New Patients in Big Cities Wait About 28 Days for Appointment

BY MARY ELLEN SCHNEIDER

New patients wait about 28 days on average to get an appointment with an ob.gyn., according to a survey of wait times in 15 large cities.

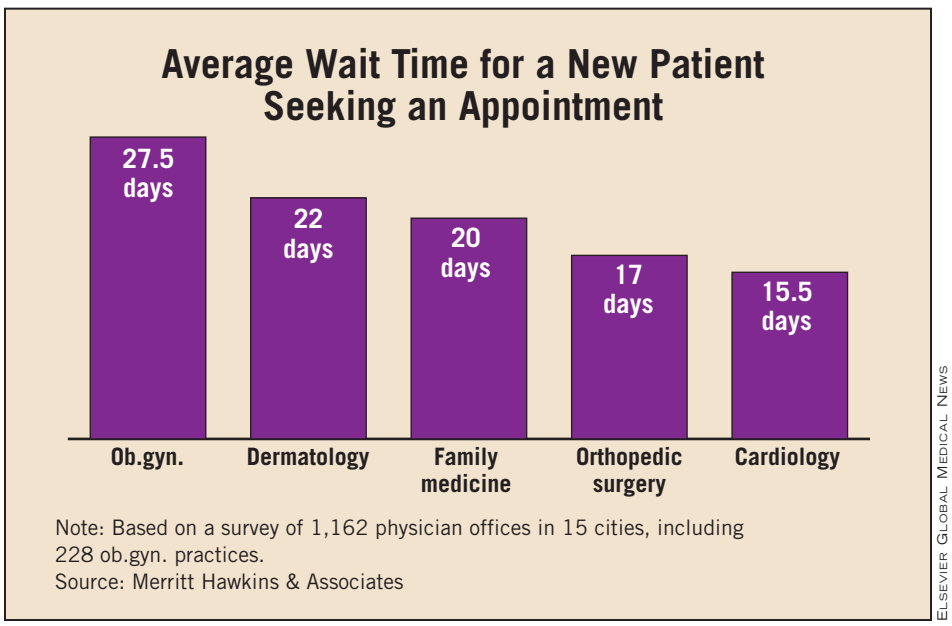
A new patient seeking an appointment for a routine well-woman gynecologic exam could wait anywhere between 2.5 and 98.7 days, with an average wait time of 27.5 days. The survey, conducted by the national physician search firm Merritt Hawkins & Associates, polled 1,162 physician offices including 228 ob.gyn. practices. The survey also examined wait times for cardiologists, dermatologists, orthopedic surgeons, and family physicians. (See chart.)

The survey showed wide variation in wait times for new patient appointments both nationally and within cities. For example, the average wait for an ob.gyn. appointment in Boston was 70 days, compared with just 5 days in Minneapolis. But within Boston, the wait times for appointments ranged from 14 days to 200 days.

"Finding an available physician can be challenging today, even in large urban areas where most doctors practice," said Mark Smith, president of Merritt Hawkins & Associates. Physician access may be even more of a problem in areas with fewer physicians, the report on the survey findings concluded.

From September 2008 through March 2009, researchers at Merritt Hawkins called physician offices in the 15 cities to schedule the first available appointment for a new patient with a nonemergent health need. The offices were selected at random through online searches.

The survey involved physician offices in Atlanta; Boston; Dallas; Denver; Detroit; Houston; Los Angeles; Miami; Minneapolis; New York; Philadelphia; Portland, Ore.; San Diego; Seattle; and Washington. ■



Note: Based on a survey of 1,162 physician offices in 15 cities, including 228 ob.gyn. practices.
Source: Merritt Hawkins & Associates

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CMS Reform Efforts Put Focus on Curbing Hospital Readmissions

BY ALICIA AULT

The Centers for Medicare and Medicaid Services has chosen 14 communities to participate in the agency's demonstration project aimed at reducing unnecessary hospital readmissions.

The CMS had already put hospitals on notice that it would find a way to curb readmissions, which have proved to be very costly to the Medicare program. In his fiscal 2011 budget blueprint, President Barack Obama said that readmissions would be targeted, largely through bundling of payments to hospitals and physicians. The budget document stated that 18% of Medicare hospitalizations result in readmissions. About $26 billion could be saved over 10 years by reducing those rehospitalizations, according to the budget document.

