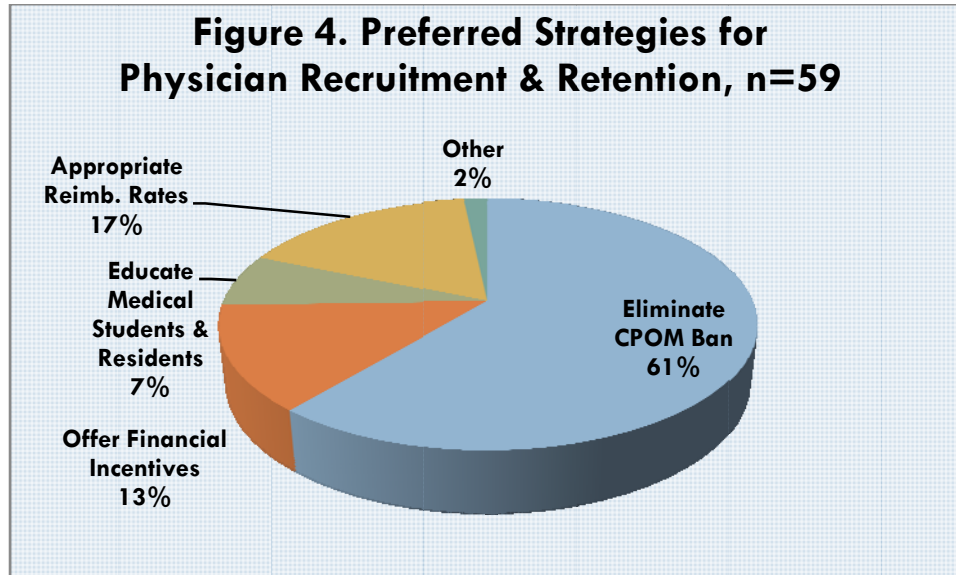
The majority of hospitals interviewed feel that the ban on the corporate practice of medicine (CPOM) in California is a great hindrance in recruiting doctors. California is one of few states that continues to ban the practice¹³. Many CEOs had previously worked in other states and had stated that hiring physicians was essential to maintaining their workforce. The ban on the CPOM was enacted by court opinion in 1913 based on the concerns of excessive caseloads, the loss of patient ability to choose their physician, divided loyalties between physicians and hospitals and the concern of hospitals interfering or influencing their employees in terms of patient care. The debate of whether the ban is still necessary is present in current political debates especially between the California Hospitals Association who is requesting an exemption to the ban to allow rural hospitals to directly hire physicians and the California Medical Association who does not support any such exemptions.

When asked to describe the most significant barrier to recruiting and retaining physicians, 31% of respondents (the greatest individual answer) stated that not being able to hire physicians was there top barrier (see figure 3).



¹³ The five states that currently do not allow hospitals to employ physicians are California, Colorado, Texas, Iowa, and Ohio. Illinois, New York and New Jersey preclude hospitals from employing physicians for services in outpatient clinics. California does allow teaching hospitals, narcotic treatment programs, non-profit research clinics and some non-profit clinics to employ physicians.

When asked about specific strategies however, 60% stated that allowing the hiring of physicians would be the best strategy to reduce recruitment problems.



“It’s time to circle the wagons and take the corporate practice of medicine ban on! Physicians are seeking employment. The foundation model has given the metropolitan areas a leg up, but rural hospitals cannot do this. The ban on hiring physicians hampers rural communities where it’s even more important. I have docs that would come here instead of Kaiser if we could employ them....let’s stop fooling ourselves and let’s do it!”

“Most physicians are not interested in the lifestyle associated with private practice—now they are focused on family and lifestyle—they want to be employed but not deal with the demands of a practice.”

“We can’t offer employment and that’s a huge barrier. Every physician I speak to in every specialty is seeking employment opportunities. Younger physicians don’t want a private practice and older physicians want to work for the hospital. They want to be on a payroll.”

