Physician discontent abounds, but recent survey offers some clues to retention, recruitment

Recent reports suggest that physician frustration is increasing and satisfaction decreasing, particularly among primary care physicians (PCP).

A survey from The Physicians’ Foundation (www.physiciansfoundations.org/news/news_show.htm?doc_id=728872) was particularly bleak, depicting widespread frustration among PCPs. But the survey, released in November 2008, also reveals important lessons for administrators struggling to attract and retain PCPs.

For example, 49% of respondents said they plan to reduce the number of patients they see or stop practicing entirely during the next three years. Perhaps most distressing, 60% would not recommend medicine as a career to young people.

Among the reasons for the widespread discontent were increased time handling nonclinical paperwork, difficulty receiving reimbursement, and burdensome government regulations.

Physicians say such issues keep them from the most satisfying aspect of their job—patient relationships.

Although the report is recent, the fact that physicians are frustrated—especially primary care doctors—is not new. So why pay attention to one more study on the issue?

Because bad news can be instructive to administrators and practice leaders, says Kurt Mosley, senior vice president of business development at Irving, TX–based Merritt Hawkins & Associates (MHA), which conducted the survey on behalf of The Physicians’ Foundation.

“If I were a CEO, I’d say, ‘Addressing doctor discontent is job 1,’ ” Mosley says.

The number and the tone of the responses are revealing. Of the nearly 12,000 respondents, 4,000 submitted additional written comments. Some were six or seven pages long and others were scribbled on a prescription pad. (See “Physician comments” on p. 3.)

“"If I were a CEO, I’d say, ’Addressing doctor discontent is job 1.’ ‘"
—Kurt Mosley

Obviously, some of the problems are systemic. For example, declining reimbursement rated highest on the list of issues physicians identified as impediments to the delivery of patient care in their practices. But it was followed by demands on physician time.

Although administrators may not be able to control the former, they can improve the latter, says Mosley. About 94% of respondents said the time they devoted to nonclinical paperwork in the past three years has increased, and 63% said nonclinical paperwork has caused them to spend less time with their patients. (See Figures 1 and 2 on p. 2.)

These responses can help practices and health systems devise ways to retain and recruit physicians—and not just PCPs. Ultimately, physicians want to practice medicine in a setting that’s efficient, open, and remunerative,” says Mosley. They want less paperwork, more time to spend with patients, and a voice in decision-making.

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Of the 11,950 responses, 27% came from family physicians, 20% from general internists, 17% from pediatricians, and a little more than 8% from OB/GYNs. Other specialties constituted the remainder. The majority of respondents (52.4%) were aged 51 years or older, suggesting a somewhat disproportionately high response from older physicians. About 47% of all physicians are aged 51 or older, according to the AMA. The majority of respondents (61.56%) are owners or partners in their practices, and the remaining 38.44% are employed.

Although the survey focused on PCPs in solo or small group practices, the lessons apply across the board, says Mosley.

Craving efficiency

Physician frustration with nonclinical demands on their time shouldn’t be a surprise, although few groups are addressing this adequately, Mosley says. But the smart ones are. For example, large groups—such as Baylor in Texas—are taking away paperwork hassle from doctors.

In return for fewer administrative hassles, physicians lose some autonomy. But increasingly, that’s a trade off physicians—especially younger ones—are willing to make, Mosley says.

Kenneth T. Hertz, principal at MGMA Health Care Consulting Group in Alexandria, LA, agrees. Work-life balance is important to younger physicians. And although issues such as call coverage and location figure into that calculation, so does paperwork.

Money is not a primary driver in recruitment, retention, or satisfaction, says Mosley. “Doctors rarely move for money,” he says. Of course, hospitals and practices need to be competitive, he adds. But what this and other surveys reveal is that physicians want to be fairly compensated.

Nevertheless, money matters, which ties in to the point about efficiency, says Hertz. Practices must operate more efficiently from a business standpoint. They have to do a better job of performing such tasks as managing revenue cycles, processing claims, and handling denials. “It’s not just about bringing in more dollars, but accelerating the flow of dollars into the practice,” Hertz says.

Open and fair

An important question for multispecialty practices to ask themselves is, “Do family practice physicians have the same say-so as surgeons?” Often, the answer is no. Many times,

![Figure 1: Nonclinical time allocation](source: Merritt Hawkins & Associates and The Physicians’ Foundation)

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<tr>
<th>100%</th>
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<td>80%</td>
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**Decreased** | **Increased**

Did the volume of nonclinical duties cause you to spend less time with patients in the past three years?

