

Many Faces of Community Health Conference

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Incentive-Based Compensation

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SESSION GOALS

- Discuss the historical situation of Community Health Centers and the impact on the organization
- Describe a Three-Tier Performance Management and Incentive Compensation System
- Measure provider performance by developing a fair and quantifiable system that incorporates all aspects of provider performance
- Review possible methodologies by which the incentive compensation pool is funded

TYPICAL HEALTH CENTER

- ✓ Patient-focused
- ✓ Mission driven
- ✓ Employees committed to serve needy populations
- ✓ Creative survival strategies

- ☺ comforting environment for patients
- ☹ not necessarily a recipe for operational and financial success

Historic Perspective

- Some organizations started small with founder's vision
- Sometimes developed from a non-health care organization
- Little chance to build reserves
- Health center not always run with "business" purposes in mind
- Disruptive activities:
 - Hostile board
 - Theft or fraud
 - Natural disaster

WHAT HAS THE HISTORIC PERSPECTIVE CREATED?

- Focus on short-term
- Strategies to survive, not thrive
- Focus on actions, not organization or infrastructure
- Distrust between management, providers, and staff

*Is your health center environment structured in a way
that ensures the highest
effectiveness and efficiencies?*

What are the components of successful health centers' culture that support an incentive compensation system?

- Accountability
- Goal Setting
- Incentive Compensation

THREE TIERED PERFORMANCE MANAGEMENT AND COMPENSATION PROGRAM

Tier I – The Management Team

Cascading goals/objectives quantitatively identified from the top (Board) to the CEO, to the rest of the management team

Tier II – Providers

Driven by combination of visit and RVU based productivity, quality, patient satisfaction, and commitment to the organization

Tier III – Staff

Driven by Financial performance, Average Billable visits per provider FTE, minimum quality and minimum patient satisfaction scores

THREE TIERED SYSTEM

Tier 1: Leaders

- Strategic
- Overall Performance
- Creating environment where others can thrive
- Creating environment for excellent patient outcomes

