



is an issue that arises in online discussion on a fairly regular basis: "Our group is talking about setting up a physician productivity measurement and I would appreciate any input about how others are doing this." The question usually involves whether RVUs should be used rather than exam volume alone and/or if in combination, how the measures should be weighted – and, more importantly, whether anyone is compensating radiologists based on physician productivity.

Physician productivity is a politically volatile topic and while the intention is easily justified on an analytical basis, the risk in terms of detonating the work culture and interpersonal relationships of the radiologists in the group can be significant. It boils down to a few simple questions: What will you do with the information once you have it? How will you reward the high producers and punish the low end of the production scale? Are you prepared to fire the non-producers? Are there factors beyond production in terms of measuring the value of each member of the group?

A Few observations

After talking with hundreds of radiologists in dozens of groups over more than 18 years, we have observed several commonalities.

Productivity measurement will validate what the group already knows or suspects: there is probably a large gap between the highest producer in the group and the lowest. That gap will likely remain even if improvements occur from the physician at the bottom of the list. Some radiologists are slower at interpreting cases than others and whether they attend extra courses to build their confidence and skills, are pressured to perform at a faster pace or subjected to the ire of the group, they will probably not change much. In some groups, these physicians have been recognized for other contributions and accepted (but nobody likes to be on the

weekend shift with them). They typically are not slower because they are lazy, but because they just process information differently and/or may have less efficient work habits than the racehorse top performers. In the billing office, these are the folks who plod along but show up for work every single day. However, in the billing office they are probably not eligible for merit-pay increases and in the radiology group, they will be full partners who are paid at the same rate as the producers.

Disparities are often greater in the highly sub-specialized practice, although productivity measurement seems to be more of an issue here than in groups in which everyone reads everything. Perhaps productivity measurement gains greater importance if it seems certain modalities are "slower" than others and/or there is an emphasis on each specialty area paying its way. The argument often centers on how to factor in the difficulty of the workload in terms of the number of images to be interpreted vs. sheer exam volume, with the arguments further complicated by specialization in neuroradiology, musculoskeletal imaging, or PET, where certain physicians may get all of the complex cases. On the other hand, there can (and often will) also be a wide range in productivity within each sub-specialized area.

Interventional radiologists will frequently not fare as well as body imagers and neuroradiologists. It doesn't matter that IR procedures have the benefit of high relative value units, they simply take enough time that volume/RVU measurements will not match those of a high-producing specialist in advanced imaging procedures. Typically there is more pressure on the interventional radiologists to pick up more of the diagnostic-radiology workload once productivity numbers are run and more often than not, the philosophical differences in the diagnostic vs. IR camps become further amplified as an objective measurement methodology is sought. In other words, if there is divisiveness in the group

The Pitfalls OF PHYSICIAN PRODUCTIVITY MEASUREMENT

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at the present time, it will probably get worse once the numbers are published.

General radiologists should receive increased gratitude, but may be demoralized. Within the sub-specialized group, the folks reading procedures comprising the heart and soul of radiology are penalized by the low RVU “worth” assigned to plain-film studies. After all, someone has to slam through the thousands of chest films and extremities. Granted, when exam volume and RVUs are combined in terms of measuring productivity, the picture improves somewhat but looking at plain-film RVU production in isolation devalues the contribution of the high-volume general radiologist. On the other hand, with advanced imaging procedures continuing to migrate to non-radiology specialties, the role of the plain-film reader may become more important to the financial health of the group but unless they are reading at least some decent level of CT and MRI studies, they will appear to underperform.

The busiest radiologists are often the most productive. Lest that appear to be a patently obvious statement, there is always a question about how other duties such as group-leadership roles, participation on hospital committees, and Medical Directorships should be factored into the volume/RVU productivity equation. More often than not (much more often), those in leadership positions also set the pace in terms of productivity – so their production as radiologists does not seem to be negatively impacted by time spent on other duties on behalf of the group. It should be noted, however, this is true in the groups that appointed strong, politically astute leaders, not in the “everyone gets a turn to be President” organizations.

What to do with the numbers

So, the numbers are in and they have been factored to production per day so vacation days are removed from each month’s numbers. Everyone talks about developing performance-based compensation models but so far few have been able to figure out how to change from equality-based partner compensation. In fact, the only group we know with a production-based model set it up as they formed. It would be exceptionally difficult to obtain support for reducing compensation to a base-pay plus bonus level when in fact two-thirds of the group would likely take a pay cut.

Production numbers have been seen to increase productivity, whether through individual pride, embarrassment, or peer pressure. In some groups underperforming physicians who felt the pressure resigned from what they felt were misplaced priorities, arguing the importance of quality over quantity. In those cases where the lower tier was forced out, the groups in fact seemed to reach greater stability and experienced less divisiveness.

Productivity measurement has also proven valuable in terms of workload balancing and staffing. For example, if the group found an underperforming physician was in fact assigned to a site with lower volume, they were able to move images there via PACS to even out the workloads.

We have also noted people have different opinions regarding what constitutes “busy” and one person’s unbearably pressure cooker schedule may be another’s comfortably busy day. After observing hiring practices that involved several physicians in the group insisting new colleagues must be hired due to crushing schedules, it became evident (with productivity numbers) the overall workloads were in fact average for today’s radiology practice. In these cases, physician production can help serve as one indicator of when another radiologist should be added to the practice.

Productivity can also help determine if it is possible (or desirable) to add a new contract or expand business within a modality, although more often than not the busiest radiologists will volunteer to take on the new business as well.

A final caution

Measuring physician productivity is counter to the old “gentleman’s agreement” radiology practice, whereby a widely disparate group of personalities, talents, and contribution were tolerated and even embraced. Part of being a gentleman was accepting that everyone would be paid the same. The idea of measuring the level of work like a manufacturing plant was downright undignified and, in most groups, getting consensus on performing productivity measurement represented a contentious and emotional process.

Then the first set of numbers is produced and they can’t possibly be right! There are accusations regarding the accuracy of the numbers, the competency of the person who developed them, and the impact of the vacation schedule on the results. The top producer validates he/she really is working that much harder than everyone else, the middle of the pack is in shock they aren’t higher on the list, and the folks at the bottom feel the bright light of intense scrutiny.

After the first few months some behavioral changes are usually evident as peer pressure impacts some members of the group and individual numbers improve. This is the positive impact of the exercise and in many cases, that’s all the drivers of the project sought – a more equitable workload distribution, with each person carrying a sufficient amount of weight. On the other hand, the group culture may also begin to disintegrate as unrest about inequities increases. Measuring productivity inherently requires accepting risk for what happens as a result and the normal levels of risk adversity in many groups make measurement an unacceptable step. Let it suffice to say there will be an impact and it may not be what was intended. The discussions about productivity measurement are not likely to end soon and perhaps radiology practices will eventually discover a way to reward top performers or at least establish minimum standards when hiring. There will be more to come in the future on this subject as we continue to learn. 

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