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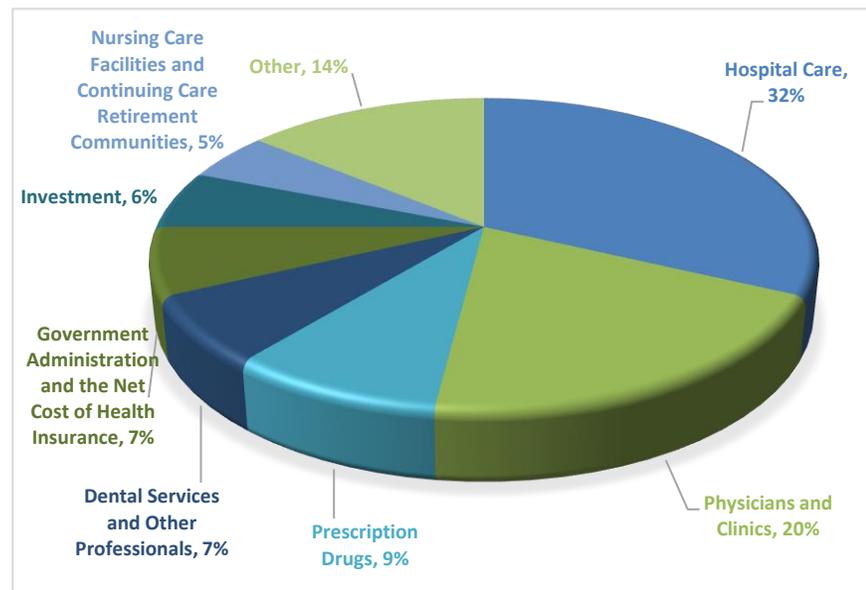
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Ten Keys to Enhancing Physician/Hospital Relations and Reducing Physician Burnout and Turnover:

Introduction

As the chart below indicates, physician and hospital services account for over half of the \$3.3 trillion that is spent on healthcare in the United States each year.



Though physicians and hospitals are separated in the chart as distinct entities (as they are separated by Medicare Part A and Part B payments) their worlds often intersect and, at times, collide.

This continues to be true even though it is generally conceded that physician/hospital integration and collaboration, often referred to as "physician alignment," is a key component of value-based delivery systems.

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However, physician alignment has been a central goal of hospital leaders for years and predates current efforts to replace the nation’s fee-for-service healthcare delivery model with a value-driven model.

In traditional, volume-driven systems, “physician alignment” meant that physicians supported hospital admissions and generated referrals and procedures to their aligned hospital rather than to a competitor. Physicians focused on the patient in front of them both from a clinical perspective and a reimbursement perspective. Typically, physician alignment was achieved, if at all, at the service line level, rather than at the strategic or mission level.

Today, physician alignment is more likely to reflect a common mindset among hospital leaders and physicians that care should be provided globally to large patient groups, that quality should be rewarded, and that financial risk should be shared within a capitated reimbursement structure. In the real world, however, healthcare is delivered along a “physician alignment continuum,” which runs from pure fee-for-service at one end where hospitals and physicians still compete directly for patients, to fully integrated population health management at the other.

Regardless of where particular hospitals are on this continuum, enhancing physician relations remains a key strategic objective. In addition, given the proliferation of the physician employment model, turnover among hospital, medical group and other health care facility staff is likely to increase. According to data firm SK&A, the annual physician relocation rate is 12%, with some specialties considerably higher than the average (see chart below):

Annual Physician Relocation Rates by Selected Specialties

| | |
|--------------------|--------|
| Urgent Care | 19.94% |
| Pain Management | 19.14% |
| Oncology | 17.88% |
| Radiology | 17.23% |
| Psychiatry | 14.57% |
| Family Medicine | 13.47% |
| Emergency Medicine | 13.33% |

Source: SK&A Annual Physician Move Rates

The Effect of COVID-19

Physician alignment, engagement and retention have been given even greater focus due to the COVID-19 pandemic. The virus has created an enormous amount of stress for many hospitals and physicians. It is during times of great stress that organizations either come together due to a sense of shared mission and risk, or come apart as underlying tensions that may have preceded the crisis are exacerbated.

