Hospital Employment of Physicians

He said, she said—a frank discussion about the pros and cons of this model

by Monique J. Marino

Oncology Issues talked with Vickie Byler, MSN, RN, director of Rex Cancer Center in Raleigh, N.C., and Jeffrey M. Crane, MD, FACP, a former private practice physician who has been employed by Rex Hospital since 2005. Here's what they had to say about their experience.

OI. ***Tell us a little about your background.***

He Said. With the advent of managed care, I became involved with the "politics" of medicine. I served as president of the North Carolina State Oncology Society and was active with ASCO [the America Society of Clinical Oncology]. In 1997 my group joined a large, nationally recognized oncology practice management group. We were the seventh practice to join the group, and we thought that decision would be the answer to all of our worries.

During that time I was Chairman of the Department of Medicine at Rex Hospital and later became president of the medical staff. I also served in an ex-officio capacity on the board of trustees there. I offer this important background because it was how I became very trusting of Rex Hospital. And the administration at Rex Cancer Center knew me well enough to know that I was approaching burnout. I was caring for patients at four different hospitals and driving throughout the city for rounds on my patients.

In 2002 the large group I was with began to contemplate what they would do to switch over from AWP [average wholesale price] to ASP [average sales price]. It became very clear to me that getting 15 percent return on their invested capital was not going to be easy. My friends—the radiation oncologists, the diagnostic radiologists—were going to be directly affected. Personally, I was not going to be able to sit down with these friends and say, "*I now want 15 percent of your revenues*." There were a number of changes that were getting ready to happen that made me feel poorly. I did not wake up in the morning looking forward to going to work; I was simply not happy.

At that same time, it had become obvious that our physician group had grown too big. We were now 15 physicians. I argued that we leave the practice management group, and I was rejected. In 2003 I began the process of "divorcing" myself from the practice. Within a few weeks I was able to bring around another senior partner to my way of thinking, and we both joined Rex Hospital. Today I am very happy, and have what I consider to be a wonderful career.

So that's a little bit about me and a little bit about what took me to the point where I decided that I wanted to become a salaried physician.

She Said. Let me first tell you a little about Rex Hospital. We are a 439-bed community hospital that has been accredited by the American College of Surgeons, Commission on Cancer as a comprehensive community cancer center since 1991. In 2009 we received accreditation by the National Accreditation Program for Breast Centers**.** The hospital joined the University of North Carolina (UNC) Healthcare System in 2000.

In 2005 the hospital formed Rex Hematology Oncology Associates, a hospital-owned medical oncology practice. Three years later in 2008 a private radiation oncology practice joined UNC as part of the Department of Radiation Oncology.

I have been employed with Rex Hospital for 23 years and have served as director of the Rex Cancer Center for 13 of those years. It has been during my tenure as director that I have worked with and gotten to know Dr. Crane both as a private physician and hospital-employed physician.

OI. ***Why choose this model?***

He Said. Why hospital employment? Simply put, I was dissatisfied with conventional private practice, specifically issues relating to governance, financial formulas, declining drug reimbursement, lifestyle considerations, and, finally, tax code changes that diminished the advantages of the equity model. The capital investment in the private practice was unlikely to appreciate or grow commensurate with either the cost of living or the physical and mental work put into the practice.

She Said. Why employ physicians? Since the 1990s, our market had become very competitive, and Rex Hospital wanted to maintain its market leadership. We were also looking to expand our comprehensive cancer services into satellite locations. The medical oncology practice we had partnered with and that had leased space in our cancer center for almost 20 years was making some dramatic changes. The group had purchased a linear accelerator and was going to start providing radiation services directly across the street from our center. The practice had now become one of our competitors.

While Rex Hospital felt it had to support its radiation oncology department, we also knew that we needed medical oncology to continue to provide the comprehensive care our hospital is known for. Our scope of care and the full range of services our cancer center is able to provide are truly what set us apart from the other cancer programs in our market.