- **Yes** (37%)
- **No** (63%)

*Source: Merritt Hawkins & Associates and The Physicians’ Foundation.*
PCPs leave because their concerns about the practice aren’t heard. Groups that are most successful at recruiting and retaining PCPs provide them an equal say. For example, such groups may have a governing board composed equally of specialists and PCPs.

Although such an approach is not common, it should be, says Mosley. PCPs already feel they are being treated unfairly by payers and the government; they need to feel their group is treating them fairly. When he speaks to large group practices, Mosley often repeats a version of this mantra: “Doctors are usually pushed out of a practice, not pulled from one.”

The challenge is recognizing what’s pushing them out. Mosley tells one story of a physician he placed in a new practice. The original practice had moved to a new building, and this doctor’s name was left off the sign. Thinking it was a hint and he was being pushed out, the physician contacted MHA and started talking about opportunities. “He thought they were saying, ‘Hit the road’ and ... he started talking to us,” Mosley says. By the time he found out it was merely an oversight, he’d already found an attractive new opportunity.

Satisfaction often comes down to practice style. Practice style trumps money and location. Mosley notes a study the Washington, DC–based Health Care Advisory Board did several years ago that identified workplace issues as the primary reason physicians leave a practice. These include billing, fairness, openness, remunerative equity—even parking. Second on the list was the lack of nursing and other ancillary support; third was lack of confidence in peers.

Thus, practices need a strong group manager not only to manage the nonclinical tasks, but also to help temper adversarial relationships among physicians, says Mosley. “Politics blows up maybe a third of our searches,” he says.

Strong physician leadership is also required, Hertz says. “In many groups, physician-to-physician issues are most often effectively resolved through physician leadership/intervention—colleague to colleague,” he says, adding that often, such leadership is lacking.

Controlling expectations

A root cause of dissatisfaction is that the practice of medicine doesn’t meet the expectations physicians brought to the profession, says Hertz. What’s needed is a deeper understanding of what to expect on the part of the physician and practice. Some of that comes from good interviewing skills.

Young doctors must do a better job of interviewing prospective employers; they need to know what to ask. Employers should also do a better job of interviewing candidates, attending to “what really makes people tick,” Hertz says. The practice culture is important for new doctors, and they need to understand it to determine whether it’s consistent with their values, he says.

“It’s about sitting down, talking together, understanding the situation, and collectively developing solutions,” says Hertz, noting that this type of collaborative process is uncomfortable for administrators and physicians, but it’s necessary.

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Physician comments

The following is a sampling of written responses to The Physicians’ Foundation’s survey The Physicians’ Perspective: Medical Practice in 2008:

- “Adopt a single-payer British-style system with alternative fee-for-service available. The Canadian system works because people can choose to come to the U.S. for fee-for-service care if they choose to go outside the national health system.”

- “The Medicare system is effective in controlling costs. State Medicaid systems should be rolled over into Medicare and everyone should be provided with healthcare coverage through Medicare. We need to study the European and Canadian systems and implement a similar system.”

- “The American physician has become increasingly angry and frustrated. We have had to learn more about insurance than about medical care. What is particularly unfortunate is that it doesn’t have to be that way. I have worked in New Zealand. Everyone was covered, no one went bankrupt for receiving medical care and, most important to me, the doctors were happy. We have much to learn from our brethren overseas.”

- “As a pediatrician, I still enjoy my job seeing patients and talking with patients’ parents. But I don’t like the fact that right now I’m a medical clerk.”
Retention

continued from p. 3

Mosley says recruiters need to be able to answer questions about:
» Patient volume
» Payer mix
» Reimbursement rates
» Collection rates
» Paths to partnership buy-in
» Overhead
» Income distribution

But most important is the ability to communicate about the vision, values, and mission of the group—its culture, says Hertz. “Values are critical,” he says. “They often become the issues that push a doc out of a practice—conflicting values—and if the interview process is conducted properly, these values will be well known to both parties early on in the process.”

Accordingly, addressing expectations needs to begin long before that first interview, say Mosley and Hertz.

Physicians are trained to be clinicians, but they are not equipped to handle the ever-expanding nonclinical issues. Med schools must address business issues in their curricula. A 2008 MHA survey revealed that residents may be equipped for the practice, but not the business, of medicine. (See the November 2008 PCR.)

“We’re going to have to start talking with these medical students before they get out of school and help them understand what the real world is like,” says Hertz. “None of the programs does a good job with that at all. They come out with unrealistic expectations, no real knowledge of real world.”

