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The Impact of the Changing Health Care Environment on Physician Faculty Compensation

Learn
Serve
Lead

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American Medical Colleges

Agenda

Part One: AAMC/SullivanCotter

National Study of Physician Faculty Compensation Programs

- Organizational characters and physician faculty compensation oversight responsibilities
- Overall full-time equivalent (FTE) and clinical FTE (cFTE) definitions, trends and approaches
- Overview of benchmarking approaches
- Compensation methodologies and prevalence of factors used for base salary and variable compensation

Part Two: University of Utah

Compensation Plan Evolution to Reflect a Value-Based Reimbursement Environment

- Guiding principles and current state
- Value-based reimbursement and compensation plan elements
- Example of value-based compensation plan
- Key attributes of value-based compensation
- Current challenges and concluding thoughts

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Objectives of the National Study

Overview based on results[1] of a survey to identify contemporary pay practices and approaches used to compensate faculty and clinical physicians by Academic Medical Centers (AMCs)

Organizational Characteristics

- AMC structure and growth goals
- Oversight and decision-making processes related to physician compensation

Work Effort and Performance Criteria

- FTE and cFTE definitions and approaches
- Promotion criteria and funding sources
- Faculty and community-based physician expectations

Benchmarking Approaches

- Faculty and community-based physician total cash compensation and productivity market benchmarking

Compensation Strategies

- Evolution of faculty compensation by specialty grouping
- Base and variable plan components
- Value-based compensation and panel size

[1] SullivanCotter presented results at the joint GFP and CMOG meeting held at the AAMC headquarters on February 8, 2018

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Participant Overview[1]

Organizational Structure

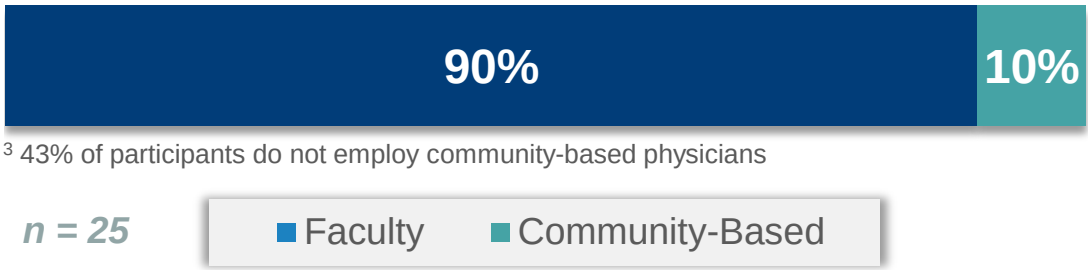
Fully Integrated	27%
Academic Integration	**39%**
Clinical Integration	16%
Independent Structures	14%
Independent FPP Structure	4%

Physician and Advanced Practice Provider (APP) FTEs

FTEs	Physicians *Faculty and Community* *n = 44*	APPs[2] *n = 41*
Median	775	188

[2] Seven percent of participants do not employ APPs

Physician FTEs Faculty vs. Community-Based[3]



[3] 43% of participants do not employ community-based physicians

[1] A total of 44 AMCs participated in the study. The participant list can be provided upon request

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Growth in Physician Staffing Levels

Over the past year, participants have experienced significant growth in physician staffing levels, especially community-based

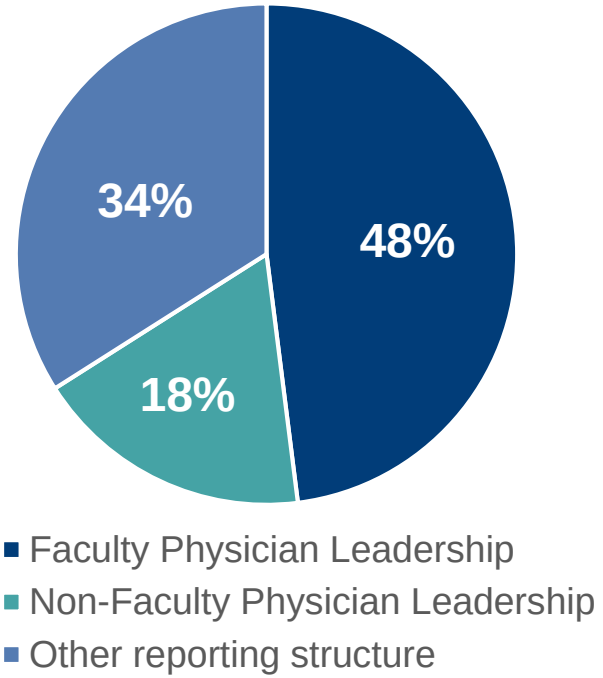
Physician Staffing
Total and Community-Based Only

Annual Median Growth Rate	Total[1]	Community-Based
Historical[2]	5%	**13%**
Projected	4%	**11%**

[1] Total includes faculty and community-based physicians. Faculty-only growth approximates total growth

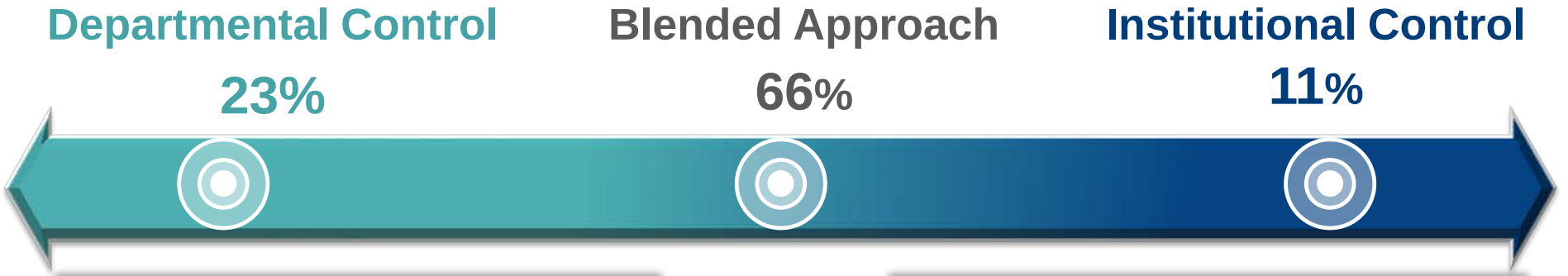
[2] Total historical growth of 10% over the last three years; 27% for community-based physicians