According to an August, 2020 survey conducted by Merritt Hawkins on behalf of The Physicians Foundation,



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20% of physicians plan to seek a new practice, opt out of patient care, or work locum tenens as a result of COVID-19. As the virus continues to challenge the healthcare system, increased volatility in the physician workforce, including increased turnover, can be expected and should be planned for.

Following are ten methods by which healthcare facilities can maintain and enhance physician relations and foster physician alignment and physician retention.

1. Understand the Value Physicians Bring

Despite the proliferation and increased importance of other types of clinicians, including physician assistants and nurse practitioners, physicians remain at the center of the healthcare system. They handle some 1.2 billion office-based, inpatient, and emergency department encounters a year, or an average of four encounters for every American, according to the Centers for Disease Control and Prevention (CDC). When not directly admitting, diagnosing, or operating on patients, they often oversee the treatment plans carried out by other professionals. From a quality of care perspective, they are indispensable.

In addition, physicians remain the drivers of healthcare economics. Physicians direct 87% of personal spending on healthcare in the United States, according to the Boston University School of Public Health, and generate \$1.6 trillion in economic activity. Each physician generates \$3.1 million in purchases, wages, and other economic activity for his or her community and supports approximately 17 jobs (*National Economic Impact of Physicians. American Medical Association. January, 2018*). According to Merritt Hawkins' 2019 *Physician Inpatient/Outpatient Revenue Survey*, each physician generates an average of \$2.4 million in revenue annually for his or her affiliated hospital.

Whether generating revenue through volume-based activities in a fee-for-service market, or by coordinating and managing both quality of care and costs in a fee-for-value market, physicians determine the economic health of the hospitals with which they are affiliated. Most doctors understand the central role they play both clinically and economically and resent it when that role is not acknowledged. The inability or unwillingness of some hospital executives to acknowledge or value physicians accordingly has negatively affected their careers, while the opposite is true for hospital leaders who understand the impact physicians have on their hospital's success.

2. Consider the Physician's Perspective

In discussions about physician/hospital relations it is commonly observed that hospital leaders and physicians come at each other from different perspectives. Hospital leaders embrace hierarchical, top-down management structures while physicians are by nature soloists who resist management. Hospital leaders are compelled to consider budgets while physicians feel patient care should not be constrained by costs. Hospital leaders are committed to serving communities while physicians are committed to individual patients.



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As hospitals and physicians work more closely together, this description is verging on a stereotype. Nevertheless, it remains true that some hospital executives do not fully appreciate the practice environment physicians function in today, the stress many physicians are under, and how they are responding to it. In particular, it is important to consider the continued disengagement of many doctors from the mechanisms of healthcare reform, including quality-based payments, hospital employment, accountable care organizations (ACOs) and electronic health records (EHR).

Insights into the current mindset of physicians are revealed by one of the largest physician surveys conducted in the United States. The biennial *Survey of America's Physicians: Practice Patterns and Perspectives*, that Merritt Hawkins has conducted four times on behalf of The Physicians Foundation (www.physiciansfoundation.org) is a valuable resources for those seeking to gauge the mindset of today's physicians. The 2018 version of the survey includes responses from approximately 9,000 physicians. In over 500,000 data points and over 2,400 written comments, physicians reveal how they regard the practice of medicine today, as well as key metrics concerning their practice volumes, hours worked, Medicare and Medicaid acceptance rates, and other data.

It will come as no surprise to those who interact with them that many doctors are frustrated and dissatisfied with the current state of the medical profession.

Physician Morale Indicators

| | |
|--|-----|
| Morale is negative | 55% |
| Pessimistic about the future | 62% |
| Would not recommend medicine as a career | 49% |
| Often/always feel burned out | 40% |

Source: A Survey of America's Physicians, Practice Patterns and Perspectives. The Physicians Foundation/Merritt Hawkins September, 2018

The primary reasons physicians cite for their dissatisfaction are regulatory/paperwork burdens, inefficient electronic health record (EHR) design, and loss of clinical autonomy, important factors that are addressed later in this white paper. What is of more consequence than their general disaffection from medicine is that many physician plan to change their practice patterns in ways that will reduce patient access to their services.

