

Sustainable Physician Compensation Model Design

Critical Success Factors for Building Productivity-Based Compensation Models



Live teleseminar with

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Owning Medical Practices: Best Practices for Sustainable Results

and

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KEY POINTS

- 1) Time-tested critical success factors for building productivity-based compensation models that are truly sustainable
- 2) The vital role these factors play in facilitating financial viability for your owned medical practices
- 3) The way in which these factors will help you build your owned medical practice network so you are making significant strides toward market leadership

Success in the future will require physician compensation models that reward high clinical quality, high service quality, and high productivity.



How do you design an employed physician compensation model that is sustainable?

A private practice setting is the gold standard for practice productivity and financial viability.

Tying employed physician compensation models to external benchmarks can cause us to lose sight of the compensation levels that can be expected in a private practice setting.

Focus on factors the physicians can control.

NOTES:

Why is the private practice setting typically more conducive to promoting patient volume and practice revenue than the hospital-owned practice setting?

Necessity motivates private practice physicians to generate and protect cash flow.



With the right incentives and a practice that supports high productivity, employed physicians can achieve the same levels of productivity as their private practice peers.

NOTES:

What are the initial questions that we should consider when developing a physician compensation strategy?

Six questions:

- 1) How do our providers perform in terms of their absolute productivity relative to their private practice peers?
- 2) How much do we compensate our providers for that productivity?
- 3) How does that rate compare to private practice in our community, which is the best indicator of a market rate of pay?
- 4) Do we have internal equity among our current employed physicians within and between specialties?
- 5) What are the local market forces affecting physician compensation?
- 6) Are we competing nationally for a particularly scarce specialty, making compensation more costly?

NOTES:



How important are the attitude and engagement of the physicians in compensation model design? How do we make certain employed physicians are interested in financial as well as clinical performance?

Measure _____ **performance** _____, change the
_____ **outcome** _____.

Physicians and management must work together to achieve:

- Clinical quality
- Service quality
- Productivity
- Financial viability

The “If we don’t work, we don’t eat!” attitude will be required if organizations are to survive over the next few years.

NOTES:



What are the most common approaches and mistakes that you see in physician compensation contracts, and how can they be avoided?

Common mistakes include:

- Tying local physician compensation to national surveys
- Failing to review compensation levels annually and adjust if needed
- Failing to engage and communicate with physicians

The best indicator of a market rate of physician compensation is found by looking at local market realities.

A “compensation committee” can help ensure that management fully understands the physician pressures and perspectives.

NOTES:



What are the most important factors we should pay attention to as far as revenue enhancement and expense control are concerned?

The key to the success of both private and hospital-owned practices lies on the revenue side of the income statement.

NOTES:

What advice would you give us about Work Relative Value Units (wRVUs) as a tool in constructing compensation models?

Important principles for an employment situation:

- 1) Employed physicians should have a high degree of control over the measures that drive their compensation.
- 2) The compensation per unit of production should be sustainable over the long term.
- 3) Hospital executives should invest the time to understand the impact of a compensation model beyond static illustration.
- 4) Fifty percent of total physician compensation should be driven by productivity.
- 5) Productivity compensation should be paid monthly rather than quarterly or annually.



Sustainability is largely a function of _____ **local** _____
_____ **practice** _____ **volume** _____ and a
well-managed _____ **cost** _____ **structure** _____.

NOTES:

Some of our compensation model engineers would like to add various components into the compensation equation, such as: clinical quality, service quality, expense control, personal behavior, or other factors.

What is your opinion of the effect this could have on the sustainability of the model?

Successful compensation models of the future will
maintain a hefty bias toward _____ **high** _____
_____ **productivity** _____.



The hidden costs of tolerating a “C” player are most evident in the frustration of “A” players.

Physicians and management should work together to achieve practice viability using both _____ **revenue** _____
_____ **enhancement** _____ and _____ **expense** _____
_____ **control** _____ tactics.

NOTES:

What are critical success factors in developing and implementing physician compensation plans that will lead to financially viable medical practices?

It is important to understand and acknowledge that:

- Changing a compensation model takes time.
- A change in the compensation model may result in an increase in total compensation costs in the beginning.
- A compensation model that is not sustainable is a bad deal!



A short-term “win” for doctors at the expense of the hospital (or vice versa) is just that—short term.

NOTES:

How important is the clinical setting to the sustainability of our physician compensation model?

The clinical setting has a significant affect on a physician’s ability to achieve optimal performance and can be improved by:

- Implementing “highest and best use staffing”
- Maintaining an efficient “productivity zone”

A barrier that adds a minute of inefficiency to each patient visit can cost two patient visits a day.

NOTES:



We have heard both Marc and Will speak about wRVUs as being a best practice for hospital-owned medical practices. What are the potential advantages and disadvantages of this approach?

RVUs provide a direct measure
of the work that the physician provides.

Through appropriate coding and documentation, the physician can control the ultimate compensation level.

Most payers structure their
reimbursement for billed charges based upon
the RVU scale.

When compensation is based on RVUs, there is a degree of alignment between services rendered and billed and compensation paid—as long as rates per unit are appropriate.

NOTES:

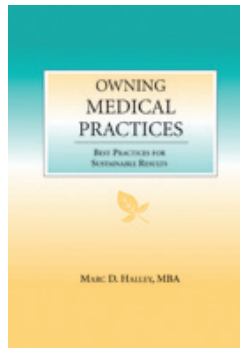


Why is there a seeming resignation of board members, hospital executives, and physician leaders to financial losses as a cost of doing business in hospital-owned medical practices?

What do you recommend as a way to change this thinking?

- Employed physicians who used to be in private practice can be effective advocates for changing this mental model.
- Senior hospital and health system leadership must learn and apply the principles for success in the medical practice business.

Owning Medical Practices: Best Practices for Sustainable Results



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Also available through www.halleyconsulting.com. Click on the Owning Medical Practices logo on the home page.

NOTES:



How can you make a productivity-based plan equitable for all providers when you are dealing with some providers who have administrative and GME teaching responsibilities as well as clinical responsibilities?

Separate administrative/teaching responsibilities from the productivity component.

The benefits of compensating these two distinct roles separately include:

- Ensuring appropriate compensation for each role
- Avoiding the confusion that occurs when elevating clinical rates to adjust for non-clinical activities

How long does it take to effectively address most of the challenges common to hospital-owned medical practices in order to create financial and operational viability?

We usually recommend allowing an 18-month
_____ timeframe to achieve the private practice
gold standard.

This allows adequate time to:

- Establish operational governance
- Develop a competent team of implementers
- Implement proper performance reporting

