

October 10, 2003

Demonstrating Community Need For Physicians

By Jennifer Moody*

The recent indictment of Tenet hospital executives in San Diego for alleged violations of federal physician recruiting laws has raised an important question: how can hospitals demonstrate that they have a need for additional doctors?

Answering this question is central to any effort to comply with Internal Revenue Service (IRS), Department of Health and Human Services (DHHS), and Stark related physician recruiting regulations. The IRS requires that any recruiting incentives offered to physicians by not-for-profit hospitals be counter balanced by a benefit to the community; specifically, by the provision of necessary physician services. DHHS indicates that recruiting incentives can be offered only to physicians providing a new or needed service to an area, and Stark reflects this same requirement.

It therefore is important that hospitals have an objective methodology for demonstrating the need for additional physicians. What constitutes such a methodology?

The IRS offered an indication in Physician Recruitment Guidelines released in October, 1994 as an attachment to a closing agreement entered into with Hermann Hospital, a tax-exempt facility located in Houston, Texas. The Guidelines indicate that a physician will not be a "permissible recruit" unless there is a demonstrable community need for the physician, as evidenced by:

- (1) A physician to population ratio as suggested by the Graduate Medical Education National Advisory Committee (GMENAC) that is deficient in the specialty being recruited.
- (2) Demand for a particular medical service in the community coupled with a documented lack of availability of the service or long waiting periods for the service, if the physician is being recruited to increase availability of that service.
- (3) Federal designation of the community at the time of the recruitment agreement as a Health Professional Shortage Area (HPSA).
- (4) A reasonably expected reduction in the number of physicians of that specialty serving the hospital's service area due to the anticipated retirement within the next three year period of physicians presently in the community.

(5) A documented lack of physicians serving indigent or Medicaid patients within the hospital's service area, provided that newly recruited physicians commit to serving a substantial number of Medicaid and charity care patients.

The Hermann Hospital Agreement has since been superseded by Revenue Ruling 21-97 released April 21, 1997, but the methods for determining community need as listed in the Guidelines remain valid, if incomplete.

ELEMENTS OF A COMMUNITY NEEDS ASSESSMENT PLAN

In order to confirm community need for physicians, the elements above and other factors should be explicated in a formal Community Needs Assessment Plan or Medical Staff Plan. Such a document verifies the need for additional physician services, and serves as part of a hospital's efforts to comply with federal physician recruiting regulations. It can be used in case of a government audit to demonstrate the rationale for physician recruiting. It also can be used as an effective recruiting tool because it objectively demonstrates to physician recruits that a need for their services exists.

Physician-to-populations ratios

Physician-to-population ratios are but one of a variety of elements in a comprehensive physician needs assessment plan. The most well known of these ratios are the GMENAC ratios alluded to above. Some ratios, such as GMENAC's, are "needs-based" and reflect the projected need for medical services in the population based on the researchers' theoretical models of per capita healthcare consumption. Others are "visits-based," such as the ratios compiled by Hicks & Glenn, researchers at the University of Missouri. Visit-based ratios look at federal government statistics indicating how many annual visits to a particular type of physician a population of 100,000 typically generates. They then divide into this the number of annual patient visits that a physician in that specialty typically sees, as tracked by the Medical Group Management Association. For example, if 100,000 people typically generate 75,000 visits to a family physician each year, and each family physician sees 2,500 patients annually, then the "right" number of family physicians is 30 per 100,000 people. The ratios vary widely in their conclusions. Four separate ratios put the need for psychiatrists per 100,000 population variously at 15.9, 7.2, 3.9, and 7.70. Each of these ratios has its adherents and detractors. GMENAC met only once and promulgated its ratios twenty-three years ago. Though its numbers are over two decades old, they are still commonly referenced in medical staff plans. The fact that GMENAC ratios pre-date the proliferation of managed care and that the population has aged considerably since 1980 only partly explains why these and other ratios are problematic. The real reason they are not definitive is that they suggest standardization is achievable in the patchwork of healthcare markets that make up a vast heterogeneous whole

For example: Can the same ratio of cardiologists-per-population really apply in young, largely immigrant South Texas and in largely geriatric sections of South Florida? Clearly, these disparate populations are as likely to utilize medical

services at the same rate as they are likely to purchase pizza, hair coloring, or shoe polish in the same quantities.

