

***Institute for Public
Policy and Economic
Analysis***

**The Challenge of
Providing
Primary Care
Services In
Spokane County**

By:

D. Patrick Jones, Ph.D.

Mary Ann Keogh Hoss, Ph.D.

David Bunting, Ph.D.

Mark Wagner, M.A.

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3. Executive Summary

This study responds to a set of questions posed by the Spokane County Medical Society (SCMS) to the Institute of Public Policy & Economic Analysis at Eastern Washington University about economic challenges facing the provision of primary care in Spokane County. This study is part of a groundswell of concern and research regarding whether the current and future primary care workforce is adequate. For purposes of the study, primary care disciplines are: family/general practice, internal medicine, pediatrics and obstetrics/gynecology. The SCMS requested that the following topics be investigated:

- A review of data and literature on norms for an adequate supply of primary care physicians, or PCPs, in Spokane County;
- Current access to PCPs by Medicare & Medicaid patients;
- A set of strategies for the recruitment & retention of PCPs locally;
- An estimate of the economic impact of an inadequate PCP base in Spokane County; and
- Recommendations to the SCMS on revenue-enhancing strategies for PCP offices.

The basis of the comparison with national data and practices was a survey sent out in the late summer and fall to all primary care offices and clinics. Federal primary care (PC) physicians, private primary care physicians in administrative roles and hospitalists were not contacted, due to the focus of the study. Questions were also posed about physician assistants (PAs). 42 out of 72 offices or clinics responded, representing

87% of all PC physicians defined on the SCMS-provided list. While the largest number of offices responding came from solo practitioners, the bulk of the Spokane PC physician workforce can be found in the practices with over 5 physicians, and especially in practices of over 10 physicians. A similar distribution of physician assistants and those PC physicians working part-time exists.

A high percentage of offices and clinics, as weighted by the physician count, is expecting some form of turnover in 2009 and the two years beyond. Offices representing 42% of all physicians expect departures in 2009 and those representing 52% of all physicians anticipate retirements within three years. 72% of all offices, as weighted by their physician count, reported that they did not have enough PC physicians or PAs. These results do not include the answers provided by the large residency program in Spokane. Not surprisingly, three quarters of offices and clinics, weighted by their physician count, expect to hire physicians in 2009; 37% anticipate hiring PAs in 2009. Interestingly, the overwhelming majority of offices reported that their starting salaries are competitive.

A review of a now large body of research on primary care physician supply is presented. National trends include an increasing reliance on international medical graduates (IMGs) and a pronounced preference by female medical school graduates for the primary care disciplines. An extensive literature review of PC physician staffing norms turned up a range of current values from 80-95 per 100,000 people. Based on the SCMS roster, the 2008 value for the County was 87. However, data from the American Medical Association show that

the ratio has slipped considerably over the past few years, especially so for family and general practice physicians. Among Pacific Northwest metropolitan statistical areas (MSAs), Spokane staffing ratios for all PC physicians are currently below the median and considerably below the ratios of the Seattle and Portland MSAs.

Current projections from national organizations that follow physician supply now point to a looming shortage over the next decade, assuming current practice patterns, gender mix and physician productivity do not change. The two most recent studies put the gap in 2025 between 35,000-46,000 primary care physicians, measured on an FTE basis. A local forecast based on national models was not attempted. However, applying likely future staffing norms of PC physicians to the age distribution of Spokane PC physicians, average retirement rates and population forecasts, yields a need of 19-20 new PC physicians a year over the next decade, by head count. On an FTE basis, the numbers will be higher.

Since approximately 20% of the current Spokane PC physician workforce consists of graduates of the University of Washington (UW), actions taken by that university's medical school to respond to these forces will be critical. That is, unless U.S. and Washington State policies allow the presence of IMGs to continue to expand. Presently, Washington State produces the second-lowest count of medical school graduates per capita among all states, and the lowest count when the five-state WWAMI (Washington, Wyoming, Alaska, Montana and Idaho) population is used. Over this decade, the state's graduate count has actually slipped, although recent

expansion of the UW WWAMI program in Spokane should reverse the decline.

Access to PC physician care was also measured. A consequence of constrained supply is constrained ability of patients insured by the two large government programs, Medicare and Medicaid, to receive primary care. The survey found that current payer mix of responding offices, weighted by the number of PC physicians, was 26% Medicare and 20% Medicaid. When asked about the ability to take on new patients, 32% and 27% of the responding physicians indicated this was possible for Medicare and Medicaid, respectively at the time of the survey. These are slightly higher shares than those found in 2002 from a survey of PC physicians undertaken jointly by the Washington State Department of Health and the Spokane Regional Health District. Slightly higher percentages, 42% and 38%, emerged from a similar query about 2009. Nonetheless, these responses indicate that a large majority of PC physicians in Spokane are not taking on new patients from the two government programs.

A review of best practices for recruiting and retaining physicians was also undertaken. In addition, Spokane PC physician offices were queried about their activities and preferences in this important activity. While the internet and networking were identified as the leading national recruitment strategies, the survey revealed that hospitals, networking and residency programs were the top three factors locally. Nationally, compensation, benefits and practice arrangements figure as the top retention issues; the local survey found a similar ranking of factors.

A second survey carried out by the study team sought to understand the backgrounds of those PC physicians who had recently left Spokane and the reasons of their departure. Here the sample was much smaller, with 30 names for which addresses could be found. Eleven responses were received, and consequently, the results are merely suggestive. The respondents were largely female, had been in Spokane generally three to four years before leaving, had worked as employees and were married with dependents. It was clear from questions about their rating of the attributes of the Spokane area that the community "fit" had often not been good. The major reasons for leaving centered on compensation and family. However, the range of replies for their departures was broad and one cannot draw too many conclusions.

National and state policies to increase recruitment and retention were reviewed. Generally, they fall into two programs: financial support of residents and new physicians, via favorable loans, and tuition scholarships granted to medical students. Both types of programs demand, in return, that the student or resident spend a certain amount of time, usually 3-4 years, in designated medically underserved areas (MUAs). Washington State has both types of programs, with a current annual budget of \$8.7 million/year. However, as Spokane County contains very few MUA slots, advocating an expansion of this program will not directly serve the needs of its PC physician community. Should the state adopt a program similar to one recently put into place in Massachusetts, where primary care medical students receive financial incentives if they stay to practice anywhere in the state, the County would more directly

benefit. The state policies with the largest impact aim at increasing the supply of medical students, via an expansion of medical school slots, and its residents, via Medicaid financial support (Graduate Medical Education funding).

Despite the difficulties of developing local estimates of the cost advantages of PC versus specialty physicians, one is made. It uses a well-known study of the cost differential between the two types of physicians in the treatment of a number of chronic diseases. Developing a very approximate estimate of these conditions' prevalence in Spokane County and then applying the cost differential yields a savings of nearly \$58 million.

The report substantiates the claim that income of primary care physicians has declined or stagnated in real, or inflation-adjusted, terms, relative to other medical disciplines. Compared to their counterparts in most other Pacific Northwest MSAs, Spokane family practice physicians have earned the least and have experienced the smallest gains over the decade. Combined with national trends, the regional compensation trends for Spokane PC physicians are troubling.

On the basis of the survey and interviews with experts, revenue-enhancing strategies were explored. The most common general strategy that emerged was the expansion of ancillary services, such as laboratory, radiology, electrocardiograms, respiratory treatments and dermatological procedures. However, these ancillary services come with costs that may render the net income effect small.

In the study team's view, the strategy with the highest pay-off is to try to increase reimbursement, specifically Medicare reimbursement, since it plays an anchor role in setting fees for all other payers. Data comparisons made available from the Dartmouth University's *Atlas of Health Care* reveal that Medicare pays Spokane area PC physicians much less than the national average per patient visit and even less than the Washington State average. In addition, Spokane physicians practice conservatively, with fewer visits to chronically ill Medicare patients than national norms. After examining national data and many case studies, leading federal organizations, such as MedPAC, responsible for advising Congress on Medicare, and the Government Accounting Office have come to the conclusion that payment reform for PC physicians should start.

However, these Federal agencies, several state Medicaid programs and one or two

groups of private insurers also recommend that payment reform take place in the context of the provision of higher quality patient care. This effort, aimed at coordinated care, greater accessibility to primary care and a higher level of patient understanding, now falls under the moniker of *medical home*. In the last legislative session, Washington State passed a bill that would set up the structure for the state to institute pilot programs for medical homes in primary care provision. With one exception, participants in the development of a state medical home framework have all come from the central Puget Sound area. In light of the advantages the Spokane physician community enjoys – a mid-size body of practitioners, advanced penetration of health IT systems and a keen awareness by the hospitals of primary care challenges - - the study team thinks that the SCMS can show statewide leadership on this important initiative.

4. Motivation of Study & Scope of Work

This report presents findings from a study designed to investigate the current primary care physician and physician extender workforce as it affects the provision of primary care in Spokane County. The intent of the study is to determine the adequacy of the current primary care workforce and the economic impact of an inadequate workforce in the County. The study was funded by the Spokane County Medical Society (SCMS), through a contract with the Institute for Public Policy and Economic Analysis at Eastern Washington University. The authors collected data from primary care practices throughout Spokane County via a variety of sources, including two surveys. Primary care physicians having left the Spokane area within the past five years were also contacted as part of this study.

The SCMS asked the Institute to augment responses to several questions beyond the survey of local providers' workforce. These were:

- To review the data and literature on norms for “necessary” amounts of primary care physicians, or PCPs, in Spokane County
- To document current access to PCPs for Medicare & Medicaid patients
- To report on a set of strategies for recruitment & retention of PCPs
- To estimate the economic impact of an inadequate PCP base in Spokane County
- To advise the SCMS on revenue-enhancing strategies for PCP offices.

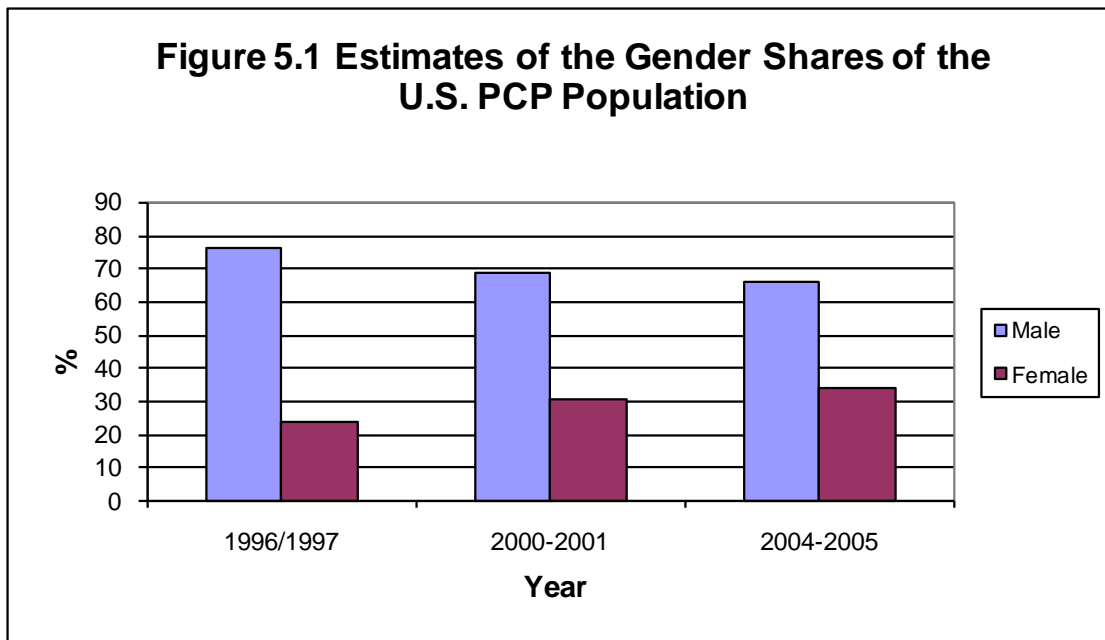
The study includes, wherever possible, the role of physician assistants (PAs). National data, however, are much more limited, and consequently few comparisons between County and national conditions can be made. The study does not cover nurse practitioners. By agreement with the SCMS, PCPs are defined as those physicians who are board-certified in family medicine, general internal medicine, pediatrics, obstetrics and gynecology. The intent of the study is to learn more about office- or clinic-based PCP practices. As a consequence, local data on the following were excluded: PCPs currently not actively engaged in patient care (administrators), PCPs employed by hospitals (hospitalists), PCPs working in Washington State or Federal settings and any PCP whose primary activity is emergency medicine. The study's goal is to arrive at a factual depiction of current conditions facing the provision of primary care from office- and clinic-based PCPs and PAs in the County, to lay out future challenges and to provide some suggested remedies.

5. Trends in the U.S. Physician Generalist Workforce

The United State General Accounting Office (GAO, 2008) defines primary care physicians (PCPs) as those practicing in family medicine, osteopathic general practice, internal medicine and general pediatrics. The American Medical Association also considers physicians practicing in obstetrics/gynecology as part of primary care. Physician assistants are health care professionals that practice medicine under physician supervision (Steinwald, 2008, p.1). Estimates vary, but most studies place the national share of PCPs in the mid-thirty percentage range of the total physician workforce. A study from the Health Resources and Services Administration (HRSA) of the U.S.

Department of Health and Human Services (2006) states that “slightly over one third of physicians are generalists (family medicine, general pediatrics or general internal medicine)”(p.5). The Center for Studying Health System Change (Tu & O’Malley, 2007) estimated the 2004-2005 share 36.7%, declining about two percentage points over the decade. The Kaiser Family Foundation’s latest data, for 2007, show the national share of non-federal PCPs to be 36% (Kaiser statehealthfacts.org, 2008).

The gender mix of primary care residents has changed dramatically over the past decade, shifting toward females. According to the 2007 study by the Center for Studying Health System Change (CSHSC), the most recent estimates show women constituting over a third of the workforce.



With their share increasing from 23.6% to 34% in a decade (statistically significant at the 95% confidence level), women are shoring up the primary care workforce (Tu & O'Malley, 2007). However, many female primary care physicians now work part-time. The 2007 survey by CSHSC found female PCPs working an average of 46.9 hours/week versus a male PCP average of 53.6, or about 12% less.

International Medical Graduates (IMGs) represent 25% of the United States physician workforce, or approximately 180,000 physicians (Smart, 2006). These IMGs play an increasingly important role in the delivery of primary care in the US. Over 5,000 IMGs enter American medicine each year (Association of American Medical Colleges, 2006). "IMGs continue to practice in primary care at higher rates than U.S. trained physicians (42.0% vs 35.4% in 2004-2005). However, IMGs, like U.S.-trained physicians, have steadily migrated into medical specialties in recent years, leading to a substantial decline in the proportion of IMGs practicing in primary care since 2000-01 (42.0% of IMGs in primary care in 2004-2005 vs. 47.1% in 2000-01)"(Tu & O'Malley, 2007). Recent research indicates that the U.S. primary care physician (PCP) workforce will include more IMGs, most of whom will be citizens or permanent residents of the United States, and graduates of Caribbean medical schools (Brotherton, Rockey, & Etzel, 2005).

The GAO (Steinwald, 2008) states, "primary care professionals nationwide grew faster than the population, resulting in an increased supply of primary care professionals on a per capita basis "(p. 6). The study reports further, "From 1995 to 2006, the number of physician residents in

primary care training programs increased 6 percent ...and primary care residency programs declined from 1,184 programs to 1,145 programs" (p. 9). However, many groups and analysts question whether this growth is adequate. The Brotherton, Rockey & Etzel study (2005) of US Graduate Medical Education (GME) concludes that "an increasing proportion of physicians are pursuing subspecialty training, while the number in primary care specialties has leveled off. Trends in GME suggest that primary care medical workforce of the future will include more women, more IMGs and more DOs" (p 1075).

Contrary to previous predictions of a glut in the medical labor pool, many experts now predict a shortage of physicians resulting in part from the aging baby boomer population, physician retirements, changing ethnic and racial demographics, increased utilization of services, a hostile malpractice environment, and an increasing number of medical school graduates (both male and female) who desire reasonable work hours (Cooper, 2002, 2003: BHPR, 2003), (Buchbinder & Shanks, 2007, p.240).

The American College of Physicians (ACP) the nation's largest specialty society representing 120,000 internists and medical students in a position paper *Creating A New National Workforce For Internal Medicine* (2006) discusses the aging, diversity and chronic care conditions of the population, as well as the rising cost of care at unsustainable levels. " These factors have already impacted access to care, health care quality, and health disparities, and may be exacerbated in the future by a looming crisis in the physician workforce"(ACP,2006,p.2). A specific concern is the adequacy of the supply of

general internists who provide care in outpatient settings. ACP wants a national health care workforce policy to reverse the impending collapse of primary care medicine.

The results of a national survey released November 18, 2008 by the Physicians' Foundation found, "An overwhelming majority - 78 percent of physicians, believe that there is an existing shortage of primary care doctors in the United States today. Additionally, nearly half of them - 49 percent-, or more than 150,000 practicing doctors-say that over the next three years they plan to reduce the number of patients they are see or stop practicing entirely"(p.1).

In a November 2008 report by the Association of American Medical Colleges (AAMC) titled, *The Complexities of Physician Supply and Demand: Projections Through 2025*, the issue of the aging population is again discussed" By 2030, more than 71 million Americans will be over the age of 65, roughly double the number there were in the year 2000; and the 65+ population uses twice as many physician services as those under 65" (p 13). This study continues, "Women comprise a larger percentage of the older population than they do of the total, and as the population ages this will have an effect on the entirety of the health care delivery service, most likely including the demand for different types of physician services....amongst those 75 years of age and older...women's demand for primary care is greater" (p 32).The 75+ group is the fastest growing segment in the older population. This study also reinforces the gender differences in US Medical School graduates, finding that females expect to retire earlier

than males and work an average of 7.4 hours per week less than their male counterparts....in female physicians under 50 years of age they value family and personal life more than their male counterparts. With the increase of women in primary care, this can have a negative effect in meeting workload demands."

The summary statement of the AAMC study dwells on the complexity of forecasting supply and demand for physicians. The following factors are noted as causing this complexity: "demographics, the needs for work-life balance, trends in retirement, the national debate on the uninsured, the role of primary care in the health care delivery system, training capacity at all stages of an increasingly international pipeline, and the role of non-physicians" (p 75).

The American College of Physicians (2008) in a white paper titled *How Is a Shortage of Primary Care Physicians Affecting The Quality and Cost of Medical Care? A Comprehensive Evidence Review* presents a summary review of over 100 studies detailing the need for primary care. The evidence presented in the paper supports the following findings

- Absent changes in policies to make primary care more attractive and rewarding to new physicians and to sustain those already in practice, the supply of primary care physicians will fall behind increased patient demand, resulting in a shortfall of tens of thousands of primary care physicians over the next decade.
- The availability of primary care is positively and consistently associated with improved outcomes, reduced mortality, lower utilization

of health care resources, and lower overall costs of care.

- Consequently, a shortage of primary care physicians will result in poorer health outcomes and more premature and preventable deaths for millions of Americans, and overall higher costs of care (p.2).

The strong implication in all of this information is that the United States is already not meeting its primary care

workforce needs and that primary care provision nationally will be dependent on IMGs. The impact of the aging population is a constant theme in this issue. A specific examination of the Spokane County PCP workforce need is taken up in Chapter 7. Reasons behind local PCP supply are provided in Chapters 9 and 11. The factors identified in the above studies shape the access question, taken up in Chapter 8, placing an even greater burden on primary care provision than has been predicted.

6. General Results from a Survey of PCPs Currently in Practice in Spokane County

6.1 Description of survey methodology & responses

Two questionnaires were developed for this study. Eastern Washington University Institutional Review Board approval was sought and obtained for the study and both surveys used. Accompanying both surveys was a letter from the chair of the Spokane County Medical Society (SCMS) board describing why they requested that the study be conducted.

The first questionnaire was developed to determine the following: the current number of primary care physicians and physicians' assistants; the perceived need for more primary care physicians and assistants; what access exists for Medicare and Medicaid patients; and successful recruitment and retention strategies used in practices in Spokane County. It contained 36 questions. It was sent out to two practice managers for review and suggestions as well as to the Spokane County Medical Society. Minor changes were made after the review. The list of physician practices consisted of names from the SCMS and a list from the phone book. Primary care physicians' offices were defined as those providing general family medicine, general practice, internal medicine, pediatrics and obstetrics/gynecology services.

This survey of physician practices, along with the letter, was sent electronically to all practice/office managers of offices

identified as primary care providers in Spokane County. Where it was not able to be emailed, the survey was sent by postal mail or faxed, depending on the request of the practice. For those not responding to the initial request, a phone call was made as part of follow-up. Those follow-up calls determined the appropriateness of the survey. Follow-up calls and emails were also made to clarify questions. Incorrect information about the practice, closures and retirements were also discovered through these calls. This information was gathered over the months of September through December.

