Compensation Models for Providers and Staff

Primary Care Leadership in a Changing World: The Next Big Thing

Friday, June 20, 2014
Augusta Civic Center, Augusta, ME

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Why Change Primary Care Compensation?
What Drives Compensation?

• Behaviors we would like to promote
• Culture we would like to have
• Outcomes of work we desire
• Processes we want followed
• Etc......

All are related to and by the Method by which we make money
Why Change Primary Care Compensation?

Because the method by which we make money will change!
Why is the method of reimbursement changing?

Because consumers of healthcare services have decided they value those services differently!
What will change?

What won’t change?

Purpose, Characteristics, and Components of compensation plans are not likely to change
Compensation Model Purpose

• Promote recruitment and retention
• Promote caregiver well being
• Promote intrinsic motivation
• Promote mission, vision and values
• Promote organizational goals and strategies
Compensation Model Characteristics

• Adaptable
• Equitable
• Fair
• Understandable
• Easy to administrate
Compensation Model Components

- Salary
- Performance
- Productivity
What will change?

- **Elements** of the components
- **Relative significance** of the components

Other changes will likely include:

- **Infrastructure** needed to support comp plans
- **Individual provider-centric culture**
Elements: Salary

• Most plans these days have some form of base salary based on some specialty-specific market survey

• Total cash compensation may not relate to current management surveys as
  – Different payor relationships may supplement primary care compensation
  – IDSs come to rely more and more on primary care practices to reach value-based purchasing goals

• Many companies are now in the range of 60-100% salary
Elements: Productivity

• Currently the two common bases are:
  – Work relative value units
  – Practice income

• Future: current performance measures may become productivity measures
  – Panel size
  – Access
  – Clinical outcomes
  – Total cost of care
  – Hospital-based VBP measures
  – Patient experience
  – Patient safety
Relative Significance

• Salary may become more significant
• Productivity, depending on how it is defined, less significant
• Performance measures more significant
Infrastructure

Think about the changes to:

- **People**
- **Process**
- **Product**

Needed to administrate compensation plans that account for and measure.....

<table>
<thead>
<tr>
<th>Salary</th>
<th>Total cost of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel size</td>
<td>Hospital-based VBP measures</td>
</tr>
<tr>
<td>Access</td>
<td>Patient experience</td>
</tr>
<tr>
<td>Clinical outcomes</td>
<td>Patient safety</td>
</tr>
</tbody>
</table>
Infrastructure: People

• **Roles**
  - Changing roles for all
  - *New roles: Patient flow manager, care manager/coordinator, access manager, population health manager*

• **Skills**
  - *Change management/leadership, analytics, team participation/reliance*

• **Number** likely increase in staff, adjust physician staff to balance supply and demand
Infrastructure: Process

• **Operations**
  • Scheduling, Access, Hours, Workflow

• **Finance**
  • Risk, shared savings, capitation, withhold

• **Technology**
  • EHR, Practice management, Patient registries, Business intelligence, Analytics, Reporting

• **Facilities**
  • Promote flow of patients, personnel, materiel, information, light, sound
Infrastructure: Product

• Services
  • Comprehensive primary care
  • Value-added services
  • Supporting services
  • Complimentary services

• Value
  • Clinical effectiveness
  • Patient safety
  • Patient experience
  • Caregiver wellbeing
  • Revenue
  • Labor
  • Non-labor
  • Inefficiency
<table>
<thead>
<tr>
<th>Services</th>
<th>Comprehensive Primary Care Services</th>
<th>Value-Added Primary Care Services</th>
<th>Supporting Services</th>
<th>Complimentary Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low acuity ill care</td>
<td>Onsite specialty care</td>
<td>Laboratory</td>
<td>Nutrition services</td>
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<tr>
<td></td>
<td>Chronic ill care</td>
<td>Precision shop</td>
<td>Radiology</td>
<td>Exercise/training</td>
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<tr>
<td></td>
<td>Preventive and well care</td>
<td>Chronic ill care</td>
<td>Pharmacy – retail,</td>
<td>Massage</td>
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<td>anticoag, refill</td>
<td>Chiropractic</td>
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<td>assistance</td>
<td>Acupuncture</td>
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Culture

• From individual to group
• Internal and external measures
• Not just for care delivery
• Will also include compensation
• Represents a very big change for physicians especially
Transition

• **Programming**: this stuff is expensive, timing will matter

• **Payor relations**: this stuff is expensive, can’t do it without support, move $ from old work to new

• **Hospital relations**: this stuff is expensive and will likely decrease hospital revenue

• **Reporting entity relations**: lack of understanding for cost and complexity, want change now
Hypothetical Compensation Plan

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
<th>Internal Measure</th>
<th>External Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>70%</td>
<td>Prior year performance</td>
<td></td>
</tr>
<tr>
<td>Performance</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Effectiveness</td>
<td></td>
<td>Evidence-based measures</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Patient experience</td>
<td></td>
<td>Access</td>
<td>CGCAHPS</td>
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<tr>
<td>Patient Safety</td>
<td></td>
<td>Correct diagnosis</td>
<td>Adverse Events</td>
</tr>
<tr>
<td>Caregiver Well Being</td>
<td></td>
<td>Engagement</td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td>Panel size</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td></td>
<td>Labor, Non-labor</td>
<td>TCoC, VBP, Utilization</td>
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</tbody>
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**Incentive:** Create bonus pool through withhold to be shared with exceptional performers

**Disincentive:** Adjust base salary down in following year for poor performance

Accountability – Value – Sustainability