THOUGHT LEADERSHIP

EMPLOYED PROVIDER NETWORKS

Provider Productivity: The Fuss, and Why It Matters

Dr. Terry McWilliams, Chief Clinical Officer

"Provider productivity." Quite the buzzword in healthcare these days – especially as it relates to employed provider networks. When mentioned by administrators, the phrase often portrays the perception that provider productivity is insufficient. When mentioned by physicians, APPs, and other direct care providers, the phrase invokes laments about excessive workloads, unrealistic expectations, not having enough time with patients and burnout. The topic tends to be rather controversial.

Based on the context in which these conversations commonly arise, provider productivity would appear to be a new phenomenon – and targeted at hospital and health system employment arrangements. Perhaps that is the case since the majority of physicians in the country are now employed by hospitals and health systems. But is it really a new concept?

In the traditional, physician-owned independent practices environment of care, provider productivity was fundamental to keeping the practice doors open and the lights on. It was measured by producing sufficient patient care revenues to exceed a practice's operating expenses, and still have residual dollars to provide suitable income to the physician owners. In addition to cultural fit, individual productivity was often a key consideration when contemplating a physician for partnership inclusion. Physician owners might have contemplated the following questions when considering an associate physician for partnership:

- Has the physician proved that he/she is capable of sustained productivity to ensure revenues continually exceed expenses?
- Has the physician adequately attracted additional patients to the practice and built a sustainable patient following?

There was an agreeable set of mutual expectations. More than a few excellent physicians have not been invited to stay as partners in independent practices due solely to individual productivity issues.

Somehow, though, the same concept with different metrics has become rather controversial in the employed provider network environment. Adequate patient volumes continue to be necessary for ensuring adequate revenues and financially sustainable operations – regardless of the degree to which the market has moved toward value-based care. Just as importantly, employed provider networks are less able to pursue additional revenue sources that many independent practices rely on, such as on site lab and imaging services. Further, employed network practice expenses tend to be higher than independent practices as physician and staff benefit packages tend to be richer and more expensive than the historically lean versions in independent practices. **In short, the employed provider networks tend to have less latitude to address the revenue minus expense equation than the independent practices, which often becomes the reason for pursuing provider-based billing opportunities.**

Also interesting is the expressed surprise that most employed provider networks have difficulty covering their expenses – even by their governance boards. In addition to the factors outlined above, many employed provider networks arose from or grew due to independent practices approaching hospitals and health systems for practice acquisition and employment when the practices were no longer able (or willing) to make ends meet, earn the level of income they expect, and/or keep the practices open. Many relinquished their independence based on the simple factor of financial unsustainability. (In fairness, some pursued employment for other reasons, such as administrative/regulatory burden and EMR implementation burden.)

Many of the physicians believed that the hospital, the health system, and the associated employed network had financial resources they did not have and would be more financially sound over the long term – and that they could transition without any changes in their practice. In many of these cases, the hospital, health system, and the associated employed network did not explicitly define expectations associated with the employment transition. Further, the transition afforded extra layers of insulation from practice operations and financial performance, so connections between cause and effect became blurred – or in the case of those who were never in private practice, they remained completely disconnected from those realities. This separation is evident in the large number of HSG Network Evaluation Survey respondents who "don't know" if their employed provider network performance is financially sustainable.

Is there a middle ground in this raging battle? If so, where is it? Since productivity is often misconceived or inadequately expressed, dissecting the concept into component parts seems to be worthwhile.

What is productivity?

Core, paraphrased elements of dictionary definitions of productivity include the following:

- The state or quality of producing something or of being productive.
- The effectiveness of productive effort as measured in terms of the rate of output per unit of input.
- A measure of how efficiently a person completes a task.
- The ability of an individual, team, organization to work efficiently within a given time frame in order to maximize output.

The fact that the basic dictionary definitions contain so many facets, there is little wonder that we have difficulty translating productivity directly into the healthcare industry. In the manufacturing industry, "producing something" has a literal or concrete meaning – often the number of products or product components tangibly produced. A worker is "productive" if he or she meets or exceeds the expected number or quota. Making a direct comparison to the manufacturing industry tends to aggravate providers – both in terms of being compared to employed industrial workers and to related productivity comparisons. This often leads to disparaging comments about "producing widgets" and objections that "we are caring for patients, not making widgets."

So, what does it mean for a provider to be productive?

