Aligning Physician Compensation with Organizational Imperatives

Health Industry Forum

Comprehensive Health Care Reform: What will it take to get there?

April 2, 2015

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Chief Executive Officer
Who We Are

An outstanding medical foundation built upon the following cornerstones:

- A multi-specialty physician group practice in which a “community of physicians” work together in a collegial manner is at the core of this model.
- The partnering of physicians, excellent business managers, professional staff, and volunteers create a team whose synergies drive our success.
- Not-for-profit, community-owned and governed.
- Mission-driven decision-making dedicated to a higher purpose in the community and the region.
- An obsessive dedication to quality and service.
Strategic Operating Plan Design

10 Key Strategies

- Clinical Quality and Patient Safety
- Personal Service Excellence
- Operational Improvement
- Innovation
- Information System Solutions
- Our People
- Organizational Culture
- Physician Leadership
- Financial Strength and Community Stewardship
- Net Revenue Growth

13 Initiatives

- Clinical Quality-Processes and Outcomes
- Patient Safety
- PSE & Patient Satisfaction
- Operational Excellence
- Clinical and Health Services Research
- People Development & Wellness
- Brand Position
- Clinical & Business Information Systems
- Physician Leadership
- Medical Education
- Financial Capacity
- Community Accountability
- Net Revenue Growth

4 Perspectives

- Patient Care
- Clinical and Business Processes
- Learning and Support
- Growth and Development
Quality and Patient Safety Goals
2013 – 2015

- Improve Performance of Appropriate Care Scores (Core Measures) to 100%
- Decrease All-cause Hospital Readmissions by 20%.
- Improve the patient and family experience as measured by meeting CMS benchmark HCAHPS scores and AVATAR scores.
- Advance the culture of safety by improving patient safety cultural assessment overall domain score to 80% agreement by December 2015.
- Reduce preventable harm by 50% by December 2015 with the ultimate goal of zero preventable harm.
- Reduce the observed to expected mortality ratio from 0.73 to 0.60.

Population Health Goal:
Composite Score for ACO Measures (8-33) for Care Coordination, Patient Safety, Preventive Care and Disease Management at Medicare Benchmark 90thile.

**Goal**: Improve performance of appropriate care scores (e.g. AMI, HF, PN, SCIP, VTE, Stroke, Outpatient and Perinatal to 100% by July 2014)

**Primary Drivers**
- Education Communication Plan
- Decision Support

**Secondary Drivers**
- Nurse and Staff Meeting Infrastructure
- Executive Rounds
- New provider orientation
- Updates as measures change
- Power plans and alerts
- Contraindications
- Advisors
- Concurrent review
- eQuality Check
- Equipment in every room
- Med Staff Best Practice Guidelines Updates: Medical, Surgical, Stroke
- Powerplan Updates & Discern Alert
- VTE Advisor Imbedded in Workflows

Core Measure Performance - Appropriate Care Score
Goal: 100% by July 1, 2014

VTE: Auditing Begins January 2013

Proven changes to test for improvement

**GOAL** ← PRIMARY DRIVERS ← SECONDARY DRIVERS

**Primary Drivers**

- Medication Reconciliation
- Risk Identification
- Medical Home Care Navigation
- Transitions of Care
- Metrics

**Secondary Drivers**

- 100% compliance with Meds History, Admission and Discharge Meds Rec
- Phone call 24 hours post Discharge to reconcile
- Inpatient and Outpatient Pharmacist Support
- Predictive modeling tools to identify at risk populations
- Interdisciplinary Plans of Care
- Project BOOST or similar
- "Hospital Syndrome" Prevention Project
- 24 hour phone call and 7 day appointment goals
- Implement readmission preventionist work list
- Best practice patient education strategies ("Teach Back")
- F/U Appt made prior to Discharge
- Communication standards for transitions at discharge to PCP
- Alignment of efforts across organization and region for nurse navigation
- Discharge Summary within 5 days
- RA rates to PCP’s and Attending Services Monthly
- Dashboards monthly to CMO’s, Dept Chairs, Regional Partners

