Pediatr Radiol (2017) 47:798–802
DOI 10.1007/s00247-017-3824-y

An honest day's work: pay for performance in a pediatric radiology department

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Received: 19 December 2016 / Revised: 22 January 2017 / Accepted: 1 March 2017 / Published online: 7 June 2017

Abstract Compensation models in radiology take a variety of forms, but regardless of practice type, successful models must reward productivity, be simple, and epitomize fairness. The ideal model should also be flexible enough to transition, based upon the changing strategic goals of a department. The plan should be constructed around rewarding the behaviors that the organization values. In this minisymposium article the author presents the value of different types of compensation plans and discusses advantages and disadvantages. Finally, the author presents a pay-for-performance model that has had long-term success at a private-turned-academic practice in pediatric radiology.

Keywords Children · Compensation · Incentive · Metric · Pay for performance · Pediatric radiology

Introduction

In an article in the *Journal of the American College of Radiology*, Rich Duszak said, "Attempts to measure productivity, reward or punish outliers, and develop fair and equitable practice policies can, at times, be more divisive than the underlying productivity differences themselves" [1]. His comments highlight the challenge in constructing effective compensation plans.

When it comes to compensation in radiology, if you've seen one plan, you've seen one plan. Almost every attempt to fairly compensate is a "one-off," with distinctive features relating to base salary, call pay and incentive plans, for example. While we should acknowledge the benefits of personal job satisfaction, respect and appreciation, in the end we all want to be paid for what we feel we are worth for an honest day's work. Although this is a universal sentiment, we have found it useful to clearly specify the value of various activities, to better equate one's subjective feeling of worth with actual compensation. It is to this end that I present and try to justify a flexible, transparent remuneration plan that is linked to productivity. Prior to this detailed analysis, it is worth acknowledging that future physician compensation plans are likely to be divorced from sheer volume of care and instead be associated with evidence-based quality measures and a reduction in medical errors. We will evolve from the present concept of "the more care we provide, the more money we will make." As we transition from fee-for-service to value-based care [2], some of what I share here will become passé.

The bottom line is that if we follow the Golden Rule of Compensation, we should incentivize the behaviors that we, as leaders, desire. To this end, we should focus on goals. In the academic setting we must support the clinical mission, recruit and retain top-quality radiologists, promote research, ensure quality in teaching and encourage departmentally directed improvements [3].

In the private setting the goals are more focused on providing quality clinical work. There are those who would argue in this private-practice setting that straight salary is more appropriate. Arguments I have heard to this effect would include: "It is difficult to measure desired outputs;" "Differences in productivity are related to work procedures, relative value unit (RVU) inequities and organizational issues;" and "People with equal positions and equal hours should be paid equally." But how does one consistently deal with outliers in terms of productivity? In the "carrot vs. stick" analogy, pay for

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performance (P4P) represents the carrot, and peer or managerial pressure the stick approach.

Does P4P encourage competition rather than collaboration? I do believe that competition can come into play if the P4P is too large of a percentage of the total compensation. But the fundamental underpinning for any compensation scheme is that those who accomplish more should receive more compensation [4]. Pay for performance can enhance retention and recruitment. No one wants to join a practice where working harder has no reward. Let's take a closer look at productivity.

Incentives

There are different types of financial incentives; however the major dichotomy is between casual and structured incentives. Casual incentives relate to thanking workers for what they do. It is a form of positive feedback, indicating that the efforts of an individual have been noted. Advantages include cost neutrality and public display of the appreciation, and this type of feedback might have a positive influence on the behavior of others who respond to internal motivation. The major shortcomings of this type of incentive include opacity, risk of envy among workers, and fears of favoritism. Additionally, the individual has little indication as to how to do better the next year.

The structured incentive is based on certain fixed accomplishments. It can fluctuate as performance changes, and should be transparent.

But the critical question here is this: How does one measure performance, particularly in an academic setting? Rules for a structured P4P plan include figuring out ways to transparently measure educational output, research productivity and administrative contributions, while also valuing longevity, commitment to quality and good citizenship. There is also a requirement to establish the percentage of total cash compensation that should be P4P-driven.