Many providers feel that it is providing high-quality care and having great patient outcomes, but that would seem to be a basic expectation in and of medicine – especially from the patient's perspective. Note that the dictionary definition elements include the concept of being able to objectively measure productivity – something that we have not objectively measured well for either a high-quality of care or great patient outcomes. Systematic attempts to measure these areas have been met with many controversies – even though we are getting better at the latter by determining patient-oriented outcomes rather than just the lack of adverse events.

> "...Systematic attempts to measure these areas [of productivity] have been met with many controversies.

Another notable difference between the manufacturing industry and the healthcare industry is that the manufacturing industry routinely establishes basic expectations for productivity and the workers are held to those expectations – whereas many employed provider networks do neither. To that end, the employed network and health system often wonder if they, as employers, are getting a fair day's work for a fair day's pay. Benchmark standards for provider productivity exist in the same fashion as they exist in the manufacturing industry. However, many health systems do not formally establish those expectations for physicians, APPs, or other direct care providers – nor hold them accountable to them… both of which can lead to consternation and misaligned impressions/perceptions.

The dictionary definition elements also include efficiency – maximizing outputs as an individual or team in a finite period. On the surface, this is a foundational tenet of team-based care delivery. However, in the context of provider productivity discussions, this element affords providers with an opportunity to regale against and blame the system, namely, "the system we work in does not allow efficient practice and therefore we cannot possibly be as productive as expected." There are not enough staff, or not enough qualified staff, or too much turnover of staff to be efficient. The EMR is not user-friendly and requires too many clicks and too much time to use.

While these issues are very important and can negatively impact individual and collective provider productivity and need to be jointly addressed, focusing solely on areas outside of individual influence and control deflects focus on things providers can directly influence and control and abdicates any role in impacting individual productivity.

How can we measure provider productivity in healthcare?

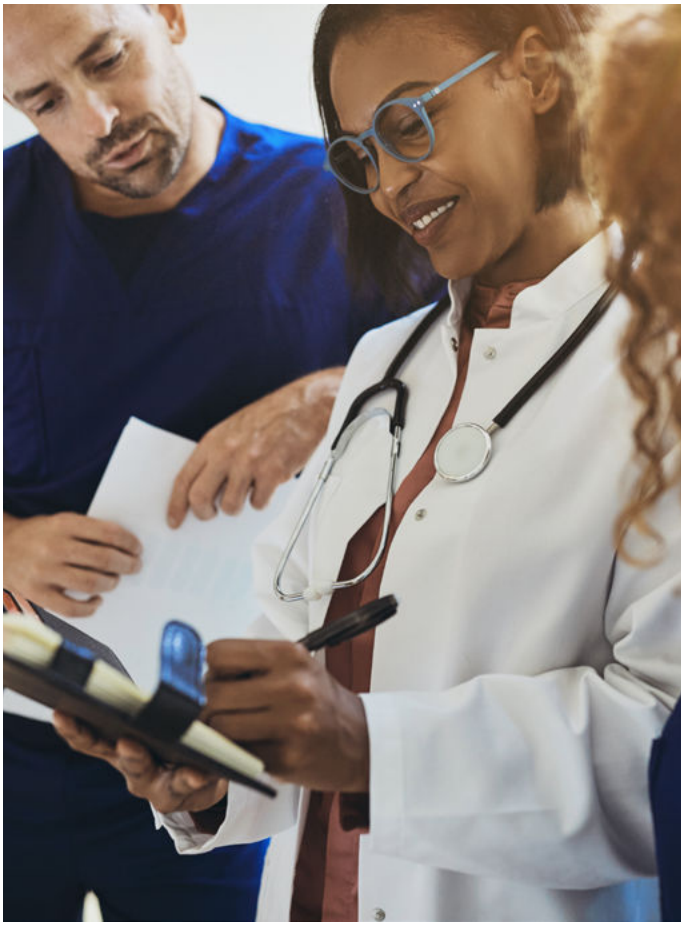
As previously noted, patient care revenues have been traditionally used to determine provider productivity in the independent practice setting. Revenues (or collections) depend on several factors that are beyond individual provider control, such as the effectiveness of the revenue cycle function and the accepted payer mix. Independent practices have an advantage in each of these areas compared to employed provider networks. Independent practices have direct control over a streamlined revenue cycle that focuses solely on professional services and limited in-house ancillaries. They can also limit their exposure to payers whose reimbursements are perceived to be suboptimal, such as Medicaid.

