MERRITT HAWKINS
an AMN Healthcare company

White Paper Series

Examining topics affecting the recruitment and retention of physicians and advanced practice professionals

Demonstrating Community Need for Physicians

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions company in the United States.

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Introduction

How can a hospital, medical groups and other organizations demonstrate that they have a need for additional physicians?

There are a variety of reasons why healthcare organizations seek to answer this key question. Prominent among them is that a physician/community needs assessment plan can be central to any effort to comply with IRS, HHS and Stark related physician recruiting regulations. Broadly speaking, these regulations allow health facilities more latitude in the incentives they can offer to recruit physicians based how urgently additional physicians are needed in the community. The greater the need for a physician the more that can be offered. A needs assessment plan can confirm the facility's need for physicians in given specialties and justify the use of a wide range of physician recruiting incentives.

In addition, the Affordable Care Act (ACA) requires not-for-profit hospitals to complete community health needs assessment plans every three years. These plans are comprehensive in nature, and include more than just a review of physician needs in the community. However, physician needs assessment can be one element of federally required community health needs assessment.

While regulatory compliance is one important reason for developing a physician needs assessment plan, there are others. A thorough assessment plan with a sound methodology:

- Provides a pro-active, strategic physician recruiting blue-print to follow.
- Creates buy-in for recruitment among the current medical staff.
- Assesses the demographics and practice patterns of current staff.
- Shows potential recruiting candidates that there is a documented need for their services.

Without a community needs assessment plan, hospitals, medical groups and other organizations are obliged to rely on the ***"Little Dutch Boy"*** approach to physician recruitment. A physician will retire or abruptly leave the community, creating a "hole in the dam" which the hospital or group will try to fill. This largely reactive posture creates stress and a lack of continuity of services. It is preferable to know what kind of physicians you are going to need in the short to mid-term and then plan and allocate resources accordingly.

A proactive medical staff/community needs assessment plan is particularly important given the growing implementation of the population health management model of care, in which integrated healthcare organizations take on the holistic care of large population groups, usually within a system of defined, capitated payments. The population health management model calls for the creation of primary care driven, inter-professional clinical teams comprised of physicians, advanced practitioners such as PAs and NPs, therapists, pharmacists and others. A needs assessment plan can help a healthcare organization to determine if it has the "clinical platforms" needed to implement the population health management model.

The Accountable Care Organization (ACO) is one example of an integrated system that may be engaged in population health management. To qualify as an ACO under Medicare requires specific staffing levels, particularly in primary care, and healthcare organizations may complete medical staff assessment plans as part of their efforts to achieve ACO status.

Building Medical Staff Buy-In

In addition, recruitment can be a major political bone of contention between hospitals and the medical staff. Existing physicians can torpedo a search if they feel there is no need for a new doctor or if they believe their opinion was not asked. By soliciting physician input through a medical staff plan, recruitment can become, in effect, the staff's idea.

A staff plan provides a guide to who your medical staff is, their style of practice, retirement plans, etc. It also can be used to demonstrate to incoming physicians that there is a need for their services in the community. A plan which indicates that 90% of local physicians support the recruitment of a new doctor and that the service area has grown by 30% makes a strong statement about the need for a doctor in the community. A hospital or group that can point to such a plan will have more credibility with candidates than a hospital or group lacking such data.

Physician Recruitment Guidelines

In the past, hospitals and medical groups had few objective yardsticks to measure community need for physicians. They would simply tell us, "We just know we need a cardiologist." Today, many facilities have an objective methodology for demonstrating a need for additional physicians. What constitutes such a methodology?

The IRS offered an indication in Physician Recruitment Guidelines released in October, 1994 as an attachment to the closing agreement entered into with Hermann Hospital regarding demonstrating community need for physicians. The Guidelines indicate that a physician will not be a "permissible recruit" unless there is a demonstrable community need for the physician, as evidenced by:

1. A physician to population ratio as suggested by the Graduate Medical Education National Advisory Committee (GMENAC) that is deficient in the specialty being recruited

2. Demand for a particular medical service in the community coupled with a documented lack of availability of the service or long waiting periods for the service, if the physician is being recruited to increase availability of that service

3. Federal designation of the community at the time of the recruitment agreement as a Health Professional Shortage Area (HPSA)

4. A reasonably expected reduction in the number of physicians of that specialty serving the hospital's service area due to the anticipated retirement within the next three year period of physicians presently in the community

5. A documented lack of physicians serving indigent or Medicaid patients within the hospital's service area, provided that newly recruited physicians commit to serving a substantial number of Medicaid and charity care patients

The Hermann Hospital Agreement has since been superseded by Revenue Ruling 21-97 released April 21, 1997, but the methods for determining community need as listed in the Guidelines remain valid even years later.