Excluded from the study were primary care physicians at the Veteran's Administration Hospital and Eastern State Hospital, as they do not see the general public. Urgent care centers operated by Empire Health were not included. Hospitalist groups were also excluded from the survey. Finally, those PCPs in administrative roles were excluded.

The response rate was high. 46 out of 72 offices contacted responded, or a rate of 64%. The responding offices include seven offices/clinics that represent 2-10 locations. Measured by the number of physicians represented by these office/clinics, the rate was much higher: 348 out of 398, or 87%.

The second survey was developed to determine why primary care physicians left practice in Spokane County. SCMS staff reviewed this survey as well and suggested some modifications, which were done. Names of physicians that had left the area were supplied by the SCMS. Physician practices were also asked for additional names. Considerable research went into the discovery of email or current physical addresses. This survey requested some

basic demographic information via 19 questions and then posed six open ended questions.

The pool of respondents who were identified was much smaller than for the survey of physicians currently practicing in Spokane. 30 PCPs who had once practiced in Spokane were located; 11 responded.

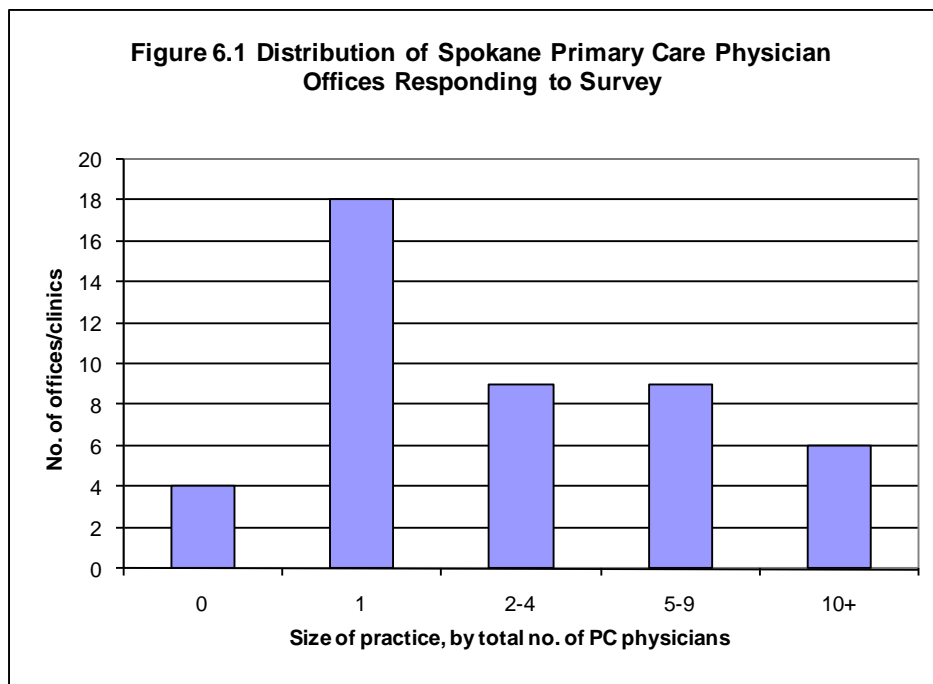
6.2 Descriptive statistics about PCP offices in Spokane County

Before the survey results are presented, it is useful to understand some essential demographic information about the current PCP workforce in Spokane County. These data come from both SCMS files and from the survey. A proxy for age, the mean graduation year from medical school in the County was 1986. For males, it was 1984; for females, it was 1990. Currently, there are 102 female PCPs in the County that fit the definition used in the survey, or about

30% of the total PCP workforce. As can be seen in the graduation date, female PCPs are considerably younger, reflecting national trends. Of the 96 PCPs who have established practice in Spokane since 1995, 49 (or 51%), are female.

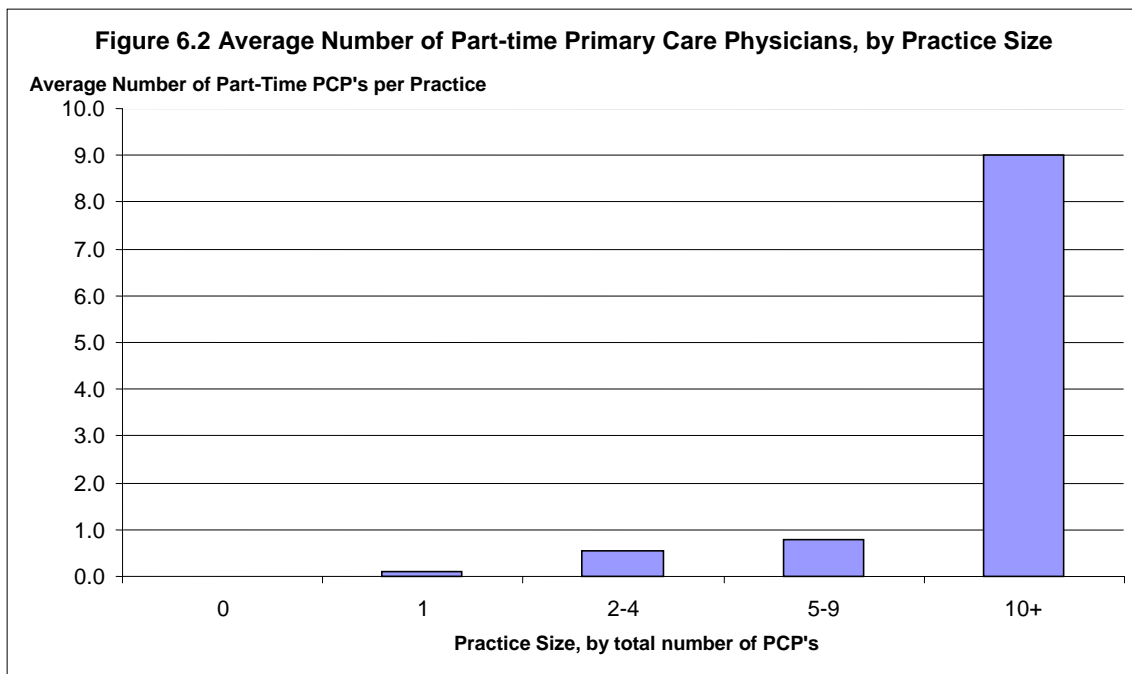
The medical school supplying the largest numbers of PCPs to Spokane has been the University of Washington, with 19% of the total. The second most-common source of new primary care physicians has been University of Oregon/Oregon Health Science University, with 6% of the total. Tied for third place are Creighton University, NE and Loma Linda, CA, with 4% of the total.

To arrive at insights about how practice size might affect survey responses, the authors created several practice size categories, as measured by the number of permanent PCPs: 0, 1, 2-4, 5-9, and over 10. A depiction of the size distribution of the 46 offices is below.



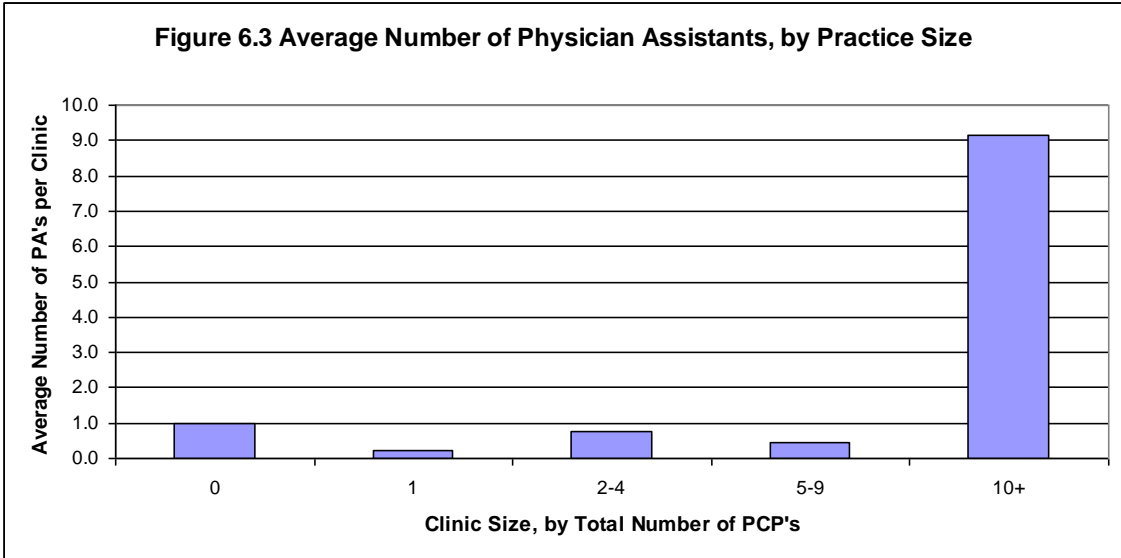
The most frequent office type was of the solo practitioner, with 18 respondents. Mid-size practices, with 2-9 physicians, number 18. There were six with a total PCP count of 10 or more. Four offices also reported no PCPs; they rely on contract physicians. The average number of physicians in the two mid-sized categories lay at the mid-points

Of the 348 responding physicians, 280 worked fulltime, or 80%. Part-time PCPs responding to the survey numbered 68. The majority of part-time PCPs, 54, work in the large practices (10+). Figure 6.2 displays the distribution of the average number of part-time PCPs by office size.



of their ranges, or 3 and 7, respectively. The average size in the largest category was much higher, at 40 physicians. However, there was a substantial range among the six offices/clinics in this category.

The number of physician assistants (PAs) represented by the responding offices numbered 74. They too, were concentrated in the large practices, at 55, as Figure 6.3 displays. Solo practitioners reported the fewest number of PAs.



6.3 Responses about PCP labor force conditions from the survey

Turnover for both PCPs and PAs is readily apparent from the survey responses. Table 6.1 summarizes the responses to several questions. The answers provided by the County's residency program, Inland Empire

Hospital Services Association, are excluded here. Given the nature of residency programs, one expects a constant turn-over of personnel. Consequently, the size of responding pool is lower for the physicians than the 348 total respondents. The office responses are weighted by the size of the number of total PCPs in their office or clinic.

Table 6.1 Departure & Retirement Intentions

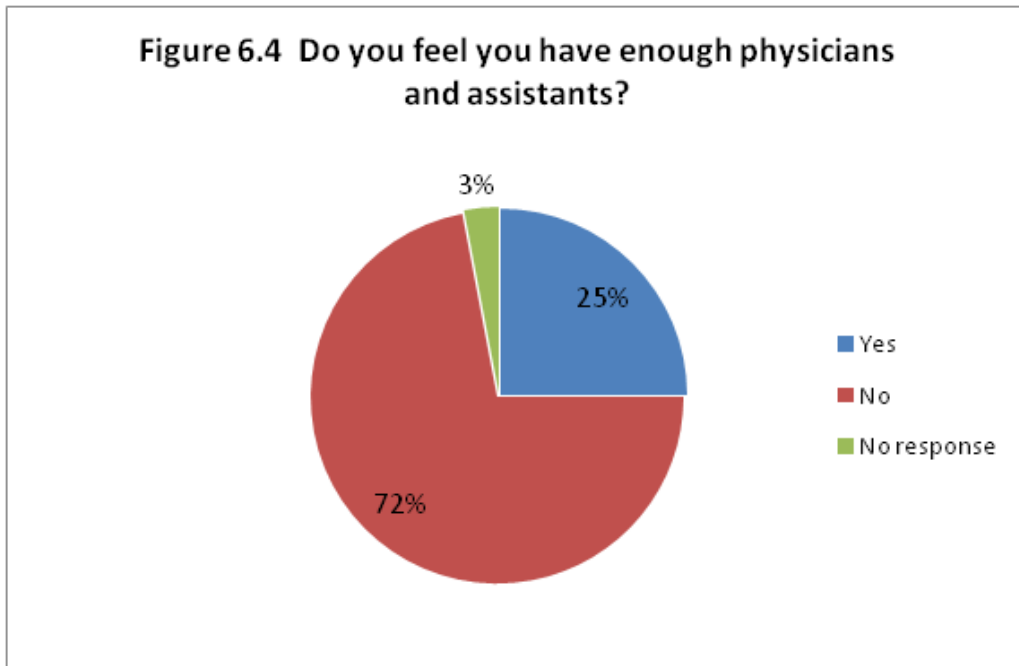
	Physicians	Physician Assistants
Percentage of Offices & Clinics Expecting Departures For 2009	42% N=288 PCP's	22% N=72 PA's
Percentage of Offices & Clinics Expecting Retirements In Next Three Years	52% N=288 PCP's	25% N=72 PA's

Offices representing over two fifths of PC physicians are expecting some form of physician departures in 2009. Offices representing over half of PC physicians are expecting retirements of some of their physician staff within the next three years. The number of offices, as weighted by their physician count, who are expecting retirements, certainly shows the need to recruit primary care physicians to the Spokane market.

As the cross-tabs in Appendix 2 make clear, these responses are not evenly distributed across practice size. The largest category, 10+, answered yes in two out of five cases, and given the numbers of physicians

involved, heavily influenced the results to both questions. However, the 5-9 mid-size practices also registered a strong affirmative response to the retirement question. Expected turnover of PAs is considerably lower. However, as in the case of physicians, the responses by the largest category drive the results.

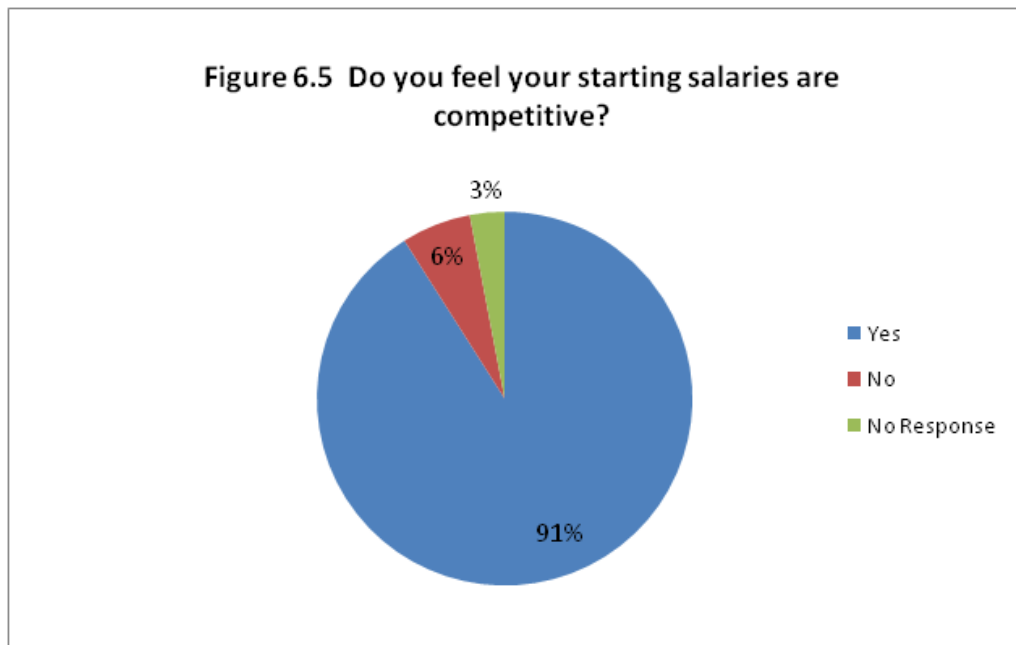
Personnel turnover is characteristic of almost every industry. A more critical issue is whether the turnover is higher or lower than expected or desired. The response to the following question sheds some light on the desired turnover or staffing levels by PCP offices/clinics in Spokane.



N = 288

As in Table 6.1, the responses of the residency program were excluded in Figure 6.4, as the intent of the study was to focus, in most questions, on permanent practices. As before, the responses by the offices were weighted by the total number of physicians in the practice. It is clear that for the bulk of the PC physician population, greater numbers are desired. As in prior

causal relationship between the price of a service (defined here as wage or salary), the amount supplied and the amount demanded. In the case of perceived shortages, prices should rise. It is consequently a curious survey finding to learn that the vast majority of the offices felt that the salaries offered are adequate, as shown in Figure 6.5.



N = 348

questions, this result is strongly influenced by the large practice groups. In fact, the majority of the small practices (< 5) responded that their staffing levels of physicians and PAs were adequate. Like the largest practices, the majority of the mid-sized (5-9) registered a no to this question. Most of the study team consists of economists, and as such, we think of a

Offices of all practice sizes answered yes with a large plurality to his question. However, the largest practices were unanimous in their affirmative response.

Given the response to the question behind Figure 6.4, it is not surprising that a majority of the offices/clinics responding plan on hiring in 2009.

Table 6.2 Hiring Intentions in 2009

Percentage of offices & clinics hiring physicians in 2009	74% <i>N=288 PCP's</i>
Percentage of offices & clinics hiring Physician assistants in 2009	37% <i>N=348 PCP's</i>

Offices representing nearly three quarters of responding PC physicians said that they plan to hire new physicians in 2009. The results are heavily influenced by the responses of the larger (>5) practices. Most practices with four or fewer PC physicians reported that they are not planning on new PC physician hires in 2009. In contrast, offices representing a little more than a third of County physicians said that they plan on hiring PAs in 2009. In the query about physician hiring, responses of the residency program were excluded, since one expects that program to engage new residents every year. However, the residency program was included in the query about PAs, as it employs a few and does not regularly hire every year.

6.4 The importance of FTE measurement

Throughout the reporting of the survey results, responses are presented on the basis of headcounts. In other words, the variation in work effort is not taken account of. Yet, it is clear from both national trends

and from the survey that PC physician work effort varies considerably. We know, for example, that nearly 20% of the physicians represented by the responding offices or clinics work part-time.

The 68 responding part-time physicians were converted to a full-time equivalent (FTE) basis to arrive at another measure of capacity, or supply. To arrive at a reasonable FTE estimate, a supplemental survey was conducted. We received a partial response that produced an average of approximately 20 hours per week, or 0.5 FTE. This ratio was then applied to part-time PC physicians from practices that did not respond. All full-time physicians are counted as 1.0 FTE each. On this basis, the survey covered about 313 FTE physicians. Expressed as a share of the headcount total, 348, this translates into a reduction of 10% of the PC physician supply when measured on an FTE basis.

This result is very similar to national data. HRSA (2006) found that the FTE growth of all physicians between 2000 and 2005 was

89% of the headcount growth. Given the known concentration of part-time work in the PC physician workforce, it is likely that the national measure of the gap between PC physician FTE and headcount numbers is

greater than 11%. As taken up in the subsequent section, the growing role of part-time work by PC physicians plays significant role in assessing the adequacy of the future local work force.

7. Adequacy of Supply of Primary Care Physicians in Spokane County

7.1 Background

A large and growing literature on assessing the adequacy of current and future physician supply now exists. This study does not attempt to critique nor analyze that literature. Nor does it try to create a quantitative answer for Spokane County. Rather, it reports on the most recent findings as they impact the issues facing the County.

Essentially, as HRSA (2006) lays out in a brief description of its forecasting method, any conclusion rests on factors affecting both the supply of physicians and the demand for their services. On the supply side, the most general list of variables includes:

- the number of slots at U.S. medical schools;
- the number of federally-supported slots for Graduate Medical Education (GME);
- the relative attractiveness of medical practice versus other professions demanding high cognitive skills; and
- U.S. immigration policies.

More specific to primary care disciplines, supply variables, that is those that affect residency choices by medical school graduates, will include: expected workloads and schedule flexibility, likely employment status within a practice (employee or partner), peer esteem and, importantly, reimbursement for services. The attractiveness of Spokane County to entrants in the primary care physician

market depends on how the County meets these criteria, in addition to the fit with the physician's outside interests and those of his/her family.

The demand for PC physician services also rests on a complex mix of factors:

- patient population characteristics (age & gender), as highlighted by the 2008 AAMC study;
- the coverage of the population by health insurance;
- practice patterns, that is, the intensity of care, an insight that the Dartmouth College of Medicine's *Atlas of Health Care* has widely studied & popularized (Fisher et al, 2003; Goodman et al, 2008) and has now been embraced by the U.S. Congressional Budget Office (2008);
- practice organization (the use of extenders and generally, physician productivity); and
- hours worked, a factor most often tied to the gender mix of physicians

While these variables are used in national studies, they are also relevant to consider locally. As in our local survey, most studies exclude physicians not involved in patient care and those working for the Federal government.

