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Executive Summary

The 2014 Physician Workforce Survey was undertaken by the Monroe County Medical Society (MCMS) in the fall of 2014 to assess physician access and identify any significant change in physician availability or in the professional environment in which local physicians operate. Data from the 2014 Physician Workforce Survey inform this report and update the results of the 2009 study.

All practicing physicians (n=3,528), residing or practicing in seven Finger Lakes' counties (Monroe, Livingston, Ontario, Seneca, Wayne, Yates and Steuben), were invited to complete the 2014 Physician Workforce Survey. A total of 331 physicians completed the survey, resulting in an effective response rate of 9.1%, which is considerably lower than the rates achieved in previous MCMS physician surveys. Survey respondents were predominately male (60%) MDs (96%), with the majority practicing exclusively in Monroe County (87.5%). Primary care specialties (Internal Medicine, Family Medicine, General Medicine, and Pediatrics) accounted for 41.3% of respondents. In total, 92 medical specialties (primary or secondary) are represented in the survey results.

Direct outpatient care accounted for an estimated 60% of professional hours reported by physicians. Among non-hospitalists (n=312), nearly all physicians (89.1%) reported some level of outpatient care with an average of 30.8 hours/week reported by physicians providing such care. Despite an increase in hospitalist care, nearly one-half of primary care physicians (49.3%) reported providing direct inpatient care. On average, physicians spend an additional 10.3 hours/week on administrative responsibilities, with wide variation reported within and across specialties. Administrative burden has increased substantially from the 6 hours/week last reported in the 2003 MCMS survey.

Of the 266 survey respondents with patient contact, 78.6% reported accepting new patients. More than one-third of physicians accepting new patients, however, do so on a restricted basis. Medicaid remains the most common restriction (23.4% of practices accepting patients are not accepting new Medicaid patients). Access is most restricted in adult primary care where less than one-third of providers report accepting new patients on an unrestricted basis. While approximately 40% of physicians indicated that they had increased the number of patient care hours they provided in the last two years, one-third indicate that they are very likely to reduce patient care hours within the next five years, with an additional 25% expecting to retire within five years. Physicians entering the profession are expected to offset much of this decline.

Personal and family reasons remain the overriding reason why physicians decide to practice in the Finger Lakes region. Career opportunities (45.8%) and geographic location (44.6%) are also significant factors in many physicians’ decision to practice in the area. While personal and family reasons attract many physicians to the region, they are also a decisive factor in relocation from the area for many physicians (32.5%). Inadequate or uncompetitive compensation (39.3%) and a difficult practice environment (37.3%) were the most frequently cited considerations for relocation. Physicians clearly regard local compensation levels, widely perceived as inadequate, as a critical professional issue.
Introduction

For many years, the Monroe County Medical Society (MCMS) and the Finger Lakes Health Systems Agency (FLHSA) have assessed physician availability in the region, as well as how conducive the region is to the practice of medicine. Under the direction of the MCMS, FLHSA conducted surveys or comprehensive studies of the regional physician workforce in 1986, 1992-1993, 1999, 2005, and most recently, 2009. An additional study was conducted by the Center for Governmental Research in 2003. The current survey, the 2014 Physician Workforce Survey, was undertaken in the fall of 2014 to update the results of the 2009 study and identify any significant change in physician availability or in the professional environment in which local physicians operate. Data from the 2014 Physician Workforce Survey inform this report.

The MCMS sponsored the 2014 Physician Work Survey. Its Physician Workforce Committee, a panel of representatives of physician organizations, area medical training programs, hospitals, insurers, public health organizations, and FLHSA, served as the advisory panel. FLHSA and Excellus staff analyzed the survey data, with FLHSA reporting the survey results. FLHSA staff extends its thanks and recognition to Excellus for also compiling and cleaning the survey data.

Methods

MCMS invited all practicing physicians, residing or practicing in seven Finger Lakes’ counties (Monroe, Livingston, Ontario, Seneca, Wayne, Yates and Steuben), to complete its 2014 Physician Workforce Survey. (Physicians practicing in Steuben County were not included in prior surveys.) Physicians were identified for study participation through the MCMS physician inventory, a database initially developed in 2005. Prior to the distribution of the 2014 survey, MCMS conducted a rigorous update of its physician database to ensure that the database accurately reflects the region’s physician workforce. Both MCMS members and non-members are included in the database. Survey invitations were delivered electronically (64.4%) or by US mail (35.6%) in late summer 2014 to the 3,528 eligible physicians identified by MCMS. Surveys were mailed to physicians for whom the MCMS did not have an email address or had an invalid email address.

