Report of the Organized Medical Staff Section

Subject: Medical Staff and Hospital Engagement of Community Physicians
(Resolution 5-I-12)

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Referred to: OMSS Reference Committee
(John Flores, MD, Chair)

Introduction

At its 2012 Interim Meeting, the Organized Medical Staff Section (OMSS) Assembly referred Resolution 5, Medical Staff Participation, to the Governing Council for report back at the 2013 Interim Meeting. Resolution 5 asked the AMA to:

"Conduct a new study addressing the problem of maintaining an organized medical staff at hospitals, and specifically recommend appropriate actions and strategies that could be incorporated by governing medical staffs that reintroduce and reincorporate primary care physicians, and other specialties, in their respective hospital centric communities, who are becoming more excluded from hospital leadership, committee and staff activity by virtue of their 'in-hospital' duties being replaced by hospitalists."

This report describes the rise of low-volume and no-volume “community physicians,” discusses the value of medical staff and hospital engagement of these physicians, and outlines a variety of strategies for medical staffs and hospitals to achieve this objective.

Background

Physicians have traditionally managed their patients’ care across multiple practice domains, providing care in both the ambulatory (outpatient) and hospital (inpatient) settings. In recent years, however, many physicians, particularly primary care physicians (PCPs), have become less likely to provide inpatient care. Inpatient care duties for these physicians’ patients have been assumed in large part by a proliferating population of physicians specializing in the practice of hospital medicine – hospitalists. In the last decade alone, the proportion of hospitals using hospitalists has more than doubled (to nearly 60 percent), as has the number of hospitalists in practice (to an estimated 30,000).

Although conventional wisdom suggests that hospitalist programs have served to crowd out PCPs from inpatient care, a causal relationship between the increasing use of hospitalists and the decreasing provision of inpatient care by PCPs has not been established. It is more likely that the
emergence of hospitalist programs has filled a void left by PCPs reacting to growing economic and other incentives to not provide care in the hospital.* For example:

- Outpatient settings may offer “better productivity with fewer hassles” than inpatient settings.5
- Technological advances have expanded the scope of procedures that can be performed safely in outpatient settings.6
- Physicians may seek to increase revenues by using provider-owned outpatient facilities.6
- Physicians may seek to avoid emergency department call responsibilities.6
- Physicians may seek to avoid the increased liability risk of providing care in hospitals.7
- Hospital use relative to the PCP population has decreased,5 leaving fewer hospitalized patient encounter opportunities per PCP and thereby reducing the economic viability of making trips to the hospital to care for such patients.

Regardless of the impetus for this change, there now exists a large and growing population of PCPs who provide a low volume or no volume of clinical services in the hospital. Although these “community physicians” often refer patients to the hospital and may even maintain medical staff membership and hold limited privileges (e.g., “refer and follow”), they typically spend little or no time in the hospital and have limited interaction with active members of the medical staff and other hospital personnel. As a result, community physicians are typically excluded from many, or even most, medical staff and hospital activities in which active members of the medical staff regularly participate. In “hospital-centric” medical communities, exclusion from these activities can serve to isolate community physicians in their clinical practices and professional lives, a precarious position in today’s increasingly interconnected health care world.

DISCUSSION

Benefits of Medical Staff and Hospital Engagement of Community Physicians

The exclusion of community physicians from medical staff and hospital activities is unfortunate given that community physicians, medical staff organizations, medical staff members, hospitals, and patients can all benefit from engagement of these physicians.

Benefits to community physicians may include:

- Access to continuing medical education and other opportunities for professional and collegial interaction with hospital-based and other community-based peers8,9
- Greater familiarity with specialists to whom the physician refers his or her patients8
- Improved care transitions and coordination of inpatient-outpatient care5,10,11
- Value of hospital affiliation - implications for maintaining managed care contracts12
- Value of hospital affiliation – prestige8,9

Benefits to medical staff organizations, medical staff members, and hospitals may include:

- Building/maintaining ties with referral base12
- Expanded medical staff population to share medical staff responsibilities12

* One notable exception is the attempt in the late 1990s by some managed care plans to mandate the use of hospitalists for inpatient care. These efforts, which in some cases would have forced PCPs out of the hospital entirely, were largely unsuccessful due at least in part to the advocacy activities of the AMA and other physician organizations such as the American College of Physicians and the Society of Hospital Medicine. See for example AMA policy H-285.964, available at http://tinyurl.com/kuj7eyt.
• Improved care transitions, improved coordination of inpatient-outpatient care, and reduced readmissions\textsuperscript{10,11,12}
• Access to perspective of community physicians on quality, safety, and other practice and policy matters\textsuperscript{9}
• Opportunities for professional and collegial interaction with community-based peers\textsuperscript{8,9}

Benefits to patients may include:
• Better-coordinated care between inpatient and outpatient settings\textsuperscript{9,10,11}
• Better-matched specialist referrals due to greater physician familiarity with specialists\textsuperscript{8}
• Care from physicians with enhanced access to continuing medical education and other opportunities for professional interaction with their peers\textsuperscript{8,9}

\textit{Setting the Table for the Engagement of Community Physicians through Medical Staff Membership}
Successful engagement of community physicians begins with establishing a formal relationship between community physicians and the medical staff/hospital, typically in the form of medical staff membership. Medical staff membership is not synonymous with the granting of clinical privileges\textsuperscript{13} – that is, while all physicians granted clinical privileges must be appointed to the medical staff in some capacity,\textsuperscript{14} members of the medical staff need not necessarily be granted clinical privileges. The application of this axiom to community physicians makes possible a wide variety of arrangements under which community physicians who provide no clinical services in the hospital may still be appointed to the medical staff and thereby take advantage of the benefits of medical staff membership.\textsuperscript{**} For example, medical staffs may appoint no-volume community physicians to “affiliate” or “associate” staff categories that permit community physicians to attend continuing medical education programs and participate to some limited extent in other medical staff activities.