The question of a norm can be answered as either an *ideal* established by a set of practice guidelines or as a *benchmark* from levels elsewhere. The literature now shows a considerable range of values, usually expressed as the number of PC physicians per 100,000 people. HRSA's model (2006) arrives at a "required" rate of 95 in 2000 for PC physicians, increasing to 100 in 2020, assuming the status of current practice patterns continues. Schueler et al (2003)

in a Washington State Department of Health study done in 2003, use a “practice ideal” of 83 per 100,000. They base this ratio on the assumption of near complete coverage of the patient population and a managed care staffing ratio.

A recent article from a team from the University of Missouri (Colwill et al, 2008) points to the current PC physician national average of 75 office- and hospital-based generalists per 100,000 for 2005. The most recent study, from the Association of American Medical Colleges (2008, p.33) shows a rate, expressed in full-time equivalents (FTEs) that varies by gender of physician. In particular, the rate is 91 FTE female PC physicians and 80 FTE male PC

physicians per 100,000 population. In light of the known lower hours worked by female PCPs, this translates into a higher headcount rate, perhaps close to 100 per 100,000 population.

7.2 Regional, state & MSA comparisons

Where does Spokane currently stack up against these norms? One measure comes from the SCMS itself. Assuming that the 398 used in the survey is correct, then a ratio based on the estimated 2008 County population, is approximately 87 per 100,000. However, comparisons from Federal and American Medical Association (AMA) data sets provide context for some trends and regional comparisons.

Table 7.1 Physicians per 100,000 People in Pacific Northwest States

	Physicians		Generalists		Specialists	
	1991	2001	1991	2001	1991	2001
Metropolitan:						
U.S.	242	267	85	94	154	171
Oregon	234	249	82	92	150	156
Washington	222	245	82	90	137	153
California	225	229	78	83	144	143
Montana	236	302	52	82	183	219
Idaho	162	198	55	69	106	128
Nonmetropolitan						
Washington	128	152	63	73	63	78
Montana	124	157	63	73	59	83
Oregon	128	156	58	70	69	84
U.S.	99	122	49	59	49	63
California	112	129	52	59	58	69
Idaho	108	129	49	54	56	73

Source: GAO (2003)

As is clear from the Table 7.1, the PC physician staffing rate in Washington State grew for types of regions over the 1990's. Spokane County is considered a metropolitan area. At the start of this century, Washington State PC physician staffing ratios were slightly lower than US averages but ahead of most other Pacific Northwest states for

metro areas. They were considerably above U.S. averages for non-metro areas, ranking highest among all states in the region.

As can be seen in Table 7.2, PC physician staffing ratios grew nationwide for small metro areas. At the start of this century, 86 per 100,000 was the national average for metro areas the size of Spokane.

Table 7.2 Generalists Per 100,000 People by County Category

County Category	Population	Number	1991	2001
Metro:				
Large	> 1 million	311	92	100
Small	50,000 – 999,999	525	73	86
Non-Metro:				
Large town	10,000 – 49,999	485	54	67
No large Town	2,500 – 9,999	1,305	46	54
Rural	<2,500	515	41	46
Overall		3,141	56	65

Source: GAO (2003)

Table 7.3 Total Primary Care Physicians per 100,000 Population

MSA	2002	2003	2004	2005	2006	% Chg
Seattle-Tacoma-Bellevue, WA	124	132	129	129	132	6.4
Portland-Vancouver-Beaverton, OR-WA	111	118	114	111	116	4.8
Billings, MT	100	106	106	103	106	5.8
Eugene-Springfield, OR	94	96	95	98	96	1.3
Medford, OR	86	100	93	94	94	9.0
Bellingham, WA	82	88	89	90	93	14.1
Spokane, WA	100	87	87	83	89	-11.0
Yakima, WA	79	83	85	85	83	5.7
Boise City-Nampa, ID	75	80	79	76	75	0.0
Richland-Kennewick-Pasco, WA	51	51	48	53	53	3.7

Source: AMA Physician Characteristics and Distribution

Table 7.3 presents ratio data over time for many metro areas in the Pacific Northwest. The results are ranked by 2006 values. At 89, Spokane MSA's (County's) ratio was more or less in the middle of the range set by the national studies above. Clearly, the PC physician staffing ratio in Spokane lay far below those of the Seattle & the Portland metro areas for that year, as it has for all years in the decade. However, it was considerably above the ratio for the other large Pacific Northwest metro area, Boise-Nampa.

The aspect of Spokane's staffing ratio that distinguishes it from the other metro areas in Table 7.3 is its declining trend. At a negative 11%, it was the only metro area that showed a negative growth rate over the five-year period depicted.

Nationally, the largest component of PC physicians consists of family/general practice. Table 7.4 makes the same comparisons of Pacific Northwest metro areas as in Table 7.3, but limits the ratios to family medicine. As in Table 7.3, the results are ranked by 2006 counts.

Table 7.4 Family & General Practice Physicians Per 100,000 Population

MSA	2002	2003	2004	2005	2006	% Chg
Bellingham, WA	41	41	43	43	46	12.3
Seattle-Tacoma-Bellevue, WA	44	45	44	44	43	-2.4
Eugene-Springfield, OR	41	41	41	42	39	-5.1
Medford, OR	32	39	38	38	37	15.4
Spokane, WA	43	36	34	32	35	-18.6
Yakima, WA	37	36	37	35	33	-9.0
Billings, MT	28	32	31	31	30	5.3
Portland-Vancouver-Beaverton, OR-WA	28	30	29	28	29	3.0
Boise City-Nampa, ID	31	32	31	30	29	-6.3
Richland-Kennewick-Pasco WA	19	18	15	17	17	-9.4

Source: AMA Physician Characteristics and Distribution

As was the case for all PC physicians, Spokane fell in the middle of those MSAs considered. With a 2006 value of 35 general practice physicians per 100,000, Spokane placed lower than the Seattle metro but higher than both the Portland and Boise metros. However, as was the case for all PC physicians, Spokane's staffing ratio of general medicine practitioners fell over the decade. This was not unique, as several MSAs registered declines in the staffing ratios. However at nearly 19%, the drop in Spokane was considerably larger than all other Pacific Northwest metro areas.

To summarize, it does not appear that Spokane's current staffing ratios of PC physicians are low by national or regional standards. This conclusion is reinforced by the current HRSA Health Professional Shortage Area score for primary care physicians. With a deficit of three, Spokane County's shortage is considerably lower

than the closest Washington state county in size, Clark (Vancouver). That county's current shortage count is 12.

However, in the period of five years, staffing ratios have slipped by a double-digit percentage. Relatively speaking, there has been some flight by PC physicians from Spokane. Some of the reasons might lie in the upcoming discussion of the survey of departed PC physicians and of revenue-generation. Before these topics are taken up, a look at future staffing ratios is in order. Given the considerable time in training new physicians, it is important to consider the implications of national forecasts.

There is much less information about physician assistant (PA) staffing norms. A. Bruce Steinwald, Director of Health Care analysis at the U.S. Government Accountability Office, noted in recent remarks to Congress (2008, p. 7) that the

national staffing ratio in 2007 was 8 per 100,000 population. The Kaiser Family Foundation State Health Facts database shows much higher numbers: 23 for the U.S. and 28 for Washington State per 100,000 population, as of January 1, 2008.

As noted in chapter 6, our survey found 74 PAs active in patient care in the County. Using 2008 Census population estimates, this total translates into a rate of slightly over 16 per 100,000. This puts Spokane below both U.S. and Washington State staffing ratios by a considerable margin, although above the GAO figure.

7.3 National forecasts of future generalist demand & supply

In a turnaround of thinking, most analyses now point to a need of increased supply of PC physicians. For most of the 1980s and 1990s, consensus by the organizations such as the Council on Graduate Medical Education and the Institute of Medicine held that the supply of physicians was more than adequate. In the current decade, that perspective has dramatically shifted, despite some opposing views from respected researchers, such as the team behind the Dartmouth Atlas. Iglehart gives a good overview of this debate in his 2008 article.

In 2006, the Association of American Medical Colleges (AAMC) recommended an enrollment increase of 30% by 2015 over its members' 2002 student numbers. This translated into an approximate increase of 5,000 students to phase in over the subsequent decade. In fact, AAMC members seem to have embraced this, as it

now appears that the target will be met by 2017 (Iglehart).

In the same year, HRSA applied its model to 2020 and arrived at a set of gaps by specialty. Interestingly, the HRSA researchers arrive at the conclusion that "the supply of primary care physicians will grow at about the same rate as requirements." (HRSA, p. 26) However, they report, this will not be true of surgery subspecialties, urology, pathology, radiology, ophthalmology and cardiology. In fact, HRSA predicted a slight surplus for pediatrics, obstetrics and gynecology.

A very recent study led by Dr. Jack Colwill (2008) at the University of Missouri Medical School comes to the opposite conclusion. They write: "The U.S. population is expected to increase 18% between 2005 and 2025, to 349 million. During the same period, the population above age sixty-five will increase 73 percent. This group seeks care from generalists almost 3 times per year- twice the rate of those under age sixty-five" (p 233). Their study points out that primary care providers are the foundation of the U.S. healthcare system, providing 52% of all ambulatory care visits. As the population ages, more service is needed to adequately monitor the chronic care conditions of the aging population.

Their findings predict a greater shortfall for adult care than many anticipate. Using a similar model to HRSA but adjusting the supply assumptions for age and gender, the University of Missouri team arrives at a 20-27% shortage of adult care generalists in 2025. That translates into a gap of 35,000-44,000. However, their analysis comes to a conclusion about pediatrics similar to HRSA's: "We anticipate that supply and

demand for children’s generalist care will be approximately in balance.” (Colwill et al, p. w236)

The most recent study on the topic, conducted by two researchers at the Center for Workforce Studies at AAMC (2008), arrives at the largest estimate of future gaps. For the entire physician workforce, the authors write, the 2025 gap will be approximately 124,000 FTEs. As in other studies, the totals exclude residents. Like Colwill et al, this report comes to the conclusion that “demand outpaces supply faster for primary care than any of the specialty groups” (p. 7). Their model puts the primary care gap in 2025 at 46,000 FTEs, followed by one of 41,000 for surgery.

It is instructive to note that the AAMC now regards its 2006 expansion recommendation as inadequate: “A 30 percent expansion in medical school enrollment and an increase in GME positions will not eliminate the projected shortage, only moderate it” (p. 7). The authors, like Iglehart, point out the key limiting role played by the Federal government supported GME slots, currently capped at approximately 25,000/year. Most studies assume that this will be relaxed to accommodate increases in medical school enrollments. To date, however, little expanded support of Medicare covering more GME slots has been found in Congress, as Iglehart notes.

7.4 Some thoughts on the future adequacy of Spokane generalist supply

This section does not try to provide similar estimates of gaps for 2020 or 2025 for

Spokane. Data are inadequate to attempt a local forecast. Rather, it points to a set of factors that will influence the local supply-demand balance.

A simple method to arrive at some sense of the need is to apply HRSA’s “required” level of PC physicians to the estimated population levels in the County by 2020. According to the Office of Financial Management November 2008 forecast (OFM, 2008), Spokane’s population is projected to grow by 95,000 by 2020. This would imply a cumulative need for 95 PC physicians by then, or 8-9 *new* MDs or DOs/year. Assuming a retirement age among current Spokane PC physicians of 65 years of age, SCMS data would imply that a total of 136 in office-based, non-federal, non-administrative positions will retire by 2020. This translates to about 12 *replacement* PCPs needed per year.

Combining the two components of demand, we arrive at total of an additional 20 PC physicians/year from 2009-2020. A slightly lower staffing norm than 100 generalists per 100,000, say 80, leads to very little change in demand, around 19 PC physicians per year.

This, of course, is a rough estimate, based on many assumptions embedded in the HRSA model that cover, among many things: practice patterns, gender mix, hours worked, size of the senior population, the ability of residents to receive/find health insurance, physician productivity, as well as the notion that the in base year used (2000) supply and demand were in balance. To the degree that local factors deviate from the national averages of the variables used in their model, local staffing needs will differ.

For example, as noted in Chapter 6, females currently make up 30% of all PC physicians in the County, by headcount. This is slightly less than the national average of 34% recently noted by Tu and O'Malley (2007). Yet, as Chapter 6 noted, 51% of all recent entrants to the Spokane PC physician workforce have been female. Will this trend continue? Will it grow? Will it, over time, be greater or equal to the projection by Colwill et al? They write: that "by 2025, half of the generalist supply will be female, with 43 percent in FM, 42 percent in GIM, and 70 percent in GPed." (2008, p. 235).

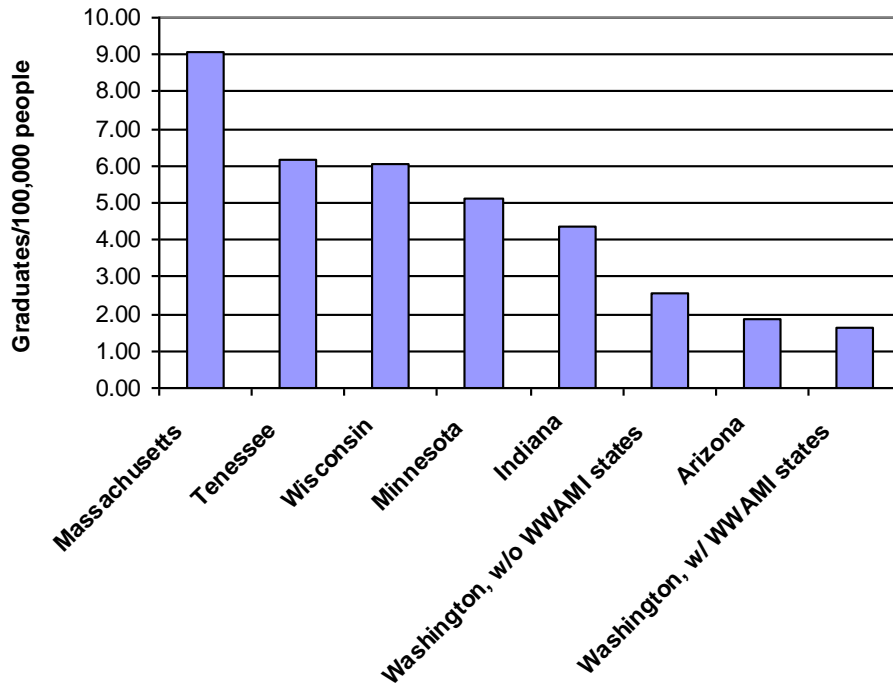
It also bears mentioning that as an average, the demand for 19-20 additional PC physicians per year assumes a linear path. This will not be the case, if only due to expected retirements of local PC physicians which are not constant over the next 12 years. However, the estimate should give the SCMS a sense of the challenge involved over the next decade to facilitate supply matching local demand.

Where might that supply of new and

replacement PC physicians come from? Unless enrollment dramatically increases at the University of Washington and its graduates choose generalist specialties, it is unlikely that the need will be met by the in-state allopathic medical college. Recall that the University of Washington currently claims approximately 20% of the Spokane County PC physician workforce as alumni, by far the largest contributor to the pool. There has been no growth in graduating classes at UW-Medical School since 2002 (AAMC Facts Table 25). In 2002, the number of graduates was 182; in 2008, it was 169. For the years in between, the numbers moved within this range.

In fact, among all 50 states, the medical graduate/population ratio is the lowest for the University of Washington, if one takes into account the four other states that create the WWAMI (Washington, Wyoming, Alaska, Montana, Idaho) program. (Data are from Kaiser Family Foundation State Health Facts and U.S. Census.) Figure 7.1 portrays the most recent ratios for Washington state and like-sized states.

Figure 7.1 Comparison of Ratios of In-state Medical School Graduates/ 100,000 Population for Selected states



The newly-established Pacific Northwest University of Health Sciences College of Osteopathic Medicine will undoubtedly help fill the gap. Most of its graduates will likely pursue PC specialties. Its first year class size was 75, and it should begin to graduate that number annually. However, it bears mentioning that, as Tables 7.3 and 7.4 illustrate, there is great need for generalist physicians in metro areas throughout the Inland Northwest. So the Spokane MSA can expect strong competition for these graduates.

The other sources of PC physician supply will be, as has recently been the case, out-of-state medical schools and from IMGs. The ability to attract the first set of graduates will depend on a host of factors, not the least of which are financial. The ability of Spokane to attract IMGs depends on U.S. immigration policies, the desire of IMGs to practice in the U.S., the ability of IMGs to land slots in the U.S. GME program, and the relative attractiveness of Spokane to foreign-born professionals.

8. Access to Primary Care by Medicare and Medicaid

8.1 General concerns

As Chapter 11 briefly takes up, Medicare payments to physicians are, on average, less than those from private insurers. Tu and Ginsburg (2007) report that Medicare fees in 2003 for the U.S. were approximately 81% of those of private payers. No specific comparisons are available for Washington state or Spokane County. Medicaid programs generally pay considerably less than Medicare for the same set of physician services.

Researchers from the Urban Institute and the Center for Studying Health System Change offer the most recent comparison between the two government programs, using data from 2003 (Zuckerman et al., 2004). Based on a survey of fee for service Medicaid programs in 49 states and weights created from aggregate state Medicaid expenditure data on physician activity from the Center for Medicare and Medicaid Services (CMS), the authors developed a Medicaid fee index, by state, for three types of physician services: primary care, obstetrics and “other” (surgery, radiology psychotherapy and inpatient hospital physician visits). A fee index, using similar methods for the same states, for Medicare services was also created. The authors then used the Medicare index as the numeraire, or basis, for the Medicaid fee index. The resulting ratios for Washington State were: 79% for primary care services, 122% for obstetric care and 64% for “other” services. Nationally, the ratios for 2003 stood at 62%, 84% and 73%, respectively.

For Washington, this implies that its Medicaid program paid primary care physicians, not including OB/GYNs, 79% of the amount they received, on average, for the same services from Medicare. For OB/GYNs, Washington’s Medicaid program, unlike most states, provided higher fees than Medicare. Many physicians regard Medicaid fees to be below their costs of providing the service, and consequently are forced to limit the number of their Medicaid patients in their practice panel to a certain share. Although Medicare pays more than Medicaid, its fees are not large enough, on average, for physicians to avoid a similar set of limits to their actual and potential senior patient panel.

In effect, most physicians have been compelled to ration care to patients, based on insurance coverage type. This chapter sets out to discover some aspects of this rationing that exists at local primary care physician offices or clinics. These results are taken up in the survey section below. The survey results do not allow for an estimation of the total number of Medicare and Medicaid patients in Spokane County who cannot find primary care physicians able to see them. Rather, they simply give the average current patient mix, by payer, at primary care offices and clinics. The results also hint at what the mix might be in the future, via their answers to prospective questions.

Medicare Payment Advisory Commission (MedPAC), an independent Congressional agency that reports to Congress on the activities/trends of CMS, is tasked, among other things, with analyzing access to care for beneficiaries of Medicare. MedPAC’s March 2008 report identified that

“beneficiary access to physicians is generally good, with no statistically significant changes from last year, but small numbers of beneficiaries continue to report difficulty making timely appointments with their current physician or finding a new primary care physician... The Commission remains concerned that repeated annual reductions in physician payment rates would threaten beneficiaries’ access to physician services” (p. xii). No state breakdown, let alone one at the county level, is given in the report.

Research suggests that increasing access to primary care providers may improve the efficiency and quality of health care delivery. When primary care physicians are unavailable, some patients turn to specialists for primary-type services. According to recent research, areas with higher rates of specialty care per person are associated with higher spending but not improved access, quality, health outcomes or patient satisfaction (Fischer et al. 2003a; Fischer et al. 2003b; Kravet et al. 2008; Wennberg, 2006). Moreover, states with more primary care physicians per capita have better health outcomes and higher scores on performance measures (Baicker and Chandra 2004; Starfield et al. 2005).