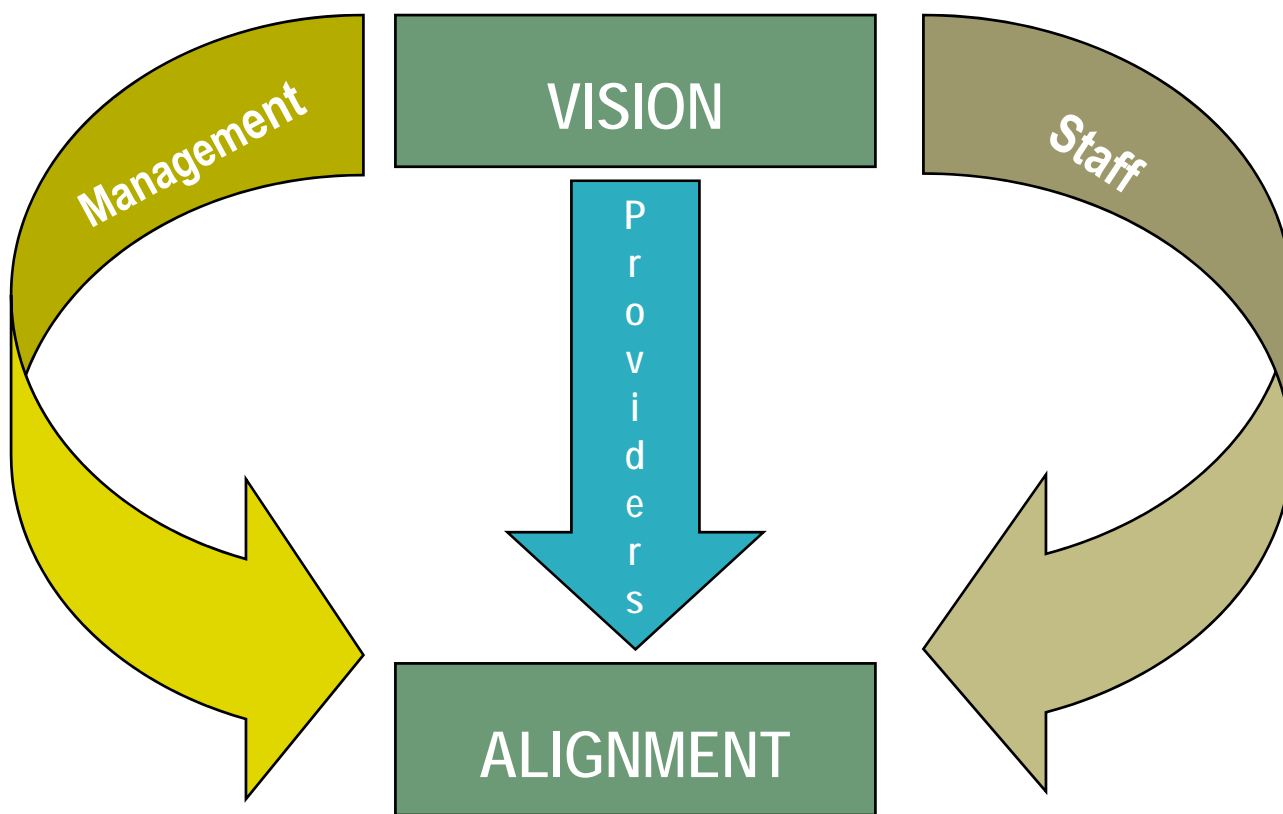
Tier 2: Providers

- Providing Care
- Responsible for excellent patient quality
- High satisfaction rates among patients
- Contributing to the organization

Tier 3: Staff

- Supporting Providers and students
- Support environment where patient outcomes are excellent
- Core members of the team

What Do You Get When Management, Providers and Staff Work Toward the Same Goals?



Considerations for a Three-Tiered Incentive Compensation System

WHAT MAKES AN INCENTIVE SYSTEM WORK?

- Transparency
 - Management, Providers and Staff have to understand how the system works, and how their job duties contribute to the overall performance of the center
 - Also must know how much they can potentially earn – either in dollars, or percent of salary
- Customization
 - An incentive system has to be designed to fit the center's operations
- Size of the Center
 - The system should be proportional and realistic
 - A center with a budget of \$5 million probably cannot support a total package of incentives worth \$500K – it is out of scale with the center's operations

MAKING INCENTIVES MEANINGFUL

- Amount of the incentive
 - ✓ Target incentive compensation must be large enough to be a meaningful incentive
 - ✓ May mean limiting participants
- Linked directly to performance
 - ✓ Incentives cannot be “pennies from heaven”
- Established around distinct criteria
 - ✓ A center should have requirements for participation in the incentive program
- Who participates – if everyone gets incentive comp regardless of individual performance, is there any true incentive?

POTENTIAL PARTICIPATION CRITERIA

- Minimum FTE requirement
 - ✓ e.g., 50% FTE minimum
- Minimum length of service, and/or prorated based on length of service during the year being incentivized
 - ✓ e.g., must be employed minimum of 6 months in the year, then prorated to actual length of service
- Employment status on date of payment
 - ✓ Must be an employee in good standing on the date of payment
 - ✓ Cannot be in a performance plan or on “probation”

CENTER CULTURE

- Establishing an incentive system can be a culture change
- Leaders, providers and staff may have chosen to work in a CHC because of a (perceived) lack of focus on accountability
- Personnel may consider a “helping” culture to be more to their liking
 - e.g., an example center where 50% of the provider team said they didn’t want incentive compensation, because it would change the workplace too much
 - They preferred an environment where the most productive physician noted that she voluntarily works extra shifts to assist her colleagues who have children and family obligations, and the team didn’t want to upset that kind of dynamic

