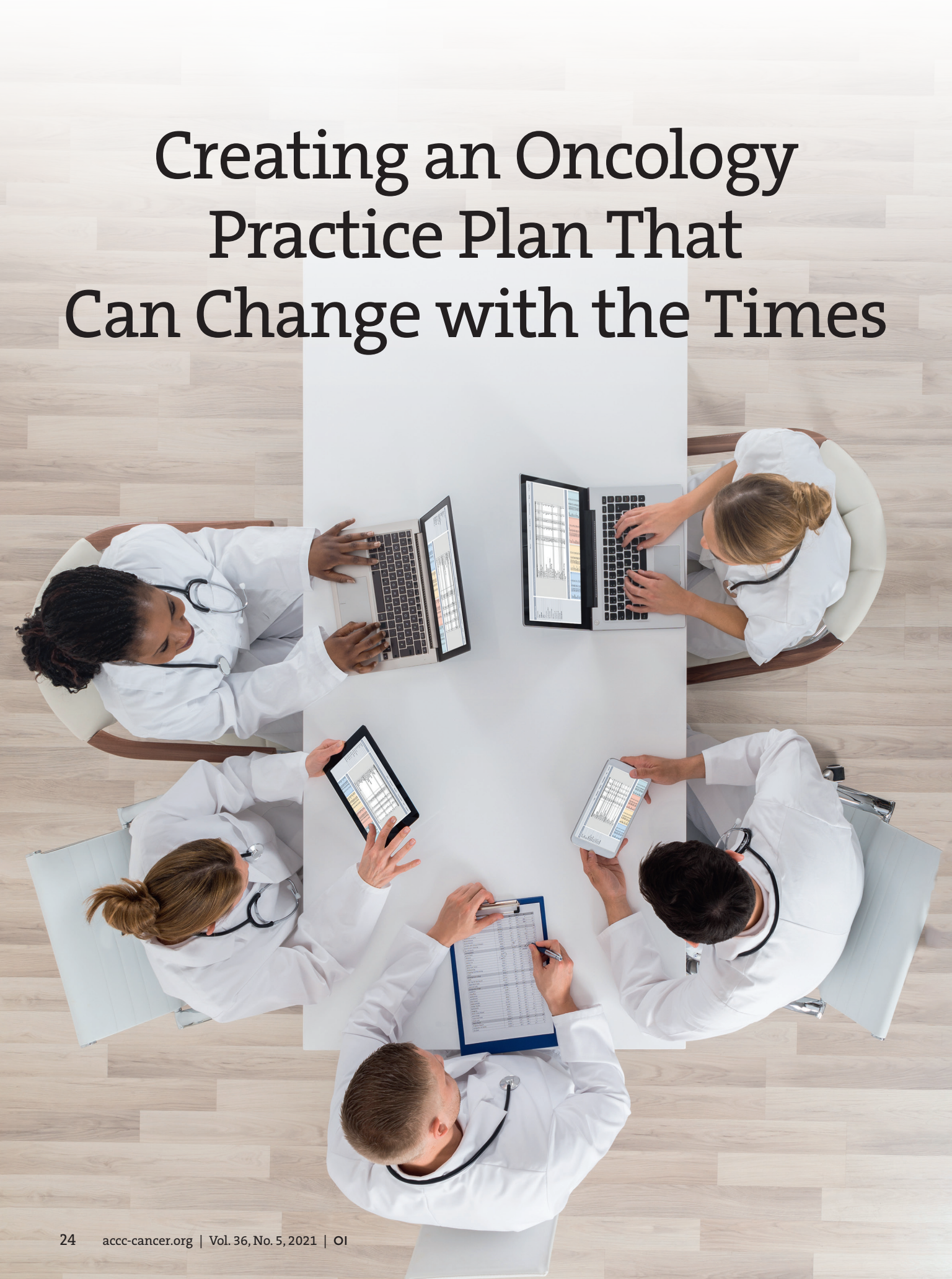
Creating an Oncology Practice Plan That Can Change with the Times



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In Brief

Medical oncologist workflows have changed dramatically in view of precision medicine, new therapeutic agents, and sub-specialization in oncology. Relative value unit (RVU)-based practice plans lack financial incentive for cooperation and sharing of knowledge and patients, which is required for current best practices in cancer care. To improve cooperation and sharing, Aurora Health Care formed a Practice Plan Development Committee of medical oncologists, service line leadership, finance leadership, and a practice plan consultant. The committee established goals that would enhance collaboration, modify physician behavior to meet the needs of the group, allow payment for non-RVU-generating activities, create a more equitable distribution of expertise, facilitate intra-group consultation, and create more evenly developed compensation. A plan was developed to reward non-RVU-generating activities that benefited the cancer program and medical group. This plan included the creation of a pool where a percentage of compensation, above a threshold, was established and equally divided at the end of the calendar year. Citizenship criteria were established to benefit the health system, medical group, and individuals and demonstrably modified behavior. All members of the medical group (physician practice) agreed to move to the new model. It has resulted in continuous improvement of defined goals with reduced variation in income, increased clinical trial volume by 400 percent, and increased sub-specialization within the medical oncology group.

