

Physician / Hospital Relationships: marriage of convenience, wedded bliss or family feud

Oregon Association of Hospitals
and Health Systems

May 22, 2009

The Pinnacle Group
Denver



1

Themes



- **The Integration Development Map**
 - Thinking through the process
 - Evaluating your options
 - Understanding the models
 - Assessing the state of your unions
- **Physician Compensation**
 - Getting what you pay for
 - Designing compensation programs
 - Seeing the results...case studies

2

How painful are your physician relationships?



PAIN ASSESSMENT SCALES

Descriptions	0	2-3	4-5	6-7	8-9	10
Face						
Words	no pain feel "ok" does not hurt	mild pain hurts a little annoying nagging	moderate pain discomforting getting worse nauseating/numbing	distressing very strong miserable/nagging agonizing	intense horrible vicious/crushing awful/dreadful	unbearable excruciating worst possible pain
SPANISH	no dolor me siento bien no me duele	poco dolor duele poco molesta incomforable	dolor moderado incomforable empeorando	perturbador muy fuerte miserable agonizante	intenso horrible vicioo muy doloroso	insufrible demoleror el mas fuerte dolor posible
PORTUGUESE	não tenho dor sinto-me "ok" não magoa	dor branda magoa um pouco é maneira incômoda enervante	dor moderada desconforto fica peor empesivo/dormente	que aflige muito forte deprimente/foedor atroz	intensa horível má/ruidadora terrível/maçador	insuportável excruciente peor dor possível
RUSSIAN	НЕГ БОЛЕЙ ЧУВСТВУЕТ СЕБЯ ХОРОШО	ЛЁГКАЯ БОЛЬ БОЛИТ НЕМНОЖКО НОЮЩАЯ БОЛЬ	СРЕДНЯЯ БОЛЬ УСИЛВЛЯЮЩАЯСЯ ТРИШТОТА/ОНЕ МЕНЬШЕ	МУЧИТЕЛЬНАЯ ОЦЕНКА СИЛЬНАЯ ТЕРЗАЮЩАЯ БОЛЬ	СТРАШНАЯ УЖАСНАЯ СОКРУШАЮЩАЯ БОЛЬ	НЕВЫНОСИМАЯ, КОТОРУЮ НЕЛЬЗЯ ТЕРПЕТЬ БОЛЬ
VIETNAMESE	không đau/nhức chợt nhẹ thấy bình thường không thấy đau/nhức	đau/nhức nhẹ đau/nhức chợt xấu bực bực phiền phức	đau/nhức vừa khó chịu đau/nhức tăng lên buồn nôn/ê	đau/nhức dữ đau/nhức nhiều đau/nhức dữ dội đau đớn	đau/nhức nhói đau/nhức kinh khủng đau lạng đau/nhức ghê gớm	Mệt chịu nổi đau/nhức dữ dội đau dữ dội
HAITIAN	pa gin doult mwen byen li pa fè m mal	doult modéré fèm mal pi m piti li ban picotman li anpil m	doult modéré mwen pa sèlè li van pi mal li fèm avwi vom	man détrè doult pi grav li mwafrab mwen an agoni	li pi fò li tèrib lap liye m li kraze	mwa capab ankò li atro doult pidi
CHINESE	不痛 感觉"可以"	轻度疼痛, 苦于痛, 不舒服	中度疼痛, 症状加重, 恶心/麻木	重度疼痛, 强烈的, 牙疼	剧烈疼痛, 可怕的, 压倒性的痛	不能忍受的痛 如此剧烈, 痛不欲生

Knowing the Market



Start with some statistics

- HFMA Survey Findings (630 respondents)
 - 55% of hospitals (respondents) plan to begin or continue to acquire physician practices in the next one to two years
 - 80% of hospitals with acquisition experience employ rather than contract with physicians, and negotiate compensation as part of the transaction
 - Less than 50% created an MSO or other entity to manage acquired practices
 - Virtually all hospitals establish revenue/expense projections... less than 33% meet projections... and less than 17% report a positive ROI within two years of acquisition.