Community-Based Physicians
Reporting Structure



Compensation Oversight and Management

AMCs moving toward a balanced approach to better align the compensation strategy with the tripartite mission and organizational strategy



Department Chairs have direct oversight, manage and administer compensation for all physicians within their department (faculty and community-based)

Organizational management of compensation with decision-making falling under an executive group. Department Chairs provide input, but do not directly administer compensation

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Physician Compensation Oversight

Decision-making will impact the level of standardization and the speed at which compensation programs can adapt to a rapidly changing health care environment

- **Multiple compensation plans**, typically one for each department
- **Varying definition** of clinical and academic time (e.g., patient charting and resident teaching)
- Use of **undefined academic effort** or unfunded academic time varies widely
- Each department **administers its own compensation plan**
- **Minimum work effort definitions** and standards vary among departments

- **Common framework**, four to six types of compensation plans, aligned with specialty groups (primary care, medical/surgical and hospital-based medicine)
- **Standardized** clinical and academic time
- **Alignment of funding and academic time**, unfunded academic time is standardized (cost-share for grant funding)
- Plan **administered by organization** (HR or Finance); department manages operational tasks (staffing decisions)

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Work Effort, Benchmarking and Compensation Plan Methodologies

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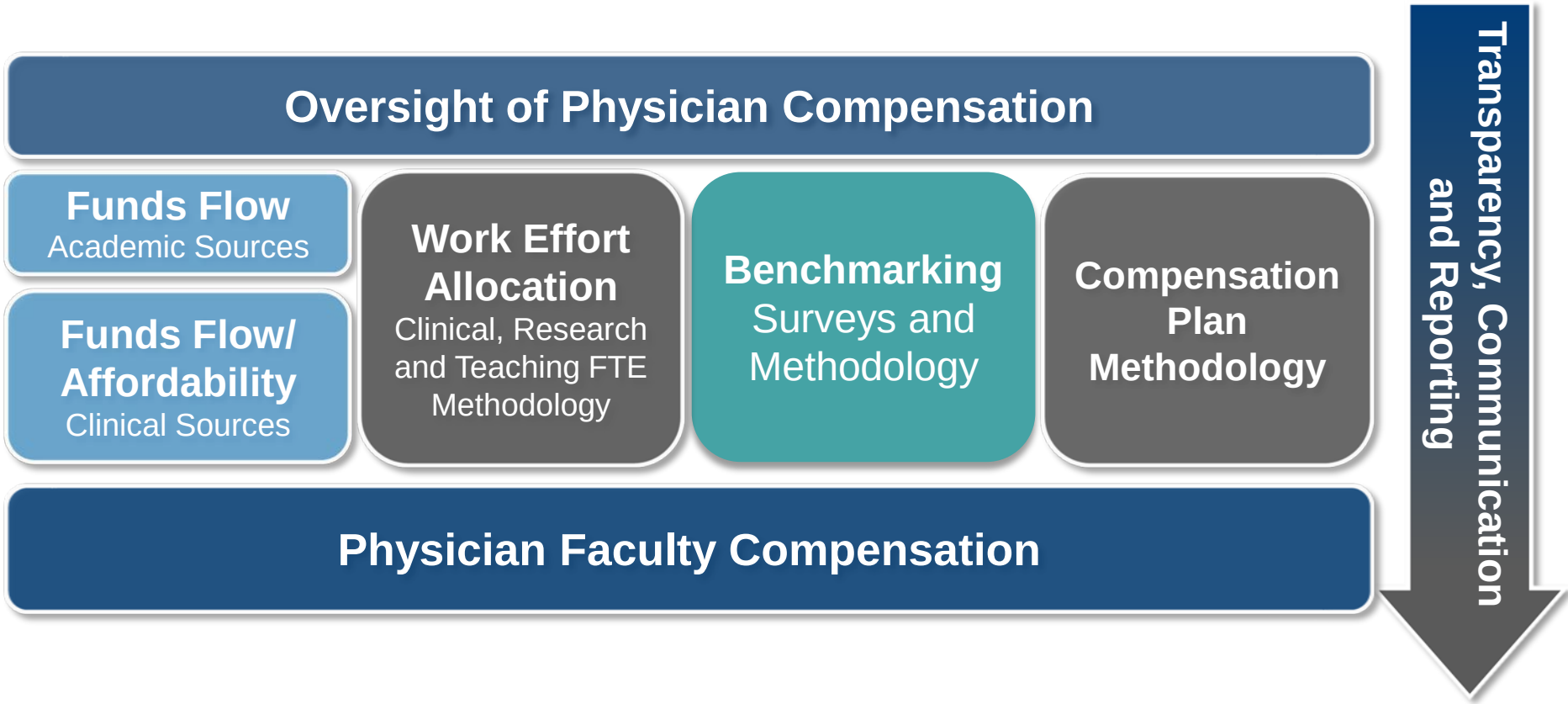
Compensation Methodologies