Feedback opportunities

Only about one-fifth to one-third of large practices conduct a focus group, says Mosley. He recommends doing one annually to identify concerns before they drive away physicians. It can be as simple as asking, “What one thing would you change in this practice?”

In addition to focus groups, there must be a system for regular and ongoing feedback for new and existing doctors, says Hertz. For new physicians, a mentor, selected from the senior members of the group, should connect with the new doctor weekly for the first several months and every two weeks after that.

“Too many groups assume things are okay and never ask the new doc or never give any feedback—either positive or negative,” Hertz says. He offers the following examples of constructive feedback:
» “Heard you did a great job with the surgery yesterday”
» “Saw one of your patients and he raved about your care”
» “Several of the referring physicians have mentioned to me that they never hear back from you after they send you a consult”

Strategies, overlooked and otherwise

Mosley says other strategies for curbing physician discontent include:
» A medical staff-development plan. Surprisingly, in Mosley’s experience, only 20%–30% of hospitals have staff development plans, despite the fact that it’s considered a practical defense against potential IRS, HHS, and Stark action. Moreover, it’s a good way to spot staffing issues before they become problems.
» A succession plan. A comparable approach for group practices is a succession plan. It helps a practice identify its stars, as well as those who are slowing down production. And as with a staff development plan, it can identify physician concerns before they turn into problems.
» Aligned recruiting goals. A frequent source of physician frustration is lack of hospital support, Mosley says. Group practices need to work in conjunction with local hospitals to develop shared recruiting goals. Too often, practices recruit against the wishes of the hospital. Hospital support for physicians’ recruitment efforts is critical to long-term physician satisfaction, says Mosley.

Some of Mosley’s tactics and strategies apply more to recruiting, some more to retention, but he doesn’t distinguish between the two. “The way you recruit is the way you retain,” he says. ⚖
Aging population, rural shortages help drive CRNA demand

These practitioners are well compensated, in great demand, and more than 90% are satisfied. Sound like the perfect specialty? Perhaps, but the providers in question aren’t doctors. They are CRNAs.

CRNA income continues to grow. Between 2004 and 2007, it increased anywhere from 10.2%–23.3%, depending on the survey. (See “CRNA median compensation trends” on p. 6.)

Median compensation was $140,000 in 2007, compared to $138,000 in 2006, according to the MGMA 2008 Physician Compensation and Production Survey.

As with physician recruitment, incentives play a crucial role. Common ones include sign-on bonuses, repayment of school loans, and moving expense reimbursement, says Jackie Rowles, CRNA, MBA, MA, FAAPM, president of the American Association of Nurse Anesthetists (AANA). Another enticement is creative scheduling, Rowles says.

Driving compensation growth

The compensation growth is a function of supply and demand. “There has been a shortage of anesthesia providers for many years,” says Rowles. That demand is not just for anesthesiologists; it’s also growing for CRNAs. An AANA workforce study, released in January, reports a 12.6% vacancy rate for CRNAs.

The shortage is particularly acute in rural areas. CRNAs are the primary anesthesia providers in underserved rural areas, says Rowles, adding that their presence allows rural facilities to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in most rural hospitals.

Rural CRNAs (locum tenens and permanent) make, on average, $10,000 more than those in metropolitan areas, says Joanna S. Kires, senior director of the permanent placement division at Salt Lake City–based CompHealth.

But it’s not merely demand driving compensation, as there’s a tremendous demand for primary care physicians (PCP), and they aren’t as highly compensated as most other physicians.

The nature of the service helps drive compensation. CRNAs perform anesthesia services for less than half the pay of anesthesiologists. The MGMA survey reports 2007 median compensation for anesthesiologists at $400,000, compared to $140,000 for CRNAs.

CRNAs contribute to the bottom line, providing services for high-paying surgical procedures that are in growing demand due to the aging population.

“Since CRNAs are revenue producers, the hospitals hire them as a more cost-effective manner of administering anesthesia procedures,” explains Kires.

“Surgical services are typically a profit center for institutions, and the provision of anesthesia care is obviously a critical component of these services,” Rowles says.

More procedures are being done in nontraditional surgical settings, such as freestanding surgery centers and physicians’ offices, says Christopher Bettin, senior director of communications at the AANA in Chicago.

Moreover, elective procedures are more common as well, although the recession has slowed this trend, Bettin says. “But as soon as the economy reverses, you’re likely to see these sorts of surgeries on the rise again,” he says.

