The physician group model is undergoing radical change…again. In some respects we are revisiting the market forces that motivated hospitals and health systems to rapidly acquire physician practices in the 1990s. Today, the twin forces of payment reform and quality initiatives are instigating closer collaboration between hospitals and physicians to affect enhanced financial and clinical performance.

Whether independent or employed, physician practices are not immune to these sweeping forces. Indeed, the ability of a physician practice to succeed may be predicated on the ability of physician and staff to streamline functions, gather and process greater amounts of information and improve the quality of patient care while maximizing earnings. The goal is to optimize efforts in such a way that the best outcome is achieved in the most efficient manner. The solution is enhanced productivity. Thankfully, technological advances, more attractive outsourcing opportunities, and new collaboration models have created a broader spectrum of ways for physicians and hospitals to approach physician group productivity.

What is physician group productivity?

Productivity is a measure of how well the entire group functions. In addition to examining the physician’s activities, every practice should critically assess the functions performed by nurses, technicians, and front and back office personnel to gain insight as to the overall practice productivity. A faltering support staff function can greatly affect physician productivity and thus the entire practice just as easily as a physician that makes little or no effort to improve his own productivity. However, since the physician’s expertise is a prime driver of group revenues, it makes sense to begin with assessing the physician’s time and efficiency. If you can better capture and report all chargeable physician encounters or change workflow so that the physician can care for one or two more patients a day, you have had a dramatic effect on the productivity, profitability and efficiency of the practice.

Physician productivity is not just a measure of patient visits or work relative value units (RVUs). Physician productivity is an amalgam of all the activities that are necessary and valuable for the practice including administrative and organizational responsibilities. Practices – including hospital-based employed groups – should reach agreement on how physicians should invest their time and efforts. Marketing activities, serving with a local or national professional society, or attending committee meetings may be determined to have value to the practice. If the practice believes that the time investment is beneficial, then it should have a mechanism for assigning a value to that endeavor.

What are the barriers to increasing productivity?

Independent physician practices. Assessing physician and practice productivity is challenging because it requires evaluating the situation from a different perspective. Change is uncomfortable for most healthcare providers especially physicians who
have established patterns of behavior that enable them to uncover the nature or cause of the patient’s complaints. One key to successfully re-engineering practice operations is to engage people in the process who are innovative in their thought processes and creative in their problem solving abilities. This often entails enlisting the aid of outside experts who are not biased to the current workflow to examine the practice with a critical eye.

Most of what a physician does is focused on building one-on-one relationships with people: patients, other healthcare providers, staff. While relationship building is highly conducive to providing quality clinical care, it makes it difficult for some physicians to adopt a business framework for decision making, particularly in the area of personnel decisions. Outsourcing accounting and bookkeeping functions can normally be accomplished at a rate far below the cost of employing the individuals necessary to provide this service internally. However, deciding to outsource the function can be a challenge for the physician who views the decision in the context of his or her relationship with the staff member(s) involved.

**Employed physician groups.**

Employed physicians operate under the policies and procedures of the hospital or health system that employs them. Some hospitals have established separate divisions or operating units managed by physicians and administrators who understand physician practices. These organizations tend to focus on continually improving the overall efficiency of the practices. However, most hospitals have policies and procedures that were not developed to support physician practice efficiencies. In this situation, it is important that the employed physicians and hospital administrators collaborate on defining a management structure and personnel that will enable the practices to improve operational efficiencies and thus profitability.

One lesson we have learned from the 1990s (see sidebar on Lessons from the 1990s) is that rewarding physicians through salary alone is not enough. Productivity incentives, quality thresholds and bonuses for patient satisfaction are additional ways to reward physician productivity. In addition, linking clinical and financial goals at the salary level sets clear goals for hospitals and physicians alike, while paving the way for pay-for-performance and other quality care initiatives. Most compensation plans fail due to poor conception, development and execution; the financial incentives of the plan do not align with the performance and quality initiatives of the organization. If the rewards don’t align with the goals, the plan is ultimately doomed to failure.

To be successful, hospitals and physicians should agree on core performance goals and a regular review progress. Quarterly performance reviews with detailed reporting on key metrics provide consistent feedback and enables physicians to adjust practice patterns as needed throughout the year. Over time, the sharing of credible data related to utilization, cost and quality can help improve operational and process efficiencies.

**How to enhance physician productivity?**

**Start by capturing all physician chargeable services.** We frequently find that practices are missing revenue opportunities because they are not properly recording or reporting the physician’s time. One simple solution is to provide a recording device for any physician who is making hospital visits, allowing the physician to record visits and notes for follow-up by billing staff. This record will help ensure that all hospital visit activities are captured. Another area of increasing charge-capture opportunity is the use of confidential electronic communication with patients. One example is by using simple cell phone technology, an individual can take a photograph of an area of concern on the skin and forward it to a dermatologist. The dermatologist can then view the picture and possibly determine if the patient needs an office visit or a prescription with follow-up. Some insurers will reimburse for this initial assessment even though the patient was not seen in the office.

