The Value and the Future of the Clinton Memorial Family Medicine Residency

Presentation to CMH Board of Trustees

September 19, 2013

Dr. Phil Diller – Chairman, Department of Family and Community Medicine, University of Cincinnati College of Medicine

Dr. Ed Onusko – Program Director, Clinton Memorial Hospital/University of Cincinnati Family Medicine Residency Program

PRESENTATION OUTLINE:

1. Foundations: *Why a Family Medicine training program at CMH?*
2. What contributions has it made to the community?
3. Two Scenarios:
   A. Future state: *Without the program, effects of program closure*
   B. Future state: *With the program, strengthening the partnership*

What Got Us Here? Recent Financials

	YTD 12/31/11	YTD 12/31/12	YTD 12/31/13 (PROJECTED; 6 mo)
Total Clinical Service Operating Revenue	$1,841,256	$1,419,775	$1,619,648
GME Revenue	$1,862,404	$1,807,503	$1,807,503
TOTAL REVENUE	**$3,703,660**	**$3,227,278**	**$3,427,151**
Total Program Operating Expense	$3,435,151	$3,484,131	$3,752,194
Depreciation/Rent	$73,777	$73,777	$74,388
TOTAL EXPENSE	**$3,508,928**	**$3,557,908**	**$3,826,582**
PROFIT(LOSS)	**$194,731**	**($330,630)**	**($399,432)**
CMH Revenues*	**$179,695,537**		

Sources: Hospital Administration and *American Hospital Directory July 2013

Value Equation: What to consider

$$\text{Value} = \frac{(\text{Quality})\ (\text{Contribution})}{\text{Cost}}$$

- Cost: program revenue & expenses
- Quality of activity: program performance
- Contribution: in terms of financial & social capital

All three terms must be considered & managed to maximize value

Why the Training Program at CMH?

1. Meets a fundamental need for the state of Ohio
2. To improve patient access to primary care in Clinton County & Surrounding communities
3. Financial Contribution to CMH: cost-savings and downstream revenue.
4. To promote a culture of physician education for CMH & develop potential medical staff leaders.
5. Pipeline for Future CMH Primary Care Medical staff.

Why the Training Program at CMH?

1. **Meets a fundamental need for the state of Ohio:**

   (Ohio Revised Code 3333.11, 1974).

   a. The UC Department of Family and Community Medicine's purpose is "*to acquaint undergraduates with and to train postgraduate physicians for the practice of family medicine.*"

   b. "*Develop residency and other training programs* for family practice in public and private hospitals, including those in nonmetropolitan areas of the state."

Ongoing need to provide Family Physicians to rural Ohio.

CMH/UC partnership is the only such partnership (rural – academic) in Ohio

Why the State thinks this is good Idea? *Benefits of Primary Care to a Community*

1. Increases **access** to health services for relatively deprived population groups
2. Offers high **quality, coordinated clinical care**
3. Promotes **prevention**
4. Institutes **early management of health problems**
5. **More appropriate care** and **reduces unnecessary or inappropriate specialty care.**
6. Care at **lower costs.**

Starfield B, Shi L, and J Macinko. Contribution of Primary Care to Health Systems and Health. **Milbank Qtrly** 2005;83(3):457-502.

Improve Primary Care Access: Office and Hospital Based

Program Clinical Sites of Service	**Family Health Center** **FY 13 18,065 visits**	**Inpatient Adult Medicine** **FY 13 ~660 admissions**	**Inpatient Maternity Care** **FY 13 189 deliveries** 170 deliveries/yr 25%
	Community Sites—Staffed by Residents and Faculty -Family Planning /STDs in Wilmington, WCH, Hillsboro & Xenia -Clinton County Free Clinic -Nursing Homes: Sabina and Wilmington		

Why the Training Program at CMH?

