

# **BENCHMARKING FOR THE FUTURE OF YOUR PHYSICIAN & APP WORKFORCE**



## **MGMA DATADIVE PROVIDER COMPENSATION**

Balance compensation with productivity with the most reliable data in the industry. *MGMA DataDive Provider Compensation* is your go-to resource for any physician or advanced practice provider (APP) compensation decisions. Use it to understand the unique differences among physician-owned, hospital-owned and academic practice benchmarks across multiple regions, practice sizes and provider experience levels. Benchmarks include:

- Compensation (including total pay, bonus/incentives, retirement)
- Productivity (work RVUs, total RVUs, professional collections and charges)
- Benefit metrics (paid time off, vacation time, sick time)

**Explore even more of what *MGMA DataDive Provider Compensation* offers.**

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# INTRODUCTION

**While healthcare providers have stretched their teams to meet rising patient demands amid staffing shortages and intense competition for workers, the dollars they earn for delivering high quality care aren't stretching as far as they once did.**

The *2023 MGMA Provider Compensation and Production* report — reflecting data from nearly 190,000 providers at more than 6,800 organizations — offers a glimpse into the evolving financial picture for providers.

Despite physician and advanced practice provider (APP) productivity continuing its post-pandemic recovery, compensation gains are being outstripped by the most severe inflationary growth in decades.

**Primary care, surgical specialist and nonsurgical specialist physician compensation all saw modest gains from 2021 to 2022;** however, none of these benchmarks rise to the elevated levels of inflation. The Consumer Price Index (CPI) rose 6.5% from December 2021 to December 2022, per [Bureau of Labor Statistics data](#), far eclipsing most gains in provider compensation measured in this data set.

In particular:

- The growth in median total compensation for primary care physicians doubled from 2021 (2.13%) to 2022 (4.41%), while inflation stood at 7% and 6.5%, respectively.
- Surgical and nonsurgical specialists saw their change in median total compensation cool slightly in 2022, dropping from 3.89% for surgical specialists in 2021 to 2.54% in 2022, and from 3.12% for nonsurgical physicians in 2021 to 2.36% in 2022.
- APPs — who saw the biggest change in median total compensation from pre-pandemic levels — saw their 2022 growth ebb slightly to 3.70%, down from 3.98% growth in 2021.

While healthcare providers continue to innovate and find new ways to grow their practices in the face of post-pandemic challenges, they must pay close attention to the shifts in economic and labor markets. The data contained within the *2023 MGMA DataDive Provider Compensation* offer a clear, up-to-date and **comprehensive sense of what medical group, health system and hospital leaders should consider in budgeting and building the compensation models that will recruit and retain the physician and APP workforce of the future.**

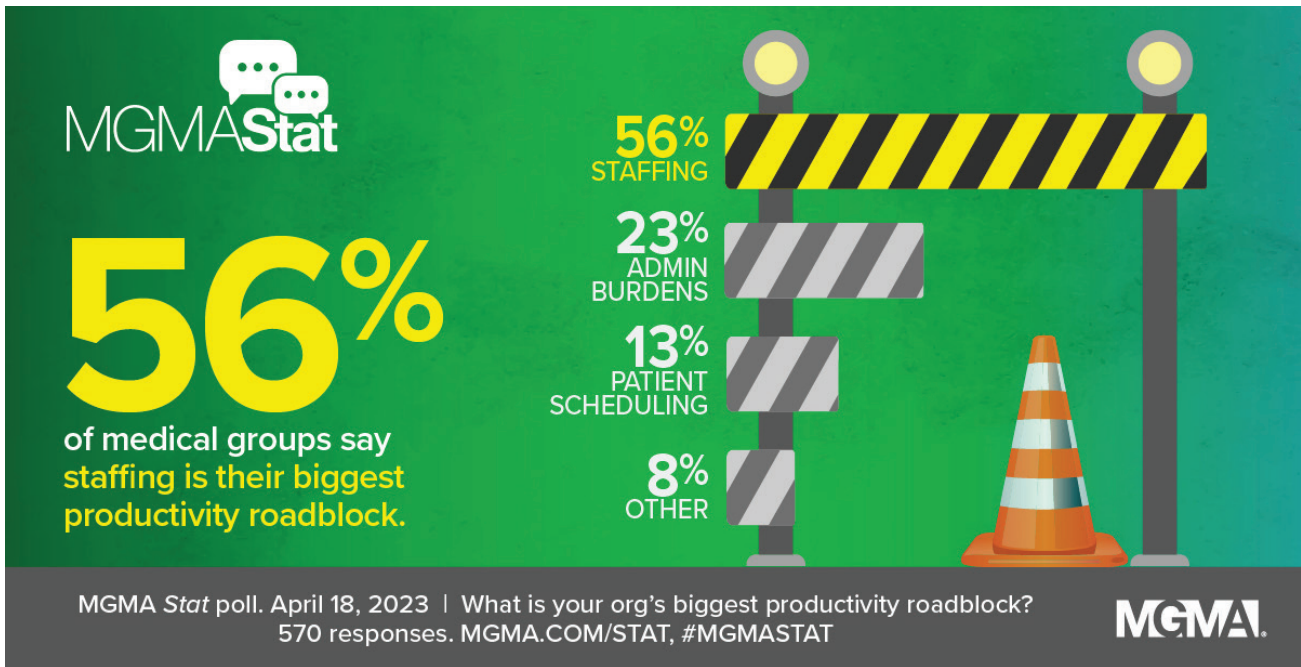
	ONE-YEAR CHANGE 2021 TO 2022:	CHANGE DURING COVID 2020 TO 2022:
Primary care physician total compensation	4.41%	6.63%
Surgical specialist physician total compensation	2.54%	6.53%
Nonsurgical specialist physician total compensation	2.36%	5.55%
Advanced practice provider (APP) total compensation	3.70%	7.82%
Consumer Price Index (CPI)	6.50%	13.50%

Sources: 2023, 2022 and 2021 MGMA DataDive Provider Compensation and Bureau of Labor Statistics

# DATA TRENDS

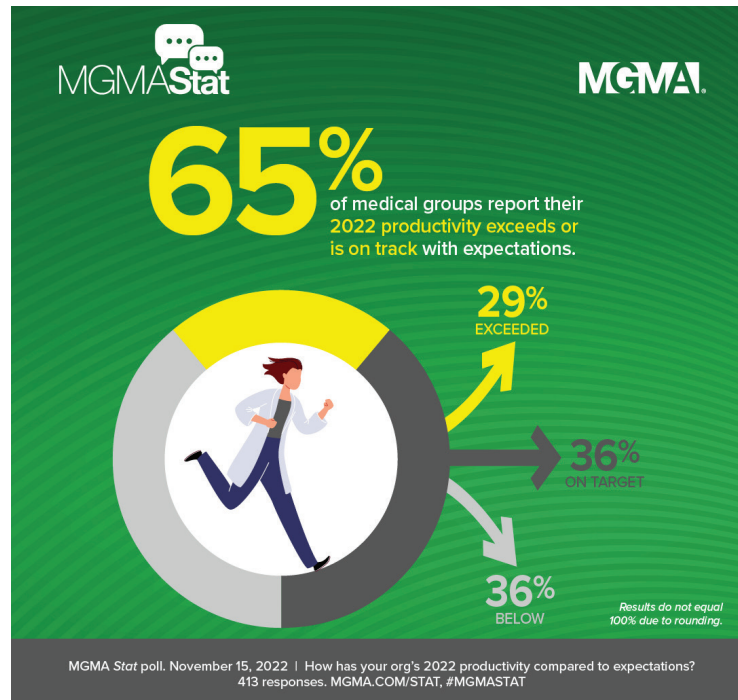
## PRODUCTIVITY

The familiar story of staffing as a major challenge across the healthcare industry still leaves many questions unanswered. For healthcare leaders, the biggest question perhaps is, **“How much are labor pains holding back productivity?”**



MGMA polling in November 2022 found a nearly three-way split on where medical groups stood heading into this year: About one in three (29%) reported exceeding their productivity goals for the year, while 36% were on target and another 36% were below their expected levels. *[Figures do not add up to 100% due to rounding.]*

Through spring 2023, those staffing challenges were recently ranked as the top roadblock to higher productivity — ahead of administrative burdens, patient scheduling and other obstacles.