**Goal 1:** Decrease all-cause hospital readmissions by 20% by June of 2014 using 2012 as baseline performance period.

<table>
<thead>
<tr>
<th>All Cause 30-Day Hospital Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: 20% fewer readmissions by June 2014</td>
</tr>
</tbody>
</table>

- **Baseline 2012:** 1.22
- **Goal: July 1, 2014:** ≤1

- **Observed to Expected Performance:**
  - 2012 Baseline: 10.47%
  - Goal: 8.59%

- **Metrics:**
  - Discharge Summary within 5 days
  - RA rates to PCP’s and Attending Services Monthly
  - Dashboards monthly to CMO’s, Dept Chairs, Regional Partners

**GOAL** ← PRIMARY DRIVERS ← SECONDARY DRIVERS

**Physician & Nurse Communication**

**Medication Communication**

**Facilities & Technology**

**Patient Portal**

**Metrics & Leadership Accountability**

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Improve the patient and family experience as measured by meeting CMS benchmark HCAHPS scores and AVATAR scores by January 2015.

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<table>
<thead>
<tr>
<th>Patient and Family Experience HCAHPS Performance Scores</th>
<th>55.00%</th>
<th>75.00%</th>
<th>95.00%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Communication</td>
<td></td>
<td></td>
<td>85.70%</td>
</tr>
<tr>
<td>Physician Communication</td>
<td>76.83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>78.17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication about Medication</td>
<td>71.52%</td>
<td>78.90%</td>
<td></td>
</tr>
<tr>
<td>Cleanliness</td>
<td>71.85%</td>
<td>73.53%</td>
<td></td>
</tr>
</tbody>
</table>

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Proven changes to test for improvement
Advance the culture of safety by improving patient safety cultural assessment overall domain score to 80% agreement by December 2015.

**GOAL**

**PRIMARY DRIVERS**

- Leadership Culture
- Reporting & Metrics
- Patient / Family Partnership
- Effective Communication & Teamwork
- Reliable Clinical Care

**SECONDARY DRIVERS**

- HPI Engagement
- Process Design & Human Behavior Accountabilities
- Teach / Adopt Just Culture
- Patient Safety Leader WalkRounds
- Safety Event Reporting
- Harm Investigation Process
- HR Staffing Metrics (turnover, absenteeism, injuries, satisfaction)
- Engaging in Bedside Rounds
- Sharing care plans with family
- Clinical Results Transparency - all results + patient portal
- Pascal Metrics Engagement ~ Team-based Engagement Model (TEM) 3-5 clinical units
- Patient Safety Training
- Learning Board Implementation
- Effective Process / System Design & Oversight
- Use of Checklists

Proven changes to test for improvement.

**Goal:** Reduce preventable harm by 50% by December 2015 with the ultimate goal of zero preventable harm.

**Primary Drivers:**
- Healthcare-Associated Infections
- Adverse Drug Events
- Surgical/ Perinatal Harm
- Adverse Event Reporting & Investigation

**Secondary Drivers:**
- Hand hygiene
- QIO LAN (CAUTI/ CLABSI/ C. diff/ SSI)
- MRSA / MDRO Reduction
- MUST Group Work
- Pharmacy Medicine Reconciliation
- Discern Alert Updates
- Stop Bang and Oversedation
- Capnography Post-op
- Reduction of preterm delivery
- Phone Line/ Desk Top Icon
- Safety Newsletter Updates
- HPI Engagement
- Falls Reduction Project
- Pressure Ulcer Reduction Project
- Appropriate Coding of Harm Events

Proven changes to test for improvement

**GOAL** ← PRIMARY DRIVERS ← SECONDARY DRIVERS

Reduce the observed to expected mortality ratio from 0.73 to 0.60 by January 2015.

**Mortality Analysis**
- Proper use of palliative care code V66.7 & DNR Code V49.86
- Acuity Scores/Documentation
- Medical Staff case review

**Sepsis and Rapid Response Team Management**
- Early appropriate level of care
- Early recognition and intervention
- Use of sepsis bundle
- Sepsis advisor - decision support

**End of Life Care**
- Appropriate setting: Acute care vs. Hospice care
- Enhancing inpatient and outpatient palliative care services
- Collaboration across the patient continuum

**Metrics**
- Data mining to determine top drivers of mortality
- Examine Rapid response team data
- Examine MEWS/PEWS alerts

Proven changes to test for improvement
Population Health Goal: Composite Score for ACO Measures (8-33) for Care Coordination, Patient Safety, Preventive Care and Disease Management at Medicare Benchmark Threshold by January 1, 2014, with 10% improvement by January 1, 2015.
Patient Safety Dashboard
Dashboards

• Dashboard updated monthly and published on the 2nd Friday of each month.

