MERRITT HAWKINS
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White Paper Series

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

Emergency Medicine: Physician Recruiting, Supply, and Staffing Considerations in Today's Healthcare System

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

Merritt Hawkins, the nation's leading physician search and consulting firm, produces a series of surveys, white papers, speaking presentations and other resources intended to provide insight into physician recruiting, physician supply and demand, physician compensation and a range of related topics.

This white paper examines recruiting and related trends in the area of emergency medicine.

Emergency medicine is practiced in the hospital emergency department (ED) and in free-standing EDs, settings which provide acute care to patients without a prior appointment.

Due to the unplanned nature of patient attendance, the ED must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. The emergency department of most hospitals operates 24 hours a day, although staffing levels may vary to reflect patient volume.

Hospital emergency departments are unique in their legal obligation to treat all patients in need, without regard to their ability to pay. As a result, EDs often serve as the "safety net of the safety net," offering accessible care for uninsured and underinsured patients who lack other options, and for insured patients who may have trouble access services in a timely manner.

For a variety of reasons, visits to the ED have increased in recent years. Patient emergency room visits rose to a record high of 141.4 million in 2014, according to data from the Centers for Disease Control and Prevention (CDC).

According to a 2015 survey of emergency medicine physicians conducted by the American College of Emergency Physicians (ACEP), 75% of respondents said that patient volume has increased since the ACA requirement for health

coverage took effect in January 2014. This increase demonstrates that enhanced insurance coverage may actually increase ED visits, as newly insured patients seeking accessible care feel they have the resources to visit the ED.

Due to the ACA's expansion of insurance coverage, an aging population with a growing volume of complex conditions, and the expectation of timely care, the trend toward an increasing number of ED visits is likely to continue.

A Historical Perspective

Emergency medicine as a distinct practice area in the United States has been established for less than 60 years. In 1960, there was no emergency medicine as a defined specialty. Typical hospital emergency rooms were staffed by residents, interns, or rotating on-call physicians of all specialties.

In 1961, four physicians led by James D. Mills M.D. left their private medical practices to staff an emergency department together in Alexandria, Virginia. Drawing upon his experience in the United States Navy, Mills desired to develop a coordinated system of emergency care led by physicians trained and credentialed in emergency medicine.

Meanwhile, a similar effort by 23 physicians occurred in Pontiac, Michigan, leading to the formation of the first national emergency medical organization, the American College of Emergency Physicians. Mills was invited to be a member of the Board of Directors leading to the “Pontiac and Alexandria Plans” for emergency medicine. Bringing together these two plans combined Mills use of skilled professional care in the emergency department with residencies in emergency medicine that would provide trained and board-certified physicians for staffing emergency departments throughout the United States.

The first emergency medicine residency was founded at the University of Cincinnati in 1970. In 1972, the American Medical Association (AMA) recognized emergency medicine as a specialty, and, in 1976, ACEP established the American Board of Emergency Medicine (ABEM).

In the 1990s, U.S. emergency medicine capacity continued to grow, fueled by the entertainment industry, which glamorized the specialty in movies and shows such as “ER”. Today, there are 191 residency training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). With the rapid development of emergency medicine, several different sub-specialties have been established including toxicology, pediatric emergency medicine, emergencies and disasters, critical care, and hyperbaric medicine.