Locum option attractive

The demand for locum CRNAs continues to grow, says Lisa Kaeck, vice president and cofounder of LocumTenens.com in the Atlanta area. The LocumTenens.com survey found that although 54% of respondents were employer-based, 42% had worked as a locum provider, and 32% reported working on a locum tenens or contract basis exclusively.

CRNAs can make as much or more doing locum work as they can in other environments, says Roger Smith, director of marketing at Delta Locum Tenens in Dallas. According to the firm, the average billed rate for CRNAs was $1,209 per day in the third quarter (Q3) of 2008 and in Q3 2007; in Q3 2006, it was $1,161.

Locum CRNAs who live in a nurse licensure compact state are especially marketable, says Smith. The compact allows a nurse to have one license in his or her state of residency and to practice in other compact states under a system of mutual recognition. The compact applies only to RN licensure, so a CRNA would still need an advanced practice license in each compact state where he or she intends to work.

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The compact states are Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.

**Demographics**

CRNAs practice in every setting in which anesthesia is delivered. According to the AANA, of its members:

- 36% are employed by a group practice
- 34.4% are employed by hospitals
- 6.5% are employed by another institution (e.g., a clinic, freestanding surgical center, or university)
- 16.3% are independent contractors and the most highly compensated
- 3.9% are owners/partners
- 2.6% are employed in the military or otherwise employed by the government
- 0.4% are categorized as “other”

**Recruitment a challenge**

“I would say the biggest recruiting challenge for some facilities—particularly those in rural and other medically underserved areas—is simply enticing enough providers to come work there,” says Bettin.

Kires has been involved with the recruitment of CRNAs at CompHealth for the past seven years. During that time, CRNA recruitment has grown more challenging, she says. Demand has increased in hospitals, outpatient surgical centers, pain clinics, and anesthesia management groups.

“The greatest challenge with recruiting CRNAs remains the high quantity of job opportunities,” says Kires.

In a trend that mirrors physician recruiting trends, CRNAs are being recruited before they are CRNAs.

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**CRNA median compensation trends**

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<td>$152,246</td>
<td>$140,013</td>
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<td><strong>MHA Review of Physician and CRNA Recruiting Incentives (average)</strong></td>
<td>$185,000</td>
<td>$164,000</td>
<td>$156,000</td>
<td>$150,000</td>
<td>12.80%</td>
<td>23.33%</td>
</tr>
<tr>
<td><strong>MGMA Physician Compensation and Production Survey</strong></td>
<td>$140,000</td>
<td>$138,000</td>
<td>$131,400</td>
<td>$127,054</td>
<td>1.44%</td>
<td>10.19%</td>
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<tr>
<td><strong>Sullivan, Cotter and Associates Physician Compensation and Productivity Survey Report</strong></td>
<td>*</td>
<td>$147,680</td>
<td>$135,256</td>
<td>$135,200</td>
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+ Survey results are based on the previous year’s data.
* Data not available at prestime.

“One of the more noteworthy trends is to place student CRNAs six months to one year prior to graduation. We have to work harder and smarter to gain access to the students prior to other recruitment firms,” Kires says, adding that it’s very competitive.

The recruiting challenges relate directly to the demand for anesthesia services; it’s certainly not related to job satisfaction. The 2007 AANA membership survey reports that 92% of CRNAs are satisfied with their career choice.

**Charged issue**

Merritt Hawkins & Associates’ 2008 Review of Physician and CRNA Recruiting Incentives stirred considerable controversy. It indicated that salaries offered to recruit CRNAs were higher than those offered to recruit PCPs.

On average, CRNAs were offered $185,000 versus $172,000 for PCPs.

The review found that CRNAs were also offered more than internists ($176,000), pediatricians ($159,000), and hospitalists ($181,000).

*The Wall Street Journal* published the findings, and the colloquy that ensued was heated. (See [http://blogs.wsj.com/health](http://blogs.wsj.com/health) and search for the article “Some nurses land higher salaries than primary care doctors.”)

Many of the commenters expressed outrage that some CRNAs made more than some PCPs. However, the MGMA median for all primary care practices is $182,322, $173,812 for family practices, and $190,547 for internal medicine. In contrast, the CRNA median of $140,000 is well below any physician specialty.

But some of the furor relates to the scope of practice.

Fourteen states have opted out of the federal rule requiring nurse anesthetists to be supervised by a physician: Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, and Wisconsin.

In the states that have retained the federal supervision requirement, nurse anesthetists must be supervised by a physician—although not necessarily an anesthesiologist, says Sarah P. Byun, advocacy communications manager at the American Society of Anesthesiologists’ Washington, DC, office. In fact, according to the AANA, 43% of its members report providing anesthesia care without medical direction from an anesthesiologist. For the AANA, this is a crucial point.

