July 17, 2006

Addendum to the Report to the County Board of Supervisors

Medical Community Response

Even before the public disclosure of the financial problems at St. Joseph Hospital the health care provider community had become increasingly aware of the growing problems in the sustainability of the overall local health care system. We have an aging workforce, with the average age of the practicing physician well over 50 years of age, and we have faced dual challenges in attrition, particularly of primary care providers, and in largely unsuccessful recruitment in primary and specialist care. Trainees are more attracted to multispecialty group practices with logistic support, excellent information systems, practice protocols, help with the burden of debt from training, and protection of personal time. As we have discussed the attributes of such a model, an increasing proportion of established providers are also interested in exploring the possibility of developing such a system here to replace our current patchwork of individual and small group practice. As practitioners retire or leave the area, the burden of patient care falls to those remaining, increasing the burn-out rate in a downward spiral, threatening the existence of a viable system of outpatient care, as well as the hospitals. We need to recruit a new workforce to replace open positions now, as well as for the future. We see the possibility of organizing one or more multi-specialty clinics, composed of all or most of the medical care providers in the area, working in cooperation with the hospitals to provide optimal care. This is envisioned as a non-profit system with adequate compensation modeled after known existing successful similar organizations. Revenue would be retained locally and reinvested in the system.

The new system would be primary care based, with a “medical home” for each citizen, coordinating and promoting preventative care as well as providing a point of entry into the comprehensive system in times of illness. Doctors and other medical care providers would be in control of medical care delivery, assessment of new technology, promulgation of care protocols, and coordination of outpatient care. Specialist care in the group would be used effectively to provide

state-of-the-art expertise with efficiency. There would be professional administrative support to free all of these medical experts to provide medical care, rather than to learn arcane aspects of medical business. The overhead cost to individual practitioners would be minimized by economies of scale and purchasing, along with sharing of support staff, better administration and use of expert knowledge of strategies known to maximize revenue. Cost savings would provide extra support to revenue, as would grants for specific projects, and, if this were to be part of a district health care system, tax support might also be available as a last resort if needed to maintain the system.

The medical community appears to be invigorated and engaged well in these discussions. Enthusiasm is growing as the brainstorming meetings continue at weekly intervals into mid-August. At the end of this process there will be a report to the community. If there continues to be growing interest and dedication to a reinvigorated system of continued service to our community that we predict now, the planning of the system will proceed in parallel with the hospital process and in concert with planning for a possible district system.

Respectfully submitted,

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