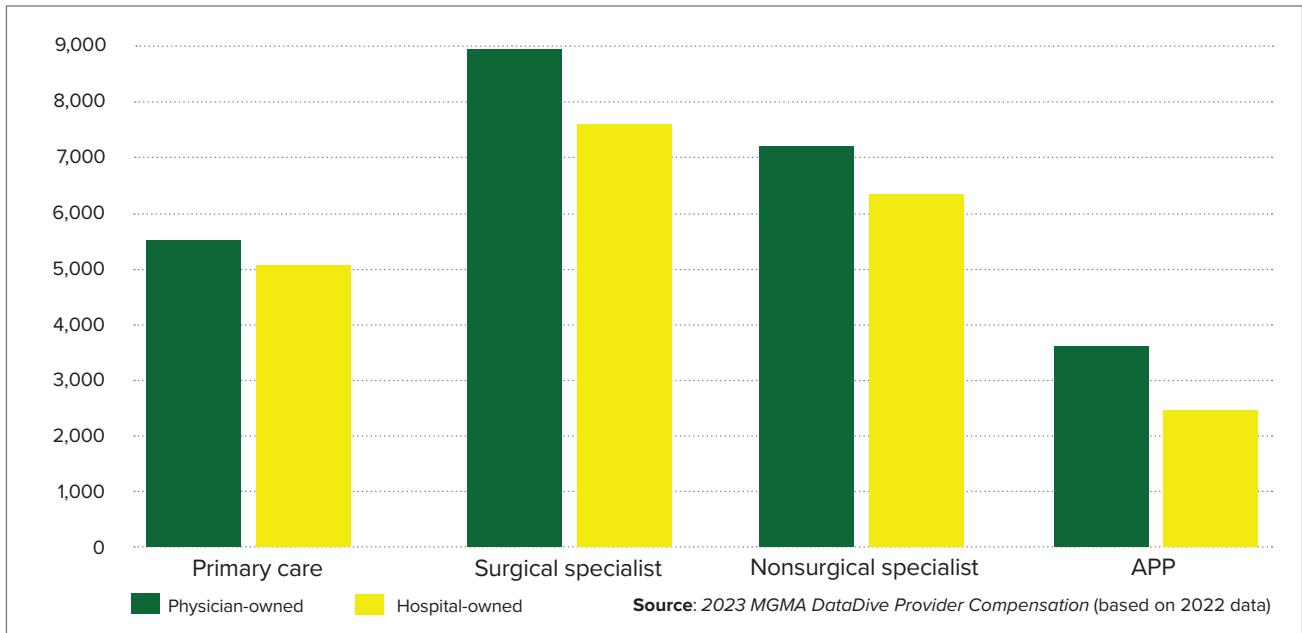
## Productivity benchmarks by ownership

Physician-owned practices reported higher levels of productivity in collections, total encounters and work RVUs (wRVUs) compared to their hospital-owned counterparts for 2022. Total encounters reflect the number of direct provider-to-patient interactions regardless of setting, including televisits and e-visits. Work RVUs also quantify productivity and take into account the complexity of the visits.

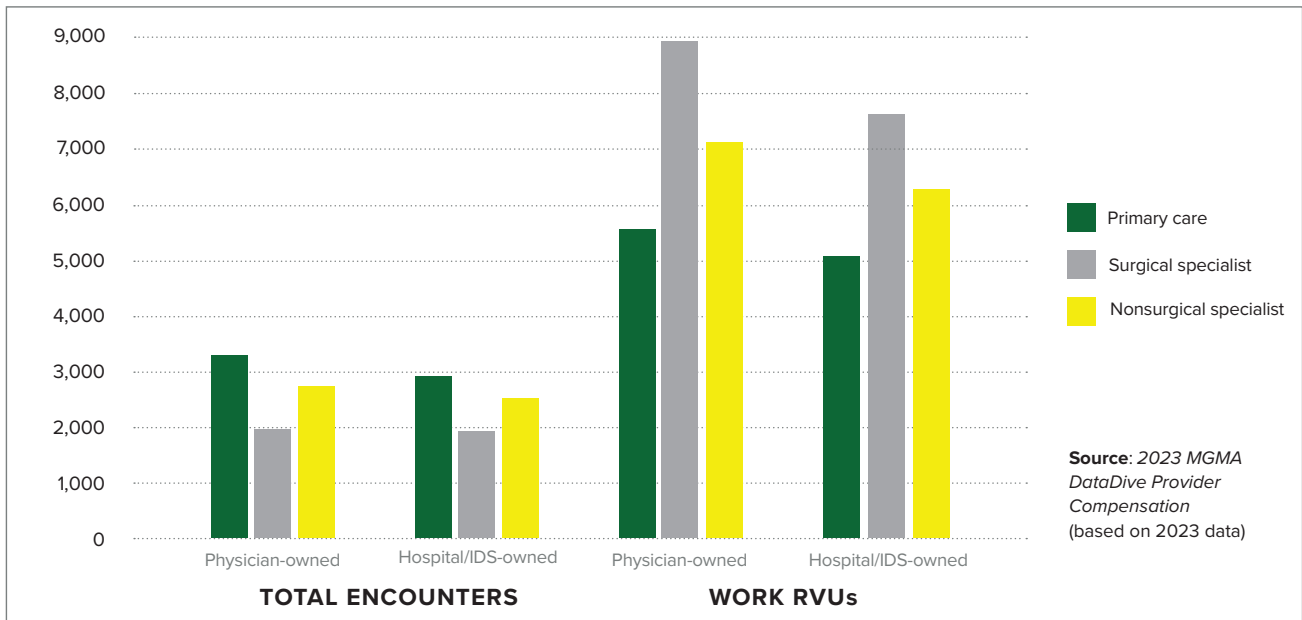
DIFFERENCE BETWEEN PHYSICIAN-OWNED AND HOSPITAL-OWNED PRODUCTIVITY			
	Collections	Total encounters	Work RVUs
Primary care physicians	\$124,804	373	397
Surgical specialists	\$96,580	65	1,371
Nonsurgical specialists	\$172,221	185	865
Advanced practice providers	\$100,715	306	1,146

Source: 2023 MGMA DataDive Provider Compensation (based on 2022 data)

## MEDIAN 2022 wRVUs BY PRACTICE OWNERSHIP



## MEDIAN PRODUCTIVITY BENCHMARKS BY PRACTICE OWNERSHIP AND SPECIALTY GROUPING, 2022



## What's working and what's not

Among practices not faring as well in the November 2022 polling, practice leaders told MGMA that their top barriers included:

- Lack of provider availability due to staffing shortages, especially among physicians, nurses, and support staff, fueled either by burnout or lower-wage workers leaving for other industries
- Increased administrative burdens from prior authorization causing disruption in care delivery
- The need for investing additional time and effort into the financial stability of the practice, including training of new billing staff and growing amounts of time spent on auditing payer reimbursement and managing claim denials
- Encountering higher levels of patient no-shows that left unfilled appointment slots in provider schedules.

However, practices that were on course or ahead of their goals noted several factors that aided them throughout 2022:

- Some practices saw improvements simply by making the investment to hire more providers and add new service lines
- Making changes to phone systems to reduce administrative work and improve scheduling
- Focusing on culture and incentives to positively drive productivity, as well as the implementation of dashboards and scorecards to set expectations and hold team members accountable for goals
- Longer operating hours in 2022 due to fewer COVID-19-related shutdowns
- A stronger focus on calling no-show patients, monitoring daily schedules and recruiting new patients.