The survey instrument consisted of a 21-item questionnaire that included opened and closed-ended questions. Survey questions closely followed the 2009, 8-item survey in content and order, although the response format was altered for several questions. For some questions, the format change made a comparison of results across surveys impossible. The current survey queried physicians’ patient availability, anticipated changes in patient availability, and the amount of professional time devoted to indirect patient or non-patient care to a greater extent than the 2009 survey.
The majority of responses were collected electronically (92.1%) through November 2014 with SurveyMonkey™, a web-based survey tool. A total of 331 physicians completed the survey with 323 responses available for analysis. The effective response rate of 9.1% is considerably lower than the rates achieved in the 2005 (41.3%) and 2009 (27.9%) MCMS physician surveys. The internet-based nature of the 2014 survey may have contributed to the low response rate. Internet response, offered as an optional response method in the 2009 survey, accounted for only 15% of the responses received in that survey. In addition, unlike earlier surveys, in which repeated mailings and follow-up telephone calls were used to increase physician response rates, no additional efforts were undertaken to solicit responses to the 2014 survey.

While low response rates are characteristic of the physician population, research suggests that physician demographic variables, including income, area and type of practice, physician gender and age, are not appreciably biased by nonresponse (Kellerman SE, 2001). As such, the response to this survey, while low, is believed to be generalizable to the physician population of the area surveyed, as well as the Finger Lakes region in its entirety.

Participant Profile

Survey respondents were predominately male (60%) MDs (96%), with the vast majority of respondents practicing exclusively in Monroe County (87.5%). Several physicians reported practicing in Ontario (n=39) and Wayne (n=34) counties, while 10 or fewer physicians reported practicing in each of the remaining counties. The majority of physicians practicing in these counties, practiced part-time in each, and many practiced in multiple counties. The average age of respondents was 52 years, similar to the average age of all physicians in the Finger Lakes region (51 years) (Center for Health Workforce Study, 2014) and all New York State physicians (52 years) (Center for Health Workforce Study, 2014), yet slightly older than the average age of all AMA-listed physicians (49 years) (Physicians’ Foundation, 2012). The age distribution of survey respondents with a comparison to all AMA-listed physicians is provided in Table 1. The comparison highlights the “graying” of practicing physicians in the Finger Lakes region and the ensuing need to continue to attract younger physicians to the area.

<table>
<thead>
<tr>
<th>Age</th>
<th>% of Survey Respondents</th>
<th>% of AMA Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>0.3</td>
<td>5.8</td>
</tr>
<tr>
<td>30-39</td>
<td>12.6</td>
<td>22.0</td>
</tr>
<tr>
<td>40-49</td>
<td>26.2</td>
<td>24.8</td>
</tr>
<tr>
<td>50-59</td>
<td>33.7</td>
<td>25.1</td>
</tr>
<tr>
<td>60+</td>
<td>27.2</td>
<td>22.3</td>
</tr>
</tbody>
</table>
Primary care specialties (Internal Medicine (15.1%), Family Medicine (13.3%), General Medicine (0.9%) and Pediatrics (12.0%)) accounted for 41.3% of respondents and are overrepresented in the survey. The overrepresentation (41.3% of survey responses versus 35.1% of physicians in the region (FLHSA, 2014)) is largely driven by pediatric providers who comprise 12.0% of respondents and approximately 8.4% of providers in the region. Other specialties represented include: Obstetrics and Gynecology (4.9%), Geriatric Medicine (4.0%) and Hospitalist (3.3%). In total, 92 medical specialties (primary or secondary) are represented in the survey results with each of the remaining specialties representing 3.0% or less of total responses. For physicians reporting both a primary and secondary specialty, responses are categorized according to primary specialty unless stated otherwise. In general, sub-group analyses are limited to primary care specialties due to the limited number of responses for other specialties.

Medical Practice

Direct Patient Care

Direct outpatient care accounted for an estimated 60% of weekly professional hours reported by physicians. Among non-hospitalists (n=312), nearly all physicians (89.1%) reported some level of outpatient care with an average of 30.8 hours/week reported by physicians providing such care. Primary care physicians averaged 32.8 hours/week in direct outpatient care, with Obstetrics/Gynecology (30.2 hours) and Geriatrics (32.4 hours) reporting a similar number of hours of outpatient care. Neurologists (29.8 hours) and Anesthesiologists (28.6 hours) reported slighter lower average hours, with a wide range in outpatient hours reported within these specialties. This finding may reflect an actual difference in outpatient hours within and across specialties or may result from the limited number of responses from specialties other than primary care.