Overview of Important Factors

When evolving compensation approaches, AMCs are considering many factors to ensure the underlying structure supports the tripartite mission and the compensation plan methodology



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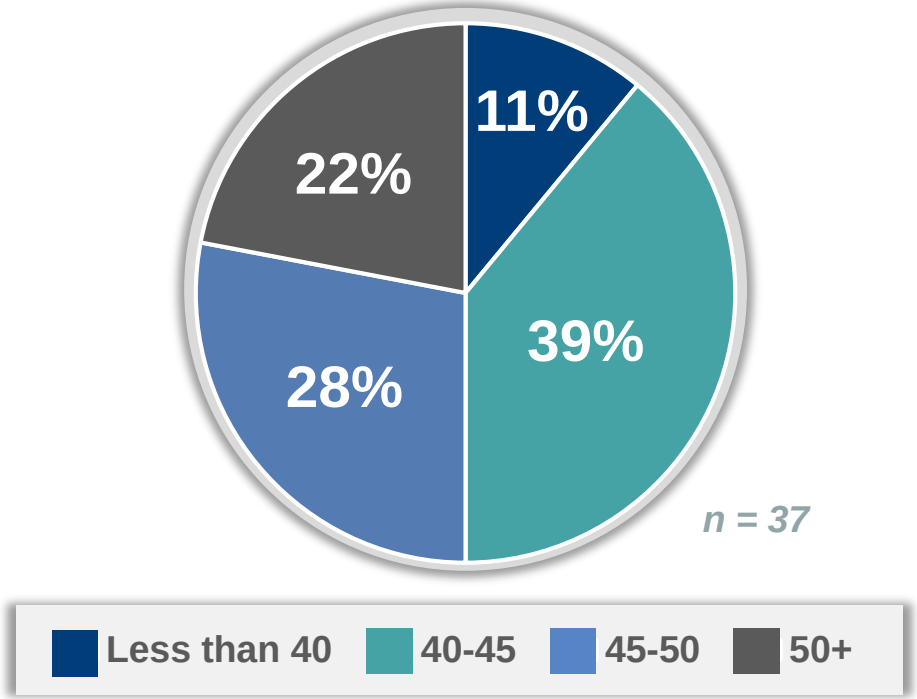
Overall FTE Definitions

Work effort allocation is managed by Department Chairs in **93%** of organizations. Less than half indicate the allocation is reviewed by an Oversight Committee

Hours Per Week that Define a 1.0 FTE



n = 37

Session
(excluding hospital-based)

93%

define a session as a **half-day** or **four hours**

n = 43

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Clinical FTE Trends and Standards

Clearly and consistently defining cFTE is a challenge among AMCs

- Decreases in overall funding sources create pressure to reduce unfunded effort
- **20%** are considering either reducing or eliminating standard academic time within the next two years

Organizational Standards	Prevalence
cFTE approach varies by department/specialty group	49%
Standard minimum amount of protected weekly time for each faculty member*	36%
Standard amount of clinical work effort is allocated to faculty members	17%

* Protected time provided per week ranged from 10% to 20% (n = 11)

n = 43

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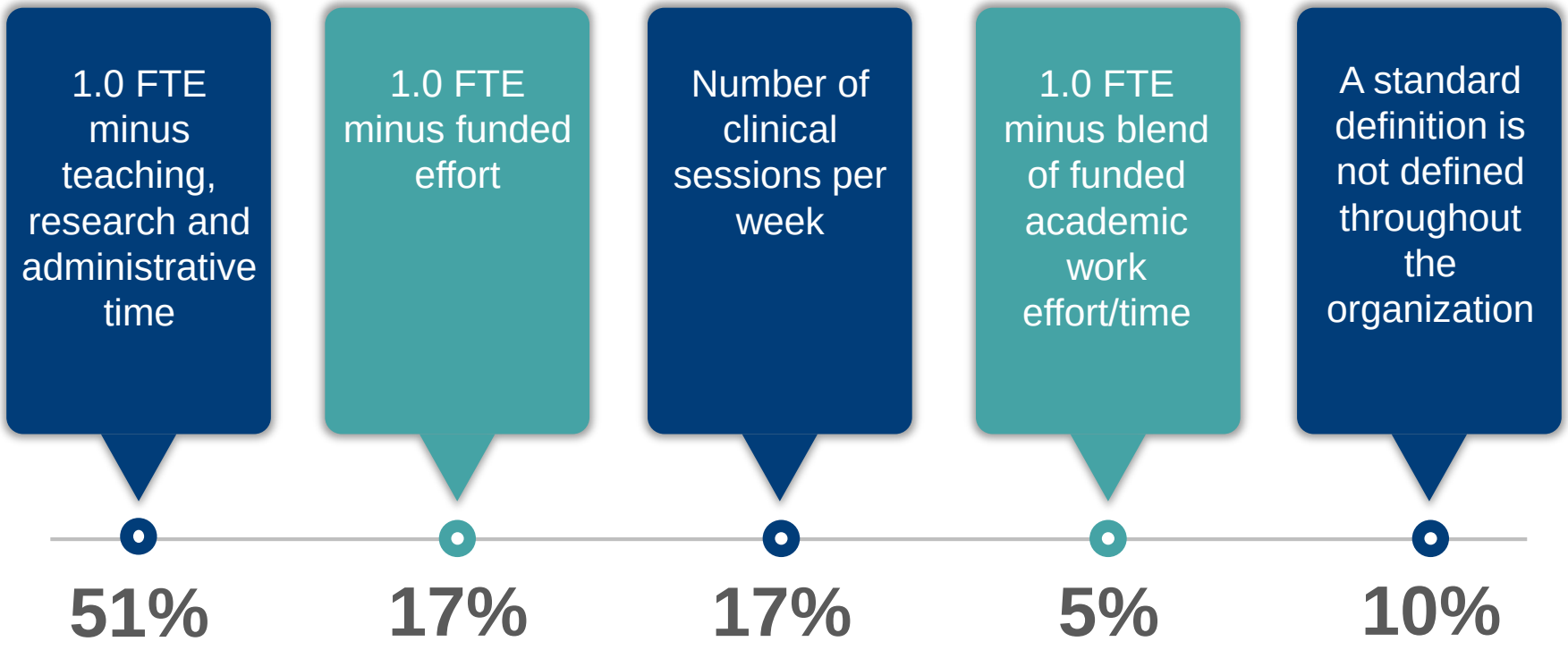
Clinical FTE Approaches