# D datadive

## WHAT'S NEW IN 2023:

### **NEW SPECIALTIES:**

Genetic Counselor  
NP: Vascular Surgery  
PA: Vascular Surgery

### **NEW FILTERS:**

Physician title (MD, DO)  
Provider Primary Shift

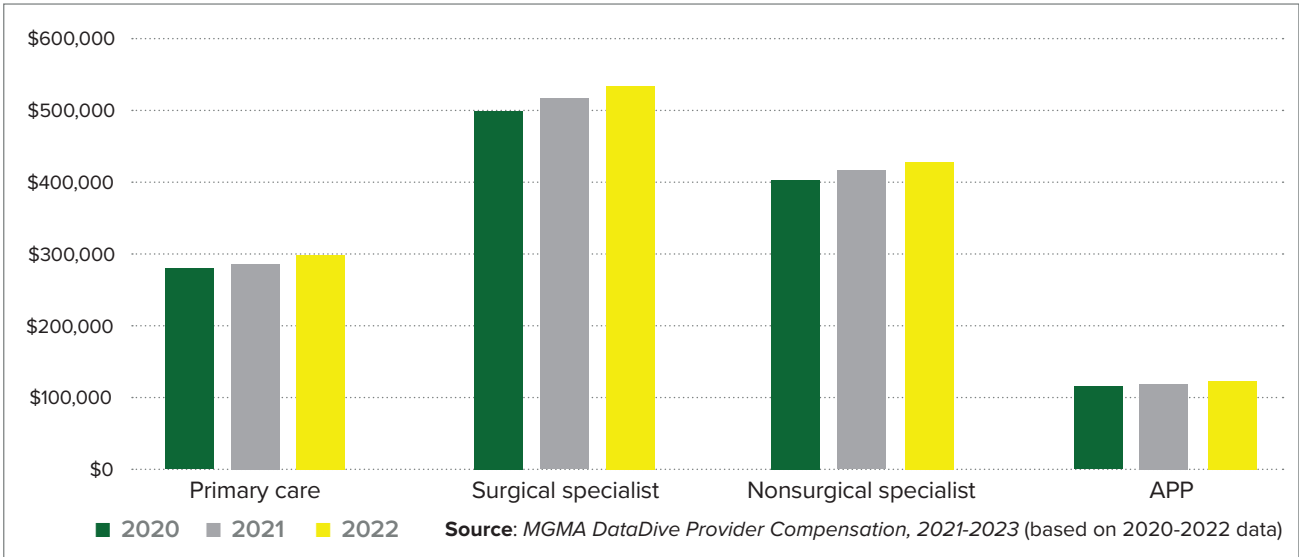
### **NEW FEATURES:**

*For Organizational Members only:* Clone reports year-over-year  
[\(Details available on Page 11 of the DataDive User Guide\)](#)

# DATA TRENDS

## PROVIDER COMPENSATION

### MEDIAN TOTAL COMPENSATION, 2020 TO 2022



Overall, compensation for most physician specialties saw slight increases between 2019 and 2022 with productivity numbers staying relatively flat in the three-year period that compares pre-pandemic benchmarks to current day.

### APP benchmarks

APP compensation experienced moderate increases in the past year, and a five-year look through MGMA DataDive benchmarks show the broader growth since 2018.

INCREASE IN MEDIAN TOTAL COMPENSATION, NPs AND PAs		
	2021-2022 change	2018-2022 change
<b>Nurse practitioner (NP)</b>		
Surgical NP	4.08%	11.51%
Primary care NP	8.10%	13.62%
Nonsurgical/nonprimary care NP	6.30%	15.48%
<b>Physician assistant (PA)</b>		
Surgical PA	7.58%	11.32%
Primary care PA	9.22%	12.44%
PA (nonsurgical/nonprimary care)	4.34%	15.47%

Source: MGMA DataDive Provider Compensation, 2019-2023 (based on 2018-2022 data)

COMPENSATION AND PRODUCTIVITY VARIATION BY SPECIALTY, 2019 TO 2022		
	Change in total comp.	Change in wRVUs
Cardiology: Invasive	7.57%	2.38%
Cardiology: Invasive-Interventional	4.89%	-3.35%
Cardiology: Noninvasive	5.69%	5.79%
Dermatology	3.96%	17.22%
Emergency medicine	3.52%	0.46%
Family medicine (without OB)	10.57%	11.75%
Gastroenterology	3.79%	5.14%
Hematology/Oncology	7.22%	13.05%
Hospitalist: Internal medicine	5.49%	0.62%
Internal medicine: General	8.16%	8.95%
Neurology	6.53%	-0.06%
Obstetrics/Gynecology: General	4.39%	1.64%
Ophthalmology	7.32%	3.49%
Orthopedic Surgery: General	3.34%	3.87%
Otorhinolaryngology	5.50%	6.51%
Pathology: Anatomic and Clinical	2.89%	1.21%
Pediatrics: General	7.30%	8.69%
Psychiatry: General	5.37%	3.06%
Radiology: Diagnostic	5.25%	3.66%
Surgery: General	7.05%	-1.10%
Urgent care	0.13%	7.59%
Urology	7.32%	4.00%

Source: MGMA DataDive Provider Compensation 2020 and 2023 (based on 2019 and 2022 data)



### Benchmarks for post-residency/ post-fellowship providers

As the industry looks to a new generation to step up as a wave of physician retirements crests, providers coming out of residency/fellowship and newly hired to a practice in 2022 reported earning more in guaranteed compensation than their pre-pandemic counterparts in 2019.

CHANGE IN MEDIAN GUARANTEED COMPENSATION FOR NEWLY HIRED POST-RESIDENCY/FELLOWSHIP PROVIDERS	
	2019-2022 change
Primary care physicians	10.43%
Surgical specialists	3.25%
Nonsurgical specialists	10.00%

Source: MGMA DataDive Provider Placement Starting Salary, 2020-2023 (based on 2019-2022 data)

### Benefits for newly hired providers

Competition for physicians and APPs has been intense since the beginning of the pandemic and now in an era of staffing shortages. The 2023 MGMA DataDive Provider Compensation data set gives context to how far many groups have gone to recruit new hires:

- Less than 50% of newly hired physicians, and less than 20% of newly

SIGNING BONUS OFFERED		
	Physicians	APPs
Yes	45.91%	17.85%
No	42.76%	69.97%
Unknown	11.33%	12.18%

MEDIAN SIGNING BONUS AMOUNT	
Primary care physicians	\$20,000
Surgical specialists	\$25,000
Nonsurgical specialists	\$25,000
APPs	\$10,000

hired APPs were **offered a signing bonus** as part of the contract offer or negotiation. A signing bonus is a financial award offered by a practice to a new employee as an incentive to sign a contract and join the organization.

- For providers offered a signing bonus who ultimately did not start employment with the practice after accepting, **about one-third were required to pay back the full bonus amount.**

SIGNING BONUS PAYBACK		
	Physicians	APPs
Full payback required	35.48%	36.75%
Prorated payback required	46.44%	33.62%
Payback not required	18.09%	29.63%

STARTING BONUS OFFERED		
	Physicians	APPs
Yes	21.87%	19.90%
No	63.49%	64.39%
Unknown	14.64%	15.71%

MEDIAN STARTING BONUS AMOUNT	
Primary care physicians	\$20,000
Surgical specialists	\$30,000
Nonsurgical specialists	\$25,000
APPs	\$10,000

**Starting bonuses were offered less frequently to newly hired physicians than signing bonuses.**

A starting bonus is a financial award offered by a practice to a new employee as an incentive at the start of his or her employment with the organization.



## INCREASE IN MEDIAN TOTAL COMPENSATION, 2019-2022 (FOUR-YEAR CHANGE)

	Eastern	Midwest	Southern	Western
Primary care physicians	6.53%	7.59%	11.29%	11.43%
Surgical specialists	6.91%	1.59%	4.06%	9.90%
Nonsurgical specialists	3.63%	0.59%	2.40%	8.27%
APPs	10.91%	5.70%	13.40%	5.74%

Source: 2023 MGMA  
DataDive Provider  
Compensation  
(based on 2022 data)

## REGIONAL TRENDS

Since the start of the pandemic, physicians in the Western region have experienced larger increases in total compensation than other areas of the country.

Primary care providers in the Southern and Western regions, as well as APPs in the Eastern and Southern regions, have experienced the largest increases in total compensation over the past four years.

For the second year in a row, primary care physicians earn the most in Mississippi, earning \$140,000 more than their District of Columbia counterparts and \$126,000 more than their counterparts in Nevada.

The difference in surgical and nonsurgical specialist pay is even greater. Surgical specialty physicians earn \$327,000 more in South Dakota than their counterparts in Louisiana, and nonsurgical specialty physicians report earning \$429,000 more in Alabama than their counterparts in Nevada.