Jeffrey M. Crane

Vickie Byler

Over the years Rex Hospital had developed a very trusting relationship with Dr. Crane. We knew his practice guidelines matched the hospital's goals for our cancer patients. Luckily all of the planets aligned, and Rex Hospital was able to bring two well-respected physicians to start a medical oncology practice at our hospital, which was a first for us.

Under this model, the hospital assumed the financial responsibility so that our physicians could primarily focus on their patients and their needs.

OI. ***Can you talk about governance issues?***

He Said. My oncology practice had leased space at Rex Cancer Center since 1986 and had built a trusting and collegial professional relationship with Rex Hospital. I knew that as an employed physician I would be respected and listened to. For example, our physicians had been actively involved in strategic planning for Rex Cancer Center dating back 10 years. Hiring and firing of cancer center staff also went through us. When I left my private practice, it was by virtue of this trust and with active participation and careful planning that we were able to construct a physician employment contract that was beneficial to all parties.

Included in this contract was language that guaranteed that I would continue to be a part of the hiring and firing of cancer center staff, as well as strategic planning for the cancer center. For other physicians looking into hospital employment, I strongly suggest that the contract stipulates that physicians have a vote on staffing models, strategic planning, hiring and firing decisions, quality assurance and improvement projects, patient and physician scheduling, and compliance and regulatory issues.

One issue that has come up relates to under-performing staff. Generally, we physicians feel that Rex Hospital takes too long to take care of a staff member who is not meeting expectations. But we are working through this issue.

Under this new arrangement, I am now aligned with the University of North Carolina and its Department of Public Health. This change was critical since I believe that the evolution of healthcare is going to be based on development of and compliance with best practice models. Twice yearly, I participate in ASCO's Quality Oncology Practice Initiative (QOPI).

Compliance and regulatory issues used to be a huge challenge. They are no more. I just do what I do best—I see patients. Approximately 15 percent of my time is spent on quality improvement projects and strategic planning. But all the headaches from compliance and regulatory issues are gone, and that's made me very happy.

She Said. Governance and decision making is one of the biggest challenges we face. *Who ultimately makes the decisions*? The answer: it depends on the decision that needs to be made.

We actually have two co-medical director**s.** One chairs our cancer care committee; the other oversees the practice's quality initiatives.

Our hospital is involved with developing budgets, financial performance, marketing initiatives, hiring and termination of staff, and ensuring compliance. Decisions about clinical care, treatment regimens, and when to hire other physicians are typically made by the physicians. We [administration and physicians] work together on issues involved with strategic planning, patient flow, and office flow and processes. Sometimes others make decisions for us and/or with us, such as Pharmacy or IT. Again, it all depends on the decision that needs to be made.

Recently the hospital engaged a consultant to help with our physician compensation model. As part of that process the consultant interviewed all the physicians that are part of Rex Hematology Oncology Associates. When the consultant's report came back, one of the physician's comments was, "*It is a bit of a mystery as to how decisions are to be made in the practice.*"

Hospital administration was used to making decisions about staffing models, hiring, and termination; however, many of the staff we initially employed followed the physicians from the private practice setting. It was a transition for them. Staff were moving from a very different environment in a private practice to one in a hospital where many more rules and regulations and policies and procedures had to be followed. It was a tough transition for some staff. Staff was used to going to the physician and having the physician make or influence certain decisions. That method became a little more difficult in our healthcare system. A phrase I would hear frequently from physicians was, "*You manage that issue. I just want to take care of my patients.*"

That said, our physicians are involved in the hiring of staff and making the decision when to add additional physicians. Sometimes we make the wrong decision. One struggle

PHOTOGRAPH/BIGSTOCKPHOTO

early on in our practice involved the third physician hired. This physician was not the "right fit" for us. As issues arose, some were process issues and some were treatment concerns, they were brought to me. I felt I had to work very hard with the physicians to address the clinical issues, as this was beyond my scope, and to develop an action plan for correction. The VP and I worked with Dr. Crane to address the issues, but ultimately the physician left our practice.

