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INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

The Dilemma
of Physician Recruiting and Pay

by Jim Burnette, President/CEO, HospitalMD

You know you need more revenue. You know you need more physicians and that recruiting them is an expensive decision, and a risky one as well. You know you must generate higher patient volume and revenue than your costs, but your experience tells you that this might not happen. You immediately become stressed.

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You will be "upside down" for 2 to 3 years before you know if your decision paid off. You move ahead and complete the deal. There is no turning back. What a dilemma.

You have been told that it's difficult to recruit to a small community. Left to chance, perhaps the word will get out and a physician might voluntarily set up an independent, local office practice. You know the odds are low. And even if a physician shows up at no cost to you, this physician may not support your hospital.

THE DILEMMA

Your decision will have consequences. You agonize over your options–leave it to chance, employ, or subsidize. You finally decide to recruit and employ a physician because you feel that you will have some degree of "control". You sign the contract, but the uncertainty has just begun. Physicians are the hospital's most expensive human resource by a large margin. You will be "upside down" for 2 to 3 years before you know if your decision paid off. You move ahead and complete the deal. There is no turning back. What a dilemma.

DID YOU PAY TOO MUCH OR PAY TOO LITTLE?

When deciding how to pay physicians, how much pay is enough? For all hospitals, and especially those that are struggling and trying to keep costs low, physician pay seems like a "necessary evil". And, this dilemma is not unique to office-based physicians. The decision involving how much you pay for hospital-based Emergency Medicine (EM) and Hospital Medicine (HM) physicians is more complex, more risky, and may have greater consequences. Why?

Regardless of how supportive your PCPs are, the EM service is the gateway for 90% or more of your most profitable (inpatient) business, and the single most expensive medical service on your financial statement. EM physicians may not know if a particular patient meets regulatory criteria for a medically necessary acute admission. The PCP may not even get the opportunity to weigh in on the decision, and the patient may be unnecessarily transferred. In this sense, the EM physician is "presupposing" his/her own knowledge and the capability of the nursing staff and Medical Staff. Is the effectiveness of the EM physician's medical decisions then related to pay?

My observation over the years is that many, if not most, small community hospitals (SCHs) tend to pay on the low side of the market range, and pay no more than they must to land a physician. Financial pressure clouds the decision process to the point at which the goal becomes paying for "coverage" rather than for growth in revenue and maximizing efficiency.

THE DOWNWARD SPIRAL

The downward spiral continues. Physician pay becomes an "expense". If you don't believe you can recruit good physicians to your small community, and you need to keep expenses at a minimum; a "doctor becomes just another doctor". This leads to an aversion to risk. If you pay too much and don't get revenue, you may lose your job. On the other hand, your Board agreed you needed a doctor. So you choose the lower risk and hire a doctor at a low price regardless of outcome.

Does paying more than market lead to high quality outcomes, higher revenue, and better customer service? Not necessarily. But higher pay attracts more prospects, and usually better prospects. But you must be able to evaluate each prospect, set the right expectations, and manage to those expectations.

There are also consequences if you pay too low. Low pay not only results in fewer choices, but the prospects may be physicians whose motives are not aligned with yours. Let's rethink this. Physicians are not just another human resource and an expense.

FOUR IRREFUTABLE TRUTHS ON PHYSICIANS

Here are four fundamental principles that I find useful:

- **TRUTH 1:** Except for the cafeteria and gift shop, the hospital generates no revenue unless a physician writes an order. That's effectively all your revenue.
- **TRUTH 2:** Only a physician has legal and regulatory authority to write orders.
- **TRUTH 3:** Hospitals need physicians. Physicians don't need hospitals.
- **TRUTH 4:** Physicians are revenue engines. View them as assets, not expenses.

These may be so simple and subtle that we ignore or forget them. I believe that they are fundamental. This doesn't mean you pay absurdly, but you try to balance pay with the results you expect. To illustrate, if you purchase a machine that produces only 700 products because you were more concerned about cost, and you really needed one that produces 1,000, you are likely to be disappointed. These principles are not the answers to your questions, but you need to consider them in making your decisions.

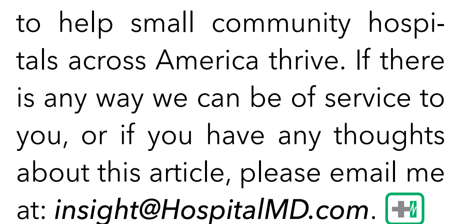
A DIFFERENT PERSPECTIVE

Let's think about pay from a different perspective. The SCH market supports far fewer physicians than urban hospitals. Financial *inefficiency* (lower revenue than cost) can be absorbed with many physicians and more volume in the urban hospital. But there is little room for error with few physicians. Physicians in SCHs must be "top guns". They must be the best you can find. Three "top guns" with a broad skill set can diagnose and treat higher acuity patients and out produce six mediocre physicians.

GREEN CEILING

We could call the physician pay decision a "green ceiling". Let's look at an example. In the ED setting, a pay rate of $20 per hour higher than market would result in an increased annual payroll of $175,200 ($20 per hour x 24 hours per day x 365 days per year). However, a SCH with an average net revenue per inpatient discharge of $6,000 could cover this increase with only 29 more acute admissions per year ($175,200 divided by $6,000), or 2.4 per month. This would seem like a "no brainer". But this is also a risk if the hospital doesn't know how to evaluate the prospect's skills, negotiate the right pay package, and know how to manage the physician relationship.

As you consider the challenges, you face, we want to stand with you. **HospitalMD** has a mission to help small community hospitals across America thrive. If there is any way we can be of service to you, or if you have any thoughts about this article, please email me at: *insight@HospitalMD.com*.



–Jim Burnette

Partner Hospitals Get CMS 4 Star Ratings

CMS published the much-anticipated hospital quality STAR ratings in July. There are a total of 5 levels (STARS) of achievement that are a composite metric of 64 performance measures for 4,600 hospitals in the U. S. Of all 4,600 hospitals, only 102 (2.2%) nationally achieved a 5-star rating which is the highest. Only 934 (20.3%) achieved a 4-star rating. Of this 934 nationally, 129 are in Georgia. Two of these 4-Star winners in Georgia are our client hospitals: **Evans Memorial Hospital**, Claxton, **and Elbert Memorial Hospital,** Elberton. Congratulations!

Many of these 64 performance measures require a high degree of integration and cooperation between the hospital's Nursing Service and its Emergency Medicine and Hospital Medicine physicans. These particular measures cannot be achieved independently.

These star ratings are provided for the public to empower people to compare hospitals across all hospitals.

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