

# Measuring Physician Performance – Physician Productivity

APPD  
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# Background

- USF Health is located in beautiful Tampa, Florida.
- USF Health encompasses the Colleges of Medicine, Nursing, Pharmacy and Public Health.
- AMC is a private physician practice and community hospital model.
- No Medicaid expansion which is threatening UPL.
- Decent state funding for education.

Payer	Mix (%)
Commercial	42%
Medicare	33%
Medicaid	15%
Self-Pay	6%



# Introduction

## The Academic Physician



- Clinical FTE
- Research FTE
- Teaching FTE
- Administrative FTE

# Introduction

Category	Standard Unit	Hours per Standard Unit	# of Standard Unit per Week = 1.0 FTEc	Weeks per Year	Annual Expected Billable Workload = 1.0 FTEc
<b>Anesthesia Services</b>					
Anesthesia	OR Days	12.0	4	46	184 OR Days
<b>Practice Services</b>					
Ambulatory Practice	Half Day (Session)	4.0	9	46	414 sessions or 230 days
<b>Emergency Services</b>					
Emergency Medicine	Shift	8.0	4	46	184 shifts
<b>Inpatient Services</b>					
Critical Care	Shift	12.0	7	26	182 shifts
Inpatient Service (Consult/Teaching)	Day	8.0	7	33	230 days
Hospitalists	Shift	12.0	7	26	182 shifts
<b>Procedural Services</b>					
Proceduralists (includes Imaging and Pathology)	Half Day (Session)	4.0	9	46	414 sessions or 230 days
<b>Surgical Services</b>					
Surgeons – OR	OR Days	10.0	3	46	138 OR days
Surgeons – Hospital Follow-up	Day	4.0	1-2	46	46 - 92 days

# Introduction

## The Problem of Un- and Under- Funded Academic and Administrative Time

- Physicians come here to be academic providers.
- They look for anyway possible to maximize protected time for academic and administrative endeavors.
- There is insufficient funds from grants, endowments, development, & GME to cover academic time.
- On top of this, administrative time is generally not compensated on the opportunity cost, forcing clinical departments to fund the differential.

# Introduction

## So, Where Have We Gone Wrong?

- We have only been measuring work effort, not true productivity.
- This is a one-sided analysis and assumes everyone's cost structure is exactly the same.
- This might work if the AMCs had total control over the costs to operate, however this is not often the case.

# Introduction

## So, Why Productivity?

- Let's say we have a practice with 4 physicians:
  - Doc 1 is energetic, motivated and experienced and can see 41 patients a day
  - Doc 2 is motivated, but new and takes longer to see a patient, seeing 26 per day
  - Doc 3 is tired and old and plods along seeing a dozen or so patients a day
  - Doc 4 is status quo; steady as she goes for 35 patients a day; day in and day out
- Who is the most productive?

# Measuring True Productivity

- Productivity is critical for the long-term competitiveness and profitability of organizations.
- Productivity measurement is a prerequisite for improving productivity. As Peter Drucker, who is widely regarded as the pioneer of modern management theory, said:

“Without productivity objectives, a business does not have direction. Without productivity measurement, a business does not have control.”
- So, what is productivity?
  - Productivity is the relationship between the quantity of output and the quantity of input used to generate that output. It is basically a measure of the effectiveness and efficiency of your organization in generating output with the resources available.



# Measuring True Productivity

- Productivity is NOT:
  - Revenue or cash collections alone
  - Expenses or costs alone
  - Work effort alone (wRVUs)
- Productivity is a ratio of Output (revenue) to Input (resources) consumed.
- Output is defined as cash collections.
- Input can either use tRVUs or expenses. It is better with expenses due to some of professional revenue with unassigned tRVUs.
- We suggest productivity is defined as:

$$\text{Productivity} = (\text{Revenue}_{\text{MD}}/\text{Revenue}_{\text{Dept}})/(\text{Expenses}_{\text{MD}}/\text{Expenses}_{\text{Dept}})$$

# Measuring True Productivity

## Steps to Measuring Productivity

### 1. Identify Collections.

<b>Provider ID</b>	<b>Specialty</b>	<b>Charges</b>	<b>Revenue</b>	<b>Collection Percent</b>
66	GE	\$ 1,293,108	\$ 584,832	45.23%
95	GE	\$ 1,442,264	\$ 604,662	41.92%
794	GR	\$ 414,329	\$ 178,483	43.08%
13	IM	\$ 977,002	\$ 570,280	58.37%
1249	IM	\$ 676,290	\$ 376,068	55.61%
71	PM	\$ 1,469,113	\$ 531,625	36.19%
1056	PM	\$ 1,329,581	\$ 432,258	32.51%
1025	RH	\$ 501,122	\$ 295,581	58.98%
8	RH	\$ 1,537,184	\$ 766,420	49.86%
		\$ 9,639,993	\$ 4,340,209	

# Measuring True Productivity

## Steps to Measuring Productivity

### 2. Identify Costs.

- Costs are direct and indirect.
- Indirect costs can be evenly spread or based upon indirect cost per total RVU or practice expense RVU.