• Meetings for Dissemination and Discussion Monthly
  – Leadership Council
  – Department Chairs
  – Hospital Practice Committee
  – Patient Safety Committee
  – Population Health Steering Committee
  – Clinic and Hospital Leadership Meetings
  – Board and Board Committee for Quality and Patient Safety
Governance Structure & Initiatives that Contribute to Population Health

Population Health Steering Committee

- Patient Centered Medical Home & Referral Management
- Patient Engagement: Patient Portal, Call Center, Retail Clinics
- Care Management
- Employee Health Plan & Employer Wellness Contracts & Employer and Community Engagement
- Shared Savings Program
- Population Health Analytics With Utilization Management
- Cultural Transformation & Physician Engagement/Documentation Improvements
- Other Related Work:
  - Bundled Payment Initiative
  - NewWest Medicare Advantage

Above Promotes/Aligns Organizational Strategies In:
- Regional Network Development
- Payor Relations
- New Business Opportunities
- Patient Steerage Opportunities
- Community Health Improvement Strategies
### Match the Patient Population to the Resource

#### Managing Three Different Types of Patients Across the Health Care System

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Characteristics</th>
<th>Resource Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Risk Patients</strong></td>
<td>~5% of patients&lt;br&gt;Complex diseases&lt;br&gt;High Utilizers of Care&lt;br&gt;(Inpatient, ER, &amp; Ambulatory)</td>
<td>- Ambulatory ICU&lt;br&gt;- Intensive Coordinated Case Management</td>
</tr>
<tr>
<td><strong>Rising Risk Patients</strong></td>
<td>~15% of patients&lt;br&gt;Chronic Disease Management&lt;br&gt;MEDIUM Utilizers of Care</td>
<td>- Patient Centered Medical Home&lt;br&gt;- Disease Management Registries&lt;br&gt;- Keep patients from moving into high risk category</td>
</tr>
<tr>
<td><strong>Low Risk Patients</strong></td>
<td>~80% of patients&lt;br&gt;Generally Healthy,&lt;br&gt;Conditions easily managed&lt;br&gt;Low Utilizers of Care</td>
<td>- Wellness Initiatives&lt;br&gt;- Patient Portal&lt;br&gt;- EVisits&lt;br&gt;- Keep patients healthy and loyal</td>
</tr>
</tbody>
</table>

Source: Advisory Board Health Care IT Suite research and analysis.
Physician Group Agreed on the ACO Metrics as the Common Data Set For Measurement:

- Addressed Challenges in Standardization
- Provided benchmark comparisons
- Provided reliable evidence based performance measures
- Focused on high impact diseases
- Highlight gaps in care (opportunities) for improvement

- ACO Metrics aligned with Meaningful Use Clinical Quality Metrics, HEDIS Measures, NQF Metrics, PQRS Metrics
### Care Coordination & Patient Safety Domain

<table>
<thead>
<tr>
<th>ACO 8 (NQF 1789)</th>
<th>Risk Standardized All Condition Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO 9 (NQF 0275)</td>
<td>Ambulatory Sensitive Conditions Admissions: COPD/ or Asthma, age 40 and up</td>
</tr>
<tr>
<td>ACO 10 (NQF 0277)</td>
<td>Ambulatory Sensitive Conditions Admissions: Heart Failure (HF), age 18 and up</td>
</tr>
<tr>
<td>ACO 11</td>
<td>Primary Care Physicians who successfully qualify for an EHR Program Incentive Payment</td>
</tr>
<tr>
<td>ACO 12 (NQF 0097)</td>
<td>Medication Reconciliation following transition in care</td>
</tr>
<tr>
<td>ACO 13 (NQF 0101)</td>
<td>Screening for future fall risk, age 65 and up</td>
</tr>
</tbody>
</table>
Preventative Care Domain

