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Calculating the Value of a Physician Assistant

MODELS THAT CALCULATE THAT VALUE

Do you ever wonder how much value your physician assistant or nurse practitioner is bringing to you practice. Today we will be discussing models that calculate that value.

You are listening to ReachMD XM-157, The Channel for Medical Professionals. Welcome to the Clinician's Roundtable. I am Lisa D'Andrea your host and with me today is Mr. Ron L. Nelson, Physician Assistant and President and CEO of Health Services Associates in Fremont, Michigan. Mr. Nelson has a broad background in both health policy and clinical delivery and is a recognized expert in the area of medical reimbursement.

LISA D'ANDREA:

Hi, Ron Welcome to ReachMD.

RON NELSON:

Thank you, for inviting me.

LISA D'ANDREA:

Ron there are many physicians who are considering adding a physician assistant or a nurse practitioner to their practice. What is necessary in terms of the relationship between the PA, NP, and the physician in order to maximize the value to the practice?

RON NELSON:

Well first of all there has to be a basic relationship that recognizes the value this individual brings and so its important that the physician recognize and treat this individual like a colleague and that the office setting is also treated that way, to not offer this individual as a second best option, but to recognize as an example I often give to people. If the patient calls and says I need an appointment with Dr. Smith and the answer is Oh! Dr. Smith is not available, but you know you can see Ron who is a PA; versus the patient who calls and says that can I get an appointment, I want to see to Dr. Smith and the answer is Dr. Smith has an opening on Wednesday. Ron, the PA,

has opening today at 2 o'clock, what would you like to do? and you can say that's semantics, but the fact is its an example of how you need to present the individual as a colleague and an equal with the physician in terms of the perception of the customer or the patient.

LISA D'ANDREA:

But if I am the patient, why would I see a PA or NP when I could see a doctor?

RON NELSON:

Well the studies have demonstrated that the quality is equal and what we are finding if you look at the studies that have been done on patient acceptance, in fact, it is generally found that often the PAs or nurse practitioners spend a little more time; and therefore often we find that the patients are very satisfied with that and what we are finding today is often patients are not as hung up about the credentials behind the individual that is providing their healthcare as much as they want to know that they are compassionate, they are concerned and that they are going to provide them the care; and so it has been said that the patient doesn't care what you know until they know which you care, and I think the PAs and nurse practitioners demonstrate that kind of empathy and care and in conjunction with physicians, what often happens is patients try the model and you find the patient is coming back saying I want to see this PA, or I want to see this nurse practitioner because they develop a relationship.

LISA D'ANDREA:

In terms of compensation, how should a physician structure a compensation package and should it include a production bonus?

RON NELSON:

Well compensation first of all I think needs to be a process that encourages productivity for this individual while at the same time allowing him personal and professional job satisfaction. Also if they are going to structure some type of incentive, which I do think it is an important part of that relationship, it should be simple with achievable targets and certain you know compensation milestones that are in that process. There are multiple sources one can go to, to get that information, but I think that what's most important is to establish what the base income of that individual should be and then based upon the type of practice, there are different models that we can look at to incentivize. As an example, some models may use, RVUs or what we call relative value units to determine if someone hits a certain threshold level and over that they will reimburse a dollar per RVU or based on charges for example or net collections that a certain base level was achieved and once that base level is achieved, then a percentage of dollars over that may be provided back to that provider as an incentive over and above base salary. There are really multiple ways to approach that and I think what's most important is that people have to be careful that whatever they are doing is realistic and they have to be careful that they should model the plan that they put together because I can tell you some stories of situations where people really got into problems because they didn't do the financial modeling before they implemented the compensation structure.

LISA D'ANDREA:

What if you implement something and it's not working out? What's the fair way to change it or length of time?

RON NELSON:

Well generally, what you look at is at least a 1-year period I think for a compensation formula and if at the end of the year, if it is determined that the targets may be too high and the individual was not able to achieve those targets, then that may be a time to reassess it. In some cases that is also a time to say to the individual, your productivity is not where it needs to be. One of the things that concerns me greatly in the consulting that I do is that there is really fairly low expectations today that I think that NPs and PAs have what their productivity should be and that is sometimes clouded by some of the figures that are out there. For example, in the Rural Health Clinic Program and in community health centers where for reimbursement policy reasons they have these minimum productivity standards, which really do not reflect what these individuals should be seeing. So I think it is important that whatever formula we choose and in reassessing that there is a periodicity scheduled, whether it is 12 months or 6 months, which I think is a short time, but there is a reassessment and then an agreement on how we will go forward, because conversely I think situations where at the end of the contract, a physician owed a PA twice what they had already paid him in salary because they didn't really understand what they had guaranteed them and now you have a real conflict existing because the contract says one thing and that was not the real intent.

LISA D'ANDREA:

What is your opinion of a pure production formula for compensation?

RON NELSON:

I get concerned about pure production models because it creates the treadmill or churning potential that this individual is constantly struggling to or working to increase the numbers, increase the dollars and takes away some of the focus on quality. One of the things that we know today is that the every insurance company is profiling. Up to 25% of Medicare is now on a commercial product and every one is looking at certain quality indicators and so I think a formula that includes both production, but also some quality indicators such as certain outcomes with chronic disease management and one might add other things in their such as the individual involved in the practice if it relates to maybe formulary committees or improving efficiency in the practice. All of those things can been structured into a formula that can incentivize the person not just on productivity, but also based on quality and helping to improve the practice overall.