The predominant methodology for determining cFTE is time-based*



* The cFTE approach did not correlate with organizational structure

n = 39

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Benchmarking Approaches

Organizations report a variety of survey sources used to benchmark compensation and productivity for faculty and community-based physicians

Surveys	Faculty n = 43		Community-Based n = 25	
	Comp.	Prod.	Comp.	Prod.
AAMC	88%	--	7%	--
MGMA – Academic	65%	58%	16%	12%
MGMA – Physician	56%	44%	56%	51%
SullivanCotter Surveys*	44%	33%	58%	51%
FPSC	--	49%	--	9%
AMGA	21%	19%	19%	16%
Other	26%	23%	7%	9%

* Reflects physician (30%), Large Clinic Group (9%) and medical group (7%) surveys

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Benchmarking Approaches

Use of each of the following benchmarking approaches varies by organization:

Compensation Implications	Prevalence*
Productivity targets exceed compensation targets by 10 percentage points or more *n = 30*	37%
The majority of organizations require physicians to cover some portion of their overhead *n = 43*	72%
Nearly half compensate academic and clinical work effort differently *n = 43*	43%

* Prevalence percentage reflects organizations that employ both faculty and community-based physicians

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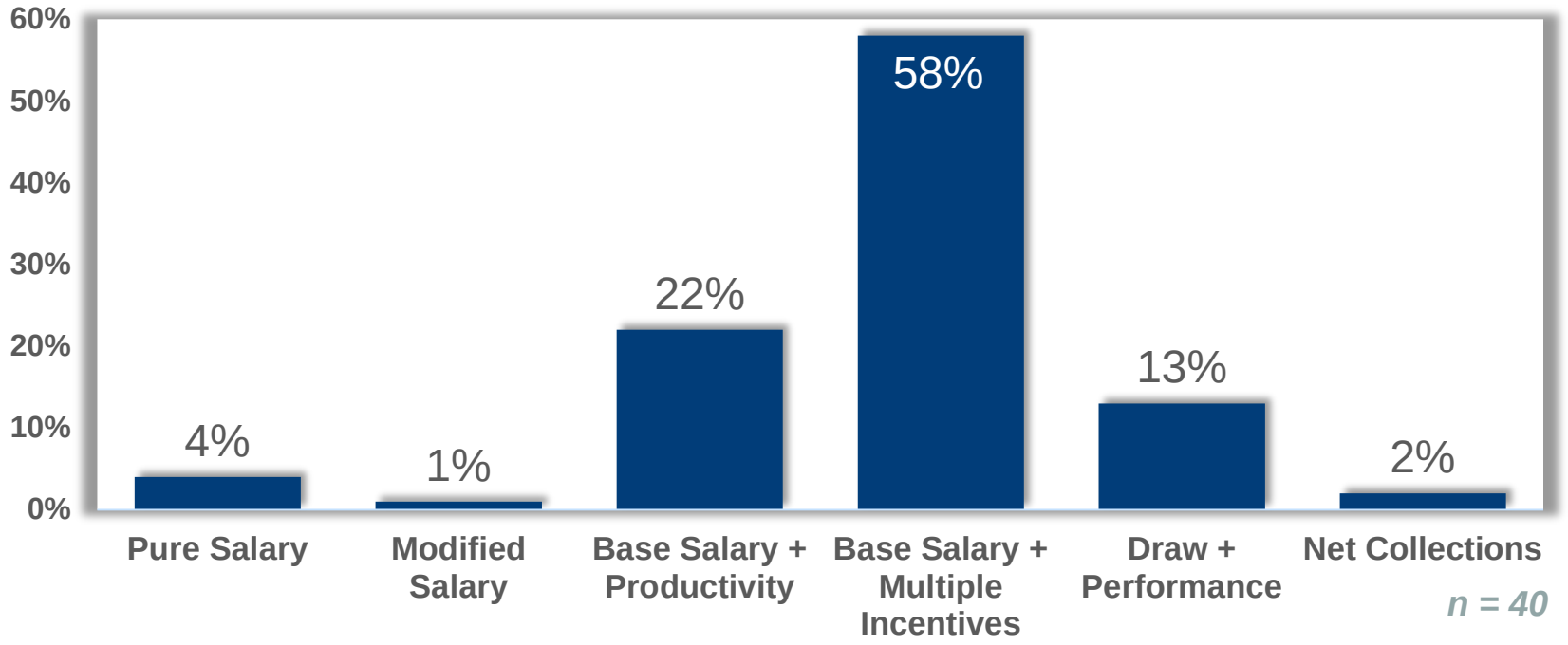
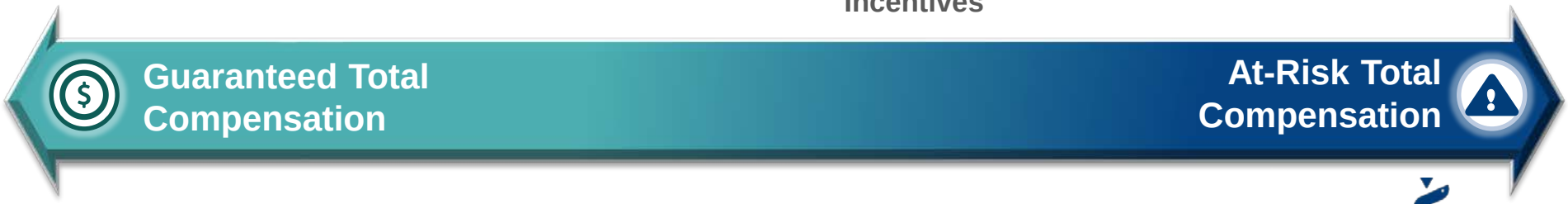
Compensation Methodologies