- ACO 14 (NQF 0041): Influenza Immunization, age 6 mo and up
- ACO 15 (NQF 0043): Pneumococcal vaccination for patients 65 years and older
- ACO 16a/b (NQF 0421): Body Mass index Screening, age 18 and up, calculated every 6 months, with follow up plan documented
- ACO 17 a/b (NQF 0028): Tobacco Use: Screening, age 18 & Up, with Cessation Intervention Documented
- ACO 18 a/b (NQF 0418): Screening for Clinical Depression, age 12 & up, with Follow Up Plan Documented
- ACO 19 (NQF 0034): Colorectal Cancer Screening, age 50-75, iFOBT 1 year, colonoscopy 10 year
- ACO 20 (NQF 0031): Breast Cancer Screening, age 40-69, with mammogram in 24 months
- ACO 21 a/b: Screening for high blood pressure, age 18 & up, with follow up plan documented
<table>
<thead>
<tr>
<th>ACO</th>
<th>Domain</th>
<th>Condition</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Diabetes Mellitus</td>
<td>HgA1c Control (&lt;8%), age 18-75</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Diabetes Mellitus</td>
<td>LDL Control &lt; 100, age 18-75</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Diabetes Mellitus</td>
<td>BP Control &lt; 140/90, age 18-75</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Diabetes Mellitus</td>
<td>Tobacco Non- Use, age 18-75</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Diabetes Mellitus</td>
<td>Aspirin or Antiplatelet Rx for DM &amp; IVD, age 18-75</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Diabetes Mellitus</td>
<td>HgA1c Poor Control (&gt;9%), age 18-75</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Hypertension (HTN)</td>
<td>Controlling BP &lt; 140/90, age 18-85</td>
<td></td>
</tr>
<tr>
<td>29 a/b</td>
<td>Ischemic Vascular Disease</td>
<td>Lipid Profile Performed, LDL Control &lt; 100, age 18 &amp; up</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Ischemic Vascular Disease</td>
<td>Use of aspirin/ alternate Rx, age 18 &amp; up.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Heart Failure</td>
<td>EF &lt; 40%, use of beta blocker</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>CAD</td>
<td>Drug therapy for lowering LDL</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>CAD</td>
<td>ACE/ ARB use if also DM or LVEF &lt; 40%</td>
<td></td>
</tr>
</tbody>
</table>
Key Strategies for Operations and Analytics

- Apply to all patients, not just at risk care patients
- “Proven performance” needed for new business strategies and steerage
- Strengthening of regional network to promote the health of patients across our state and region.
- Using Registry Analytics for patient attribution by:
  - Financial Class
  - Disease Registry
  - PCP
  - Demographics
1. Un-blinded Monthly Dissemination of Data
   - Physician, Pod (Medical Home), Department, Location
   - Text, Email, Intranet

2. Process:
   1. Standing Agenda Item at Department Meetings (including compensation model)
   2. Analytics for physicians to drill down on data
## ACO Report Card

### Physician Report Card

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO 1</td>
<td>92</td>
<td>90</td>
<td>91</td>
<td>91</td>
<td>93</td>
<td>92</td>
<td>91</td>
<td>92</td>
<td>91</td>
</tr>
<tr>
<td>ACO 2</td>
<td>92</td>
<td>91</td>
<td>93</td>
<td>93</td>
<td>94</td>
<td>93</td>
<td>94</td>
<td>94</td>
<td>95</td>
</tr>
<tr>
<td>ACO 3</td>
<td>91</td>
<td>93</td>
<td>94</td>
<td>94</td>
<td>95</td>
<td>94</td>
<td>95</td>
<td>95</td>
<td>96</td>
</tr>
<tr>
<td>ACO 4</td>
<td>93</td>
<td>95</td>
<td>96</td>
<td>96</td>
<td>97</td>
<td>96</td>
<td>97</td>
<td>97</td>
<td>98</td>
</tr>
</tbody>
</table>

### Overview

- The report card includes various measures related to patient safety, care management, and disease management.
- Each measure is rated with a performance score, ranging from 0 to 100.
- The data is presented for different months, with cumulative results shown from May to January.

