

Bridging the Gap between Physicians and the Organization At



There are those who believe there is an inherent conflict between physician incentives and the quality of care. The argument suggests that if physicians are more interested in the financial aspects of the organization, they will pay less attention to caring for patients and providing sound quality of care. Organizations that have established quality- and patient-based physician incentive plans have experienced just the opposite. When physicians have a portion of their compensation linked to the effective management of care, the patient and the employing organization benefit. This has been the experience of Harvard University Health Services.

There is much controversy about physician compensation. As managed care organizations or private physician groups employ more and more physicians, the issue of designing a fair compensation program is of paramount importance. The reason is simple: They need to encourage and reinforce the right behaviors. The development of a compensation program needs to consider a variety of personal, healthcare, and business factors. It involves more than just providing competitive salaries and pay increases based on seniority.

Traditionally, physicians joined managed care organizations for lifestyle reasons. They made trade-off decisions of compensation opportunity for the ability to have more free time, operate with greater autonomy, and be free of the business responsibilities of managing a practice. However, pressures of the marketplace have caused many of these employing organizations to change these role expectations. Physicians need to consider the resource utilization necessary to provide the highest quality of care, and they need to coordinate care across a wide array of groups, including nursing and specialties, and participate actively in many organizational committees and programs. The confluence of the different requirements has created significant conflict in these healthcare organizations.

Dealing with Change

Harvard University Health Services (HUHS) has faced these issues and made significant progress. HUHS is owned by Harvard University. It serves the faculty, students, and staff members of the university and operates as an independent managed care organization. Faculty and staff members have several choices for healthcare insurance, so HUHS needs to “compete” for patients like any private health maintenance organization (HMO). Fortunately, it has achieved the distinctive reputation of providing excellent care and is the lowest cost provider of these services.

HUHS faces the same marketplace and service pressures as most managed care companies. It primarily employs internist and pediatric physicians, as well as a strong nurse-practitioner staff and a network of health centers and administrative services. It has service contracts with specialty physician groups (e.g., surgeons, obstetricians) and two major Boston teaching hospitals.

HUHS continually develops and implements programs to improve its ability to manage disease and care for patients. In 1994, it decided to take a bold step to change the compensation arrangement for its physicians. The actions that resulted from this decision have made fundamental changes in the culture and performance systems of the organization.

The Task of Designing a New Compensation Program

HUHS decided to change the physician compensation program for several reasons. First, it was having increasing difficulty in attracting and retaining new talent. While long-service physicians continued to earn above market pay levels, other organizations were offering more attractive pay packages to new physicians. HUHS needed to compete for talent.

Second, the organization had never fully clarified the work expectations for its physicians. What is an acceptable level of clinical time? How should physicians participate in organizational committees? How many patients should they have in their panel (or assigned to them)? Should physicians be responsible for hospital rounding? What about being on call or covering for other physicians? The performance requirements for the organization were changing, and it needed a “new deal” with the physicians.

To begin this process, Director of Health Services David Rosenthal, M.D., and Associate Director of Administration Mary Hennings, along with several chiefs of clinical services, agreed that the compensation program needed to be clarified and changed. For the next several months they conducted meetings with many of the formal and informal leaders to create support for change. While HUHS did not experience the same major competitive pressures of the other Boston-area HMOs, it did need a reason for change. Through these discussions, the focus became creating a program that would enable them to attract and retain new talent and provide a compensation program that was fair and reflective of the contributions made by the physicians.

Once a general consensus had been achieved, the senior managers selected a design team to work with administration and an outside consultant to review the current compensation plan and recommend a new primary care compensation plan. They were charged specifically with the responsibility of developing guidelines for the work expectation and a variable pay program for physicians.

The group met biweekly for more than 15 months. There were several status report meetings with the general physician population, and they solicited input and consensus from many sectors of the organization. The group included physicians as well as administrators. While many of the discussions were quite protracted, the group ultimately developed a workable plan and achieved approval of its recommendations.

The primary objectives of the physician compensation plan included the following:

1. Motivate and reward achievement of strategic goals.
2. Ensure the quality of care.
3. Attract and retain excellent physicians.
4. Encourage teamwork.
5. Foster organizational commitment.

Work Expectations and Base Salary

The first task the design group tackled was defining work expectations. They wanted to relate salaries to the basic performance requirements to ensure pay was internally equitable and externally competitive. The basic work expectations describe the baseline level of responsibilities for the physician. They are expected to evolve and develop over time as roles and organizational needs change. The expectations needed to relate to the desired level of compensation that was comparable to other organizations. This was a simple principle of “market work for market pay.” If individuals achieved the desired level of basic work expectation, they would be able to participate in the variable compensation plan.

The work expectations define the following key accountabilities:

1. Provide primary care to members of the University Health Services.
2. Serve the patient’s medical and psychosocial issues which include the number of clinical hours, collaboration with other care team members, educating and advising patients, referring patients to the appropriate specialists when necessary, and other care responsibilities.
3. Fulfill one’s responsibility for acute treatment services at HUHS.
4. Admit patients to the infirmary network hospitals or other appropriate continuous care provider organizations.
5. Oversee patients’ inpatient care.
6. Participate in departmental and organizational activities, such as committees, workgroups, and teaching and continuous medical education programs.

Each of these expectation statements is defined more fully than presented here. They were discussed with the physicians and clarified. They are calibrated based on the full-time equivalent (FTE) status of employment. The physicians are evaluated annually on each of these expectation factors and receive up to a maximum of 100 points. This provides the physician with a performance score.