In the clinical arena, the P4P plan, regardless of type of practice, needs to be based on work relative value units (wRVUs). While I understand that utilizing an RVU-based P4P scheme could be contentious for some, we need a metric, and if we are to arrive at an efficiency metric for a radiologist, RVUs are the logical yardstick. Measures such as revenues collected and charges for procedures are essentially out of the control of the individual radiologist and should not be used as measures of productivity. In addition, using sheer volume of procedures heavily favors those who interpret conventional radiographs. This being said, there are problems with measuring only wRVUs. There are no RVU differences between simple and complex cases. No RVUs are awarded for consulting or attending conferences. Efforts to enhance the practice are not RVU-based. And from a quality perspective, measuring RVUs could promote effort and not the results of those efforts. An additional risk of rewarding RVU productivity is that this could provoke detrimental competitive behavior, resulting in cherry-picking studies.

In the academic environment, other metrics are needed to account for academic productivity [5]. Again, it is critical to reward what your organization values, and to do so in a transparent, quantifiable fashion [6].

Blended model

Most leaders in radiology believe that some combination of flat salary plus a productivity-based pay metric represents the best compensation model, balancing clinical and non-clinical demands. At the same time, if attempts are made to benchmark every behavior there is a risk of the compensation plan being too complex. Simplicity is critical for easy comprehension of what the plan is designed to accomplish and for execution of the plan. This might mean not rewarding certain desired behaviors that are essential to administrating a high-quality practice. Some of these behaviors might simply be expectations of the position (e.g., consulting with clinicians, attending tumor board, taking call).

If one is committed to the blended model with salary plus P4P, a decision must be made as to what percentage of total compensation is performance-based. This percentage is variable, generally comprising between 15% and 50% of total compensation. From the radiologist's perspective, increased compensation has to be worth the extra work, and this is achieved by striking the right balance in the percentage of the compensation that is tied to the productivity portion. There is a critical amount of incentive that must be at risk in order to change behaviors, and in my opinion it's probably at least 15%. That being said, there are those who would not respond positively to even higher percentages of performance-based compensation. This is the reason that I generally refer to these "additives" as P4P rather than incentives. They DO reward performance, whether or not they serve to incentivize behavior.

The Texas Children's Hospital model

The fundamental concept of a P4P plan is to devise a program that appropriately rewards behavior expected as part of the core clinical service, and then take the plan a step further to provide payment for going above and beyond expectations. At Texas Children's Hospital (TCH) we have formulated a simple point-based system. At the start of each fiscal year we start a new slate. The 19-point program links points to dollars. In the budgeting process, dollars are set aside at the beginning of the year to distribute at the end of the year. The program rewards clinical productivity, academic productivity, teaching performance, administrative skills, longevity and citizenship, and more recently we have added quality metrics.

The base salary starts in Year 1 with a fixed amount that is tied to years of post-fellowship work. Newly minted pediatric radiologists who are fresh out of fellowship would start at this minimum base. Each year for the first 6 years, they receive a small yearly increase in salary. After 6 years there is no subsequent change in base salary. If an individual starts with 6 years of experience elsewhere, he or she starts at the maximum base salary. Some programs might choose to link this base salary to academic rank, but we have not done so. It is essential to make this baseline salary adequate and fair.

In addition to this base salary, any radiologist who has been on the faculty for at least 9 months can participate in the P4P plan. The point-based system allocates a dollar value for each point, regardless of how the point is earned. The point value can be established based upon budgetary considerations.

The largest component of the P4P plan revolves around clinical productivity. This is a scalable system based on productivity benchmark data that are collected each year and based on wRVUs. These data can come from SCORCH (Society of Chairs of Radiology at Children's Hospitals), SCARD (Society of Chairs of Academic Radiology Departments), Sullivan and Cotter, AAARAD (Association of Administrators in Academic Radiology), MGMA (Medical Group Management Association) or any other reputable auditing group focused on radiology procedures. At TCH an individual is allocated 6 points for reaching the 90th percentile of the SCORCH productivity data. The point score is then calculated as a percentage of that 90th percentile. For example, if the 90th percentile is 8,000 wRVUs and an individual performed 6,000 wRVUs, they would receive 6,000/8,000 of 6 points, equaling 4.5 points. Every individual is placed on this scale and assigned a point value. While all radiologists have assigned worklists, which change daily, there are an abundance of conventional radiographs that everyone has access to for additional wRVUs.

