

Compensation in the Cardiovascular Practice in 2020

Recent MedAxiom reports offer insights on compensation trends for cardiovascular providers and advanced practice providers, as well as an early look at how COVID-19 impacted practices.

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As the annual MedAxiom membership survey wrapped this past spring, the United States and the world were thrust into a public health emergency. Like many industries, the COVID-19 pandemic altered the course of cardiovascular medicine for the foreseeable future. Changes occurred in quick succession and affected how cardiovascular health care is provided in unpredictable ways. At MedAxiom, keeping physicians and providers informed on these developments and how to respond became our top priority alongside the overall safety of our patients. The role of data may be more important than ever as we continue to wade through the COVID-19 environment and make informed decisions that will impact all aspects of the care continuum.

During the beginning of the COVID-19 pandemic, MedAxiom released three reports: the "Cardiovascular Provider Compensation and Production Survey Report," the "Cardiovascular Advanced Practice Provider Compensation and Utilization Report," and the "COVID-19 Cardiology Impact Preliminary Report." This article provides a summary of these reports to provide valuable insights into current and future trends in cardiovascular care delivery.

CARDIOVASCULAR PROVIDER COMPENSATION AND PRODUCTION SURVEY REPORT

This report revealed trends in compensation for cardiology, surgery, and advanced practice providers (APPs). The insights in this year's report are crucial for cardiovascular organizations as they face a new normal and reevaluate compensation models and the

definition of work productivity. The results included responses from 168 groups, representing 2,363 full-time cardiovascular physicians, 1,458 APPs, and 119 part-time physicians for a total of 3,940 providers.

Survey Demographics

The demographics of this year's report show that the South region once again led in overall participation, comprising 63% of respondents. A review of respondent subspecialty data showed nearly 60% of total private group physicians were interventional, but this subgroup only made up about a third of the total integrated practice population. Half the groups that responded were smaller in size (one to 10 physicians), with professional services agreements representing < 10% of the integrated cohort.

Interventionalist Compensation Continues to Rise

An increase in overall compensation per full-time equivalent (FTE) continued across the board, with electrophysiology (EP; \$678,495) and interventional physicians (\$674,910) leading the way (Figure 1). This year, more programs became integrated with hospitals and health systems; as in previous years, cardiologists in integrated ownership models outearn private physicians in every subspecialty.

Invasive and Interventional Service Volumes

Looking at the breakdown of services, echocardiography is the most popular and nearly all programs offer it (Figure 2). MRI has not penetrated cardiology significantly, and nuclear positron emission tomography has grown but not significantly in the past year, with fewer than one in four

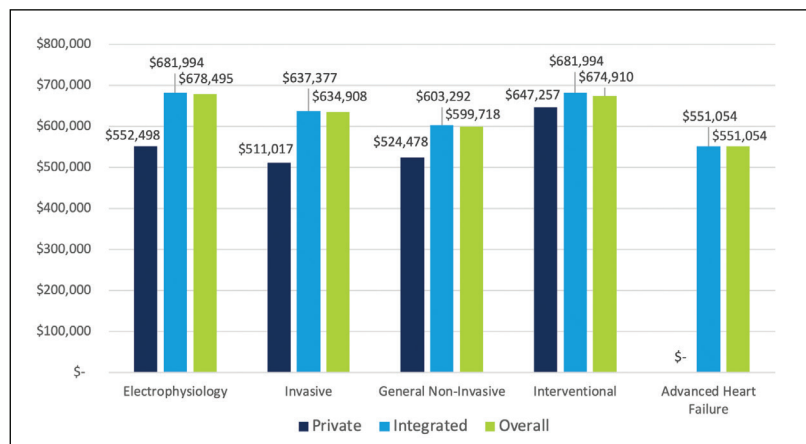


Figure 1. Median total compensation per FTE by subspecialty.