Market...



- **More stats...**

- More than 75% of hospitals report problems with the practices they acquired
 - Declining physician productivity
 - Reluctance of physicians to relinquish control
 - Inadequate information systems, staffing and poor communications between physicians and the hospital
- Over 70% of hospitals view practice acquisition as an effective way to enhance the hospital's strategic position

5

Market...



- **Favorite Survey Finding**

- "The jury is still out on the long-term viability of practice acquisitions: only time, experience and more data will tell the whole story."

- **Timeframe**

- When was this survey conducted?

6

Market



- **And today...**

- On average, Integrated Delivery Systems lose **\$97,807** per FTE physician
 - Primary Care Only: **\$89,049**
 - MGMA 2008 Cost Survey Report
 - Generally excludes ancillary revenue

7

Managing the Pain



- **Don't Commit the Sins of the Past**

- Overpay physicians
- Ineffective compensation programs
- Unrealistic (and unmonitored) performance expectations
- Passive practice management
- Poor health plan contracting
- Exclude physicians from leadership
- Select the wrong physicians as partners / employees

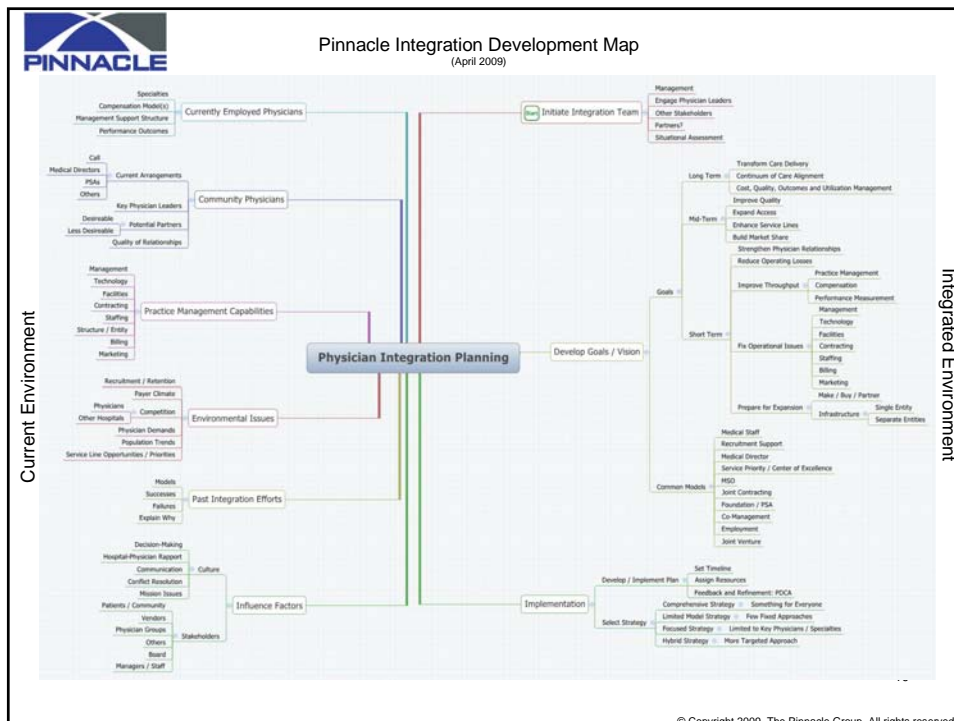
8

Managing...