## TOP FIVE HIGHEST- AND LOWEST-PAYING STATES FOR MEDIAN TOTAL COMPENSATION, BY PROVIDER TYPE

	Primary care	Surgical specialist	Nonsurgical specialist	APP
Highest-paying	Mississippi	South Dakota	Alabama	Louisiana
#2	Arkansas	Wyoming	North Dakota	Washington
#3	North Dakota	North Dakota	Mississippi	Iowa
#4	South Dakota	South Carolina	Arkansas	California
#5	Indiana	Mississippi	South Dakota	Idaho
#47	Massachusetts	Massachusetts	Maine	South Dakota
#48	Maryland	Tennessee	Louisiana	Ohio
#49	Maine	Georgia	Massachusetts	Kentucky
#50	Nevada	New Hampshire	Idaho	North Carolina
Lowest-paying	District of Columbia	Louisiana	Nevada	Alabama
<b>RANGE BETWEEN HIGHEST- AND LOWEST-PAYING STATES</b>				
	<b>\$141,727</b>	<b>\$327,404</b>	<b>\$429,138</b>	<b>\$80,526</b>

Source: 2023 MGMA DataDive Provider Compensation (based on 2022 data)

# NEW DATA SPOTLIGHTS

## SUPERVISORY DUTIES AND SHIFT DIFFERENTIALS

Reporting physicians with supervisory duties over APPs or equivalent, excluding resident(s), report earning 7% to 15% more in total compensation.

Primary care physicians working the night shift report earning a median total compensation of \$358,253 — \$70,000 more than their counterparts working the day shift and nearly \$23,000 more than their counterparts working the swing (afternoon to evening) shift.

APPs working swing shift or night shift report earning \$10,000 to \$11,000 more in median total compensation than those working the day shift.

### PHYSICIAN HAD SUPERVISORY DUTIES

Yes	14.55%
No	85.45%

### DIFFERENCE IN MEDIAN TOTAL COMPENSATION FOR PROVIDERS WITH SUPERVISORY DUTIES VERSUS THOSE WITHOUT

Primary care physicians	6.94%
Surgical specialists	15.43%
Nonsurgical specialists	12.66%

# QUALITY AND THE EVOLUTION OF PHYSICIAN COMPENSATION MODELS

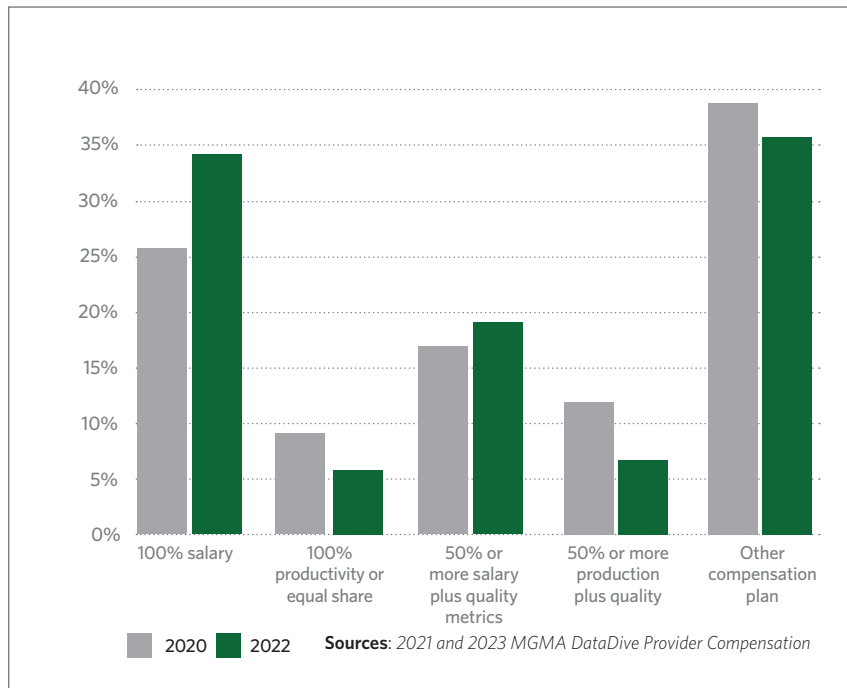
The slow and steady embrace of value-based care across healthcare picked up some steam in the past year, as confirmed by *MGMA DataDive Provider Compensation* benchmarks, as well as recent *MGMA Stat* polling.

In our 2022 data report, retired MGMA senior fellow David N. Gans, MSHA, FACMPE, broke down the compensation methods for all practices based on 2020 data. With the release of the *2023 MGMA DataDive Provider Compensation* data set, we see a steady shift toward salary-based models and a corresponding decrease in production models since 2020.

Evidence of growing use of salary-based compensation models aligns with the broader trend of

consolidation of medical practice ownership toward hospitals and integrated delivery systems, whereas the receding number of independent groups, in which pure productivity models have historically been more common.

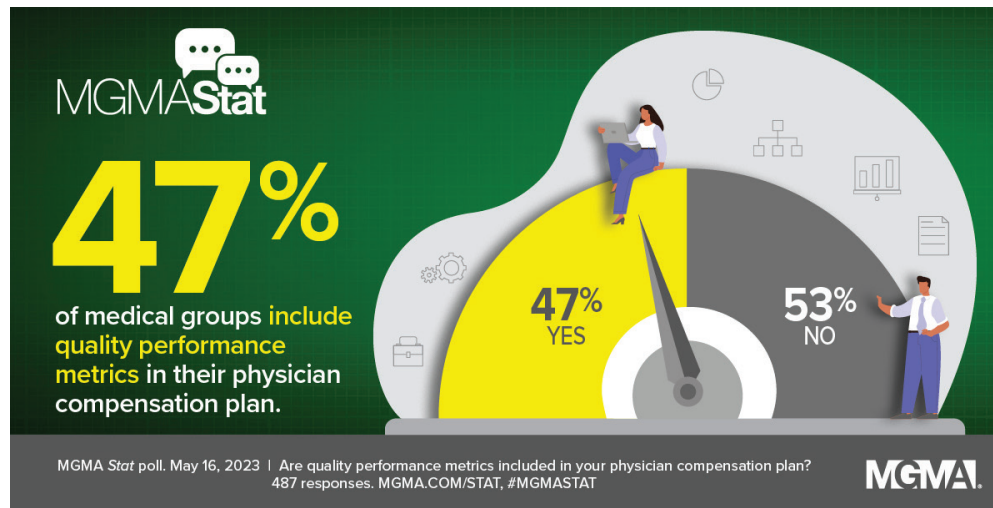
**FIGURE 1. COMPENSATION METHOD FOR ALL PRACTICES**



Similarly, a [May 16, 2023, MGMA Stat poll](#) points to the slow adoption of value-based care throughout the industry nudging more medical groups toward incorporation of quality metrics in their comp models: **47% of medical groups tie quality performance metrics to physician compensation plans**, according to the poll, versus 53% that do not. This represents a 5-percentage-point jump from a similar poll conducted May 24, 2022. The latest poll had 487 applicable responses.

These new figures mark another uptick in the use of quality metrics within physician compensation models after years of very slow growth prior to and during the COVID-19 pandemic:

- Just more than one in four (26%) medical groups tied quality performance to physician compensation in 2016.
- By July 2018, the share of groups with quality tied to compensation rose to 36%.
- A March 2019 poll — the last such poll MGMA Stat conducted on this topic prior to the pandemic — found that nearly 4 in 10 (38%) of groups had tied quality performance to physician compensation.



Several healthcare leaders told MGMA that they were in the process of considering more elements of quality in their compensation models as they have restored productivity after tough years during the pandemic. “Now that we have stable volumes, we can focus more on quality performance,” one respondent told MGMA. Another respondent said that their group previously had quality performance tied to compensation before the pandemic but “took them out” of the physician compensation formula during the COVID-19 lockdowns. That group is now planning to bring back their quality performance component in the coming months. Other practice leaders said that as contracts renew, they are taking a fresh look at how they weight existing quality performance against elements such as productivity.