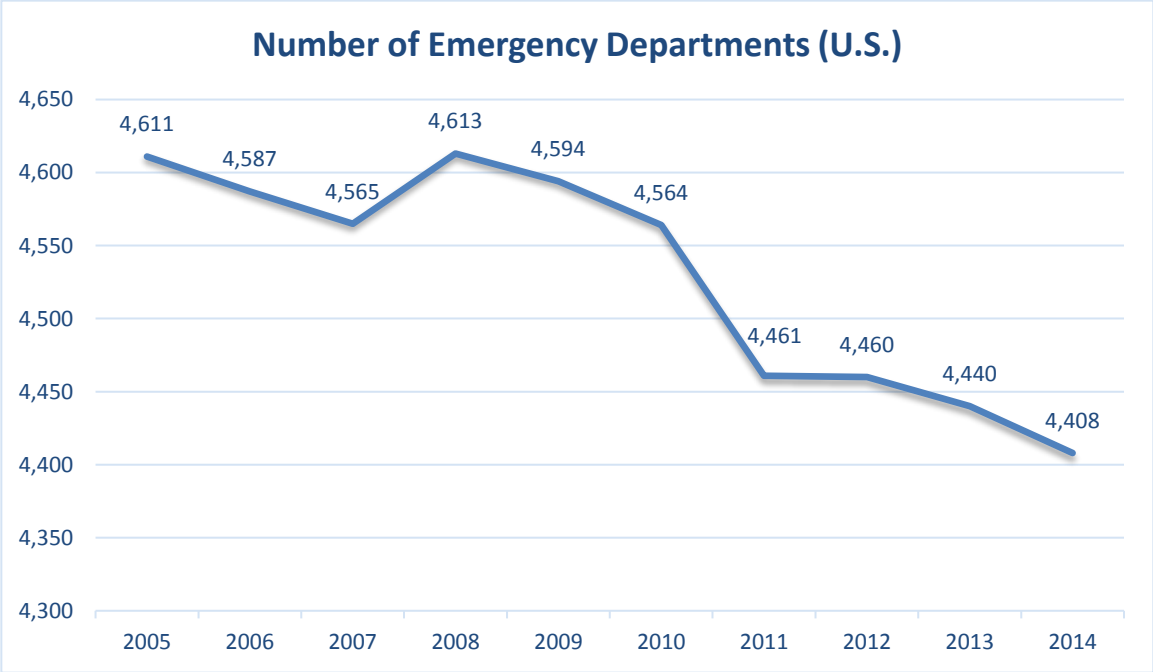
Emergency medicine has grown rapidly over the last 60 years and will continue to do so as the need for quality emergency medical care increases.

Emergency Medicine Today

According to ACEP, there are approximately 42,000 emergency medicine physicians in practice today, an increase of more than 10,000 physicians since 1999. Over 33,000 of them are board certified.

The increase in emergency medicine physicians can likely be attributed to the increasing demand for emergency services in the United States. According to the CDC, emergency room visits rose to a record high of 141.4 million in 2014. ACEP projected the number of ED visits to exceed 150 million in 2016.

While utilization of the emergency department has increased, the overall number of emergency departments in the United States has decreased. According to the American Hospital Association (AHA), the number of emergency departments in 2014 was the lowest in 20 years (see chart below).



Source: American Hospital Association

From 2005 to 2014, the number of hospital EDs declined by 4% while the AHA states that emergency department visits have increased by 19% in the same time period. Hundreds of EDs have closed in the past decade, along with hospitals, and even more since the early 1990s when the number of hospital EDs was greater than 5,000.

Though the ACA is intended to reduce ED admissions by allowing more patients with insurance coverage to

see office-based physicians, three-quarters of emergency physicians saw an increase in patients since the implementation of the ACA (*ACEP, May 2015*). While Medicaid expansion provided more patients with medical coverage, many are seeking care in emergency departments because Medicaid reimbursement rates are so low that physicians will not see them. Adults with Medicaid insurance use emergency departments at more than double the rate of adults with private insurance (*JAMA, August 2010*).

As the number of ED visits increase and ED wait times grow longer, more emergency medicine physicians will be needed to staff hospitals and other healthcare facilities, which are already facing a physician shortage. Researchers at the Massachusetts General Hospital assessed the emergency medicine workforce and concluded that the United States has 55% of what is needed to staff one board-certified ED physician in each of its emergency departments 24 hours a day (*Academic Emergency Medicine, September 2008*).

Additionally, even if all current board-certified emergency physicians remained in the field, it would take 14 years before all EDs would have the number of emergency medicine physicians that patient volume requires, according to the Massachusetts General Hospital researchers. Unfortunately, according to *Becker's Hospital Review,* that is unlikely to occur as nearly 30% of emergency medicine physicians are nearing retirement (over 55 years of age). Also, 52% of emergency medicine physicians have reported feelings of burnout in their careers (*Medscape, January 2015*). These number will only further escalate the physician shortage in the specialty, a specialty where the impact of a shortage is greater as emergency medicine physicians cannot book patients out weeks or months in advance.

With a growing shortage and ever-increasing ED utilization, demand for physicians who work in the ED, particularly for physicians board-certified in emergency medicine, remains robust. According to Merritt Hawkins' *2017 Review of Physician and Advanced Practitioner Recruiting Incentives*, emergency medicine was the firm's 7th most requested search in 2016/17. Additionally, the number of searches conducted by Merritt Hawkins for emergency medicine physicians increased by 12.5% over 2016.

