Rewarding Better Care at Lower Cost:

Re-Designing MD Compensation in the World of Accountable Care

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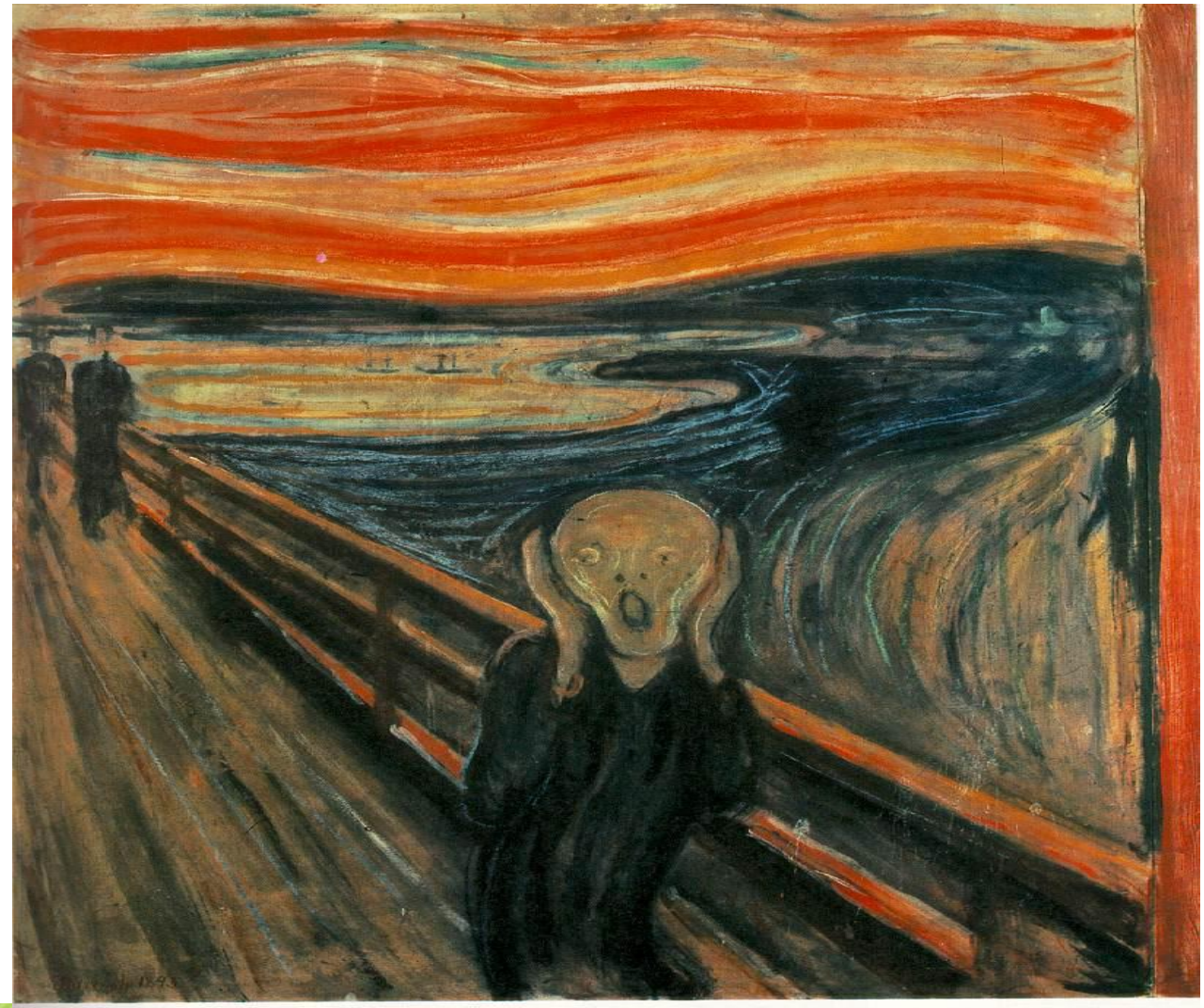
Our Discussion Today