### Key Sections

- **Patient Safety Domain**
- **Care Management Domain**
- **Disease Management Domain**

### Specific Measures

- HbA1c Control<br>  
- LDL Control<br>  
- BP Control<br>  
- Cataract Disease (IVD): Lipid Profile performed, age 18 & up<br>  
- Cataract Disease (IVD): LDL Control < 100, age 18 & up<br>  
- Cataract Disease (IVD): Use of aspirin or antiplatelet fix for DM & IVD, age 18 & up<br>  
- Cataract Disease (IVD): Use of beta block for age 18 & up<br>  
- Cataract Disease (IVD): Use of beta blocker (age 18 and up)<br>  
- Use if also DM or LVEF < 40% (age 18 and up)
### Monthly Performance: Num/ Dem & %

<table>
<thead>
<tr>
<th>Panel Size</th>
<th>Measure</th>
<th>Total/ Dem</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO 8</td>
<td>NOF 1789</td>
<td>20647</td>
<td>24212</td>
</tr>
<tr>
<td>ACO 9</td>
<td>NOF 0275</td>
<td>8291</td>
<td>9454</td>
</tr>
<tr>
<td>ACO 10</td>
<td>NOF 0277</td>
<td>20353</td>
<td>22872</td>
</tr>
<tr>
<td>ACO 11</td>
<td>NOF 0097</td>
<td>707</td>
<td>15807</td>
</tr>
<tr>
<td>ACO 12</td>
<td>NOF 0097</td>
<td>25103</td>
<td>22872</td>
</tr>
<tr>
<td>ACO 13</td>
<td>NOF 0097</td>
<td>545</td>
<td>2980</td>
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<tr>
<td>ACO 14</td>
<td>NOF 0041</td>
<td>20647</td>
<td>24212</td>
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<tr>
<td>ACO 15</td>
<td>NOF 0043</td>
<td>8291</td>
<td>9454</td>
</tr>
</tbody>
</table>

### Color Symbols for Benchmarks

- Red: Exceeded benchmark
- Green: Met benchmark
- Yellow: Below benchmark

### Hyperlink to CMS Specifications Sheet

- [CMS Specifications Sheet](#)
Timely Frontline Information

• As or more important than compensation strategies
• Real promise in this arena over the next 2-5 years
Billings Clinic MD Compensation Goals

- Desired Features of Compensation System
  - Supports organization's mission, vision & values
  - Considers constraints & maximizes flexibility of current systems
  - Competitive based on comparable “market” analysis
  - Perceived as equitable by physicians
  - Represents sound business principles

- Philosophy
  - Achieves alignment & consistency within Billings Clinic
    - Facilitates group concept within Billings Clinic
    - Incentivizes individual productivity & enhances individual satisfaction
    - Provides incentives for achievement of Clinic goals
  - Avoid inappropriate incentives
    - For ex booking credit for ancillaries ordered
    - Ownership incenting unnecessary volume

- Architecture
  - Is understandable & uniform in administration
  - Provides fair & accurate measurement across all revenue lines
  - Enhances the ability to recruit & retain physicians in the market
  - Aligns with organizational objectives and is affordable
  - Regulatory Requirements
  - Improves the competitive strength of the system
MD Compensation Evolution

- “Eat what you kill”
- % Net Bookings
- RVUs and conversion factors
- % individual production vs share in group practices
- How to benchmark MD non-RVU work
- Increasing MD diversity
- Approaches to market total compensation
Billings Clinic MD Compensation

• 100 % RVU/conversion factor productivity
• 100 % RVU cf productivity plus QSL (5-10%)
• Straight salary
• Straight salary plus QSL (5-10%)
• Equal weight productivity/value metrics
Primary Care Compensation Strategy

• Value Based Movement
  – Focus from production to value based care
  – Primary Care compensation model is a blended model
    • Salary model based on median salary adjust for four components of performance
    • 10% Based on Team Production (Location based)
    • 40% Based on Individual Production (MD only)
    • 25% Based on Individual Quality Measures
    • 25% Based on Team and Individual Access Measures
  – Four components are based on three tiers
    • Minimum (25% lower than AMGA median compensation)
    • Median
    • Maximum (25% higher than AMGA median compensation)
  – Model design in 2012; transition year was 2013 when the blended method was modeled for Primary Care with the first impact to their salaries happening in 2014
# Internal Medicine Compensation