Whether and to what extent the appointment of community physicians to the medical staff entails voting and other citizenship rights (e.g., holding leadership positions) will vary from medical staff to medical staff. Some medical staffs may choose to grant citizenship rights of any kind only to physicians who provide some relatively high threshold volume of inpatient care, effectively denying such rights to community physicians. Alternatively, some medical staffs may opt to grant full citizenship rights to community physicians who provide no inpatient care but refer a large number of patients to the hospital.\textsuperscript{9} Most medical staffs are likely to choose some middle ground – for example, permitting community physicians to serve on, but not chair, medical staff committees and to attend, but not vote at, full meetings of the medical staff.

\textit{Strategies for Engaging Community Physicians}
Having established formal relationships with community physicians, medical staffs and hospitals can begin to engage these physicians in ways that benefit community physicians, medical staffs/hospitals, and patients alike. We outline below a variety of strategies to achieve this objective:

\textbf{Engagement Strategy #1 – Involve Community Physicians in Medical Staff Duties and Leadership}
Community physicians offer a unique perspective on quality, safety, and other practice and policy matters that often differs from the perspective of physicians with more hospital-centric practices. Although the voice of the community physician may not be relevant in all matters,

\textsuperscript{**} Incidentally, such arrangements can also minimize the need for the difficult task of conducting peer review for low-volume providers, many of whom are community physicians who maintain clinical privileges for the primary purpose of maintaining medical staff membership and its attendant benefits.
hospital medical staffs would be well served to capture this perspective and apply it where relevant to the functions of the medical staff. Thus, for example, a medical staff may choose to appoint community physicians to various medical staff committees or even to include a community physician as a non-voting member of the medical executive committee.

**Engagement Strategy #2 – Involve Community Physicians in Hospital Governance**

The voice of the community physician is equally important to the governance and administrative activities of the hospital, especially insofar as this perspective can inform strategic decisions on “community based issues and relationships.” As such, hospitals may opt to appoint community physicians to any number of non-medical staff steering/advisory committees – for example, community relations/development committees. Some hospitals may even choose to set aside governing body seats for community physicians; survey data from the Governance Institute suggests that nearly 20 percent of hospital governing bodies include physicians who are not active members of the medical staff.15

**Engagement Strategy #3 – Involve Community Physicians in Population Health Management Initiatives**

Hospitals are increasingly charged with managing not only the acute care needs of patients treated in their facilities but also the overall health of the communities they serve.16 Given their ongoing relationships with the patients who comprise the populations served by hospitals, community physicians are integral to any hospital efforts in this regard. Unfortunately, hospitals all too frequently engage community physicians only, if at all, during the implementation phases of their population health management initiatives (e.g., community physician participation in a disease registry program). Hospitals can augment their engagement of community physicians while enhancing their community health initiatives by additionally including community physicians in the planning and evaluation phases of these interventions. For example, a hospital may choose to appoint community physicians to various committees and other groups that focus on population health.

**Engagement Strategy #4 – Involve Community Physicians in Transitions of Care Initiatives**

Community physicians and hospitals share an interest in improving their patients’ transitions between inpatient and outpatient care settings. This shared pursuit of better-coordinated care presents unique opportunities for medical staffs and hospitals to engage community physicians. As with population health management initiatives, medical staffs and hospitals can include community physicians in the planning, implementation, and evaluation of programs seeking to improve care transitions. Hospitals can further engage community physicians by facilitating, typically through financial assistance, these physicians’ acquisition of EHR systems and other technologies that improve care transitions. An EHR system offered to community physicians need not be the same as that used by the hospital; indeed, many community physicians would object to being tied to a hospital’s particular EHR system. Nevertheless, the physician and hospital EHR systems must be interoperable, not only to promote coordinated care but also to ensure compliance with Stark and anti-kickback laws that govern relations between hospitals and referring physicians.10

**Engagement Strategy #5 – Provide Community Physicians Opportunities for Professional and Collegial Interaction**

Community physicians typically have limited access to continuing medical education (CME) and other opportunities for professional and collegial interaction with their peers. Medical staffs can thus engage community physicians by offering valuable access to hospital-based learning opportunities such as grand rounds and other CME activities. Medical staffs can
further engage community physicians by including them in the collegial and other social functions of the medical staff, such as medical staff dinners, golf outings, etc.***

CONCLUSION

Primary care physicians have become increasingly less likely to provide patient care in the hospital. As the volume of inpatient care provided by these “community physicians” has decreased, so too has their involvement in the activities of the organized medical staff and of the hospital. Medical staff and hospital engagement of community physicians, facilitated by the establishment of appropriate medical staff membership categories for low-volume and no-volume providers, can benefit community physicians, medical staff organizations, medical staff members, hospitals, and patients alike. Medical staffs and hospitals should be encouraged to involve community physicians, as appropriate, in an array of medical staff and hospitals activities.

RECOMMENDATIONS

The OMSS Governing Council recommends that the following be adopted in lieu of Resolution 5-I-12 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage medical staffs to develop medical staff membership categories for primary care physicians who provide a low volume or no volume of clinical services in the hospital (“community physicians”);

2. That our AMA encourage medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities including but not limited to: (a) medical staff duties and leadership; (b) hospital governance; (c) population health management initiatives; (d) transitions of care initiatives; and (e) educational and other professional and collegial events.

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*** Note that hospital funding of medical staff social events is viewed as non-monetary compensation to referring physicians and therefore subject to a Stark law limit of $300 per year per physician. Funding of such events using medical staff funds (e.g., dues) does not invoke these limits.