LISA D'ANDREA:

Ron can you walk us through a simple formula of how to compensate a PA or an NP?

RON NELSON:

Well I can give you an example and I want to stress that this is one fairly simplistic process and I have seen multiple types of formulas that take into consideration many different factors as we have already discussed including <_____> participation and production. But it is one example if someone had a base salary of $75,000, there is often thought within, you know, the industry that 2-1/2 times the salary of an individual is what the overhead would be so if this individual's salary is 75,000, 2-1/2 times that would be 187,000. You then deduct from the total amount that they produced that 187,000, which leaves a balance of what we call net production of 99,000 and this is based on gross charges. You would then say okay how do we calculate that 99,000? How much should we give back to the PA or nurse practitioner? There are some things that are calculated, called production ratios or production to salary ratios and what that basically is, is a ratio of the amount of salary one is paid compared to the total amount of gross production. For example based on Medical Group Management Association or MGMA standards, for a PA or nurse practitioner is about 26%. So in this case, we could say that the net production of this individual after 2-1/2 times their salary deducted from their gross production is 99,000; 26% of that would be a $25,000 additional compensation. So this individual would make a salary of 100,000, 75% of it salary, 25% of it is production bonus based on producing just under 300,000 in charges. That's a lot of numbers; but that's a simplistic way to say the base salary, take that salary, multiply it times 2-1/2, the individual has to produce at least that and cannot get any production incentives unless they produce more than 2-1/2 times of salary.

LISA D'ANDREA:

In the overhead costs, are direct costs included in their or just indirect costs of the PA or NP?

RON NELSON:

Well generally what you put in the overhead is going to be, it includes all the direct costs associated with that individual, which is one of the things that I think practices often don't realize that these individuals have direct costs such as facility, human resource cost, physical appliance, utilities, phone, all of those things are overhead for this individual to be in the practice, so that has to be considered as part of the overhead.

LISA D'ANDREA:

When you talk about the gross number, that is the billing or is that the money that is received into the practice?

RON NELSON:

Well the example I gave you, I was using gross charges, one could do it based on net collection, but I think it also important to understand that because PAs and nurse practitioners work in varied situations that that billing number is not the only number to consider when looking at the value they bring to the practice.

LISA D'ANDREA:

Because a lot of PAs and NPs work in administration in the practice as well and how do you compensate for them?

RON NELSON:

Well if they are doing an administrative role in addition to clinical practice, I think then we have to look at compensation based on what the administrative salaries are paid for the kinds of duties that they are performing, but often you will find that PAs and nurse practitioners are providing other aspects of education to the patient, interaction in doing you know informed consents, pre and postop care that's often bundled and it is important to recognize that while we bundle that for the purposes of getting paid, for the purposes of calculating value within CPT, there is a mechanism to unbundle and understand the value of the time and the service that was provided by that individual. When you do that, it changes the ultimate number that that individual has in terms of impact and value.

LISA D'ANDREA:

How about the PAs and NPs that work in surgical specialties or in the hospital? Often they don't bill for services, so how do you measure their productivity?

RON NELSON:

Well, the biggest problem is that the hospitals don't understand how to do it and don't want to do it. That is complicated also by often hospitals, who are employing PAs and NPs and then have them providing services to private physicians, which creates some reimbursement policy issues, but having said that, I think when you look at the surgical specialties, we did a study for example in one of largest cancer hospital centers and one of big 8 cancer centers in the country looking at surgical specialties and what we did is we took those services that are bundled such as preop, H&Ps, and postop care and we put an economic value to that. We also looked at the time that was spent by these individuals and they were both nurse practitioners and PAs in services that ranged from breast surgery to neurosurgery and what we ultimately came up with then was the direct billable, which is those that we know that clearly you can bill for the PA and nurse practitioner doing. We then took the bundled services that normally were bundled into the physician's time or into their billing for the surgical services; and then we took the time they spent time doing the bundle services and recognized that the PA and NP did not do that, then the physician had to do it and we took that additional time factor, and put an economic value to it based on additional cases and/or consults by the physicians and demonstrated that even though the direct billable in this particular group was about $130,000 to $140,000 dollars worth of direct charges they were billing. When you took the bundle and the additional physician time, the total value calculated was $469,000 for a surgical PA. So there is a significant component of value in those surgical PAs. It is not always calculated because of lack of understanding how to bill or the roles that they are providing in terms of bundled of services.

LISA D'ANDREA:

I want to thank you my guest Ron Nelson for coming on the show. I am Lisa D'Andrea, and you have been listening to the Clinician's Roundtable on ReachMD XM157, the Channel for Medical Professionals. Please visit our web site at reachmd.com which features our entire library through on-demand podcasts or call us toll-free with your comments and suggestions at triple 8- MD-XM157 (888-MD-XM157) and thanks for listening.

This is Dr. Robert Klitzman with Columbia University in New York City and you are listening to ReachMD XM-157, the Channel for Medical Professionals.