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MARKET WATCH™

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## IN THIS ISSUE...



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Submissions of articles and perspectives on the PA practice environment and job market that may be of interest to readers are welcomed. Please contact the publisher or editor for more information and guidelines.

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# Bright Outlook: Surgery Advanced Practice Clinicians' Compensation Rising Steadily

**By Bonnie Darves**

The good news for physician assistants and nurse practitioners practicing in the surgery realm is that, from the standpoint of compensation if not workload, the picture is bright. Pay increases, modest to negligible in some APC specialty sectors, have been solid in surgery. The three national compensation surveys that track PAs and NPs by specialty sector—the American Medical Group Association (AMGA), the Medical Group Management Association (MGMA) and NERVES (Neurosurgery Executives' Resource Value and Education Society)—all found median compensation increases over the prior year of 2% or more, with some increases as high as 4%.

"From an administrative standpoint, we're also hearing that practices are hiring more surgical APCs because patients are much more open to being seen by PAs and NPs now versus physicians—they realize that they'll have more time with APCs," Mr. Hartley said. "The other trend we're seeing is that states continue to expand practice scope for PAs and NPs, which means that practices' APCs are moving toward more of the patient care than in the past, freeing surgeons to focus on surgery and OR efficiency—and that's paying dividends in improving access," Mr. Hartley said. That in turn is benefitting practices' bottom line, he and other sources noted.

> **"Survey data assists with setting or adjusting compensation, but much is dependent on specific responsibilities, which vary APC to APC."**
>
> – Mike Radomski, NERVES

Although the ascendancy of PAs and NPs generally, across specialties, has long been attributed primarily to practices' and healthcare organizations' challenges recruiting physicians, that's no longer the sole driver, industry observers claim. Practices that develop well-designed care models that highly integrate APCs in multidisciplinary teams and continually broaden APCs' scope to the extent feasible are reaping operational and financial benefits, accordingly to Wayne Hartley, MHA, chief operating officer for AMGA's consulting practice.

"In specialties such as neurosurgery, practices are using PAs and NPs to cover far seeing more patients without direct physician supervision." For both reasons, he added, the increases in surgical APCs' prevalence and compensation are likely to continue.

## How the subspecialties stack up

Within the surgical specialties, PAs in cardiovascular surgery and cardiothoracic surgery were the top earners, based on AMGA's 2018 Medical Group Compensation and Productivity Survey data, with median compensation of $145,185 and $140,273, respectively. NPs in those specialties posted medians of $128,564

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# Compensation Rising

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and $108,041—a far larger spread. At the top end of the scale, Mr. Hartley noted, cardiovascular surgery PAs neared primary care physician pay levels, earning $181,074 at the 90th percentile.

Not surprisingly, orthopedic surgery APCs took the second spot in AMGA's survey, with median compensation of $126,396 for PAs and $109,041 for NPs. Neurosurgery NPs' median compensation was $110,820, compared to $122,415 for PAs.

Following are AMGA survey findings for other surgical subspecialties:

- General surgery PAs earned a median of $116,311, and NPs' median compensation came in at $102,307.
- Trauma surgery NPs' median compensation was $111,223, compared to a $114,867 for PAs.
- Vascular surgery was another high-earning subspecialty, with PAs' median compensation at $120,231 and NPs' at $113,558.
- Urologic surgery PAs, whose respondent base included 28 groups, posted median compensation of $117,488 for PAs and $107,968 for NPs.
- In pediatric orthopedic surgery, an admittedly small group, NPs had median compensation of $109,179; there was no corresponding data for PAs.

In the AMGA survey, the number of group responses overall in the surgery categories was 131 for PAs and 120 for NPs, and individual APC responses totaled 1,972 and 1,613, respectively. The AMGA survey provided the most detailed view of subspecialty surgery PAs' and NPs' compensation levels.