### THE SLOW ROAD BACK TO NORMALCY...

As retired MGMA senior fellow David N. Gans, MSHA, FACMPE, explored in recent Data Mine articles for *MGMA Connection* magazine, gains in productivity over the past two years show a medical workforce that, amid the challenges of the pandemic and staffing shortages, have found a way back to pre-COVID benchmarks:

- In his [July 2022 Data Mine](#), Gans’ analysis of the 2020 to 2022 *MGMA DataDive Physician Compensation* data sets found that medical compensation for physicians across seven specialties who practice in physician-owned and hospital-/health system-owned practices shared a common theme: Their compensation in 2021 had fully recovered from the impact of the pandemic and, in some cases, increased significantly.
- That same analysis found that physicians in physician-owned practices had greater productivity than their counterparts in hospital-owned practices in six of those seven specialties, as measured by median work RVU (wRVU) production.

- In his [October 2022 Data Mine](#), Gans examined MGMA DataDive benchmarks for the three-year pandemic experience. While 2021 saw major gains in median wRVUs per full-time-equivalent (FTE) physician in most practices versus 2020, they were not as striking compared to pre-pandemic levels: Physician-owned multispecialty groups reported a 13.5% increase in wRVUs and a 3.2% decrease in total RVUs compared to 2019, while hospital/IDS-owned groups had a 7.4% increase in wRVUs and a 9.1% decrease in total RVUs over two years.

### ...INTERRUPTED BY A LABOR CRISIS

It's common knowledge that staffing was the biggest challenge facing medical groups the past two years (as shown from MGMA *Stat* polling from [late 2021](#) and [late 2022](#)). What has been more difficult to quantify is the frontline impacts on productivity and compensation. What we do know is:

- As detailed earlier in this report, a majority of medical groups report staffing (56%) is their biggest roadblock to higher productivity and, by November 2022, less than two-thirds of medical groups were on track to meet or exceed their productivity goals for the year.
- Two-thirds of medical groups [added or improved patient self-service tools in 2022](#) amid the Great Resignation to take workload off strained healthcare teams.
- Only 28% of medical groups added an ancillary service in the previous year, according to [an October 2022 MGMA \*Stat\* poll](#), with many noting that hiring and recruitment difficulties held back their efforts in this area.

One bright point amid this turmoil: [An Aug. 2, 2022, MGMA \*Stat\* poll](#) found that a majority of medical groups reported their patient no-show rates stayed the same (39%) or decreased (12%) since 2021, despite many of those who saw their rates worsen report that long wait times exacerbated by low staffing were a top driver of no-shows.

## EXPERT INSIGHTS FROM MGMA CONSULTING



**JESSICA MINESINGER**  
CMOM, FACMPE

**MGMA Consultant /  
Founder and CEO,  
Surgical Compensation  
& Consulting (SCC)**

#### AREAS OF EXPERTISE:

Compensation consulting  
for surgical practices  
Individual/small group  
physician compensation,  
analysis and negotiation  
Physician recruiting/retention  
Gender pay equity  
Physician cultural fit

#### **MANY PRACTICES WORKED HARDER TO MAINTAIN PRODUCTIVITY AMID STAGNANT REIMBURSEMENT – WHICH AREAS SHOULD THEY FOCUS ON TO HELP BOOST PRODUCTIVITY AND COMPENSATION?**

Physician burnout is rampant and has a detrimental effect on productivity. Taking a customized, positive, and proactive approach to identifying the causes and finding effective ways to reduce the impact of burnout on your physicians is critical. This includes recognizing the challenges unique to female and male providers and generational differences in the workforce. A one-size-fits-all approach won't suffice.

#### **BUDGETS ARE BEING HIT HARD BY RISING EXPENSES – WHERE SHOULD PRACTICE LEADERS PAY CLOSEST ATTENTION TO REIN IN BALLOONING COSTS?**

Physician turnover and early retirement, exacerbated by an impending physician shortage and an aging workforce. The key ingredients to minimizing turnover, disruption to staff, lost revenue and productivity, and recruitment costs are:

- Onboarding
- Retention
- Promotion
- Engagement
- Well-being
- Transparency

Leaders who invest in and promote these values will see a return on investment, a return on time, and promote high-producing and engaged teams.

#### **WHAT STRATEGIES AROUND NEW SERVICE LINES OR OFFERINGS SHOULD PRACTICE LEADERS EXPLORE IN 2023 TO RESTORE FINANCIAL SUSTAINABILITY?**

Establish and invest in leadership roles and departments tasked explicitly with increasing provider recruitment, retention, and well-being. Address the well-documented gender wage gap in medicine and the ongoing challenges female physicians face with openness and transparency.

I often think of the healthcare system in terms of Maslow's Hierarchy of Needs. The ultimate goal is to provide the best possible patient care, experience, and outcomes. To reach that goal, we must first care for physicians and providers responsible for patient care.

# SOLVING PROVIDER STAFFING CHALLENGES: APPs remain key features of medical practice redesign

Physician and nurse shortages have many healthcare leaders finding ways to update their staffing models by bringing on new advanced practice providers (APPs).

APP roles — certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) — all are projected to experience outsized growth through 2031, per the Bureau of Labor Statistics (BLS) Occupational Outlook Handbook:

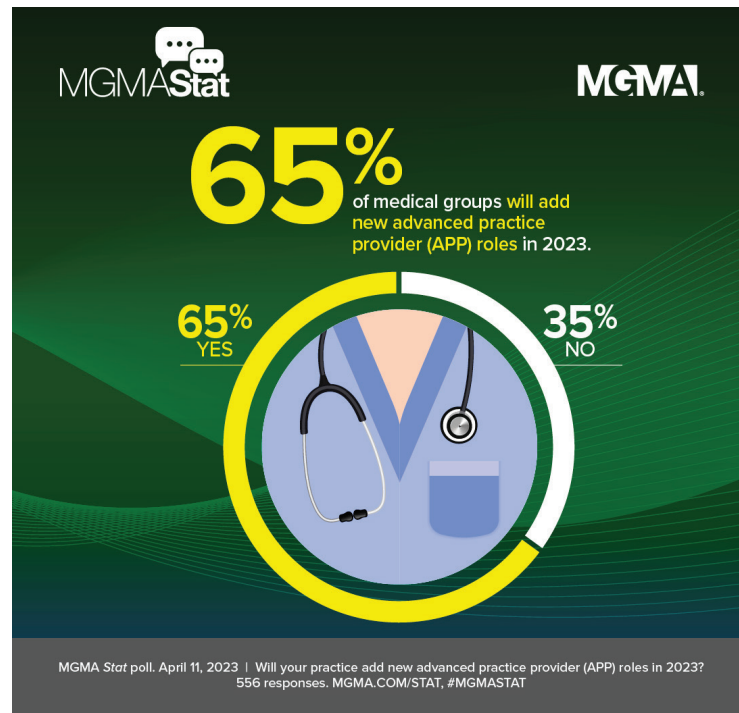
- [PA jobs](#) are expected to grow by 28% (much faster than average) through 2031, with 38,400 new positions estimated to be added.
- [Nurse anesthetist, nurse midwife and NP jobs](#) are expected to grow by 40% in that same period, with 118,600 new positions created through 2031.

Additionally, nearly one in five (19%) of search engagements for healthcare search and consulting firm Merritt Hawkins in 2021 were for APPs, up from only 13% two years earlier, with NPs topping the list of most-requested search engagement. Per a 2022 AMN Healthcare review of physician and APP recruiting incentives ([PDF](#)), this was driven in large part by a shift toward “convenient care” settings (e.g., retail, telehealth, urgent care centers) that are largely staffed by APPs.

An April 11, 2023, MGMA *Stat* poll found that these projections are right on track, as nearly two out of three (65%) medical groups plan to add new APP roles in 2023, versus only 35% that do not. The poll had 556 applicable responses.

As Allison Dimsdale, DNP, NP-C, AACC, FAANP, associate vice president for advanced practice for the Private Diagnostic Clinic at Duke University Health System, [recently told HealthLeaders](#): “It makes sense that if our absolute top goal is to take care of lives, then we have to optimize our clinical workforce” by finding ways to incorporate more NPs and PAs while the search continues for hard-to-recruit physician and nurse roles — a process she calls “practice redesign.”

That redesign seems well underway for many healthcare organizations: Among the one-third of poll respondents who said “no,” a significant number of them told MGMA that the reason they aren’t adding APP roles is because they’ve already successfully recruited for their needs, often finding “top-performing” candidates to help cover many different specialties, and engaging them with monthly lunch-and-learn sessions alongside the compensation packages of pay and benefits offered.