<table>
<thead>
<tr>
<th>Primary Care Example</th>
<th>Survey median</th>
<th>Minus 25% (Minimum)</th>
<th>Plus 25% (Maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 FTE</td>
<td>$ 250,000</td>
<td>$ 187,500</td>
<td>$ 312,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component</th>
<th>Weight</th>
<th>Median</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>25%</td>
<td>$ 62,500</td>
<td>$ 46,875</td>
<td>$ 78,125</td>
</tr>
<tr>
<td>Access</td>
<td>25%</td>
<td>$ 62,500</td>
<td>$ 46,875</td>
<td>$ 78,125</td>
</tr>
<tr>
<td>Team Production</td>
<td>10%</td>
<td>$ 25,000</td>
<td>$ 18,750</td>
<td>$ 31,250</td>
</tr>
<tr>
<td>Individual Production</td>
<td>40%</td>
<td>$ 100,000</td>
<td>$ 75,000</td>
<td>$ 125,000</td>
</tr>
</tbody>
</table>
## Production Scorecard – Produced Monthly

(Amga 2012)

<table>
<thead>
<tr>
<th>Access</th>
<th>Frequency</th>
<th>Meas Target</th>
<th>Target Source</th>
<th>Min</th>
<th>Med</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Production*</td>
<td>Monthly</td>
<td>% of AMGA Median</td>
<td>AMGA</td>
<td>0-84%</td>
<td>85-114%</td>
<td>115%+</td>
</tr>
<tr>
<td>Individual Production*</td>
<td>Monthly</td>
<td>% of AMGA Median</td>
<td>AMGA</td>
<td>0-84%</td>
<td>85-114%</td>
<td>115%+</td>
</tr>
</tbody>
</table>

* FTE Adjusted Measure

<table>
<thead>
<tr>
<th>Provider</th>
<th>Team</th>
<th>Clinical FTE</th>
<th>Actual OP RVU's</th>
<th>FTE Adj RVU's</th>
<th>AMGA Median</th>
<th>% Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM Phys 1</td>
<td>Delta</td>
<td>0.8</td>
<td>4,600</td>
<td>5,750</td>
<td>4,717</td>
<td>122%</td>
</tr>
<tr>
<td>FM Phys 1</td>
<td>Delta</td>
<td>1.0</td>
<td>4,700</td>
<td>4,700</td>
<td>4,890</td>
<td>96%</td>
</tr>
<tr>
<td>Primay PA</td>
<td>Delta</td>
<td>0.9</td>
<td>3,500</td>
<td>3,889</td>
<td>3,665</td>
<td>106%</td>
</tr>
<tr>
<td>Primary NP</td>
<td>Delta</td>
<td>1.0</td>
<td>3,400</td>
<td>3,400</td>
<td>3,315</td>
<td>103%</td>
</tr>
<tr>
<td>Team Total</td>
<td></td>
<td>3.7</td>
<td>16,200</td>
<td>17,739</td>
<td>16,587</td>
<td>107%</td>
</tr>
</tbody>
</table>
# Access Score Card

<table>
<thead>
<tr>
<th>Spec Code</th>
<th>1210 Team FTE</th>
<th>6.41</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team</td>
<td>IMR Faculty</td>
<td>Amb FTE</td>
</tr>
</tbody>
</table>