Although no state has a requirement for anesthesiologist supervision, CRNAs work with physicians all the time—the surgeons, Rowles says. “No patients are without physician involvement in the provision of their surgical care,” she explains.

Moreover, states that opt out of the physician supervision requirement simply allow the hospitals in those states to bill for anesthesia services under Medicare Part A, not Part B, says Rowles. Currently, anesthesiologists can medically direct up to four CRNAs simultaneously and obtain 50% of their case pay.

The politics related to the CRNA’s role can affect recruiting and placement; just how politically charged the relationship is varies by facility.

“We gauge the political atmosphere of a facility when creating the job order and can appropriately advise the candidate. On occasion, we run into challenges [regarding] autonomy and types of cases,” says Kires. However, she reports an increase in acceptance of CRNAs by physicians overall throughout the years.

Political disagreements aside, CRNAs and anesthesiologists collaborate well, says Bettin. “For both ... patient safety and comfort is their primary concern.”

**PCR sources**

Christopher Bettin, senior director, communications, American Association of Nurse Anesthetists, 222 South Prospect Avenue, Park Ridge, IL 60068-4001; 847/655-1143; cbettin@aana.com.

Sarah P. Byun, advocacy communications manager, American Society of Anesthesiologists, 1501 M Street, NW, Suite 300, Washington, DC 20005; 202/289-2222.

Lisa Kaeck, vice president and cofounder, LocumTenens.com, 3650 Mansell Road, # 300, Alpharetta, GA 30022; 800/930-0748.


Jackie Rowles, CRNA, MBA, MA, FAAPM, president, American Association of Nurse Anesthetists, 222 South Prospect Avenue, Park Ridge, IL 60068-4001; 847/692-7050.

Roger Smith, director of marketing, Delta Locum Tenens, 1755 Wittington Place, Suite 175, Dallas, TX 75234; 877/456-2867, Ext. 4202; www.deltalocums.com.

**Questions? Comments? Ideas?**

**Contact Editor Roxanna Guilford-Blake**

E-mail: roxanna@healthleadersmedia.com

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Compensation trends: Family practice versus internal medicine

by Max Reiboldt, CPA

The landscape of physician practices and their compensation is in constant flux. With changing reimbursement and a major push for hospitals to again employ physicians, many questions arise as to how best to compensate them.

A key component of the hospital-employed physician arena is primary care. Likewise, multi- and single-specialty private practices are almost universally faced with the need for more primary care.

Within a hospital-employed setting, the compensation paid to doctors—especially in primary care—is not usually based on their excess of revenue over expenses (i.e., overhead). Although this is more common in private settings, it is becoming less the norm even for employed physicians. As compensation for hospital-employed and some private practice physicians is less tied to the profitability of the practice, it requires using independent metrics to establish market-based compensation.

Likewise, the clinical functionality of certain primary care physicians (PCP) has also been in flux, especially in comparison to internal medicine and family practice. Within more rural settings, the traditional view holds true: The internist serves as the referral source for the family practitioner and can also function more akin to a subspecialist.

In suburban and metropolitan environments, the clinical lines between family practitioners and internists are increasingly blurred. Many family practitioners are performing clinical work that has heretofore been mostly restricted to internists. Further, midlevel providers are becoming much more prominent in the primary care arena. This allows the family practitioners to focus on the more complex cases.

Training continues to differ. Family practitioners are generally trained to manage the health needs of patients of all ages, whereas internists’ training mainly focuses on adults, with a special emphasis on treating certain chronic illnesses. Nonetheless, the training of both specialties allows them to complete fellowships and, potentially, subspecialize.

Thus, the question is whether family practitioners should be paid the same as internists. The short answer is no. The reason is not due to family practitioners’ being lesser-valued physicians, but the undeniable ingredient we all must consider relative to physician compensation: market conditions.

In analyzing compensation trends, it is appropriate to consider the compensation data from the surveys. However, even recent surveys often consist of data compiled more than one year before publication. In the meantime, the market conditions and, even more importantly, the clinical responsibilities of the physicians under consideration (i.e., family practice versus internal medicine) are changing.

The most recent benchmark data indicate the market pay for an internal medicine physician is still higher than that of a family practitioner. This is true when considering total cash compensation, as well as such metrics as wRVU conversion factors.

Even when looking at this from a historical perspective, there is not a clear trend of any change (i.e., narrowing the gap between family practitioners’ and internists’ pay). The data clearly indicate that a variance in internal medicine and family practice compensation continues to exist at levels similar to those reported in the most recent surveys.