Employed network revenue cycle processes tend to be more complex and may be interwoven with hospital-based entities that are not fully aligned with or knowledgeable of professional services processing. In addition, employed networks associated with not-for-profit hospitals and health systems are required to accept all insurances and all patients regardless of their ability to pay. For these reasons, the time-honored metric of patient revenue generation (or collections) tends to be a suboptimal measure of individual provider productivity within employed networks.

The "gold standard" of provider productivity for employed networks over the past couple of decades is Work Relative Value Units (wRVUs). Created with the conversion of physician/provider payments to the Resource-Based Relative Value Scale (RBRVS) methodology in 1992, wRVUs are assigned to each CPT and HCPCS Level II code and are meant to account for the provider's work effort and expertise when performing a procedure or service. They factor in variables that are directly reflective of provider efforts, such as the technical skills, physical effort, mental effort and judgment, stress of patient risk, and amount of time required to perform the service or procedure. wRVUs are objective, well-defined, translatable, scalable, universal across the country, applicable to most specialties (anesthesiology being a notable exception), and completely independent of payer mix and revenue cycle effectiveness – and they are externally benchmarkable by specialty. Plenty of reasons to make them the gold standard by which to measure provider productivity.

Some providers object to wRVUs being considered the best measurement of provider productivity as they feel it aligns their work with solely "making widgets." Many caution the practice of considering wRVU achievement as a sole measure of effectiveness and having wRVU achievement as a sole motivator. Both concerns have merit but tend to be rather extreme in their application. Measuring provider productivity by wRVU production is one facet of these elements, not the buy all and end all. This is why many compensation models include various aspects of non productivity incentives. Regardless, measuring provider productivity by a metric that accounts for patient and interaction complexity, that is objective based on medical record documentation of patient encounters, and that is externally benchmarkable has merit.

Additional mechanisms that can measure provider productivity include patient visits (or numbers of patients seen) and patient panel size (in primary care). Patient visits can be effective if all visit durations are the same, i.e., if all patient visits are created equal. This tends to not be the case for most practices regardless of specialty. External benchmarking of this metric is suboptimal due to low reporting numbers, but national comparisons of the numbers of encounters per day by specialty do exist. Patient panel size has grown in favor as value-based care grows but has its own issues as a productivity measure. Concerns about attribution processes (criteria for inclusion; proactive attribution v. retrospective attribution), patient risk stratification weighting, data integrity (who can change the attribution), and benchmarking are commonly encountered.



Probably the greatest drawback for considering this as a measure of provider productivity is that panel size does not equate to care rendered or patient access to that care. A primary care provider can accept numerous patients on a panel but have terrible access to care for those patients, especially if few patients are seen or cared for each day. Embracing this metric is complex and most applicable to full-risk (capitated) models of care. It tends to be a suboptimal indicator of actual provider productivity.

What should we do with this information?

HSG recommendations would include –

- Have difficult conversations about provider productivity and its impact on sustainability.
- Adopt wRVUs as the metric of choice to determine individual provider productivity.
- Establish base expectations for the minimum level of productivity expected of providers by specialty and provider type.
- Base the expectations on external benchmarks and local market forces.
- Directly link the productivity expectations within the provider compensation model.
- Provide monthly reports to providers delineating the number of wRVUs achieved versus individual expectations and external specialty benchmark performance.
- Monitor progress over time.
- Establish organizational programs for provider and staff well-being to offset all the factors that may adversely affect individuals – not just productivity.

ABOUT HSG ADVISORS

HSG Advisors partners with health systems to transform their approach to markets, services, and providers for improved growth and operational and financial sustainability.

SERVICES

HSG CLAIMS DATA ANALYTICS

Data analysis leveraging all-payer healthcare claims data with HSG's insights and expertise to evaluate competitive dynamics related to markets, service lines, providers, and patients.

HSG STRATEGY

Strategic development for health systems' long-term goals and direction that allow for simultaneous pursuit of immediate market opportunities, with a focus on Growth Strategy and Medical Staff Development Planning.

HSG EMPLOYED PROVIDER NETWORKS

Building Shared Vision, designing organizational, leadership, and governance support structures for better quality and financial performance, and developing solutions for overall Operational Excellence.

HSG COMPENSATION AND COMPLIANCE

Provider compensation model development and implementation guidance for hospitals and health systems focused on sustainable solutions that promote market competitiveness, financial sustainability, and regulatory compliance.

CONTACT THE AUTHOR

Dr. Terrence R. McWilliams
MD, FAAFP
Chief Clinical Officer

(502) 614-4292
tmcwilliams@hsgadvisors.com