In 2014 Aurora Health Care's 15 hospitals and many sites of care comprised the largest healthcare system in Wisconsin. Its sites covered approximately 60 percent of the state's population, extending along Wisconsin's eastern border, from Green Bay, in the north, and south to the Wisconsin-Illinois state line. Aurora was formed by combining multiple hospitals into a system and within medical oncology, blending multiple groups of private medical oncologists into an employed-physician model. As a result, 36 medical oncologists, practicing at 21 sites in groups that ranged in size between 1 and 8, were paid according to 14 variations of 9 individual practice plans. Additionally, there were different RVU payment rates, limited system consistency of practice, multiple local tumor boards, and minimal communication in what seemed like a loose confederation rather than a vertically integrated program. With many of the original medical group contracts moving toward expiration in 2014, we felt that the window of opportunity was optimal to convert individual sites into a functionally cohesive and interactive group using financial goals and rewards to encourage behavioral changes.

Creating a Practice Plan Development Committee

We first obtained approval from medical group leadership to evaluate the potential to develop a practice plan specific to medical oncology. Next, a committee was formed comprising representatives from service line leadership, medical group financial leadership, and multiple legacy medical oncology groups, including a mix of both high and low earners and producers, as well as an external practice plan consultant. At initial committee meetings, goals for the development of a new practice plan were evaluated and set. The consultant conducted interviews with approximately half of the medical oncology group members to identify their

concerns about existing oncology practice plans and desires for the future integrated plan. Simultaneously, oncology service line leadership worked to create a new consolidated vision for the medical oncology group.

Securing Funding and Essential Infrastructure

Oncology service line leadership was also working to create a cohesive program that could standardize evidence-based care, create subspecialty expertise within the group, enhance disease-specific video conferences and improve physician participation, and increase the number of patients participating in clinical trials. A decision was made to incorporate evidence-based pathways into the electronic health record. Grants from the state of Wisconsin and Aurora Health Care were obtained to provide video-conferencing to and from all clinic sites, including high-definition videoconferencing capabilities from the desktops of each medical oncologist, surgical oncologist, and radiation oncologist. A National Cancer Institute Community Oncology Research Program grant was obtained to increase the number of clinical trials that could be offered at each site. Additionally, each medical oncologist was required to declare a primary and secondary disease interest, so they could also provide internal consultation throughout the system.

To facilitate these goals, all system outpatient offices and hospitals moved to Epic as their electronic health record. In addition, the service line selected Via Oncology pathways (now known as ClinicalPath), which are evidence-based clinical decision-making tools that require staging of patients and answering patient-specific questions (e.g., tumor markers, etc.) in order to generate a set of treatment options ranked first by clinical trial availability and then by treatment efficacy, toxicity, and cost. The pathways are evidence based and evaluated quarterly by national disease-specific committees co-chaired by representatives from both academic and community health institutions. Medical oncologists were required to attend at least half of the conferences that focused on one of their two designated subspecialty interests. These conferences were attended by medical and radiation oncologists, surgeons, surgical oncologists, radiologists, pathologists, tumor registrars, genetic counselors, nurses, navigators, and clinical trials nurses. Conference discussions usually centered on workup and management issues. This was in keeping with the multidisciplinary model being used for most cancer programs.[1]

The approaching expiration of many initial contracts and their inherent guarantees provided both an incentive and degree of urgency to move toward a more cohesive practice plan model.

Identifying Problems with Existing Practice Plans

Interviews with individual medical oncologists raised several consistent themes surrounding their dissatisfaction with existing practice plans, which included:

- RVU payment models perpetuated an "eat what you kill" mentality, regardless of quality
- A medical record that was unforgiving and difficult to negotiate
- Increasing demands for uncompensated tasks
- Very limited concern and attention to work/life balance
- An overall feeling of disengagement
- No incentive to work as a cohesive group
- Widely inconsistent pay rates resulting from RVU evaluations conducted during four different time periods
- Significant inequality of income across medical oncology practice groups.