- **Do Create the Environment for Success**

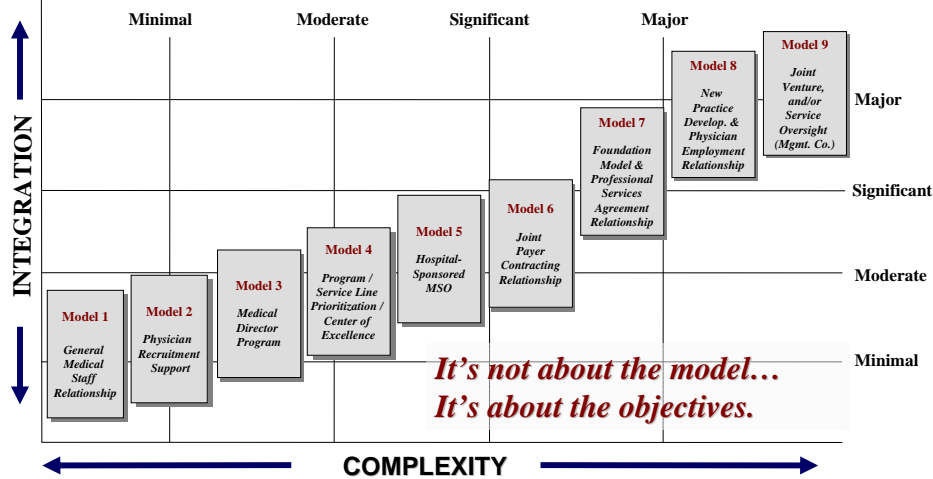
- Establish the organization and expectations before taking on physician employment
 - Set your goals / establish vision
- Be selective / set priorities
- Construct compensation programs that promote specific objectives
- Be candid about physician retirement strategies
- Share control and accountability with physicians
 - Engage physicians in devising your integration strategy
- Ensure appropriate management support
 - Monitor and address performance issues before crisis



Physician-Hospital Integration Continuum



Hospital Systems Continue to Re-Assess the Necessity of Utilizing a Broad Range of Affiliation Options with Physicians to Advance Their Shared Missions / Visions



11

Illustration courtesy of HeartWorks

Convenience, Bliss or Feud



- **Are you just addressing isolated challenges / responding to physician demands?**
 - What precedents are you setting and how might they affect other/future physician relationships?
 - What are your competitors doing and why?
- **What are you trying to achieve?**
 - Fix an immediate problem / build foundation for the future?
 - Focused or comprehensive solution?
 - What are your specific goals, timeline?
- **What role will physicians play?**
 - Employees, partners, leaders, other?
 - How will you deal with physicians you don't want?
- **Are you prepared to meet the management needs of physician practices?**
 - Do you have the infrastructure to support efficient and productive practices?
 - Are there issues other than compensation methods contributing to lower practice performance?

12

Case References



- **Physician Engagement Strategy (Large Community Hospital)**
- **Physician Compensation (Critical Access Hospital)**
- **Specialty Outreach Program (Rural Hospitals part of Large System)**

13



- **Developing Effective Compensation Plans**

14

Compensation



- **Connecting Pay with Strategy**
- **Elements of Effective Compensation Plans**
- **Plan Structures**
- **Design Process**

15

Connecting Pay with Strategy



- **Fundamental**
 - Financial viability
 - Relationship stability
- **Clear and Shared Expectations**
 - Income
 - Performance and Management
 - Opportunity
- **Objective-driven Compensation Plans**
 - Well-defined and devised
- **Reflect Contributions**
 - Productivity, leadership, etc.
- **Effectively Managed**
 - On time with accurate data