Hiring practices differ between the hospital and practice setting. By the time you acquire approval for a position, develop and post a job description, interview and fill the position, bring them on for hospital orientation, and then conduct department orientation, the process could take months to even more than a year. We focus on making sure that we hire the "right" person. We have learned from experience the amount of work it takes if you don't get it right from the start.

I have had many physicians say to me that it takes too long for the hospital to do anything with employees that are not meeting expectations. In private practice if a staff member was not meeting expectations, it was much easier for the physician to terminate that individual. In the hospital setting, we go through a process of coaching and counseling, making sure that the staff member has the tools to be successful in his or her job. Again that process takes time, sometimes months, before we see any performance improvement or the staff member "finds their success elsewhere."

I'd like to address decision making around our clinic schedule. When we first started this collaboration, I had not supervised a medical oncology practice before. So as the manager and I took on this new practice, the physicians said to us, "*Here's our scheduling template. These are the appointment intervals. We're also going to block off a certain amount of time for us to do our inpatient rounds, administrative work, reviewing test results, and calling patients.*" The scheduling system worked for a while. Then our volumes grew as our reputation for quality care and patient-focused care grew. It became a challenge to get new patients in to see a physician in a timely manner. In hindsight, it would be interesting to count the number of meetings we have held to discuss this particular topic. We set a benchmark, and when we were not able to hit the benchmark, the scheduling template was "tweaked." The physicians have been flexible, but scheduling is still one of those areas that we are working on as administration and physicians don't always see eye-to-eye on this issue.

OI. ***Can we briefly touch on ROI and reimbursement?***

He Said. When I left my practice to join Rex Hospital, I was fairly well attuned to where our cost centers and profit centers were in the practice. I think most medical oncologists recognize that we have two profit centers—E&M codes and chemotherapy—and one big cost center, which was chemotherapy administration. It was financial data that I could look at. I was aware weekly of how we [the practice] were doing. And by simply changing how we administered drugs or how we prepared for the maintenance of chemotherapy-induced nausea and vomiting, we were able to reduce certain costs.

At one time it was very easy to align incentives among my partners to maximize how the practice was doing financially. But as AWP went away and ASP appeared, what started happening in private practice, which does not happen as an employed physician, is that the once even division of the pie was "de-stabilized." In other words, as the pie "shrank" in the private practice setting, we began to see a Level III code suddenly step up to a Level IV code. And Level IV codes suddenly becoming Level V codes. And since in private practice we divided the pie by a physician's relative percentage of RVUs, if a physician didn't "shift" as others did, then your income shrank. That situation doesn't happen as a salaried physician.

My primary goal now is: how can I maximize revenue for the cancer center so that we provide the best and yet most cost-effective medical care for our patients. It is very easy to see how in a large healthcare system like UNC those incentives align very well. We are able to work together to streamline chemotherapy administration and to sit down and actually talk about which treatment regimens we will use for certain patients. And that collaboration, which was very difficult in private practice, has been a source of joy as an employed physician.

The downside—there is simply no way to know where the dollar goes once it enters into the healthcare system. Before I became a salaried physician, I always thought that my biggest asset to the hospital was so-called downstream revenue. And it is. But for physicians thinking about going into a salaried position in a hospital, I can tell you that there is absolutely no way to calculate this dollar amount.

As medical oncologists evolve through this next phase of healthcare reform, we are the loss leaders. It is very difficult to affect the profit and the cost centers in a timely fashion. It can be done. I know it can be done. But because of the committees, the lawyers, and the administrators, what used to take four weeks in private practice now takes almost nine months. I do not know who or what is responsible for this change. But it has been a source of concern. All of a sudden you look at your profit and loss sheet and contractuals show up. Contractuals from two years ago were 120 or 130 percent of Medicare, and all of a sudden you look at them today and you feel like your practice is losing the hospital money. That makes you feel very badly. But trust me, once I brought this concern up, one of our financial analysts sat

…but scheduling is still one of those areas that we are working on as administration and physicians don't always see eye-to-eye…

down with me and said, "*This is really what's happening.*" I've come to realize that my practice is not quite the loss leader that I originally thought.

