ADGAP Collective Action Project

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

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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 \( \approx 4700 \) 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?