Elements of A Physician Community Needs Assessment Plan

In order to confirm community need for physicians, the elements above and other factors should be included in a formal Community Needs Assessment Plan or Medical Staff Plan. Such a document verifies the need for additional physician services, and serves as part of a hospital's efforts to comply with federal physician recruiting regulations. It can be used in case of a government audit to demonstrate the rationale for physician recruiting. It also can be used as an effective recruiting tool because it objectively demonstrates to physician recruits that a need for their services exists.

Physician-to-Population Ratios

Physician-to-population ratios are one of a variety of elements in a comprehensive physician needs assessment plan. The most well-known of these ratios are the GMENAC ratios alluded to above, which were established in 1980 and are generally not germane today, though they are still referenced. Some ratios, such as GMENAC's, are "needs-based" and reflect the projected need for medical services in the population based on the researchers' theoretical models of per capita health care consumption. Others are "visits-based," such as the ratios compiled by Hicks & Glenn, researchers at the University of Missouri.

Visit-based ratios look at federal government statistics indicating how many annual visits to a particular type of physician a population of 100,000 typically generates. They then divide into this the number of annual patient visits that a physician in that specialty typically sees, as tracked by the Medical Group Management Association. For example, if 100,000 people typically generate 75,000 visits to a family physician each year, and each family physician sees 2,500 patients annually, then the "right" number of family physicians is 30 per 100,000 people.

Below are various ratios which indicate the number of physicians in various specialties required by a population of 100,000 people. The ratios include those developed by the late Richard "Buz" Cooper, M.D. of the University of Pennsylvania/Wharton School, nationally acknowledged as one of the leading physician utilization and supply experts in the United States.

Working with Merritt Hawkins, Dr. Cooper developed a unique Hospital Specific Physician Requirements Model which indicates at the hospital service area level the number of physicians in various specialties that a community can support.

Dr. Cooper's model differences from other ratios listed on this document in that it is more contemporary, having been developed in 2013, compared to models such as the one developed by GMENAC, which was developed in the Eighties and has not been updated since.

Dr. Cooper's model also is different in that it is a "demand-based" model indicating the number of physicians by specialty that a population is able to economically support rather than the number it may theoretically need or the number of visits to a physician it may theoretically generate. Dr. Cooper's numbers below are based on national figures and are not necessarily universally applicable as local demographic, economic and physician practice pattern variations can cause suggested physician-to-population ratios to differ.