“We need the ability to be more creative in regards to the physician’s relationship to the hospital. Doctors today are a different breed, they don’t want to work as hard and want a better quality of life. Hiring is better than contracting in the long run as you can do more things for the physicians and they can focus on patient care rather than administrative and financial issues.”

“Allowing the corporate practice of medicine will make it easier for hospitals to better serve their communities. We would break even by employing a doctor even if we lose money in the outpatient setting as we would make up for it in labs and inpatient care.”

“If a hospital could employ physicians, they could more easily compete with hospitals in urban areas and hospitals that are out of state that can employ physicians.”

“It’s a matter of equity...rural hospitals need the ability to hire physicians like community clinics and medical groups are capable of doing.”

“Even seasoned docs who will work down here want to work as an employee. They have no desire at all to manage practice, even the new guys don’t want to manage a practice. We have found an orthopedist that is interested but he wants to be employed. We are too small to create a foundation model so we need to find someone else in town like a Federally Qualified Health Center (FQHC) or physician group to hire him.”

Respondents also suggested that the role of CHA is to act legislatively on their behalf as advocates. As stated before, 60% of respondents stated that CHA’s main role is to lobby on behalf of lifting the ban on the corporate practice of medicine.

“Having CHA support legislation to lift the ban on the CPOM helps the smaller critical access hospitals. Combined rural hospitals serve a large proportion of the population, but we often feel like the underdogs.”

“CHA can help the California Medical Association recognize that young physicians have no interest in setting up their own practice. Hospitals need relief from the CPOM in order to recruit these physicians because they don’t want the administrative hassle of running a practice. CMA has some fear that doctors will have to be employed. Well-they all want to be employed.”

“Ban of CPOM is a joke...we are Neanderthals, dinosaurs walking the earth wondering why it’s cold. Just hire physicians in rural hospitals cleanly without all the weird gimmicks, once you do that everyone will realize that is what the new docs want anyhow, old dogs are the only ones barking about it now. This will make an easy model for rural hospitals and the community is far better served. Right now if I lose a doctor, I still can’t get one...let’s say I lose 100,000 a year in outpatient setting, but will still make money in surgery in hospital and labs--break even..it does not create unnecessary utilization...it lowers health care costs. It’s our inability of being nimble. “

“We have a ton of doctors who have been practicing since the 1970s and they are about to retire. The doctors coming in don’t want a private practice headache. They want income guarantee, practice management assistance. I was recently talking to an ob gyn, and his preference was that the hospital hire him...if we could hire, we would have better recruitment. It’s inevitable; we have to be able to hire physicians. I have had 10 interviews recently with prospective physicians and all want to be hired. They just want to practice medicine.”

Survey Implications

The findings of this survey have various implications for California's rural hospitals. One respondent summed up the main issues in this description as to why the physician workforce shortage exists in rural areas:

1. *"There is a national shortage of primary care physicians;*
2. *Fewer people are interested in rural living;*
3. *Employment and social opportunities for the spouse are challenging;*
4. *There are negative perceptions of small rural school districts;*
5. *There is chronic under-funding of Medi-Cal which leads to perceptions of financial instability of hospitals;*
6. *Hospitals can't hire physicians and the younger generations are not interested in having their own practice. They want an employee-employer relationship with all the benefits (401K, health benefits, etc.)*
7. *Physicians instinctively know that better quality, greater efficiency and less wasted energy occurs in systems (i.e. Mayo Clinic & Cleveland Clinic)."*

There is something rural hospitals can do...

While results of this survey illustrated that rural hospital administrators are aiming for legislative action, they also identified multiple strategies that have been successful in obtaining an adequate number of physicians.

