Measuring Physician Productivity

Taking the Pulse of a Practice

by Eliot L. Friedman, MD, and Teri U. Guidi, MBA

Implementation of provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) will bring a shift in reimbursement methodology for anticancer drugs. In 2005 oncology practices will be reimbursed based on average sales price (ASP) rather than average wholesale price (AWP). Many believe that the changes mandated by the MMA will make it nearly impossible for small medical oncology practices to stay in business, because they will not be able to keep expensive inventories of chemotherapy drugs, antiemetics, and other supportive drugs necessary for the treatment of their patients.

We believe that this change in Medicare reimbursement methodology may lead to a paradigm shift in which an increasing number of private practices will partner with community hospitals to provide oncology care for patients in the community. Measuring physician productivity is an essential element of any new hospital-based practice structure to help ensure practice viability and growth. Furthermore, hospitals must take care to help physicians transition to a new practice model and create ways to ensure fair and open communication

Several years ago, Lehigh Valley Hospital and Health Network in Allentown, Pa., partnered with a local three-physician medical oncology practice, creating a health system-owned medical oncology practice structured as a private practice but using the hospital-based outpatient infusion center. This practice—Hematology Oncology Associates (HOA)—has succeeded and could serve as a model for future cancer care in the community.

How HOA Came To Be

In 1994 the Lehigh Valley Hospital created the John and Dorothy Morgan Cancer Center, a state-of-the-art facility in Allentown, Pa. A radiation oncology private practice already existed in the hospital. There were two, three-physician private medical oncology practices in the community. These practices used the hospital for their patient admissions but were not interested in becoming employed by the hospital or in becoming a health-system owned practice.

The health system's multi-specialty physician group hired its own medical oncologist and placed him in a single-provider practice located in the cancer center. A second physician was hired for this practice in 1999. Shortly thereafter, negotiations began anew with one of the two community-based practices. The senior partner of the practice was considering retirement and the acquisition of the practice by the health system would enable him to retire with financial stability and without demanding an onerous buy-out from his partners. So, the private practice was purchased by the health system and the practice's office moved into a rented suite in the hospital cancer center. The senior partner has since retired, new physicians and a certified registered nurse practitioner (CRNP) have been added (for a total of six physicians), and a second office has been established in another network-based hospital.

Practice Set-Up

The office practice (patient visits, labs, nurse, and CRNP visits) still exists as a private practice. Complete blood counts are run in the office. All services rendered are coded at the time of service. The practice contracts for billing services through the health system's Management Services Organization and all office-generated charges and collections are managed and reported separately and distinctly from other aspects of the hospital's medical oncology services. The practicing physicians code their visit (level 1-5) and are credited with the appropriate number of work Relative Value Units (wRVUs) for the visit. Services rendered for hospital inpatients are billed in the same way and wRVUs are credited as well. Physician productivity totals are included in the monthly practice business report and are reviewed monthly at the practice business meeting, which is typically attended by all physicians in the group, the nurse practitioner, the practice manager, and the practice vice president. At this meeting, all physicians are apprised of their patient-visit volumes and have access to the same figures for the other members of the group.

Chemotherapy infusion is performed separately from the day-to-day clinical office practice in the hospital's infusion center. Nursing and clerical staff for the practice and for the infusion center are completely separate. The charges and collections for infusion services are handled by the hospital's Patient Accounting Department and include the drugs (chemotherapy, supportive drugs, growth factors, etc.) and the administration of the drugs. The expense and revenue are reported separately and distinctly from the office practice.

The services billed and collected for the office practice are not sufficient to cover the total costs of operating the practice (staffing, rent, supplies, contracted billing services, physician-related expenses and salaries, etc.). However, the health system is able to sustain the expense of owning the practice because the revenue generated by the rest of the cancer service line, including the infusion center, meets or exceeds the variance, essentially keeping the practice whole. Any revenue in excess of the combined expenses (office practice, infusion center, and infusion pharmacy) is retained by the health system and not distributed to the practice or physicians.

For the health system, an added benefit of owning the practice is the potential to capture 100 percent of the ancillary services (unless restricted by insurance companies), including diagnostic and interventional radiology and lab-

Meeting are (left to right) Teri Guidi, HOAI Vice President, Dr. Robert Post (standing), Dr. Basil Ahmed (physician guest), Dr. Gregory Harper, Dr. Lloyd Barron (standing), Dr. Eliot Friedman, HOAI President, and Dr. Suresh Nair. (Additional HOAI staff not pictured: Dr. Katherine Harris; N. Susan Gardner, nurse practitioner; Pamela Repetz, practice manager.)