IMPLEMENTING AN INCENTIVE SYSTEM

- A center must develop a system that works within the environment that exists at the center in terms of its finances, culture, and operations
- Incentive systems ultimately call into question every operating tenet that the center has
 - Changes the way the center views teamwork, cost containment, roles and responsibilities, outreach, customer service, etc.
- With the alignment of goals, expect that outspoken members of the team will question the activities of coworkers, including senior leaders, who become more accountable to the rest of the team as to how their jobs impact the center's performance

Management Incentive Compensation

INDIVIDUAL GOALS

- The goal setting process described previously can be the source of goals for the incentive compensation plan.
- “Right-size” individual goals, and the resulting incentive comp, with organization finances.

QUANTIFIABLE MEASURES

- All tasks should be substantiated with quantifiable specific targets and realistic milestones. Such measurements will facilitate the evaluation process of an individual's performance.
- Targets provide an objective means to determine if an individual achieved a task, and ultimately, a goal.

MANAGEMENT INCENTIVE COMPENSATION

- Incentive compensation for senior management should be based on overall organizational performance in conjunction with attainment of individual goals
 - This creates the alignment among providers and line staff as well.
 - Incentive system should be structured to ensure that the organization has positive financial performance before making any payout – a stretch goal.

STRETCH GOALS

- Incentive compensation for senior managers should be set based on a stretch goal of organizational performance
 - Example: If the health center's FY budget projects a net surplus of \$100,000, an incentive-triggering stretch goal would be:
 - ✓ Incentives will be paid if the health center achieves net surplus of \$300,000, including the accrual of the incentive payment
 - ✓ Accrual of the incentive throughout the year is essential for tracking purposes
 - ✓ The incentive is a number smaller than the difference between budgeted performance and the stretch goal amount.
- Individual goals should relate to the Senior Manager's area of responsibility

PAYING MANAGEMENT INCENTIVES

- Example: A health center has 5 Senior Managers, (CMO, CFO, COO, CIO and VP HR). The team shares the goal of attaining the stretch goal of \$300,000 in net surplus at the end of the fiscal year. Each Senior Manager is responsible for setting 3 individual goals in conjunction with the CEO at the beginning of the fiscal year.
- The three goals should all have individual dollar amounts assigned to them so there is complete transparency to the compensation
- The senior manager and the CEO should agree on whether or not the goal has been attained and the CEO should provide documentation of the same to the Senior Manager.

PAYING MANAGEMENT INCENTIVES

Senior Management Incentive Plan CHIEF OPERATING OFFICER

		Achieved	Payment Due
Total Bonus Potential:	\$15,000		
Distribution:			
Organizational Stretch Goal Attainment:	\$5,000	YES	\$5,000
Individual Goals:			
1. Achieve JCAHO Reaccreditation	\$5,000	YES	\$5,000
2. Reduce DMS Staff Turnover Rate to 15%	\$2,500	NO	\$0
3. Reduce Variable Expenses per Visit by \$1	\$2,500	YES	\$2,500
Total	\$15,000		\$12,500

Provider Incentive Funding and Participation

FACTORS TO CONSIDER PRIOR TO IMPLEMENTATION

- *Provider eligibility* – Participation should be based on a minimum FTE standard.
- *New Hires* - providers should be on staff for one quarter prior to participation to allow providers time to familiarize themselves with the program and to build up a patient panel.
- *Threshold* - The distribution of the funding for each component is distributed among participating providers based on the performance standards set by the organization. Performance standards are set by determining acceptable minimum thresholds.
- *Weight of Component* – Each component carries a percentage “weight” that determines the value of each component when calculating the overall performance rating of a provider.

INCENTIVE POOL FUNDING

- Linking performance to incentive compensation could be executed in the following manner:
 - A. Risk
 - 1) Cost of living adjustment at 3% to fund the pool
 - B. Opportunity-Based Increase
 - 1) Group productivity incentive at 20% of net collections over standard

INCENTIVE POOL FUNDING

A. Risk

In lieu of annual salary increases for providers, the cost of living adjustment can be utilized to fund the incentive compensation plan.