1. It is imperative that physician recruiters for rural areas target physicians who are already rural intending and ensure that they will fit in their community.
2. Telemedicine has been successful for many rural hospitals in filling in gaps when specialists and subspecialists are lacking. Additionally, telemedicine allows for renowned physicians to take part in rural medicine.
3. Rural hospitals have successfully set up workaround arrangements to ensure salaries and benefit of physicians through the use of the California Foundation Model, 1206D clinic model and hospitalist programs. While there are limitations to who qualifies to set up these programs, it is beneficial for hospitals to explore these options.
4. Collaboration and integration efforts appear to be the most useful for rural hospitals. In order to increase efficiency and cut down on costs, many hospitals have joined forces with other hospitals or community agencies in formal agreements to work together. This method appears to be very effective especially in smaller communities where the creation of large healthcare systems and physician groups are not possible.

Rural hospital administrators want to hire physicians...

The issue of rural hospitals and physician workforce shortages is layered and extremely contextual. There is clearly a perception from this survey that having the ability to hire physicians is a positive first step in addressing the physician workforce issues. But results of this survey also suggest that it is not the entire solution and will not solve the problems of all hospitals. In other words, it appears to be potentially necessary but not sufficient.

This sentiment is also echoed outside of this survey introduced in the legislature. Multiple legislative efforts are currently underway to address the ban on the corporate practice of medicine. Currently there are three bills that have been introduced to the legislature regarding rural hospitals and physician workforce shortages.

1. AB 648 (Chesbro) would allow all healthcare districts, urban and rural, and non-profit clinics serving the medically underserved areas and populations to hire physicians while enacting safeguards to ensure that hospitals will not interfere with, control or direct physicians' medical judgment.
2. AB 646 (Swanson) would permit healthcare districts that serve medically underserved urban communities to employ physicians.
3. SB 726 (Ashburn) would permit rural hospitals, hospitals within medically underserved areas or designated health professional shortage areas to employ up to 5 physicians contingent upon trustee and medical staff approval.

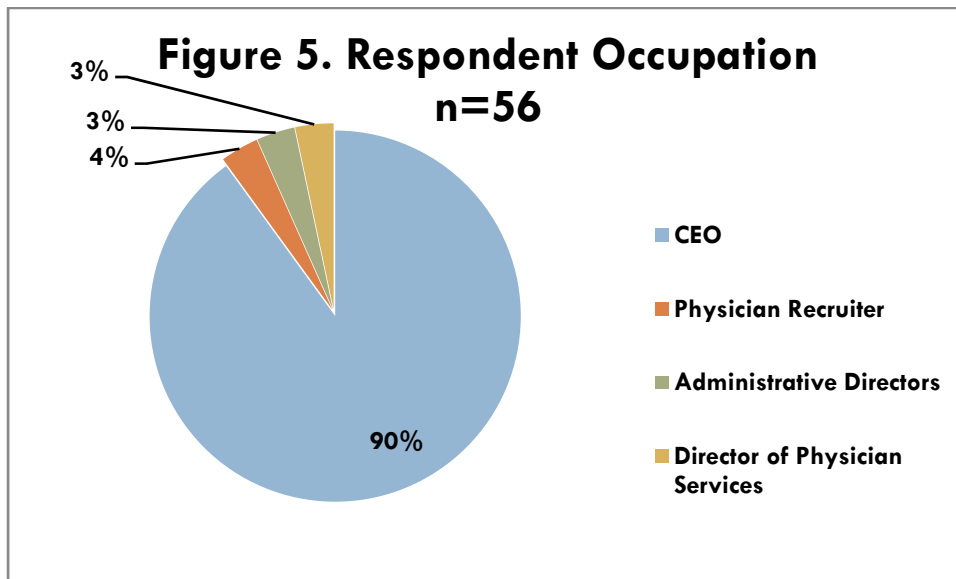
It is accepted nationally that there is virtue in hospitals hiring of physicians in that it enhances integrated service delivery systems which in turn have been shown to improve quality and reduce cost. Whether or not California changes its current law banning hospitals from hiring physicians, it is evident from this study that some dramatic action needs to be taken in order to facilitate rural hospitals meeting their physician labor shortages.

