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High Performance Physicians:

How to Recognize and Reward Physicians in a Quality Environment

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High Performance Physicians: How to Recognize and Reward Physicians in a Quality Environment

February 16, 2010

HASC Webinar

In Cooperation With

Integrated Healthcare Strategies

www.ihstrategies.com

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Agenda for Webinar

1. Introductions
2. Forces Driving Need for Modern Physician Alignment
3. Physician Leaders Key to Alignment Success: Factors that Frustrate and Facilitate Effective Physician Leaders
4. Physician Leadership Development: Programs of Promise Insights
5. Q & A
6. Physician Leader Pay for Performance: New insights to recognize and reward high performance physicians: base pay, benefits and incentive pay
7. Q and A

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Investing in Physician Leadership Development:

Forces Driving Need for Modern Physician Alignment

12 Signs You Need a Hospital-Physician Alignment Strategy

1. Shortage of primary care physicians.
2. Difficulty recruiting physician specialists.
3. On-call coverage problems in the emergency department.
4. Insufficient engagement of physicians in hospital-wide strategic planning.
5. Insufficient engagement of physicians in managing hospital product and service lines.
6. Insufficient engagement of physicians in hospital programs to improve efficiency, clinical quality, and patient safety.
7. Disconnected silos of currently employed physicians, owned practices, and joint ventures that don't collaborate to manage costs and quality.
8. Hospitals lack options for private practice physicians not interested in employment.
9. Medical staff organization isn't an effective forum for aligning interests.
10. Physicians are unwilling to volunteer for medical staff leadership roles.
11. Inability to respond to market demands for bundled pricing.
12. Inability to create a single hospital-physician "brand."

Barry Bader in "Great Boards"

Alignment Matters

Alignment is means to broader ends.

Many forms of alignment now possible.

New generation of Physician alignment requires new generation of physician leaders.

"Hospital-physician alignment" may be defined as a close working relationship in which a hospital and physicians place a priority on working toward common economic and patient-centered goals, and they each avoid conduct that damages the other.

"Over the next 10-20 years, it is likely that most physicians will be employed by systems, hospitals, or medical groups."

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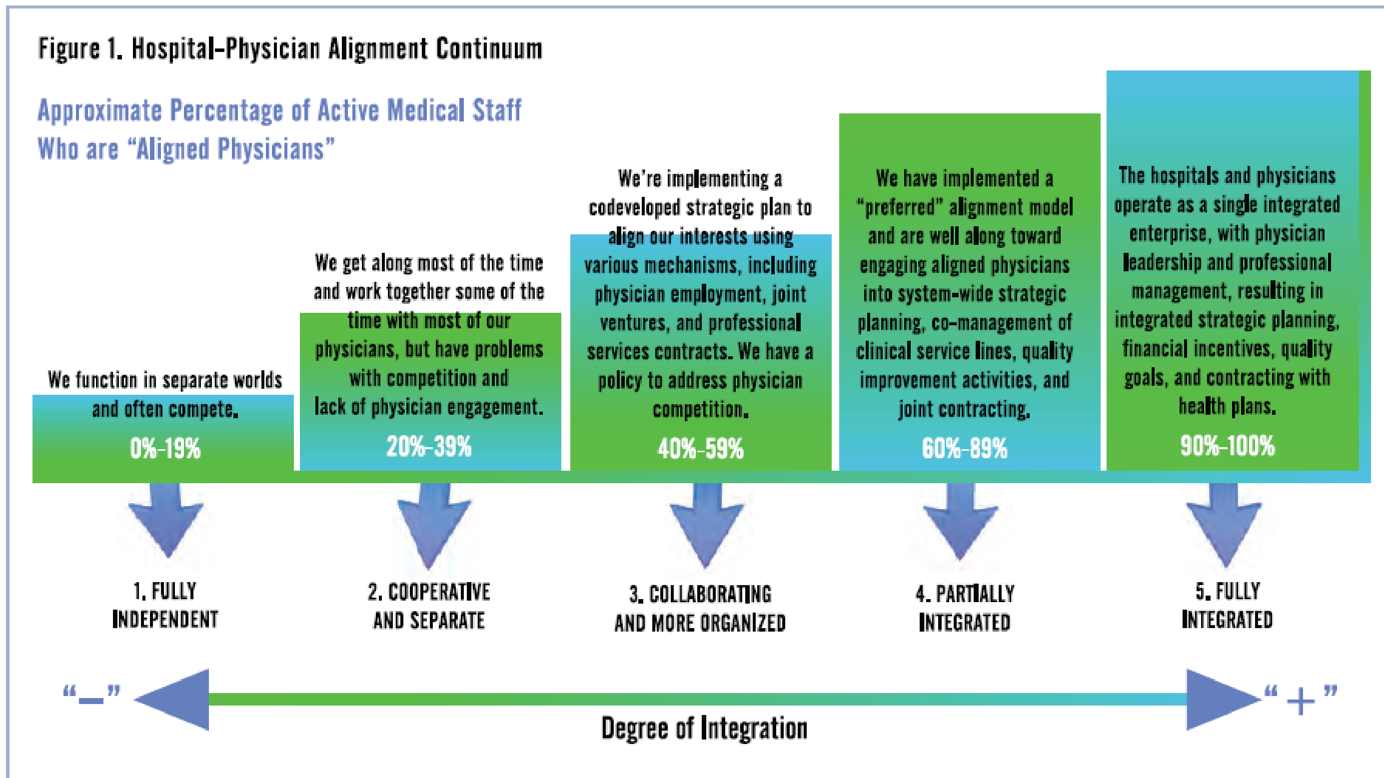
Physician Community Evolving