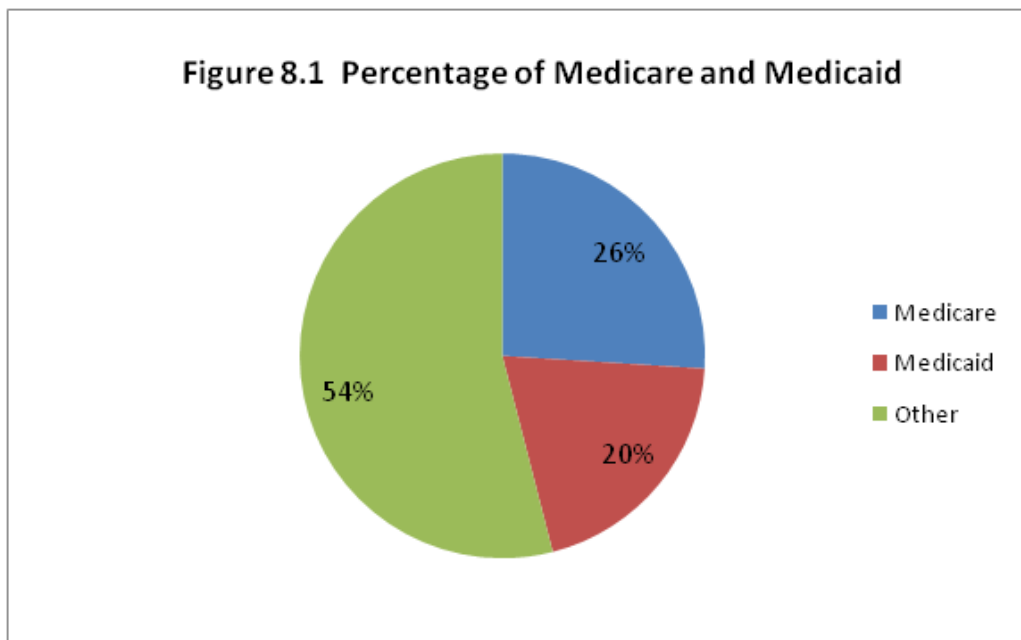
In a 2007 study by the National Association of Community Health Centers, Capitol Link and the Robert Graham Center, titled *The Primary Care Payoff*, Community Health Centers are seen as a smart investment because they never turn anyone away on

the ability to pay and they are local, non profit, community-owned and federally supported. This report states “If every American made use of primary care, the healthcare system would save \$67 billion in savings annually. This reflects not only those who do not have access to primary care, but also those who rely extensively on costly specialists for most of their care, leading to inefficiencies in the system” (p. 2).

8.2 Local survey results

The question of access for Medicare and Medicaid beneficiaries to appropriate health care is a serious one in any community, as it is for the country as a whole. In the summaries of answers to these questions from the survey, the size of the physician pool response varied. This reflected, in most cases, the inability or unwillingness of office managers to project their operations into the future. For this set of questions, the residency program was excluded. We assume that there is little constraint on resident’s ability to take on new patients with public program insurance coverage. Further, the study’s goal is to understand the challenges facing the provision of primary care from private, office-based practices.

The first question concerned the present (2008) mix of payers. Physician practices stated that currently 26% of the practices are composed of Medicare patients and 20% are Medicaid, as depicted in Figure 8.1.



N = 288

The survey further explored the issue of access for Medicare by asking practices about their ability to accept *new* Medicare patients now (2008), in 2009 and within the next 5 years. These answers are summarized in Table 8.1. Slightly less than a third of all primary care physicians were accepting new Medicare patients at the time of the survey. Only 42% foresaw the ability to accept these patients in 2009. From the perspective of access, the outlook for five years out was bleak, as only about 15% of the responding physicians indicated that they thought they could take on new senior patients. However, the size of the respondent pool dramatically declined for

this question.

The response to these questions varied by practice size. Generally, smaller practices indicated the least ability to take on new Medicare patients. The one exception was the response to the query about five years hence. Here, the largest practices indicated the lowest ability to accept new Medicare patients. As noted, however, the response rate varied and for this question it was the lowest of all access questions (142 out of 288). The results to all survey questions by size of practice are reproduced in Appendix 2.

Table 8.1 Survey Response Summary to Primary Care Physicians' Acceptance of new Medicare Patients

<p>PCP's currently accepting new Medicare patients</p> <p>N=265 PCPs</p>	<p>31.7%</p>
<p>PCP's who foresee being able to accept new Medicare patients in 2009</p> <p>N=206 PCPs</p>	<p>42.2%</p>
<p>PCP's who foresee being able to accept new Medicare patients in next five years</p> <p>N=142 PCPs</p>	<p>14.8%</p>

Table 8.2 contains a similar outlook from information gathered about policies toward *new* Medicaid patients. As expected, a slightly lower percentage of physicians, 26.5%, were accepting new Medicaid patients at the time of the survey, compared to the same query about Medicare patients. As expected, a slightly smaller share of primary care physicians, 38%, anticipated being able to accept new

Medicaid patients in 2009 than was the case for Medicare. Yet, the long term outlook for access to care for Medicaid patients was better than for Medicare patients. This is likely due to the greater number of physicians responding to these questions: 201 vs. 142. It may be also be due to the fact that pediatric practices indicated their willingness to continue to accept Medicaid patients.

Table 8.2 Survey Response Summary to Primary Care Physicians' Acceptance of new Medicaid Patients

<p>PCP's currently accepting new Medicaid patients</p> <p>N=272 PCPs</p>	<p>26.5%</p>
<p>PCP's who foresee being able to accept new Medicaid patients in 2009</p> <p>N=209 PCPs</p>	<p>38.3%</p>
<p>PCP's who foresee being able to accept new Medicaid patients in five years</p> <p>N=201 PCPs</p>	<p>34.3%</p>

Interestingly, there was a close relationship between practice size and positive response to these three questions about Medicaid patients. Generally, the smaller the practice was, the higher the percentage of physicians who declared their willingness to accept new Medicaid patients.

How do these results compare with any prior efforts to understand issues of access to primary care physicians in Spokane County? In February 2003, the Washington Department of Health and the Spokane Regional Health District released the results from a set of questions similar to those of Tables 8.1 and 8.2 (Schueler et al, 2003). Their results were

similar: only 23% of primary care physicians reported that they were accepting new Medicare patients; and 22% of primary care physicians were accepting new Medicaid patients. These are lower, especially for Medicare, than the percentages found by the current survey.

As described in Chapter 6, anticipated departures and retirements appear to be high. If hiring does not go as anticipated, and the number of anticipated departures is realized, this could create further access issues. There currently exists a sense among many observers of health care in Spokane County of not meeting the current needs

for the low-income and senior populations. If around 40% of current primary care physicians are not taking new patients from these populations in 2009, who will offer these services? The likely candidates are new entrants to the local physician pool. However, is the number of new PC physicians, *net of* retirements, growing fast enough to absorb these patients? This study cannot provide answers, since it is based on a snapshot, while the answers will be found over time.

It is difficult to forecast the likely future Medicaid population, as it will depend both on the strength of the economy and on policy decisions made in Washington, D.C. and Olympia. However, we can be more confident of demography. Population growth projections through 2030 for the 65+ population show a strong, albeit gradual increase; and as Chapter 5 reviewed, this population requires higher level of care, due to one or several chronic conditions that many seniors will face.

These trends, coupled with projected departures and retirements of primary care physicians, may mean critical future access issues for Medicare patients. The Office of Financial Management (OFM) projections for Spokane County for the size of the 65+ population are:

- 2010: 56,338, or 12.1% of the population
- 2020: 81,959, or 15.5% of the population
- 2030: 107,975, or over 18% of the population.

For 2005, the OFM estimated that the 65+ population in Spokane was 52,179. In other words, by 2020 it will have increased by nearly 30,000. Will the annual estimate of 19-20 new and replacement PC physicians given in Chapter 7 be adequate to absorb the changing demographics of the Spokane population? If not, then expect the approximate 40% of primary care physicians not accepting new Medicare patients in 2009 to surely rise.

9. Strategies for Recruitment & Retention

9.1 Review of best practices

Physician recruitment can be a very costly endeavor, with turnover making it even more so. Costs involved in recruiting generally include the following: salary/income guarantees, staff or recruiter time and fees, recruiting sources (networking, direct mail, journal advertising, Internet), interviewing, relocation, practice marketing, and meeting commitments made (Merritt, 2002). “According to a Merritt, Hawkins & Associates (a national physician search and consulting firm) survey, the majority of physicians coming out of training today receive 50 or more job solicitations. The process of recruiting doctors has become more time-intensive and requires more resources than it has in the past, and it is likely to become even more challenging in the future” (Hawkins, 2007, p.17).

A 2006 survey of final year medical residents by Merritt, Hawkins and Associates, indicated that:

- 77% of residents identified the internet as the best source for job opportunities.
- 76% cited personal networking as a best source for opportunities.
- 40% begin looking for work at least one year before completing their training.
- 79% report geographic location and lifestyle remain a top consideration.
- 91% prefer a salary with a production bonus compensation structure.

Adkisson & Bjelich (2004) strongly suggest development of a recruitment plan which lays the foundation for future searches. The plan includes identification of community needs, physician needs validated with medical staff, and a profile of the ideal candidate. They stress preparation and control of the interview process as well as selling the community. If the person is the right candidate, sell the opportunity and offer a contract immediately. Borglum in *Medical Economics* (2008), states “The main factor in successful recruiting is to find an associate who wants to live in or close to your community, often because of having family nearby. Location and family may rank highest in the competition for associates, but these factors are rarely enough to overcome weak financial performance” (p.22).

Borglum has six suggestions for “How to become a desirable practice” (p.25):

- Offer a solid pay package and fast track to ownership
- Highlight area perks
- Clean up your practice environment
- Clean up your books
- Have a marketing plan
- Make the visit memorable

Borglum also stresses offering flexibility. New physicians are looking for a balanced lifestyle and this communicates that a practice is willing to entertain that.

Shi et al (1997), in a study on physician recruitment and retention states, “Models of physician recruitment and retention often focus on three groups of factors: the characteristics of the physician, the practice and the community” (p.1342). Shi et al (2001) defines practice characteristics as:

- Workload

- Income and benefits
- Opportunity to join partnership or group practice
- Chance for professional Interaction
- Continuing education
- Presence of a local hospital
- Medical technology
- Staff support
- Referral to specialists
- Level of practice autonomy

- Colleagues, culture and career
- Location and lifestyle
- Compensation

Shi defines community characteristics as:

- Spouse employment and satisfaction
- Good educational Institutions for children
- Climate and geography
- Culture and lifestyle
- Religion
- Medical needs
- Recreation & sport facilities
- Socioeconomic characteristics
- Affordable housing

Shi's top recruitment activities included: Having spouse accompany on site visit, paying interview expenses, developing site visit to meet candidate's needs, focusing on spouse during site visit, providing a copy of group's physician contract, performing a background check, recognizing and overcoming problem areas. Shi's top recruiting benefits include malpractice insurance, health insurance, professional dues, relocation costs, life insurance, continuing medical education allowance, and disability insurance. Also discussed were automobile allowance and sign on bonus.

Physician's Weekly (2006), in defining "Sensible Strategies for Recruiting and Retaining Physicians," says to consider physicians' requirements for:

- Patients and causes

All of the strategies presented reinforce the concept of having a well developed recruitment plan. Valancy, in *Physician's Weekly*, states: "It is important to clearly explain to the physician how their performance will be measured, and to actively help them improve" (2006, p.12). Practice productivity measures should be carefully explained to include productivity goals, clinical benchmarks and patient satisfaction survey results from the beginning.

Evelyn Torkelson, a recruiter with over 20 years experience in Spokane and the region, reinforced the strategies outlined above in a recent interview. She clearly stated that spouses are making the decisions on locations. Also, decisions are made based on where elderly parents are located. Third year residents tell her that they receive 10-12 emails a day with job opportunities. Their time is limited because of a packed schedule their third year. She agreed that the internet is their number one way of evaluating where they will go for interviews. They can access the internet when they have time and evaluate the information that is available. As a result, residents are making decisions based on what is available via the internet.

Mrs. Torkelson stated that she is now seeing second year residents making inquires. So instead of looking one year out, some are looking two years out for job prospects. Because students often have large medical school debt and with the current downturn in the economy, residents may not leave the area they are in

because, they can't sell their current home for what it is worth and they can't afford to carry two mortgages. This is a severe limiting factor in current recruiting. She also stated that recruitment for primary care physicians is getting more difficult because they have the additional option of becoming hospitalists.

Retention is key, once successful recruitment has occurred. In a survey by Cejka Search and the American Medical Group Association (AMGA) conducted in 2005 on physician recruitment, physician satisfaction plays a key role (NEJM Career Center, July-August 2005). The retention process needs to be a part of the recruitment plan. Retention efforts start at the signing of the contract. "A key finding of the survey shows that more than half (54%) of physicians who leave their medical groups do so within the first five years"(NEJM, July-August, 2005, p 1). The average rate of turnover was at 9%, which is 4 % higher than commonly believed. The top reasons for leaving were as follows:

- Practice Issues
- Compensation
- Location
- Spouse's career
- Pressure of clinical practice
- Broken promises

Most often medical groups did not have formal retention plans. This can have an impact on retention. A study in the American Journal of Medical Quality on physician turnover (2004), advises "Potential causes of professional conflict should be identified beginning at the pre-employment phase and continuing with regular assessment of these factors throughout the physician's tenure, because they relate to physician satisfaction"(Misra-

Hebert et al, pg 65). The study continues on to discuss increasing physician involvement in organizational decision making, promoting a team approach and assuring mentorship. All of these are felt to be needed to retain physicians with a major emphasis on mentoring.

In a 2007 survey again by Cejka and AMGA on physician retention, mentoring of newly recruited physicians was noted as increasing retention. It stated that "hiring hospitalists for call and hospital responsibilities is a strategy used for attracting and retaining primary care physicians" (p 9). This strategy was also discussed by Evelyn Torkelson. The Cejka/AMGA survey also discusses the activities mentors perform. Thorough orientation for the new recruit is a must. Multiple organizational links are stressed. Part of the mentoring process includes regular meetings, clinical support, feedback, coaching, and serving as a resource and link to other community and physician connections. The social aspect of coming to a new community is also discussed for both the physician and spouse.

This study states that the most vulnerable time period for turnover is between the first and third years, with small groups being more vulnerable during the first year. This survey echoes the 2005 one, in its reasons for turnover:

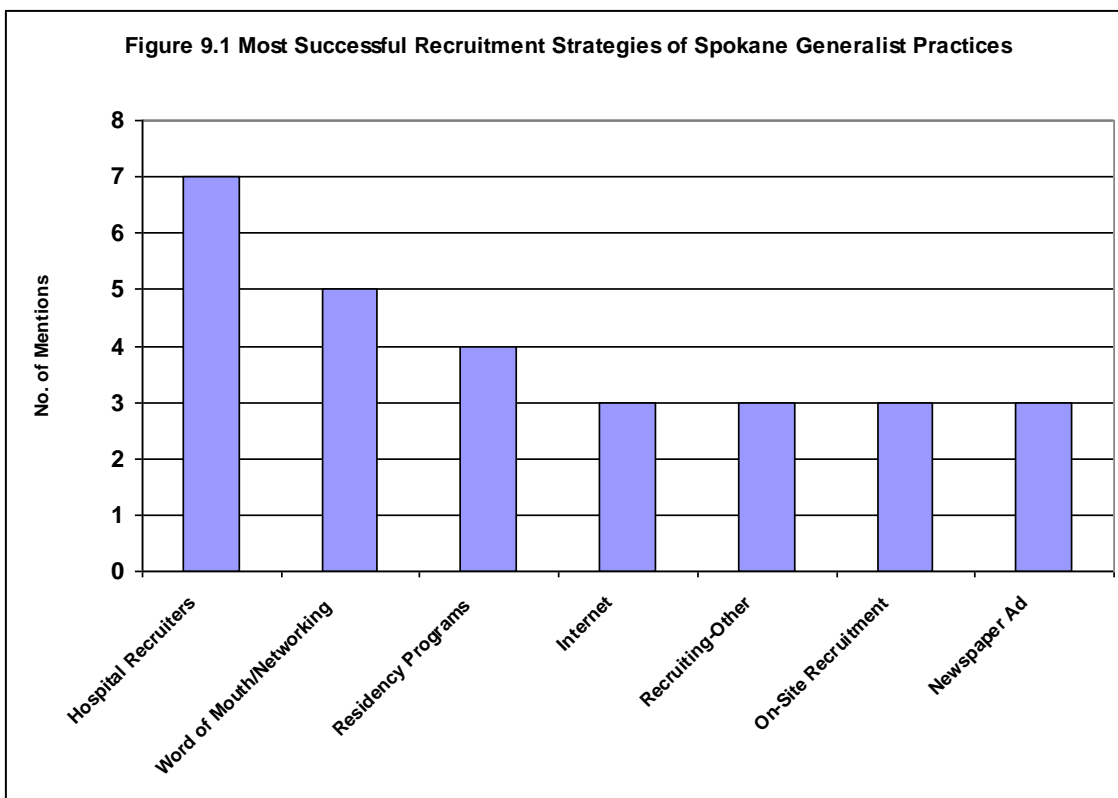
- Relocation to be closer to own or spouse's family
- Seeking higher compensation
- Spouse's job required relocation
- Poor cultural fit

This study also discussed strategies for recruitment and retention. These are:

- Hiring hospitalists for call and hospital responsibilities
- Increasing use of PAs and ARNPs
- Increasing base salaries and/or guarantees
- Increasing amounts of signing bonus, loan repayment or other incentives

9.2 Results from the survey of current practices toward recruitment & retention

The survey results listed in figure 9.1 are successful recruitment strategies for

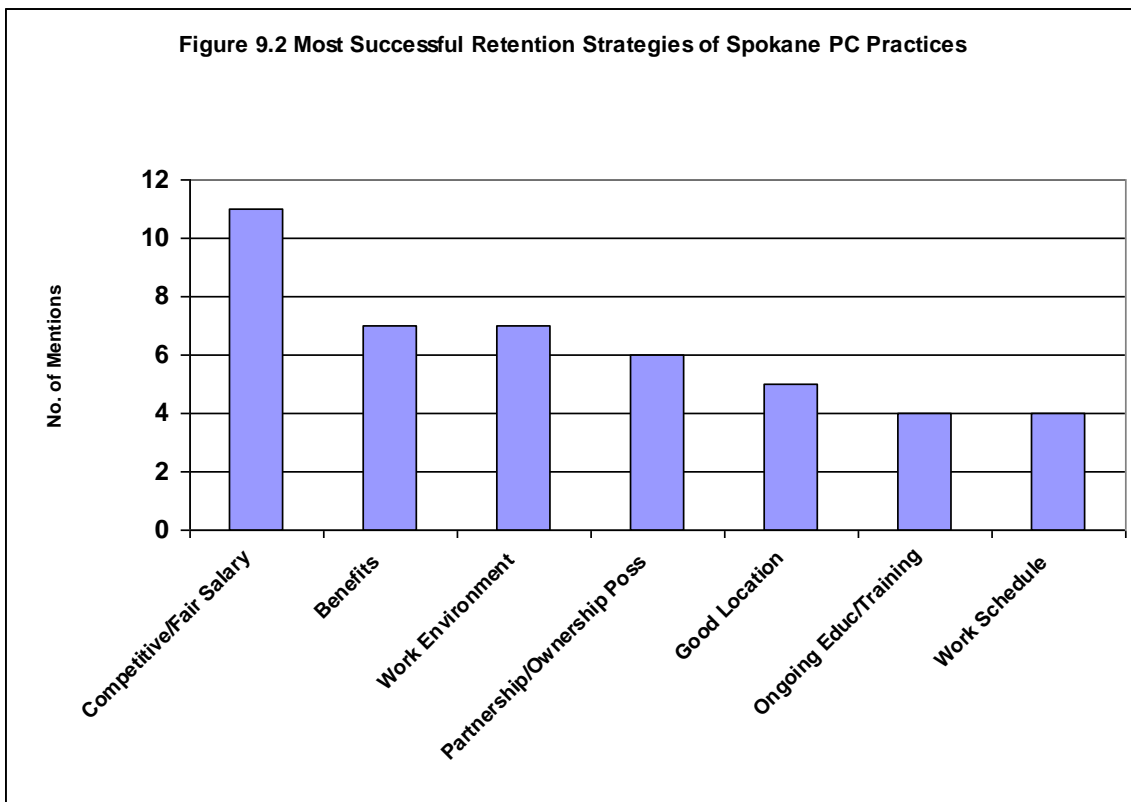


Retention is multifaceted, with the key issue being physician satisfaction. Having a solid mentoring plan and relationship in place appears to be the primary strategy for ensuring physician satisfaction and retention. As stated earlier, retention needs to be a part of a formal written recruitment plan.

Spokane practices. Hospital recruiters constitute the most frequently cited strategy. This is not a strategy cited in the literature and appears to be unique to the Spokane area. The second most cited strategy is word of mouth/networking, which is a frequently cited strategy. The residency program is rated third. This could

also be coupled with networking, as residents interact with many physicians in the community and start to build a rapport prior to completion of their training. Listed fourth in Spokane is the internet as a successful recruitment strategy. This is identified by our local expert as a most

Figure 9.2 represents the most successful retention strategies in Spokane primary care practices. The most frequently cited strategy in the survey responses was a competitive/fair salary. This is reinforced in the literature. Benefits, work environment and partnership/ownership possibilities are



important tool and is also identified by Merritt, Hawkins and Associates (2006), from a residents' survey as the best source for job opportunities. This may be an area local practices need to evaluate and explore as part of the recruitment process.

the next three highest cited strategies, in that order. These also appear in the literature. Mentoring was not cited in the survey, yet nationally it is identified as one of the most important issues in retaining physicians. Also, formal retention plans

were not cited whereas nationally these are strongly encouraged. Mentoring and formal retention plans may be areas of development for Spokane practices.

