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Maintaining Surgical Quality in a Productivity-Driven Reimbursement Environment

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Editorial

Surgeons in private-practice have long-been compensated based on their productivity and collections. Surgeons employed by hospitals or universities have more often been compensated by a salary model. In an effort to encourage productivity, hospitals are now frequently using a component of productivity in their compensation models for surgeons. The most popular measure of productivity is work relative value units (wRVUs) [1]. The number of wRVUs a surgeon generates is a surrogate for revenue to the hospital, although many would argue that net collections is more accurate since it factors payer mix and uncompensated work the surgeon may perform [2]. Still, the majority of physician productivity bonuses are based on wRVUs [3]. Hospitals employing surgeons may base compensation solely on a surgeon's productivity or may offer financial incentives for reaching certain productivity targets. These incentives can comprise a considerable amount of the surgeon's total compensation. As more of the focus turns to productivity, quality may receive lower prioritization.

Do productivity incentives necessarily lead to decreased quality?

No. Or at least it is not a certainty. Productivity and quality are not mutually exclusive [4]. High-volume surgeons can have high-quality results. So true is the converse. However, we cannot ignore the reality that when a hospital rewards productivity surgeons may prioritize quality a little less in exchange for higher volumes. This shift of focus is unlikely conscious, but a consistent message from the hospital that higher volumes are to be rewarded can push a subtle message that quantity should take precedence over quality.

What quality means to a hospital: Hospitals are ranked by various organizations on numerous factors. Some rankings are less fact-based and more survey-or popularity-based (such as US News and World Report and Doximity) [5]. Others are highly data-driven and pay close attention to outcomes (such as Vizient, Leapfrog, and the National Surgical Quality Improvement Project) [6-8]. Payers are also focusing more on quality. The Centers for Medicare and Medicaid Services (CMS) has already instituted quality payment programs such as the Merit Based Incentive Payments System [9]. The results of these ranking and reimbursement programs is a better-informed patient population when it comes to quality, as well as an environment where high-quality results are rewarded and low-quality results face economic consequences

Balancing productivity and quality: Hospitals do not have to choose between productivity and quality. There are methods to balance these potentially competing goals.

In addition, a pure salary model is to abolish the incentive for productivity, including minimum case volumes and wRVU targets. Surgeons in a strict salary model without a productivity quotient have no incentive to increase volume at the expense of quality. There is scant evidence that surgeons earning a salary without productivity incentives are apt to be unproductive. Many would argue that the surgeon personality is incentive enough to ensure productivity. However, human nature being what it is, without an incentive to be productive some surgeons may develop practice patterns over time with lower volumes. For a hospital this is an especially worrisome pattern for more senior surgeons who may hold tenured faculty positions and earn the highest salaries. The hospital is financially motivated to ensure these surgeons remain productive. Chiefs-of-staff or surgery department chairmen can track the productivity of individual surgeons and address low outliers. A surgeon who takes advantage of the guaranteed salary while not earning his or her keep should be addressed fittingly, but little can be done if the surgeon holds tenure. A pure salary model without productivity incentives may fail to attract highly motivated surgeons who seek to augment their income by working harder. A hospital can overcome this by offering a sufficiently high salary, but this is a risky proposition from hospital perspective as there is no guarantee the surgeon's productivity will cover the salary expense.

Another method to balance quality and productivity is to utilize a quality-based incentive system without a productivity component. Some hospitals are already offering financial incentives to surgeons with high-quality results. This creates a culture where quality is prioritized, and the surgeon and hospital's motivations are aligned. Since measuring quality does not involve the same smooth gradient as productivity based on wRVUs, incentive programs based on quality tend to rely upon hitting specific quality targets and then receiving a predetermined financial reward. Potentially this creates an all-or-nothing incentive program where surgeons exceeding the quality cut-off receive a bonus and the others do not. Alternatively, smaller incentives can be awarded stepwise for each quality goal a surgeon achieves such as for acceptable readmission rates, wound infections, unplanned returns to the operating room, or venous thromboembolism. The downside of this model is that there is still no financial incentive for revenue generation.

Quality and productivity can be balanced in a model which offers incentives for both. Productivity-based incentive programs can be modified to include a quality component, either in an incentive or disincentive fashion. Hospitals offering a productivity incentive based on wRVUs can increase or decrease the surgeon's bonus based upon meeting or failing to meet a quality metric. The hospital must carefully balance the weight of the quality component to ensure that there is no incentive to overcome a quality deficit with additional productivity.

Such a model might offer a 25% increase in the productivity bonus payment for meeting 3 of 5 quality metrics and a 50% increase for meeting 5 of 5. Another model might cut a surgeon's productivity bonus by a significant percentage for failing to meet predefined quality metrics. The weight that the hospital places on the quality component of the bonus will drive the surgeons' focus on quality. A hospital that offers a small additional bonus for quality will not engender the same attention to quality as a hospital that threatens to withhold an entire productivity bonus for failing to meet quality standards.

Beware of mixed messages: While a hospital's incentive program to surgeons may adequately balance quality and productivity, the hospital must take care to prevent subtle messages that productivity is the true goal. Such messages might come from an operating room manager who chastises surgeons for not utilizing enough of their block time or publicly complains of being overstaffed when there are unutilized operating rooms. Other messages might come from department chairs who focus too heavily on case volume or revenue. Hospitals that successfully foster a culture balancing productivity with quality align all parts of the organization in the pursuit of those joint targets. The message conveyed from top to bottom within the hospital must be that quality is every bit as important as productivity.

Conclusion

Balancing productivity with quality is not an easy task. Hospitals that successfully do so motivate all employees, including surgeons, to pursue both goals concurrently. While there may be some trade-off between quality and productivity, the two concepts need not necessarily compete with each other. In today's quality-focused healthcare environment, hospitals are being rewarded for quality in addition to productivity. The trend is likely to continue with an increasing focus on the quality component. Hospitals that successfully motivate their surgeons toward that goal are likely to be recognized in rankings and rewarded by patient loyalty.

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