In addition to physician care, most practices employed at least one nurse practitioner (NP)(58.2%) or one physician assistant (PA)(39.0%) with 28.5% of practices employing both mid-level providers. Nearly one-third of practices (31.3%) employed neither a NP, nor a PA. The median number of full-time equivalent NPs and PAs (total) reported per practice was two.

Hospitalists (n=11), who by definition provide inpatient care exclusively, reported an average of 53.7 inpatient hours/week. Excluding hospitalists, 63.5% of physicians reported providing direct inpatient care. Of non-hospitalists providing inpatient care, nearly 40% reported spending between 1-7 hours/week (the lowest response category) on such care, with one-half (52.5%) reporting between 1-15 hours/week on direct inpatient care. Using the midpoint of each time category as the response value, the average level of direct inpatient care across all non-hospitalists is estimated at 22.1 hours/week, and is skewed upward by hospital-intensive specialties. Among primary care physicians, 49.3% reported providing direct inpatient care which averaged 14.1 hours/week. The majority of primary care physicians (63.6%), however, reported spending less than 7 hours/week on inpatient care.
Time distributions of direct inpatient care for all non-hospitalist providers and primary care providers alone are provided in Chart 1 and Chart 2.

Chart 1. Non-Hospitalist Direct Inpatient Hours/Week for Physicians Who Reported Providing Direct Inpatient Care

Chart 2. Primary Care Direct Inpatient Hours/Week for Primary Care Physicians Who Reported Providing Direct Inpatient Care
Administration

Slightly more than half (56.5%) of respondents reported spending between 1-7 hours/week on patient or practice administration, with one quarter of respondents (25.7%) spending 8-15 hours/week on administration. On average, physicians spend 10.3 hours/week on administrative responsibilities, a substantial increase from the 6 hours/week last reported in the 2003 MCMS survey. While the 2005 MCMS study did not capture administrative time per se, physicians did comment on an increase in non-patient time requirements over 2003 levels. (Administrative workload was not assessed in the 2009 survey.)

Time spent on administrative work varied widely by specialty. Primary care providers (n=112) averaged 9.6 hours/week, while psychiatrists (n=8), geriatricians (n=13), and hospitalists (n=8) reported spending more than twice as much time on administration as primary care providers, averaging 19.5, 21.4, and 22.5 hours/week, respectively. Unlike the majority of primary care physicians (86.2%) who reported spending less than 15 hours/week on administrative duties, geriatricians and hospitalists reported a wide range of variation in time on administration. Approximately one-half in each specialty reported less than 15 hours/week and one-half reported between 27 and 56+ hours/week. The large differences in time spent on administrative work within specialties may reflect differences in physicians’ interpretation or definition of administrative work, rather than actual workload differences. Time spent on administration across all providers is summarized in Chart 3.

Chart 3. Administrative Hours
Teaching and Research

Nearly three quarters of respondents (70.3%) reported teaching during the year with the majority (69.2%) teaching between 1-7 hours/week, on average 30.5 weeks/year. All Hospitalists reported teaching, with a large percentage of Obstetrician/Gynecologists (75%) and Pediatricians (70%) also reporting teaching obligations. Research accounts for a smaller percent of professional time than teaching. Approximately one quarter of physicians (27.6%) engage in research-related activities, with most (64.0%) spending less than 8 hours/week in this endeavor. Research activity was reported across multiple specialties, with no single specialty accounting for a preponderance of research activity.

Physician Access

The broadest measure of physician access is the population-adjusted number of physicians practicing in a region. The Center for Health Workforce Health Studies 2010 data indicate 3,484 physicians in the 7 county area, a 16% increase over 2009 (FLHSA, 2010). (The actual increase is less than 16% as the data sources for 2010 and 2009 are different. The 2010 data include licensed, non-practicing physicians; the 2009 data do not.) Nearly 40% of these physicians (39.3%) are primary care providers, a slight decline from the 41.1% who identified themselves as primary care providers in the prior year. As Chart 4 illustrates, the population-adjusted number of physicians varies dramatically between Monroe County (and to a lesser extent Ontario County) and the other counties in the region.

Chart 4. Physician per 100,000 Persons by County

Source: FLHSA Regional Profile-2014
Physician access may be better measured by the number of physicians accepting new patients and the wait time to obtain an appointment. Of the 266 survey respondents with patient contact, 78.6% reported accepting new patients. More than one-third of physicians accepting new patients (37.3%), however, do so on a restricted basis. The most common restriction is Medicaid (23.4% of practices accepting patients are not accepting new Medicaid patients), followed by insurance plans offered through the NYS Exchange, which physicians report accepting on a limited basis (17.7%), or not at all (5.3%). The percentage of physicians not accepting Medicaid remains unchanged from 2009. “Other” restrictions are imposed by 10.0% of physicians accepting new patients. Exchange related and “Other” restrictions are presumed to be payment driven.