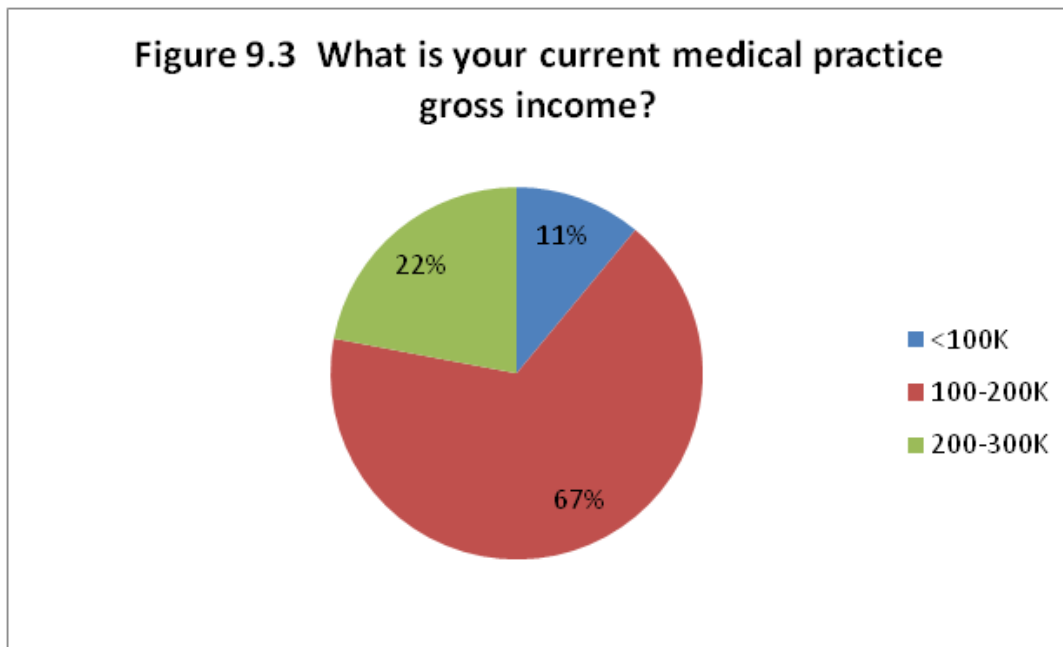
9.3 Insights from a survey of PC physicians who have left Spokane

Physicians having left the Spokane area were also surveyed. At 30 names, the pool of potential respondents was much smaller than those who are currently in practice in Spokane. The pool was composed of names from the Spokane County Medical Society and a list from a large clinic. The study team spent considerable effort locating, contacting and trying to elicit a response. Ultimately, 11 physicians responded. Because of the small number, this summary is suggestive, not definitive.

The survey consisted of 25 questions.

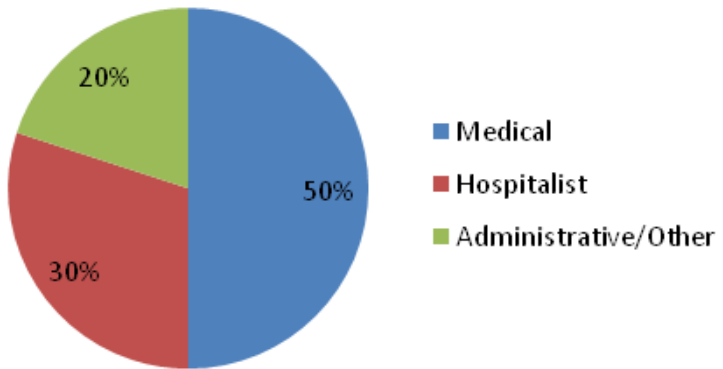
Several of them were demographic in nature, while the core set aimed at discovering their Spokane experience. Seven women and four men returned responses. All are married and had dependents under age 18. Over 90% were employed fulltime while in practice in Spokane. The average length of time in Spokane was approximately six years; excluding two responses, the average tenure here dropped to three years. Over 50 % are licensed in two states. While in Spokane, 73% of the respondents said that they had been employees, not partners, in their practices.

The following graphs state the current income level of the respondents, their current and former job type. There has been a slight shift in positions since leaving Spokane.



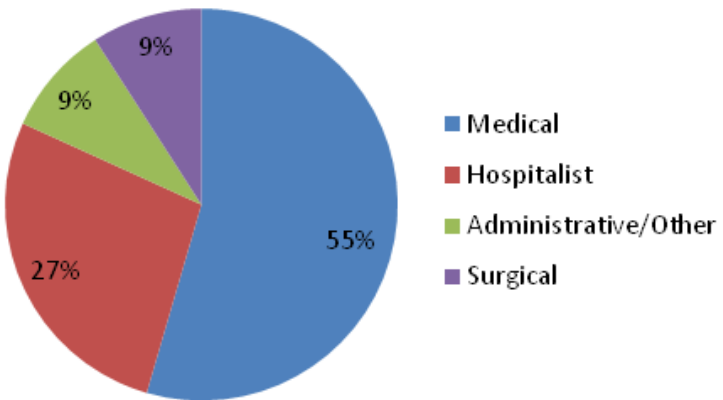
N = 11

Figure 9.4 What is your current job type?



N = 11

Figure 9.5 What was your job type while in Spokane?



N = 11

Figure 9.6 presents the results of the survey's request to rank opportunities in Spokane. None of the respondents rated any of the areas as particularly outstanding. All were in the average to poor range. Children's educational opportunities were

rated highest, with social opportunities second. As noted above, a fit between the physician and the location is one of the keys to retention. These respondents did not appear to be engaged in the community or view the location highly.

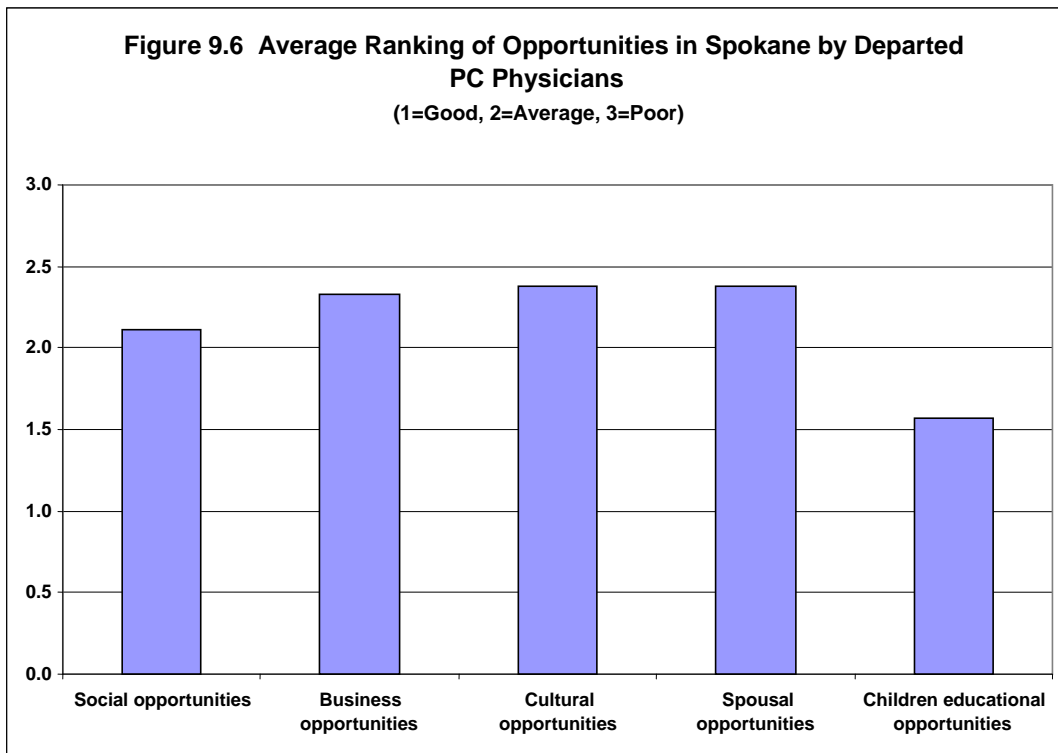
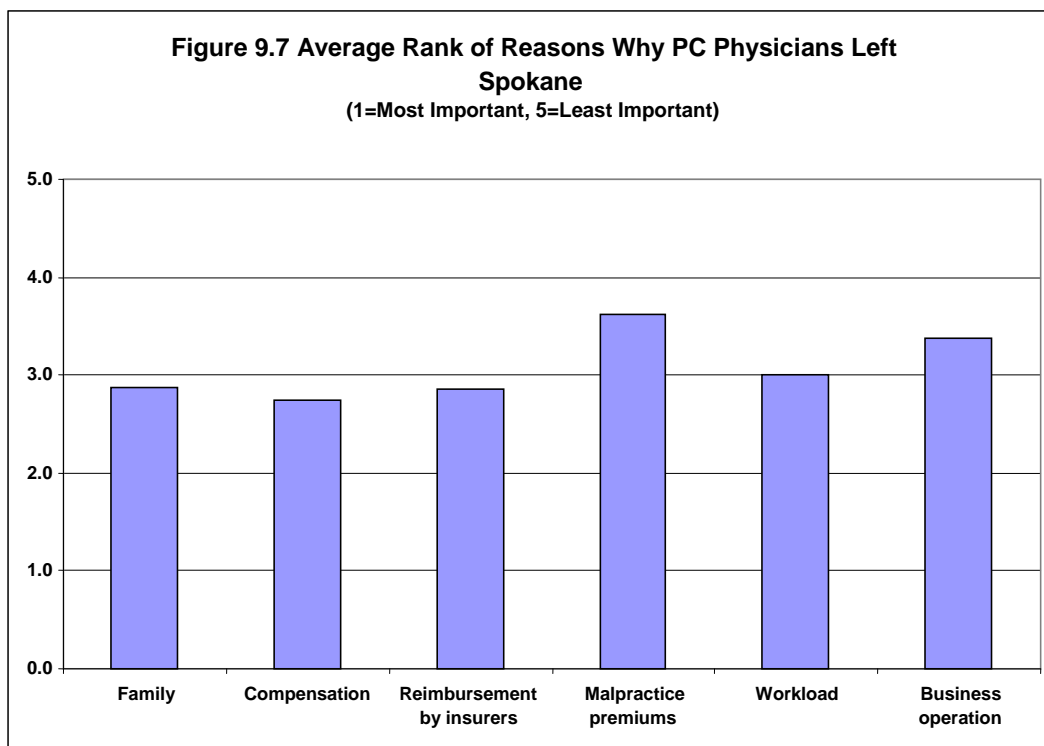


Figure 9.7 identifies the most commonly cited reasons for leaving Spokane. Compensation, followed by family, reimbursement and workload, were the top ranked reasons for leaving Spokane. Keeping in mind that this is a small number responding, there appears to be some difference of perspective regarding compensation, as 91% of the practices felt

cultural and fellowship opportunities while one mentioned a quieter lifestyle. So the suggestive conclusion is that physicians left for a variety of reasons.

When asked how they would improve primary practice, the five who responded generally pointed to improving the financial profile here, largely higher reimbursements.



that their compensation was adequate.

When asked “what the departed physicians have now that they didn’t have in Spokane”, no clear pattern emerged. Family issues and higher income opportunities were mentioned most often, at a three times each. Two mentioned an absence of

Finally, when asked “what one thing would have kept you in Spokane”, the departed physicians hardly share common views. Here is a sample of the answers: “Great partners,” “fellowship at a university,” “a more rural lifestyle,” “better job opportunities for spouse,” and “nothing, I don’t belong there.”

9.4 National & state policies addressing recruitment and retention

The Federal government operates at least two programs that influence recruitment and retention. The first is the National Health Service Corps, which offers scholarships for medical education. The second, much smaller, is the support for state loan repayment programs. Both are administered by the Health Resources and Services Administration (HRSA), of the Department of Health and Human Services. Both cover education in a variety of areas within the health care profession. Besides physicians, the eligible list of professions includes: physicians assistants, nurses, dentists, dental hygienists, pharmacists, chiropractors, optometry, allied health and public health professionals. Both programs demand, in return for financial assistance, service in underserved areas, Health Professional Shortage Areas (HPSAs), commensurate with the amount of financial aid.

These programs appear to have few direct effects on Spokane County. As mentioned in Chapter 7, the County currently only has three positions in localized HPSAs, many fewer than similar-sized counties in the Pacific Northwest. Generally, both programs receive modest funding, although bills introduced in the recent 110th Congress would have doubled or tripled the annual amounts. At this time, re-authorization of the programs has not taken place. If the Health Service Corps is re-authorized at higher levels and a major federal constraint on the training of new physicians is not relaxed, one might even see PC physicians attracted to HPSAs in greater numbers, leaving a smaller pool for Spokane County.

The constraint is the current cap on Medicare-funding of Graduate Medical Education (GME). In the Balanced Budget Act of 1997, the six leading national organizations governing medical education issued a “consensus statement” that Congress should “reduce the number of GME positions funded by the federal government to a number close to the graduates of U.S. allopathic medical schools” (Iglehart, 2008). This, in fact, happened. Yet, most if not all of these organizations, most prominently the AAMC, have now reversed positions on the future physician supply-demand balance. GME consists of “Direct” and “Indirect” Medical Education payments from Medicare to teaching hospitals. Were GME funds to be expanded, it would be more likely that the current increases in medical school enrollments convert into increased numbers of residents and ultimately into a larger physician pool. A greater national supply of generalists would surely make it easier for Spokane practices to recruit and probably retain.

Most states have versions of the HRSA National Health Service Corps and loan program. The one review of these programs by Pathman et al (2000) used data that are now more than a decade old. Yet from our review of a few individual state programs, it is unlikely that the general results have changed. Pathman et al found 29 programs in 1996 that offered medical education scholarships in return for a length of proscribed service after the training was complete. They found 29 programs that offered loan repayment for senior residents and practitioners in exchange for a period of proscribed service. The third most common program consists of low-interest loans to students that could be repaid with

service. In all cases, service consisted, as in the National Health Service Corps, of professional work in medically underserved areas. Nearly all programs restricted physician participation to generalists.

Washington State operates similar programs. They are co-administered by the Department of Health (DOH) and the Higher Education Coordinating Board. The larger of the two state programs is the *Health Professional Loan Repayment* program. As in the federal program, it is available to a variety of health care workers: Physicians (MD, OD or ND), PAs, NPs, LNs, midwives, pharmacists, dentists and dental hygienists. It provides up to \$25,000/year for agreeing to work after their training is complete for a minimum of three years at one of dozens of medically underserved sites statewide.

The 2009 eligible site list for Spokane County lists five sites for PC physicians: the Maple Clinic of Community Health Associates of Spokane (CHAS), the Deer Park Family Care Clinic, the Airway Heights Department of Corrections (DOC) Center, the Pine Lodge DOC Center for Women and the NATIVE Health Clinic. The “midlevel” (PAs and NPs) eligible site list adds the CHAS Northeast Clinic and the Spokane Falls Yakima Valley Farm Workers Clinic, but does not list the two DOC sites or the Deer Park Family Care Clinic.

Parallel to other states and the federal government, Washington also offers a *Health Professional Scholarship* program. The same eligibility list of professionals applies. The same minimum commitment of three years in a medically underserved area of the state holds. The stipend is not based on financial need. Interestingly, one need not be a Washington resident, nor is one

required to attend a Washington state institution for the medical education.

According to Chris Wilkins, administrator of the program at the DOH, funding for the entire program, which also includes funds dedicated to community health organizations and matches to the National Health Service Corp, has tripled over the past five years to a total of \$8.7 million per year (personal communication). By far, the largest component is the loan repayment program, at \$3.687 million per year. Ms. Wilkens reported that in recent years, about 60 professionals or students received awards. About one-fifth to one-third of these awards went to current or future physicians, with the midlevel medical professions capturing another half of those physicians’ numbers.

All Washington state programs and nearly all state programs across the country designed to retain primary care physicians carry a geographical restriction. The recent exception is Massachusetts. In July 2008, the state’s legislature agreed to waive fees for students at the University of Massachusetts Medical School who agree to serve as primary care physicians *anywhere* in the state for four years (*Medical News Today*, 2008). Were Washington State to adopt a similar program, it would likely bring broader benefits to Spokane County than the current scholarship program, since most of the County does not qualify for those slots.

As well-intended as the current Washington state programs are, they simply do not carry the same impact as policy changes in two other areas might. The first targets increasing the pool of in-state medical school graduates. As noted in Chapter 7,

Washington ranks near or at the bottom of all states in the production of new physicians. Chapter 6 found that the largest supplier of primary care physicians in Spokane has been the University of Washington (UW). This is not a surprising finding, given the long established connections between that university, local residency programs and practicing physicians here. It will be easier to recruit and retain primary care physicians if the size of the pool of UW graduates interested in primary care expands. While a Massachusetts-style program of awarding tuition to medical students who promise to practice primary care might have some impact on the numbers of PC physicians in Spokane County, the impact will be larger if the graduating classes increase.

Imagine the consequences, for example, if the state of Washington reached the level of medical graduates per capita given by Minnesota, the state roughly in the middle of states presented in Figure 7.1. At the estimated 2008 state population, this would imply a UW Medical School graduating class of 336 of Washington students alone, versus the most recent total of 167. Surely the Spokane medical community could expect to attract a share of this increment. Should plans be realized for a branch medical school in Spokane, it seems to reasonable to assume that, over time, far more than 20% of the community's primary care physicians would declare UW as their alma mater.

Another supply-increasing state strategy rests with state support of graduate medical education (GME). Like Medicare, most states use Medicaid funds to provide

support for GME, largely to hospitals. Data from a study of the American Academy of Family Physicians show Washington 2002 Medicaid GME funds at \$88 million (AAFP, 2005). As in Medicare's support of GME, Washington State funds have gone to teaching hospitals in the form of "direct" and "indirect" payments. The AAFP study points out that, while important, hospitals do not provide the typical environment in which primary care physicians practice. It recommends that states follow the lead of 10 states which now allow Medicaid funds to be used in certain ambulatory settings, rural and urban, or target some of the money toward certain types of health care professionals.

Consequently, the SCMS might consider both of these supply-enhancing state policies: expanding the slots at UW Medical School and the size of Medicaid's support for GME, while advocating for some Medicaid GME re-imburement that takes place outside hospitals. A final policy topic that influences recruitment and retention is taken up in Chapter 11: reimbursement to primary care physicians. Like supply-increasing policies, the likely impact of changes in policies affecting revenue is very large. As a research team at the University of Vermont College of Medicine recently wrote: "The consensus conclusion of the expert and seasoned readers (of the practice environment in Vermont) was that the factors related for workload and reimbursement are serious structural problems, which cannot be sufficiently addressed by educational loan repayment alone" (Hurowitz et al, 2007).

10. Thoughts on the Economic Impact of an Inadequate PC Supply

In a general “synthesis of the literature and new analysis done by the Robert Graham Center to support policy options that could advance the ability of primary care practices to deliver on their potential for American health and healthcare” that was sponsored by the American Academy of Family Physicians, Phillips et al (2004) analyzed National Health Interview Survey data for 2002. They found that primary care physicians “cared for 67 percent of all American adults and 80 percent of all American children and that only 27 percent of adults and 13 percent of children saw a sub-specialist.” The authors reviewed the consequences of this provider choice and concluded that the “salutary effects of primary care for people are established. More than two decades of accumulated evidence reveals that having a primary care based health system matters (p. 8).”

Phillips et al reviewed a number of studies to come to this conclusion (p 8). The authors cite the general “poor performance of U.S. health care,” as opposed to that of “other nations, which is directly associated with measurements of primary care.” They cite “reduced health disparities, particularly for areas with the highest income inequality, for more complete immunization, better blood pressure control, and better oral health.” Based on comparative studies, they find that when a primary care physician is the usual source of care, fewer medical tests are conducted, higher patient satisfaction is realized, lower medication use results and care-related costs are less. Specific studies find that with “adequate access to primary care ...reduced

all-cause mortality and mortality due to cardiovascular and pulmonary diseases, less emergency department and hospital use, better preventative care and better detection of breast cancer and reduced incidence and mortality due to colon and cervical cancer.”

In a review of the burden of chronic disease, Phillips et al indicate that “nearly half the U.S. population, 125 million people in 2000, had a chronic condition.” Based on a review of cost estimates for fifteen chronic conditions from the 2000 Medical Expenditure Survey, the authors conclude that national savings of over \$37 billion in 2007 prices using the medical services CPI (BLS, 2008) could be achieved, if patients “had a family physician or general physician as their usual source of care (p.12-13)” Their data were used to estimate the potential saving for Spokane County patients with chronic conditions who did not have a “generalist”, or primary care physician, but instead depended on specialists (“Other”) as their usual source of care.