Establishing Goals for the New Practice Plan

To address the identified problems and add components that medical oncologists had expressed in their interviews would increase satisfaction, service line leadership helped establish these goals for the new practice plan:

- Declaration of subspecialty interests by each oncologist to ensure that medical expertise was available in all disease states within the system. (There was general agreement by all involved that oncology is a field that is too vast and rapidly changing for individual physicians to maintain expertise across all cancers.)
- Standardization of the compensation model throughout the system using the same RVUs per service and payment per RVU
- A mechanism to compensate individuals for activities that did not generate RVUs
- A mechanism to reward individuals who performed activities that benefited the program in general (e.g., writing peer-reviewed papers, serving on national committees, giving lectures to local groups and national societies, etc.)
- A value-based care practice plan
- Protection for individuals who would take the largest potential loss to their income during any transition period, including a payment floor
- Elimination of silos that had been created among different markets
- Encouragement of positive behavioral change, such as attending conferences, referring patients to other members within the group and to clinical trials, participating in multidisciplinary clinics, and creating standardized approaches to disease.

Next, the committee held monthly meetings to discuss potential practice models that would accomplish these goals. Medical group leadership directed that a new practice plan could be adopted if 90 percent of the medical oncologists agreed to transition from their existing payment model and minimal change was made to the total current payroll amount. To promote reliable and consistent communication while new practice models were being considered, quarterly meetings were held with the remaining medical oncologists.

Standardized Compensation and Incentivization for Achieving Goals

Salaries in our employed medical group started at the 50th percentile of the average of three compensation and productivity surveys: Medical Group Management Association, SullivanCotter, and American Medical Group Association.[2-4] Compensation per RVU was also determined by the three-survey average. In addition, because most of the medical oncologists had transitioned to Aurora hospital-based clinics from a private practice setting where

they could bill for chemotherapy, it was proposed that the number of RVUs (relative value units = assigned value of any given medical service) performed would need to be increased by 15 percent to compensate for the loss of chemotherapy revenue.

The consultant suggested that use of an incentive pool would best facilitate compensation standardization across the group. To encourage at least a base level of activity, the new plan would require a minimum number (3,500) of RVU production to join the incentive pool. Once that threshold was crossed, various percentages of the average would be deposited into the pool. After extensive discussion, it was decided that 20 percent of the average was appropriate, initially, and the percentage could increase over time. In cases where productivity was greater than the 90th percentile of the three-survey average, 40 percent of production beyond the 90th percentile would go into the pool. At the end of each year, the pool total would be equally divided and distributed among all pool contributors.

The committee anticipated that the incentive pool model would also facilitate and expedite the achievement of several other practice plan goals: medical oncologist sub-specialization because the pool would allow internal patient referrals to members with different subspecialty expertise without concern for significant loss of revenue; reduction of the "eat what you kill" mentality; growth of patient caseloads for physician recruits through new patient transfers; support for physicians practicing in less desirable or less active markets; and physician encouragement to attain threshold earnings.

Promoting Physician Citizenship

Medical oncology leadership also reflected on plan components that would promote physician engagement in service line program and healthcare system initiatives. They proposed a set of five citizenship criteria to gain physician collaboration and commitment in areas that would benefit both the program and the system:

- Criterion 1. The option to 1) enter at least 70 percent of new patients into multidisciplinary disease-specific clinics or conferences, ClinicalPath, or Study Share (a McKesson product for conference presentation) or 2) arrange a consult between the patient and a physician with the appropriate primary or secondary subspecialty concentration either in person or at a disease-specific conference.
- Criterion 2. Achieve a minimum of 24 hours of documented participation in multidisciplinary care conferences per year.
- Criterion 3. Documented attendance for at least 50 percent of the disease-specific conferences that the physician chose as their primary or secondary subspecialty.
- Criterion 4. Reach a minimum total of 300 patients who have been considered for inclusion in a National Cancer Institute-approved clinical trial and referred to the clinical trials group for screening.
- Criterion 5. Pursue other citizenship activities approved by medical oncology leadership as eligible for payment per instance, subject to overall cap. Qualifying citizenship activities include publications, speaking engagements, membership on national organization committees or presentations at national meetings, and participation in a quality of care review committee or an approved strategic program development team.

Service line leadership decided that 5 percent of the mean three-survey average salary could be used to compensate those who met citizenship criteria 1 through 4, and 2.5 percent of the median survey average could be used to compensate those who met criteria 5. The plan was designed to allow a change in the criteria and percentages on a yearly basis, with approval of the medical group compensation committee. In addition, physicians were also paid an hourly rate for attending conferences, which took time away from RVU production, and multidisciplinary disease-specific clinics, previously perceived in the system to be an inefficient use of time.