16

Elements

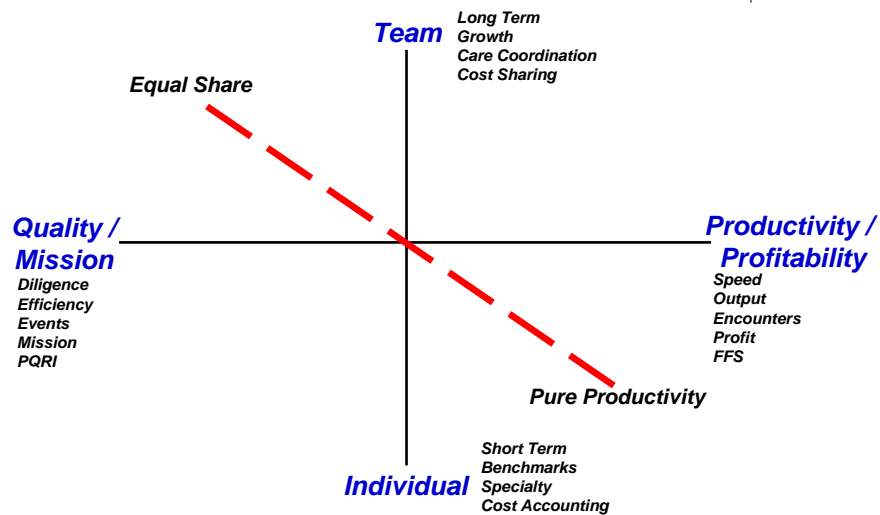


1. Directly linked to goals and objectives
2. Encourage/reward hard work and production
3. Balance individual and team responsibility
4. Clarify performance expectations
5. Aligned with reimbursement environment
6. Simple, understood and explainable
7. Clearly defined and consistently applied
8. Open and transparent
9. Fiscally responsible
10. Legally compliant

- Johnson and Walker-Keegan

17

Dimensions of Compensation



18

Objectives



- **Recruitment / Retention**
 - Benchmarks and market comparable data
- **Productivity**
 - Charges, collections, WRVUs
- **Profitability**
 - Minimizing losses
- **Organizational Improvement / Advancement**
 - Patient Satisfaction
 - Quality
 - Citizenship / Leadership
- **Access / Coverage**
 - Creating service lines, 24/7 expectations, etc.

19

Structures



- **Models – Integrated Practices**
 - Base plus Incentive(s)
 - Relate to Objectives
 - Revenue – Expense
 - Modified for other objectives
- **New Physicians**
 - Guarantee plus discretionary bonus
 - Relocation, sign-on
 - Know your market
 - Mentoring and feedback

20

Structures...Primary Care



Key Challenges	<ul style="list-style-type: none"> - Very poor productivity (< 25th percentile) – no accountability - Straight salary history and physician mind-set - Poor payer mix, and mission to “care for everyone” - Moderate recruiting difficulties - Inefficient infrastructure (facilities, staffing, etc.) - Physicians had no data on performance - Desire to earn more money – recognize other service (teaching)
Objectives	<ul style="list-style-type: none"> - Competitive incomes for recruitment and retention - Promote productivity - Shield providers from poor payer mix - Ease transition to new compensation / productivity expectations - Compliance

21

Structures...Primary Care...cont.



Philosophy	<ul style="list-style-type: none"> - Allow physicians to earn market competitive incomes despite payer disadvantages - Walk before they run - Require market competitive productivity
Formula	<ul style="list-style-type: none"> - Establish benchmark compensation and productivity expectations (base line) - Create 3-Phase transition to Base Plus Incentive Compensation Arrangement (P1 - 90% of benchmark, P2 – 85%, P3 – 80%) - Incentive Threshold based on 50% of 25th Ptile WRVUs (national) - Threshold initially set low to make incentive tangible – threshold raised to 60% of benchmark in P3 - \$8/WRVU incentive in P1 to \$22/WRVU in P3
Outcomes	<ul style="list-style-type: none"> - Immediate increase in productivity - Addressing operational limitations (staffing, etc.)
Cautions	<ul style="list-style-type: none"> - “Cut in Pay” - Gaming the WRVU system – need for education and audit control - Accurate data and quarterly bonuses

22

Structures...ED



Key Challenges	<ul style="list-style-type: none"> - High patient demand environment - Moderate physician productivity - Crummy patient satisfaction - Some quality concerns – physician personality problems - Loosely administered compensation incentives – total compensation <u>capped</u> near 75th Ptile - Some physician turnover - High performers dissatisfied with cap on compensation - Hourly employee mentality
Objectives	<ul style="list-style-type: none"> - Competitive incomes for recruitment and retention - Promote productivity / efficiency <ul style="list-style-type: none"> - Ensure coverage of second campus with lower volume - Fix physician dissatisfaction - Address patient satisfaction - Assure high quality of care - Compliance

23

Structures...ED...cont.