Overall

Over half (58%) of organizations use a base salary plus multiple incentives. Multiple incentives may include productivity, value-based metrics and/or academic performance





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Compensation Methodologies

By Specialty

The prevalence of compensation plans with higher at-risk pay is greater among Primary Care and Surgical specialties than Medicine and Hospital-Based, a small percentage of which still utilize pure salary plans

Specialty Group *n = 40*	Pure Salary	Modified Salary	Base Salary + Productivity	Base Salary + Multiple Incentives	Draw + Performance	Net Collections
Medicine	8%	--	**33%**	**46%**	10%	3%
Surgical	--	--	6%	**74%**	16%	3%
Hospital-Based	8%	--	**30%**	**48%**	13%	3%
Primary Care	--	3%	10%	**72%**	14%	--

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Key Factors: Base Salary and Variable

Prevalence (Highest to Lowest)

Compensation Factor	Base Salary
Faculty rank	95%
Length of service	60%
Chair discretion	53%
Research stipend	50%
Work Relative Value Units (wRVUs)	43%
Teaching stipend	40%
Citizenship	23%
Professionalism	18%
Patient satisfaction	10%
Adherence to standards of care/clinical protocols	8%

Compensation Factor	Variable
wRVUs	95%
Citizenship	62%
Patient satisfaction	59%
Chair discretion	56%
Patient care outcomes	56%
Professionalism	51%
Patient access	46%
Adherence to standards of care/clinical protocols	44%
Research stipend	38%
Teaching stipend	31%

n = 33

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Key Factors: Individual, Group, Enterprise

Prevalence

Key factors in determining compensation are **largely based on individual performance**, with group and enterprise performance considered to a lesser degree

Performance Measure[1]	Prevalence
Individual	**69%**
Individual and Group	24%
Enterprise-Wide	34%

Top Five	Individual *Top 5 Reflects 49% of Total*	Individual and Group *Top 5 Reflects 62% of Total*	Enterprise-Wide *Examples (Not in Particular Order)*
1	Faculty Rank	wRVUs	Charting
2	Chair discretion	Patient access	Cost
3	Research stipend	Patient satisfaction	Access / New Visits
4	Citizenship	Patient care outcomes	Patient Experience
5	Professionalism	Chair discretion	Mortality

[1] Group only reflected 7% prevalence

n = 33

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Value-Based Metrics

Primary Care compensation plans have the **highest percentage** of total cash compensation (TCC) attributed to **value-based performance**

However, the number of metrics used within the compensation plans is **similar for all specialty groups**

58%

of organizations are **considering the use of panel size** metrics in their primary care compensation plans

Specialty Group *n = 25*	Percentage of TCC			
	Average	Median	Min	Max
Medicine	6.9%	5.0%	0.5%	20.0%
Surgical	6.9%	5.0%	0.5%	20.0%
Hospital-Based	6.3%	5.0%	0.5%	20.0%
Primary Care*	8.9%	9.5%	1.0%	25.0%

Specialty Group *n = 25*	Number of Metrics			
	Average	Median	Min	Max
Medicine	4	3	1	14
Surgical	4	3	1	14
Hospital-Based	4	3	1	14
Primary Care	4	3	1	14

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University of Utah Evolution to Value-Based Compensation

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Guiding Principles

Compensation Plans

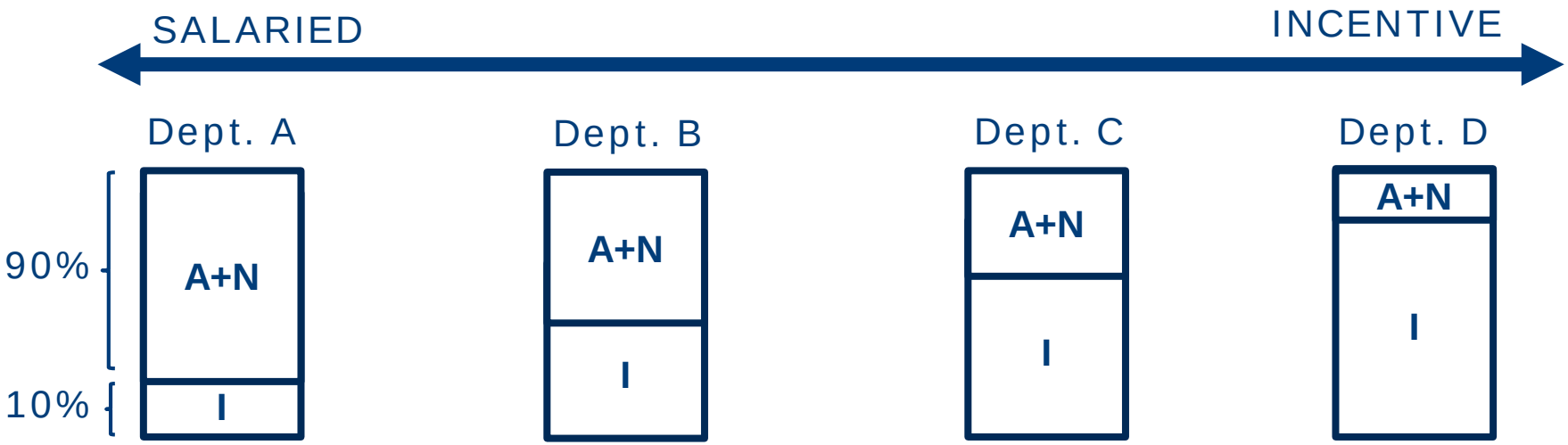
- Simple, sustainable, transparent, fair
- Incentivize clinical system priorities
  - ✓ Quality, value, performance
- Promote academic excellence in research and education
  - ✓ Consistent with institutional goals and departmental initiatives
- Ensure market competitiveness