Physician Practice Plans in the Next 1-3 Years (more than one answer possible)

| | |
|-------------------------|-------|
| Retire | 17.4% |
| Cut back on hours | 22.3% |
| Switch to concierge | 4.5% |
| Work locum tenens | 8.4% |
| Cut back on patients | 7.5% |
| Seek a non-clinical job | 12.4% |



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| | |
|--------------------------|------|
| Work part-time | 8.5% |
| Seek hospital employment | 4.3% |

Source: A Survey of America's Physicians, Practice Patterns and Perspectives. The Physicians Foundation/Merritt Hawkins September, 2018

As these numbers indicate, many physicians plan to retire, cut-back on hours worked or patients seen, seek non-clinical roles or retire from medicine altogether. Hospital executives must consider that a significant number of physicians will be seeking to disengage from clinical roles unless their practice circumstances change for the better. Physician retention programs and physician liaison services will be even more important to organizational success than they have been in the past.

It also is important to consider that while many physicians surveyed indicate they are employed by a hospital or a hospital-owned medical group, most are dubious about hospital employment of physicians. Over 57% do not agree that hospital employment of physicians is a positive trend likely to enhance quality of care and decrease costs. Even many physicians employed by hospitals do not agree that hospital employment of physicians will enhance quality or reduce costs, according to the survey.

The 2018 *Survey of America's Physicians* asked doctors to assess the current state of physician/hospital relations. Their responses were telling (see below):

How Would You Describe the Current State of Relations Between Physicians and Hospitals?

| | |
|-----------------------------------|-------|
| Mostly positive and cooperative | 6.1% |
| Somewhat positive and cooperative | 25.6% |
| Neither positive nor negative | 21.8% |
| Somewhat negative and adversarial | 34.4% |
| Mostly negative and adversarial | 12.0% |

Source: A Survey of America's Physicians, Practice Patterns and Perspectives. The Physicians Foundation/Merritt Hawkins September, 2018

As these numbers indicate, almost half of physicians (46.4%) describe physician/hospital relations as negative and adversarial, compared to only 31.7% who describe physician/hospital relations as positive and cooperative. Even many doctors who are themselves employed (39%) rate the current state of physician/hospital relations as negative.

Given that employment of physicians is a key physician alignment strategy of many hospitals and health systems, the lack of physician buy-in of this model is significant and suggests that merely employing physicians will not create physician/hospital alignment. Most physicians surveyed also express little enthusiasm for EHR, another key element of physician alignment and healthcare reform. Only 25.2% say EHR has enhanced efficiency in their practices, while 56% say it has detracted from efficiency.



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COVID-19 Adds to Physician Stress

As was referenced above, COVID-19 has added to the stress and burnout that many physicians feel. The 2020 version of the *Survey of America's Physicians that Merritt Hawkins* conducted on behalf of The Physicians Foundation focused exclusively on how physicians have been affected by the coronavirus. As the numbers below suggest, it has had a negative effect on their overall well-being.

Response of Physicians to the Effects of COVID-19 on Their Practices

| | |
|--|-----|
| Seek medical attention for a physical problem | 24% |
| Seek medical attention for a mental problem | 13% |
| Increase use of medication, alcohol or illicit drugs | 18% |
| Feel hopeless or that you have no purpose | 30% |
| Feel inappropriate anger, tearfulness or anxiety | 50% |

Source: 2020 Survey of America's Physicians, Part Two. The Physicians Foundation/Merritt Hawkins

The challenge for hospital leaders will be to create practice conditions that allow physicians to reengage with medicine. Understanding the physician's perspective is the first step to achieving that goal.

3. Have a Vision

As the *Survey of America's Physicians* indicates, many doctors are concerned about the future of healthcare and their place in it. To ensure positive physician relations, hospital executives will need to express their vision to physicians about the future direction of their facilities. The key is to delineate where the facility will be along the continuum between traditional fee-for-service and the integrated, value-driven model. While the latter model is proliferating, typically through ACOs in which physicians usually are employed by a healthcare system, variants are possible. These include bundled payment models in which health systems and independent physicians share from the same revenue pool, the "practice leasing" model, in which hospitals provide management services to independent doctors, and physician/hospital joint ventures.