2. To improve patient access to primary care in Clinton County & Surrounding Communities

a. Residency physicians function as key providers of the **Safety Net for vulnerable patients/uninsured patients**

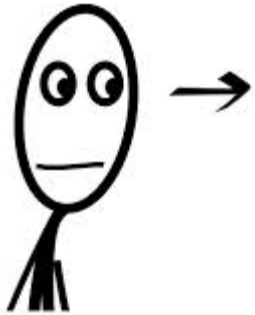
   i. Avoid CMH Emergency Department for primary care.

      Save costs to the system

   ii. De-compress care coverage by CMH medical staff in the community and the hospital.

Why the Training Program at CMH?

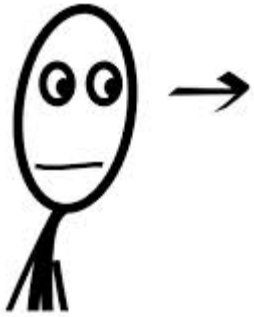
3. **Financial Contribution to CMH: Downstream $$ Impact**



Residency Program
Direct Program
Cost: Profit/Loss
Revenues -- Expenses

Primary Care Patient $$ Revenue Through Hospital

AND



Inpatient admissions

Ancillary Tests & Procedures

Referrals
Specialists
Therapists

Specialists
Admissions

Why the Training Program at CMH?

3. **Financial Contribution to CMH: Downstream $$ Impact**

Contribution Margin: Net revenues less direct costs generated from patients that originate from a specific primary care office in a set period of time.

	Source of Margin	*+ Contrib Margin/PCP FTE*
	PCP Inpatient admissions	*$230,000*
	Outpatient tests & Procedures	*$236,667*
PCP sends patient to specialist	*Specialist OP tests & procedures*	*$436,667*
PCP sends patient to specialist	*Specialist Inpatient admissions*	*$996,667*

Fahey P et al. Analysis of Downstream Revenue to an Academic Medical Center from a Primary Care Network. **Acad Med**. 2006;81:702-707

Survey of 5000 hospital CFO's ask to supply the combined net inpatient and outpatient revenue generated annually by a single, full-time equivalent (FTE) in a variety of specialties through various procedures, tests and treatments; *Primary care physicians asked to determine the revenue from direct admissions, procedures performed and lab tests; does not include referrals to specialists*

Physician Generated Revenue vs. Average Salaries

Specialty	% Salary	Average Revenue	Average Salary
Neurosurgery	20	2,815,650	571,000
Invasive Cardiology	21	2,240,366	475,000
Orthopedic Surgery	23	2,117,764	481,000
General Surgery	15	2,112,492	321,000
Internal Medicine	11	1,678,341	186,000
Family Practice	11	1,622,832	173,000
Hematology/Oncology	22	1,485,627	335,000
Gastroenterology	27	1,450,540	393,000
Urology	29	1,382,704	401,000
OB/GYN	19	1,364,131	266,000
Noninvasive Cardiology	32	1,319,658	419,000

Hospital-Employed Physician Networks: Are Primary Care Physicians Undervalued?
Michael A. Patmas, PEJ November•december/2010:12-14

Why the Training Program at CMH?

3. **Financial Contribution to CMH: *Cost-savings*.**
   a. *Care providers—resident salaries are covered by GME payments*
   b. *Avoids/Reduces Emergency Room use for primary care needs.*
   c. *Economical Hospitalist service for adult patients and with favorable lengths of stay for inpatients*
   d. *Reduced Medical Staff recruitment costs: $50-100K per recruit*

Why the Training Program at CMH?

4. To contribute to CMH's culture of physician education: *Social Capital*

a. Add to CMH medical staff, a group of university faculty of clinician-educators; active hospital leaders

Dr. Bain – current Chief of Staff – multiple terms as Director of Department of Medicine; multiple other CMH committees.

Dr. Leeds – current Director of the Department of Medicine. A great asset in the CMH efforts to adopt an inpatient EMR

Dr. Onusko – former Director of the Department of Medicine. CMH Quality Outcomes Committee member.