In Table 10.1, Spokane patients with “Other” providers as their usual source of care are estimated as a proportion of all U.S. patients with each chronic condition. (This is a simple application of the County to the U.S. population.) Cost differences of generalists versus other providers for each chronic condition are taken from the Phillips et al study. A positive number implies costs savings of treatment by a generalist; a negative number cost savings of treatment by a specialist. As one can observe, generalist care does not delivery savings for all conditions. The largest savings for generalist care, per condition, come in treatment of rheumatoid arthritis,

anxiety and congestive heart failure. The largest savings for specialist care, per condition, come from the treatment of multiple sclerosis, mental disorders and glaucoma.

Based on these numbers, the estimated total cost difference from using a physician

other than a generalist as their usual source of care for chronic conditions for Spokane County is estimated to be \$55.8 million. As the right-hand column reveals, about 75 percent of this additional cost is accounted for by three chronic conditions: hypertension, diabetes with no complications and anxiety/somatoform.

Table 10.1 Cost Differences between Generalists and Specialist Physicians in the Delivery of Care for Chronic Conditions and their Estimated Costs in Spokane County

Chronic Health Condition	Estimated Spokane Patients using "Other" Providers	Estimated Cost Difference between Generalists & "Other" per Condition	Total Cost Savings of Treatment by Generalists (\$M)
Hypertension (Essential)	6,613	\$3,060	\$20.24
Coronary Heart Disease	670	-1,911	-1.28
COPD/Emphysema	1,261	2,891	3.65
Congestive Heart Failure	613	5,199	3.19
Asthma	1,102	-28	-0.03
Multiple Sclerosis	150	-5,135	-0.77
Parkinson's Disease	130	-2,367	-0.31
Diabetes (No Complications)	3,015	3,478	10.49
Diabetes (With Complications)	137	-1,391	-0.19
Glaucoma	626	-2,477	-1.55
Blindness/Vision Defects	1,382	4,018	5.55
Senility/Organic Mental Disorders	377	-4,897	-1.85
Affective Disorders	234	1,046	0.24
Anxiety/Somatoform	1,515	7,691	11.65
Rheumatoid Arthritis	542	10,823	5.87
Osteoarthritis	421	2,055	0.87
Total			\$55.75

Source: Estimated from Phillips, et al (2004)

Reasons why patients initially consult specialists rather than primary care physicians, despite additional costs, seem to be largely the result of patient choice. In a study sponsored by the Robert Wood Johnson Foundation, researchers at the University of Washington School of Medicine studied the impact on patient care when specialist physicians assumed the generalist role. Key findings of the study were that “with few exceptions—for example, for rheumatology, pulmonary medicine and general surgery—most specialists rarely provide primary care for their patients...They do not provide for diagnoses outside their specialty, and they do not get involved in basic preventive services such as immunization.” Also, “generalists do a better job of providing continuity, comprehensiveness and preventive care.” Finally, “many specialists missed many opportunities to provide effective preventive care for their patients (Rosenblatt, 2002)

Differences in health care costs between primary and specialist were reviewed in a 2006 Report from the American College of Physicians (2006). Generally, primary care has been shown to have “the potential to reduce costs while maintaining quality... States with higher ratios of primary care physicians to population had better health outcomes, including mortality from cancer, heart disease or stroke...States with more specialists have higher per capita Medicare spending...Increases in primary care are associated with significant increases in the quality of health services, as well as a reduction in costs.”

And the report continues: “Primary care

physicians ... have been shown to deliver care similar in quality to that of specialists for conditions such as diabetes and hypertension while using fewer resources... Studies of certain ambulatory care sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care...Patients receiving care from specialists for conditions outside their area of expertise have been shown to have higher mortality rates for community-acquired pneumonia, congestive heart failure, and upper gastrointestinal hemorrhage...Studies have shown that expenditures for care for common illnesses such as community-acquired pneumonia were higher when provided by specialists than if provided by primary care physicians, with no differences in outcomes.”

In conclusion, it is very difficult to arrive at an estimate of costs savings from treatment by generalists versus specialists based on medical data specific to Spokane County. Generally, outside of hospitalizations (“potentially avoidable hospitalizations”), these data are simply unavailable. As a consequence, we must make estimates that are suggestive, but appear to be based on solid, national research. It is telling that the watchdog of federal government activity, the General Accounting Office (GAO), comes to the general conclusion of Phillips et al and this study. In its general review of the economic impact of an inadequate primary care physician supply, the GAO (2008, p15) found that “ample research in recent years concludes that the nation’s over reliance on specialty care services at the expense of primary care leads to a health care system that is less efficient. ...

Research shows that preventive care, care coordination for the chronically ill, and continuity of care—all hallmarks of primary

care medicine—can achieve better health outcomes *and* cost savings.” (authors’ emphasis)

11. Revenue-enhancing Strategies for Spokane Primary Care Physicians

11.1 A look at the challenges

When one examines recent physician compensation trends, it is easy to understand the grounds for concern. Table 11.1 depicts research of national data, via a large sample of 6,600-12,000 physicians from the Center for Studying Health System Change (Tu & Ginsberg, 2006). Real, or inflation-adjusted, net income figures are presented next to

cognitive skills, rose 6.9% in real terms over the period. As is clear from Table 11.1, primary care physicians experienced the largest drop in real net income, followed by surgeons. (Bodenheimer et al, 2007, using data from nearly the same period, come to the same conclusion.)

The authors of the study note that Medicare rate increases were 13% over the period while inflation was 21%. Payments from private insurers compounded the real decline, as the multiple of their fees to Medicare sank from 1.43 to 1.25.

Table 11.1 Physician Net Income 1995-2003

	Average Reported Net Income				% Change
	Nominal dollars		1995 dollars		1995 \$
	1995	2003	1995	2003	1995-03
All patient care physicians	180,930	202,982	180,930	168,122	-7.1%*
Primary care physicians	135,036	146,405	135,036	121,262	-10.2%*
Specialists	210,225	235,820	210,225	195,320	-7.1%*
Medical	178,840	211,299	178,840	175,011	-2.10%
Surgical	245,162	271,652	245,162	224,998	-8.2%*
Private sector professional, technical specialty occupations					6.90%

**statistically significant at the 95% confident level
Center for Studying Health System Change (2006)*

nominal ones. While physician incomes rose over the eight year period in nominal terms, they sank when adjusted for inflation. (The authors use the general Consumer Price Index, CPI, to deflate the 2003 values.) In contrast, the wages of professional and technical workers, jobs also demanding high

A similar analysis for physicians in the Pacific Northwest, and even more specifically for those in Spokane, is not available. However, some comparison of the salaries of family practice physicians in Washington State can be made for this

decade. The following graph examines three years of salaries for Spokane County and the closest Metropolitan Statistical Areas (MSAs) by size. (“SW Washington” is largely Clark County, or the Vancouver area.) Data are not available to allow a similar comparison for the other primary care physician disciplines.

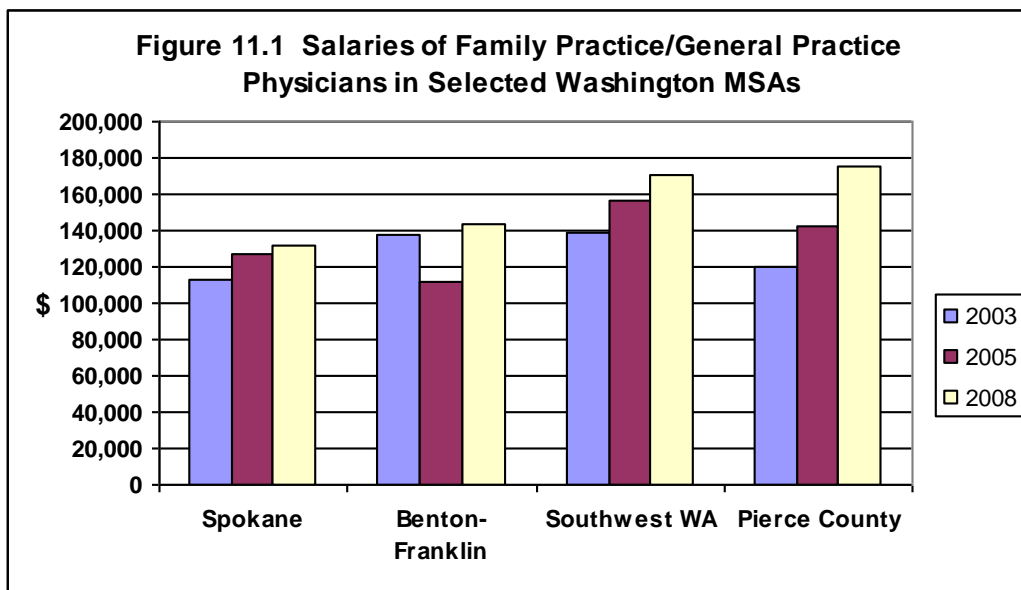
While all MSAs registered a (nominal) increase in salaries over the five-year period, the rate for Spokane physicians was the lowest, at 16%. When the same general CPI used by Tu and Ginsberg is applied to the nominal increases, a real salary gain of 1% over the period emerges. While (barely) positive, the growth of real incomes of family practice physicians in Spokane lagged behind those in two of three comparison MSAs. As important, Spokane family care physicians began the period at the lowest level among the comparison MSAs.

Appendix 3 contains a table with 2006 and 2007 salary data of family practice/general practice physicians for a larger set of Pacific Northwest MSAs. The comparative results

are the same. Clearly, there are some factors at work in Spokane that are different from the practice of primary care in other parts of the state. Some explanations are offered shortly. Before these are taken up however, the results of the authors’ efforts to gather information about revenue-enhancing strategies from the local survey and from national best practices are presented.

11.2 Revenue-enhancing strategies from the survey of PC physician practices and expert interviews

As part of the 36 questions posed in the local survey, Spokane primary care physician practices were asked to share their revenue enhancing strategies and identify the most effective one. A variety of strategies were identified. Most fell in one of two areas. One area looked at administrative processes and the other at ancillary services. Administrative areas suggested for revenue enhancement were: proper coding, negotiating competitive contracts, faster charge capture and co-pay



Source: Washington State Employment Security Department, Workforce Explorer, “Occupational Wages”

posting at time of collection. Ancillaries, however, were identified by most as the best strategy.

The study team interviewed Bob Perna, FACMPE, Director, Health Care Economics at the Practice Resource Center of the Washington State Medical Association (WSMA). Mr. Perna felt ancillary services are where everyone looks, but feels they largely increases costs. He best path for primary care physicians to improve revenue via the medical home model taken up below. The study team contacted the Medical Group Management Association, the leading national organization on physician practices. We were pointed to a series of articles appearing in their newsletter on ancillary services. These articles suggest increasing laboratory and/or radiology services.

In contrast to WSMA, ancillary services are thought to provide substantial payback to a medical group. MGMA best practice data show 35% of total practice revenue coming from ancillary services. When planning to add extra services, however, several costs and risk areas need to be considered:

- Cost of training existing personnel
- Need to hire new personnel
- Equipment outlay
- Reimbursement per procedure
- Liability risk
- Regulatory implications
- Legal implications

For primary care practices, MGMA suggests that best options for profit include electrocardiograms (EKGs) and breathing treatments. Areas that require more training are flexible sigmoidoscopy, dermatologic procedures, cardiac stress testing (non-nuclear), laser tattoo, hair

removal and cryotherapy. Botox injections, which require specialized training and are not covered by insurance, can be profitable. Radiology services may include general x-ray, mammography and a full-body bone densitometry scanner.

In addition, the MGMA suggests that patient satisfaction may be higher because they are able to receive the services at the same location. From a provider perspective, management of the patient may be easier with ancillaries close at hand. Regardless of the size of the financial gain, experts stress that the ancillary services provided need to be a complement to the patient population served.

11.3 The real issue: reimbursement

The most significant revenue-enhancing strategy, in the authors' opinion, lies in Medicare reimbursement. First, as noted above, most of the strategies reviewed yield small effects next to changes in the prices for which primary care physicians are paid. Second, these prices, whether from other public and private payers, are generally established by Medicare. Medicaid and private insurers vary the multiple of the fee, but the baseline and its components – conversion fee, a geographical price index (GPCI) and the relative value units (RVUs) – are set by Medicare.

A long-running and now widely cited study at the Dartmouth College of Medicine, the *Health Atlas*, reveals some insights about Medicare reimbursement to primary care physicians in Spokane. The project is an offshoot of the College's Institute for Health Policy & Clinical Practice and was founded by Dr. John Wennberg, 2008 winner of the

Institute of Medicine (IOM) Lienhard award for contributions to the improvement of health care delivery in the U.S. Wennberg and his team have developed massive databases of Medicare practice, patient outcomes and costs for all small geographical areas and even hospitals in the U.S. The Dartmouth team has been able to show that rates of procedures in areas with similar populations varied greatly, that the variations stemmed primarily from differences in physicians' treatment preferences and that higher local costs did not necessarily lead to improved outcomes.

The *Atlas*, now led by Drs. Elliott Fisher and David Goodman, has been adopted as baseline information by the federal government in the Medicare reform debate. (Congressional Budget Office, 2008). In its award, the IOM wrote:

“For more than 30 years, Dr. Wennberg’s research and advocacy have focused on spending. He was the first to suggest – and to show conclusively – that more care is not always best and that patient outcomes are often better with more conservative treatment. His vision 30 years ago started to unravel the mystery of an irrational national health care system.”

The *Atlas* typically looks at medical practice, outcomes and costs during the final two years or six months of a person’s life. This focus on this timeframe fits with the

Dartmouth Institute’s emphasis on chronic illness. It also allows a normalization of the patient population, along with demographic controls, across regions, since the prognosis is ultimately the same for all patients. While Medicare only represents a certain (but growing) segment of the population, the Dartmouth team has produced studies showing that the medicine is not practiced much differently for patients less than 65 years.

What does the *Atlas* currently reveal about primary care practice in Spokane? Consider Table 11.2. It is composed of treatment data during the final two years of life for Medicare patients who died from 2001-2005. The data are based on a 20% sample of Medicare patients with at least one of nine types of chronic diseases who had occasion to visit a hospital for a non-surgical treatment related to their disease. See Wennberg et al (2008) for further details. The table compares the six hospital “referral regions” (HRR) in Washington to the state and national averages for metrics specific to primary care physicians. Since the Spokane HRR is composed of six counties in northern Idaho and nearly all counties in Eastern Washington, except for Yakima and Kittitas, the data do not precisely measure Spokane County. However, Spokane is the dominant county in the HRR by size of (Medicare) population.

Table 11.2 Primary Care Physician Provision, Costs & Outcomes During Last Two Years of Life for Chronically Ill Medicare Patients: 2001-2005

	Part B spending for evaluation & management services per decedent (\$)	Total Part B spending per decedent (\$)	Primary care physician visits per decedent	Total physician visits per decedent	CMS Hospital Compare Composite Quality Score (all patients, 2005)
National Average	3,630	9,043	29.26	61.29	87.25
Everett	2,599	6,816	23.65	41.03	84.62
Olympia	2,299	7,857	19.75	37.69	86.55
Seattle	2,924	7,840	21.98	45.01	88.5
Spokane	2,236	7,305	23.21	41.33	88.01
Tacoma	2,781	8,173	20.74	42.92	86.08
Yakima	2,225	6,992	22.37	39.43	89.28
State Average	2,645	7,687	22.06	42.56	87.88

*No. of Deaths are from a 20% sample
Source: Dartmouth Atlas of Health Care*

The results confirm the Dartmouth general finding of wide variation across the U.S. First, Washington State is much more efficient in its provision in primary care than the national average for this patient group, as measured by the physician visits. Second, Washington physicians are paid less for their services than the national average, as both spending columns reveal. “Evaluation and Management” is the code for most of the activity of primary care physicians, involving patient visits either in the office or in the patient’s care setting. Part B spending includes many non-hospital activities, such as physician care, home health care, outpatient therapies, some hospital outpatient care, diagnostic tests (including x-rays), durable medical equipment purchases/leases and drugs that cannot be self-administered. However,

physician work constitutes the largest set of expenditures under Medicare Part B.

A third insight from Table 11.2 is that physicians in the Spokane HRR receive slightly less than the state average for either revenue category. For example, spending in the Spokane HRR on Evaluation & Management per decedent was 62% of the national average and 85% of the state average. Part B spending showed a similar relationship for the Spokane HRR: 81% of the national average and 95% of the state average. Visits by Spokane HRR PC physicians per decedent were only 79% of the national average but slightly higher than the state average, by 5%.

The *Atlas* uses data from the U.S. Center for Medicare & Medicaid Service (CMS) *Hospital Compare*,

Table 11.3 Medicare Payments to Physicians at Selected Washington Hospitals for Medicare Patients in Their Last Two Years of Life 2001-2005

Hospital	Rates during the last two years of life			Ratios to U.S. Average				
	Total Payment (\$)	All visits	Payment/Visit (\$)	Total Payment	=	All visits	x	Payment / Visit
Swedish Medical Center	3,943	58.5	67	0.94	=	0.83	x	1.12
Overlake Hospital Medical Center	3,611	54.7	66	0.86	=	0.78	x	1.1
Valley Medical Center	3,388	51.5	66	0.81	=	0.73	x	1.1
Virginia Mason Medical Center	3,322	60.4	55	0.79	=	0.86	x	0.92
Sacred Heart Medical Center	2,896	51.4	56	0.69	=	0.73	x	0.94
Holy Family Hospital	2,819	46.2	61	0.67	=	0.66	x	1.02
Deaconess Medical Center	2,748	52.3	53	0.65	=	0.75	x	0.88
Valley Hospital and Medical Center	2,618	47.5	55	0.62	=	0.68	x	0.92
United States	4,201	70.1	60	1	=	1	x	1

available on the internet, to measure medical quality. As Table 11.2 shows, the quality of care at Spokane HRR hospitals was slightly higher than the state and national averages.

Physician payments are made up of both quantity of the service provided and payment per service. Table 11.3 offers some insights into the practice patterns by all physicians in Spokane who treated Medicare patients in a hospital setting during the last two years of life. The data are not population based as in Table 11.2, but hospital-specific. The hospitals presented are the four acute care facilities

in Spokane County and four acute care facilities in King County. Implicitly, all U.S. hospitals are compared to the eight Washington facilities, since cost and volume information is expressed as a percentage of the U.S. average in the right-hand columns. The results are presented by hospital rank of total physician payment.

Several observations follow. Whether one looks at the three columns on the left that express average numbers of physician activity and payment, or the three on the right that express the same as a fraction of the U.S. average, the same general conclusion from Table 11.2 holds here:

Physicians in Washington State cost Medicare much less than the U.S. average. For Spokane, physicians at all hospitals except Holy Family received less in Medicare fees per visit than the national average, ranging from 88-94%. This validates the local conventional wisdom about Medicare payments to the Spokane medical community. Interestingly, payment rates for these patients at three of the four King County hospitals were higher than the national average, ranging from 92-112%.

Uniformly below the national average for all eight Washington hospitals was the average number of physician visits to Medicare patients in the last two years of life. This was especially true for the four Spokane hospitals, where these visits ranged from 68-75% of the national average. Without knowing the reasons, we can state that the practice patterns by Spokane physicians are conservative, compared to national averages. As a result, the average payment to local physicians for these Medicare patients lies far below the national average, ranging from 62-69%. Reimbursement is, in a word, a volume and a price issue.

The Dartmouth *Atlas* allows one to calculate aggregate surplus or deficit of practice patterns and Medicare fees for each Health Service Area (HSA). HSAs are the smallest local geographic unit measured by the *Atlas* and are defined at the catchment area for a group of hospitals. In the case of Spokane, the HSA consists of the four Spokane acute care hospitals, plus the

Newport Community Hospital. Here, the Atlas data set allows the calculation on the basis of Part B reimbursements for “medical care,” that is, to physicians. (Other metrics are available to calculate HSA surplus or deficits.) So the payments cover more than PC physician services in Table 11.4.

The table allows one to consider the consequences, in this case for 2005, of differences in Medicare payment *and* local practice patterns compared to a benchmark. In Table 11.4, the benchmark is the U.S. average; surplus/deficits are calculated for the HSAs that represent the largest MSAs in the state. Here, the Part B rates (reimbursements) are the average over the entire Medicare population in an HSA, not just for the chronically ill in the last two years of life.

The results are displayed in a ranking of the HSA reimbursements rates to the U.S. average. The only large HSA in the state with a higher ranking than the U.S. average was Richland. The right hand column contains the consequences of a higher or lower ranking, relative to the U.S. average. For Spokane, it is negative, implying a deficit compared to the U.S. In other words, if the Spokane medical community had received total Medicare Part B reimbursement rate equal to the national average in 2005, payments to physicians would have been approximately \$8.5 million higher. Since Medicare fees serve as an anchor for all other payers, the total deficit is a multiple of \$8.5 million.