She Said. At the beginning of our relationship what I heard on more than one occasion from physicians was, "*I don't have to worry about that because I'm salaried. I don't have to worry about insurance payments; the hospital will take care of those. I'm just going to take care of my patients.*"

In the almost five years we have been working together, it's been very seldom that a physician has asked for specific financial information. When we started this collaboration, I would run a financial report and take it to our meetings. On the occasions when the report wasn't ready in time for a meeting, I noticed that the physicians never asked for it. As a result, I no longer reported it. Recently I took to one of our meetings a year-to-year comparison. I looked at February 2009 and compared it with February 2010 year-to-date. The comparison showed that even though our patient volumes were continuing to increase, we were seeing the effects of declining reimbursement. Only one physician made a comment, and there was no real discussion, which I interpreted as a lack of physician interest since the hospital manages this area. But this is one area where I feel we need to have more engagement from the physicians so as to identify opportunities to be more efficient and better manage expenses.

Drug selection is another area where we need to do more work. A good example of how we might improve was actually brought up by our pharmacy director. She came to administration and the physicians and said, "*We've got Drug A and Drug B. In your treatment of patients, do you really have a preference over one or the other? The reason I ask is because Drug A is more costly than Drug B.*" There was a good discussion on the issue, and we chose to use Drug B, with the understanding that if a physician wanted to use Drug A, he or she could. We weren't getting rid of Drug A—just shifting the majority of ordering to the more cost-effective drug, but not forcing a physician's ordering decision.

Unlike private practice, our hospital finances have estimations built into the budget process. Contractuals and charity care are estimated based on the previous year for the hospital. We do not know month to month our actual contractual percentages as you would in private practice. Over the last two years with the impact of the downturn in the economy, our hospital and our cancer center have seen a dramatic increase in charity care. Rex Hospital does not turn away anyone, regardless of their ability to pay. Rex Assist is our program to support patients that need financial help. We have seen some chemotherapy administration shift from outpatient to inpatient as well.

Overhead is another estimate that is calculated using a formula based on the number of staff and the square footage of our space, and is not a reflection of true overhead. Many departments support the work of the cancer center and this medical oncology practice, but we do not have a true cost of this support.

So penny for penny….where is it? We've come to accept that private practice and hospital finances are simply different models.

OI. ***What physician compensation model do you use?***

He Said. When I went to Rex Hospital, I was in the driver's seat. They had a great cancer program, and then suddenly there were no medical oncologists. I had excellent counsel, and I learned very quickly the validity of the MGMA model. I would say, though, that if you use the MGMA model, it pre-supposes that you are entering a market that is at near 100 percent capacity. It's been difficult for some of the younger physicians who have joined our practice to hear that we are going to hold them to an MGMA percentile even though we are hospital-based and a growing practice.

Physician compensation is a hybrid model based on a negotiated salary and physician productivity. Typically, I work a 4½ day week—4 days of clinical work seeing typically 2 new patients and 15 follow-up visits each day and half a day of administrative functions. On a busy day, I might see 4 to 5 new patients and 20 follow-up visits.

While I like the full-salary model, ultimately I wanted to be reimbursed for some productivity. Today our program is growing at a more rapid rate. I don't have time for lunch. And my time to swim and have physical activity during the day is gone. So, for me, it makes sense to use a hybrid compensation model. There are physicians who have joined us since that are working under a nearly full-productivity model.

I would counsel that the differences between these three models [MGMA, hybrid, and productivity] are very much a basis of trust. If the hospital is going to hire a physician under the full-productivity model, they have to know that that physician is not charging a Level IV visit inappropriately. And if a physician is going to choose the full-salary model, he or she has to know that non-clinical time—the time spent talking about prostate cancer at a local television studio, doing community outreach for breast cancer programs, the time spent on strategic planning—cannot take up so much time that your hourly income drops.