Suggested Physician Ratios per 100,000 Population

	Academy Phys 2009	GMENAC 1980	Hicks and Glenn 1989	Lifton Associates 2007		Solucient 2003					Health Leaders Guide 2009	Health care Strategy Group	Cooper from AMA Masterfile Patient Care Physicians MD+DO 2012			
YEAR of DATA	DHHS 1976	1980	1983	AMA Masterfile 2000	HRSA/ Lewin Proj for 2020	Nation 2003	MW	NE	South	West	Health Strategies and Solutions 2008	2011	Actual Supply w/o Residents 2010	DEMAND w/o Residents 2010	DEMAND w/o Residents 2020	Actual Supply including Residents 2010
Total	**142.5**	**211.5**	**153.2**	**284.3**	**310.0**	**154.3**	**140.2**	**173.1**	**154.5**	**152.3**			**224.7**	**238.6**	**258.9**	**258.7**
Primary Care																
Family Practice	40.0	25.2	33.7	38.3	40.5	22.5	27.9	19.0	22.5	20.2	27.7		30.4	31.0	31.0	33.2
Internal Medicine	12.8	28.8	17.6	38.2	42.7	19.0	14.2	21.8	20.1	19.9	18.5		26.5	29.6	30.8	31.9
Hospitalist											4.0		7.6	8.0	10.0	7.6
Pediatrics	7.3	15.0	12.9	18.4	17.2	13.9	11.9	17.1	12.7	15.2	8.8		16.3	16.1	17.6	18.7
Primary Care Total	60.1	69.0	64.2	94.9	100.4	55.4	54.0	57.9	55.2	55.3	59.0		80.8	84.7	89.4	91.4
ALL Medical Spec. except FP													84.2	95.1	104.4	95.9
Internal Med SubSp w/o Neurol, Psych		18.3	15.2	30.7	35.7	19.0	15.0	23.2	19.0	19.5	22.8		29.6	28.2	31.5	31.5
Allergy	4.0	0.8	1.0			1.7	1.1	1.5	2.0	2.0	0.6		1.2	1.3	1.4	1.3
Cardiology	1.0	3.2	3.8	7.3	8.8	4.2	3.6	6.8	3.4	3.9	6.5	3.0	6.5	7.1	7.8	7.9
Dermatology	2.0	2.9	2.1			3.1	2.3	4.0	3.2	3.2	2.6		3.4	3.6	4.0	3.9
Endocrinology		0.8	0.7								0.8		1.5	1.7	2.0	1.7
Gastroenterology	2.0	2.7	1.7			3.5	1.6	3.5	4.4	4.0	3.3		3.8	4.0	4.4	4.3
Hemel/Onc	2.5	3.7	2.3			1.1	1.3	0.9	1.0	1.1	2.6		3.4	3.7	4.2	3.9
Infectious Disease		0.9	0.6								0.9		1.6	1.6	1.7	1.9
Nephrology		1.1	0.9			0.7	0.4	0.3	1.0	1.1	1.4		2.3	2.4	2.5	2.6
Neurology	1.3	3.4	2.2			1.8	0.9	1.8	2.1	2.2	2.9	1.6	3.8	4.6	5.1	4.6
Psychiatry (w/child)	10.0	23.2	10.0	13.6	14.1	6.3	5.3	9.7	5.1	6.5			13.0	14.7	16.0	12.5
Pulmonary	1.0	1.5	1.5			1.3	0.9	1.6	1.8	0.5	3.2		3.4	3.7	4.0	4.0
Rheumatology		0.7	0.7			1.3	1.0	1.5	1.5	1.2	0.9		1.3	1.4	1.5	1.5
Other Medical				23.4	26.9	2.0	2.8	3.1	0.6	2.5			1.0	1.3	2.0	1.6
Medical Spec. Total	23.8	44.9	27.4	44.3	49.8	27.1	21.3	34.6	26.2	28.2	25.7		**46.4**	**51.1**	**56.6**	**51.5**
Surgery																
General Surgery	10.0	9.7	13.6	13.9	15.5	6.0	6.7	5.8	6.4	4.8	6.4		7.9	10.7	11.4	10.4
Cardio/Thoracic	1.0		0.7								1.6	1.5	1.4	1.4	1.5	1.5
Neurosurgery	1.0		1.3								1.0	1.2	1.5	1.5	1.6	1.9
OBGYN	9.1	9.9	11.1	14.7	14.1	10.2	9.1	10.2	11.8	8.6	8.2		12.5	13.0	14.0	14.0
Ophthalmology	5.0	4.8	4.8	6.5	7.5	4.7	4.0	5.8	4.5	4.8	4.7		5.5	5.5	5.5	6.0
Orthopedic Surgery	3.3	6.2	5.4	8.6	9.4	6.1	4.5	7.5	5.8	7.2	5.2	5.0	7.6	7.9	8.4	8.9
Otolaryngology	2.0	3.3	2.4	3.5	3.7	2.8	3.2	2.5	2.9	2.7	2.4		3.0	3.1	3.2	3.5
Plastic	2.0	1.1	1.2			2.2	1.7	3.1	2.3	2.0	1.2		2.3	2.3	2.4	2.4
Urology	3.3	3.2	2.9	3.7	4.3	2.9	2.5	3.5	3.0	2.5	3.4		3.1	3.4	3.6	3.5
Vascular											0.4		1.4	1.4	1.5	1.6
Other Surgical				5.8	6.6	2.2	2.9	2.6	1.5	2.3			0.5	0.5	1.0	0.6
Surgery Total	36.8	38.2	43.4	56.7	61.1	37.1	34.6	41.0	38.1	34.8	34.5		**46.6**	**50.7**	**54.1**	**54.2**