### Scoring Measures

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Calendar Year</th>
<th>Month</th>
<th>Q4 2014</th>
<th>Q4 2014</th>
<th>Q4 2014</th>
<th>Calendar 2014</th>
<th>Calendar 2014</th>
<th>Calendar 2014</th>
<th>% of Target</th>
<th>Comp Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Oct</td>
<td>73</td>
<td>195</td>
<td>184</td>
<td>2,134</td>
<td>2,134</td>
<td>3,356</td>
<td>63.6%</td>
<td>1</td>
</tr>
<tr>
<td>Billed ambulatory visits - AMGA Definition</td>
<td></td>
<td>Nov</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dec</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCC Score 2014 Standards (Age &gt; 18 Only)</td>
<td></td>
<td></td>
<td>0.755</td>
<td>0.755</td>
<td>0.755</td>
<td>0.755</td>
<td>N/A</td>
<td>0.669</td>
<td>112.9%</td>
<td>2</td>
</tr>
<tr>
<td>Team Panel AMGA weighted (Quarterly)</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Same Day Appointments Physician</td>
<td></td>
<td></td>
<td>11.6%</td>
<td>11.7%</td>
<td>12.2%</td>
<td>8.5%</td>
<td>N/A</td>
<td>6.5%</td>
<td>130.4%</td>
<td>3</td>
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<tr>
<td>% Same day appts team</td>
<td></td>
<td></td>
<td>19.8%</td>
<td>17.4%</td>
<td>17.8%</td>
<td>18.3%</td>
<td>N/A</td>
<td>10.0%</td>
<td>183.4%</td>
<td>3</td>
</tr>
</tbody>
</table>

Provider is part of Team Roll Up Y

### Scoring

- < 85% of Target = 1
- >= 85% of Target - < 115% of Target = 2
- >= 115% of Target = 3
Panel Reporting 2015 (Healthy Registry)
Process

• The Physician Compensation Committee (PCC) is integral in the compensation plan for the organization
  – The PCC oversight of physician compensation in the organization. Membership is a combination of senior leadership, physicians and compensation analysts
  – Committee role
    • Review staff physician compensation and production and compare to annual market data. The Committee makes recommendation to Leadership Council (LC)
    • Identify issues and alternatives for pay plan design, standard pay practices and policies
    • Discuss all special requests and make recommendation to LC
Department recommendations

• Department Chair and Leadership may bring recommended department compensation model for review by the PCC
  – Intensivist compensation model
  – Primary Care

Lessons Learned

• Core principles for all compensation plans important
• One compensation model does not meet the needs for variability between departments
• When incorporating quality metrics the EHR should be robust to provide electronic collection of data for providers
<table>
<thead>
<tr>
<th>FY14 Billings Clinic Data</th>
<th>AMGA 2014</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrvu %tile</td>
<td>50th %tile (median)</td>
<td>At or above</td>
</tr>
<tr>
<td>Effective CF: Total compensation / wrvu (survey definition)</td>
<td>Comp to work ratio</td>
<td>Within 10%?</td>
</tr>
<tr>
<td>Wrvu</td>
<td>Wrvu %tile</td>
<td>Alignment &amp; &quot;Gap&quot; within 10%tile points</td>
</tr>
<tr>
<td>FY14 Wrvu X CY14 CF + other comp</td>
<td>Comp %tile</td>
<td>(if producing &gt; median) at or above best fit &amp; within 1 std deviation</td>
</tr>
<tr>
<td>Wrvu, total compensation</td>
<td>Scatter gram</td>
<td>Other Department specific issues</td>
</tr>
<tr>
<td>Other items for discussion:</td>
<td>Recruitment Retention</td>
<td>Other Department specific issues</td>
</tr>
</tbody>
</table>
MD Compensation and Value

• “Market” competitiveness remains critical
• Underlying RVU and CF process determinations critical and controversial
• Uneven FFS payment issues (including hospital) at play as well and influential
• Recognizing work outside of patient visits
• Retail, Televisits, Outreach, Remote Consultation
Value Based Payment: Thoughts

- Current MSSP and Bundling designs complex and imperfect
- Data and real time information issues
- Beneficiary attribution and engagement
- Risk/benefit balance
- Low volume and low cost markets
- Socioeconomic and demographic variation
- Immature Electronic Health Information Systems
- Cost
MD Compensation and Health Reform

• Culture and values remain important
• Value can be delivered in most payment systems- importance of collegiality and investment in teams, timely information, patient centered focus, partnerships across the continuum
• Non-financial incentives critical
Non Financial Incentives

• Resources: Team including NP, PA, LPN, MA, RN navigators, Pharmacists, Social Workers

• EHR w real time feed back and analytics (this remains a mixed bag for MDs but is slowly improving)

• Sense of better results for patients than historical time-limited intermittent patient visit
Questions

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- 406-238-2609
- nwolter@billingsclinic.org