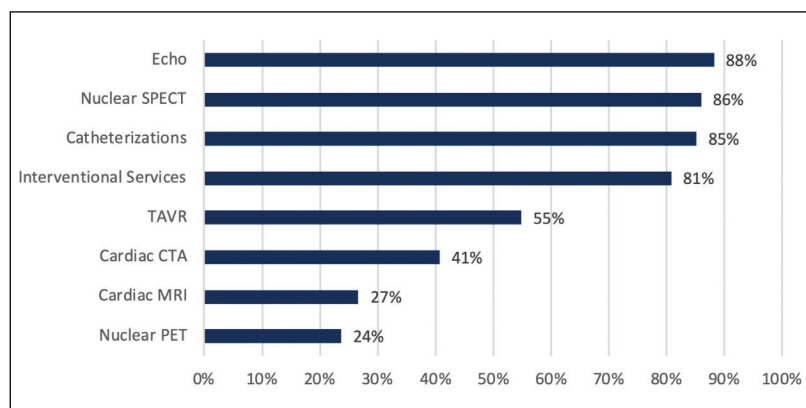


Figure 2. Percentage of programs providing service. PET, positron emission tomography; SPECT, single-photon emission CT.

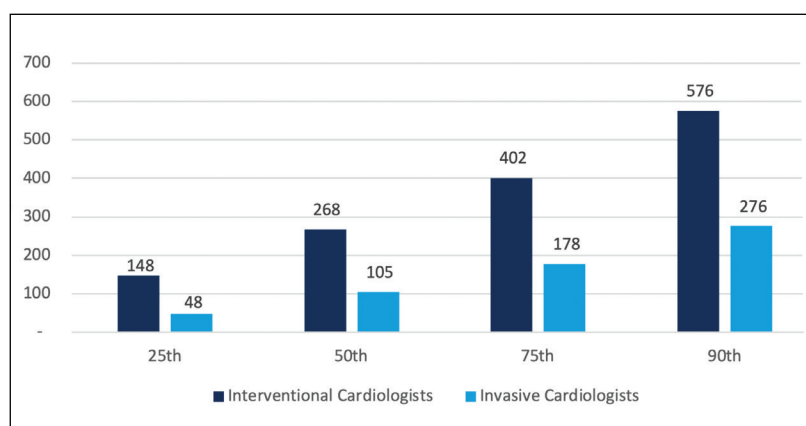


Figure 3. Percentile catheterization lab volumes by operator.

groups offering it. Invasive services are offered by 85% of reporting groups, with slightly less also offering percutaneous coronary intervention (PCI). However, more than half of the groups provide structural heart procedures, using

transcatheter aortic valve replacement (TAVR) as the surrogate measurement.

For invasive services, Figure 3 shows percentile volumes for the two catheterization lab operators: invasive/non-interventional cardiologists and interventional cardiologists. At the median, interventional cardiologists perform about 2.6 times more catheterizations than their invasive cardiologist peers. As noted in the 2019 survey, the prevalence of invasive/noninterventional physicians in contemporary cardiology programs has declined over time. Once representing nearly 30% of the total cardiology population, in 2019 that percentage had fallen to 13.5%.

MedAxiom added two new interventional measures this year: PCI acute myocardial infarction only (AMI); ST-segment elevation myocardial infarction [STEMI]) and PCI chronic total occlusion (CTO) only. Using available data, we were able to create historical trends. These data are helpful as we review other interventional volumes per interventional cardiologist (Figure 4). It is also important to note that of the reporting interventional cardiologists, 56% provide CTO PCI while only 22% provide TAVR.

Cardiologist Production Trends—Supply and Demand Predictions

The median work relative value unit (wRVU) per FTE cardiologist in the private practice setting increased in the past year. The different cardiology subspecialties reported significantly variable levels of wRVU production per FTE. EP was again the leading producing subspecialty with a median wRVU production of 12,731, and interventional was second with a reported median of 11,541 per FTE. Advanced heart failure (HF) physicians reported the lowest wRVU production per FTE

with a median production of 4,554 in 2019. Production has been steadily increasing for these cardiologists each year, up from approximately 3,000 wRVUs per FTE in 2016. Interestingly, HF physician compensation per

wRVU is high compared with other specialties due to factors such as the patient population needing more time per encounter and working more in the office than their subspecialty counterparts.