Dr. Gick – member of the Medical Staff Quality Improvement Committee (MSQIC).

Dr. Sneed – member of the Patient Safety Committee; Medical Director of CMH Home Health Agency

Why the Training Program at CMH?

4. To introduce a culture of physician education into CMH. *Medical Staff Impact*

a. Introduce teaching opportunities for the CMH medical staff; increase satisfaction & stimulation
   i. 30+ CMH Medical Staff Voluntarily teach
   ii. Support for Drs. John Merling and Tina Gabbard to continue to do Obstetrics in their Family Medicine practice

Why the Training Program at CMH?

4. To introduce a culture of physician education into CMH. *Quality Impact*

a. Quality of the care discussions at CMH become part of the culture.

   i. *"What is the best way to manage this?"*

   ii. *"What new evidence is available?"*

   iii. *Program mean LOS inpatients 2.34 compared to hospital mean LOS inpatients 2.67 (FY13)*

Shorter Lengths of Stay translates into increased hospital margin

Why the Training Program at CMH?

5. Future CMH Medical staff: create a pipeline of future high-quality CMH primary care medical staff members committed to the community.

a. 59 Graduates of the program:

b. Current CMH residency grads practicing in the CMH service area include (12): Drs. Swick, Rogers, Sneed, Wetherington, Ravikumar, Lasala, Bach, Bayomi, Llanes, Bankston, LaCroix and soon Cacas

c. Prior graduates who have practiced in the CMH service area included (6): Drs. Liu, Holderman, Allgeyer, Omoruyi, Murthy and Chaparro.

d. Many others currently practice in the Dayton area and elsewhere in Ohio.

Two Future Scenarios

- ***Without the Program***
- ***With the Program***

Future state: *Without a Program*

I have been down that road when Mercy Mt. Airy Hospital stopped GME activity in 2002. The results are predictable.

1. Save Expenses. In the short-term maybe? But:
2. *Need to replace the faculty and residency providers with new physicians to staff the FHC.*
   a. Recruit new primary care physicians at premium
   Mt. Airy practice with 28,000 visits—re-staffed, but two years later practice closed. Loss of patients, too costly to run, MDs unhappy and left.
3. *Patients in the FHC make choices where to seek care.*
   Mt. Airy– some stayed with new practice, others used the ED for primary care, and many left. Patient loyalty to physicians is very strong.

Future state: *Without a Program*

4. Safety net for vulnerable population in Clinton County becomes strained
   -patients seek out other community providers or delay care
   -Even if covered under ObamaCare, increased demand

5. Will need to staff up for inpatient hospitalists service; Loss of 24/7, OB and pediatrics coverage.
   -Mt. Airy--Added expense of hospitalist service compared to resident-staffing model with faculty supervision.
   -Mt. Airy--arranging care-coordination post discharge more complex. Who will see the unattached patients with loss of FHC to see patients in follow-up?
   -Look for: LOS lengthens?? Reduced profitability??

Future state: *Without a Program*

6. Loss of faculty physicians to CMH, including the key medical staff leadership roles they play

   -Mt. Airy—after program closure all faculty left the hospital and none have returned in 10+ years.

   -Significant change in reputation and culture of hospital over time noticed by patients and staff.

   -Loss of potential future leaders for medical staff

7. Loss of GME revenue ($1.8M) and likely loss of resident training positions through redistribution if unused. Very difficult to restart.

   Mt. Airy—we were asked to return 3 years later; positions never used again at that hospital.

Future state: *Without a Program*

8. Loss of physician workforce pipeline for CMH

   Mt. Airy--Placed 20 physicians in Mt. Airy associated groups in first 10 years, followed by 1 after closure over the next 11 years.

   -Recruiting costs for new PCPs—average $50-100K per recruit vs Residents who train at CMH more likely to stay with minimal recruiting costs. Mercy has paid a premium to build its primary care network.