Adopting the New Plan and Ensuring Fair Compensation

After numerous meetings and discussions, all medical oncologists agreed to move to the new practice plan, which was instituted on Jan. 1, 2016. Due to the inconsistencies among existing legacy practice plans, the committee realized that it needed to address compensation discrepancies that would result following the initiation of the new plan (i.e., some oncologists' incomes would increase while others decreased). Therefore, the committee decided to offer a three-year period of protection for physicians whose income fell by a measurable amount. Of the medical oncologists who were employed on Jan. 1, 2016, twenty-eight physicians (78 percent) earned incomes that remained neutral or increased following implementation of the new plan's elements. For the eight physicians (22 percent) whose incomes declined, they received a "bonus" of 75 percent of their overall loss in income at the end of the first year, 50 percent "bonus" at the end of the second year, and 25 percent "bonus" at the end of the third year. The payment protection plan stopped beyond three years.

The practice plan, as outlined above, is now in its fifth year of function. Standardization of RVUs, the 15 percent increase in compensation (as a replacement for chemotherapy added income) for working in hospital-based clinics, and rewarding physicians for non-RVU generating activities all contributed to the achievement of practice plan goals. Moreover, physician engagement in the citizenship initiatives not only benefitted the patients, program, and ultimately the healthcare system but also led to modification of behaviors and greater physician satisfaction overall.

Long-Term Benefits: Compensation Equivalence and Physician Citizenship Improvements

Compensation adjustments were tracked for those physicians who were employed when the new practice plan was adopted. By the fourth year following adoption, 46 percent of the physicians experienced an increase in compensation, 42 percent encountered a decrease greater than 1 percent, 4 percent had a decrease that was less than 1 percent, and 8 percent experienced other changes related to their position since year one, such as taking on percentages of their position assigned to salaried status.

Adjustments were also made for individuals who held less than a 1.0 full-time equivalent status. For these physicians, the RVU requirement was prorated to allow them to join the incentive pool, and at the end of the year they received the appropriate percentage of a full pool participant payment. However, if part-time physicians generated over 3,500 RVUs, they received the full pool payment.

Physician qualification of citizenship criteria improved following plan adoption and remained consistent. In 2018, 100 percent of physicians met criteria 1 and 4, 36 physicians (92 percent) met criteria 2 and 3, and 17 physicians (44 percent) participated in criteria 5, with 4 physicians (24 percent) of those physicians receiving the maximum dollars allowed. Today, the oncology service line enjoys the highest physician engagement scores of all 10 service lines represented within the medical group.

Once consistency of the new patterns of behavior was demonstrated over a three-year period, the citizenship criteria were modified, with the approval of the medical group compensation committee. In 2019, the criteria were changed to further improve desired behaviors and physician engagement.

- Criterion 1 now requires 80 percent (up from 70 percent) of new patients to receive a multidisciplinary evaluation through multidisciplinary disease-specific clinics or conferences, ClinicalPath, or Study Share.
- Criterion 2 raised the minimum attendance at multidisciplinary care conferences from 24 to 36 hours per year, with at least 50 percent in the physician's primary subspecialty interest.
- Criterion 3 increased physician engagement 10 percent by requiring in-person attendance at a minimum of 3 of the 5 system medical oncology meetings.
- Criterion 4 was modified to align with our medical oncology group's Quality Oncology Practice Initiative certification and improve one of the Quality Oncology Practice Initiative quality measures where scores were below what was expected. To increase compliance, 75 percent of patients must have an oral chemotherapy written plan for ongoing and regimen-specific assessment of each patient's adherence and toxicity at each clinical visit. This replaced the previous initiative to increase clinical trial participation, which had increased by more than 400 percent following implementation of the new practice plan and introduction of ClinicalPath.
- Criterion 5 remained the same, with eligibility for payment per instance of other citizenship activities, such as publications, speaking engagements, and participation in a quality of care review committee or an approved strategic program development team.

Growing the Multidisciplinary Conference and Clinic Program

One of the committee's original concerns involved potential abuse of attendance at multidisciplinary conferences and clinics. However, this proved not to be the case. Hours of participation in conferences during the first three years were 2,333; 2,245.5; and 2,533 hours, respectively. Participation in multidisciplinary clinics from 2016 to 2018 was 786.5; 1,537.5; and 1,339.75 hours, respectively. This overall rise was expected as the number of disease-specific multidisciplinary clinics increased and the greater number of patients seen in these clinics became consistent over time. As a direct result of the new practice plan, the multidisciplinary clinic program saw substantial growth. In addition to the benefits for our patients, it enabled adequate billing for individual physicians, which has eliminated the need to provide physicians with an hourly stipend beginning in 2021. The service line now provides 14 weekly disease-specific, systemwide multidisciplinary videoconferences where all new and complex patient cases are presented.

