

# Production-Based Compensation for Hospitalists Overlooked Too Often?

How it increases your ability to decide for yourself how hard you want to work.  
Part two of two ■ By John Nelson, MD.

**S**hould hospitalists, or doctors in general, be compensated based on their production? This question has received increased attention in the last few years. A major criticism of production-based compensation is that it is essentially a system that pays doctors for doing *more*, not for doing *better*. There is a growing interest in shifting at least some of physician (and hospital) compensation to a system based on the quality of care delivered.

At this point it isn't entirely clear how all of this will play out in the coming years. What is clear is that for the time being the financial health of our practices is very dependent on our production (as well as other factors such as financial support from a hospital). So until Medicare and other payers change their system of physician reimbursement, I think it can be a good idea in many practices for at least some of a hospitalist's income to be based on production because that helps connect him/her to the economic health of the practice.

In my May 2006 column (p. 50) I suggested that you consider production-based compensation because it can allow you and your partners to take more control of decisions about how hard you want to work and when you want to add additional doctors to your group. Most production-based compensation formulas allow doctors in the same group to work different amounts, such as working a different number of days on the schedule, and carrying different patient loads. In contrast, groups in which the hospitalists have a fixed salary (or one with a very small production-based component) usually require the doctors to work the same number of days on the schedule, and try to ensure all doctors have similar daily patient load.

When I discuss this idea with hospitalists around the country they often express concern that it would be too risky to go on a production-based salary system. They say things like, "I can't go on production because I can't control how many patients are referred to our practice."

While it's true that we have little control over patient volume from one day to the next, we have *significant* control over volume for any lengthy interval such as a year. If you provide good service to referring doctors and usually accept referrals graciously you will have a much higher volume than if you regularly resist referrals.

And I'll bet that the majority of the other doctors at your hospital can't precisely control their patient volume, but their compensation is based entirely on individual production. This is true of many emergency department and radiology practices, and some medical subspecialty groups. Why should hospitalist practice be different?

Another misconception about production-based compensation is that it is synonymous with foregoing any financial support from your hospital or other sponsoring institution. It isn't. You can still pay individual doctors on productivity and include financial support from the hospital. For example, if the doctors are paid \$55 for every wRVU generated, then \$40 of that might come from professional fee collections, and \$15 from the hospital (employer).

Others fear that a salary based on production will cause doctors to work at unreasonably high workloads, leading to poor patient care or patient satisfaction, or less efficient use of hospital resources (e.g., keep patients in the hospital longer). This is a potential risk, but not a common problem in my experience. There can also be concern that compensation based on productivity will cause the doctors within a group to compete with one another for patients (and income), leading to stress within the group. This is an uncommon problem, and—if it occurs within your group—it probably means that there are too many doctors in your practice (or that you should market the practice to attract more patients) rather than proving that productivity-based compensation is a bad idea.

But an explanation that clarifies objections to productivity-based compensation certainly isn't enough of a reason to support it. You need to be convinced of some of its benefits. Hospitalists who aren't used to being paid based in part or in whole on production tend to see it as a very stressful—or even oppressive—way to be paid. But I hope to convince you it

is actually *liberating*.

In the absence of a production component, many groups try hard to ensure that every doctor works the same amount. For example, a group that pays a fixed annual salary to all doctors typically encourages or insists that each doctor must work almost the same amount. But when paid on production, each doctor in the group can, within reasonable boundaries, decide how much he or she wants to work. Of course all of the group's work must be taken care of, but in nearly every group some doctors are probably willing to work a little more and others a little less than the average workload for the group.

Nearly 15 years ago, before I married and had children, I got hooked on the idea of learning to fly airplanes. Wow, did I enjoy it. But it is pretty time consuming to get a pilot's license, to say nothing of the expense. There were a number of days that I was to be the admitting doctor for our practice, but great weather and an available plane and instructor would lure me away. On a number of occasions at 4 or 5 p.m. I called my partner who had gone home for the day and said, "Chuck, would you be willing to cover admissions so I can go flying?" He usually said "sure," at which point I'd tell him that there were already two patients waiting in the ED.

This system made both of us happy. After nine months I was a licensed pilot and for that year my partner had a much higher income than I did. We both got what we wanted, and paying ourselves on production is what made this possible. If we were in a group with a fixed salary I can't imagine he would have been willing to help me out so often (if ever), and I would have been limited to taking flying lessons only on my days off. Or I would have needed to pay my partner back by making up the evenings he covered for me.

My point in telling this story is that so many people think of paying hospitalists based entirely, or in part, on production is just a way to get them to maintain unreasonably high work loads. But I think it simply liberates the doctor to decide for himself what the right workload is, while owning the economic consequences of that choice. It allowed me the opportunity to work *less*.

A few hospitalists paid on production might choose badly and choose to work at an unreasonable (or unsafe) pace, but nearly all will make reasonable decisions. And members of a group can periodically adjust their workload up or down according to their need at the time; there is no requirement to work at the same load year after year. In fact, my partners and I in Florida didn't even keep track of precisely how often each of us was on call over the year because there wasn't any reason it needed to be the same for each person. (We did make some effort to distribute call evenly, but didn't worry when it never worked out just right because each doctor could take more or less call and see a corresponding change in income).

I realize that there is no perfect compensation system, and one based on production can have shortcomings. But I think too many hospitalists assume the only reasonable system is one such as a fixed annual salary, or an hourly rate, or some method that intentionally avoids paying for productivity. You should think about how liberating productivity compensation can be. Basing a significant portion (say 40% or more—or even 100%) on productivity might be a good idea for you.

And there is nothing about productivity-based compensation that interferes with also providing financial reward for good quality of care. I'm a fan of both. If payers increasingly use quality of care as the basis for physician reimbursement in the future, individual physician compensation formulas should be based more on quality than production. **TH**

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