Limitations

This survey was meant to investigate the concerns and needs of rural hospitals so that they can better serve their communities. The survey was conducted in a very aggressive timeline and therefore a limited audience was questioned. This survey only represents the opinions of hospital administrators and their perceptions on physician behaviors. A recommended supplement to this survey would be to survey medical residents in California specifically regarding preferences for practicing rural medicine.

Appendix A. Characteristics of Survey Respondents

There were 69 state and/or federally designated rural hospitals in California at the time of this survey. While 66 hospitals are state designated, 3 are federally designated. Fifty nine hospital administrators were interviewed yielding an 86% response rate. The majority of counties with rural hospitals were interviewed. There are 42 out of 58 California counties with rural hospitals and 35 of the 42 counties with rural hospitals are represented. Interviewers arranged to speak to CEOs or if unavailable scheduled an interview with another administrator. At times hospital CEOs felt the best respondents would be a physician recruiter, Director of Physician Services or other administrative director. However CEOs were eager to participate in this survey making up 90% of respondents (see Figure 5). Hospitals varied in size with a range of 4 to 186 beds with the majority of hospitals having less than 44 beds.



Appendix B. Survey Result Data Tables

1. Does your hospital have sufficient physician coverage to meet its needs (n=59)?

| Yes | No |
|--------|---------|
| 15%(9) | 85%(50) |

a. If no, where are you having the most difficulties (n=59)?

| Specialists | Primary Care | ER | Multiple | No Problem |
|-------------|--------------|-------|----------|------------|
| 30% (18) | 35%(20) | 3%(2) | 17%(10) | 15%(9) |

2. Is recruitment or retention the most problematic (n=59)?

| Recruitment | Retention |
|-------------|-----------|
| 80%(47) | 20%(12) |

3. What have you been doing to overcome this problem (n=59)?

| Increase Recruiting Efforts | Using creative ways to hire physicians ¹⁴ | Financial Incentives ¹⁵ | Locum Tenens | Other | Nothing |
|-----------------------------|--|------------------------------------|--------------|---------|---------|
| 37% (22) | 20% (12) | 17% (10) | 9% (5) | 14% (8) | 3% (2) |

4. Have you been successful in your efforts to overcome this problem (n=59)?

| Successful | Somewhat successful | Not Successful | Too soon to tell |
|------------|---------------------|----------------|------------------|
| 20%(12) | 46%(27) | 31%(18) | 3%(2) |

¹⁴ Hospitals essentially hire physicians through the establishment of foundations, use of rural health clinics, contracting with physician groups or setting up a foundation.

¹⁵ Financial incentives include income guarantees and loan repayment.

5. What do you think is the largest barrier to maintaining and recruiting an adequate physician workforce?

| Cannot Hire Physicians | Can't build viable practice | Reimbursement & Financial Constraints | Payer Mix | Location | Other |
|------------------------|-----------------------------|---------------------------------------|-----------|----------|---------|
| 32%(19) | 2%(1) | 31%(18) | 5%(3) | 10%(6) | 20%(12) |

6. Is access to care impaired for your residents as a result of physician workforce shortages (n=59)?

| Yes | No |
|----------|---------|
| 53 (90%) | 6 (10%) |

a. If so, how?

| Travel Long Distance | Forego Care | Appointment Delay | Other | Access not impaired |
|----------------------|-------------|-------------------|---------|---------------------|
| 26(44%) | 5 (9%) | 12(20%) | 10(17%) | 6(10%) |

7. What would be a successful strategy for elimination physician recruitment and retention issues (n=59)?

| Eliminate CPOM Ban | Offer Financial Incentives | Educate Medical Students & Residents | Change Reimbursement Rates | Other |
|--------------------|----------------------------|--------------------------------------|----------------------------|-------|
| 60%(36) | 14%(8) | 7% (4) | 17%(10) | 2%(1) |

8. What do you feel the California Hospital Associations role is in helping with this issue (n=59)?

| Lobby to lift the ban on CPOM | Research medical needs of rural communities | Lobby for appropriate reimbursement | Other |
|-------------------------------|---|-------------------------------------|--------|
| 60%(36) | 7%(4) | 28%(16) | 5% (3) |