The MGMA 2018 Physician Compensation and Production Survey, whose sample includes predominantly mid-sized and smaller groups and whose findings have long been considered a leading physician compensation benchmark, has been tracking PA and NP compensation levels more extensively in recent years.

Nick Fabrizio, PhD, FACMPE, a principal consultant with MGMA's consulting practice, points out that as NPs and PAs have become "increasingly embedded in many clinical areas," surgery practices and primary care and subspecialty groups have continued to expand their APC teams, for the same access and operational benefits that Mr. Hartley cited.

That means, in turn, that groups are competing for experienced APCs in the surgical and medical subspecialties, sources noted. That is driving up compensation in some sectors and in regions that are undersupplied generally.

In neurosurgery, PAs saw their median compensation increase from $119,285 in 2017 to $122,793 in the MGMA 2018 survey data. NPs, however, experienced a slight decline—from a median of $115,846 in 2017 to $107,089 in 2018. That difference, and other fluctuations between 2017 and 2018, might be attributable in part to the shift in the responding survey population, according to MGMA survey staff; overall participation in the provider survey increased 11% between the two years.

## NERVES PA and NP data expanding

The NERVES survey, by far the most comprehensive nationally in neurosurgery, has been expanding its coverage of the PA and NP sectors in recent years, to provide a bigger picture of how groups are compensating clinicians across the board.

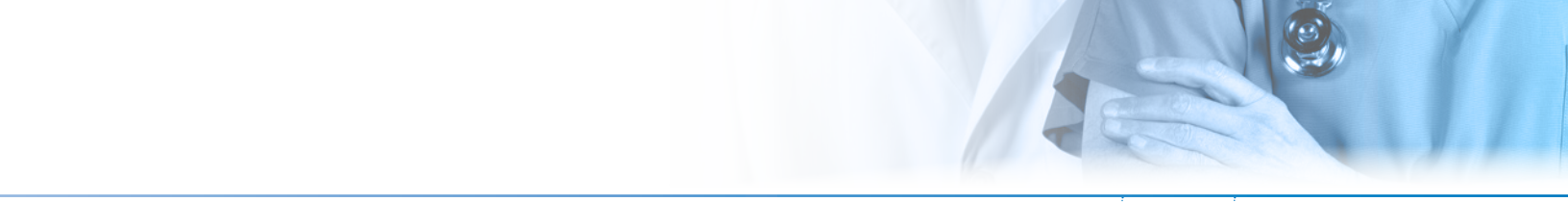
The most recent survey found median compensation up for both PAs and NPs. Their median earnings, respectively, were $113,000 and $106,000. PAs' median compensation was up 3.6% over last year's survey, and NPs saw a 2.0% increase. The reporting participant base for this year's survey included 314 NPs and 299 PAs.

On the big-picture front, the ratio of APCs to neurosurgeons is decreasing, NERVES found, as more groups boost their PA and NP staff to streamline care and reduce bottlenecks in the clinic and the OR. Among the groups surveyed, the ratio of APP to neurosurgeon in 2017 was .75:1.

The NERVES survey also provides a sense of the revenue contributions of PAs and NPs in neurosurgery groups and its relation to their compensation. NPs generate collections at approximately 50% of their compensation; for PAs, it's 100%. This data is representative of the more detailed picture of how APCs are compensated and utilized in neurosurgery-dedicated practices that NERVES is attempting to develop, according to Mike Radomski, a NERVES senior officer who is CFO and vice president of finance at the Mayfield Clinic in Cincinnati.

"APC compensation is a topic of frequent conversation among NERVES members, but the survey itself currently does not address many of the questions," he said, that members pose about APCs. For that reason, NERVES has expanded the survey

> **"In some cases, we're also seeing more significant [provider] compensation differences from state to state than region to region, which is a relatively new finding."**
>
> – Nick Fabrizio, MGMA





this year (currently underway) to gather more information regarding the distribution of APC responsibilities and more complete details on salary, bonuses and other compensation components.