The panel size per FTE cardiologist is a tried and true measure for active patients and can explain what to expect for demand in the office. The median is around 1,800 per FTE cardiologist. The impact of APPs is growing, and the groups at the top in terms of APP utilization were able to maintain significantly larger active patient panels and generate more new patients. Another strong practice health indicator is the new patient volume that comes through the office that shows a group's accessibility. New patient volumes per FTE were > 2,000 per cardiologist in 2019.

In a recent poll of MedAxiom webinar attendees, nearly 90% said they will be recruiting for cardiology in 2021, which is somewhat surprising given the tumultuous year health care has experienced. The highest subspecialty recruiting was general/noninvasive (69%) followed by interventional (63%). Although this poll represents a small portion of overall cardiologists, it reinforces the fact that we are facing a physician shortage, with many cardiologists getting older and taking on less responsibility. When considering the role of age, these data showed that once physicians reach their 60s, production drops; however, it's common to see cardiologists practicing into their 70s. When call participation is dropped by a physician, there is a near 50% reduction in compensation.

Final Thoughts

Several national physician surveys provide good data for cardiovascular provider compensation and wRVU production. At MedAxiom, we work hard to go beyond providing the numbers and explain what the data mean, digging deep into cardiovascular production irrespective of location—be it hospital, office, ambulatory surgery center, or even at home. Looking ahead, we see virtual care—hardly utilized in cardiovascular medicine before the pandemic—will play a prominent role in our survey beginning in 2021. This is an example of the continual evolution of MedAxiom's survey and rich member data.

CARDIOVASCULAR APP COMPENSATION AND UTILIZATION REPORT

Before the launch of the comprehensive 2020 Cardiovascular Provider Compensation and Production

	25th	50th	75th	90th
PCIs	67	114	117	267
PCI AMI Only	9	17	28	44
PCI CTO Only	1	3	7	13
TAVR	17	33	54	90

Figure 4. Interventional services per FTE interventional cardiologist.

Survey, MedAxiom released an inaugural report focused on APP compensation and utilization. This report has been a welcome publication as the industry continues to realize the importance of APPs within the team-based care model.

APPs have worked in cardiovascular medicine for many years, yet basic questions around optimal staffing ratios, workhours, workload, compensation, benefits, and typical roles and responsibilities continue to be common among programs. The power of the MedAxiom community came together to answer these questions, with 50 programs providing information on their team-based care models. Although this survey was conducted before the COVID-19 outbreak in the United States, it provides great insights as team-based models continue to evolve.

APP Staffing and Workload Norms

The median APP FTE per physician has slowly increased over the last 5 years, which is a great sign of the adoption of the team-based care model. The median APP FTE to physician ratio is approximately 0.5; in other words, at the median, for every one FTE cardiologist there is a half FTE APP. Data from the compensation and production survey showed groups in the top quartile for their deployment of APPs per cardiologist were able to maintain significantly larger (22%) patient panel sizes than the database as a whole. However, the clinical need of the program must dictate the right ratio for individual programs. Areas such as access, top of license roles and responsibilities, and the ability to meet the clinical needs of the patient population should be the primary drivers of the correct ratio for each program. Work expectations also play a role, and the survey found that most APPs are exempt employees and work between 40 and 45 hours per week to be considered full-time. Call responsibilities were noted by 48% of programs, with half of those taking call responsibilities from home.