Provider ID	Specialty	Spread Cost	Direct Expense	Total Expense
66	GE	\$ 69,947	\$ 634,082	\$ 704,029
95	GE	\$ 69,947	\$ 634,082	\$ 704,029
794	GR	\$ 69,947	\$ 197,579	\$ 267,526
13	IM	\$ 69,947	\$ 215,675	\$ 285,622
1249	IM	\$ 69,947	\$ 215,675	\$ 285,622
71	PM	\$ 69,947	\$ 328,764	\$ 398,711
1056	PM	\$ 69,947	\$ 328,764	\$ 398,711
1025	RH	\$ 69,947	\$ 288,011	\$ 357,958
8	RH	\$ 69,947	\$ 288,011	\$ 357,958
		\$ 629,521	\$ 3,130,643	\$ 3,760,164

Provider ID	Specialty	Spread Cost	Direct Expense	Total Expense
66	GE	\$ 75,899	\$ 634,082	\$ 709,981
95	GE	\$ 77,695	\$ 634,082	\$ 711,777
794	GR	\$ 21,717	\$ 197,579	\$ 219,296
13	IM	\$ 78,265	\$ 215,675	\$ 293,940
1249	IM	\$ 49,515	\$ 215,675	\$ 265,190
71	PM	\$ 110,724	\$ 328,764	\$ 439,488
1056	PM	\$ 84,842	\$ 328,764	\$ 413,606
1025	RH	\$ 26,770	\$ 288,011	\$ 314,781
8	RH	\$ 104,094	\$ 288,011	\$ 392,105
		\$ 629,521	\$ 3,130,643	\$ 3,760,164

# Measuring True Productivity

## Steps to Measuring Productivity

3. Calculate Revenues and Expenses as a Percent of Total.

Provider ID	Specialty	Percent Charges	Percent Revenue	Percent Total RVU	Percent Work RVU	Percent Expense
66	GE	13.41%	13.47%	12.56%	12.96%	18.72%
95	GE	14.96%	13.93%	16.10%	18.61%	18.72%
794	GR	4.30%	4.11%	5.77%	7.26%	7.11%
13	IM	10.13%	13.14%	9.81%	8.12%	7.60%
1249	IM	7.02%	8.66%	8.74%	9.27%	7.60%
71	PM	15.24%	12.25%	13.14%	10.01%	10.60%
1056	PM	13.79%	9.96%	14.86%	16.23%	10.60%
1025	RH	5.20%	6.81%	6.16%	7.42%	9.52%
8	RH	15.95%	17.66%	12.86%	10.10%	9.52%

# Measuring True Productivity

## Steps to Measuring Productivity

### 4. Calculate Productivity Ratios.

- Ideally productivity ratio  $\geq 1.0$ , however may be fine to establish productivity targets less than 1.0 (i.e. cognitive specialties; poor payer mix, etc.)
- RVU methodology only works when majority of codes have RVUs associated.

Provider ID	Specialty	Percent Revenue	Percent Total RVU	Percent Expense	RVU Productivity Ratio	Expense Productivity Ratio
66	GE	13.47%	12.56%	18.72%	1.07	0.72
95	GE	13.93%	16.10%	18.72%	0.87	0.74
794	GR	4.11%	5.77%	7.11%	0.71	0.58
13	IM	13.14%	9.81%	7.60%	1.34	1.73
1249	IM	8.66%	8.74%	7.60%	0.99	1.14
71	PM	12.25%	13.14%	10.60%	0.93	1.16
1056	PM	9.96%	14.86%	10.60%	0.67	0.94
1025	RH	6.81%	6.16%	9.52%	1.11	0.72
8	RH	17.66%	12.86%	9.52%	1.37	1.85

# Measuring True Productivity

- The challenge is measuring productivity at an individual physician level. Should at least be done at division and department levels.
- Eliminates FTE consideration and is agnostic to non-clinical work.
- Need buy-in by all parties concerned.
- For physicians who provide most of their time in hospital-based settings (i.e. hospital medicine, emergency medicine, anesthesiology, laboratory, imaging), productivity should be defined differently.
  - Number of shifts and patients seen per shift.
  - Should also consider turnaround times; wait times; LWOBs; length of stay.

# Measuring True Productivity

## USFPG

### Budget Summary

Collections per wRVU	\$	70
Collections per Billed Encounter	\$	105
Margin Expectation		2%
Budgeted Expenses	\$	225,000,000
Contract, Foundation and Other Revenue	\$	75,068,971
UPL	\$	6,671,849

		<u>wRVUs</u>	<u>Encounters</u>
Budgeted Expenses	\$ 225,000,000	3,214,286	2,142,857
Margin Expectation	4,500,000	64,286	42,857
<b>Budgeted Revenue</b>			
Contract and Foundation	- 75,068,971	- 1,072,414	- 714,943
UPL	- 6,671,849	- 95,312	- 63,541
Patient Service Collections	<b>\$ 147,759,180</b>	<b>2,110,845</b>	<b>1,407,230</b>

# Questions for Group?

- How do you measure true productivity?
- Are your faculty held accountable for expense control at the department, division and/or individual level?
- Easier to measure clinical productivity, but how do or would you measure academic productivity?
- How would you control for overhead or indirects?