PHOTOGRAPH/COURTESY OF HEMATOLOGY ONCOLOGY ASSOCIATES

oratories. In addition, all admissions from the practice are virtually guaranteed to the hospital and referrals are often made to other network groups—for instance, surgical oncology and thoracic surgery—many of which are also owned by the health system.

Administrative Leadership of the Practice

The president of the practice is a practicing member of HOA. He reports directly to the chief medical officer of the network and is responsible for the policies and practices of the group. The vice president of cancer services is the administrative parallel to the clinical position of president. The vice president of cancer services reports to the chief operating officer and the chief medical officer of the hospital and is responsible for all outpatient oncology services throughout the system (radiation oncology, infusion services, support services, breast health services, clinical trials, tumor registry, and the office practice). These two professionals work closely together to ensure fairness to physicians in developing practice policy, to balance "practice" and "program" priorities, and to maintain a close eye on overall productivity and the bottom line.

Physician Responsibilities

Some of the physicians in HOA are full-time in the clinical practice and spend all of their time in clinical activity, including making rounds with the residents and fellows when on inpatient hospital service. A number of non-clinical activities in the cancer center also require the physicians' involvement. Several physicians in the practice are involved in these non-clinical activities, and several also have administrative, programmatic, and/or academic positions. Consequently, some practice physicians do not devote 100 percent of their time to seeing patients. However, all physicians in the practice spend equivalent time on hospital service, weekend rounds, and night coverage. Those physicians with other administrative responsibilities are scheduled for proportionately fewer office hours. This arrangement means that several of the physicians in the group are "part-time" in the practice. The percent of a "part-time" physician's clinic schedule with respect to a full-time physician's clinic hours is what defines his or her percent of time devoted to the practice. The physician's wRVU expectations are adjusted accordingly.

As physicians near retirement, however, consideration is given to special needs and curtailment of clinical responsibility. In this practice, the initial reduction of an older physician's duties eliminated weekend rounds and night call. The following year the physician reduced his clinical hours. This physician's salary was pro-rated accordingly, with a value given to each part of the physician's compensation. For instance, if weekends were calculated to comprise 14 percent of physician productivity, a physician who is no longer doing weekend rounds would experience a 14 percent salary reduction. The reduction in the retiring physician's salary was apportioned to the remaining physicians whose clinical duties rose proportionately.

Physician Productivity in HOA

Measuring physician productivity has been a critical step in structuring this hospital-based practice. In any private practice, the revenue stream will go through good and bad times. If the practice has a financially successful year, partners will do well and vice versa. When the revenue stream is good, the natural tendency is to pay less attention to detail, which might lead to periodic decreases in billing and collection, ultimately creating uneven take-home pay by the partners. Since the principals of the practice are directly affected by the ups and downs of revenue stream, the physicians in the private practice setting work together to try to even out resultant billing and collection. They will analyze all physicians' productivity and peer pressure will drive all physicians in the practice to maximize their efforts and charges.

Physicians' productivity in the private practice setting is measured easily by tabulating charges and collections of all aspects of clinical practice provided by each physician.

Productivity in the private practice is based on all revenue generated, including E&M codes, infusion codes, and margin made on chemotherapy. Some practices will gener-

ate additional income by performing additional services, including laboratory tests, X-rays, ultrasounds, echocardiograms, and pulmonary-function testing. Other clinical services, such as nutritional counseling, psychological support, and acupuncture, can be provided for patients and can sometimes enhance the revenue stream.

In a hospital-based practice, such as HOA, the practice physicians are salaried. Salaries are based on seniority and expected productivity. A formula sets the threshold number of wRVUs expected from each physician, taking into account whether the physician is full-time clinical or split between clinical and administrative activity. The wRVU threshold of each physician is tallied to calculate the group RVU threshold. If an individual physician exceeds the proscribed number of wRVUs, he or she could receive a bonus based on a dollar figure per wRVU over the threshold. However, for a physician to receive this bonus for exceeding expected individual productivity, the group as a whole must also exceed the expected number of wRVUs for the entire group. If the group does not reach its expected threshold of wRVUs, no physician bonuses are given.

At HOA, physician wages are paid biweekly at a rate estimated to meet the individual's annual salary and bonus expectation. Each quarter, adjustment payments are made for physicians exceeding their thresholds. The converse is also possible—where a physician is falling short of the threshold, the biweekly payments may be reduced in an effort to avoid the need for a "pay back" at the end of the fiscal year. Alternatively, the following year's salary could be adjusted to compensate for lack of productivity in the prior year. These productivity numbers are reviewed monthly at business meetings, giving all physicians in the practice an understanding of who is pulling his or her weight or who is not.