Table 11.4 **Part B Medicare Reimbursements to Selected Hospital Service Areas for Medical Care Services: Surplus or Deficit Compared to National Norms 2005**

Area	Population	Rates	Ratio to Benchmark	Surplus/Deficit
Richland	6,476	1,135	1.13	864,880
Tacoma	39,668	961	0.96	-1,586,517
Spokane	54,571	846	0.84	-8,503,329
Washington	511,588	826	0.82	-89,827,459
Seattle	69,225	770	0.77	-16,004,483
Vancouver	18,292	746	0.74	-4,677,643
Yakima	18,617	696	0.71	-5,679,411
U.S. Average	26,736,021	1,001	-	-

Thus, the three tables using the Dartmouth *Atlas* data reveal that primary care physicians in Spokane face a very challenging set of circumstances: Medicare rates are far lower for them than the national average and somewhat lower than the Washington state average; practice patterns – for whatever set of reasons - are conservative, leading to fewer billable interactions with patients; and like all primary care physicians in the U.S., they face stagnant Medicare payments for their core services. These findings underscore our conclusion that the best revenue-enhancing strategies lie in the realm of public policy, both federal and state.

Efforts to re-arrange the *geographical* mix of Medicare reimbursement formulas have foundered in the Congress. This is not surprising, since the proposals have been typically brought forward under the banner of revenue-neutrality, which have invoked all the problems of a zero sum game

involving legislators committed to representing their districts' interests. Changes in these formulas would, of course, affect not only primary care physicians, but all providers of Medicare services. The conservative practice patterns, while penalizing physician reimbursement, seem to be a condition that the Spokane medical community would likely not want, or be unable, to change substantively. If nothing else, the findings of the Dartmouth *Health Atlas* about Spokane and Washington State practice patterns and patient outcomes should give this region a certain cachet in the reform debate.

Consequently, the most promising public policy path for the Spokane County Medical Society appears to lie in taking advantage of expert opinion and political momentum that has coalesced around Medicare payment and practice reform for primary care physicians. Numerous influential voices have concluded that the payment status quo for primary care physicians is eroding

the ranks of the largest segment of the U.S. physician population. Without a large and financially health PC physician base, national efforts to raise health outcomes are likely unattainable. The policy goes by the general moniker of “medical home.” Before a brief synopsis of medical home policy proposals is presented, it is useful to consider recent comments about primary care reimbursement.

The Center for Studying Health System Change concluded in its Tracking Report (2006) on physician incomes:

“Although Medicare’s physician fee schedule is supposed to reflect relative physician work and practice expense and is updated periodically, the failure to identify many services for which relative values should decline because of increasing productivity has resulted in overpayments for some services, especially procedures associated with rapidly advancing technology.....The upshot is that the relative rewards for evaluation and management services and other cognitive-based services, where substantial productivity gains are unlikely, are declining sharply over time. With many commercial insurers incorporating Medicare’s relative value scale into their own payment schedules, the negative impact of specialties such as primary care, for which office visits are an important source of revenue, extends beyond Medicare patients.”

The Medicare Payment Advisory Commission (MedPAC) is a 17-member Federal agency charged with advising the Congress on Medicare issues. It issues two reports per year. The most recent, released in June 2008, took up the issue of payment for primary care services. Its conclusions:

“Primary care services – which rely heavily on cognitive activities such as patient evaluation and management (E&M) – are undervalued and they risk being underprovided relative to procedurally based services. ...Given signals that primary care is undervalued, the Commission has approached the problem three ways. First, the Commission recommended improvements to the process for reviewing the relative value of physician services (MedPAC 2006)...Although the formal process for reviewing the service values has not changed, the physician work component of certain E&M codes increased substantially in 2007.

The second initiative...concentrates on services furnished by practitioners whose practices focus mostly on primary care. The Commission recommends increasing Medicare Part B payments for primary care services furnished by such practitioners...The services selected for the adjustment – a subset of E&M services within the statutory definition of primary care – would be office visits, home visits and visits to patients in certain nonacute facility settings (skilled nursing, intermediate care, long-term care, nursing home, boarding home, domiciliary and custodial care).”

Of course, professional organizations such as the AAFP and the American College of Physicians (ACP) have, in their journals and position papers, pointed out the very same. According to the American Academy of Family Physicians (AAFP), 2004, in the *New Model of Primary Care: Knowledge Bought Dearly*, “The current payment system rewards doing more things as often as possible and punishes spending time with patients to understand them in their particular situations. There is almost no

compensation for assuring care is organized correctly and integrated in a way that makes sense to patients....despite decades of annual increases in overall health care expenditures, a vast majority of expenditures occurs in sectors other than primary care. Consequently, there is insufficient revenue in family medicine and primary care to cover costs” (p 1). (See Bodenheimer et al, 2007 for view from the ACP.) Professor Barbara Starfield at the Johns Hopkins School of Public Health has been making these points in journal articles and professional forums for many years (Starfield et al, 2005).

The report by the GAO earlier this year to Congress on the state of primary care provision (Steinwald, 2008) similarly argues:

“Fee-for-service, the predominant method of paying physicians in the U.S., encourages growth in specialty services. Under this structure...a financial incentive exists to provide as many services as possible, with little accountability for quality or outcomes. Because of technological innovation and improvements over time in performing procedures, specialist physicians are able to increase the volume of services they provide, thereby increasing revenue. In contrast, primary care physicians, whose principal services are patient office visits, are not similarly able to increase the volume of their services without reducing the time spent with patients, thereby compromising quality.

The conventional pricing of physician services also disadvantages primary care physicians. Most health care payers, including Medicare... use a method for reimbursing physician services that is resource-based, resulting in higher

fees for procedure-based services than for office visit ‘evaluation and management’ services.”

However, the GAO concludes that payment reform is not enough:

“In our view, payment system reforms that address the undervaluing of primary care should not be strictly about raising fees but rather about recalibrating the value of all services, both specialty and primary care. Resource-based payment systems like those of most payers today do not factor in health outcomes or quality metrics; as a consequence, payments for services and their value to the patient are misaligned.”

This trade-off of higher fees for improved patient outcomes is at the heart of the medical home discussion.

11.4 The Medical Home: The Way to Improve Primary Care Medicine for Provider and Patient?

As mentioned, the pre-eminent national reform proposal for primary care physicians centers on the notion of a medical home for patients. It represents the third of MedPAC’s June 2008 recommendation to the Congress. The GAO ends its 2008 review of the challenges facing the supply of primary care professionals with a discussion and implicit endorsement of the idea. The AAFP, the American College of Physicians, the American Academy of Pediatrics and the American Osteopathy Association have all jointly released medical home principles. Since the AAFP position paper release, an additional 13 national organizations have endorsed these principles.

Medical home is not a new concept. It originated in pediatrics over 50 years ago as a way to ensure that special needs children received comprehensive care (AHIP, 2008, p 1). The AAFP (2007) defines medical homes as patient centered, regular, and continuous sources for care, coordinated by a team of medical professionals committed to quality improvement. MedPAC defines medical home as a “central resource for a patient’s ongoing care” (p 25).

MedPAC envisions a medical home program would encourage Medicare beneficiaries to seek or remain with a physician who can manage their overall care. Under such a program, Medicare would direct separate monthly payments to medical homes to promote the important role that personal physicians and their health care team play in care delivery, particularly for patients with multiple conditions. A goal for medical homes is to improve patients’ understanding of their own conditions and of medical advice they receive and, in turn, reduce the use of high- cost settings such as emergency rooms and inpatient care. Ideally, through better care coordination, medical homes could also enhance communication among the providers, thereby eliminating redundancy and improving quality (p 39).

In June 2008, America’s Health Insurance Plans (AHIP) released new principles for medical home adopted by its board of directors. This approach redesigns the care delivery model by assessing the level of illness or disease, based on sound medical evidence; promoting the coordination of care; and, improving accountability for outcomes, patient experience, and utilization of services. AHIP focuses on the following:

- Practice redesign so care is delivered in response to a patient’s needs and preferences
- Clear criteria for patient participation
- Adoption of health information technology to facilitate evidence-based integrated care
- Accountability
- Engaging and educating consumers and improving personal responsibility and behavior
- Structuring payment to align with measurable improvements
- Pilot testing before moving forward with reformed payment models or practice redesign (p 1).

Following the national discussion, many states are now embracing the notion of medical home. According to the Commonwealth Fund’s catalog of state health policy innovations, Kansas, Massachusetts, Michigan, New Jersey, New York, North Carolina, North Dakota and Pennsylvania have all begun some form of policy experiment or instituted pilot programs. Most involve public programs, such as Medicaid. Some, like Pennsylvania, have attracted attention for the participation of private payers in its pilot, in addition to Medicaid. Blue Cross, Aetna and Cigna have signed on to the Pennsylvania three year program that is estimated to cost payers \$13 million (New York Times, July 21, 2008).

Washington State has also recently embraced a version of medical home. It is now working on operation definitions and has identified performance measures for medical home pilots, according to the Commonwealth Fund. The Washington

State Legislature defines medical home as “an approach to delivering primary health care through a ‘team partnership’ that ensures health care services are provided in a high quality and comprehensive manner” (p. 10 House Bill 2549). The legislation passed on March 8, 2008, and its intent is to explore payment options related to primary care medical homes. A report to the Legislature from the Departments of Social and Health Services and the Health and the Health Care Authority will be issued during January 2009.

Concepts from the Washington State Primary Care Coalition have been incorporated into this report. In a draft version, there are two payment options outlined. The first is a fee for service plus a bonus payment, based on either the current coding system or an add-on payment separate from the code based system. The second option involves payment reengineering, which also covers two options- a bundled fixed payment or full-risk capitation. Incorporated into the state house bill were the core principles of AHIP as well as the chronic care model concept from AAFP.

The draft goes on to discuss medical home standards. Two of the most standardized are the Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) and Bridges to Excellence Medical Home Recognition (BTE). These are discussed as reasonable starting points, while neither is “endorsed” by the state. PPC-PCMH standards are based on the joint principles from AAFP and others working with the National Committee for Quality Assurance. There are 30 different elements and about 170 separate measures.

Currently, Washington State is one of nine competitively selected states for “The State Quality Improvement Institute,” funded through the Common Wealth Fund/Academy Health to implement patient centered care through medical homes. “Washington’s core team for the QI program is a public/private partnership of state agencies and representatives from the Puget Sound Health Alliance and Group Health Cooperative” (p. 9, draft).

Another example of activity related to medical home in Washington State appeared in the *Hospital and Health Networks* November 2008 issue, in an article on “The Disappearing Primary Care Physician.” Seattle’s Swedish Medical Center is launching a new primary care clinic in 2009 in Ballard based on the medical home concept. They believe this to be the first such clinic in the country. It is to serve as a prototype for the Swedish network of 450 primary care physicians and will move Swedish away from its current physician productivity model. Swedish is working with private health insurance companies on reimbursement innovations, including a flat fee per patient per month and risk adjustment based on age and health status. The clinic is to have 4-5 primary care physicians, one nurse practitioner, and one care coordinator, and it will make extensive use of the Swedish electronic medical record (Meyer, 2008). This article also discusses the partnering of primary care physicians and clinics with hospitals along with the pros and cons of this type of approach for primary care.

Clearly Washington State has a jump start in the area of medical home. In a study team interview with Bob Perna of WSMA, he clearly indicated his belief that this was the

answer for Washington State reimbursement reform for primary care physicians. On behalf of WSMA, he has been involved in the projects occurring on the west side of the state. In particular, with the Puget Sound Health Alliance efforts

There are clearly hurdles to the adoption of a general version of medical home in any state or region. Dr. Elliott Fisher, from the Dartmouth College Medicine, discussed them in a recent article in the *New England Journal of Medicine* (2008). As difficulties, he mentions interoperability issues among health IT systems, the willingness of all physicians to help coordinate care, possible rejection of coordination by patients and the expected difficulty of payers, public and private, to arrive at revenue-neutral reordering of the payment system. Nonetheless, he is hopeful about medical home prospects if the following occurs: "Success will be more likely if primary care reforms... are aligned with reform strategies that foster shared accountability among all providers for measurably and transparently improving the quality of care and reducing its cost" (p. 1204).

In conclusion, medical home now dominates the policy reform debate, at the

national and state levels, for primary care provision. It combines the widely-shared societal objective of improving patient care with a path for increasing primary care physician revenue. It seems to the authors of this study that the Spokane physician community should lend support to their professional organizations to accelerate the expansion of national efforts. Currently, Medicare is spending \$100 million on a three-year pilot on eight states; Washington is not one of them.

The state effort can also be joined by the Spokane medical community. Other than in the one pediatrics office, Spokane physicians do not seem to be involved in the initial stages of the "collaborative" called for by HB 2549. That legislation specifically wants the pilot to collaborate with providers and payers throughout the state. Given the size of the Spokane medical community, its level of physician practice professionalism and the relatively high penetration of health IT systems among all providers here, the preconditions appear favorable for Spokane to participate in, if not co-lead, the state's medical home program.

12. Conclusions & Paths of Possible Future Research

Determining the adequacy of the numbers of primary care providers in Spokane County is a multifaceted question. The survey conducted and the responses given demonstrate the commitment of primary care providers to explore an issue which is critical to the health of the community. This study presents information on the current primary care provider labor force in Spokane County. Current numbers in the County appear to fall into the low end of the normal range established by national and regional data on PCP staffing norms.

The access issue for Medicare and Medicaid populations is summarized using current patient populations and projections for 2009 through 2012. A current assessment of access for these populations is not good, with about 40% of primary care physicians accepting new patients in 2009. The outlook beyond 2009 is uncertain and must be carefully watched.

A positive outlook for PC physician supply is very unclear, based on the projected departures and retirements in the County. If recruitment efforts are successful, they will certainly help to ease access for the low-income and senior populations. If they fail, access will only slip from an already tenuous position. Without substantial growth in physician supply, the growth of the 65+ population beyond 2012 will certainly worsen access, since a large part of this population is expected to deal with one or more chronic diseases.

Strategies for recruitment and retention are reviewed from via national best practices and contrasted to Spokane practices. Spokane County largely depends upon the hospital and residency program for recruitment of primary care physicians. Other avenues need to be explored, given the consequences of an inadequate supply of PC physicians. The economic impact of an inadequate PC physician supply is discussed and an attempt made to estimate the effects of a reliance on specialist care for treatment of chronic conditions in the County.

Strategies for increasing PCP revenues, relating national trends and local practices, are also presented. Most strategies are not new with the exception of medical home. The strategies range from small to large, with the difficulty of implementing them increasing as the strategy becomes more ambitious. Certainly, payment reform from the public insurers, especially Medicare, is the most important but most difficult strategy for primary care physicians. The medical home presents an opportunity to realize payment reform, albeit with additional costs and responsibilities.

Based on the insights gathered in this study, a number of other issues have surfaced that could be explored about the state of primary care provision in Spokane County:

- Are salaries for primary care providers competitive by national standards?
- Do physician practices/clinics have formalized recruitment /retention plans?
- What is the impact of ARNPs on primary care in Spokane?

- Does the SCMS have a plan for promoting and implementing the medical home alternative in the County? Medical home has a number of

components, such as health IT systems, which could individually be explored, should this become a focus for Spokane's medical community.

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Appendix I; SCMS Clinic/Office Manager Survey Results

Q1. 1. Please provide the following information:

Answer Options	Response Percent	Response Count
Name:	100.0%	46
Title:	100.0%	46
Practice/Clinic:	100.0%	46
	answered question	46
	skipped question	0

Q2. 2. Are your physicians employees or owner/partners?

Answer Options	Response Percent	Response Count
Employees	30.4%	14
Owner/Partners	69.6%	32
	answered question	46
	skipped question	0

Q3. 3. How many contract physicians or locum tenants do you have?

Answer Options	Response Average	Response Total	Response Count
Full-Time	1.52	44	29
Part-Time	1.67	40	24
Total	2.03	75	37
		answered question	42
		skipped question	4

Q4. 4. How many total primary care physicians do you have?

Answer Options	Response Percent	Response Count
Full-Time	84.8%	39
Part-Time	45.7%	21
Total	93.5%	43
Current Vacancies	71.7%	33
	answered question	46
	skipped question	0

Q5. 5. How many total physicians' extenders do you have?

Answer Options	Response Percent	Response Count
Full-Time	58.5%	24
Part-Time	61.0%	25
Total	95.1%	39
	answered question	41
	skipped question	5

Q6. 6. How many total physicians' assistants do you have?

Answer Options	Response Percent	Response Count
Full-Time	56.8%	25
Part-Time	54.5%	24
Total	88.6%	39
Current Vacancies	68.2%	30
	answered question	44
	skipped question	2

Q7. 7. Are you anticipating any departures of your pc physicians this year?

Answer Options	Response Percent	Response Count
Yes	11.1%	5
No	88.9%	40
	answered question	45
	skipped question	1

Q8. 8. Do you have any pre-planned retirements of primary care physicians in the next three years?

Answer Options	Response Percent	Response Count
Yes	22.2%	10
No	77.8%	35
	answered question	45
	skipped question	1

Q9. 9. Do you have any pre-planned retirements of physicians' extenders in the next three years?

Answer Options	Response Percent	Response Count
Yes	6.8%	3
No	93.2%	41
	answered question	44
	skipped question	2

Q10. 10. Did you have any departures within the past five years?

Answer Options	Response Percent	Response Count
Yes	41.3%	19
No	58.7%	27
	answered question	46
	skipped question	0

Q11. 11. Would you share the name and location of the person(s)?

Answer Options	Response Count
answered question	19
skipped question	27

Q12. 12. Please state the reason(s) for the departures.

Answer Options	Response Count
answered question	20
skipped question	26

Q13. 13. Are you anticipating any departures for your physician assistants this year?

Answer Options	Response Percent	Response Count
Yes	6.8%	3
No	93.2%	41
	answered question	44
	skipped question	2

Q14. 14. Do you have any pre-planned retirements of physician's assistants in the next three years?

Answer Options	Response Percent	Response Count
Yes	7.0%	3
No	93.0%	40
	answered question	43
	skipped question	3

Q15. 15. Did you have any departures within the past five years?

Answer Options	Response Percent	Response Count
Yes	22.2%	10
No	77.8%	35
	answered question	45
	skipped question	1

Q16. 16. Would you share the name and location of the person(s)?

Answer Options	Response Count
answered question	12
skipped question	34

Q17. 17. Please state the reason(s) for the departures.

Answer Options	Response Count
answered question	12
skipped question	34

Q18. 18. Do you feel you have enough primary care physicians and assistants to meet the demands of your practice/clinic?

Answer Options	Response Percent	Response Count
Yes	61.4%	27
No	38.6%	17
	answered question	44
	skipped question	2

Q19. 19. What percentage of your practice is Medicare?

Answer Options	Response Count
answered question	43
skipped question	3

Q20. 20. Are you currently accepting new Medicare patients?

Answer Options	Response Percent	Response Count
Yes	45.7%	21
No	54.3%	25
	answered question	46
	skipped question	0

Q21. 21. Do you foresee not being able to accept new Medicare patients in 2009?

Answer Options	Response Percent	Response Count
Yes	47.6%	20
No	52.4%	22
	answered question	42
	skipped question	4

Q22. 22. Do you foresee not being able to accept new Medicare patients in five years?

Answer Options	Response Percent	Response Count
Yes	55.8%	24
No	44.2%	19
	answered question	43
	skipped question	3

Q23. 23. What percentage of you practice is Medicaid?

Answer Options	Response Count
answered question	44
skipped question	2

Q24. 24. Are you currently accepting new Medicaid patients?

Answer Options	Response Percent	Response Count
Yes	44.4%	20
No	55.6%	25
	answered question	45
	skipped question	1

Q25. 25. Do you foresee not being able to accept new Medicaid patients in 2009?

Answer Options	Response Percent	Response Count
Yes	50.0%	22
No	50.0%	22
	answered question	44
	skipped question	2

Q26. 26. Do you foresee not being able to accept new Medicaid patients in five years?

Answer Options	Response Percent	Response Count
Yes	41.9%	18
No	58.1%	25
	answered question	43
	skipped question	3

Q27. 27. What are your top five most successful recruitment strategies?

Answer Options	Response Percent	Response Count
1	100.0%	29
2	62.1%	18
3	37.9%	11
4	20.7%	6
5	17.2%	5
	answered question	29
	skipped question	17

Q28. 28. What has been your single most effective recruitment strategy?

Answer Options	Response Count
answered question	17
skipped question	29

Q29. 29. Do you feel your starting salaries are competitive?