Physician-to-population ratios, then, are only a signpost or general indicator of physician need, rather than a definitive benchmark. A reliable projection of community need for physicians requires a thorough analysis of local conditions, including the following.

Physician counts

Exactly how many physicians are practicing in the service area already—not just on the recruiting hospital's staff, but in total? No projection of current and future physician need can be accurate without this core data. Deriving an accurate physician count can be difficult, however. Some physicians may split time in two different service areas, and so cannot be considered full-time-equivalents (FTEs) in either area. Family physicians or internal medicine practitioners may be providing OB or cardiology services, and therefore are neither FTEs in primary care nor in a particular specialty. Residents may also contribute services without being considered FTEs.

The only way to conduct an accurate physician count in some medical markets is to profile each physician's practice, usually through telephone canvassing of the physicians or their office administrators. Only by doing so can you obtain a more or less definitive view of how many true FTEs are in the area. Short of this, a scrupulous attempt must be made to count physicians by examining the hospital's staff roster, the local phone books, and AMA listings of physicians in the area. Keep in mind that just because a local physician is not on the recruiting hospital's staff does not mean he or she is not providing services to the community. What is being measured in a community needs assessment plan is the needs of the community, not necessarily of the hospital.

Physician demographics

How old are established physicians and when are they likely to retire? How many residents are on the staff? How many female physicians? The latter is an important consideration as female physicians on average work 18% fewer hours a week than male physicians, according to the AMA. A comprehensive community needs assessment plan will include a breakdown of local physician demographics.

Demand for services

Local physicians usually have the best insight into local demand for medical services. Physicians know if there are long wait times to schedule their patients with specialists. They also know which specialty services their patients need that currently are not available in the community. A survey of established physicians can reveal how busy they are relative to national averages, whether their practices are open to certain populations such as Medicare patients, and what recruitment needs they see in the community. In my experience, physicians often are conservative in their assessment of how many new physicians are needed in their communities. If more than 25% of physicians surveyed indicate that a particular specialist is needed then it often can be inferred that such a need exists. A physician survey also allows physicians to participate in the medical

staffing process, building a consensus that can be essential during physician recruiting.

Patient demographics

Is the local population growing? What segments are growing the fastest (Medicare patients utilize some medical services at three times the rate of younger populations, so patient aging is a key factor). Which are the geographic areas of fastest growth? What level of insurance and access to healthcare services does the population have? Is language a barrier to care? These and other questions pertaining to patient demographics must be answered to accurately gauge physician need.

Disease incidence

Healthcare challenges differ from region to region. Cardiovascular disease is rampant in some areas of the Midwest, while skin cancer rates often are high in sunny, coastal areas. Hospital admissions data and other statistics can reveal how local disease incidence varies from national averages and may provide a rationale for recruiting physicians who can address local healthcare needs.

HPSA designations

A federal designation as a Health Professional Shortage Area (HPSA) offers a strong indication that there is a need for additional physicians in a community. However, HPSA designations only indicate a shortage of primary care physicians and psychiatrists. A HPSA designation will not necessarily support the need for a surgical or diagnostic specialist, which must be supported by additional data. From this combined data, a portrait will emerge of the local service area, showing the number, age, and practice patterns of established physicians, current patient demographic trends, disease incidence and areas of immediate and long term physician need. Physician-to-population ratios can add depth or perspective to this picture.

The final document should be updated annually to ensure accurate physician counts and related information. While useful in the event of an audit of physician recruiting practices, a comprehensive physician needs assessment plan also can be a working tool offering strategic direction and marketing data for hospital administration.

* Jennifer Moody is Vice President of AmeriMed Consulting, a healthcare consulting firm based in Irving, Texas. She can be reached at jmoody@amerimedconsulting.com