- ***The Rationale:*** Our imperative for re-aligning incentives
- ***The Models:*** An overview of Dean's primary care and specialty value-based incentive models
- ***The Lessons Learned:*** Changing physician compensation is like changing culture- it takes time, patience, and lots of communication
- ***A Broader View:*** Trends in the Group Practice environment and predictions for the future

The Rationale

Our Imperative for Re-aligning Incentives

Non-Alignment of Incentives was transformative at Dean



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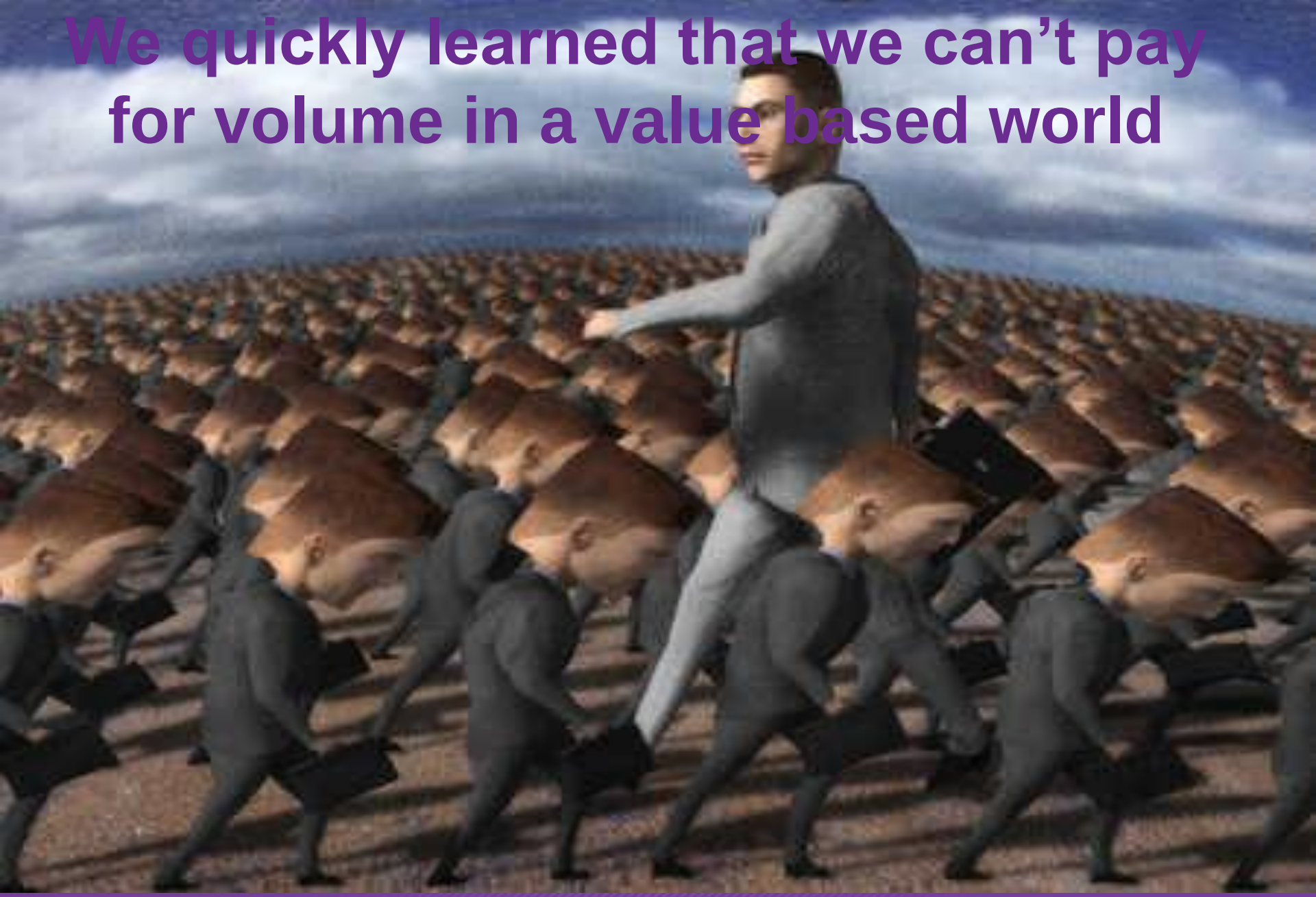
Dean's Vision and Focus

- Our Vision: "We are passionate about keeping our patients healthy, exceptional at caring for them when they are sick, and efficient in providing them with the best value and service."