The CMS Care Transitions Project "is a new approach" for the agency, Dr. Barry M. Straube, the agency's chief medical officer, said in a statement. Participants "will look in their own backyards to learn why hospital readmissions occur locally and how patients transition between health care settings." Care transitions teams will then design strategies to go after the "underlying local drivers of readmissions."

The pilot sites will be Providence, R.I.; Upper Capital Region, N.Y.; Western Pennsylvania; Southwestern New Jersey; Metro Atlanta East; Miami; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing (Mich.) area; Omaha, Neb.; Baton Rouge, La.; Northwest Denver; Harlingen, Tex.; and Whatcom County, Wash.

The pilot will continue through summer 2011. The agency plans to make readmission rates at hospitals around the country available to the public later this year on the Hospital Compare Web site at www.hospitalcompare.hhs.gov. ■

Compensation for On-Call Duties Lower for Ob.Gyns.

BY MARY ELLEN SCHNEIDER

Nearly two-thirds of physicians receive additional pay for providing on-call emergency department services, according to a survey from the Medical Group Management Association.

The survey of more than 2,500 physicians and other health care providers found that 38% of respondents did not receive additional compensation for on-call coverage, while 62% received some type of added payment. Of those who received additional payment, the most common method of payment was a daily stipend.

The hospital administration's willingness to pay for on-call ob.gyn. coverage generally depends on the supply of ob.gyns. in the area and the risk of getting sued.

This is the first year that MGMA has surveyed physicians and other health care providers about on-call compensation levels.

"Historically, on-call duties have been sporadically compensated by hospitals. However, we're seeing more hospitals compensating physicians, and we're seeing hospitals paying more," Jeffrey Milburn, a consultant with the MGMA Health Care Consulting Group, said in a statement. "Hospitals are realizing they must compensate group-practice physicians for on-call duties."

For those who get paid for on-call coverage, more than two-thirds were paid only by the hospital. About 16% received added pay from their medical group only, and another 16% received some type of added pay from both the hospital and the medical group.

Neurological surgeons had the highest median daily rate for providing on-call coverage, about $2,000 a day.

Also at the top of the pay scale were neurologists ($1,500), cardiovascular surgeons ($1,600), internists ($1,050), and anesthesiologists ($800).

Among the specialists earning lower median daily rates for on-call compensation were family medicine without obstetrics ($300), ob.gyn. ($750), gastroenterology ($500), ophthalmology ($300), psychiatry ($500), and general surgery ($500), according to the MGMA survey data.

The survey also found that for most specialties, physicians working in multispecialty group practices received higher on-call compensation than those in single-specialty practices.

Regional pay variations also were seen. For example, orthopedic specialists received higher compensation in the East, while general surgeons were paid at a higher rate in the Midwest than other areas of the country.

Some of the regional variation is likely due to the medical malpractice climate in the state, said Crystal Taylor, MGMA assistant director of survey operations, adding that physicians also were likely to be paid more if they provided on-call duties in a trauma center.

But Michael Fleischman, a principal at the health care consulting firm Gates, Moore & Company, is skeptical of the MGMA survey findings. The survey, which included responses from more than 2,500 physicians, is too small to provide meaningful trend data, he said. "I just don't think the numbers are valid," he said.

Mr. Fleischman, who works with physicians to negotiate pay for on-call coverage, said the hospital administration's willingness to pay for on-call ob.gyn. coverage generally depends on the supply of ob.gyns. in the area. In Atlanta, where he works, there is little opportunity for ob.gyns. to get paid for call. However, an ob.gyn. working in a rural area, where there may be physician supply issues, has much more leverage when seeking compensation, he said.

Other factors that influence whether a hospital will compensate physicians for on-call coverage include whether the ob.gyns. are at a higher risk of being sued when they take call, he said. For example, if they are performing a large number of deliveries for unassigned patients who haven't had prenatal care, they would have a stronger case to receive additional compensation.

The MGMA survey findings appear on target, said Dr. Robert W. Yelverton, chief medical officer of Women's Care Florida, a 100-physician ob.gyn. practice with offices in central Florida.

But whether a physician will be paid for on-call coverage and how much he or she will receive varies by region and by hospital, he said.

In the Tampa area, for example, some hospitals will pay ob.gyns. for on-call coverage if they don't have a laborist program in place or have a residency program.

For those hospitals that don't have in-house staff to handle call, many seem willing to consider paying for on-call coverage, he said.

"There seems to be gradual acceptance of this," he noted.

The payment arrangement also varies by hospital and by region, with some contracting for a set amount, and others reimbursing for the hours spent on call, Dr. Yelverton said. ■