"Survey data assists with setting or adjusting compensation, but much is dependent on specific responsibilities, which vary APC to APC," Mr. Radomski said. Bonus structures are typically dependent on a productivity measure of some type, he added, in the same manner that neurosurgeons' productivity figures in their total compensation.

The AMGA survey found that among 139 groups (across specialties) that reported on compensation determinants for PAs and NPs, while 83% use market salary data, only 21 groups reported using a production-based compensation plan in setting salaries. Other non-productivity incentives that figured in PA and NP compensation included patient satisfaction and clinical quality/outcomes as the key metrics, at 73% and 62% of reporting groups, followed by patient access and citizenship, both at 37%.

## Regional compensation view in neurosurgery and orthopedics

Even if hiring organizations tend to use national survey data as their primary starting point for both APC and physician compensation, the MGMA survey regional data has historically been considered a reliable barometer of provider compensation trends in the different geographic regions.

In the MGMA 2018 survey, in both orthopedics and neurosurgery, regional compensation differences were widespread. Orthopedic surgery PAs in the Western region had median compensation of $138,356. At the low end of the regional scale, Eastern region PAs earned a median of $117,894. Southern orthopedics PAs took the second spot at $125,245, followed by a median of $111,792 in the Midwest. Data for orthopedics NPs was limited; those in the Eastern region had posted median compensation of $116,081, compared to $104,666 in the Midwest.

Some of the year-to-year regional increases were pronounced in the PA orthopedics sector. Last year, PAs in the Western region had a median of $119,655, nearly $20,000 less than this year's median. In the Midwest and Eastern regions, orthopedic surgery PAs' median compensation increased only slightly, by approximately $2,000 in both cases. Compensation was effectively flat in the Southern region.

Mr. Fabrizio notes that although the regional differences are one indicator of compensation-fluctuation trends, most hiring organizations tend to use national data as their primary benchmark starting point. That means that job-seeking APCs shouldn't necessarily expect compensation levels that prospective employers offer to reflect regional numbers, sources maintained. In Mr. Fabrizio's view, local market factors might be more telling than regional ones in the final compensation equation.

"In some cases, we're also seeing more significant [provider] compensation differences from state to state than region to region, which is a relatively new finding," Mr. Fabrizio said.

*Ms. Darves, a freelance healthcare writer and editor based near Seattle, is editor of Surgery PA Market Watch and Neurosurgery Market Watch.*

# FEATURED OPPORTUNITY

## New Jersey Hospital Seeks Lead Neurosciences Advanced Practice Provider

A hospital in central New Jersey is seeking a lead advanced practice provider (APP) for its neurosciences inpatient program. The department seeks a candidate with at least five years of experience and preferably some management experience in neuroscience and/or neuro-critical care. Certification as an acute care clinician is strongly preferred.

The lead APP will have administrative and clinical duties and will share in call with the department APPs. The neuro-ICU is staffed 24/7, and all PAs work 7:00-7:00 shifts. All PAs work 13 shifts in a cycle, which is three to four shifts per week, with approximately 50% of those night shifts. APPs also are required to work two weekends in every six-week period.

The incoming candidate will provide support services and patient care under the supervision of the neurosurgeon and neurointensivists, as directed by the appropriate state laws. The work will include providing preoperative and postoperative care for the neurosurgical patients, and continued care for neurocritical care patients. This includes but is not limited to medical workups for inpatients, assisting in acute critical care procedures, participating in preoperative workup, providing post-operative care and follow-up, and performing other medical and surgical activities.

The facility will provide a very competitive compensation package including salary, vacation, relocation, CME, and a full benefit package. The area is in an upscale community in central New Jersey approximately an hour from New York City and an hour from Philadelphia, and only 45 minutes from the beach. The area has excellent school systems, and the local public school system is in the top five percent in the country.