The vision statement also may include how the facility intends to build its medical staff – whether through recruitment of new doctors, through the acquisition of practices already in the community, or through some combination of the two.

Clearly articulating a vision removes uncertainty and promotes the retention of physicians likely to buy-into the direction the facility is heading, while allowing those physicians who may impede the facility from realizing its vision to move on. When developing an organizational vision, it is important to solicit physician opinions and allow physicians to have a direct influence on the direction the organization will take (see #4 below).



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4. Seek Input

Hospitals should develop a formal survey for seeking input from physicians regarding their practice patterns, how they rate hospital services and management, their practice needs and their concerns. The content of the medical staff survey may vary depending on a variety of factors, including the hospital's size and its relationship with its physicians. Below is an example of a medical staff survey that offers a general template and which should be modified as appropriate.

Medical Staff Survey Sample Survey Instrument

(Name of Hospital) is committed to meeting the needs of our medical staff. We would like to learn more about the challenges you face, the staffing, equipment, and operational needs you would like to see addressed, and how we may be able to assist you with these and other matters.

Please take a moment to complete the attached survey. You may take the survey anonymously, or include your name and contact information if you would like the results of the survey sent to you. Please complete the survey and return it by (insert date). We greatly appreciate your consideration and look forward to assisting you.

Your name (optional):

Your specialty (optional):

Would you like results of the survey sent to you? Yes No

If yes, please include your contact information,

Address:

Email:

1. What type of medicine do you practice?

- Primary Care Surgical Specialty Diagnostic Specialty Other

2. Which of the following best describes your current practice?

- I am too busy I am not busy enough I am as busy as I want to be

3. Which best describes your current feelings about your practice?

- I am very satisfied with my practice
 I am somewhat satisfied with my practice
 I am somewhat dissatisfied with my practice
 I am very dissatisfied with my practice

4. How satisfied are you with your current compensation?



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- I am very satisfied with my practice
- I am somewhat satisfied with my practice
- I am somewhat dissatisfied with my practice
- I am very dissatisfied with my practice

5. Is any of your compensation tied to value/quality? (This question may be more appropriate for physicians who may not be employed directly by the hospital but refer to it)

- Yes No

6. If yes, what percentage of your total compensation is tied to quality/value?

- 0-10 11-20 21-30
 31-40 41-50 51 or more

7. If yes, are the quality/value metrics used to determine your compensation clear and fair?

- Yes No

8. How many times has your compensation structure, including production bonus, been revised over the last three to five years?

- It has not been revised 1-2 times 3-4 times 5 times or more

9. Have the reasons for revisions to your compensation structure been adequately explained to you?

- Yes No Not Applicable

10. Do you feel you understand the strategic direction the hospital is taking?

- Yes No Not Applicable

11. Do you feel your voice is heard by hospital administration?

- Yes No

12. Is there someone within hospital administration to whom you can speak about your concerns?

- Yes No

13. Have you become employed by this hospital within the last year?

- Yes No

14. If yes, has the hospital scheduled follow-up sessions with you or created a post on-boarding program to ensure your effective integration into the staff?



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Yes No

15. Does the hospital have a mentoring program or future leadership development program in place?

Yes No Not Sure

16. If you have an office-based practice, about how many patients do you see in your office a month? ____

17. Is this an appropriate number?

Too few
 Too many
 Appropriate

18. How far are you booked out for (non-emergent) new patient appointments?

Same day 1 week or less 2-3 weeks 4-6 weeks
 7-8 weeks 9-10 weeks 11-12 weeks 13 weeks or more

19. Do you have trouble referring your patients to local physicians?

No, local physicians usually can see my patients in a timely manner
 Yes, it is often difficult for my patients to schedule timely appointments with local physicians