Recruitment trends must also be considered when reviewing compensation. Even with the aforementioned lag, most healthcare organizations faithfully rely on the most recent benchmarking data to establish market-based compensation levels. In effect, they are still the best data available.

Nonetheless, another way to validate the data within the benchmarks is to ask recruiters. Although not a scientific study, we discussed this with several sources and essentially drew the same conclusion: Internists continue to be compensated 5%–10% more than family practitioners.

Summary
Debate is increasing about whether compensation should differ for a family practice physician and an internist since:

» Hospitals are employing more physicians
» Compensation within hospital-employed settings is not based on bottom-line performance
» The differences in clinical functionality between internists and family practitioners are becoming blurred

Available data indicate that, although they may function similarly, internal medicine physicians continue to command a higher salary than family practitioners. With the healthcare industry constantly changing, refocusing data relative to
compensation is constantly needed. PCPs are experiencing increased compensation, and the difference from a functional/clinical standpoint between family practice and internal medicine is growing narrower. Their training continues to differ somewhat, but it appears that the clinical responsibilities of internists and family practitioners are becoming more aligned. Nevertheless, internists still command higher compensation than family practitioners.

However, it is entirely possible that within the next three to five years, that differential (5%-10%) will lessen.

Some day, the market data may support the two specialties making virtually the same incomes. "

Editor’s note: Reiboldt, managing partner and CEO of The Coker Group, can be reached at mreiboldt@cokergroup.com or 678/832-2007.

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Locum tenens thrives, even during a recession

The use of locum tenens physicians is ubiquitous, and for the past few years, it has been a standard part of medical staffing. Even during a recession, it’s seeing double-digit growth. Staffing Industry Analysts in Los Altos, CA, forecasts 14.5% locum growth between 2008 and this year.

Lisa Kaeck, vice president and cofounder of LocumTenens.com in the Atlanta area, has been in the industry 17 years. Kaeck says spending on locum tenens services has more than doubled in the past four years. Overall, according to the company, locum firms produce more than $2 billion in revenue annually. In the past, organizations didn’t budget money for locum tenens expenses. Now, it’s part of most master staffing plans, Kaeck says.

Roger Smith, director of marketing at Delta Locum Tenens in Dallas, has been in the industry for six years, and in the past four, locum placements have become more common—and the contracts longer. Although a locum contract can be as short as one day, most of those Smith sees are at least three months.

A 2007 survey by Salt Lake City–based Staff Care found that 77% of healthcare organizations had used locum tenens physicians sometime in the previous 12 months; that’s essentially unchanged from the 79% in 2005. The 2008 Review of Temporary Physician Staffing Trends Based on 2007 Data (www.staffcare.com/pdf/2008scisurveytemptrends.pdf) also found that 53% use from one to three locum tenens physicians in a typical month.

According to Staff Care, 56% of those surveyed indicated that their facilities were actively seeking locum tenens physicians. This number has gradually risen during the past several years, from 53% in 2005 and 51% in 2004, suggesting a steady increase in the demand for locum doctors.

Multiple applications

Locum doctors can be used to staff new facilities, handle increased patient load while permanent providers are recruited, or to cover for an absent staff member. Some practices hire temporary physicians to help determine whether or where they should expand, says Kaeck.

The use of locum tenens services can also be part of a retention plan to avoid burning out permanent staff physicians, says Billie Wickstrom, spokesperson for LocumTenens.com.

For some organizations, locum tenens is an integral component of their master staffing plans, Kaeck says. Such organizations generally staff moderately and use locum firms to supplement the permanent staff during peaks in census.

“Generally, this is more efficient and cost-effective than maintaining peak staffing levels and paying for a lot of staff downtime,” says Wickstrom.

One common approach—using a locum doctor to cover until a permanent physician comes to town—may become more common due to problems in the housing market, says Smith. If physicians have trouble selling their homes, they can’t move to their new job. Locum doctors fill the gap until the full-time physician can assume the position. According to the Staff Care survey, the primary benefit of using locum tenens physicians is to maintain continual treatment of patients, cited by 80% of those surveyed. Preventing revenue loss was cited by 53%. Prevents existing staff burnout was cited by 34%.

Demand

Locum demand often reflects the supply-and-demand trends in the permanent placement market. Perhaps not
Locum
continued from p. 9

surprisingly, the greatest demand is in rural areas; more than 60% of LocumTenens.com’s business is there.

