

# *Engaging Physicians in the Process of Change At*

## **Community Health Plan**

The healthcare industry is undergoing such fundamental change that few can agree on its direction. Hospitals are no longer the primary providers of healthcare services, physicians no longer exclusively control the provision of services, reimbursement organizations are seeking to manage costs and services aggressively, and managed care organizations are no longer boutiques in the marketplace.

Patient care has become multidimensional, including access to services, disease prevention, clinical treatment, and interpersonal effectiveness. Accountability for the costs of providing care and the access to the delivery of care are being influenced by a complex array of groups. At the vortex of the whirlwind of change is the physician. The physician's role is changing from a primary focus on caring for patients to managing a complex array of resources to achieve desired clinical outcomes. Yet the basic framework on which physicians are compensated has not changed in most organizations.

### **Background of Community Health Plan: The Vermont Region**

The Vermont region of the Community Health Plan (CHP) has taken the bold step of changing the way it compensates physicians. This organization is the medical group that serves the needs of member patients in Vermont and nearby New York communities. It included approximately 70 physicians in pediatrics, adult medicine, and family practice. They were located in 16 health centers in Vermont.

There were several factors that led to this decision. First, the organization was facing increasing competition from group practices and other managed care organizations. It needed to improve effectiveness in delivering services as well as the pay levels for clinical practitioners. Second, it had completed several important reorganizations that changed staffing levels within the health centers and developed new care management programs. Finally, it was increasingly difficult to reduce certain major costs that were attributed directly to the physicians. These included hospital utilization, referrals and consults with external specialists, and other related costs. The challenge was to retain a high level of patient care while reducing the associated costs.

To this end, Vermont Regional Medical Director Paul Jarris, M.D., M.B.A., and Bruce Nash, M.D., the vice president of medical affairs for Community Health Plan, decided to develop an incentive compensation program for the physicians. The Vermont region would serve as a pilot site for the new program. If the plan were successful, it would contribute to their ability to grow the practice and invest in the capabilities of the organization.

## Developing the Physician Incentive Program

To design the program, Dr. Jarris and his staff selected a design team of full-time practicing physicians and physician managers. There were 10 people on the team. They met for a series of sessions over five months and worked with an external consultant who planned and guided the meetings. The plan was approved by management and was implemented in the fall of 1995.

In developing the program, the design team had to address several critical issues. First, there needed to be a compelling reason for the program so that it would be appealing to physicians. The group discussed at length the issues facing the organization and came to realize that physicians needed to take more accountability over the care of the patients and the resources of the organization. A key outcome of this discussion was to identify a set of characteristics that defined the “ideal practice” of the organization. This process identified the conditions that should exist if the organization were practicing medical care in an “ideal” fashion. Some of these factors included:

- Meet or exceed that patient’s expectation for service.
- Create valuable healthcare services for our patients and payers.
- Improve the health status of the population we serve.
- Deliver services in innovative ways that anticipate changes in the marketplace.
- Work as a team throughout the organization.
- Be respected as active participants in community programs.

Second, the question of ethics in healthcare and the role of physician incentives was the single most important topic for discussion. Although an exploration of the ethical issues is beyond the scope of this case study, the fundamental conclusion was that incentives would indeed be appropriate if they were balanced and measured improvements in care. For example, measures of productivity must be balanced with patient satisfaction and quality of care measures to avoid the churning of patients. The design team addressed this issue at numerous times throughout the design process, in particular when identifying performance measures and establishing the emphasis between individual and team rewards.

Third, selecting the performance measures was perhaps the most important and challenging aspect of the design process. Not only did the team need to identify the “right” measures and achieve a desired balance, they needed to ensure that the systems were in place and the measures provided effective feedback on performance.

The group identified five areas that would be important to the physicians and the organization:

1. Patient satisfaction. A survey of patients was conducted by an external public opinion survey company, with measures based on the satisfaction with health center and clinical care providers.
2. Clinical quality. These specific department measures (e.g., pediatrics) were

selected from priorities identified by CHP, and were among those measured by the National Committee for Quality Assurance and HEDIS (the Health Employers Data Information Set).

3. Resource management. This entailed how well the health center utilized its resources for hospitals, emergency room visits, specialty referrals, and other associated costs of providing high-quality care.
4. Personal productivity. Relative value units (RVUs), a method developed by the U.S. Healthcare Financing Agency (HCFA), was used to measure the amount, intensity, and complexity of the services provided by individual clinicians.
5. Teamwork effectiveness. An internal survey of peers was conducted by regional administration to determine the degree to which clinical providers worked in a collaborative and supportive manner.