Among primary care physicians, one-third (32.8%) reported not accepting new patients. This represents a large increase from the 25% of primary care physicians who reported not accepting new patients in 2009 (FLHSA, 2009). This restriction is driven by adult primary care providers of whom 42.1% reported not accepting new patients. Moreover, among adult primary care practices accepting new patients, 44.4% do so on a restricted basis with Medicaid patients most often restricted. Physician access is less restricted among pediatric providers where one in ten pediatricians reported not accepting new patients. Among pediatricians accepting new patients, nearly 60% had no restrictions on such acceptance. Medicaid was the most common restriction (21%) among pediatric providers with new patient restrictions.

Physicians reported seeing an average of 66 patients per week with a great degree of variation (range: 0-500) in the number of patient visits per week reported by physician and across practice areas. If physicians who reported 200 or more patient visits per week (e.g.; radiologists and pathologists) (n=6) are excluded, average visits decline to 61 patients/week. Among both adult primary care providers and pediatricians, median weekly patient visits was 75. Adult primary care providers reported a similar number of patient visits in 2009, while pediatric providers reported 80 visits/week. A histogram of primary care weekly patient visits is provided in Chart 5.

**Chart 5. Primary Care Weekly Patient Visits**
Physician availability, expressed as wait time for an appointment, differs markedly by patient acuity (acute or non-acute) and status (established or new). This pattern, illustrated in Chart 6, is consistent with published research that suggests patient wait time for an appointment is a function of patient acuity and status. Over 60% of providers see established, acute patients the same day, with an additional 15.7% of providers seeing these patients the next day. Non-established patients do not fare as well. Providers are nearly twice as likely to see an established, acute patient the same or next day, as they are to see a new patient over the same time period. Differences in wait time for non-acute visits between established and new patients are demonstrated as well. Almost one-half of physicians (44.8%) report seeing established patients for non-acute visits within one week, while the wait time for new, non-acute patients averages nearly 3 weeks.

**Chart 6. Appointment Wait Time by Patient and Visit Status**

Approximately 40% of physicians (n=128) indicated that they had increased the number of patient care hours they provided during the last two years. Of those providing additional hours, 50.0% provided up to an additional 5 hours/week, with 35.2% providing between 5 and 10 additional hours/week. This increase was partially offset by the 17.9% of physicians (n=58) who reported reducing patient hours by an average of 9.7 patient hours/week during the same period. A summary of reasons driving increases and decreases in patient care hours among providers reporting a change in hours (n=186) is provided in Chart 7. Multiple responses were allowed.
Physicians were also asked to assess their likelihood of making specific professional changes within the next 2 and 5 year time periods. The likelihood of change was assessed on a 10 point Likert scale with “1” indicating “less likely” and “10” indicating “most likely.” For analysis purposes, responses were aggregated as follows: 1-3 (“Not Likely”), 4-7 (“Neutral”), 8-10 (“Very Likely”). Responses for two- and five-year time periods are summarized in Table 2. Reflective of the region’s aging physician workforce, nearly one-quarter of practicing physicians (24.2%) indicate that they are very likely to reduce patient care hours within the next two years, with this percentage increasing to 33.3% over the five-year time horizon. These findings, while not directly comparable to the 2009 survey results due to different time horizons and response scales, are consistent with the 2009 survey in which nearly 20% of physicians indicated they were very likely to reduce patient hours in the next 2 years. It appears fewer physicians (33.3%) now expect to reduce their hours over the next five years than in 2009, when nearly half (48.5%) indicated they were very likely to reduce hours in the next 10 years. Physicians’ retirement plans have remained remarkably consistent. In 2009, approximately 25% of respondents indicated plans to retire in 10 years; 5 years later, 25% of respondents expect to retire in 5 years. These reductions in workforce, anticipated proportionately across primary care providers and other specialties (in aggregate), will influence the future of this region’s health care.
Table 2. Professional Change: 2 and 5 Year Views