Total Providers 2006 Annual Base Salary	\$800,000
Expected 2007 Cost of Living Adjustment (3%)	\$24,000*
Total Providers 2007 Base Salary	\$800,000
Expected 2008 COLA (3%)	\$24,000
2008 Incentive Pool Funding	\$48,000

INCENTIVE POOL FUNDING

B. Opportunity-Based Increase

Step One: Calculate Total Productivity

	<u>FTEs</u>	<u>Current Annual Visits</u>	<u>Target Annual Visits</u>
Physician Standard Billable Visits	20	4,000	4,200
Mid-level Standard Billable Visits	10	2,400	2,500

(Billable visits count after provider has worked for six months)

Note: Target visits is approximately 5% above current productivity

INCENTIVE POOL FUNDING

B. Opportunity-Based Increase *(continued)*

Step Two: Calculation of Incremental Visits

	<u>FTEs</u>	Visit <u>Target</u>	Total <u>Visits</u>
Physicians	20	4,200	84,000
Mid-levels	10	2,500	<u>25,000</u>
Total Visits			109,000
Target Quarterly Visits (109,000/4)			27,250
Billable Visits for Quarter (actual)			29,250
Incremental Visits (Actual –Target)			2,000

INCENTIVE POOL FUNDING

B. Opportunity-Based Increase *(continued)*

Step Three: Calculate an average collection per visit using current billable visits

Evaluation of Collections:

Cash Collected for Quarter:	\$1,112,500
330 Grant Quarterly Allocation	<u>350,000</u>
Total Collections	\$1,462,500
Current Billable Visits for Quarter	29,250
Average Collection Per Visit (\$1,462,500/29,250)	\$50.00
Incremental Visit Collections (\$50 X 2,000)	\$100,000
Funding of the Pool (\$100,000 X 20%)	\$20,000

Provider Distribution Option 1: Goal Setting and Evaluating Total Performance

COMPONENTS OF A PROVIDER PERFORMANCE MONITORING PROCESS

- Goals should be carefully chosen to balance conflicting priorities, such as encouraging improvement in provider efficiency and effectiveness while maintaining a high level of quality of care. Categories of goals could include:
 - Productivity
 - Patient Satisfaction
 - Quality of Care
 - Contribution to the Organization

PROVIDER PRODUCTIVITY

- Productivity is a key measure of provider performance. Increasing productivity can:
 - Maximize patient throughput
 - Realize additional revenue
 - Increase a health center's capacity to meet the needs of the community
- The most effective way to evaluate provider productivity is to use visits to measure financial contribution, and Relative Value Units (RVUs) to measure service contribution.

WHAT IS AN RVU?

- The Medicare program took a major step to reform physician payments by implementing the Medicare Fee Schedule (MFS) on January 1, 1992.
- The Resource Based Relative Value Scale (RBRVS) used in the MFS includes three components:
 - (1) total physician work
 - (2) practice expenses, and
 - (3) malpractice expenses.
- Each component is measured in terms of relative value units (RVUs).

RELATIVE VALUE UNITS

- *Components of RVUs*
 - The National Physician Fee Schedule Relative Value File has columns for the individual components of RVUs, as well as for the total RVU.
 - *Work RVU* - measures the provider skill and effort required to complete the service;
2007 Work RVU for a 99213 = .67
 - *Practice Expense ("PE") RVU* - measures the practice expense/overhead resources required to complete the service; *2007 Overhead RVU for a 99213 = .69*
 - *Malpractice ("MP") RVU* - measures the malpractice risk associated with the particular procedure. *2007 Malpractice RVU for a 99213 = .03*
Total RVU for a 99213 = .67+.69+.03 = 1.39