Practice Plan Demonstrates Financial Viability

The expense of the new practice compensation plan was compared to service line leadership projections for the first three years post-adoption and is shown in Figure 1, right. The expenditures ran within a 2.1 percent variance of projections every year, proving the plan's financial viability. When considering the benefits to patients, physicians, the oncology program, and the healthcare system that resulted from implementation, the new practice plan also demonstrated its cost-effectiveness.

A practice plan model is described that was instituted for an employed medical oncology group across a geographically expansive network. This model could be employed in other disciplines as well. It is important to define the goals that the plan aims to achieve and, if appropriately managed, can be accepted by a diverse group of providers and used to stabilize expenditures, enhance engagement, and maintain acceptable costs. The model also successfully modified behavior to meet the needs and enhance the reputation of the practice and the system in general. OI

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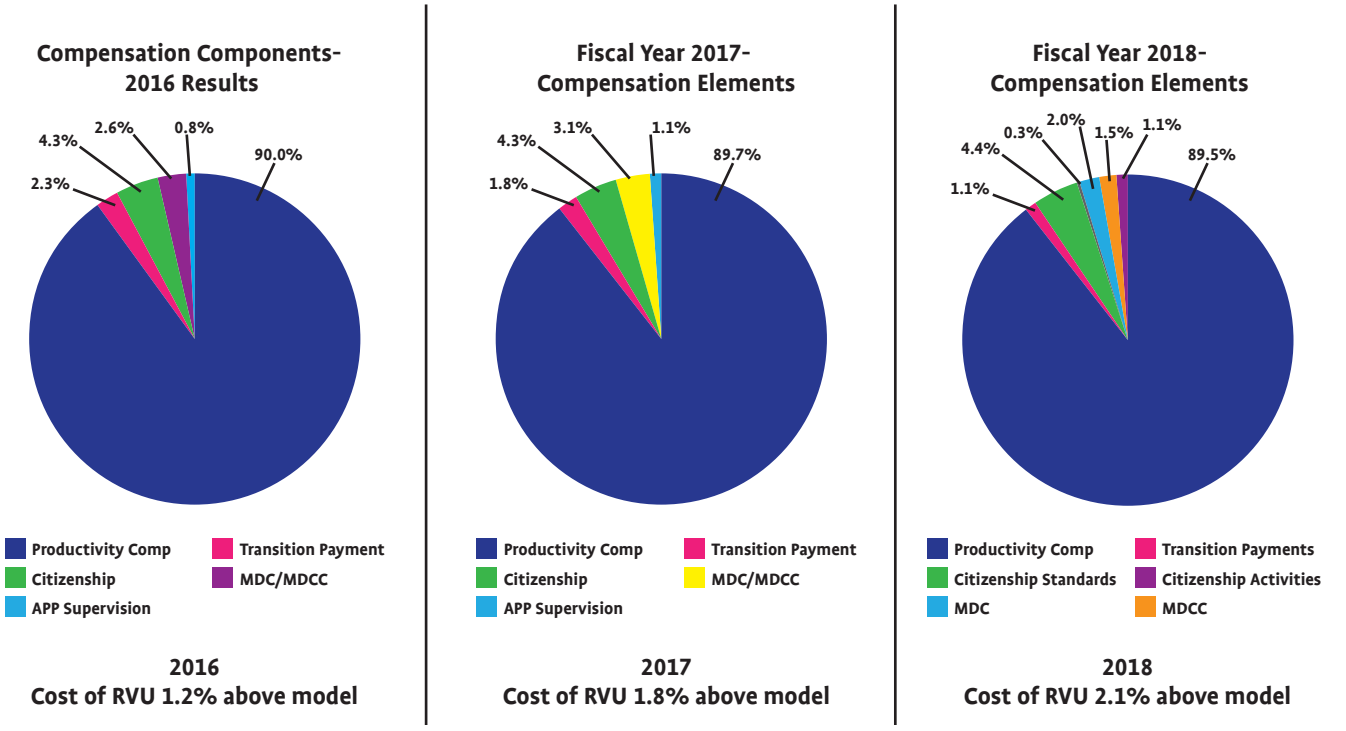
Figure 1. Financial Accomplishments of the Practice Plan



The distribution of total dollars paid to physician participants in the medical oncology practice plan over the first 3 years. Colors represent different areas of expenditures. APP = advanced practice providers, including nurse practitioners and physician assistants; MDC = multidisciplinary clinics, MDCC = multidisciplinary care conferences

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