- Our Focus: **Let the rest of our industry focus on Volume. We're focusing on Value.**

  - Delivering Effective Care
  - Delivering Patient-Centered Care
  - Delivering Efficient Care

We quickly learned that we can't pay for volume in a value based world



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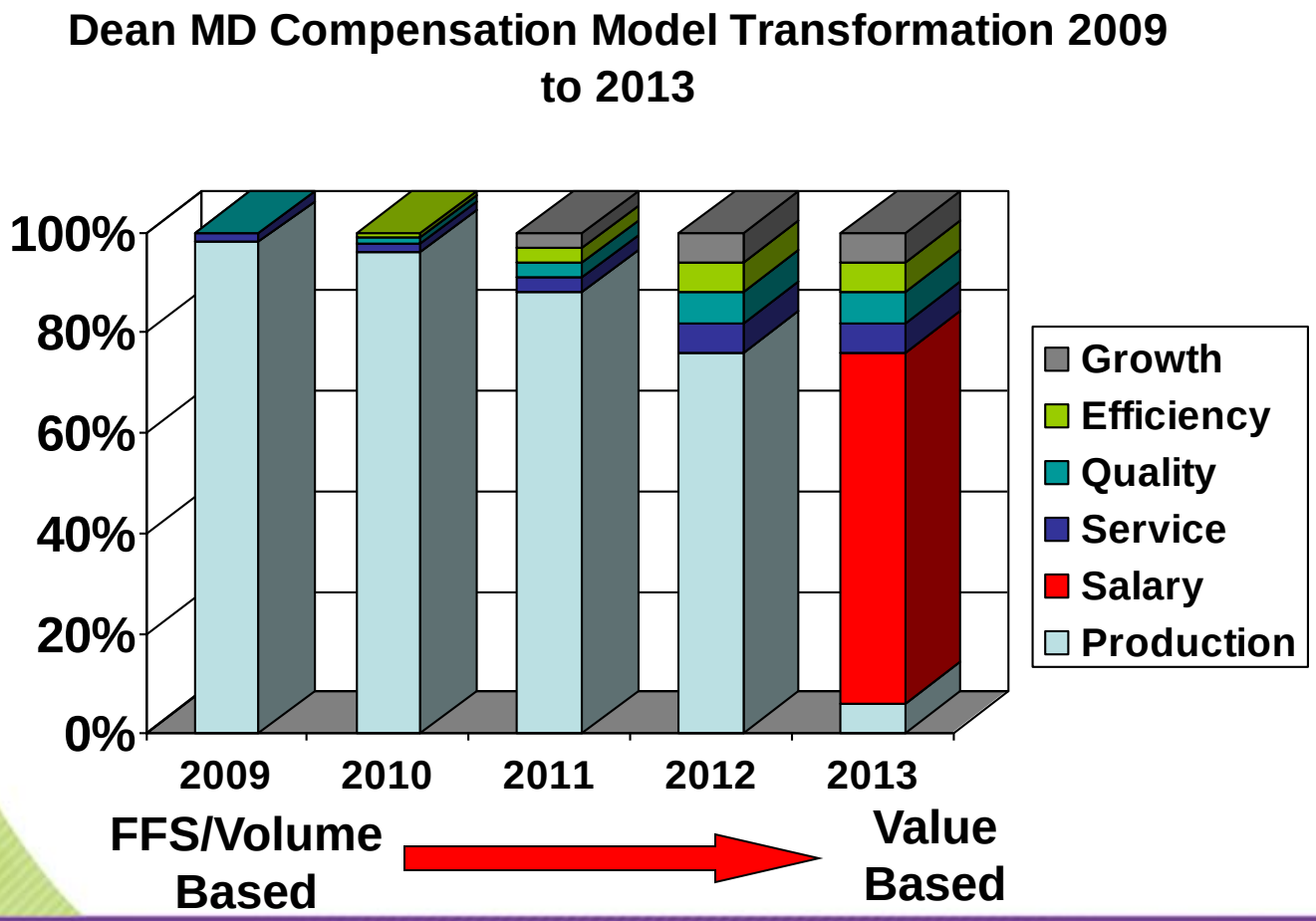
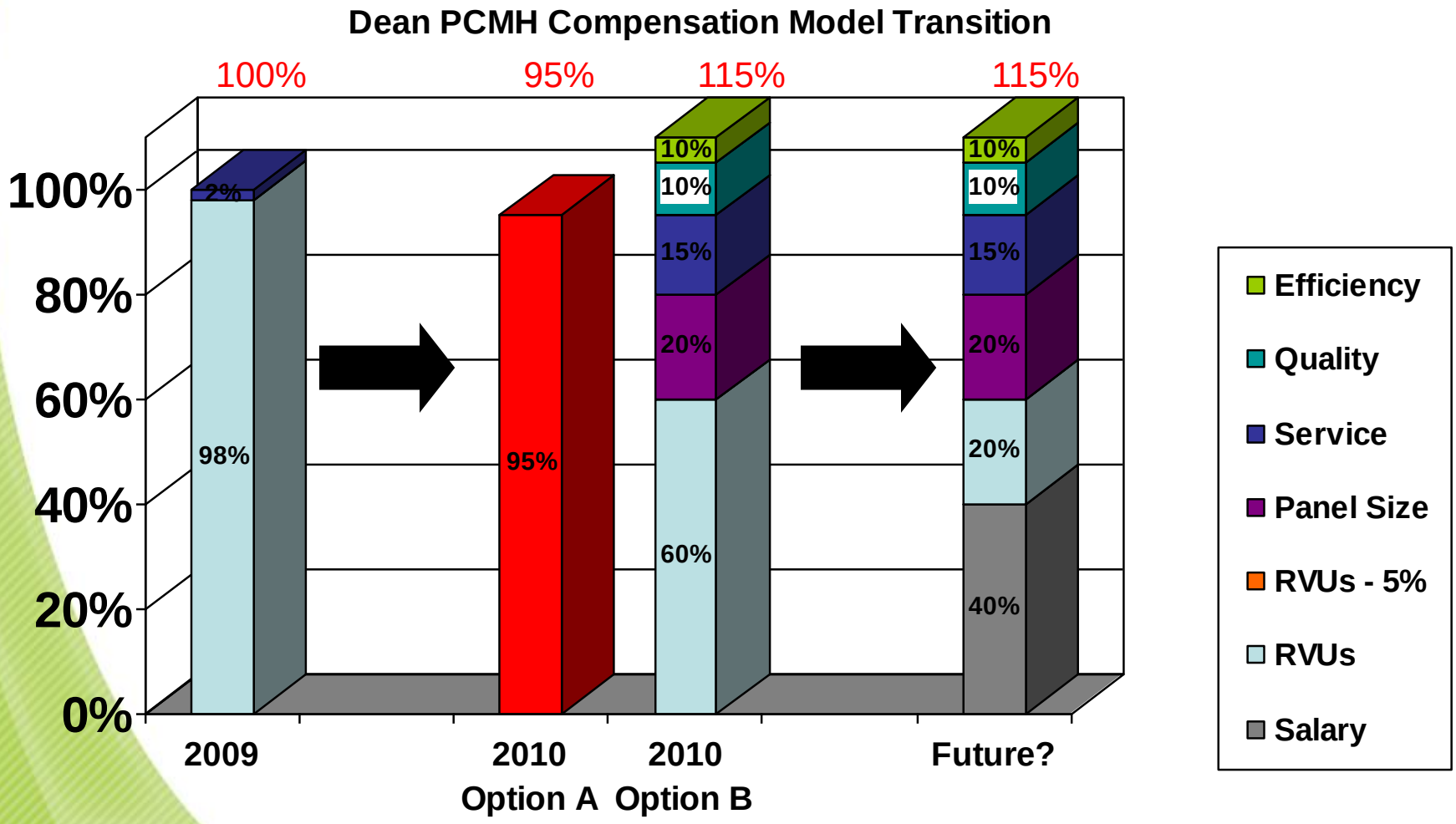
The Models

