
PHYSICIAN COMPENSATION & RECRUITMENT

PCR 2007 index

Compensation models

- Academic medical center develops productivity-based incentive plan for academic, clinical work. May, p. 4.
- Bottom line becoming the driver in physician compensation plans. Feb., p. 10.
- NC hospital turns practices around with productivity. Oct., p. 7.
- New wRVU values skew certain compensation plans. Sept., p. 7.
- Offer nonqualified deferred compensation to boost physician compensation without costing the practice a dime. April, p. 7.
- Pay attention to factors that indirectly influence compensation. May, p. 6.
- The earning curve: How production, comp change over time. Sept., p. 8.

Government/regulations

- CMS scrutinizes hospital-physician financial relationships. Nov., p. 11.
- Expect additional Stark changes in 2008. Dec., p. 1.
- Legal restrictions hinder hospital-physician gainsharing. July, p. 4.
- Phase III adds flexibility to Stark regulations. Oct., p. 4.
- Proposed Stark changes may limit entrepreneurship. Sept., p. 1.
- Review deferred comp plans for compliance with new regs. Sept., p. 11.

Management/comp planning

- Define the daily duties of your compensation committee. March, p. 11.
- Focusing on overhead can cost practices revenue, compensation. July, p. 8.
- Identify fixed, variable expenses for efficient cost accounting. Aug., p. 4.
- Poll physicians to gauge compensation plan preferences. March, p. 6.

- R-E+S: Subsidize hospital-employed physicians to reap the benefits of the private practice compensation model. July, p. 10.
- Reconsider full-time equivalent definitions when incorporating part-time physicians into your practice. May, p. 11.
- Sample physician employment agreement. May, p. 8.
- Service line management offers alternative to on-call pay. June, p. 7.
- Some hospital-physician relationships require PSAs. Oct., p. 9.
- Strengthen ED coverage with these 15 alternatives to on-call pay. Feb., p. 8.
- Think beyond productivity to measure physician performance. April, p. 4.
- Update buy-sell agreements to sidestep conflict. Aug., p. 10.

Recruitment/retention

- Boost physician recruitment by using health professional shortage area designation to your advantage. March, p. 4.
- Consider two alternatives to noncompete clauses. Oct., p. 11.
- Create fair employment agreements to recruit, retain doctors. Dec., p. 9.
- Exception to 'incremental expenses' rule will aid rural recruitment. Nov., p. 10.
- Focus on supplemental compensation when recruiting physicians. June, p. 10.
- Orthopedics, primary care most requested specialties. April, p. 10.
- Recruit docs to rural areas with these five tips. Feb., p. 7.
- Strategies for recruiting and retaining top hospitalists. Aug., p. 9.
- The art of negotiation: What not to do. Jan., p. 4.
- Turnover rates reflect shifting demographics. April, p. 1.
- Use of recruitment incentives spikes in 2006, survey shows. Jan., p. 10.

Reimbursement

- 2007 wRVU changes will affect year-end comp calculations: MGMA offers new tool to account for new values that may skew certain income distribution plans. Dec., p. 11.
- Get acquainted with the Physician Quality Reporting Initiative. June, p. 6.
- Pay for performance experiences growing pains. Aug., p. 6.
- Practices hesitate to participate in upcoming PQRI program. June, p. 4.

Specialty-specific analysis

- Compensation growth slows down for cardiologists. Nov., p. 8.
- CRNA compensation rivals some physician salaries. Sept., p. 4.
- Demand, compensation climb for female urologists. April, p. 5.
- Low comp creates challenges for neurology. Feb., p. 1.
- Lower-earning females keep primary care afloat. Aug., p. 1.
- Median psychiatry comp nears \$200K as physician pool shrinks. July, p. 6.
- NPPs see minimum compensation increases in 2006. Feb., p. 4.
- Patient mix, low reimbursement keep geriatric compensation low. June, p. 8.
- Payer mix, ED crowding drive emergency physician comp. Dec., p. 5.

Tables/graphs (specialty-specific):

- Cardiology compensation trends. Nov., p. 9.
- CRNA median compensation trends. Sept., p. 5.
- Emergency medical physician total compensation by region, 2004–2007. Dec., p. 6.
- Gastroenterology median compensation trends 2004–2006. Nov., p. 9.
- Geriatrics median compensation trends, 2004–2006. June, p. 9.
- Neurology median compensation trends 2004–2006. Feb., p. 2.
- Nonphysician practitioner compensation 2005–2006. Feb., p. 5.
- Psychiatry median compensation trends. July, p. 7.
- Urology median compensation trends, 2004–2006. April, p. 6.

Tables/graphs (other)

- Academic and private practice compensation trends 2001–2006. May, p. 2.

- All physicians' first-year compensation in a new practice 2005. Jan., p. 3.
- Average physician revenue and starting salary. June, p. 2.
- Changes to wRVUs for E/M codes. Sept., p. 7.
- Deferral-plan payments at retirement. April, p. 8.
- First-year postresidency or fellowship compensation. Jan., p. 3.
- Limitations of pay for performance. Aug., p. 8.
- Locum tenens salary and days requested, 2005. March, p. 2.
- Male and female physician incomes, 1997–2005. Aug., p. 3.
- Median compensation trends for select specialties. Nov., p. 7.
- Most frequently cited reasons for voluntary turnover. April, p. 3.
- On-call pay rates, Nov., p. 4.
- Physician compensation by years in specialty. Sept., p. 9.
- Physician recruiting incentives. Oct., p. 3.
- Practice operating cost per full-time equivalent physician. July, p. 3.
- The Delta companies' specialty compensation summary. March, p. 11.
- Trends in quality-based compensation incentives. March, p. 9.

Trends

- Academic practices emphasize clinical work to compete with private sector and close comp gap. May, p. 1.
- Aging doctors present part-time compensation obstacles. Dec., p. 7.
- Compensation experts offer predictions for 2008. Dec., p. 3.
- Competition between physicians, hospitals contributes to decline in physician-generated revenue. June, p. 1.
- Doctors want slower pace, lower liability rates, MGMA survey says. Jan., p. 1.
- Facilities are learning from past physician management and compensation mistakes. Oct., p. 1.
- Hospitals still searching for on-call pay solutions, Nov., p. 1.
- Locum tenens demand shifts towards primary care. March, p. 2.
- Many geographic regions see malpractice rates level off. Jan., p. 8.
- MGMA surveys reveal importance of management. July, p. 1.
- More physicians compensated based on quality, HSC survey shows. March, p. 8.
- Surveys show flattening physician compensation: Growth shifts to multispecialty practices, nonphysician providers in MGMA and AMGA reports. Nov., p. 5.
- Survey shows more physicians planting roots in rural areas. Feb., p. 6.
- Survey turns up turmoil between hospitals and physicians. Jan., p. 6. ■