PROVIDER PRODUCTIVITY USING WORK RVUS

CPT Code	Work RVU	PROVIDER A		PROVIDER B	
		Procedures	Total Work RVUs	Procedures	Total Work RVUs
99203	1.34	159	213.06	885	1185.90
99212	0.45	1,142	513.90	401	180.45
99213	0.67	1,749	1171.83	904	605.68
99214	1.10	1,163	1279.30	1,722	1894.20
SUBTOTAL VISITS		4,213		3,912	
11600	1.31	85	111.35	22	28.82
16000	0.89	34	30.26	18	16.02
TOTAL PROCEDURES/RVUS		4,332	3,320	3,952	3,911

PROVIDER PRODUCTIVITY SCORING

- Providers (both physicians and mid-levels) can be evaluated against benchmarks appropriate for each provider level. Sample quarterly benchmarks are as follows:

<u>Score Standing</u>	<u>Score</u>	<u>Quarterly Work RVU per FTE</u>
Exceeds Expectations	4	≥ 900
Meets Expectations	3	≥ 750
Needs Improvement	2	≥ 600
Does Not Meet Expectations	1	< 600

- Based on this example, a provider with 700 Work RVUs per FTE would score a 2 (Needs Improvement). RVU-based productivity is calculated utilizing CPT Code information. It is therefore imperative that provider coding patterns are monitored.

PATIENT SATISFACTION

- Patient satisfaction is critical to maintaining and/or increasing market share. Efforts to increase productivity and efficiency should enhance rather than mitigate patient satisfaction. Providers who strive to meet their patients' expectations should be acknowledged and rewarded.
- It is extremely important to extract provider satisfaction from the patient's overall health center experience. Therefore, factors beyond the provider's control, such as health center amenities, waiting times not associated with provider efficiency, front office staff performance, etc., should not be included in the evaluation instrument.

PATIENT SATISFACTION

- The following issues could be included when selecting goals relating to patient satisfaction:
 - Medical care received
 - Ability to communicate treatment/medicine requirements, etc.
 - Listening and addressing questions/concerns
 - People Skills

- The best way to gather this information is to use a provider-specific patient satisfaction questionnaire. This questionnaire would be stand for all providers and can be distributed to patients on a quarterly or on-going basis.

PATIENT SATISFACTION QUESTIONNAIRE SAMPLE

- 1. Do you feel your provider listened and understood your concern(s)?**
Not at all ____ Somewhat ____ Well ____ Very Well ____ Does Not
Apply ____
- 2. How well did your provider meet your primary medical needs?**
Poor ____ Fair ____ Good ____ Excellent ____ Does Not
Apply ____
- 3. How complete was your provider in explaining your condition and treatment options?**
Poor ____ Fair ____ Good ____ Excellent ____ Does Not
Apply ____
- 4. Would you recommend your physician/provider to family and friends?**
Not at all ____ Maybe ____ Likely ____ Absolutely ____ Does Not
Apply ____

PATIENT SATISFACTION SCORING

Evaluating a provider's performance regarding patient satisfaction can be accomplished by collecting the completed questionnaires and calculating the total number of points realized by each provider divided by the total possible points.

For example:

How interested is your physician/provider in you and your medical problem(s)?

Not at all	___	Somewhat	___	Interested	___	Very Interested	___	Does Not Apply	___
<i>Points</i>	<i>(0)</i>		<i>(1)</i>		<i>(2)</i>		<i>(3)</i>		<i>(0)</i>

- Suppose twenty patients completed a 5-question questionnaire for Provider A, resulting in a total of 200 points out of a possible 300 (66.7%).

PATIENT SATISFACTION SCORING

- Each of the survey questions will be totaled using the same methodology to derive an overall score as follows:

<u>Score Standing</u>	<u>% of Total Point Targets</u>	<u>Score</u>
Exceeds Expectations	$\geq 70\%$	4
Meets Expectations	$\geq 60\%$	3
Needs Improvement	$\geq 50\%$	2
Does Not Meet Expectations	$< 50\%$	1

- Based on this scoring system, Provider A having received a score of 62.5% would receive a score of 3.