20. How long does it take to schedule your patients when you refer them to the following types of physicians?

| | 1 week or less | 2 weeks | 3 weeks | 4 weeks | 5 weeks | 6 weeks |
|----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Family Practice | <input type="radio"/> |
| Internal Medicine | <input type="radio"/> |
| Pediatrics | <input type="radio"/> |
| General Surgery | <input type="radio"/> |
| Orthopedic Surgery | <input type="radio"/> |
| Cardiology | <input type="radio"/> |
| Gastroenterology | <input type="radio"/> |
| Dermatology | <input type="radio"/> |
| Urology | <input type="radio"/> |
| Add others as needed | <input type="radio"/> |

21. Please consider medical services in our area. How would you rate the need for additional physicians in the following specialties?

| | No need | Need in 1-2 years | No need for 2+ years |
|---------------------------|-----------------------|-----------------------|-----------------------|
| Family Practice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| General Internal Medicine | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pediatrics | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| General Surgery | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



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| | | | |
|----------------------|-----------------------|-----------------------|-----------------------|
| Orthopedic Surgery | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Radiology | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| OB/GYN | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gastroenterology | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cardiology | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Add others as needed | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

22. How would you rate the need for additional physicians in your own practice?

- No need now
- I would like to add an associate within the next 12 months
- I would like to add an associate within the next 12-24 months
- Other

23. When do you plan to retire?

- Within the next six months
- Within one year
- 1-2 years
- 3-4 years
- 5 years or more

24. Rate the hospital in the following areas:

| | Excellent | Good | Average | Poor |
|----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Patient registration | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Patient discharge | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Medical records | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Operating rooms | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pathology/Lab | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Emergency room | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Diagnostic imaging | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

25. In what ways can the hospital assist you?

- Marketing the practice
- Physician recruitment
- managed care contracts
- IT/EHR support
- Other

26. The healthcare system is evolving away from traditional fee-for-service medicine and toward a fee-for-value model. In what ways should (name of hospital) respond to these changes? What direction would you like to see (name of hospital) take in terms of health reform, medical staff development, adding physician leaders and supporting the medical staff?



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Thank you for your participation. Should you have any questions about this survey or wish to discuss it, please contact (name of the medical director or physician liaison).

It should be noted that the key to physician engagement surveys is not merely to conduct them. Hospital leaders must demonstrate they have responded to physician input and that specific actions were taken to address physician concerns.

5. Recruit to Retain

The physician recruiting process can be a foundation on which positive physician relations rests or it can undermine the relationship physicians have with hospitals. Problems created or compounded by physician recruiting practices arise in two areas. The first is an insufficiently detailed or accurate practice opportunity presentation. If expectations regarding required work hours, patients seen per day, group governance, quality metrics, compensation and related issues are not clearly communicated to candidates on the front end of the recruiting process, misunderstandings that lead to physician disengagement or turnover can result on the back end.

It is important to delineate in writing exactly what is expected of the physician, and make sure to accurately project the financial potential of the practice so that expectations are realistic and achievable. The majority of these details should be communicated during the candidate screening process, before the physicians arrives for the on-site interview.

A second consideration is that recruiting new physicians can alienate those already practicing in the service area, unless the recruiting effort is based on an objective, data-driven need for additional doctors. A community needs assessment plan can help convince staff physicians that new doctors are needed and that they do not need to feel threatened by potential competition. It should be noted that the Affordable Care Act (ACA) requires tax-exempt hospitals to perform a community health needs assessment every three years effective March 12, 2012 or risk a \$50,000 fine.

The physician/hospital relationship typically begins at the recruitment stage. A thorough, candid recruitment process can build the trust and cooperation needed to ensure physicians and hospital leaders are able to work through the challenges that almost inevitably will arise at some point in this key relationship.

6. Add Physician Leaders

Physicians traditionally have achieved leadership roles in hospitals through board memberships, medical directorships and committee assignments. These leadership roles have allowed physicians to have influence over the patient care issues which of are most importance to them, particularly at the departmental level.



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However, the role of physician leaders is magnified in the era of health reform as they are viewed as the key change agents needed to implement the transition from the fee-for-service delivery model to the value-based model. There are various reasons why physicians may resist the transformation that is taking place in healthcare today, even if they believe that tying reimbursement to quality and managing population groups are valid concepts in theory.