Current SOM

Compensation Plan Model

Academic (BASE) + Negotiated (VARIABLE) + Incentive (CIP) = Total

Set Annually;
Guaranteed for One Year



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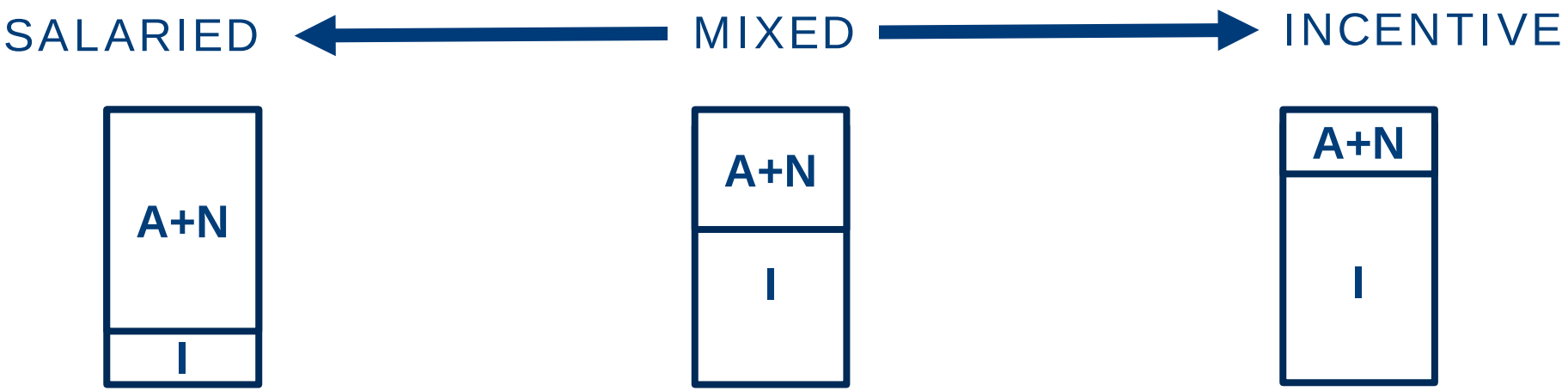
Percentage By Department and Division

55% **20%** **25%**



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Evolving Compensation Models