**Incorporate technology solutions.**

Capitalize on time-saving technology and systems to create more practice capacity and reduce costs. Online appointment scheduling, prescription refills and patient registration kiosks can reduce staff time while also improving patient satisfaction. Establishing a daily feedback mechanism through which the physician reviews the services provided...
to each patient enables verification that the correct supplies and equipment were charged as well as corroborates that every patient was billed appropriately. Having the right systems in place can also help satisfy the clinical reporting necessary for PQRI and other pay-for-performance plans necessary to gain federal funds through the HITECH Act and meaningful use guidelines.

Examining areas that take large amounts of physician time can yield creative solutions. For example, some procedure-based offices are showing videos of the physician providing informed consent information to patients, followed by a more streamlined one-on-one session with the physician to reiterate highlights and address patient questions and concerns. This process change can free 10 minutes of physician time during the pre-op patient visit.

**Track productivity.** The productivity measures utilized will vary greatly depending on the type of practice, location and the goals of the organization. In addition to common dashboards and benchmarks, non-hospital-based practices are advised to track new patient volume and record transfer requests to keep on top of volume trends. Practices should also compare operating overhead against practices of comparable size, location and payer mix. Organizations such as the Medical Group Management Association along with medical specialty associations can provide detailed comparison metrics.

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**Employed Physician Practices**

**Lessons from the 1990s**

The acquisition of physician practices by hospitals and integrated delivery networks in the 1990s failed to achieve many of the stated organizational goals. The industry has learned that the healthcare organizations that establish realistic expectations and forge a relationship with physicians based on true collaboration are likely to perform better in an era of payment reform.

- **Appropriate performance standards.** Incorporate a few, highly relevant performance standards into the operating contract. Go beyond the common relative value units (RVUs) and patient visits to include activities that are valued by the organization such as committee work and marketing support.

- **Fair valuation of practices.** Admittedly not as much of an issue as in the past, but organizations must establish a fair price for the practice based on realities of the current local market.

- **Accept that physician motivation will change.** It is human nature to work harder for yourself than you will for someone else. Hospitals need to accept that physician productivity will be affected and ensure that the contract clearly stipulates the expected productivity.

- **Compensation extends beyond salary.** While salary is clearly an important consideration for any physician seeking employment, hospitals can expand the compensation package to include incentives for reaching or exceeding key productivity, quality and patient satisfaction metrics, just to name a few.

- **Different skill sets are needed.** While successfully managing hospitals and physician practices are related skill sets, hospital administrators often do not have the understanding or orientation to effectively manage physician practices. Recognizing this shortcoming clears the way to hire practice leaders that have the regulatory knowledge and entrepreneurial orientation to successfully manage the physician practice component of a hospital or health system.

- **Employment is not the only option.** Today’s integration models provide a continuum of cooperative opportunities that can be tailored to meet the needs of both the organization and the physician. Stipends, gain sharing, joint ventures and management services organizations are examples beyond employment that can achieve physician-hospital integration.
All of these metrics can help determine if the practice is performing at, above or below the chosen benchmarks. But even if the practice is performing at the benchmark, there is room for improvement. The benchmark is the median — the middle of how the other reporting entities are doing overall. The best performing practices look at the benchmark as a starting place and establish goals that they hope will move them above the benchmarks in performance. Each practice needs to establish metrics that are relevant for them and that provide motivation for improvement and obtainment of the goals they wish to reach.

**Why is physician productivity important?**

_The implications of not examining the operational effectiveness of a practice are significant._ Regardless of whether the practice is independent or employed, physicians need to evaluate the expertise of key practice management. The lack of appropriately trained personnel can lead to incredible exposure. Take, for example, the impact of changes to the management of credit balances within a practice that became effective January 1, 2011. If you have not refunded to Medicare or other government payer a $1 credit balance by the 61st day after you identified and verified the credit balance, the practice by statute now owes $1 plus the $15,000 fine attached to the late refunding of a credit balance. If practice managers are not keeping up with the changes in legislation due to healthcare reform, it can lead to an extreme risk for the practice.

**Productivity and practice financial health.**

The objective of continued productivity improvements is a better quality of life for the physicians and staff along with improved financial health for the practice. Focusing on workflow enhancements, streamlining processes, and improved gathering and reporting of critical information requires a fresh perspective, creative problem solving and ongoing attention. At its core, the quest for productivity is a constant search for new and better ways to perform the most important tasks. Regardless of practice size or ownership, the need for productivity is the same and the consequences for being inefficient are too great to risk.

**About the Author**

Keith E. Chew, CMPE
Senior Consultant
McKesson Practice Consulting Solutions

For the past 12 years, Keith Chew has focused on the operational and strategic management of radiology and imaging services. During a 24-year career that includes senior administrative positions in medical group practices and health systems, Keith has honed an expertise in new venture development, mergers and acquisitions, financial management, contracting, and compensation.