So certainly, each of these three physician compensation models has pros and cons. We ultimately adopted a mixed salary and productivity model that also took into

…we also wanted a way to recognize the physicians for patient satisfaction and quality initiatives.

account some MGMA criteria, and we selected a percentile that would allow us to have a quality of life. We are not oncologists out to make a million dollars a year—or even half of that amount. We are oncologists who want to be reimbursed for working, at times, 70 hours per week.

She Said. This is an area where you will see a little bit about our differences in definitions.

Understand that over time our physician compensation model has varied. In 2005 when we first started the practice, we used what I call a full-salary compensation model, because it was so heavily weighted toward the salary end versus productivity. Since the end of 2006, when we hired two new physicians, our compensation model was a little less salary weighted and a little more productivity weighted. By the time our latest physician was hired in 2008, the compensation model was heavily weighted towards productivity.

Now as an administrator, it has been very challenging to manage all of these different physician compensation models. Keeping up with who gets paid productivity quarterly versus annually, what the targets are, as well as all the nuances of individual contracts, has taken up more of my time than it probably should. The physicians that were hired in 2006 were hired under an initial three-year contract and it is time for renewal. We all want to develop a physician compensation model that will carry us into the future, but what that model should be is the big question. So in an effort to move forward, we brought in the consultant I spoke of earlier.

The feedback from the interviews highlighted the concern physicians' felt over having different models of compensation. One physician noted that while individual situations had not been shared among them, there are salary and productivity disparities and the hope is they will be reduced over time. Other questions from the interviews included: "What is the right dollar amount to set as the base salary for employed physicians? What is the right figure for productivity? What are the physician and hospital expectations? What are the incentives?"

As we began to work on revising our physician compensation model, we also wanted a way to recognize the physicians for patient satisfaction and quality initiatives. We are struggling like every other healthcare system to implement our EHR—one step forward and five steps backwards. But it takes physician time and input to be able to successfully implement an EHR. And what about clinical trials? Should a physician who participates more in clinical trial activity be recognized? Or what about the physician who participates in process improvement?

But one goal we both agree on is that the physician compensation model we develop must not erode the shared philosophy that we have on quality of care and patient satisfaction. Our practice has been built on the great reputations of our physicians, quality staff, and our high patient satisfaction. We use a national organization to measure our patient satisfaction, and we have earned their top performer award for the last two years with 100 percentile patient satisfaction. And we are on track for a third year. That kind of patient satisfaction does not happen by chance. We do not want to alter what we have built by adopting a compensation model that requires physicians to see as many patients as they can as quickly as they can to increase their RVUs. On the other hand, with declining reimbursement, we have to find a physician compensation model that we can all live with. So we continue in our efforts to find that "right" compensation model. We've probably been working on this project for six to nine months. We're still not quite there yet; we're getting closer. And hopefully in the next couple of months, we will have that issue solved.

OI. ***Any last words?***

He Said. It took me a great deal of effort to come up with the negatives of hospital employment. I am happy to say that this collaboration is a work in progress. And for the most part, I have been professionally and personally fulfilled by this move. It has allowed me to do a couple of things that I never could have done in private practice. For example, in private practice, I was involved mostly in Phase IV trials. Today I am heavily involved in UNC's research program and looking at adjuvant trials, which is very difficult to do in private practice.

For physicians who are looking at possible hospital employment, I would suggest they ask themselves this question—*Do you want to take a bet on making a better living under the old [healthcare] system or do you want to take a chance on an established, respected position with a [financially] healthy hospital*?

In my case, not only has my quality of life improved on the personal front, but my professional life has improved as well. Would I do it all over again? In a heartbeat.

She Said. From the hospital side we share the same sentiments. Like with any relationship, it is about finding the right "partners." You must have a shared philosophy and the same goals. Does this mean that we don't disagree? No. Sometimes we choose the wrong path, and have to be re-directed down a better path, but we continue to evolve. Would Rex Hospital do it all over again? Most definitely.

Monique J. Marino is managing editor at the Association of Community Cancer Centers in Rockville, Md.