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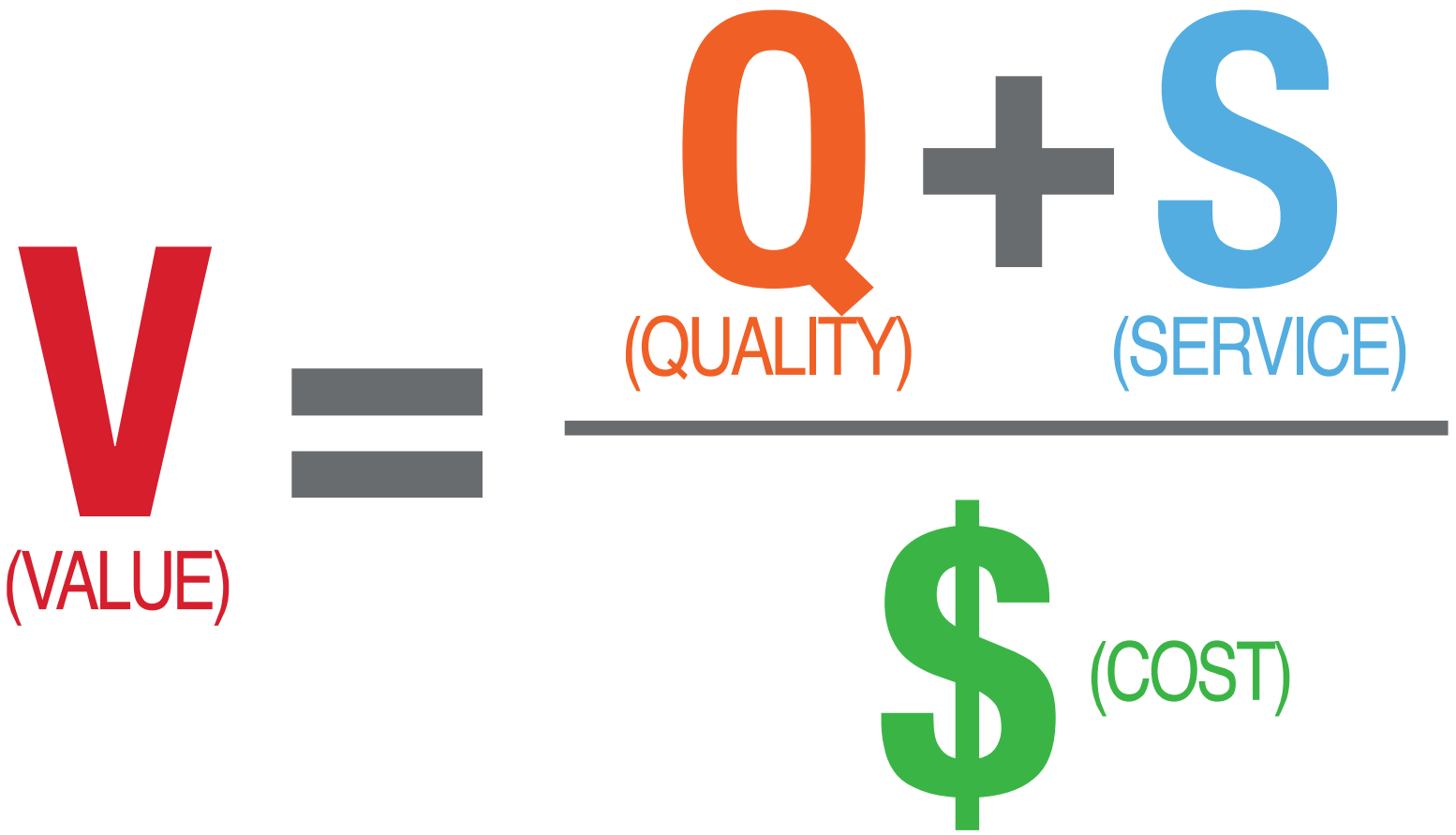
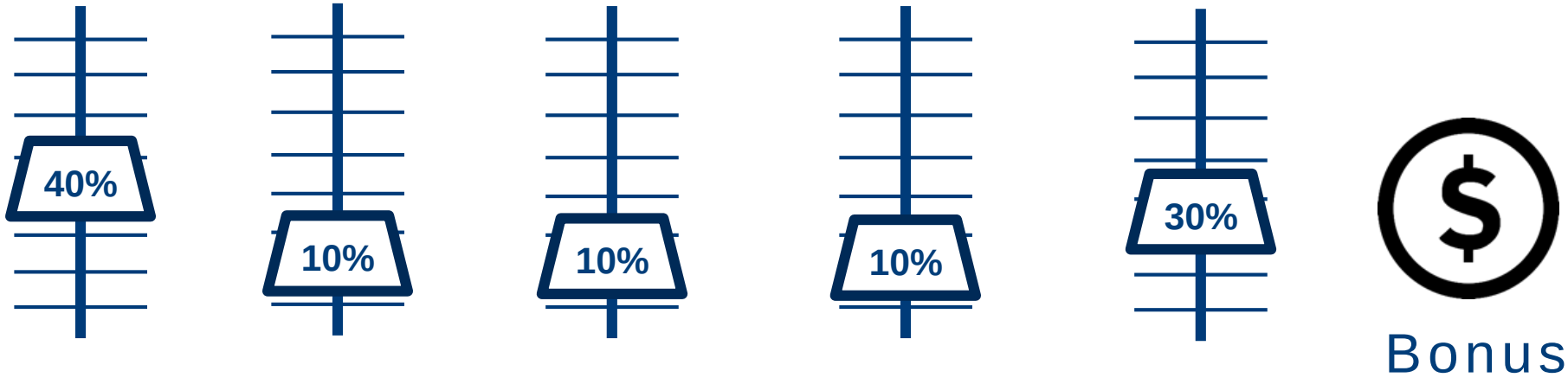
Value Equation



