Special Article

Activities and Compensation of Advanced Heart Failure Specialists: Results of the Heart Failure Society of America (HFSA) Survey

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ABSTRACT

Background: In the current era, where advanced heart failure (AHF) has become an American Board of Internal Medicine−certified subspecialty, new data are needed to benchmark and value levels of clinical effort performed by AHF specialists (AHFMDs).

Methods and Results: A 36-question survey was sent to 728 AHFMDs, members of the Heart Failure Society of America, and 224 (31%) responded. Overall, 56% worked in academic medical centers (AMCs) and were younger (48 ± 9 y vs 52 ± 10 y; $P < .01$) and were represented by a higher proportion of women (34% vs 21%, $P < .01$) compared with non-AMCs. The percentage of time in clinical care was lower in AMCs (64 ± 19% vs 78 ± 18%; $P = .002$), with similar concentration on evaluation and management services (79 ± 18% in AMCs vs 72 ± 18 % in non-AMCs; P = NS). The majority of nonclinical time was spent in program administration (10% in both AMCs and non-AMCs) and education/research (15% in AMC vs 5% in non-AMCs). Although 69% of respondents were compensated by work-relative value units (wRVUs), only a small percentage knew their target or the amount of RVUs generated. The mean annual wRVUs generated were lower in AMCs compared to non-AMCs (5,452 ± 1,961 vs 9,071 ± 3,484; $P < .001$). The annual compensation in AMCs was lower than in non-AMCs (45% vs 10% <$250,000 and 17% vs 61% >$350,000; $P < .001$) and the satisfaction with compensation was higher in non-AMCs.

Conclusions: AHFMDs' compensation is largely dependent by practice type (AMC vs non-AMC) and clinical productivity as measured by wRVUs. These data provide an opportunity for benchmarking work effort and compensation for AHFMDs, allowing distinction from segments of cardiologists with greater opportunity to accrue procedural wRVUs. They also show several differences between AMCs and non-AMCs that should be considered when formulating work assignment and compensation for AHFMDs. (*J Cardiac Fail 2015;21:924−929*)

Key Words: Compensation, relative value units, heart failure specialists, academic medical center.

Heart failure (HF) is a chronic condition with a substantial and growing burden to society, and its management requires increasingly specialized clinical interventions. Attracting and training new cardiologists to specialize in advanced heart failure (AHFMDs) is of paramount importance. Unfortunately, a key determinant of attracting young cardiologists to specialize in HF is the current level of compensation for existing specialists. The first important step in helping to define the appropriate compensation level is to clearly differentiate the AHFMDs from general cardiologists that treat patients with HF. This recognition takes

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See page 929 for disclosure information.

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into account the ability to manage patients requiring advanced therapies such as ventricular assist devices (VADs) and heart transplantation. The American Board of Internal Medicine (ABIM) has approved the certification of specialists in advanced heart failure and transplant cardiology, and the first such examination took place in 2010.[1] There are presently ~800 physicians who have taken and passed the Board examination. Future testing will be carried out biannually starting in 2016.

The changing environment in HF (new ABIM certification, increasing number of VADs implanted for destination therapy, and associated reimbursement) and health care economics (including penalties for HF readmissions, decreasing reimbursement for imaging and some interventional procedures, implementation of accountable care organizations) as well as the increasing numbers of advanced HF programs outside of traditional academic medical centers (AMCs) make it imperative that a current understanding of the activity, productivity, and compensation of AHFMDs takes place for benchmarking purposes.

The purpose of the present study was to characterize the activities of AHFMDs and the methodology used at various institutions (AMCs and non-AMCs) to reflect the work effort and compensation of the AHFMDs, so that AHFMDs receive appropriate compensation for their efforts.

Methods

Under the auspices of the Heart Failure Society of America (HFSA), we conducted a survey of its members who identified as AHFMDs. We developed 2 questionnaires: a comprehensive 36-question survey (Appendix 1) that was sent in late 2012, and a 2nd brief 6-question survey that was sent in late 2013 (Appendix 2). Because most practices were transitioning to a work-relative value units (wRVUs)–based compensation model in 2012–2013, the purpose of the 2nd survey was to capture updated information in that regard. The questionnaires captured detailed data on the physicians' institutions, including services offered, such as cardiac transplantation or VAD implantation. In addition, it queried the activities of AHFMDs regarding the percentages of time allocated to clinical care (including evaluation and management [E&M] services, specialized therapeutic and diagnostic procedures, and other associated procedures, such as imaging), research, education, administrative/program development, and outreach. Finally, it captured comprehensive data on compensation schemes, including wRVUs and salary data. To keep the survey to a reasonable length and because other structured surveys addressed practice and work structure (eg, number of hours worked per week, midlevel providers and nursing support, etc), our survey did not collect that information. The questionnaires were pretested by the members of the HFSA Advocacy Committee before they were distributed to the AHFMDs. The surveys were deployed with the use of the Survey Monkey web-based service, and the HFSA staff administered and tracked the questionnaires and, because the surveys were blinded, sent reminder e-mails to potential respondents.

Results of the surveys were analyzed with descriptive statistics (means or medians for continuous variables and proportions for binary variables) and comparisons were made with the use of *t* tests for continuous variables and chi-square for categoric variables. Regression analysis was used to explore the relationship of clinical productivity, measured by RVUs, with the percentages of clinical effort and E&M services.

Results

Of the 728 questionnaires distributed, 224 (31%) and 174 (24%) were completed and returned for the 1st and 2nd surveys, respectively; only 30 respondents overlapped in the 2 surveys. Fifty-six percent worked at AMCs, and compared with the AHFMDs working at non-AMCs they were younger, included a higher proportion of women, and were more likely to be in practice for <5 years (Table 1). In both practice settings, nearly 80% of respondents were ABIM certified in advanced heart failure and transplantation. More respondents working in AMCs were taking care of both VAD and transplant patients compared with respondents working in non-AMCs (94% vs 86%, respectively; $P < .05$; Table 1).

In general, the distribution of HF patients was similar between AMCs and non-AMCs, but AMCs tended to care for a higher number of VAD and heart transplant patients than non-AMCs (Table 2). Although non-AMCs tended to see higher numbers of new HF patient referrals, AMCs tended to implant a higher number of VADs and perform a higher number of heart transplantations annually than did non-AMCs (Table 2).

The percentage of time AHFMDs allocated to clinical care was lower in AMCs compared with non-AMCs (64 ± 19% vs 78 ± 18%; $P = .002$), whereas the percentage of time spent on education and research was higher at AMCs (Table 3). Table 3 provides a breakdown of the

Table 1. Demographics of Advanced Heart Failure Specialists (n = 224)

	Academic Medical Centers (n = 126)	Nonacademic Medical Centers (n = 98)	*P* Value
Age, y			.035
Mean ± SD	48 ± 9	52 ± 10	
Median (range)	47 (35–70)	51 (36–85)	
Sex (% women)	34	21	.001
ABIM certified (%)	78	80	NS
Time in practice (%), y			<.01
<5	39	23	
6–10	15	18	
>11	46	59	
Type of patients seen (%)			.021
VAD only	6	14	
Transplant and VAD	94	86	
US geographic region (%)			.039
Northeast	29	19	
Southeast	18	20	
Midwest	26	36	
Southwest	8	5	
West	19	20	

ABIM, American Board of Internal Medicine; VAD, ventricular assist device.