ADGAP Collective Action Project

The RVU Model in Academic Geriatric Programs: Benefits, Risks, and Brainstorming the Way Forward

Neil M. Resnick, MD
Nichole Radulovich, CRA

ADGAP/Hartford Leadership Retreat -- January, 2012

Background

- US healthcare is challenged by quality and cost
- Care of seniors epitomizes the problems
- Academic Health Center (AHC) Geriatricians are optimally positioned to address the issues
- To do so, requires time, support, and recruits
- Productivity assessments should align with these goals. Does the RVU system do so?

Session Goals

- Background for Collective Action Project (CAP)
  - Overview of wRVUs as a productivity measure
  - Alignment of wRVUs with geriatric mission?
- Group Discussion
  - Retain the RVU metric, complement it with other factors, or substitute another measure(s)?
- Determine next steps

Relative Value Units (RVUs)

- Developed at Harvard by Hsaio (1988)
- "RVUs are **objective, standardized** indicators of the **value** of services and measure relative differences in **resources** consumed… primarily for **reimbursement** of services performed, but also for **productivity** measurements, cost analysis and **benchmarking**."

RVUs

- Three resource inputs
  - Total Work performed by MD
    - Before service
    - During service
    - Following service
  - Practice costs, including malpractice premiums
  - The opportunity cost of specialty training

Validity of the RVU-Based System?

- Geriatrics was not included in its derivation
- Doesn't adjust for many key geriatric variables
  - Patient's socioeconomic status/caregiver availability
  - Patient's clinical characteristics (e.g., % demented)
  - Quality of care (not included)
  - Impact of trainees (#, level, %)
  - Use of EMR vs. paper charts
  - Role/impact of midlevel providers
  - Clinic staffing or layout

Does the RVU-Based System Align with the Needs Of Older Patients Or Our Mission?

AHC Geriatrics' Mission

- *Define* and *deliver* state-of-the-art quality care congruent with patients' values and goals
- Because ↑elderly, ↓geriatricians must also:
  - Teach/excite all level trainees *and* ↑ #geriatricians
  - ↑ "system's" ability to deliver better care
- Conduct/collaborate on research to improve care

RVUs for Reimbursement: Example

- Cost of a clinical geriatrician (median) $235k
  - Median MGMA AHC geriatric salary $158k
  - Fringe Benefits (24%) + Acad Overhead (20%) $77k

- Convert $235,000 to RVUs: Institutions vary but at UPMC, $235k would equate to ≈ 4700 RVUs. Thus, ***if*** we used a benchmark of 4700 at UPMC, how could faculty reach it?
  - ***Office-based***: 1 new + 6 f/u pts/session x 10 sessions/wk (new coded at level 5; follow-ups at level 4) $235k
  - ***Hospital-based*** (3 new/d, ADC=10-12) $220k
  - ***SNF-based*** (with FT CRNP) $207k
  - Note: above ***excludes*** expenses of practice + CRNP
  - Thus, it is difficult to financially support 1:1 geriatrics care under present reimbursement policies. The RVU model has other effects…

Potential Implications

- Potential practice impacts
  - "Cherry pick" to compensate for ceiling effect?
  - ↓ access for new/urgent/recently discharged pts?
  - ↓ important services that don't generate RVUs?
- Ignores care quality, including pt's values/goals
- Impedes teaching?
- Feasible x 10 sessions/week?
- If so, *appealing* to trainees we need to entice?
- Incorporates/impedes major values of geriatrics?

Alternatives to RVUs?

- Collections, visit volume, # sessions, etc.
- But geriatrics' contribution to value also includes:
  - ↑ Quality measures (eg, care α with patient values/goals, ALOS, readmission rates, HACs, smooth care transitions)
  - *System-wide* implementation of geriatric principles to all levels of care, as well as education of system HC providers
  - Offload most difficult patients → ↑PCP productivity
- Alternatives to compensating faculty via RVUs
  - System improvement in healthcare quality → savings that likely far outweigh our impact through 1:1 patient care
  - Invest savings in ↑programs, infrastructure, and salaries
  - Would also underscore geriatrics' value and may inspire more trainees to enter the field.

Today's Assignment

- Should we retain the RVU system?
  - If so, appropriate benchmark?
  - If so, should we modify it? How?
- If not, what alternative system would better align with geriatrics' mission/goals?
- Should we incorporate quality? How?
- How to facilitate and reward other clinical efforts associated with system improvement?
- What additional data should we collect from ADGAP members, our faculty, dept. chairs/deans/CEOs?
- What consultative expertise should we seek?

Next Steps for CAP

- Determine project focus: Clinical productivity? Faculty compensation? Faculty value-add? Other?
- ID Collaborators: please let Erin Corley know
- Data collection:
  - Current benchmarks; how do we identify and adequately adjust for confounders?
  - Survey? If so, what to include and from whom?
  - Seek outside consultant expertise? Which type?