Hospital-Based																
Emergency	2.7	5.5	3.0	9.3	9.5	12.3	12.3	12.7	13.1	11.0			10.0	10.4	11.0	11.8
Anesthesiology	7.0	9.1		13.4	15								13.5	13.5	14.0	15.5
Radiology	8.0	8.9		11	12.2								9.1	9.5	10.2	10.9
Nuclear Med													0.4	0.4	0.5	0.4
Pathology	4.1	6.5		6.1	6.7								4.7	4.9	5.2	5.6
Physical Medicine		1.3				1.4	1.4	2.0	1.1	1.6			2.5		2.7	2.9
Preventive Med		3.0											0.6	0.6	0.7	0.7
Hosp-Based Total	21.8	34.3	3.0	39.8	43.4	13.8	13.7	14.6	14.2	12.6			**40.8**	**39.3**	**44.3**	**47.8**
Pediatric Spec.																
Cardiology		0.5				0.2	0.1	0.2	0.3	0.2			0.5	0.9	1.0	0.7
Pediatric Neurology						0.1	0.1	0.1	0.1	0.2			0.3	0.6	0.8	0.4
Child Psychiatry		3.7				0.6	0.5	0.8	0.6	0.5			2.1	3.0	3.5	2.4
Neonatology		0.5											1.2	1.7	1.9	1.4
Other Pediatric		2.0				0.9	0.9	0.8	0.8	1.1			1.8	3.2	3.3	2.4
Ped Sp w/o Psych	7.3	21.7	12.9	18.4	17.2	15.7	13.6	19.0	14.4	17.2			**3.8**	**6.4**	**7.0**	**4.8**
Other Specialties				17.9	19.6								6.4	**6.5**	**7.5**	8.9
Physicians per 100K		**207.8**		284.3	310.0	**153.7**	**139.7**	**172.3**	**153.9**	**151.9**			**224.7**	**238.6**	**258.9**	**258.7**

Additional Information About Ratio Sources Referenced Above

GMENAC (Graduate Medical Education National Advisory Committee) was a one-time, ad hoc committee of health care experts convened by Congress to assess U.S. health care manpower needs. In 1980, GMENAC issued estimates of the number of physicians needed per 100,000 population. No such estimates have been issued from the government or from government-sponsored agencies since. The GMENAC numbers are over 30 years old and are considered dated by many.

Hicks & Glenn, two Ph.Ds. affiliated at that time with the University of Missouri School of Medicine, projected physician-per-population needs based on the current rate of patient visits generated to particular specialists as determined by the *Department of Health and Human Services' National Ambulatory Healthcare Administration* report divided by the number of patient visits physicians typically handle, as determined by the Medical Group Management Association.

Solucient is a health care consulting firm. Its number are based on a 2003 study and are therefore the most recent figures available after Dr. Cooper's. Solucient employed a methodology similar to Hicks & Glenn which analyzed National Ambulatory Health Care Administration patient/physician visits data, Medical Group Management Association physician productivity data, and private and public claims data showing patient/physician visit rates by age.

Taking a Closer Look

Clearly, the ratios vary widely in their recommendations. Four separate ratios put the need for psychiatrists per 100,000 population variously at 10.0, 6.3, 14.7, and 23.2 and none of the ratios can be considered definitive without examining conditions in a given service area.

Consider that the same ratio of neurologists-per-population would be unlikely to apply to a young, largely immigrant, economically challenged South Texas community and to an old, largely geriatric, prosperous section of South Florida. Clearly, these disparate populations are as unlikely to utilize medical services at the same rate as they are to purchase pizza, hair coloring, or shoe polish at the same rate.

Physician-to-population ratios, then, are only a signpost or general indicator of physician need, rather than a definitive benchmark. A reliable projection of community need for physicians requires a thorough analysis of local conditions.

Physician Counts

Exactly how many physicians are practicing in the service area already – not just on the recruiting hospital's staff, but in total? ***No projection of current and future physician need can be accurate without this core data.*** Deriving an accurate physician count can be difficult, however. Some physicians may split time in two different service areas, and so cannot be considered full-time-equivalents (FTEs) in either area. Family physicians or internal medicine practitioners may be providing OB or cardiology services, and therefore are neither FTEs in primary care nor in the specialty they are crossing into. Medical residents may also contribute services without being considered FTEs.