Despite those successes, several medical group leaders said there are challenges, especially in creating physician buy-in for broader use of APPs, as well as recruitment challenges in some underserved areas.

Additionally, the overall cost of hiring new APPs — while not as high as hiring new physicians — has been on the rise, as detailed earlier in this report.

## WHERE APPs ARE BEING ADDED — AND WHY

The most common specialties where APP utilization was reported in our poll were primary care (especially family medicine and pediatrics), pulmonology, urology, GI, urgent care, cardiology and surgical specialties.

The most common reasons for increased APP use involved normal practice growth or the need to update staffing models amid difficulties attracting physicians — especially in rural care settings — amid higher rates of doctors retiring. Several medical group leaders pointed to PAs and NPs playing a significant role in helping clinical teams to stay on track and mitigate concerns around patient wait times.

Having more APPs for office and hospital work (e.g., rounding and on-call) were frequently cited rationales, as well as the desire for many medical groups to reinforce a shift to team-based care.

As Dimsdale explained in her [Q&A with HealthLeaders](#), Duke Health began redesigning teams in 2020 to address issues with access in cardiology and working to get NPs and PAs working to the top of their scope on an interprofessional team of four physicians, one APP and four nurse clinicians. That model allowed the APP to see returning patients, acutely triaged patients, and hospital follow-up patients. **“This freed up the physicians to see complex patients new to our practice and establish a plan of care,” Dimsdale said. “This met our aim of all members of the team working to the top of their scope of practice, while increasing access for our patients.”**

Respondents to the MGMA *Stat* poll noted they found specific uses for new APPs in areas such as:

- NP parent management training specialty for pediatrics alongside nutrition and wellness, COPE training, autism testing, and lactation services
- Expanded weekend availability for sick child visits.

## APP TURNOVER TRENDS

The *2023 NSI National Health Care Retention & RN Staffing Report* ([PDF](#)) highlighted that APPs and allied health professionals recorded turnover rates below the average for all hospital staff turnover (22.7%) in 2022, and many positions saw year-over-year decreases in turnover:

- Certified registered nurse anesthetist (CRNA) turnover dropped by nearly half, from 22.9% in 2021 to 12.0% in 2022.
- Nurse practitioner (NP) turnover ebbed from 15.3% in 2021 to 12.4% in 2022.
- One exception to this was physician assistant (PA), which saw turnover increase from 10.7% in 2021 to 18.5% in 2022.

# SOLVING PROVIDER STAFFING CHALLENGES:

## Physician shortages forcing medical group leaders to be more flexible in their staffing models

A historic physician shortage that's poised to only get worse is forcing many medical group leaders to draw up new recruiting and staffing strategies to ensure a healthy supply of doctors to serve their patient populations.

An April 4, 2023, MGMA *Stat* poll found that almost half (47%) of medical group leaders have added or created part-time or flexible-schedule physician roles in the past year, while 53% did not. The poll had 470 applicable responses.

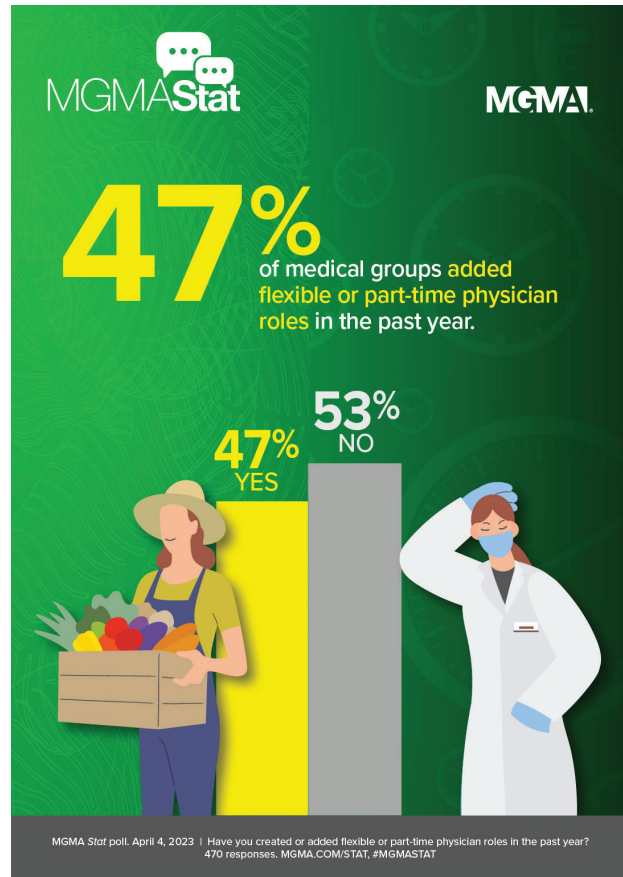
Medical group leaders responding to the poll told us some of the reasons for the updates to their hiring strategies:

- “Our older docs requested a more flexible part-time policy to help them keep working. Our old policy only allowed half- and three-quarter time.”
- “To relieve some of the stress from emergency call.”
- “It provides the work-life balance that meets their needs or extends their retirement date further out.”

Among practice leaders who did not add new part-time or flexible-schedule physician roles, the prospect of hiring for nontraditional roles in the future depended largely on:

- Whether looming retirements come from hard-to-recruit specialties
- Physical space limitations within existing facilities
- Being able to do part-time in the given specialty and take equal call
- The economic costs of onboarding and credentialing versus the lower revenue creation of part-time physicians
- Determining whether staffing models could be adjusted to add more clinical support staff for existing physicians, including part-time and flexible-schedule physician assistant (PA) and nurse practitioner (NP) positions.

Still, there are many organizations that are laser-focused on finding physicians who are eager to work a full schedule or have had poor experiences with part-time hires in the past, especially around the physician's expectations to earn closer to full-time compensation. “It never works out to where they see enough patients” to either cover costs or earn the type of living they hope for, one practice leader told MGMA. Others said it's just a matter of mindset for the organization: “We need fully engaged physicians,” one practice leader told us.



## CONSIDERING THE COSTS OF PHYSICIAN VACANCIES

In a recent MGMA webinar [“Thinking Outside the Box: Creative Physician Recruiting for Hard-to-Fill Positions,”](#) Tara Osseck, MHA, and Neil Waters, both regional vice presidents of recruiting at Jackson Physician Search, detailed the new approaches that help secure the right candidates amid growing competition for a shrinking supply of physicians, as **about 2 in 5 physicians will reach retirement age in the next 10 years** with a mostly stagnant residency slots despite increasing medical school enrollments.

Finding the right solutions should consider the costs of losing a key physician without a replacement lined up. **“The estimated lost revenue for a noninvasive cardiologist opening that sits vacant for six months is about \$1.15 million,”** Osseck said. **“A gastroenterology vacancy sitting open for the same amount of time is about \$1.4 million. ... An ophthalmology vacancy is the equivalent of \$1.6 million in lost revenue.”**

When it comes to time to fill a vacancy, Osseck noted that **the industry average across all specialties is around that six-month mark, but the most-competitive specialties or most-difficult-to-recruit regions might need an additional six months to fill a physician vacancy.**

Beyond the lost revenue of physician vacancies, there are other major implications, such as lost market share, the effect of burnout on other physicians and providers trying to make up for the vacancy, and added costs from using a locum tenens provider, Osseck added, while the search for a permanent replacement is underway.

“Physicians now know their financial worth more than ever ... and they’re deciding for themselves how their current positions stacks up,” Osseck noted, to offers for improved benefits packages or the promise of a better work-life balance in a flexible scheduling scenario.

## SHIFTING WORK-LIFE EXPECTATIONS

Waters recalled work to help find a psychiatrist for an East Coast hospital to meet the burgeoning demands for mental health specialists. While psychiatrists saw exceptional growth in telehealth during the COVID-19 pandemic, the hospital could not make it work for this role, as the psychiatrist would be needed to evaluate admitted patients.

**To find a workable solution for candidates, a seven-days-on, seven-days-off schedule helped make the position more enticing** despite the on-site requirements in a high-demand specialty. This more flexible approach got the vacancy filled in 90 days rather than the specialty average of 8.4 months. Other hard-to-recruit physician roles have even seen longer periods of days off following a seven-days-on work schedule.