Barry Bader in "Great Boards"

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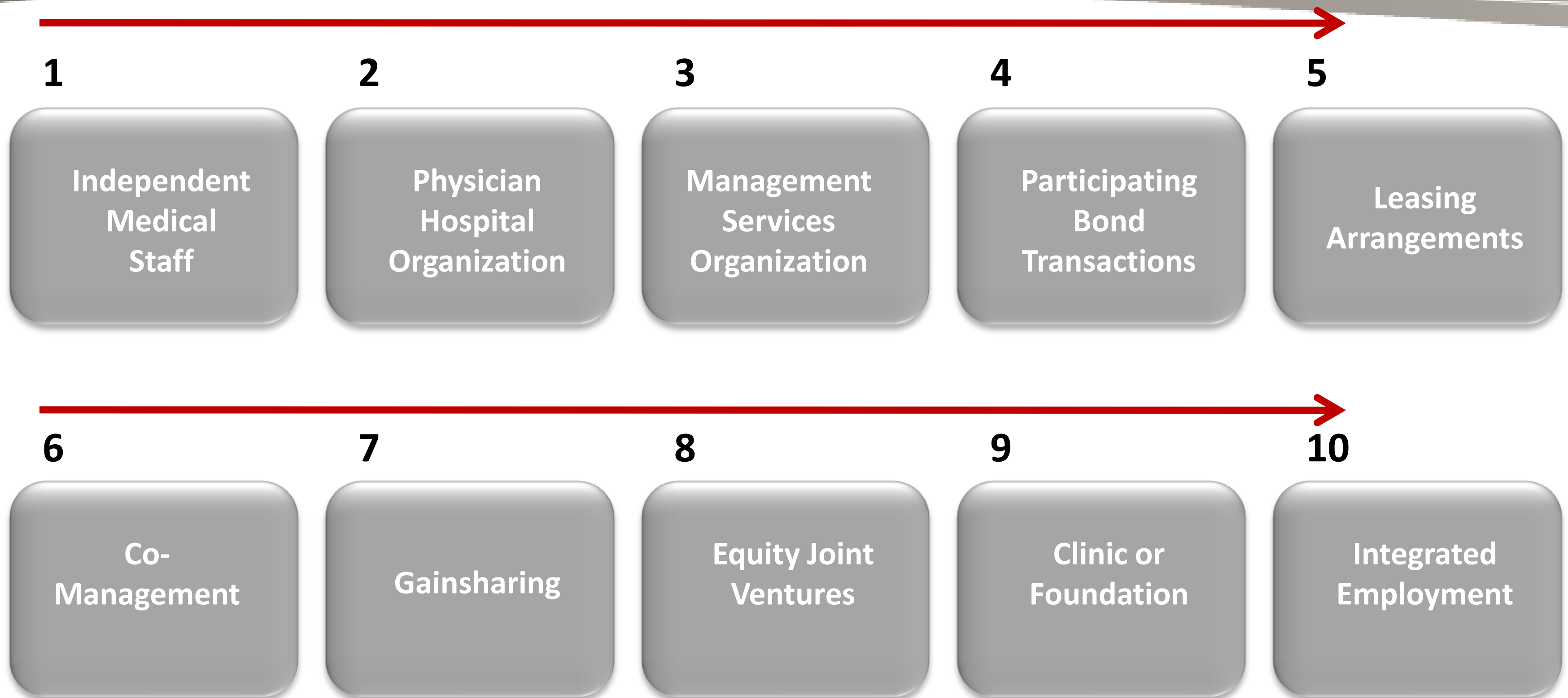
Many Alignment Options