Prominent among these is a key objective of the population health management approach, which is to reduce utilization of diagnostic and surgical services through prevention and the interventional management of patients with chronic conditions (i.e., “frequent flyers”). The success of this approach depends on the elevation of primary doctors in the medical hierarchy as coordinators or “quarterbacks” of clinical teams, and the relative reduction of the use and influence of specialists. Because fee-for-service dynamics still are prevalent throughout the healthcare system, high revenue producing specialists retain their rainmaker status, but they can see the writing on the wall. Physician leaders may be needed to convince specialists that new delivery models can work for them and for their patients.

In addition, if physicians of all types are going to be evaluated and paid on their adherence to evidence-based treatment protocols and to quality metrics, they expect that these protocols and metrics will be defined by their fellow doctors. They then can trust that protocols will be good for patients and not just for the bottom-line. The same principle holds true for electronic health records (EHR), which can be made more palatable to the medical staff when selected by physician leaders who understand the clinical and patient interaction implications of various systems.

Physician leaders can play a pivotal role in getting medical staff members to embrace the levers of healthcare reform (quality payments, population health, standardized care, EHR), provided such leaders are perceived to have real authority and are not mere figureheads. A growing number of hospitals and health systems are seeking physician CEOs or are creating new titles such as Chief Transition Officers (CTOs) to ensure physician leaders have the authority they need to implement change.

In the 2020 *Survey of America’s Physicians that Merritt Hawkins* conducted on behalf of The Physicians Foundation, physicians were asked to rate the most important policy steps that could be taken to ensure better access to quality care for all. Their first priority was to increase access to health insurance, but their second priority was to increase the number of physician leaders.

It therefore is in the hospital’s best interest to incorporate multiple avenues by which physicians can evolve as leaders, including mentoring and future leadership programs, and to encourage their participation in governance and administrative issues. All physicians, in the broad sense, are leaders as they direct the patient care experience. Some are latent administrative as well as clinical leaders, and it will be increasingly important in the future for hospitals to identify and develop the leadership capabilities of key medical staff members.



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7. Employ the Physician

Among the various alternatives physicians have to traditional private practice, including part-time practice, concierge medicine, non-clinical practice, and locum tenens, the one they are most frequently embracing is employment. In the *2012 Survey of America's Physicians* conducted by Merritt Hawkins for The Physicians Foundation, 49% of doctors identified themselves as private practice owners or partners. In the 2016 survey, that number decreased to 33% and dropped to 31% in the 2018 survey. In 2004, only 11% of Merritt Hawkins recruiting assignments featured employment of the physician by a hospital. Today, the number stands at about over 40%. Over 90% of Merritt Hawkins recruiting assignments last year featured employment of the physician by a hospital, medical group, urgent care center, Federally Qualified Health Center (FQHC) or other entity, while less than 10% featured a true private practice setting.

Physicians are embracing employment as a safe harbor from the financial uncertainty, regulatory burdens, and reimbursement challenges of private practice, and this trend will like accelerate due to the effects of COVID-19 on physician practices. Hospitals, in particular, have become more adept at employing physicians than they were during the physician employment/practice acquisition wave of the 1990s, when ineffective management and compensation models led to financial losses and the general abandonment in most markets of the health maintenance organization (HMO) model.

Employment of physicians by hospitals and health systems is seen as necessary to achieve the care coordination, EHR standardization, and global revenue sharing typical of ACOs and other value-based delivery models. It remains the most nimble and effective pathway to integrating various medical staff cultures and compensation formulas during today's era of hospital and group mergers and is viewed by many healthcare executives as the bedrock of physician/hospital alignment.

However, as was referenced above, the majority of physicians do not see hospital employment of doctors as a means of enhancing care or reducing costs. Even many physicians who are themselves employed by hospitals are dubious about the benefits of the employed model and can be considered reluctant participants. From the hospital perspective, employing physicians does not equal alignment. By federal law, hospitals cannot reward physicians for referrals, cannot compel them to refer only to one hospital, and cannot prevent them from obtaining privileges at other hospitals. In addition, merely employing physicians does not guarantee that they will embrace the behaviors and practice patterns required to make the transition from volume to value. There may even be instances where this transition is made easier by independent groups that have embraced the value-based concept and are leading the charge to implement it, rather than by employed physicians who may resist the value-based concept.