Waters said that most healthcare organizations have an idea of how much flexibility they could ultimately offer when casting the net for a new physician but don’t incorporate it into the recruiting strategy, which can be costly in the long run.

**“If you have the strategy in mind, go ahead and start talking about it early, even before you start your recruitment,”** Waters suggested. **“The quicker you can implement those strategies aggressively, you’re going to be putting your best foot forward. ... If it drags out, it’s just going to cost more money in the long term.”**



# SOLVING PROVIDER STAFFING CHALLENGES:

## Formalizing your physician retention strategies

Hanging onto your best physicians isn't something you want to leave to chance, yet many practice leaders skip over the structure for a successful retention strategy.

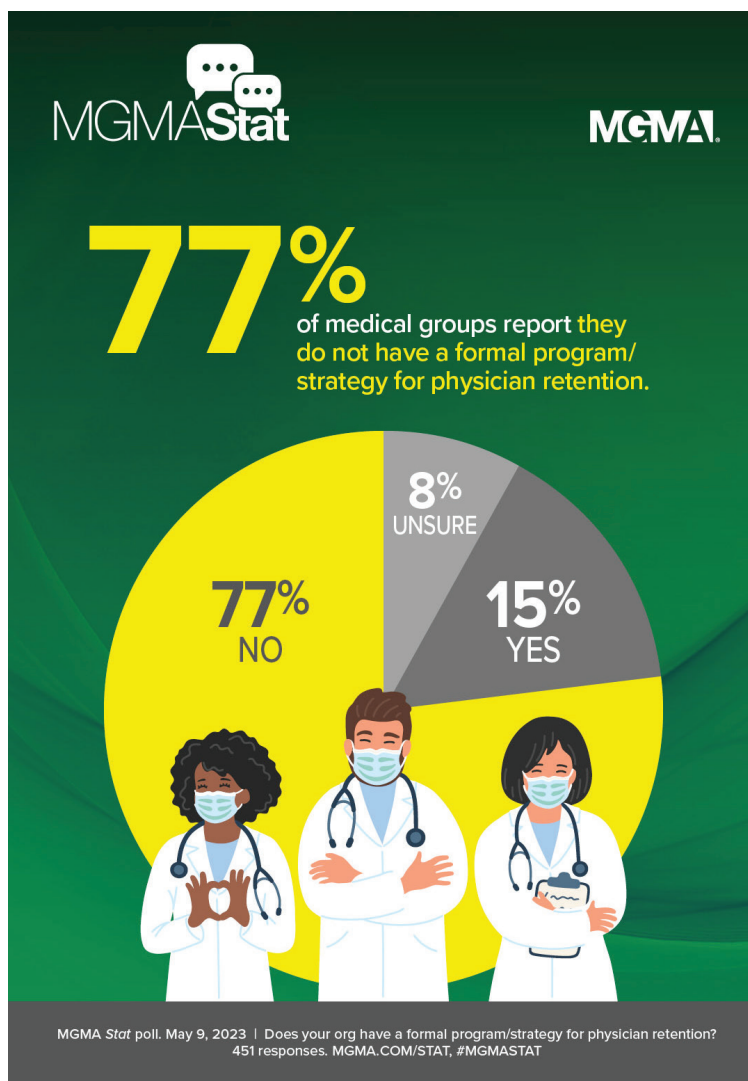
A May 9, 2023, MGMA *Stat* poll asked medical group leaders if they have a formal program or strategy for physician retention. The majority (77%) said “no,” while only 15% reported “yes,” and another 8% responded “unsure.” The poll had 451 applicable responses.

### PREPARING FOR A WAVE OF PHYSICIAN DEPARTURES

One of the most critical areas for medical group staffing are the most experienced physicians in the workforce. As noted in [a recent whitepaper by MGMA Executive Partner Jackson Physician Search](#), a record number of physicians are nearing retirement age. Data from the Association of American Medical Colleges (AAMC) found that nearly half (46.7%) of practicing physicians were over the age of 55 in 2021.

Additionally, multiple pandemic-era surveys have shown physicians expressing increased desire to retire early or leave the practice of medicine:

- In a 2021 Jackson Physician Search survey, more than half of physicians said COVID-19 had changed their employment plans. Of that group, one in five were seriously considering early retirement.
- An [Aug. 23, 2022, MGMA \*Stat\* poll](#) found 40% of medical practices had seen a physician retire early or leave the practice due to burnout.



Of course, while many physicians may want to retire as soon as possible, the volatile economy has pushed the timeline for 38% of all respondents. Concerning physicians over age 60, the percentage is slightly higher, with 46% saying they have delayed their plans.

## THE DOS AND DON'TS OF PHYSICIAN RETENTION

As Kurt Scott, founder and CEO of The Physician Leadership Career Network, [wrote for MGMA Connection magazine](#), building an effective physician retention strategy will require a lot of listening and commitment from the organization's senior leadership to address issues that come up.

"It's important not to gloss over any issue; doing so will be the fastest way to lose your credibility," Scott wrote. "This does not mean you have to agree with all the recommendations of a retention committee. It means you need to address each, even by simply acknowledging disagreement or explaining why an issue cannot be addressed at this time."

## CREATING A PHYSICIAN RETENTION COMMITTEE

Looking at current turnover rates and other bits of data, it's evident that having a committee to review and analyze the numbers for common themes is an important step to "brainstorm and make recommendations for remedies and improvements," Scott wrote.

**"In my experience, this piece of the process will improve physician turnover instantly by 5% to 10%. By demonstrating that the issue of physician turnover is being addressed in a structured, formal way, physicians and staff will understand that it is important to the organization, which brings hope for improvements," he added.**

Scott recommends that for larger medical groups of 100 doctors or more, the committee should be six to 10 physicians, including your organization's head of physician recruitment/retention. For a group of only a few dozen physicians, the committee should be four to six doctors and whomever leads your group's recruitment efforts.

Scott also urges caution about bringing in many nonclinical voices. "Avoid including nonphysician administrators or vice presidents, which can make the committee less credible among the doctors," Scott wrote. "However, include a couple of your most vocal and influential physician naysayers or critics. If you can engage this group, it will help turn them into advocates who will help promote the positive results."

## GATHERING UNIQUE DATA

Scott suggests groups categorize data into five to 10 categories to address. Individual data points include the following:

### Turnover rate and assessing departures

How many physicians are leaving your organization of their own free will or involuntarily? Scott recommended excluding any temporary, interim and locum tenens physicians (any physician you hire or contract with a defined end date) to make your baseline more meaningful.

- **Voluntary departures:** You should understand the issues behind physicians leaving voluntarily. There are two main ways to get this information:
  1. **The autopsy approach:** The exit interview is the best way to hear firsthand about the reasons your physicians leave. Each should be well documented and blinded (name removed) to lower the risk of bias and provided to the committee for analysis.
  2. **Send a simple survey to those who left in the past year:** This can be done electronically via email for better response rates, or it can be mailed.
- **Involuntary departures:** It's important to review everyone's involuntary termination to look for issues that may have been overlooked during the hiring process. Information obtained is sensitive and should be handled appropriately. Results should be blinded before shared with the committee.

## **CURRENT STAFF**

Create a simple electronic survey to be sent to all your physicians regarding their current feelings about practicing with your organization. You can include multiple reminders to help get more staff engaged.

The survey should ask physicians:

- What one or two issues create the highest level of dissatisfaction in practicing with us?
- What one or two things are responsible for your highest level of satisfaction?
- What one or two issues would cause you to leave for another opportunity?

Results should be tabulated and grouped by category through your retention committee.

## **RETENTION COMMITTEE RECOMMENDATIONS**

Once the data is collected, the committee should review and categorize. Each category should be addressed individually with recommendations for improvements.

A findings report should be developed for presentation to senior leadership for consideration. That presentation should be attended by your CEO, COO, CMO, CFO and CHRO, head of physician recruitment/retention and the designated retention committee representative or spokesperson.

Discuss all issues, evaluate recommendations, and determine what can be agreed to in this initial meeting. Leave the final report with recommendations for attendees to review on their own, and schedule a second meeting for the following week with expectations that each category will be discussed and addressed.