Value-Based Compensation Plan

One Example



Base
Productivity

Quality
Determined by specialty

Access
Panel size, new patient visits

System
System and other department goals

Academic
Teaching and Research

100%

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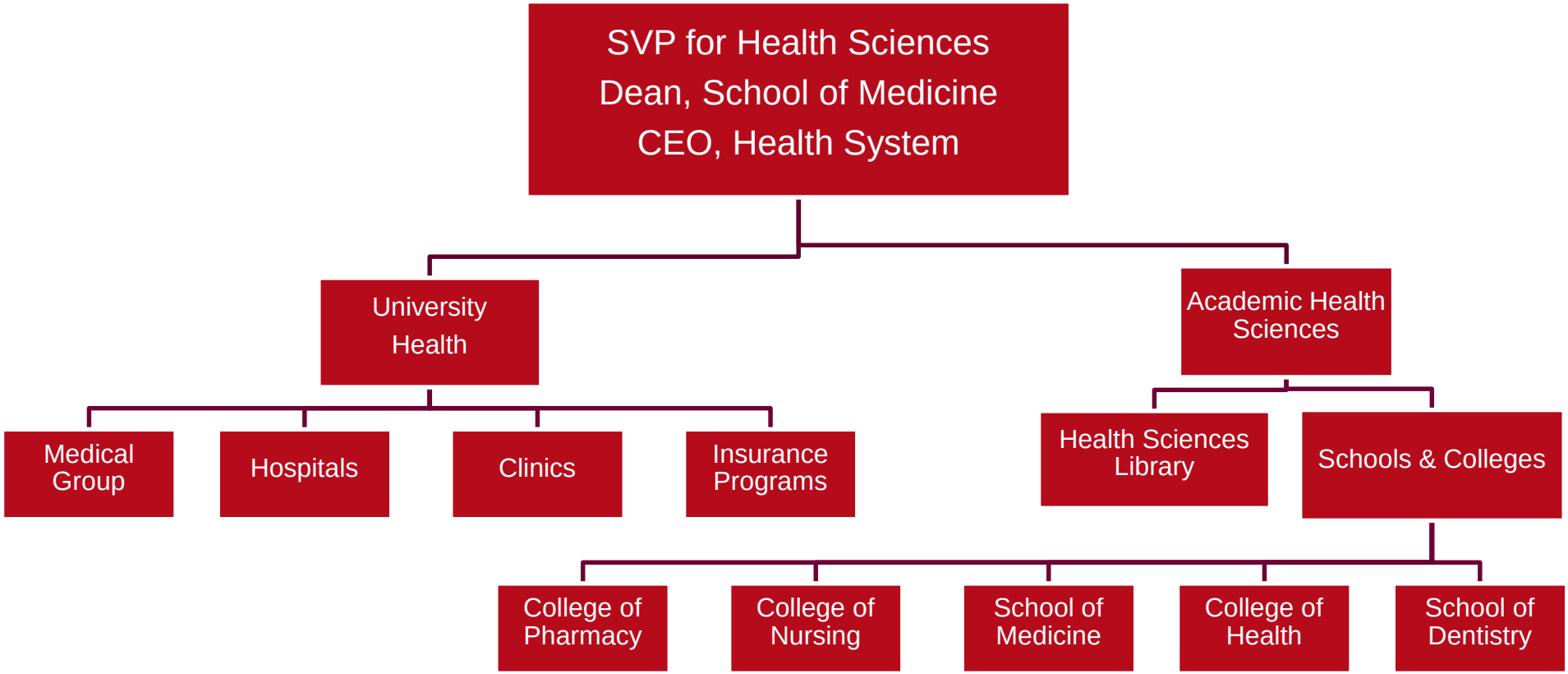
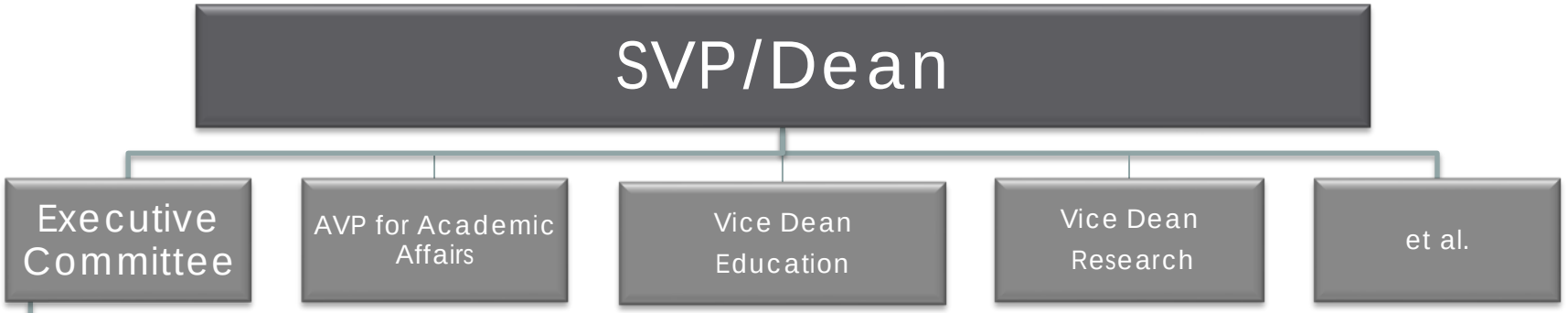
Organizational Structure



School of Medicine Executive Committee



Voting Members
Chair: Jon-Kar Zubieta, Psychiatry
Vice-Chair: Satoshi Minoshima, Radiology
William Couldwell, Neurosurgery
Michael Deininger, Internal Medicine
Talmage Egan, Anesthesiology
Angela Fagerlin, Pop Health Sciences
Robert Fujinami, Assoc Dean, Acad Affairs
Chris Hill, Biochemistry
Kolawole Okuyemi, DFPM
Wayne Samuelson, Vice Dean – Education
Robert Silver, OB/GYN
Daniel Vargo, Surgery
Willard Dere, Interim Vice Dean - Research

Non Voting Members
Michael Good, HSC SVP/Dean
Cynthia Best, Assoc Dean/MBM Director
Ed Clark, HSC Assoc VP Clinical Affairs
Gordon Crabtree, Interim Hospital CEO
Grant Lasson, HSC Assoc VP Strategy
Tony Tsai, Director of Education Strategy
Chair Emeritus: Peter Jensen, Pathology

Our Journey

Over time we have shifted from fixed salary to more incentive and value-based models

- One size did not fit all
  - ✓ Each department has a different set of challenges
  - ✓ Acknowledged that chairs understand the whole field
  - ✓ Salary plan is really the department mission statement (a/k/a what do we value)

Our Journey (cont'd)

- Began to incorporate more activity/productivity measures
  - ✓ Departmental and institutional goals
  - ✓ National trends
  - ✓ Sharing of ideas and experiences
- Measurement is key
  - ✓ Started with self-reported cFTE as part of annual prospective effort survey
  - ✓ Have moved to "paid-to-do" cFTE completed by department chairs and division chiefs

Our Journey (cont'd)

- 55% salaried was 60% two years ago
  - ✓ Shifts in both directions
- Overall, **more metrics and explicit expectations have been added**
- Our process has been **evolutionary**, not revolutionary

We continue to evolve

Concluding Thoughts

Observations

- Need to remember what problem we are trying to fix
  - ✓ Strict income incentive often comes at the expense of the academic mission and value....need a balance
- We want to promote our missions and improve the reputation of the institution and department
  - ✓ e.g., patient satisfaction, presentations, publications, funding
- Focusing on academics involves institutional and departmental priorities and reliable data
- Change is hard
  - ✓ Need time to think differently about the work

Current Challenges

- Moving from volume to value at a pace that matches reimbursement
- Balancing the need to incentivize and recognize the academic mission
- Developing faculty leadership to change culture
- Changing culture by aligning compensation plans with goals and guiding principles

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