With high demand comes increased competition. Many administrators and managers are looking to recruit emergency medicine physicians to their facilities. In order to fill open positions with qualified physicians, administrators and managers must ensure their strategic physician recruiting strategies and processes reflect the realities of the post-health reform world.

Recruitment in the Emergency Department

Emergency physicians are in high demand across the United States. Consequently, recruiting and retaining the best of the best in emergency medicine will be a significant challenge for hospitals and health systems moving forward. In order to be competitive, it is best to first "walk a mile in the shoes" of emergency medicine physicians and understand the benefits and drawbacks the specialty offers.

As previously noted, 52% of emergency medicine physicians experience burnout, a rate three times greater

than that of the average physician. Long practice hours, high stress levels, and high patient volume can all lead to increased feelings of burnout. To attract the best emergency medicine physicians, hospital administrators must make preventing burnout a priority. To do so, administrators must commit to providing a strong ED team, appropriate staffing levels, a supportive practice environment, and perhaps most importantly: work-life balance.

According to Merritt Hawkins' *2017 Survey of Final-Year Medical Residents*, younger physicians today are seeking a controllable lifestyle that allows for a balance between their practice and their personal life. "Lifestyle" was rated a most important factor by 74% of residents. Today, practice hours, call schedules and vacation times often are the key factors in physician contract discussions, supplanting salaries or bonuses, as the primary points over which physicians and hospitals, medical groups, or other employers tend to negotiate. Providing fair and equitable scheduling, in which all physicians share responsibility for working nights, weekends, and holidays, goes a long way in promoting a stable, team-centric practice environment. Typical scheduling practices in the industry include:

- Work 8-12 hours at a time, at all hours of the day
- Work between 1500 and 2000 hours per year
- Limited to zero on-call time
- Time off is often during the weekdays
- Many emergency medicine physicians work part-time or take extended vacations
- Not uncommon to devote time to other professional pursuits such as administration, leadership, research, or education

Improving the efficiency of the practice environment, reducing the administrative burden, and providing physicians with greater flexibility and control over their work can also help with physician burnout. According to the *2016 Survey of America's Physicians: Practice Patterns and Perspectives*, conducted by Merritt Hawkins on behalf of The Physicians Foundation (www.physiciansfoundation.org), regulatory and paperwork burdens were the most cited factors causing physician dissatisfaction. The second most frustrating factor cited in the survey was the erosion of clinical autonomy.

Medicine is one of the most highly regulated if not the most highly regulated profession in the United States. New value-based payment models, such as the one mandated by MACRA, require physicians to track the "quality measures" they have taken in treating patients. Because of rising regulatory burdens and the growing demand for their services, the great majority of physicians find themselves burned out and overworked. Additionally, physicians often find that their ability to make what they believe are the best decisions for their patients is obstructed or undercut by bureaucratic requirements or third parties who are non-physicians. Administrators must look at the burdens placed on today's doctors and let them do what they do best. They must support them in their efforts to take care of the healthcare population in the way the physicians see fit.

Providing a supportive practice environment is a simple way to accomplish this. Empowering physicians to take ownership of the processes and protocols within their departments and find opportunities for improvement is one way to alleviate these feelings. Encouraging physicians to find innovative ways to improve

inefficiencies empowers physicians to change the status quo. Physicians have intimate knowledge of the operations within their department and can have extremely insightful views on what needs to be fixed. Giving physicians a venue in which to raise these issues and offer solutions increases their engagement and job satisfaction, while also identifying process improvements. Furthermore, when process improvements are generated by the physicians themselves, they are automatically invested in the success of their solution. Not only can hospitals help physicians feel more fulfilled in their careers, but in doing so, the hospital as a whole stands to benefit.

Emergency Medicine Compensation

Hospital and health system administrators should also be aware of the market rate for emergency medicine physicians in order to offer them a competitive salary offer. The competitive nature of emergency medicine searches is reflected in rising emergency medicine starting salaries. The chart below illustrates the increase in emergency medicine starting salaries over the last several years as tracked in Merritt Hawkins' *2017 Review of Physician and Advanced Practitioner Recruiting Incentives:*

Average Emergency Medicine Starting Salaries

	Low	Average	High
2016/17	$250,000	$349,000	$450,000
2015/16	$250,000	$304,000	$425,000
2014/15	$300,000	$345,000	$434,000
2013/14	$220,000	$311,000	$400,000
2012/13	$210,000	$288,000	$450,000

Source: Merritt Hawkins 2017 Review of Physician and Advanced Practitioner Recruiting Incentives

Listed below are average compensation numbers for emergency medicine physicians as tracked by various other sources, as well as by Merritt Hawkins.