APP Roles and Responsibilities

APPs who work in the clinic reported that their primary responsibility is face-to-face patient visits, with 40% noting an average patient load of 14 to 16 patients

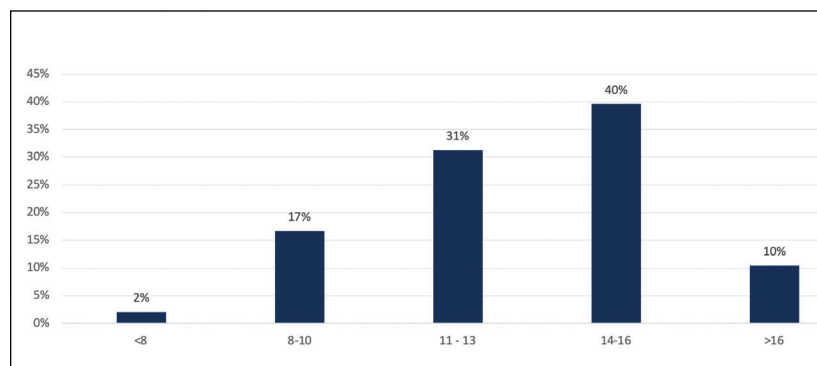


Figure 5. The typical number of patients APP schedule allows per full day.

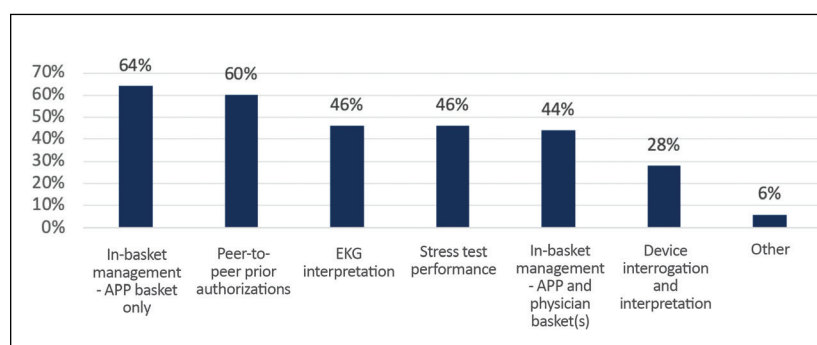


Figure 6. APP responsibilities in the clinic. EKG, electrocardiogram.

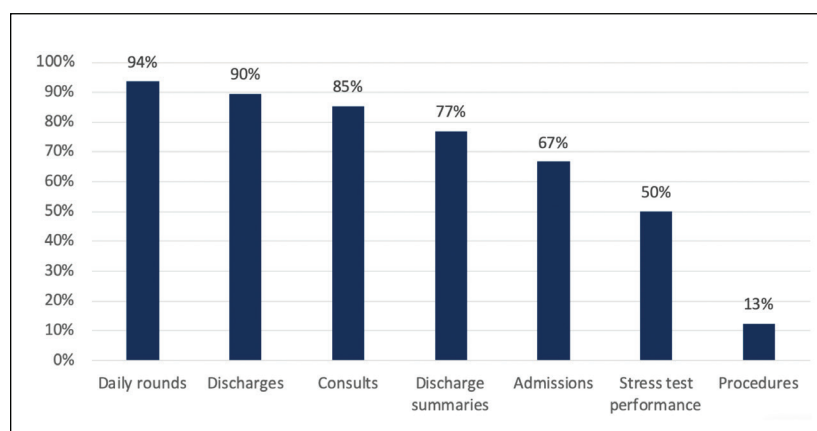


Figure 7. Types of hospital services APPs are involved in.

per day (Figure 5). All programs noted posthospital follow-ups as a typical patient type while most programs included routine follow-up, postprocedure follow-up, urgent patient visits, and device clinic patients on the list. Almost all programs noted that their APPs perform independent visits in the clinic. Specialty clinic patients and new patients were less common. Of those who see patients in specialty clinics, HF was by far the most common at 52%. Additional responsibilities in the clinic

included in-basket management, peer-to-peer prior authorizations, electrocardiogram interpretations, and stress test performance. Most programs note that support for the APPs included medical assistant support for rooming patients and registered nurse support for patient calls (Figure 6).