The second largest component, which can be adjusted according to the needs of the department, relates to academic productivity. There is a 4-point maximum, allocated depending upon manuscript production, abstract presentations and participation in national committees. The current scale awards 0.4 points for being the first author on a peer-reviewed publication (or second author if a trainee is the first author) and 0.2 points for other authorships. We have not based this score on impact factor because of our commitment to ensure that the submissions are matched to appropriate journals. However one could consider impact factor as an additional modifier to recognize the quality of a particular publication. For case reports, chapters and review articles, only the first author is awarded, at 0.1 points. This could also be changed based upon departmental priorities. Scientific abstract presenters are awarded 0.1 point for being the first author (or second author after a trainee). The remaining authors get no credit until a publication is generated from the abstract, at which point the publication scoring prevails. National committee work generates 0.1 points per committee. One can note from this description that there are no monetary awards for successful grants, a marker for academic excellence. Successful grant-awardees buy time with their grant funding, and that time is their reward for their efforts. Invited lectures, moderatorships and visiting professorships are not financially rewarded. This does not indicate that they are not valued, just that these tasks bring inherent rewards in terms of reputational recognition.

The third component of the P4P system focuses on teaching skills. Every faculty member undergoes resident (annually) and fellow (semiannually) evaluations through a survey instrument. The faculty members are scored on a 0–4 scale with regard to teaching at the viewbox and lecturing. This final score is divided in half to arrive at a score on a 2-point scale because the maximum number of available points is 2.

The fourth component of the P4P system awards administrative skills. This is the most subjective component of the scoring system. All division chiefs and the program director undergo end-of-the-year evaluation by a group of leaders in the department, including the radiologist-in-chief, the associate radiologist-in-chief, the director of radiology, the practice administrator, and the executive vice president over radiology services. A 2-point scale is used and the faculty members are evaluated independently. Subsequently, each individual is discussed and a composite score is created. This has been useful in that most aspects of each leader's skills in dealing with subordinates, peers and directors are assessed.

Longevity is also rewarded, serving as a retention tool. Each faculty member is given 0.05 points per year of service to our hospital. Although this category has a maximum of 2 points, we don't expect many to reach this maximum because it would take 40 years. We have purposefully kept this reward value small because any leader understands that longevity can be a double-edge sword.

Finally, we have a reward for citizenship. This reward is a bit discretionary but permits the chief to recognize behaviors that were above and beyond the traditional work responsibilities. One must be cautious with this reward, however, because it sets a precedent. We have offered portions of a point for such things as creating all of the departmental structured reporting templates or overseeing all of the departmental scheduling. In addition, serving on an institutional review board has been recognized as worthy of a small reward. These should be announced to the entire faculty, so that there are no concerns about favoritism.

This year we have added one component to our P4P plan — quality. A single point has been evenly distributed between report turnaround times (0.5 points) and use of standardized reports (0.5 points). If the radiologist has >95% of reports signed within 6 h and is using >95% standardized reports, this individual will reap a 0.5 point reward for each task, creating a full additional point if both goals are met. Quality initiatives

will likely change from year to year as benchmarks are achieved. While measurement of report turnaround times will likely remain for years, the use of standardized reports, once fully adopted, will disappear from this list.

In our system, call is distributed evenly, so no premiums are given for call hours. In addition, we have not included premiums for different subspecialties because I have not seen significant discrepancies in productivity among our pediatric neuroradiologists, interventional radiologists and body radiologists. If there are significant discrepancies, which tend to occur in most adult-oriented departments, the wRVU benchmarks might be established at different levels, or points might be distributed according to how individuals do within their division (half the 6-point wRVU award) and how individuals do within their department (the other half of the reward). Another consideration might be to reward divisions, in addition to individuals. This might incentivize teamwork, but to date we have not implemented this as part of the P4P plan.