## PERSPECTIVES

# Preparing for PA Practice: Start Early and Get Organized

*Jason Prevelige, PA-C, chair of the American Academy of Physician Assistants' Early Career PA Commission, recently spoke with Surgery PA Market Watch about the FAQs he hears from PAs heading into practice. An emergency medicine and neonatology PA, Mr. Prevelige is Lead Advanced Practice Provider for Envision Physician Services in the Emergency Department at St. Mary's Hospital, in Waterbury, Ct., and also practices at Connecticut Children's Medical Center.*

**What are the top three FAQs that PA graduates (or those who are nearing graduation) pose to you and your fellow commission members?**

There are a few questions that come up regularly when people are looking for guidance. PAs nearing graduation want to know what paperwork and documentation prospective employers will require as they start looking for practice opportunities. We also get a lot of people asking, "What do I do next?" right after they take their national certification exam. The other key question is: How do I get a license?

One thing that we stress is the importance of planning ahead to address some of these issues. If a PA is just starting to ask these questions after graduation, she or he might not be working for a while. Dealing with all the paperwork takes time.

On a more specific note, we frequently hear from PAs who've been offered jobs and will be the first PA in that practice or organization—the trailblazers. They understandably have a lot of questions about how to set up their practice within the organization. We recently created the Mentor Match Huddle program to help connect new PAs with PAs who have potentially helpful experience or PAs who have similar interests.

It's interesting that we are also increasingly hearing from employers seeking guidance on how to onboard PAs.

**In that planning vein, how long before graduation should PAs get started on tasks to prepare themselves to start exploring opportunities, and what can they realistically do before they're licensed?**

Of course, PAs can't really do a lot of official things until they graduate, and nothing really moves forward until they take the national certification exam. But they can address the big-picture issues: What do you want to do in your practice and where do you want to practice? Making those decisions enables PAs to start researching options, focusing their job search and familiarizing themselves with different states' statutory and regulatory requirements for new PAs. The latter can vary considerably.

For example, some states—like Connecticut—allow PA students to get started on licensing paperwork before they graduate. And some states even issue temporary licenses while PAs are waiting for exam results.

PA students who have already lined up a job, pending their licensure, can get started on the credentialing process, which can take a long time. Start gathering credentials and certifications and procedure logs and ask the employer for a detailed list of what is needed. That can save time later and might enable you to start practicing sooner, once you're licensed.

It's worth noting that health plan credentialing cannot start before you are licensed and official; the same goes for Medicare and Medicaid.

**Is there any way to expedite the paperwork processes?**

There are and there aren't, but the more organized you are, the quicker it will go. And our commission has developed a checklist that PA students nearing graduation can use to streamline their efforts. Start by putting all your documents in a file and making copies, because you'll need them for multiple purposes. You could also take advantage of the AAPA's new PA Portfolio, an online tool for gathering and securely sharing PAs' essential documents.

In addition, PAs can be proactive about entering their data and self-reporting credentialing information to the CAQH, a web-based repository that collects and disseminates healthcare provider data to participating health plans, hospitals, health systems and provider groups. This could speed up health plan credentialing.

## CONTRIBUTIONS WELCOMED!

**Help shape Surgery PA Market Watch by contributing opinion articles that address issues affecting surgical APC practice or that provide guidance on career matters. We also seek ideas for articles on topics of potential interest to our readers.**

To discuss an idea or to propose a coverage topic, please contact Surgery PA Market Watch editor Bonnie Darves at **425-822-7409** or **bonnie@darves.net** or publisher Katie Cole at **303-832-1866** or **katie.cole@harlequinna.com**.



# Navigating the Job-Search Cycle

## Deciding When to Start Interviewing for a New Job and When to Give Notice Can Get Tricky

By Katie Cole

You've decided you would like a new surgical PA job, but you're not sure when is the best time to start interviewing. As a rule of thumb, it takes, on average, three months after you've signed to obtain an official start date. This is after you've already interviewed and accepted an offer.