Three of these measures were captured at the team level—clinical quality for the department, resource management, and patient satisfaction for the health centers. Only the personal productivity and teamwork effectiveness were linked to the individual physician. This therefore achieved a desired balance between individual and team, health center, and the clinical discipline. Performance improvements in these areas would reflect a positive impact on the patient, the reputation of the organization, and the overall effectiveness of the Vermont region.

The program included physicians, nurse practitioners, and physician assistants. A performance score from the incentive plan “scorecard” would determine the payouts. See Figure 8-4 for an illustration of the CHP performance scorecard. The payouts were determined by multiplying the performance score by a percent of the individual’s income over the performance period. This enabled adjustments for individuals who were not working a full-time schedule. Payouts were planned for every six months.

Measures	X Weight	Threshold			Budget/Plan			Target			Exceptional			Points
		50	60	70	80	90	100	110	120	130	140			
Patient satisfaction by health center	25%	80	82	84	86	87	88	89	90	91	92		28	
Quality indicator by department (HEDIS target)	25%	50-59	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130-139	140		30	
Resource measurement by health center	15%	110%	105%	100%	97%	94%	92%	90%	88%	86%	82%		15	
RVUs by provider	25%	4200	4300	4400	4500	4600	4800	4900	5000	5100	5200		28	
Teamwork survey average score by provider	10%	82	84	86	88	90	92	93	94	95	96		9	
												<b>Total Score</b>	<b>110</b>	

Points: Performance level achieved (50-140) x the weight assigned to the measure

**Figure 8-4. The performance scorecard used at CHP.**

## **Implementing the Incentive Compensation**

The implementation process proved to be as critical as the design process. During the design meetings, team members frequently discussed the questions and concerns that were voiced to them by their peers. This was highly beneficial to manage any issues about the program and build support during the development period. The rollout of the plan included a presentation of the plan to all physicians. This was intended so everyone understood how the plan worked and all heard the same message. Members of the design team who were clinical peers attended the session and answered many of the providers' questions; this enhanced the credibility of the program.

Second, each physician received a brochure that described the program and addressed the most frequently asked questions. This brochure served as a reminder and to update new physicians on the program. Third, all physicians met as a team with other department members or one-on-one with their managers to review specific goals and questions. They used this time to develop strategies and specific action plans to improve performance in the critical areas. The goal of these meetings was to provide the needed guidance on the desired actions.

What became very clear was that the program provided an important mechanism to guide actions and reward the gains that were realized. No one was placed in a situation where they received less income; instead the program was added to existing salaries. The region had not provided pay increases for several years due to its overall financial performance. The program provided a mechanism for the group to catch up to the market and go beyond it if high levels of performance were achieved. It was anticipated that over time the payout levels would increase as the people gained confidence in the program and the program was supported by stronger information systems.

## **Assessing the Impact**

The results of the program have been quite remarkable. The most significant improvements in performance occurred in the quality of care and physician productivity areas. In particular, the group developed and implemented a greater number of asthma treatment plans and significantly increased the use of peak flow meters. It also increased the number of women receiving mammography tests and children being fully immunized. These preventative actions paralleled a decrease in use of emergency room services. The median performance in personal productivity (i.e., RVUs) increased by close to 10%. This was achieved by physicians increasing their panel size with new members, opening appointments for fee-for-service patients, and assuming patients of physicians who terminated employment.

The Vermont region of CHP experienced an important improvement in quality of care and a strong overall rise in financial performance. Although the program was not dependent on financial results, the achievements realized from this program clearly increased the financial strength of the organization. Over the several performance periods, an increasing

number of physicians received payouts. Dr. Jarris indicated that “the program did not really become operational until the providers received their first payouts. Then they knew we were serious and they could make a difference.”

The distribution of payouts to providers over the first year of the plan was:

No payout: 15%

Between \$500 and \$1,000: 5%

Between \$1,000 and \$3,000: 20%

Between \$3,000 and \$5,000: 19%

More than \$5,000: 41%

The medical group was able to demonstrate approximately a 4:1 return on investment from the program. This meant that if the group paid out \$350,000 in incentives, it realized \$1.4 million in increased income and savings. The funding of the program was built into the measures and performance levels. During the design process, the design team examined the payout opportunities and associated these to the measures. They realized that they did not need an additional funding mechanism for the program. This technique proved to be an important confidence-building process for the physicians and kept the program focused on quality of care (not financial) issues.

### **Going Forward**

The program has achieved its primary objective of improving performance and building a strong sense of commitment by the providers. This program has enabled physicians to realize personal benefit from the actions they take to improve the quality of care, being more responsive to patients and improving the overall organization. One physician indicated that the program was a useful mechanism to measure and recognize contributions, and that physicians seldom received such feedback. It gave them an opportunity to share in the improvements they help create.