QUALITY OF CARE

- Quality of Care is a tenet of any healthcare organization and is a central component of provider responsibility. Providers should be held accountable to provide the highest quality of care to his/her patients. Quality of Care can be measured on many levels. Categories could include:
 - Prevention/Primary Care
 - Immunizations/Vaccinations
 - Vision and Hearing Screening
 - Cholesterol Screening
 - Annual Pap Smear
 - Condition/Disease Specific
 - Asthma Management (Adult and Pediatric)
 - Diabetes Management
 - Hypertension Management

QUALITY OF CARE

- Documentation
 - Accurate Documentation of Medical Record
 - Match Between ICD-9 and CPT Codes
 - Up-to-date Problem List

- Providers and Management must work together to pre-determine the specific quality goals within each category as well as benchmarks that should be used to evaluate the providers with respect to the achievement of such goals.

QUALITY OF CARE SCORING

- Quality of Care can be measured on a PASS/FAIL score.
- An overall Pass/Fail score for each participating provider will be assigned based on results from the selected measures.

- Because the overall evaluation of participating providers is a weighted average of the four component scores, the Pass/Fail score for Quality of Care must be assigned a numeric value. The Pass/Fail results will be linked to a numeric score as follows:

Pass/Fail Result	Numeric Score
Pass	4
Fail	1

CONTRIBUTION TO THE ORGANIZATION/COMMUNITY

- Providers play an important role in improving operations by ensuring continuity of and access to care, and by actively participating in their communities. These activities often go “beyond the job description” and should be encouraged and rewarded.

- Contribution to the organization/community can be measured in many ways, including the following:
 - Participation in internal and external committees
 - Participation in marketing, outreach and community service activities which enhance the health center’s exposure
 - Participates in teaching, mentoring or research activities either internal and or external
 - Maintenance of CME requirements
 - Maintenance of academic appointments, participation in teaching programs, participation in research

CONTRIBUTION TO THE ORGANIZATION/COMMUNITY SCORING

- A provider's contribution to the organization/community can be evaluated by collecting the completed questionnaires and calculating the total number of points realized by each provider divided by the total possible points.

Example

Response scores for questions may vary. Suppose using a ten question form, Provider A has a total score of 20 points out of a total possible score of 30 points, or 66.7% of total possible points.

<u>Score Standing</u>	<u>% of Total Possible Points Targets</u>	<u>Score</u>
Exceeds Expectations	≥ 75%	4
Meets Expectations	≥ 65%	3
Needs Improvement	≥ 55%	2
Does Not Meet Expectations	< 55%	1

Based on this scoring system, Provider A would have received a score of 3.

OVERALL SCORING

- The Provider Performance Monitoring Process will utilize benchmarks to score three of the four components. The benchmarks for these components are linked to the following numeric scoring range:
 - 4=Exceeds Expectations
 - 3=Meets Expectations
 - 2=Needs Improvement
 - 1=Does Not Meet Expectations
- The Quality of Care results of Pass or Fail are assigned an automatic numeric score of 4 or 1, respectively.

OVERALL SCORING

- The overall score of the provider's results is determined by the weight distribution of each component. In the example below, the sample organization chose to distribute the overall score in the following manner:

Provider Productivity	40%
Quality of Care	30%
Patient Satisfaction	20%
Contribution to the Organization	<u>10%</u>
Total	100%

OVERALL SCORING

To calculate a total weighted summary score, multiply each component score by its respective weight and then sum the totals. Below is the weighted summary score for a sample provider:

<u>Component</u>	<u>Score</u>	<u>Weight</u>	<u>Weighted Score</u>
Provider Productivity	2	35%	.7
Quality of Care	4	25%	1.0
Patient Satisfaction	3	20%	.6
Contribution to the Organization	3	20%	.6
Weighted Summary Score		100%	2.9