Depending on what your time frame is, it's smart to plan that credentialing will take a minimum of 60 to 90 days. If you aren't licensed in the state where you're seeking a new job, that process typically takes at least a month.

If you have decided to explore new jobs, I recommend reaching out to potential practices and hospitals at least four to six months ahead of the time you would ideally leave your current position. You also must budget time for phone interviews and travel, if you're considering leaving your current area, and time for relocating to the new city. That's an important aspect of the overall time frame that job-searching advanced practice clinicians (APCs) tend to "under budget" for, which can compound the stress of starting a new position if you're living out of boxes.

### Deciding when to give notice

Once you've signed a contract, you might be inclined to go ahead and give notice to your current employer. That's often too soon, in my experience. I have had many candidates who gave notice, only to find that the onboarding process would be delayed—leaving them stuck with no job for several months, in some cases. Extensive delays aren't the norm in surgery APC hiring processes, but it is important to be prepared. It's not unusual for onboarding to be affected by unexpected delays, usually due to credentialing or changes within the department the APC is joining.

Depending on how much time your current employer requires for giving notice, even if you have signed an employment agreement, I advise waiting to give notice until you have an official start date with your new employer. I have seen start dates pushed back several months after a candidate has signed an employment agreement, for a variety of reasons.

At the same time, don't push your notice so late that your current employer ends up in a situation where clinical coverage is compromised. In other words, don't burn bridges or disadvantage your current colleagues, if that can be avoided.

After you have an official start date (in writing, ideally) and your credentialing is either completed or nearing completion, you can feel secure in giving notice. Make sure you meet the employer's time requirement for giving notice, which can be anywhere from two weeks to two months. It's also important to look at your original or current employment agreement before giving notice, to ensure you're aware of any additional guidelines, requirements or established rules that you must to comply with before you leave. It's important to leave on good terms because, as we all know, it's a small world.

Once you have signed a new employment agreement, you're ready psychologically to move on. The next challenge is to plan the transition well so that you can truly look forward to a fresh start and avoid unnecessary stress and possibly compromising your income.

*Ms. Cole is a Denver resident and publisher of Surgery PA Market Watch and Neurosurgery Market Watch.*

## SURGERY PA AND NP JOBS

Farmington, NM: *Hospital Employed-General Surgery*
Greenville, NC: *Hospital Employed-Neuro-ICU PA/NP*
Fairfield, CA: *Hospital Employed-Neurosurgery PA*
Farmington, NM: *Hospital Employed-General Surgery PA/NP*
San Antonio, TX: *Academic-Neuro-ICU PA/NP*
Long Island, NY: *Private Practice-Neurosurgery PA*
Fairfield, CA: *Hospital Employed-Critical Care NP*
Raleigh, NC: *Academic-Neurosurgery PA/NP*
Trenton, NJ: *Hospital Employed-Lead PA/NP Job for Neuro-ICU*
Fresno, CA: *Priva-demic-Neurosurgery PA/NP*
Las Vegas, NV: *Private Practice-Neurosurgery PA/NP*
Salina, KS: *Hospital Employed-Orthopedic Surgery PA/NP*
Macon, GA: *Private Practice-Neurosurgery PA/NP*
Farmington, NM: *Hospital Employed-Neurosurgery PA/NP*
Pinehurst, NC: *Hospital Employed-Neurosurgery PA*
Indianapolis, IN: *Hospital Employed-Pain Management PA/NP*
Greenville, NC: *Hospital Employed-Orthopedic Trauma Surgery PA/NP*
New Haven, CT: *Academic-Neurosurgery PA/NP*
Reno, NV: *Private Practice-PM&R PA/NP*
Stuart, FL: *Hospital Employed-Intensivist PA/NP*
Long Island, NY: *Private Practice-Neurosurgery PA*

# PROFILE

**Who:**
Beth Thompson, PA-C

**Position:**
Neurosurgery PA, Georgia Neurosurgical Institute, Macon, Georgia

**What will you be doing in your new job, and what appealed to you about the position?**

I knew that I wanted to practice in the surgery field and that I wanted to work in the hospital setting, so the position at GNI was ideal. I considered the position a one-of-a-kind opportunity for me because neurosurgery is definitely an appealing area for PAs and one that's highly sought after. I previously worked in orthopedics and enjoyed it, so I knew I wanted to stay in surgery.