Finally, because there are frequently new faculty additions to departments, and because even with simple P4P programs people forget the details, it is essential to present the components of the plan every year. This refreshes those who already understand it and initiates the new members. In addition, this faculty meeting time slot can be used to announce any minor modifications to the plan and to deal with questions.

The argument against pay for performance

Not everyone agrees with the arguments for a pay-for-performance plan. In his book titled *Drive*, Daniel Pink [7] talks about the joy of performing a task being its own reward. Pink presents convincing evidence that tools designed to increase motivation can actually have the opposite effect. It is difficult to argue with overwhelming proof that if one is engaged in heuristic thinking, focusing only on the reward might narrow our focus and stifle creativity. However in our P4P plan only a small portion of the plan is focused on creativity. Rather, we are trying to motivate behavior to perform routine tasks. This should not minimize the importance of correctly interpreting a chest radiograph, a bone age or a radiograph to measure the degree of scoliosis. But for most pediatric radiologists the approach to many of these studies is a mental checklist process, which does not entail significant creativity. When it comes to tasks that do not require deep thinking, rewards can enhance performance [8].

In addition, people's reaction to money is highly idiosyncratic. In our current times, when everything can be personalized to fit our needs, it may be asynchronous to think that a single compensation plan works for every person. There are considerable individual differences in people's tendency to think about money. People value money for different reasons — not just as a source of currency but because of what it confers to that person (power, freedom or security). There are some, who Pink characterizes as Type X, who respond positively to these external motivators [7]. And there are Type I people who are more responsive to internal motivation. Most departments have a mix of these types of people, underscoring the importance of finding out what makes people tick. Both positive reinforcement as well as external rewards might have a positive effect, depending upon the individual being rewarded.

Advantages of the Texas Children's Hospital plan

(1) It is relatively simple and transparent. If an individual desires more compensation, that person can "pick from the menu."
(2) It is an effective recruitment and retention tool.
(3) It rewards teaching and academic endeavors.
(4) It recognizes administrative excellence.

Disadvantages of the Texas Children's Hospital plan

(1) It promotes effort and not quality effect.
(2) It might provoke competitive behavior.
(3) It does not reward all of the non-interpretive functions (e.g., consulting, conferences).
(4) It might undermine teamwork.

Future enhancements

Perhaps part of the beauty of the TCH plan is that it can be tuned from year to year depending upon departmental needs. As we transition to more quality metrics we can incorporate these into our point system. Patient and referring physician evaluations of us, as radiologists, are likely to play an increasing role in the P4P plan. In addition, this plan can redistribute points depending upon areas with deficiencies. If clinical productivity is lacking, points can be added or moved to the clinical bucket. If academic productivity is weak, one can move points from an area that is over-performing to the academic bucket. However it is critical to establish the rules before the fiscal year begins. It is unreasonable to explain the justification for changes to the scoring system in hindsight.

Summary

Creating a comprehensive compensation plan for a pediatric radiology department is a difficult task. Deviating from a

formulaic, transparent plan can result in unintended consequences. An effective plan must balance flexibility with concerns for patient care, education, research and administration. The plan must also be relevant and consistent. Each plan must be data-driven, with subtle minor exceptions. And it is essential to keep the plan relatively simple. Clare Boothe Luce [9] believed that "the height of sophistication is simplicity." Compensation plans tend to be inherently complex to begin with, but if you wander too far outside the box when it comes to complexity, people miss the message.

One could find fault with many of the metrics described in this manuscript. Arguments could be made that the system is too heavily weighted toward academic productivity (which is non-revenue-producing), or that teaching is not weighted sufficiently, or that consulting with clinicians is not rewarded. But the beauty of this P4P system is that it can be modified according to what the individual institution needs, simply by adjusting some of the variables. We have used this P4P system for 7 years and have found it to be a fair remuneration model.

Compliance with ethical standards

Conflicts of interest None

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