However, demand can vary, even across firms. For example, about five years ago, Delta’s call for radiologists was high, but it has since diminished, says Smith. Alternatively, LocumTenens.com reports continued high demand for the specialty. Delta also reports strong demand for hospitalists, which Smith attributes to the growth in the specialty itself.

For some specialties, demand is consistent across firms, location, and years. For example, Kaeck and Smith report a consistently strong demand for locum tenens in primary care and anesthesiology. Aside from primary care physicians, the most consistently strong demand may be for ED coverage. Physicians don’t want to take ED call, so hospitals increasingly rely on locum doctors. Another reason for strong demand is that some locum tenens firms don’t handle ED placements because of the potential liability, says Smith.

Using locum tenens physicians for call coverage can allow smaller, more remote facilities to avoid sending emergency cases to larger metro facilities, thus maintaining their revenue base and reducing overcrowding in metro area EDs, says Wickstrom.

Locum tenens physicians are used frequently in the ED setting to provide coverage for emergency physicians (EP) who are on vacation or on leave for an extended period (e.g., maternity or short-term disability), says David McKenzie, director of reimbursement at the American College of Emergency Physicians. McKenzie has also seen an increase in the use of locum tenens in EDs. The increase in female EPs, aging of the EP work force, and the extended need for deployed EPs in the wars are among the possible explanations.

Opting to be a temp

Some physicians test-drive different practice styles and locations before making a permanent commitment. Kaeck compares it to dating before getting married. This is especially true among those fresh out of residency.

Many residents are unhappy with their first permanent practice setting, often because the style of practice is not what they expected, says Wickstrom. Locum tenens allows a physician to earn income while considering long-term goals and how well various components of a given practice setting or geography match, she explains.

Midcareer physicians use locum tenens for a variety of reasons. Smith says he works with several who take working vacations via locum assignments.

Only 18% of respondents to the LocumTenens.com 2008 Physician Compensation and Employment Survey declared their employment status as “locum tenens or independent contractor exclusively,” but 26% said they had worked as a locum tenens provider.

The largest cohort—48%, according to LocumTenens.com—is around retirement age.

About 5% of company-placed physicians end up working permanently with the facility, says Kaeck, adding that the hassles of private practice may lead some physicians to locum work. “It’s not a bad way to live,” she says.
Most locum physicians work through agencies, but a few are solo; they usually have a pool of local clients they work with regularly, says Smith.

**Cost and other challenges**

Compensation is rising, which means the cost of hiring locum doctors is rising, Smith says.

Depending on specialty and location, a locum can cost $900—$3,000 per day, says Kaeck. (See the table below.)

Often, the locum doctors can set their terms, especially for hours and call coverage. Delta usually works 30—90 days ahead. The tighter the time frame, the easier it is for the physician to make the contract as favorable as possible. Money isn’t the only challenge. Unless the client and the locum doctor are in the same area, the business is subject to the vagaries of travel, and weather-related issues can prevent the temporary physician from reaching the client, Smith says.

Moreover, bringing in an outsider unfamiliar with the hospital’s protocols, formulary, referring physicians, and EMR system can reduce efficiency and throughput times—at least until that individual comes up to speed, says McKenzie.

Similarly, continuity of care is always a concern to hospitals, groups, and surgery centers. Relying on locum doctors is not the ideal solution, Kaeck says. “I don’t want to hire a temp here at work either,” she says. But sometimes, it’s the best possible solution. “We are a necessary evil.”