Average Emergency Medicine Compensation

Sullivan Cotter	$353,985
Merritt Hawkins	$349,000
AMGA	$348,178
Compdata	$337,100
ECG Management	$318,277

In addition to base salaries, emergency medicine physicians are generally provided with sign-on and production bonuses. A Merritt Hawkins' client in the Midwest recently offered an emergency medicine physician a $415,000 salary with sign-on and production bonuses creating a potential annual compensation of $465,000.

Emergency medicine physicians choose the specialty because it allows them to see a tremendous variety of patients, provides constant challenges, and puts them on the frontline where they are expected to make quick decisions and act on incomplete information. They greatly enjoy their career, but certain things must be done to keep them happy in their job. Regardless of the steps healthcare administrators take, making a conscious effort to support the physicians during work and protect their personal time outside of work will show how much they value the physicians and increase the overall care quality in the emergency department.

Emergency Medicine Staffing Considerations

Because the emergency department is often either overstaffed or understaffed due to unevenly distributed patient volume, it is difficult for administrators to know if they are staffing their emergency department appropriately and efficiently. According to BestPractices, Inc., it starts with two things. Administrators must know the number of patients each physician can see per hour and the number of patients entering the ED per hour. The next step is identifying when patient volume spikes and when it dips. Once all these factors have been determined, goals and targets for staffing can be set. A variety of benchmarking tools are available to compare to other hospitals with similar volume and throughput. Some benchmarking resources include the following:

- ACEP
- VHA
- Emergency Department Benchmarking Alliance
- Premier Inc.
- University HealthSystem Consortium

It might also be the case that no matter how schedules are changed, coverage issues still occur. BestPractices, Inc. suggests administrators should consider adding a provider when the following start to occur:

- If average patient per hour starts to exceed 2.0
- When emergency department volume begins to exceed 18,000 visits a year
- Turn around times are elevated
- LWOT (patients who leave-without-treatment) rates are unacceptably high
- When there are concerns about the shift being too long
- Patient satisfaction is unacceptably low
- If clinician satisfaction and/or retention is low

Staffing an emergency department can also be difficult as emergency medicine physicians do not work alone. Life in an emergency department requires collaboration and the coordinated efforts of specialized emergency

nurses, emergency technicians, paramedics, scribes, and physician assistants and certified nurse practitioners to deliver quality patient care. A successful emergency department generally enjoys productive interpersonal staff relationships and works well as a team.

Seasoned nurses have the insight to prevent mistakes. A primary emergency department nurse may clean wounds and burns, suction an airway, administer intravenous fluids, aid in neurological evaluations, field family members' concerns and arrange for transportation to another floor of the hospital. Some emergency departments also staff a charge nurse, an experienced nurse responsible for overseeing the flow and dynamics of the entire nursing department and managing complex patient cases.

Emergency departments also use the services of emergency care technicians. The technicians help with IV catheters, drawing blood, getting electrocardiograms, and transporting patients. Some staff technicians are also certified to perform X-rays, CT scans, and other tests on patients.

Injured or critically ill patients transported to the ED by ambulance or helicopter also encounter paramedics. Their responsibilities include monitoring vital signs, gathering medical history, and providing emergency care such as CPR during transport. Paramedics have additional training that allows them to administer medications, interpret imaging tests, and perform more complicated medical procedures. At the hospital, EMTs and paramedics move patients to the ED and provide a detailed report on the patient's condition to ED nurses and physicians.

Scribes are essential as they allow physicians to use more of their time to actually treat patients. The chief responsibilities of scribes are to document patient charts, retrieve lab results, and complete other administrative work typically done by physicians. Scribes can also assist nurses in their documentation duties if the department is nearing capacity.

In addition to physicians, nurses, and other ancillary staff, emergency departments employ physician assistants (PAs) and nurse practitioners (NPs) to treat patients in the ED. Roughly 30% of patients in an average emergency department can be seen independently by a physician assistant or nurse practitioner (*ACEP, August 2009*). A team-based patient intake process where the physician sees and discharges the patient while the PA or NP does the processing work can optimize efficiency and quality.