The only way to conduct an accurate physician count in some medical markets is to profile each physician's practice, usually through telephone canvassing of the physicians or their office administrators. Only by doing so can you obtain a more or less definitive view of how many true FTEs are in the area. Short of this, a scrupulous attempt must be made to count physicians by examining the hospital's staff roster, the local phone books, and AMA listings of physicians in the area. Keep in mind that just because a local physician is not on the recruiting health facility's staff does not mean he or she is not providing services to the community. What is being measured in a community needs assessment plan is the needs of the community, not necessarily of the hospital, medical group or other recruiting entity.

Physician Demographics

How old are established physicians and when are they likely to retire? How many residents are on the staff?

How many female physicians? The latter is an important consideration as female physicians on average work see fewer patients per day and work fewer hours a week than male physicians. In addition, anecdotal evidence suggests that female physicians retire at an earlier age than male physicians. A comprehensive community needs assessment plan will include a breakdown of local physician demographics.

Physician Input

Local physicians usually have the best insight into local demand for medical services. Physicians know if there are long wait times to schedule their patients with specialists. They also know which specialty services their patients need that currently are not available in the community. A survey of established physicians can reveal how busy they are relative to national averages, whether their practices are open to certain populations such as Medicare patients, and what recruitment needs they see in the community.

In our experience, physicians often are conservative in their assessment of how many new physicians are needed in their communities. If more than 50% of physicians surveyed indicate that a particular specialist is needed then it often can be inferred that a need exists. A physician survey also allows physicians to participate in the medical staffing process, building a consensus that can be essential during physician recruiting. Physicians usually are less likely to resist physician recruiting initiatives when their opinion has been asked and considered.

Patient Demographics

Is the local population growing? What segments are growing the fastest? Medicare patients utilize some medical services at three times the rate of younger populations, so patient aging is a key factor. Which are the geographic areas of fastest growth? What level of insurance and access to health care services does the population have? Is language a barrier to care? These and other questions pertaining to patient demographics must be answered to accurately gauge physician need.

Disease Incidence

Health care challenges differ from region to region. Cardiovascular disease is rampant in some areas of the Midwest, while skin cancer rates often are high in sunny, coastal areas. Hospital admissions data and other statistics can reveal how local disease incidence varies from national averages and may provide a rationale for recruiting physicians who can address local health care needs.

HPSA Designations

A federal designation as a Health Professional Shortage Area (HPSA) offers a strong indication that there is a need for additional physicians in a community. However, HPSA designations only indicate a shortage of primary care physicians, behavioral health professionals and dentists. A HPSA designation will not necessarily support the need for a surgical or diagnostic specialist, which must be supported by additional data.

Portrait of Need

From this combined data, a portrait will emerge of the local service area, showing the number, age and practice patterns of established physicians, current patient demographic trends, disease incidence and areas of immediate and long-term physician need. Physician-to-population ratios can add depth or perspective to this picture.

The final document should be updated periodically to ensure accurate physician counts and related information. While useful in the event of an audit of physician recruiting practices, a comprehensive physician needs assessment plan also can be a working tool offering strategic direction and marketing data for hospital administration. The plan should conclude with a specialty-by-specialty analysis that sums up the general data and indicates what recruiting steps should be taken, if any. The chart below provides a hypothetical example.

Specialty by Specialty Analysis of Need: Internal Medicine

FTE Count	2.75 in MSA
Ratios	Two show a deficit, two show a surplus
Physician Demographics	Two IMs 55 or older, one female IM
Physician Practices	All IMs see more patients than MGMA average All scheduled three weeks out One planning to retire One wants to add an associate
Physician Survey	75% of existing staff sees an immediate need for IM
Patient Demographics	Largely geriatric population
Disease Incidence	High incidence of diabetes, COPD, neurological disorders
HPSA	No
Action Item	Begin immediate search for two IMs, two more in next 24-36 months

With a data driven staff plan in place, a hospital or medical group is in position to initiate those search requirements identified as being the most immediately pressing, while also completing a physician recruiting compliance document, building consensus among existing staff for recruiting additional physician, and establishing a strategic blue print for future recruiting efforts.

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 assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- The Growing Use and Recruitment of Hospitalists
- Ten Keys to Enhancing Physician/Hospital Relations: A Guide for Hospital Leaders
- Rural Physician Recruiting Challenges and Solutions
- Psychiatry: "The Silent Shortage"
- 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
- RVU FAQ: Understanding RVU Compensation in Physician Employment Agreements
- The Economic Impact of Physicians
- Ten Keys to Physician Retention
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