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## What Would You Do?

# how should the medical staff and hospital be aligned in a post-reform market?

*Community Medical Center (CMC) believes its existing voluntary medical staff model and loose relationship with physicians will be insufficient to carry it forward in a much more competitive, post-reform market. How should its physician relationships change, and how can medical staff members be persuaded to support such change?*

### The Situation

CMC is located in a small city in the South. It serves a population base of about 100,000 that is equally divided between the city and the surrounding largely rural area. A smaller, for-profit hospital operates in the southern end of its service area, and larger medical centers serve somewhat more populous cities to the north and south.

CMC is a fairly traditional hospital organization, including a 200-bed general acute care hospital with a full range of secondary care and tertiary services in cardiovascular disease and cancer. The medical center has about a 50 percent share of the inpatient market in its total service area. It has a broad range of outpatient services, including a few freestanding ambulatory care centers strategically placed throughout its service area. It lacks most other continuum of care services, and many providers of such services are located throughout CMC's service area.

CMC has an active medical staff of about 125 physicians who are largely dedicated to CMC. The staff has about 35 family and general internal medicine physicians, 10 pediatricians, 12 obstetricians/gynecologists, and a full range of specialists and subspecialists except for neurosurgery. Modest overlaps of some specialists with the for-profit hospital's medical staff exist. A few subspecialists

practice part-time in the community under an arrangement with an academic medical center 100 miles to the north.

The physician community is also quite traditional in its practice structures. The largest group practice consists of 10 primary care physicians. About half of the specialists are organized into single-specialty groups of two to three. There are two groups of five each, and the remainder are in solo practice. Physicians have been very entrepreneurial, however, as evidenced by the proliferation of office-based imaging, single-specialty and office-based surgicenters, and a surprising amount of other ancillary activity.

Both the hospital and medical staff have flourished historically. Physician incomes have been high, and hospital operating margins consistently have exceeded the state average. But beginning with the economic downturn in 2008 and continuing today, physician incomes have flattened or declined and the hospital's margins have eroded. The growth of the uninsured population, postponement of elective procedures and care by the insured, and reimbursement pressures have all contributed to the decline.

Physician retirements have also been an ongoing concern of CMC for the past 10 years. The size of the medical staff decreased from 140 to 125 in that period. With only two exceptions, specialty practices have not replaced retiring specialists; the practices claim that they have been unable to recruit new physicians, even with hospital start-up support. To address this challenge, the hospital established a small group of hospital-employed physicians three years ago and has been able to

recruit six primary care physicians, two obstetricians/gynecologists, and two general surgeons to this new group. This development has been highly controversial among members of the voluntary medical community.

At a recent CMC strategic board retreat, the viability of the hospital and medical community consumed the entire agenda. Some board members pressed for CMC to step up its recruitment into the employed medical group, while others, chastened by the debacle of hospital employment of physicians in the 1990s, were dead-set against this strategy. Three of four physician board members strongly advocated stepped-up hospital support of private practice recruitment; the other physician board member said that the physicians were ignoring reality and needed to form a multispecialty group, with or without the hospital's support. All agreed that something more needed to be done soon, especially with the prospect of implementation of healthcare reform looming. An ad hoc board task force was appointed to brainstorm solutions and make a recommendation to the board on how to proceed within 90 days.

### Alternatives Considered

A subgroup of members of the task force were asked to review the activities of other similar hospitals and communities and present findings to the entire task force in 30 days. The subgroup's research turned up a diversity of strategies being employed by other hospitals:

- > About 25 percent were not intervening in any material way with private medical practices.
- > About 25 percent were actively growing hospital employment of physicians and had 50 to 75 percent of total active staff employed.
- > About 10 percent had large private medical groups that were increasingly "gobbling up" small and solo practices.
- > The rest had a mixed model—growing hospital employment, mergers of private groups, and a shrinking base of solos and small groups.

Lacking evidence that CMC's peers were benefiting from a dominant and clearly successful

strategy, the task force was left to consider which of the above approaches to take in the near future. Not intervening was easily and quickly rejected as a head-in-the-sand strategy. Large private medical groups acquiring the small and solo practices was also rejected as an option given the current medical community. So the task force was left, essentially, with two alternatives: actively grow the hospital medical group or support and encourage the medical staff to coalesce under a private practice model, with close alignment to CMC. What should the task force recommend as the desired approach to the full board?

### The Decision

*The discussions of the task force were extended and wide-ranging. Ultimately, four of the six members concluded that a privately sponsored, multispecialty group would be most consistent with the culture of CMC and its medical staff, and that despite being difficult to achieve and not entirely within the hospital's control, it would also be the most desirable solution.*

*However, as a hedge, and to some degree a catalyst, to private efforts, the task force also recommended rapid growth of the hospital employed group, at least for the near term. The task force believed that expanding the hospital-employed group not only would be necessary to reverse the decline in the size of the medical community, but also would be the only way to foster growth in the short term. Assuming a hospital-supported effort to create a private, multispecialty group would be successful, the task force further recommended that the board consider merging the hospital group into it in the future, thereby creating a hybrid private-hospital multispecialty practice model.*

*Finally, the task force recommended formation of a new special task force between CMC and the medical staff to explore whether to form a multispecialty group and, if so, how to proceed. The task force also recommended that CMC underwrite the vast majority, but not all of the expenses for outside advisers, noting that physicians should have at least some skin in the game. ●*

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