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### Locum rates for selected specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Third quarter (Q3) 2006 avg. cost</th>
<th>% change</th>
<th>Q3 2007 avg. cost</th>
<th>% change</th>
<th>Q3 2008 avg. cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology (interventional)</td>
<td>$2,155/day</td>
<td>17%</td>
<td>$2,515/day</td>
<td>0%</td>
<td>$2,515/day</td>
</tr>
<tr>
<td>Cardiology (invasive)</td>
<td>$1,844/day</td>
<td>4%</td>
<td>$1,924/day</td>
<td>0%</td>
<td>$1,924/day</td>
</tr>
<tr>
<td>Emergency medicine (residency)</td>
<td>$237/hour</td>
<td>0%</td>
<td>$237/hour</td>
<td>4%</td>
<td>$247/hour</td>
</tr>
<tr>
<td>Emergency medicine (no residency)</td>
<td>$185/hour</td>
<td>0%</td>
<td>$185/hour</td>
<td>3%</td>
<td>$190/hour</td>
</tr>
<tr>
<td>Family medicine (no OB)</td>
<td>$98/hour</td>
<td>7%</td>
<td>$105/hour</td>
<td>14%</td>
<td>$120/hour</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>$1,486/day</td>
<td>16%</td>
<td>$1,729/day</td>
<td>0%</td>
<td>$1,729/day</td>
</tr>
<tr>
<td>General surgery</td>
<td>$1,428/day</td>
<td>13%</td>
<td>$1,617/day</td>
<td>0%</td>
<td>$1,617/day</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>$133/hour</td>
<td>9%</td>
<td>$145/hour</td>
<td>12%</td>
<td>$163/hour</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>$105/hour</td>
<td>6%</td>
<td>$111/hour</td>
<td>5%</td>
<td>$117/hour</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>$2,792/day</td>
<td>5%</td>
<td>$2,923/day</td>
<td>0%</td>
<td>$2,923/day</td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>$1,710/day</td>
<td>24%</td>
<td>$2,113/day</td>
<td>0%</td>
<td>$2,113/day</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$94/hour</td>
<td>14%</td>
<td>$107/hour</td>
<td>9%</td>
<td>$117/hour</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$1,164/day</td>
<td>19%</td>
<td>$1,386/day</td>
<td>0%</td>
<td>$1,386/day</td>
</tr>
<tr>
<td>Radiation oncology</td>
<td>$1,439/day</td>
<td>6%</td>
<td>$1,529/day</td>
<td>0%</td>
<td>$1,529/day</td>
</tr>
<tr>
<td>Radiology (diagnostic)</td>
<td>$2,262/day</td>
<td>-7%</td>
<td>$2,103/day</td>
<td>0%</td>
<td>$2,103/day</td>
</tr>
<tr>
<td>Radiology (interventional)</td>
<td>$2,722/day</td>
<td>4%</td>
<td>$2,819/day</td>
<td>0%</td>
<td>$2,819/day</td>
</tr>
<tr>
<td>Urology</td>
<td>$1,374/day</td>
<td>8%</td>
<td>$1,479/day</td>
<td>18%</td>
<td>$1,743/day</td>
</tr>
</tbody>
</table>

**Note:** Data indicate the average rates billed for locum tenens coverage in each specialty. Daily rates are based on an eight-hour day. Exact rates may vary.

**Source:** Delta Locum Tenens, Dallas.

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Ask the experts

Productivity remains a key variable

Editor’s note: PCR asked our experts about the variables organizations are considering as they develop physician compensation programs. If you have a question for our experts, send it to roxanna@healthleadersmedia.com.

Kim Mobley, principal, Sullivan, Cotter and Associates

The key variables I have seen with regard to physician compensation programs include wRVU, quality, and patient satisfaction. I have seen some movement away from using collections as a basis for determining physician incentive plans. When an organization uses a quality variable in its physician compensation plan, it typically represents a small amount of the total cash compensation (e.g., 2%–3%).

Max Reiboldt, CPA, managing partner and CEO, The Coker Group

Variables currently under consideration can be divided into productivity and other components:

» Productivity. In hospital-employed settings, the current focus is on using wRVUs as a measure of productivity. Historically, the MGMA’s benchmarking survey has been used as the premier source in establishing wRVU-based compensation arrangements. As the market continues to focus on these types of compensation schemes, other surveys such as those from Sullivan, Cotter and Associates and AMGA are gaining prominence to ensure that the compensation arrangements are established at market rates. Hospitals are also recognizing the need to build a reality check into the model, since compensating based on wRVUs has little, if any, correlation to overall profitability.

Accordingly, variables such as industry benchmarks for compensation-to-collections percentages and net income/loss per physician are being used to establish some parameters to the compensation afforded under a wRVU model. In private practice, the typical compensation variables continue to involve an eat-what-you-kill arrangement wherein the more productive members generate higher levels of compensation.

» Other components. As productivity-based compensation arrangements mature, organizations are realizing the need to provide nonproductivity incentives. Additional variables are being inserted into the overall compensation arrangement. Among them are patient satisfaction, quality, good citizenship, expense control, oversight of midlevel providers, excess call coverage, and coding accuracy and compliance.

James W. Lord, principal, ECG Management Consultants, Inc.

Physician compensation programs continue to be very focused on productivity metrics (i.e., wRVUs) or economic metrics (e.g., cash collections). Both of these elements are critical to running a successful physician enterprise. Historically, quality and satisfaction metrics have been somewhat limited due to their lack of objective data.

Today, we find many organizations taking a new look at objectifying quality within their organization and broadening patient satisfaction to include referring provider satisfaction metrics. The balance between economic and quality incentives is a critical next step for physician compensation planning.

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