9. Loss of downstream revenue very likely due to reduced size of a primary care practice.

   Mt. Airy—struggled financially for the next decade and will close in 2013 in a merger with another West-side hospital

Future state: *With the Residency Program*

1. Is there cultural alignment of the program with CMH?

Yes, CMH's mission, vision and values statements express what the residency program provides to the CMH service area:

Our Mission

- To improve lives through compassionate, quality healthcare

Our Vision

- To become the best community hospital in America

Our Values

- Safety, Trust, Respect, Integrity, Voice, Excellence, Service

Future state: *With the Residency Program*

2. What needs to be done to make the partnership mutually successful and improve?

a. **Transparent Reports.** Regular accurate, financial reporting that enables the different program areas to be effectively managed.

b. **Oversight.** Empower program leadership working with CMH to ensure to manage to the mission and vision.

c. **Clear Goals.** Define clear, mutually agreed upon program goals & financial targets.

d. **Accountability.** Review program progress in meeting goals/targets. Make sure the program is adding value to CMH.

Future state: *With the Residency Program*

3. Recognize that Primary Care will be even more valuable to the hospital in the future.

a. Increasing demand for primary care providers.

-Demographic shifts with aging population, growth in population; aging MD workforce; difference in work-ethic in younger physicians

-Obamacare will increase patients needing a primary care physician.

b. Shortage of 200-250 primary care physicians in 9 county area in Greater Cincinnati – Greater Cincinnati Health Foundation study July 2013.

Heightened Competition for Primary Care Physicians

Future state: *With the Residency Program*

Addressing Program Finances

4. The income of the residency program should increase significantly in the coming year.

a. Designation of the Family Health Center as a Rural Health Clinic by Medicare/Medicaid is estimated by CMH's consultant to immediately increase the residency's annual income by about $125 K.

b. Increased primary care payment for Medicaid patients by State of Ohio. (to Medicare rates).

Future state – *With the Residency Program*

Addressing Program Finances

d. **Grow FHC patient volume.** More patient's expected to be seen in FHC. ObamaCare will mandate an increase in the number of insured patients starting in 2014. Pressure to comply will be put on both employers and individuals.

c. **Improve Collections FHC/Inpatient.** Improved revenue cycle performance. Identify opportunities.

e.g., rise in technical fees without a commensurate rise in professional fees?

e. Higher GME Payments? Could rise at CMH with successful recruitment of key medical staff; as hospital volumes grow on all hospital business and Medicare bed days increase; this translates into higher GME$$ based on current IME rules.

Future state: *With the Residency Program*
Emerging Opportunity for Workforce

Number of US medical school graduates has increased without increasing the number of residency positions.

More high quality US graduates are available for residency programs competing with high quality foreign medical graduates

Other health systems (*Grow Your Own PCP group*):

- Adena Health System in Chillicothe has an inaugural class of 11 osteopathic residents in July 2013
- UC-West Chester Medical Center (planning).

Two scenarios: *Two very different outcomes*

Program Closure: with predictable outcomes

1. Reduced access for vulnerable populations in the community
2. Replacement costs
3. Reconstituting Physician Services & increased demand throughout service area
4. Recruitment of Primary Care MDs in highly competitive times
5. Loss of Program Social Capital & Culture Impact
6. Loss of Primary Care pipeline for CMH & Ohio—4 less per year.

Keep the Program: Work on Improved Collaboration

1. Mutual goals/targets
2. Improving Financials
3. Strong Primary Care Base that can reproduce itself
4. Education Culture
5. Future Medical Staff Leaders

QUESTIONS?

$$\text{Value} = \frac{(\text{Quality})\ (\text{Contribution})}{\text{Cost}}$$

Reference (handout): Journal of Graduate Medical Education, June 2010.
The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their Sponsoring Institutions and Communities