All Benefit from Effective Physician Leaders

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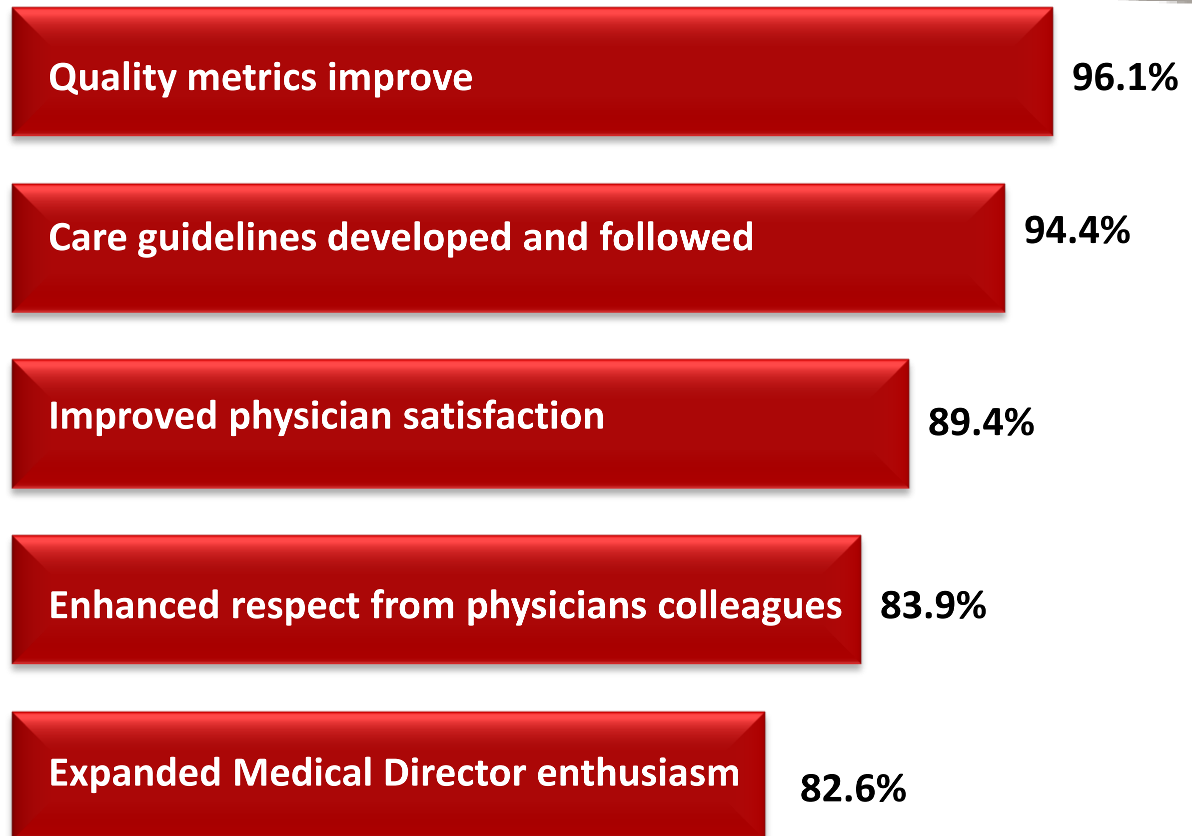
Physician Leaders Key to Alignment Success:

Metrics for Physician Leader Effectiveness

Top 5 Metrics for Physician Leader Effectiveness

Service Line Physician Managers have more economic metrics



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Physician Leaders Key to Alignment Success:

Factors that Frustrate and Facilitate Effective Physician Leaders

7 Factors that Frustrate

TOP FACTORS
Resistance from other physicians about being led / managed by a physician
No clear performance goals/measures
Not enough staff support from hospital
Lack of time and time management skills
Weak project management skills
Poor group/interpersonal management skills
No clear job duties

Physician Leaders Key to Alignment Success:

Factors that Frustrate and Facilitate Effective Physician Leaders

12 Factors that Facilitate

STRATEGIES
Clear job descriptions of duties/results
Formal orientation to job duties
Mentoring support
Administrative partner
Easy access to staff support
Coaching about earning respect from physicians
Competitive base pay for work
Incentive pay based on results
Website access to best practices information
Seminars with other medical directors from other cities
Support for mini-MBA executive education
Good access to Board of Directors

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Programs of Promise Insights

Physician Leadership Development:

Profiling 10 Physician Leadership Academies

Cedars-Sinai Medical Center
Alegent Health
Baylor Healthcare System
Heartland Health
Mayo Foundation
Lehigh Valley Health Network
Sanford Health System
Virginia Mason Medical Center
Carillion Health System
Advocate Healthcare

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The Mayo Leadership Model Competencies

Physician Leadership Development:

Personal Attributes

1. Inspiring Trust
2. Adaptability and Resourcefulness
3. Foster Mutual Respect/Diversity
4. Judgment

People Leadership

1. Consensus Building
2. Developing Talent
3. Developing Teams
4. Foster Learning Environment
5. Skillful Communication

Strategic Leadership

1. Visionary Thinking
2. Quality and Service Commitment
3. Change Management
4. Organizational Alignment
5. Advocacy for "3 Shields: care, education-research-administration

Business Acumen

1. Business & Finance
2. Results Oriented

Each with curriculum and case studies

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Physician Learning Styles

Parallel Residency Training with Mentors and Applied Case Studies

Philosophies to guide their learning experiences.

- Reliance on small groups of physician cohorts for group learning while encouraging interdisciplinary projects and case studies
- Emphasis on real-time case studies of serious challenges that relate to enhancing the patient experience, process improvements and measurable economic gain
- Support of learning about self-awareness, listening and dialoguing
- Reliance on a mix of in-house expert faculty with outsourcing and in-sourcing with local business schools, national health leader associations or professional firms
- Requirements for short, bite-size sessions of two to four hours, spread over several weeks, to encourage applications in real world settings and to be respectful of physician time
- Cautious reliance on new digital learning tools such as webinars, podcasting, teleconferencing and dedicated Web sites for knowledge downloads and expert bulletin boards

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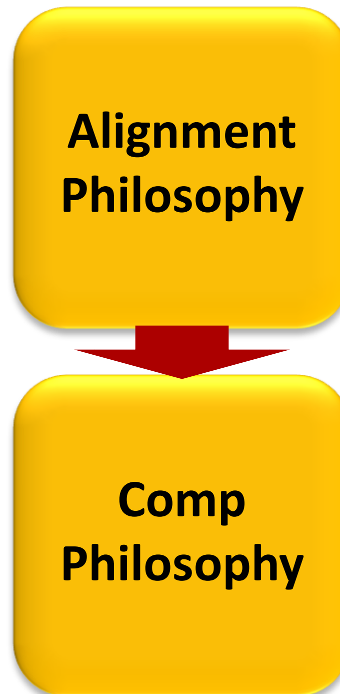
Organization's Strategic Plans

Physician Leader Pay for Performance:

New Insights to recognize and reward high performance physicians:

Innovations for:
Base Pay, Benefits and Incentive Pay



Trends
Issues
Design
Systems
Samples

Physician Leadership Incentive Compensation Plans

The basic concept of the

Physician Leadership Incentive Compensation Plan ("PLICP") :

The basic concept of the PLICP is to better align the Physician Executive incentives with the goals of the organization based on the premise that better alignment of incentives should result in higher organizational performance.

Physician Incentive Compensation

As physician buy-in is critical to the success of any incentive plan, Integrated Healthcare Strategies recommends a transparent process with physician leader input.