As mentioned earlier, physicians in a hospital-based medical oncology practice will not generate enough income through the E&M codes to pay for themselves and their staff. Additional income needs to come from revenue generated from chemotherapy (infusion and pharmacy) in order to keep the practice whole. The total revenue of both clinical practice and infusion must exceed the entire salary structure, rent, and ancillary expenses. If the total income does not equal or exceed the expenses, the physicians' salaries will be adjusted or other changes will be made in following years to ensure that the practice meets its bottom line.

Salaries are therefore reflective of the direct productivity of the physician. Accordingly, physician patient visit volume (and total of wRVUs) is the key data that needs to be reviewed monthly. Volume through the practice drives total profitability. Throughput in the clinical practice will be reflected in volume coming through the infusion suite. In turn this practice is translated into revenue from infusion charges and chemotherapy drugs utilized. Those physicians that are responsible for administrative duties will receive part of their compensation from the practice (to which they are less than full time) and the balance from the other places, such as the Department of Medicine for Education, where they perform other duties.

Matching Productivity Measures to the Practice

Working with productivity measures can present challenges. For example, because the physicians in HOA are salaried, they are not dependent on the month-to-month production of the practice for their direct take-home income. Most physicians in this situation will not pay attention to their monthly productivity. Physicians may take simultaneous vacations, set up clinic schedules at their convenience, or neglect practice productivity.

In addition, physicians joining a practice may come from different professional settings. A physician coming from an academic practice might be accustomed to scheduling a 30-minute slot to see follow-up patients. On the other hand, a physician coming from a private practice may expect to see a patient every 15 minutes. These differences affect individual as well as group production, and can also have an impact on access to physicians who limit the number of appointments available for seeing patients.

At HOA, the president of the practice is responsible for ensuring consistency within the practice. The president also ensures that members of the practice do not take liberties with the schedule and that even month-to-month productivity is maintained. When physicians take vacation, additional clinic sessions must be scheduled for those physicians covering the practice. When physicians who have limited time in the clinic due to administrative responsibilities return from vacation, they will need to schedule additional clinic time as well. If all physicians' bonuses are pegged to group productivity, cooperation among all physicians to maintain productivity should follow.

Additional Challenges

One of the more unusual characteristics of HOA is the mix of full- and part-time physicians: two physicians are full-time equivalent (FTE) to the practice; one is .5 FTE; two are .7 FTEs; and one, who is gearing down from full-time towards retirement, is .92. Because the practice accepts "directed" referrals (referrals to a specific physician), and because several of the physicians have specific areas of clinical expertise, each physician's schedule fills differently. This situation creates some challenges in assuring timely access for patient appointments. Adding to this challenge is the fact that different physicians prefer differ-

Figure 1. Physician Distribution over One Fiscal Year

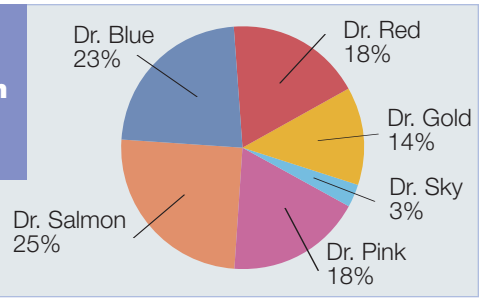
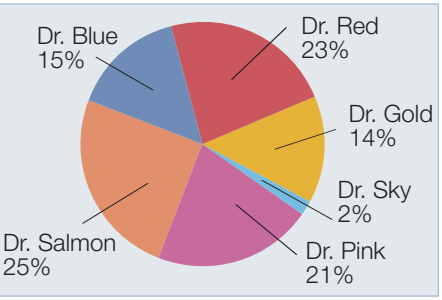


Figure 2. Work Relative Value Units Physician Distribution over One Fiscal Year



ent appointment lengths. In the case of a part-time physician, this element can obviously reduce the total number of open appointments and create unacceptable delays in scheduling. At the same time, physician productivity is presently measured entirely in terms of wRVUs with no consideration of throughput, access, or cost effectiveness. So, a particularly popular provider could be highly productive, but, at the same time, be the source of restricted access and restricted growth for the group as a whole.

Because wRVUs and patient visits are reported "publicly" in the monthly business meeting, the issue of productivity is often discussed with regard to who is carrying the largest burden of work. For this reason, the president and vice president of the practice are beginning to place more emphasis on visit volumes categorized by "new" versus "established" visits. This process will allow a clearer picture of each physician's contribution to the practice's overall growth and of the practice's long-term survivability.