Provider Distribution Option 2: Direct Pool Distribution

FUNDING DISTRIBUTION AMONG PROVIDERS

- Total Incentive Compensation Funding - \$20,000
- Provider Productivity Funding Distribution – 50%
- Provider Productivity Pool Distribution - \$10,000
- Quality Required - No

Provider	Work RVUs/FTE	Dist %	Pool Distribution
Handler	2,500	31%	\$3,100
Jeffreys	2,600	33%	\$3,300
Smith	2,900	36%	\$3,600
Total	8,000	100%	\$10,000

FUNDING DISTRIBUTION AMONG PROVIDERS

- Total Incentive Compensation Funding - \$20,000
- Patient Satisfaction Funding Distribution – 25%
- Patient Satisfaction Pool Distribution - \$5,000
- Quality Required - Yes

Provider	Patient Satisfaction*	Dist %	Pool Distribution	Quality
Handler	94%	52%	\$2,600	Pass
Jeffreys	82%	N/A	\$0	Fail
Smith	86%	48%	\$2,400	Pass
Total	180%**	100%	\$5,000	

* percentage of total available survey points

** total of applicable providers only

FUNDING DISTRIBUTION AMONG PROVIDERS

- Total Incentive Compensation Funding - \$20,000
- Contribution to the Organization Funding Distribution – 25%
- Contribution to the Organization Pool Distribution - \$5,000
- Quality Required - Yes

Provider	Contribution Calculation	Dist %	Pool Distribution	Quality
Handler	50%	41%	\$2,050	Pass
Jeffreys	100%	N/A	\$0	Fail
Smith	80%	59%	\$2,950	Pass
Total	135%**	100%	\$5,000	

** total of applicable providers only

FUNDING DISTRIBUTION AMONG PROVIDERS

- Total Incentive Compensation Funding - \$20,000
- Totals By Provider

Provider	Productivity	Patient Satisfaction	Contribution to the Organization	Total Pool Distribution
Handler	\$3,100	\$2,600	\$2,050	\$7,750
Jeffreys	\$3,300	\$0	\$0	\$3,300
Smith	\$3,600	\$2,400	\$2,950	\$8,950
Total				\$20,000

TIER III: STAFF GOAL SETTING

- All staff of the health center, not participating in either the Tier 1 (Management) or Tier 2 (Provider) programs, will be encouraged to support:
 - a highly productive organization
 - a high quality organization
 - an organization where patient satisfaction is required
 - superior customer service
 - efficiency, attendance, and “pitching in”

TIER III: STAFF GOAL SETTING

- All line staff are “in alignment” when they can clearly articulate how their job responsibilities can assist the center in meeting its stretch goals
- Because it is usually impractical to consider individual goals for all staff members, one method is to compare organizational performance in terms of billable visits per provider FTE for the whole year
 - An increase is a good proxy measure for increased revenues
 - Remember: self-pay visits are considered **billable**, so there is no conflict with the health center’s mission

STAFF INCENTIVE COMPENSATION

- Assumption: Prior year average billable visits per provider FTE was 3,500
- Model: Organization must pass minimum quality standard and minimum patient satisfaction standard, and the center meets its target of \$400,000 net income (after accruing for incentive payments)
- If these are passed, and billable visits increase by at least 5% or 3,675 billable visits per provider FTE, staff would be incentivized as follows:

SAMPLE STAFF INCENTIVE COMPENSATION

<u>Current Year Billable Visits Per Provider FTE</u>	<u>Bonus on Salary</u>
3,675 – 3,850	1.5%
3,850 – 4,025	2.5%
4,025 – 4,200	3.5%
> 4,200	5%

- Note that this method would already take into account a pro-rating of an employee's FTE

SUMMARY

- Performance measurement must be quantified
- Set goals for the organization as well as for individual providers, and align them
- Measure productivity, quality, satisfaction and organizational contribution
- Fund incentive compensation pool from business margins and/or planned salary increases
- Make systems transparent, and communicate about them often