However, the employed model can promote physician alignment and positive physician relations when it is used in concert with other steps outlined in this white paper, in particular, when employment leads to a more positive practice environment for physicians and when physicians perceive that they are not just cogs in the corporate wheel (see #8 below).



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8. Create a Positive Workplace

Like snowflakes, no two medical practices are alike. Some practices are more appealing than others, not necessarily because they are located by a beach or near the mountains, but because they feature a practice style and a work environment tailored to what doctor's today prefer. Hospitals cannot control the fact that they are not close to an ocean, but they can to some extent control the quality of the medical practice environment they are offering.

The **"primacy of the workplace"** may be the most important factor to consider when seeking to enhance physician/hospital relations. First and foremost, physicians want a safe, efficient place to treat their patients, one in which they can focus on what they were trained to do. To the extent they can provide this type of positive environment, hospital leaders are likely to build physician loyalty and rapport. For hospitals that cannot create positive working conditions for physicians, physician disengagement and turnover are inevitable.

Following are some ways to maintain a premier physician "workshop."

- Offer clear, competitive, fair compensation (see #9 below).
- Maintain a qualified, appropriate nursing staff. A key irritant to many physicians is lack of appropriately trained nurses
- Improve physician access to patient data
- Enhance test turnaround times
- Ensure timely, efficient OR capability
- Ensure timely, efficient patient admissions and release
- Enhance ER triage/patient turnaround
- Implement a hospitalist/surgicalist/laborist/nocturnist/complexivist program
- Provide flexible scheduling
- Use locum doctors during peak usage periods to avoid physician burn-out
- Provide convenient parking/access for physicians
- Implement efficient, physician-friendly EHR
- Maintain appropriate equipment
- Add specialty support as needed
- Maintain a quality medical staff. Physicians are very sensitive to the training and professionalism of their peers.
- Reduce as much as possible regulatory, pre-authorization, reimbursement and related non-clinical paperwork ("let doctors be doctors").

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A Positive Workplace Post-COVID-19

The coronavirus pandemic has created new conditions for physicians and other healthcare professionals to which hospitals must respond. A positive physician workplace in the COVID-19 era includes the following elements:

- Adequate personal protective equipment (PPE)
- Safety protocols for both healthcare workers and patients
- Implementation of telehealth treatment pathways
- Enhanced incorporation of physician leaders
- Strategic and sequential reintroduction of elective procedures
- Streamlined administrative duties
- Outreach by administration to ensure physician wellbeing and support of physician families

Life for physicians, as for most professionals, revolves around work. Physicians who leave their practices at the end of the day satisfied that they have provided quality care to their patients and that they have utilized their training to the best of their ability look forward to coming to work the next day. Those who feel otherwise look for work elsewhere.

9. Offer Clear, Competitive, Fair Compensation

When the majority of physicians were independent practice owners and essentially paid themselves, data on physician compensation was limited. Today, there are a variety of sources that track physician earnings, including the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA), Sullivan, Cotter & Associates, The Hay Group, the Hospital and Healthcare Compensation Service, and others.

Merritt Hawkins, in its annual *Review of Physician and Advanced Practitioner Recruiting Incentives*, tracks physician starting salaries, rather than total physician compensation, as is reported by other data sources. It therefore offers benchmarks for what hospitals, medical groups, and other facilities are offering to attract physicians, either those out of residency or those already in practice. Below are average starting salaries for several highly recruited specialties as tracked by the 2020 *Review*:

Average Starting Physician Salaries by Specialty

| | |
|--------------------|-----------|
| Family medicine | \$240,000 |
| Internal medicine | \$255,000 |
| Psychiatry | \$276,000 |
| Orthopedic Surgery | \$626,000 |



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Source: Merritt Hawkins 2020 Review of Physician and Advanced Practitioner Recruiting Incentives

The *Review* also tracks average signing bonuses, relocation allowances, continuing medical education (CME) allowances and other incentives used to recruit physicians.