Answer Options	Response Percent	Response Count
Yes	81.6%	32
No	18.4%	7
	answered question	39
	skipped question	7

Q30. 30. What are your top five best retention strategies?

Answer Options	Response Percent	Response Count
1	100.0%	27
2	81.5%	22
3	74.1%	20
4	48.1%	13
5	29.6%	8
	answered question	27
	skipped question	19

Q31. 31. What has been your single most effective retention strategy?

Answer Options	Response Count
answered question	21
skipped question	25

Q32. 32. Are you anticipating hiring any primary care physicians in 2009?

Answer Options	Response Percent	Response Count
Yes	37.8%	17
No	62.2%	28
	answered question	45
	skipped question	1

Q33. 33. Are you anticipating hiring any physician assistants in 2009?

Answer Options	Response Percent	Response Count
Yes	20.0%	9
No	80.0%	36
	answered question	45
	skipped question	1

Q34. 34. Have you utilized any revenue enhancing strategies during the last five years?

Answer Options	Response Percent	Response Count
Yes	28.6%	12
No	71.4%	30
	answered question	42
	skipped question	4

Q35. 35. Would you please share your strategies:

Answer Options	Response Percent	Response Count
1	100.0%	17
2	56.3%	9
3	31.3%	5
4	18.8%	3
5	12.5%	2
6	6.3%	1
7	6.3%	1
	answered question	17
	skipped question	29

Q36. 36. What has been your best revenue enhancing strategy?

Answer Options	Response Count
answered question	14
skipped question	32

SCMS Clinic/Office Manager Survey Weighted Results

N=348 unless otherwise stated

Q7a. Are you anticipating any departures of your pc physicians this year?

Yes	35%
NO	48%
No response	17%

Q7b. Are you anticipating any departures of your pc physicians this year? N=288

Yes	42%
NO	58%
No response	0

Q8a. Do you have any pre-planned retirements of primary care physicians in the next three years?

Yes	43%
NO	40%
No response	17%

Q8b. Do you have any pre-planned retirements of primary care physicians in the next three years? N=288

Yes	52%
NO	48%
No response	0

Q9. Do you have any pre-planned retirements of physicians' extenders in the next three years?

Yes	25%
NO	57%
No response	17%

Q10. Did you have any departures within the past five years?

Yes	68%
NO	32%
No response	0

Q13. Are you anticipating any departures for your physician assistants this year?

Yes	22%
NO	77%
No response	1%

Q14. Do you have any pre-planned retirements of physician's assistants in the next three years?

Yes	25%
NO	57%
No response	18%

Q15. Did you have any departures within the past five years?

Yes	48%
NO	51%
No response	0.33%

Q18a. Do you feel you have enough primary care physicians and assistants to meet the demands of your clinic?

Yes	20%
NO	77%
No response	3%

Q18b. Do you feel you have enough primary care physicians and assistants to meet the demands of your clinic? N=288

Yes	25%
NO	72%
No response	3%

Q19a. What percentage of your practice is Medicare?

Answer	26%
--------	-----

Q19b. What percentage of your practice is Medicare? N=288

Answer	26%
--------	-----

Q20a. Are you currently accepting new Medicare patients?

Yes	70%
NO	30%
No response	0

Q20b. How many of your primary care physicians are currently accepting new Medicare patients? N=265

Answer	32%
--------	-----

Q21a. Do you foresee not being able to accept new Medicare patients in 2009?

Yes	32%
NO	66%
No response	2%

Q21b. How many of your primary care physicians will be accepting new Medicare patients in 2009? N=206

Answer	42%
--------	-----

Q22a. Do you foresee not being able to accept new Medicare patients in five years?

Yes	35%
NO	64%
No response	1%

Q22b. How many of your primary care physicians will be accepting new Medicare patients in five years? N=142

Answer	15%
--------	-----

Q23a. What percentage of your practice is Medicaid?

Answer	20%
--------	-----

Q23b. What percentage of your practice is Medicaid? N=288

Answer	17%
--------	-----

Q24a. Are you currently accepting new Medicaid patients?

Yes	53%
NO	47%
No response	0.57%

Q24b. How many of your primary care physicians are currently accepting new Medicaid patients? N=272

Answer	27%
--------	-----

Q25a. Do you foresee not being able to accept new Medicaid patients in 2009?

Yes	27%
NO	72%
No response	1.0%

Q25b. How many of your primary care physicians will be accepting new Medicaid patients in 2009? N=209

Answer	38%
--------	-----

Q26a. Do you foresee not being able to accept new Medicaid patients in five years?

Yes	19%
NO	80%
No response	1.00%

Q26b. How many of your primary care physicians will be accepting new Medicaid patients in five years? N=201

Answer	34%
--------	-----

Q29a. Do you feel your starting salaries are competitive?

Yes	91%
NO	6%
No response	3.00%

Q29b. Do you feel your starting salaries are competitive? N=288

Yes	89%
NO	5%
No response	6.00%

Q32a. Are you anticipating hiring any primary care physicians in 2009?

Yes	61%
NO	39%
No response	

Q32b. Are you anticipating hiring any primary care physicians in 2009? N=288

Yes	74%
NO	26%
No response	

Q33. Are you anticipating hiring any physician assistants in 2009?

Yes	37%
NO	62%
No response	1%

Q34. Have you utilized any revenue enhancing strategies during the last five years?

Yes	47%
NO	49%
No response	4.00%

SCMS Departed Primary Care Physician Survey Results

Q1. 1. Please provide the following information:

Answer Options	Response Percent	Response Count
Name:	100.0%	11
Address:	72.7%	8
City/Town:	90.9%	10
State:	100.0%	11
ZIP:	90.9%	10
Date of Birth	90.9%	10
State Born:	90.9%	10
	answered question	11
	skipped question	0

Q2. 2. What is your gender?

Answer Options	Response Percent	Response Count
Male	36.4%	4
Female	63.6%	7
	answered question	11
	skipped question	0

Q3. 3. Are you currently married?

Answer Options	Response Percent	Response Count
Yes	100.0%	11
No	0.0%	0
	answered question	11
	skipped question	0

Q4. 4. How many total dependents under age 18 do you have?

Answer Options	Response Percent	Response Count
Number of Dependents:	100.0%	11
	answered question	11
	skipped question	0

Q5. 5. Where did you receive your degrees?

Answer Options	Response Percent	Response Count
High School Diploma (State)	90.9%	10
Name of Undergraduate College/University	90.9%	10
Name of Medical School	100.0%	11
Residency	100.0%	11
	answered question	11
	skipped question	0

Q6. 6. In what states are you licensed?

Answer Options	Response Percent	Response Count
State 1	90.9%	10
State 2	54.5%	6
State 3	9.1%	1
State 4	0.0%	0
State 5	0.0%	0
State 6	0.0%	0
State 7	0.0%	0
	answered question	11
	skipped question	0

Q7. 7. What is your current med practice gross income?

Answer Options	Response Percent	Response Count
<100K	11.1%	1
100-200K	66.7%	6
200-300K	22.2%	2
300K+	0.0%	0
Decline to Answer	0.0%	0
	answered question	9
	skipped question	2

Q8. 8. What is your current job type?

Answer Options	Response Percent	Response Count
Medical	50.0%	5
Surgical	0.0%	0
Hospitalist	30.0%	3
Administrative/Other	20.0%	2
	answered question	10
	skipped question	1

Q9. 9. Are you currently full or part-time or retired?

Answer Options	Response Percent	Response Count
Full-Time	81.8%	9
Part-Time	9.1%	1
Retired	9.1%	1
	answered question	11
	skipped question	0

Q10. 10. What is your current medical employment type?

Answer Options	Response Percent	Response Count
Employee	80.0%	8
Owner/Partner	20.0%	2
Independent Contractor	0.0%	0
Locum Tenant	0.0%	0
	answered question	10
	skipped question	1

Q11. 11. What was your length of time in practice in Spokane?

Answer Options	Response Count
answered question	11
skipped question	0

Q12. 12. What was your size of practice in Spokane?

Answer Options	Response Count
answered question	10
skipped question	1

Q13. 13. What was your job type while in Spokane?

Answer Options	Response Percent	Response Count
Medical	54.5%	6
Surgical	9.1%	1
Hospitalist	27.3%	3
Administrative/Other	9.1%	1
	answered question	11
	skipped question	0

4Q14. 14. While in practice in Spokane were you full-time or part-time?

Answer Options	Response Percent	Response Count
Full-Time	90.9%	10
Part-Time	9.1%	1
	answered question	11
	skipped question	0

Q15. 15. What was your medical employment type while in Spokane?

Answer Options	Response Percent	Response Count
Employee	72.7%	8
Owner/Partner	27.3%	3
Independent Contractor	0.0%	0
Locum Tenant	0.0%	0
	answered question	11
	skipped question	0

Q16. 16. What was your marital status while in Spokane?

Answer Options	Response Percent	Response Count
Married	100.0%	11
Non-Married	0.0%	0
	answered question	11
	skipped question	0

Q17. 17. How many total dependents under age 18 did you have while in Spokane?

Answer Options	Response Percent	Response Count
Number of Dependents:	100.0%	11
	answered question	11
	skipped question	0

Q18. 18. How would you rate living in Spokane?

Answer Options	Good	Average	Poor	Response Count
Social opportunities	6	2	3	9
Business opportunities	4	4	3	9
Cultural opportunities	4	3	3	8
Spousal opportunities	3	5	2	8
Children educational opportunities	5	3	0	7
Comments				0
			answered question	11
			skipped question	0

Q19. 19. Rank the reasons for leaving Spokane:

Answer Options	Most important	2	3	4	Least important	Response Count
Family	4	0	0	1	3	8
Compensation	0	4	3	0	1	8
Reimbursement by insurers	1	3	1	0	2	7
Malpractice premiums	1	1	2	0	4	8
Workload	2	0	4	0	2	8
Business operation	1	1	2	2	2	8
Other	2	0	0	0	0	2
Comments						3
					answered question	9
					skipped question	2

Q20. 20. Based on recruitment promises that brought you to Spokane, were expectations met?

Answer Options	Response Percent	Response Count
Yes	70.0%	7
No	30.0%	3
Comments		2
	answered question	10
	skipped question	1

Q21. 21. What do you have now that you didn't have in Spokane?

Answer Options	Response Count
answered question	11
skipped question	0

Q22. 22. What are your suggestions on how to improve primary care practice in Spokane?

Answer Options	Response Count
answered question	6
skipped question	5

Q23. 23. Other comments regarding Spokane practice:

Answer Options	Response Count
answered question	3
skipped question	7

Q24. 24. All in all, was your decision to leave Spokane a good one?

Answer Options	Response Percent	Response Count
Yes	88.9%	8
No	11.1%	1
Comments		2
	answered question	9
	skipped question	2

Q25. 25. What one thing would have kept you in Spokane?

Answer Options	Response Count
answered question	11
skipped question	0

Appendix II; Cross Tabs for Current Physician Practices

Q4. Total Primary Care Physician Distribution

Total Number of PCP's	Number	Average	S.D
0	4	0.00	
1	18	1.00	0.00
2-4	9	3.11	0.78
5-9	9	6.89	1.62
10+	6	40.00	19.73
Grand Total	46	7.57	14.51

N=348

Q4. FULL TIME Primary Care Physician Distribution

Total Number of PCP's	Number	Average	S.D
0	4	0.00	
1	18	0.89	0.32
2-4	9	2.56	1.42
5-9	9	6.11	2.20
10+	6	31.00	15.87
Grand Total	46	6.09	11.34

N=280

Q4. PART TIME Primary Care Physician Distribution

Total Number of PCP's	Number	Average	S.D
0	4	0.00	0.00
1	18	0.11	0.32
2-4	9	0.56	1.01
5-9	9	0.78	0.83
10+	6	9.00	8.76
Grand Total	46	1.48	4.20

N=68

Q6. Physician Assistant Distribution

Total Number of PCP's	Number	Average	S.D
0	4	1.00	2.00
1	18	0.22	0.43
2-4	9	0.78	1.20
5-9	9	0.44	0.53
10+	6	9.17	8.13
Grand Total	46	1.61	4.10

N=74

Q7. Are you anticipating any departures of your pc physicians this year? No IEHSA

Total Number of PCP's	%Yes	No	Yes	Grand Total
0	25.0%	3	1	4
1	0.0%	18		18
2-4	11.1%	8	1	9
5-9	11.1%	8	1	9
10+	40.0%	3	2	5
Grand Total	11.1%	40	5	45

Q8. Do you have any pre-planned retirements of primary care physicians in the next three years? No IEHSA

Total Number of PCP's	%Yes	No	Yes	Grand Total
0	0.0%	4		4
1	16.7%	15	3	18
2-4	0.0%	9		9
5-9	55.6%	4	5	9
10+	40.0%	3	2	5
Grand Total	22.2%	35	10	45

Q9. Do you have any pre-planned retirements of physicians' extenders in the next three years?

Total Number of PE's	%Yes	No	Yes	No Response	Grand Total
0	0.0%	27	0	1	28
1	0.0%	5	0	0	5
2-4	11.1%	7	1	1	9
5+	50.0%	2	2	0	4
Grand Total	6.5%	41	3	2	46

Q13. Are you anticipating any departures for your physician assistants this year?

Total Number of PA's	%Yes	No	Yes	No Response	Grand Total
0	3.6%	26	1	1	28
1	0.0%	4		1	5
2-4	0.0%	9			9
5+	50.0%	2	2		4
Grand Total	6.5%	41	3	2	46

Q14. Do you have any pre-planned retirements of physician's assistants in the next three years?

Total Number of PA's	%Yes	No	Yes	No Response	Grand Total
0	0.0%	26		2	28
1	0.0%	5			5
2-4	11.1%	7	1	1	9
5+	50.0%	2	2		4
Grand Total	6.5%	40	3	3	46

Q18. Do you feel you have enough primary care physicians and assistants to meet the demands of your practice/clinic? No IESHA

Total Number of PCP's	%Yes	No	Yes	No Response	Grand Total
0	50.0%	2	2		4
1	72.2%	4	13	1	18
2-4	66.7%	3	6		9
5-9	33.3%	5	3	1	9
10+	20.0%	4	1		5
Grand Total	55.6%	18	25	2	45

Q19. What percentage of your practice is Medicare?

Total Group	Average
0	10.0%
1	25.8%
2-4	20.1%
5-9	23.3%
10+	29.8%
Grand Total	22.8%

Q20. How many of your primary care physicians are currently accepting new Medicare Patients?

Total Number of PCP's	Total Doctors Surveyed	Total Docs Yes	Percentage	Average	S.D.
a 0	0	0		0.0	0.0
b 1	18	4	22.2%	0.2	0.4
c 2-4	21	10	47.6%	1.4	2.3
d 5-9	46	18	39.1%	2.6	3.4
e 10+	180	52	28.9%	10.4	13.2
Grand Total	265	84	31.7%	2.1	5.6

Q21. How many of your primary care physicians will be accepting new Medicare Patients in 2009?

Total Number of PCP's	Total Doctors Surveyed	Total Docs Yes	Percentage	Average	S.D.
a 0					
b 1	15	5	33.3%	0.3	0.5
c 2-4	21	10	47.6%	1.4	2.3
d 5-9	41	19	46.3%	3.8	3.8
e 10+	129	53	41.1%	13.3	13.5
Grand Total	206	87	42.2%	2.8	6.3

Q22. How many of your primary care physicians will be accepting new Medicaid Patients in five years?

Total Number of PCP's	Total Doctors Surveyed	Total Docs Yes	Percentage	Average	S.D.
a 0	0	0		0.0	
b 1	17	3	17.6%	0.2	0.4
c 2-4	17	3	17.6%	0.5	1.2
d 5-9	29	10	34.5%	2.5	4.4
e 10+	79	5	6.3%	2.5	3.5
Grand Total	142	21	14.8%	0.7	1.9

Q23. What percentage of your practice is Medicaid?

Total Group	Total
0	43.6%
1	18.8%
2-4	19.8%
5-9	20.3%
10+	15.6%
Grand Total	21.8%

Q24. How many of your primary care physicians are currently accepting new Medicaid patients?

Total Number of PCP's	Total Doctors Surveyed	Total Docs Yes	Percentage	Average	S.D.
a 0	0	0		0.0	
b 1	18	6	33.3%	0.3	0.5
c 2-4	19	8	42.1%	1.3	2.2
d 5-9	55	12	21.8%	1.5	2.8
e 10+	180	46	25.6%	9.2	12.5
Grand Total	272	72	26.5%	1.9	5.3

Q25. How many of your primary care physicians will be accepting new Medicaid patients in 2009?

Total Number of PCP's	Total Doctors Surveyed	Total Docs Yes	Percentage	Average	S.D.
a 0	0	0		0.0	
b 1	18	9	50.0%	0.5	0.5
c 2-4	21	10	47.6%	1.4	2.0
d 5-9	41	13	31.7%	2.6	3.2
e 10+	129	48	37.2%	12.0	12.8
Grand Total	209	80	38.3%	2.4	5.5

Q26. How many of your primary care physicians will be accepting new Medicaid patients in five years?

Total Number of PCP's	Total Doctors Surveyed	Total Docs Yes	Percentage	Average	S.D.
a 0					
b 1	15	9	60.0%	0.6	0.5
c 2-4	17	5	29.4%	0.8	1.3
d 5-9	40	7	17.5%	2.3	4.0
e 10+	129	48	37.2%	12.0	12.8
Grand Total	201	69	34.3%	2.5	6.0

Q29. Do you feel your starting salaries are competitive? No IESHA

Total Number of PCP's	%Yes	No	Yes	No Response	Grand Total
0	75.0%	1	3		4
1	55.6%	5	10	3	18
2-4	66.7%		6	3	9
5-9	77.8%	1	7	1	9
10+	100.0%		5		5
Grand Total	68.9%	7	31	7	45

Q32. Are you anticipating hiring any primary care physicians in 2009? No IESHA

Total Number of PCP's	%Yes	No	Yes	No Response	Grand Total
0	25.0%	3	1		4
1	16.7%	14	3	1	18
2-4	33.3%	6	3		9
5-9	66.7%	3	6		9
10+	80.0%	1	4		5
Grand Total	37.8%	27	17	1	45

Q33. Are you anticipating hiring any physician assistants in 2009?

Total Number of PCP's	%Yes	No	Yes	No Response	Grand Total
0	0.0%	4			4
1	11.1%	15	2	1	18
2-4	22.2%	7	2		9
5-9	22.2%	7	2		9
10+	50.0%	3	3		6
Grand Total	19.6%	36	9	1	46

Appendix III

Average Annual PCP Income in Pacific Northwest MSAs

Table x shows average annual incomes received by family and general practitioners at various Pacific Northwest locations. The data, compiled from the Occupational Employment Statistics Survey conducted by the Bureau of Labor Statistics, covers only physicians who are “employees,” part-time or full-time workers who are paid a wage or salary. It does not cover those who are self-employed or owners and partners in unincorporated

firms. Missing data reflects the coverage of the survey. The table also includes an index of average income with Spokane = 100. As can be seen, while average Spokane GP incomes are greater than those in Yakima or Medford, they are 10 to 20 percent less than those in locations most comparable to Spokane such as Bellingham, Eugene or Boise. Overall Spokane average incomes lag behind Pacific Northwest GP incomes by more than 10 percent.

Area	2006	2007	Index	
			2006	2007
Tacoma, WA	144,750	172,210	117	133
Salem, OR	156,740	167,850	127	129
Bellingham, WA	171,800	164,710	139	127
Portland-Vancouver-Beaverton, OR-WA	159,330	155,180	129	120
Eugene-Springfield, OR	136,160	150,820	111	116
Seattle-Bellevue-Everett, WA	140,050	146,480	114	113
Boise City-Nampa, ID		143,020		110
Olympia, WA	138,080	142,990	112	110
Kennewick-Richland-Pasco, WA	114,640	140,920	93	109
Wenatchee, WA	135,110	137,970	110	106
Mount Vernon-Anacortes, WA		133,540		103
Spokane, WA	123,200	129,710	100	100
Yakima, WA	107,330	120,820	87	93
Medford, OR		106,560	0	82
Average	138,835	143,770	113	111

Occupational Employment Statistics Survey, BLS <http://www.bls.gov/oes/>

The **Occupational Employment Statistics (OES)** program produces employment and wage estimates for over 800 occupations.

These are estimates of the number of people employed in certain occupations, and estimates of the wages paid to them. Self-employed persons are not included in the estimates. These estimates are available for the nation as a whole, for individual States, and for metropolitan areas; national occupational estimates for specific industries are also available.

Employee definition: "Employees" are all part-time and full-time workers who are paid a wage or salary. The survey does not cover the self-employed, owners and partners in unincorporated firms, household workers, or unpaid family workers.