<table>
<thead>
<tr>
<th></th>
<th>Two Year Time Horizon</th>
<th>Five Year Time Horizon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n Not Likely %</td>
<td>Likely %</td>
</tr>
<tr>
<td>Relocate from Rochester metropolitan area</td>
<td>318</td>
<td>84.3</td>
</tr>
<tr>
<td>Increase patient care hours</td>
<td>311</td>
<td>75.6</td>
</tr>
<tr>
<td>Decrease patient care hours</td>
<td>314</td>
<td>45.5</td>
</tr>
<tr>
<td>Change primary specialty</td>
<td>312</td>
<td>95.2</td>
</tr>
<tr>
<td>Retire/Leave active practice</td>
<td>310</td>
<td>77.7</td>
</tr>
</tbody>
</table>

The Finger Lakes Area

Personal and family reasons remain the overriding reason why physicians decide to practice in the Finger Lakes region; nearly 70% of respondents indicated personal and family considerations as a determinant factor. Career opportunities (45.8%) and geographic location (44.6%) were also significant factors in many physicians’ decision to practice in the area. While personal and family reasons attract many physicians to the region, they are also a decisive factor in relocation from the area for many physicians (32.5%). Inadequate or uncompetitive compensation (39.3%) and a difficult practice environment (37.3%) were the most frequently cited considerations for potential relocation. Physicians clearly regard local compensation levels, widely perceived as inadequate, as a critical professional issue. Compensation ranked first among considerations in relocating from the region and last among reasons to relocate to the region. Attractions and deterrents of practicing in the region are provided in Chart 7. Although survey questions addressing the reasons for selecting the Finger Lakes region as a practice area and reasons for relocation from the area were asked in the 2009 survey, the responses were formatted differently. As such comparisons to the prior survey are not provided. Nonetheless, response rankings remain generally consistent across survey periods.
Chart 7. Practicing in the Region: Attractions and Deterrents

Practicing in the Region: Attractions and Deterrents

- Spouse’s career opportunities
- Professional atmosphere
- Practice environment
- Financial compensation
- Geographic location/Lifestyle
- Career opportunities
- Personal Reasons/Family

% Responding (multiple responses allowed)

- Deterrent
- Attraction
Discussion and Conclusions

The 2014 Physician Workforce Survey was undertaken to identify significant changes in regional physician availability and the professional environment since the completion of an earlier study: Availability of Physician Services in the Rochester Area, 2009. The current analysis is not a comprehensive study like that undertaken in 2009. However, it provides a snapshot of the regional physician workforce and environment, and reveals a workforce and environment fundamentally unchanged from 2009, albeit with increasing signs of strain.

As reported by the Center for Health Workforce Studies, the physician workforce continued to grow with an estimated 3,484 physicians practicing in the region in 2010. Despite an increase from 2009, physician capacity is beginning to show signs of constraint, particularly among adult primary care providers. To some extent, new physicians entering practice are expected to offset the projected reduction in the local physician workforce.

A large and increasing number of providers do not accept new patients or restrict the new patients they accept, most often by payment source. Individuals on Medicaid continue to be the most affected by restrictions. However, 23% of physicians reported limiting acceptance of some or all insurance plans offered through the NYS Exchange. Low reimbursement rates are thought to be influencing this provider decision. For those insured through the NYS Exchange, access hinges on physician acceptance of NYS Exchange plans. Given current constraints on adult primary care access and the predicted wave of new patients seeking primary care under the Affordable Care Act, physician acceptance of insurance plans offered through the NYS Exchange bears monitoring.

Physicians’ administrative workloads continue to increase and now average 10.3 hours/week. Differing interpretation of administrative work across physicians and specialties may explain some of the widespread variation in administrative burden reported. However, the variation is largely unexplained and warrants additional research. Despite an increase in administrative hours from 6 hours/week in 2003, adult primary care physicians maintained the same number of patient visits/week reported in 2009. This was accomplished by nearly 40% of physicians increasing the number of patient care hours they provided during the last two years. Of those increasing their hours, one half provided up to an additional 5 hours/week, with 35.2% providing between 5 and 10 additional hours/week. Increased hours represent a short-term solution to capacity constraints, but are not a sustainable long-term solution.

Personal reasons and family remains the dominant reason why physicians practice in the Finger Lakes region. It is also a significant factor in deciding to leave the region and suggests that these reasons are important, yet not amenable to professional influence. Career opportunities and lifestyle also remain highly ranked among the factors for practicing in the region with nearly 45% of respondents indicating each a factor in their decision making. Conversely, compensation remains the number one reason for relocating from the region and the lowest ranked among factors in deciding to practice locally. A difficult practice environment is increasingly cited as a reason for leaving the region and, as such, becoming a growing concern. Additional research is warranted to ascertain whether local, state or national issues are driving this area of increased physician dissatisfaction.