The results and agreed-to recommendations should be compiled into a report and presented to the medical staff. This is a subject that hits home with them, so be prepared for a large turnout. The designated committee representative along with senior leadership should be involved in making the presentation to ensure credibility.

Expect this process to take about three to four months to complete. It needs to be a priority, so senior leadership should be driving it forward at every possible opportunity.

Following this process, Scott writes that you should expect:

- A 30% to 40% reduction in physician and physician executive turnover
- Happier and more engaged physicians
- An increase in successful recruitment
- Significant revenue saved with fewer departures
- Additional revenue through a more productive staff.

As Scott notes, having a non-documented retention plan will only reduce your physician turnover by 5% to 10%. By documenting it, your results will improve significantly — even if the plan needs some work.

# SOLVING PROVIDER STAFFING CHALLENGES: Ongoing demand for contract, locums work in 2023

Permanent hires remain in short supply for America's medical groups, with demand for contract and locum tenens work remaining steady in the early months of 2023.

A Feb. 14, 2023, MGMA Stat poll asked medical group leaders how their levels of contract and locum tenens work would change in 2023 versus 2022. A solid majority (52%) said they expect those levels to stay the same compared to last year, while almost 3 in 10 (29%) expect to use less contract/locums work, and only 20% reported an expected increase in the year ahead.

The poll had 307 applicable responses; the figures reported do not add up to 100% due to rounding.

Among respondents who expect to use more contract and locums work this year, the top roles they're seeking were:

1. Physicians — 63%
2. Nurses and APPs — 14%
3. Administrative — 7%
4. Other — 7%
5. Nurse practitioners — 5%
6. Medical assistants — 4%.

**Besides physicians (especially in emergency medicine), travel nurses and APPs, the top contract and locums roles**

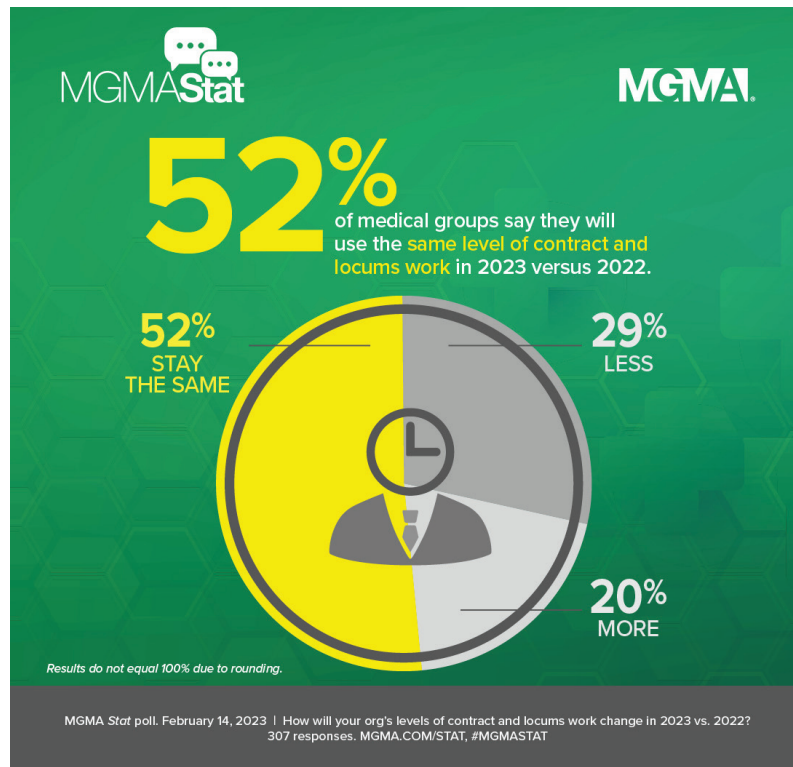
**expected to decrease this year were technicians, contract revenue cycle staff and various other roles, including therapists, educators, contact tracers and greeters.**

Additionally, several respondents noted that they did not have any contract or locums workers on the clinical side or only used a limited number of nonclinical temporary workers at lower-wage positions.

## LABOR AVAILABILITY, EXPENSES REMAIN CRUCIAL

Several major health systems posted major losses for 2022, including a [\\$4.5-billion net loss for Kaiser Permanente](#), driven in large part by surging expenses brought on by inflation, labor shortages and continued higher costs related to COVID-19 care.

Those pain points were echoed in the results of a recent survey of hospital CEOs, which found that [workforce and financial challenges](#) rank as the top two concerns facing their organizations. A [January 2023 Kaufman Hall flash report](#) dubbed 2022 “**the worst financial year for hospitals and health systems since the start of the COVID-19 pandemic.**”



As COVID-19 hospitalization rates stabilized in the past year and a winter spike in cases did not reach the previous year's levels amid the initial Omicron wave, many medical groups reported a continuing surge in demand for care, with many groups experiencing increased outpatient volumes as patients avoided inpatient settings, per the Kaufman Hall report.

## **CONTINUED CLINICIAN INTEREST IN LOCUM TENENS**

In a recent webinar on the future of work arrangements for clinicians, Chris Franklin, president of LocumTenens.com, and Dr. Miechia Esco, a vascular surgeon and chief medical resource advisor for LocumTenens.com, detailed the forces affecting today's clinicians and how many are looking to redefine their work-life balance to mitigate burnout, improve flexibility and forge new career paths.

"Our study found that 80% of respondents were willing to consider nonclinical roles on a project basis as they move forward," Franklin said. Understanding these trends is especially vital amid projected physician shortages and a trend of providers who are leaving clinical practice at earlier ages than ever before, as outlined in the recent whitepaper, [\*The Future of Work: Redefining the Role of Physicians in The Gig Economy\*](#):


- 11% of clinicians under 40 are not currently practicing medicine
- 12% of clinicians in their 40s have left clinical practice
- 15% of clinicians in their 50s no longer practice medicine.

**Burnout, the COVID-19 pandemic, existing plans to retire and plans to leave medicine for another career were the top reasons cited by clinicians in the study for leaving patient care, but recent economic shifts might give some pause,** Franklin noted.

"These are traditionally the prime or peak earning years for clinicians, so to see more movement away from traditional practice, from a younger demographic of clinicians is something that will be very interesting to watch in the coming years," Franklin said. **"With factors like inflation, with the stock market falling off a bit, I do think that that will have some impact on some early retirements and maybe get some clinicians to kind of rethink or maybe postpone retirement or maybe even come back out of out of retirement."**

These demographics mirror what Franklin has seen relative to the clinicians who work locum tenens assignments. **"The number of clinicians with 10 years of practice experience or less, we've seen that number double on a percentage basis over the last three years,"** Franklin said. **"And we see that to be one of the fastest-growing demographics within locum tenens clinicians."**

# ADDITIONAL RESOURCES



**D** **datadive**

MGMA DataDive utilizes thousands of healthcare metrics, allowing you to analyze your organization's performance and discover areas of improvement. Available to all organization sizes, MGMA DataDive's benchmarks and filters provide accurate comparisons to regional and national competitors' key performance indicators (KPIs), such as provider compensation, practice operations, management and more.



**D** | **datadiscovery**  
DISCOVER A NEW WORLD OF DATA

Our intelligent medical group analytics tool, visualizing your practice performance.

## [MGMA Stat polls](#)

Join thousands of other healthcare leaders sounding off in our weekly, text-based polls and be the first to receive data stories telling the stories of the hottest topics in the industry.

## [MGMA Consulting](#)

Leverage the industry leader in creating meaningful change in healthcare, one organization at a time.

## [2023 MGMA Summit: Moving Healthcare Forward](#)

Immerse yourself in an online event designed for you as a medical practice professional, June 6-8.

### **ABOUT MGMA**

Founded in 1926, the Medical Group Management Association (MGMA) is the nation's largest association focused on the business of medical practice management. MGMA consists of 15,000 group medical practices ranging from small, private medical practices to large national health systems, representing more than 350,000 physicians. MGMA helps nearly 60,000 medical practice leaders and the healthcare community solve the business challenges of running practices so that they can focus on providing outstanding patient care. Specifically, MGMA helps its members innovate and improve profitability and financial sustainability, and it provides the gold standard on industry benchmarks such as physician compensation. The association also advocates extensively on its members' behalf on national regulatory and policy issues. [mgma.com](https://www.mgma.com)