An overview of Dean's Primary Care and Specialty Value-Based Incentive Models

So, we began the journey toward creating a variable comp plan



In our Medical Home, the urgency for re-alignment was even greater



Dean Physician Incentive Model 2013

Access/Growth
- Unique Patients Metric (or)
- CG-CAHPS Access Measure Individual (or)
- CG-CAHPS Access Group

Patient Satisfaction
- CG-CAHPS Overall Rating of Doctor at the individual level (or)
- CG-CAHPS Overall Rating of Doctor at the department level (or)
- Service Improvement process metric

Quality
- Successful attainment of quality metric as identified by benchmarks or CAVE analysis

Supplemental Goals
- Superb Service Score
- Department Budget
- Staff Satisfaction with MDs
- Total Cost of Care

Cost
- Successful attainment of efficient metric as identified by benchmarks or CAVE analysis

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The Lessons Learned

Changing physician compensation is like changing culture- it takes time, patience, and lots of communication

Lessons Learned along the Way

- "It's a team effort"
  - While it takes time, and its fraught with many headaches, we encouraged the Dean Board and a committee of physicians to lead the comp re-design process (rather than management). When all that your culture knows is "pay for volume", it takes time and effort to design an effective solutions for a value-based world.
- "Comp Re-Design Doesn't Solve Everything"
  - The flaw of most compensation model re-designs is that they try to do too much. Remember that vision, data, peer-pressure, values, compacts, or guilt can sometimes be an effective way to bring people along.
- "Create a Balanced Scorecard"
  - If you want to reward value, the incentive plan (or other persuasion techniques) need to have balanced measures to encourage service, quality, cost, growth and production.
- "Reward Corporate, Department and Individual Performance"

Lessons Learned along the Way (continued)

- "Measure First"
  - It is most ideal to measure and report first, and link to comp second.
- "Options made the transition palatable"
  - Given the fear and anxiety associated with comp change, we created a menu of options so that there were multiple chances to receive the incentive.
- "Incentive size made the transition palatable"
  - We initially set the incentive at very small percentages, e.g. 1-2% each.
- "Low thresholds made the transition palatable"
  - We initially made the goals as achievable as possible
- "We changed the metrics, decreased the options, increased the weights, and raised the thresholds over time"
  - Once comfort with the new model set in, physicians were comfortable with more modifications.

A Broader View

Trends in the Group Practice Environment and predictions for the future

The GPIN Experience October 2012:

"If you were to identify which quadrant your group falls in as of today, which would you pick?"

The Value Model: Group's risk-based payments are >= 25% AND Physician's incentives for value are at least 10% of total cash compensation or greater **5%**	***The Charitable Model:*** Group's risk-based payments are <25% AND Physician's incentives for value are at least 10% of total cash compensation or greater **1%**
The Funky Model: Group's risk-based payments are >=25% AND Physician's incentives for value are less than 10% of total cash compensation **3%**	***The Volume Model:*** Group's risk-based payments are <25% AND Physician's incentives for value are less than 10% of total cash compensation **90+%**

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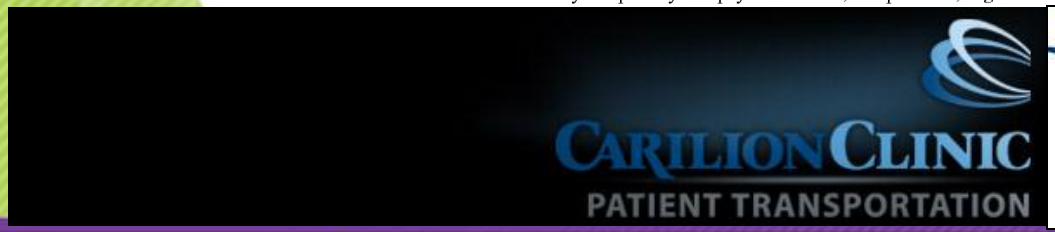
Will incentive re-design be restricted to ACOs, or will it go further?

EON Enhanced Online News

MASSACHUSETTS Beth Israel Deaconess Physician Organization, LLC

Blue Cross Blue Shield of Massachusetts and Beth Israel DeaconessPhysician Organization Sign Alternative Quality Contract

"With nearly 500 primary care physicians and 1,300 specialists, aligned across the entire spectrum of care, we are



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