Appendix C. Participating Hospitals

| Hospital | County |
|--|----------------|
| 1. Adventist Health Central Valley | Kings |
| 2. Adventist Health Hanford Community | Kings |
| 3. Adventist Health Selma Comm. Hospital | Fresno |
| 4. Banner Lassen Medical Center | Lassen |
| 5. Barstow Community Hospital | San Bernardino |
| 6. Barton Memorial Hospital | El Dorado |
| 7. Catalina Island Medical Center | Los Angeles |
| 8. Coalinga Regional Medical Center | Fresno |
| 9. Colorado River Medical Center | San Bernardino |
| 10. Colusa Regional Medical Center | Colusa |
| 11. Eastern Plumas Healthcare | Plumas |
| 12. El Centro Regional Medical Center | Imperial |
| 13. Fairchild Medical Center | Siskiyou |
| 14. Fallbrook Hospital | San Diego |
| 15. Frank R. Howard Memorial Hospital | Mendocino |
| 16. George L Mee Hospital | Monterey |
| 17. Glenn Medical Center | Glenn |
| 18. Healdsburg District Hospital | Sonoma |
| 19. Hi-Desert Medical Center | San Bernardino |
| 20. Jerold Phelps Community Hospital | Humboldt |
| 21. John C. Fremont Healthcare District | Mariposa |
| 22. Lompoc Valley Medical Center | Santa Barbara |
| 23. Mad River Community Hospital | Humboldt |
| 24. Mammoth Hospital | Mono |
| 25. Mark Twain St. Joseph's Hospital | Calaveras |
| 26. Marshall Medical Center | Placer |
| 27. Mayers Memorial Hospital | Shasta |
| 28. Memorial Hospital Los Banos | Merced |
| 29. Mendocino Coast District Hospital | Mendocino |

| Hospital | County |
|---|-----------------|
| 30. Mercy Medical Center Mt. Shasta | Siskiyou |
| 31. Modoc Medical Center | Modoc |
| 32. Northern Inyo Hospital | Inyo |
| 33. Oak Valley Hospital District | Calaveras |
| 34. Ojai Valley Community Hospital | Ventura |
| 35. Palm Drive Hospital | Sonoma |
| 36. Palo Verde Hospital | Riverside |
| 37. Pioneers Memorial Healthcare District | Imperial |
| 38. Plumas District Hospital | Plumas |
| 39. Redwood Memorial Hospital | Humboldt |
| 40. Ridgecrest Regional Hospital | Kern |
| 41. San Bernardino Mtns. Comm. Hospital | San Bernardino |
| 42. Seneca Healthcare District | Plumas |
| 43. Seton Coastside | Mateo |
| 44. Sierra Kings District Hospital | Fresno |
| 45. Sierra Nevada Memorial Hospital | Nevada |
| 46. Sonora Regional Medical Center Adventist Health | Toulome |
| 47. Southern Inyo Hospital | Inyo |
| 48. St. Elizabeth Community Hospital | Tehama |
| 49. St. Helena Hospital/Clearlake | Lake |
| 50. St. Mary Medical Center | San Bernardino |
| 51. Surprise Valley Healthcare District | Modoc |
| 52. Sutter Amador Hospital | Amador |
| 53. Sutter Coast Hospital | Del Norte |
| 54. Tahoe Forest Hospital District | Nevada |
| 55. Tehachapi Valley Healthcare District | Kern |
| 56. Trinity Hospital | Trinity |
| 57. Twin Cities Community Hospital | San Luis Obispo |
| 58. Ukiah Valley Medical Center/Adventist Health | Mendocino |
| 59. Victor Valley Community Hospital | San Bernardino |

Appendix C. Map of State Designated California Rural Hospitals (Federally designated hospitals missing include; Adventist Health/Central Valley, El Centro Regional Medical Center and Mad River Community Hospital).