In the emergency department, an extensive workforce team is necessary to ensure quality interactions with providers, quality explanations, expert-level pain management, and limited length of stay.

Emergency Department Return on Investment (ROI)

Traditionally, emergency departments have been viewed as a cost to the hospital and a setting in which healthcare is at its most expensive.

This view should be tempered, however, by the fact that EDs are generating an increasing number of hospital

admissions. Hospital admissions from the emergency department increased by 17% from 2003-2009 (*RAND Corporation, June 2013)*. Hospital inpatient care comprises 31% of US health care spending, suggesting that the ED can be a source of considerable revenue, according to the RAND Corporation study.

Even with the increasing rates of hospital admissions, emergency departments are often seen as having a low return on investment due to high fixed costs and an unfavorable payer mix. However, a Health Affairs study indicates that emergency departments actually have rather high profit margins. In 2009, emergency department admissions resulted in $78.7 billion in revenue. Subtracting the $72.5 billion in costs, the operating income totaled $6.1 billion, which equated to a 7.8% profit margin (*Health Affairs, May 2014)*.

The researchers also found that by 2023, emergency department visits are likely to become more profitable for hospitals, with profit margins rising to 11.7%. In addition, as more patients have gained coverage through the health insurance exchanges and Medicaid expansion, hospitals are seeing fewer uninsured patients in their emergency departments.

Free-Standing Emergency Centers

Emergency care can now frequently be found outside of a hospital emergency department. Specialized urgent care type facilities staffed by emergency medicine physicians have been gaining popularity in the past decade, with the ability to perform x-rays, reduce simple fractures, and repair lacerations. A number of these types of facilities will administer IV antibiotics, perform diagnostic ultrasounds, as well as perform EKGs and point of care diagnostic blood tests.

There now are approximately 400 free-standing emergency centers (FECs) spread over 32 states (*Modern Healthcare, October 2016*). Texas, which in 2009 was the first state to enact a law allowing private, for-profit entities to provide emergency services, has a proportionately high number of FECS. Approximately half of all FECs are located in the state.

FECs typically are owned and managed by either hospitals, independent, for-profit groups or joint ventures between the two. Over 54% of all FECs nationally are hospital-owned or hospital-affiliated while over 45% are independent (*Dallas Morning News, August 2016*).

How FECs operate and the rules governing them are still in flux. Of the 32 states with FECs, 17 have established specific policy requirements, according to *Modern Healthcare,* with 15 of 32 states requiring a physician to be on-site during all hours of operation and 11 requiring certified emergency physicians to be on-site at all times. Eighteen states with FECs have rules comparable to EMTALA, the law requiring all patients presenting to the ED to be seen regardless of ability to pay. Texas is one state that does have an EMTALA-like requirement. It should be noted that hospital-owned FECs must accept all patients for screening and stabilization because they come under the federal EMTALA law.

One factor limiting the ability of FEC expansion, particularly into traditionally underserved areas, is that Medicare and Medicaid generally will not pay for their services. In addition, FECs generally don't have the depth of services of hospital emergency departments and may have to transfer patients to hospital emergency after stabilization.

FECs do offer convenience, however, and generally shorter wait times than hospital emergency departments. Whether their numbers will proliferate will demand on consumer preferences and the regulatory/compliance environment.

Surprise Billing

Surprise medical bills occur when patients cannot avoid being treated by providers outside their health plan's contracted network — either because the provider is not chosen by the patient or because patients are not even aware that the provider is involved in their care, such as a pathologist examining a biopsy. Patients might be able to challenge such surprise bills in court, but the expenses and time involved in such situations leave many patients unable or unwilling to undertake litigation.

Two recent nationwide studies, published in *Health Affairs* and *The New England Journal of Medicine*, both found that 20% of emergency department visits and resulting admissions at in-network facilities involved an out-of-network physician.

There is widespread agreement that this problem needs to be addressed. At this point, more than a dozen states have enacted various measures to address it. However, states cannot protect more than half of commercially insured consumers due to a federal law, known as the Employee Retirement Income Security Act of 1974 (ERISA), which exempts almost 100 million people in private insurance plans from state regulation because their plans are self-funded by employers.

Various approaches have been laid out to address this issue, but nothing has been agreed upon at this time.

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
- Trends in Incentive-Based Physician Compensation

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