Physicians are aware of these data sources and usually have a fairly accurate view of what is competitive in their specialty. Hospitals seeking to maintain or enhance physician relations should offer physicians income in the range of what is competitive to ensure they feel valued and do not seek opportunities elsewhere.

However, today the way physician compensation is structured may be as important as the amount that is offered. Seventy-two percent of the 3,251 search assignments Merritt Hawkins conducted in the last year featured a salary with a production bonus. The production bonus is the physician's path to maximizing his or her financial potential. A family physician, for example, might be paid a base salary of \$240,000 with a potential production bonus of \$50,000.

In most physician contracts, the production bonus is achieved through the number of Relative Value Units (RVUs) the physician generates, number of patients seen, or amount of revenue collected. As is apparent, these are all volume-based metrics typical of the fee-for-service model. Sixty-four percent of the search assignments Merritt Hawkins conducted last year that featured a production bonus included a value-based component in the bonus structure.

MACRA replaced the old method of physician reimbursement under Medicare (known as the Sustainable Growth Rate formula) with a new method. The new method, while still in flux, will require physicians to participate in a payment formula with a strong value-based component (known as MIPS) or participate in an ACO-like entity known as an alternative practice model (APM). Private payers are likely to follow Medicare's physician reimbursement formulas (for more information on this subject see the Merritt Hawkins white paper, *Physician and Hospital Reimbursement: From Lodge Medicine to MIPS*).

This means a growing number of physicians will be evaluated on outcomes, quality measures, use of healthcare information technology, cost effectiveness, and patient satisfaction. These measures are more subjective, less easily understood, and usually less well-received by physicians than are standard volume-based measures, which are comparatively easy to understand. It will be important for hospital leaders to follow evolving physician payment models and to ensure physician performance and pay metrics are as clear as possible. This entails keeping the number of metrics as low as possible and having evaluation measures be physician-directed. It also entails tracking outcomes data, such as which physicians achieve low rates of diabetes or low blood pressure among their patients, which have low readmission rates, positive patient satisfaction scores and other benchmarking metrics. Buy-in is more likely when physicians are presented with physician-instituted quality standards and meaningful outcomes data.

The "right" physician compensation formula is hard to come by, particularly when consolidation is taking place and physicians from various groups are joining a central system where compensation must be standardized. The "Goldilocks zone" in which physicians are rewarded sufficiently for volume to stay productive, yet also are rewarded enough on value to embrace new delivery models, is still aspirational for many healthcare



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facilities. This will continue to be a challenge, but the facilities that can keep their compensation formulas transparent and equitable will go a long way toward maintaining or enhancing their relations with physicians.

10. Continually Communicate

Several years ago, Merritt Hawkins recruited a neurologist to a growing group practice. When contacted some months later to see how he was fitting in with the group, we were informed that he was leaving because the group had not yet put his name on the door or on other signage, and he therefore assumed he was not wanted. A simple lapse in communication almost caused this group to lose a good doctor. This anecdote illustrates the importance of continual communication with the medical staff, and the hazards of assuming physicians have received a message when it has not been explicitly stated.

Physician communication should be both:

- Formal, through regular medical staff surveys, and
- Informal, through regular contact in the physicians' lounge, at lunch, in the operating room, or at informal gatherings such as "pizza conferences" or "ice cream conferences."

This concept is best encapsulated in a quote from a health system CEO that further reiterates the importance of communicating with staff physicians:

"When you need the goodwill of physicians, it is too late to create it. My advice is get ahead of the competition by having a really good relationship with your doctors."

About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician



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assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- ❖ Psychiatry: "The Silent Shortage"
- ❖ Rural Physician Recruiting Strategies
- ❖ The Aging Physician Workforce: A Demographic Dilemma
- ❖ Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- ❖ The Physician Shortage: Data Points and State Rankings
- ❖ Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- ❖ How to Assess a Physician Practice Opportunity
- ❖ The Economic Impact of Physicians
- ❖ Physician Recruiting and Federal Immigration Laws
- ❖ Family Medicine Supply, Demand and Recruiting Trends

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