Key Decision Points:

- Establish compensation philosophy consistent with executive and physician compensation philosophy
  - Guaranteed Salary vs. Pay at Risk (market position and peer group definition)
- Select number of goals and weighting of each category
- Define performance measures for each indicators
- Outline process and timing for measurement
- Define link to pay

Goal Setting Questions:

Organizations that embark on physician performance management must clearly articulate the goals of the initiative to define the performance measures:

1. How will measurement information be used other than for the incentive plan? (e.g. feedback, quality improvement, consumer information, etc.)
2. Which physician leaders will be included in the PLICP and rationale?
3. Will physician leaders be measured individually, departmentally, based on organizational performance, or a combination?
4. How will compensation be tied to the incentive plan (i.e., how are high performing physician leaders rewarded?)
5. What consequences, if any, will be imposed on lower performing physician leaders?
6. Will physicians be measured on quality, cost efficiency, or other "balance scorecard" measures?
7. How often will the measures be monitored?

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Outcomes:

Physician Incentive Plans should achieve these outcomes:

1. Achievement of organizational goals
2. Greater effort devoted to administrative roles
3. More cross – departmental collaboration on organization-wide goals and initiatives
4. Better alignment of effort
5. Better understanding of physician leadership position expectations and role
6. A more competitive compensation plan that recognizes the performance by physicians in leadership roles
7. Proactive approach to setting standard criteria for physician leadership positions (linked to positions descriptions)

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What performance criteria should be included in the PLICP?

Should physician leaders remain clinically active to some extent (i.e., minimum productivity threshold should be set for each leader; conversely a minimum administrative time requirement should be set)?

If allowed to also stay in a current staff/clinical incentive plan, it will be important not to duplicate the same quality and service goals.

Sample Measures for PLICP:

1. Organizational Goals (Quality, Long-term Goals, Growth, Executive Enterprise Goals)
2. Patient Satisfaction
3. Referring Physician Satisfaction
4. Recruit and Retain Physician Talent
5. Quality of Care Indicators/Processes
6. Productivity (Department and/or Individual)
7. Performance Relative to Budget
8. Service measures
9. Promoting medical education and research
10. Ability to Execute strategy (oversee process and take an active role)
11. Professional growth and development of physician staff

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Staff Physician Non-Production Incentives
Key Performance Indicators:

Healthcare organizations incorporate a "Group Balanced Scorecard Incentive" into compensation for staff physicians, and more recently the respective physician leaders plan

- **Patient Satisfaction**: measured by Press Ganey Office Survey
- **Referring Physician Satisfaction**: measured by mail survey
- **Performance to Budget for the Group (if employed)**: FYO9 Net Income (Loss)
- **Group Service Goal**: % of Call Coverage, response time, etc.
- **Quality of Care Indicators**
- **Adoption of Information Technology**
- **Cost Efficiency Measures:** expense per procedure, test, case, etc.

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Group Quality Incentives

Evidence-based benchmarks – national standards as determined by independent professional associations, health quality organizations, and quality regulatory agencies

- Should be evidence-based, broadly accepted, and clinically relevant
- Often derived from clinical guidelines and quality measures from government agencies:

  Agency for Healthcare Research and Quality; National Institutes of Health; Centers for Disease Control and Prevention); health quality organizations (e.g. Joint Commission on Accreditation of Health Organizations, Leapfrog Group, National Quality Forum, Health Watch); and professional medical societies (e.g. CAP, American Academy of Pediatrics, American Heart Associations)

Examples of Physician Quality Measures

- ***Family or General Practice*** - Percentage of patients who received an influenza immunization; percentage of patients who received a pneumococcal immunization; percentage of patients with diabetes with one or more A1C test(s) conducted during the measurement year; hypertension.
- ***Internal Medicine Heart disease***: coronary artery disease- percentage of patients who were prescribed a lipid-lowering therapy based on current ATP III guidelines; hypertension (percentage of patient visits with either systolic blood pressure >140 mm Hg or diastolic blood pressure >90 mmHg with documented plan of care for hypertension).
- ***Endocrinology/ Diabetes/Metabolism*** - Percentage of patients with diabetes with one or more A1C test(s) conducted during the measurement year.
- ***Gastroenterology*** - Appropriate attention to patient monitoring before, during and after the procedure when using conscious sedation measures; the percentage of patients who had appropriate colorectal screening.
- ***Hema-Oncology*** **-** Percentage of patients reporting pain; percentage of patients reporting nausea/vomiting; percentage of patients reporting fatigue.
- ***Nephrology*** - Regular measurement of the delivered dose of hemodialysis.