Philosophy	<ul style="list-style-type: none"> - Allow high performers to earn high performer incomes - Quality and patient satisfaction are paramount - Align productivity and compensation
Formula	<ul style="list-style-type: none"> - Establish benchmark compensation and productivity expectations - Base Compensation set above Median (regional) - Establish Quality and Patient Satisfaction Measures <ul style="list-style-type: none"> - Individuals required to meet quality standards to be eligible for productivity or patient satisfaction incentives - Fixed \$ for Patient Satisfaction based on group and individual scores (\$4,000 / quarter) - Productivity Incentive Threshold based on Median Ptile WRVUs (national measured per hour) + \$ differential for second campus work - Total compensation must be within FMV (audit trigger)
Outcomes	<ul style="list-style-type: none"> - Majority of physicians above 75th Ptile productivity - Group patient satisfaction scores at 98th Ptile (PG)
Cautions	<ul style="list-style-type: none"> - Coding, being too quick to order tests and consults (cost and quality concerns) - Need for strong physician leader

24

Structures...Specialists



Key Challenges	<ul style="list-style-type: none"> - Competition for physicians in limited supply - Demand of physicians to earn above average incomes - Need for productivity to support income and expenses - Poor payer mix and mission to “care for everyone” - Some physicians carry administrative duties in addition to full clinical schedule – some with <u>disproportionate</u> call
Objectives	<ul style="list-style-type: none"> - Attractive incomes for recruitment and retention, including incentives - Stable / improved access to key specialty services - Promote financial viability - Recognize non-patient care contributions - Consistency across specialties - Compliance

25

Structures...Specialists...cont.



Philosophy	<ul style="list-style-type: none"> - Offer competitive salary guarantees with incentives for contributions above employment / practice costs - Reflect private practice arrangements
Formula	<ul style="list-style-type: none"> - Establish benchmark base compensation – varies by specialty - Identify Professional Collections per WRVU (benchmark or actual) - Determine Employment Costs (Salary, Benefits and Taxes) - Determine Practice Cost (billing, malpractice, facilities, support, IT, etc.) - Calculate WRVU Cost Equivalent (Total Costs / Collections per WRVU) - Identify Compensation per WRVU (benchmark or actual) - Bonus physician based on % of Compensation per WRVU above Cost Equivalent - Reduce Base Compensation if physician fails to meet Cost Equivalent - Stipends / hourly compensation for additive administrative services
Outcomes	<ul style="list-style-type: none"> - Higher physician satisfaction / retention - Competitive levels of productivity
Cautions	<ul style="list-style-type: none"> - Clear expectations about performance - Effective cost management

26

Design Process



- **Plan**
 - Educate and inform
- **Gather Data**
 - Evaluate Performance
- **Assess Environment**
 - Internal and external
- **Agree on Objectives**
 - Management and physicians
- **Develop and Finalize Models**
 - Know the market

27

Implementation



- **Document**
 - Performance, objectives and methods
- **Ensure Compliance**
 - Medicare and IRS
- **Educate and Inform**
 - Physicians and managers
- **Data and Management Systems**
 - Regular reporting and timely administration
- **Transition Plans**
 - Ease the pain
- **Monitor and re-evaluate**
 - Assess against objectives and strategy

28

Questions



- **Closing Thoughts**

- Integration
- Compensation
- Pinnacle Fair Market Value Program

- **Contact**

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