Hospital care is another common role for cardiovascular APPs, with 98% of programs noting that their APPs provide acute care services. Types of responsibilities included daily rounds, discharges, consults, discharge summaries, admissions, and stress test performance (Figure 7). APPs performed procedures in only 13% of the programs that responded to the survey. Shift length in the hospital was noted to be 8 hours by 72%, 10 hours by 26%, and 12 hours by 2% of the programs. Weekend responsibilities were common, with 46% noting one out of five weekend requirements and only 15% noting no weekend responsibilities.

Final Thoughts

The team-based care model is important for effective patient care delivery in cardiovascular programs. Historically, the cardiovascular industry has not been great at effectively utilizing this valuable part of the team. Top of license utilization, performance management, organizational structure, and appropriate roles and responsibilities all need to be aligned for a high-performing team. This survey highlights several best practices that include an

expanded APP workforce in cardiology with primary responsibilities focusing on direct patient interaction in a shared-care model with a degree of autonomy to provide independent visits. In the era of COVID-19, the utilization of this valuable team member is even more important both clinically and financially. It is important to assure that the clinical workforce and care delivery models are optimized. Due to the pandemic, many programs introduced telehealth and virtual services for

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which APPs can play a significant role. Outside of the physician workforce, APPs are the most expensive member of the cardiovascular team. Therefore, optimizing their role to assure top of license responsibilities that drive patient access, quality outcomes, and program growth is imperative.

COVID-19 CARDIOLOGY IMPACT PRELIMINARY REPORT

No matter the capacity in which you interact with health care, we have all been affected by COVID-19. From providers to patients and caregivers, everyone has had to make decisions based on accessibility, safety, and need. Those decisions are sometimes due to the elective nature of a procedure, but in some cases, the inherent implications faced after a procedure caused some to be put on hold or not done at all. With cardiovascular issues, waiting to be seen can cause the disease to worsen, with some interventional treatments no longer able to be performed. It is important to track changes resulting from COVID-19 and how programs are recovering. As such, we surveyed our membership on the preliminary impact of COVID-19 on cardiovascular programs. The data reported are through May and another survey is currently underway.

Production, Revenue Declined Rapidly

There was a steep drop in production (44% decline in wRVUs from January to April 2020) and then a gradual recovery that translates into a challenging economic period. Recovery will take some time, especially for hospitals as they navigate COVID-19 patient care and patients who may be avoiding hospitals due to the pandemic.

The good news is that we are not hearing about a lot of major changes due to the financial strain in the last few months, but the full economic toll will be slow to come. We saw a decline in outpatient procedures for echocardiography but a slower falling-off for inpatient services. Here is where we can see the lasting revenue hangover on the financial side.

As we look at testing relative to our interventional subspecialty, we see that catheterizations saw a significant reduction and were still not back on track as of May. MedAxiom members did not see as significant of a decline for PCI-AMI (STEMI) from March to May as other procedures. PCI-CTO is more elective and the data showed a decline. Finally, ablations had steep declines early but started bouncing back in May.

Virtual Care in the Spotlight

The switch to virtual care happened very quickly and many members wonder if it's here to stay. The data showed that new telehealth patients spiked in April but started going back down in May. Most programs are predicting that we will not return to pre-COVID-19 telehealth levels, which were dismal. The question is how programs approached virtual care during the pandemic. Did they use it as a tool solely to continue seeing patients through the early days of the public health crisis or did they take a proactive approach and implement a long-term telehealth strategy?

Final Thoughts

MedAxiom continues to survey the cardiovascular community to track trends and gain insights into the effects of the pandemic on practices, hospitals, and most importantly, patients. The data are also used for advocacy efforts to ensure that telehealth regulations are revisited to allow for expanded use. Practice managers and health systems alike are reexamining their approach to team-based care and the expansion of care delivery into the ambulatory setting. In this climate, reliable and comprehensive data that go deep into the cardiovascular program are critical. ■

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