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Examples of Physician Quality Measures

- ***Neurology*** - Appropriate treatment of ischemic stroke; stroke rehabilitation; diagnosis of dementia.
- ***Pulmonology*** - Percentage of patients with COPD who had a spirometry evaluation documented; percentage of patients with systemic corticosteroids for acute exacerbation.
- ***Rheumatology*** Osteoarthritis: functional assessment - % of patients diagnosed with symptomatic osteoarthritis assessed for function and pain annually.
- ***Plastic &Reconstructive -*** Prophylactic antibiotic received within one hour prior to surgical incision; surgical patients with recommended thromboembolism prophylaxis.
- ***Surgery – General*** - % of patients who have an autogenous arteriovenous fistula for dialysis vascular access; prophylactic antibiotic received within one hour prior to surgical incision; surgical patients with recommended thromboembolism prophylaxis.
- ***Ophthalmology*** - Appropriate management of primary angle open glaucoma; appropriate post-op care for filtering surgery patients; complete post-op examination post cataract surgery; glaucoma screening.
- ***Orthopedic*** - Prophylactic antibiotic received within one hour prior to surgical incision; surgical patients with recommended thromboembolism prophylaxis; appropriate diagnosis and treatment of back pain.

Examples of Physician Quality Measures

- ***Thoracic/Cardiac*** - Percentage of patients undergoing isolated coronary artery bypass graft (CABG) who received an internal mammary artery graft; prophylactic antibiotic received within one hour prior to surgical incision; surgical patients with recommended thromboembolism prophylaxis.
- ***Anesthesiology -*** Prophylactic antibiotic received within 1 hour prior to surgical incision; surgical patients with recommended thromboembolism prophylaxis; appropriate evaluation of the patient – pre, during, and post procedure.
- ***Critical Care*** - Prevention of intra-vascular catheter-related infections; treatment of intra-vascular catheter-related infections; appropriate weaning from mechanical ventilator support.
- ***Emergency Medicine*** - Aspirin and beta blocker treatment at arrival for acute myocardial infarction.
- ***Obstetrics/Gynecology -*** Rate of mammography screening; rate of cervical cancer screening.
- ***Pathology*** - Appropriateness of tests and appropriate communication of results.
- ***Physical Medicine and Rehabilitation*** - Stroke rehabilitation and the prevention of complications.
- ***Radiology -*** Appropriateness criteria for various diagnosis procedures such as chest x-ray; computed tomography (CT) for detection of pulmonary embolism in adults) and appropriate communication of results.

Design Factors

Many organization continue to tie performance only to the base salary of the position; annual performance review

Common design approaches:

- Incentive criteria links back directly to the performance accountabilities/requirements outlined in the new job descriptions
- Incentive measures based on group performance (Physician collectively in their department/service line) on qualitative and productivity measure
- Incentive measures highly aligned with the organization's executive plan (financial, patient satisfaction, service excellence)
- Best Practice to incorporate all three approaches and set individual, department, and organizational goals

Design Best Practices

- Limited number of goals (e.g. 4 – 6 goals)
- Goals should be graduated versus all-or-nothing (e.g. threshold, target, maximum levels)
  - ✓ Quarterly updates on performance relative to goals would be helpful
- Half the goals focused on organization and half the goals focused on departmental/individual goals
- 10% to 25% of Base Pay is the common range although fixed amounts can be found as well in the industry
  - ✓ Assumes base salary is appropriately set

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Key Challenges

Physician Leadership Incentive Plans

1. Addressing how to tailor the plan based on size of department and administrative FTE status
2. Appropriateness of allowing a physician to participate in more than one incentive plan (i.e., clinical and PLICP)
3. How to recognize physician leader's clinical specialty when setting compensation
   - Value to have surgical representation in leadership and these physicians should not be penalized financially (no "take away")
   - Versus some credit could be factored in but not at the "full value"
4. What is the eligibility requirement?
   - By Title
   - By Minimum administrative FTE requirement
   - Other criteria

How should the plan be funded?

- Plan typically not successful if funded by a “carve out” of base salary
- Review of base pay needed first to determine market position relative to compensation philosophy
- Plan may replace other incentive plans or discretionary incentives which may offset costs
- Often added cost to the current physician leadership pay program
  - ✓ Common approach – set base pay and allow for higher levels of compensation through the incentive plan
  - ✓ Transition plan critical to successful implementation of new PLICP

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