In my new position, I'll serve as first assist in the two to three days a week and work two to three days a week in the clinic. I'll also be on call five days a month, because GNI is affiliated with a Level 1 trauma center. That will take some getting used to, but I'm excited and ready for the challenge!

**What drew you to the medical field in general and physician assistant practice specifically?**

When I was a young child, I had a traumatic accident and had to have emergency surgery. The doctors and staff who cared for me were wonderful. I knew that someday I wanted to be able to help people in the same way that I had been helped.

As I got older, I began shadowing different physicians. Initially, I was headed for medical school, but then then my cousin, an ER physician, encouraged me to also consider PA school. He introduced me to a few PAs, and when I saw their compassion and drive, it was inspiring—I knew that the field would fulfill the desires of my heart.

I chose PA practice for a few reasons. I appreciated the gratifying interactions that I saw PAs have with patients and the fact that PAs can spend a bit more time with patients than physicians can. I also liked the fact that PAs have the option of working in many fields and have a potentially more flexible lifestyle than physicians do.

**Why did you choose to practice in neurosurgery, and what about the field do you expect to find gratifying?**

The appeal of neurosurgery is that it's a complex but also a highly interesting and dynamic area of medicine. I know that my new position will be very fulfilling and challenging at the same time. In PA school at the University of Texas, I found neurophysiology and neurosurgery fascinating, so I am excited about the opportunity to learn more through firsthand experience as I care for complex patients.

**If, based on your own experience, you could give your colleagues coming up (those seeking a first opportunity) some advice on how to approach their search, what would you recommend?**

In my case, I was looking for location—my husband and I knew we wanted to return to Georgia—so I began applying for positions fairly early, about six months before graduation. I think that's a good, and acceptable, time to start applying.

One thing I did that worked well was to schedule all three interviews for the same week, and based on my experience, I recommend that PAs schedule interviews as close together as possible. I was fortunate to end up having three potential jobs, which made my ultimate decision a lot easier because I was able to create my pros and cons list by Sunday. No one was waiting for me to complete other interviews.

When you start looking, it's important to have a good sense of what you're looking for and where you want to practice—and to avoid wasting anyone's time. If you have a phone interview and you don't really want the position enough to go to a site interview, it's best not to continue the conversation.

In preparing for interviews, I recommend being candid. I was honest and sincere and open in my interviews because I wanted those interviewing me to know who they might be hiring. I shared my own compassion and my passion for the field, but I was also honest about what I enjoy and what I expect.

Finally, be prepared to ask questions. The key ones, for me, were these: How many ACPs have you had and how long did they stay—and if they left, why was that? How many patients do you expect me to see a day, initially and after I've settled in? That's a very important question to ask as a new graduate, because if a practice expects you to see 35 patients a day soon after you start, that's not realistic.

# SURGERY PA EVENTS

**Point of Care Ultrasound Conference**
❏ January 19, 2019
Orlando, Florida

**AASPA Pre-PA Meeting**
❏ January 19, 2019
Orlando, Florida

**Ortho In the West - The A-Zs of Arthritis to Arthroplasties**
❏ February 15-17, 2019
Phoenix, Arizona

**APACVS 38th Annual Meeting**
❏ April 4-7, 2019
Miami, Florida

**Extremities in the Carolinas - Trauma for General Orthopaedics**
❏ May 17-19, 2019
Charlotte, North Carolina

**AAPA 2019**
❏ May 18-22, 2019
Denver, Colorado