The score translates into base pay increases and variable compensation eligibility. Physicians receiving a score of less than 80 will not receive a pay increase. If the performance is not improved beyond this point over three years, these are grounds for dismissal. Individuals receiving between 80 and 84 points will receive a pay step increase, but will not be eligible for variable pay. If the score is 85 or higher, the physician will receive the pay step increase and be eligible for variable pay. Individuals at the top of the salary range who receive a performance score of 85 or greater will be eligible for variable pay but not a salary increase. This links the work expectations directly to the pay base step increase system of HUHS.

The Physician Variable Pay Plan

The purpose of the variable pay plan is to recognize and reward physicians who demonstrate significant contributions as team members. The goals are established each year based on the strategic priorities of the organization. They are communicated to all members of the organization, and discussed in depth with the physicians. Prior to making any payout the HUHS organization needs to reach or surpass its targeted budget. The payouts will be suspended if this overall financial level of performance is not achieved. The percentage payout is based on the correct step rate for the physicians regardless of current actual pay; this is adjusted for FTE status.

The variable pay plan uses five independent measures and a maximum payout of 3% for each. A payout can be earned on any or all of the measures. There is a point score for each measure based on performance in specific dimensions. The total performance determines the total payout.

The measures include the following:

1. Excellence of care. This measure incorporates HEDIS measures, NCQA (National Council for Quality Assurance) medical records standards, and the chief's rating of quality decision making.
2. Collaboration. This measures how well the physicians coordinate the care of patients with other members of the care delivery team, including fellow physicians, nurses, specialty clinics, and workgroups. This is measured through a survey feedback process.
3. Patient satisfaction. HUHS conducts periodic patient satisfaction surveys, and these responses are applied to each physician. This measure also examines the growth in the physician's panel size and the number of patients who seek a midyear change in

primary care physician.

4. Practice management. This involves the use of resources internal or external to HUHS. Practice management includes hospitalization and home care services, laboratory and other tests, and the rate of referrals to specialists. It also includes a variety of activity measures.
5. Overall contribution. This measure involves the degree to which the physician makes a meaningful and significant contribution to improving the quality of care, the delivery system, and the annual goals of the department. The payout of this measure is restricted to only 10% of the physicians and is a full or no amount for payout (i.e., no prorating).

As stated earlier, these five areas represent important performance factors of the organization and support its mission and strategic goals. Improvements are needed in each area. Physicians have a high degree of influence in each of these areas. There are a variety of tools and systems needed to support these measures. The important concept for HUHS is that it is developing measures because it is important to have information on these areas, not to support the variable pay plan per se. The compensation program became a catalyst to focusing on the most important factors of the organization.

The Impact of the New Compensation Plan

When the design team first met with the physicians to discuss the work expectations and compensation program, there was significant negative reaction. The physicians had been used to having little control over their activities and few positive or negative consequences as long as they worked within broad parameters. This program represented the organization's efforts to clarify accountabilities and performance requirements. There would be clear consequences for performing or not performing to these standards. Over the next several weeks, most of the strong performing physicians appreciated the effort and started supporting the objectives. The resistance diminished, and in some areas the opportunity to be recognized for their contributions became an important benefit of the program.

The measures that use peer feedback became the most valued by the physicians. Performance assessments provided by peer physicians and specialists in specific dimensions are very valuable. It not only became credible, but it provided important information about what behavior is important. This information has become a major force for influencing physician behavior.

Performance in many of the quality of care measures increased, and the costs associated with them have decreased. This was achieved by the physicians' taking a more proactive approach to managing care. Rather than letting the "system" care for the patients, many of the physicians increased their efforts to support the care delivery system. The patient satisfaction survey score increased slightly. HUHS exists in a highly demanding

environment because many of the members are faculty and students of Harvard University. They tend to be well read and will challenge the physician's judgment regarding prescriptions and treatment methods. Yet patient satisfaction remains strong.

One additional area of improvement has been in the patient assignments. Physicians are seeking to add patients to their panels and to formalize the relationships. This establishes an important connection between the member and the health services organization. People now clearly understand whom they need to go to for healthcare, and the continuity of care has been enhanced.

When asked if the results were worth the effort, Mary Hennings said, "Absolutely. The program has given us what we needed to focus and talk about the key issues. We have created a sense of common goals and accountability. We have much to do to improve, but the change has been dramatic."

The Future of Physician Incentives

There are two key areas of desired change in the physician incentive plans. First, the feedback on the measures needs to be provided to the physicians in a faster and easier-to-understand format. It is essential for the physicians to understand the data during the performance period so they can have the chance to adjust and modify their actions. This involves both systems tasks and simplifications of the measures.

Second, physicians need coaching in how to maximize their performance. In the past, it was an informal process by which a physician learned about different programs, how to handle difficult patients, and how to support the health centers. Some found an effective means to achieve strong results; other floundered. HUHS is identifying best practices and then creating information and coaching sessions for the physicians on how to dramatically improve their contributions. Most of the areas will not be in clinical tasks, but in handling patients, educating them, and managing the resources of the broad network of healthcare resources. If the physicians excel in their performance, everyone wins.

The change process is clearly under way at HUHS. The threats from external competitors are no longer very effective. Instead, the organization is looking to focus the physicians and all providers with a vision of what the organization can become. It wants to create a foundation from which to make major advances in promoting health and managing disease. The tasks will be to improve many of the things HUHS does very well and to enhance the collaboration and coordination of efforts. One point is clear: If it is successful in achieving these important developments, the physicians and all members of the organization will share in these gains.