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

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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
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
### Participant Overview

#### Organizational Structure

<table>
<thead>
<tr>
<th>Structure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Integrated</td>
<td>27%</td>
</tr>
<tr>
<td>Academic Integration</td>
<td>39%</td>
</tr>
<tr>
<td>Clinical Integration</td>
<td>16%</td>
</tr>
<tr>
<td>Independent Structures</td>
<td>14%</td>
</tr>
<tr>
<td>Independent FPP Structure</td>
<td>4%</td>
</tr>
</tbody>
</table>

#### Physician and Advanced Practice Provider (APP) FTEs

<table>
<thead>
<tr>
<th></th>
<th>FTEs</th>
<th>Physicians Faculty and Community</th>
<th>APPs&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>n = 44</td>
<td>n = 41</td>
</tr>
<tr>
<td>Median</td>
<td></td>
<td>775</td>
<td>188</td>
</tr>
</tbody>
</table>

<sup>2</sup> Seven percent of participants do not employ APPs

#### Physician FTEs Faculty vs. Community-Based<sup>3</sup>

<table>
<thead>
<tr>
<th></th>
<th>Faculty</th>
<th>Community-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 25</td>
<td>90%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<sup>3</sup> 43% of participants do not employ community-based physicians

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

<table>
<thead>
<tr>
<th>Annual Median Growth Rate</th>
<th>Total¹</th>
<th>Community-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical²</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>Projected</td>
<td>4%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

- Faculty Physician Leadership: 48%
- Non-Faculty Physician Leadership: 34%
- Other reporting structure: 18%
AMCs moving toward a balanced approach to better align the compensation strategy with the tripartite mission and organizational strategy.

**Departmental Control**

23%

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

**Blended Approach**

66%

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

**Institutional Control**

11%
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

Departmental Control

- 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

Institutional Control

- 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)
Work Effort, Benchmarking and Compensation Plan Methodologies
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.

Oversight of Physician Compensation

- Funds Flow
  - Academic Sources
- Funds Flow/Affordability
  - Clinical Sources

- Work Effort Allocation
  - Clinical, Research and Teaching FTE Methodology

- Benchmarking Surveys and Methodology

- Compensation Plan Methodology

Physician Faculty Compensation

Transparency, Communication and Reporting
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**

- 11% (n = 37)
- 22% (n = 37)
- 28% (n = 37)
- 39% (n = 37)

**Session (excluding hospital-based)**

93% define a session as a half-day or four hours.

- Less than 40
- 40-45
- 45-50
- 50+

n = 43
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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>cFTE approach varies by department/specialty group</td>
<td>49%</td>
</tr>
<tr>
<td>Standard minimum amount of protected weekly time for each faculty member*</td>
<td>36%</td>
</tr>
<tr>
<td>Standard amount of clinical work effort is allocated to faculty members</td>
<td>17%</td>
</tr>
</tbody>
</table>

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

The predominant methodology for determining cFTE is time-based*

- 1.0 FTE minus teaching, research and administrative time
- 1.0 FTE minus funded effort
- Number of clinical sessions per week
- 1.0 FTE minus blend of funded academic work effort/time
- A standard definition is not defined throughout the organization

<table>
<thead>
<tr>
<th>Methodology</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 FTE minus teaching, research and administrative time</td>
<td>51%</td>
</tr>
<tr>
<td>1.0 FTE minus funded effort</td>
<td>17%</td>
</tr>
<tr>
<td>Number of clinical sessions per week</td>
<td>17%</td>
</tr>
<tr>
<td>1.0 FTE minus blend of funded academic work effort/time</td>
<td>5%</td>
</tr>
<tr>
<td>A standard definition is not defined throughout the organization</td>
<td>10%</td>
</tr>
</tbody>
</table>