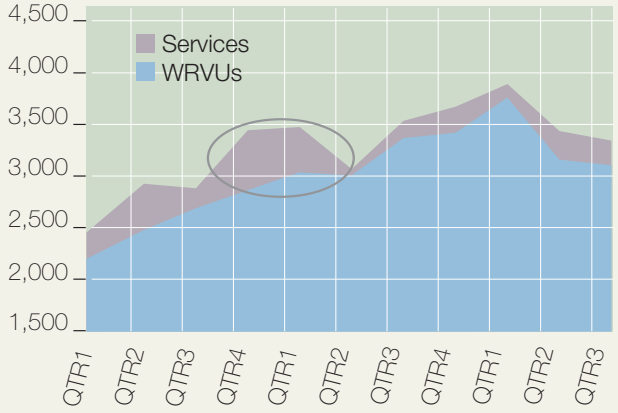
Still, individual comparisons are inevitable. A physician will sometimes forget that while he is 70 percent of a full-time clinician and his wRVUs may reflect 70 percent of the expected level for a full-time physician, his *overall* contribution to the group's productivity should also be in appropriate proportion to the share of the labor pool that he represents. For example, a .4 FTE physician should certainly generate 40 percent of the wRVUs expected of a full-time physician. But if that physician also represents 50 percent of the *total* physician labor pool, then he or she should generate 50 percent of the group's wRVUs. HOA labor pool and wRVU distributions are shown in Figures 1 and 2 (note that Dr. Sky was only a member of the practice for one month of the fiscal year shown). Notice that Dr. Blue is 23 percent of the available physician labor, but he is generating only 15 percent of the group's wRVUs. Conversely, Dr. Red is 18 percent of the labor and 23 percent of the productivity. Does this mean that Dr. Blue is lazy or that Dr. Red is working too hard? Not necessarily. Directed referrals can influence wRVUs, especially if Dr. Blue specializes in rare tumor types. It might also mean that Dr. Blue has a larger proportion of low-level visits, which have smaller wRVU values.

Since one goal for the practice is to balance new and established patient visits, it is important to keep an eye on those figures as well. A mature practice will be more heavily populated with long-term follow-ups as will the schedule for a physician with more years in practice. In this instance, the *number* of services should also be tracked as compared to wRVUs. Figure 3 clearly illustrates a situation late in the first fiscal year shown. Data indicated a rise in the number of services without a commensurate rise in wRVUs. On closer examination, management was able to identify multiple causes. Some physicians were not including all the appropriate information on the superbill to properly document and substantiate a higher visit level. Some physicians were seeing an increasing number of six-month follow-ups and not moving some patients to longer visit intervals. Office staff worked with the physicians to improve their documentation and to shift some patients to annual follow-up and others to alternating visits with the nurse practitioner. Over the course of three or four months, the balance was regained.

When a physician leaves a practice, as happened to HOA very early in fiscal year 2004, a decline in wRVUs might be expected. Fortunately for the practice, all of the physicians committed to working more sessions to pick up the load. In fact, as shown in Figure 4, even with one vacancy, the wRVUs continued to rise at a steady rate. Fortunately, after 11 months, a replacement physician joined the group in August 2004.

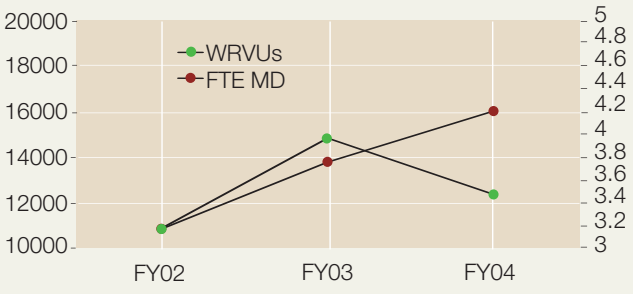
It is always a challenge to measure productivity on both the individual and the group level in enough ways to ensure continued success, fair distribution of workload, and appropriate incentives to work harder and smarter. In the next few years, as employment contracts come up for renewal, HOA will continue to use wRVUs as one measure of productivity. Other incentive methodologies will also be introduced to better account for various priorities including growth in group wRVUs, growth in new patient visits, and improved efficiency of practice operations.

Figure 3. Number of Services Compared to Number of Work Relative Value Units



Note: Circled period indicates a rise in the number of services without commensurate rise in wRVUs. Balance is regained in subsequent periods. See text for details.

Figure 4. Number of Work Relative Value Units for the Group as a Whole Compared to Physician FTEs in the Group



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