* The cFTE approach did not correlate with organizational structure

n = 39
Benchmarking Approaches

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

<table>
<thead>
<tr>
<th>Surveys</th>
<th>Faculty n = 43</th>
<th>Community-Based n = 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAMC</td>
<td>88%</td>
<td>--</td>
</tr>
<tr>
<td>MGMA – Academic</td>
<td>65%</td>
<td>58%</td>
</tr>
<tr>
<td>MGMA – Physician</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>SullivanCotter Surveys*</td>
<td>44%</td>
<td>33%</td>
</tr>
<tr>
<td>FPSC</td>
<td>--</td>
<td>49%</td>
</tr>
<tr>
<td>AMGA</td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>26%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Compensation Implications</th>
<th>Prevalence*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity targets exceed compensation targets by 10 percentage points or more</td>
<td>37%</td>
</tr>
<tr>
<td>* Prevalence percentage reflects organizations that employ both faculty and community-based physicians</td>
<td></td>
</tr>
<tr>
<td>The majority of organizations require physicians to cover some portion of their overhead</td>
<td>72%</td>
</tr>
<tr>
<td>Nearly half compensate academic and clinical work effort differently</td>
<td>43%</td>
</tr>
</tbody>
</table>

n = Number of organizations for which data was collected.
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.

Guaranteed Total Compensation

At-Risk Total Compensation

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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.

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>Pure Salary</th>
<th>Modified Salary</th>
<th>Base Salary + Productivity</th>
<th>Base Salary + Multiple Incentives</th>
<th>Draw + Performance</th>
<th>Net Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>8%</td>
<td>--</td>
<td>33%</td>
<td>46%</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>Surgical</td>
<td>--</td>
<td>--</td>
<td>6%</td>
<td>74%</td>
<td>16%</td>
<td>3%</td>
</tr>
<tr>
<td>Hospital-Based</td>
<td>8%</td>
<td>--</td>
<td>30%</td>
<td>48%</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>--</td>
<td>3%</td>
<td>10%</td>
<td>72%</td>
<td>14%</td>
<td>--</td>
</tr>
</tbody>
</table>
# Key Factors: Base Salary and Variable Prevalence (Highest to Lowest)

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

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

\( n = 33 \)
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.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>69%</td>
</tr>
<tr>
<td>Individual and Group</td>
<td>24%</td>
</tr>
<tr>
<td>Enterprise-Wide</td>
<td>34%</td>
</tr>
</tbody>
</table>

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

1 Group only reflected 7% prevalence

n = 33
### 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.

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>Percentage of TCC</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Median</td>
</tr>
<tr>
<td>Medicine</td>
<td>6.9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Surgical</td>
<td>6.9%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Hospital-Based</td>
<td>6.3%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Primary Care*</td>
<td>8.9%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>Number of Metrics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average</td>
<td>Median</td>
</tr>
<tr>
<td>Medicine</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Surgical</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Hospital-Based</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

58% of organizations are considering the use of panel size metrics in their primary care compensation plans.

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University of Utah
Evolution to Value-Based Compensation
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

\[
\text{Academic (BASE)} + \text{Negotiated (VARIABLE)} + \text{Incentive (CIP)} = \text{Total}
\]

Set Annually; Guaranteed for One Year

**SALARIED**

- **Dept. A**
  - 90% A+N
  - 10% I

- **Dept. B**
  - A+N

- **Dept. C**
  - A+N

- **Dept. D**
  - A+N

**INCENTIVE**
Percentage By Department and Division

55%  20%  25%

SALARIED  MIXED  INCENTIVE

A+N  I  A+N
     I  A+N  I
Evolving Compensation Models
Value Equation

\[ V = \frac{Q + S}{\$} \]

- Value (V)
- Quality (Q)
- Service (S)
- Cost ($)

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Value-Based Compensation Plan
One Example

Base Productivity: 40%
Quality: 10%
Access: 10%
System: 10%
Academic Teaching and Research: 30%

Bonus: 100%

Determined by specialty
Panel size, new patient visits
System and other department goals
Organizational Structure

SVP for Health Sciences
Dean, School of Medicine
CEO, Health System

University Health
- Medical Group
- Hospitals
- Clinics
- Insurance Programs

Academic Health Sciences
- Health Sciences Library
- Schools & Colleges
- College of Pharmacy
- College of Nursing
- School of Medicine
- College of Health
- School of Dentistry
School of Medicine Executive Committee

SVP/Dean

Executive Committee
AVP for Academic Affairs
Vice Dean Education
Vice Dean Research

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

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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