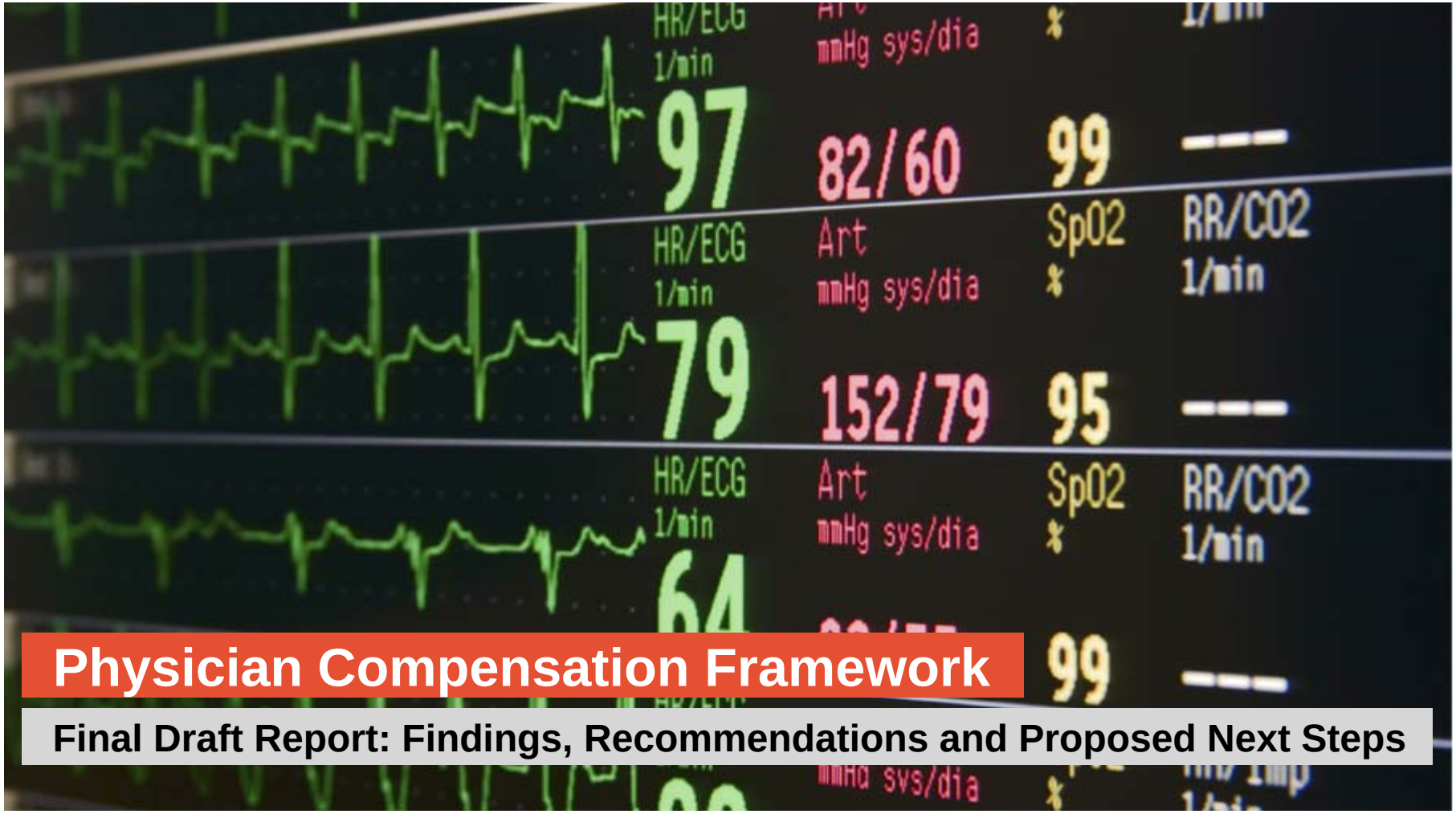


Physician Compensation Framework

Final Draft Report: Findings, Recommendations and Proposed Next Steps

Bermuda Hospitals Board

TOWERS WATSON

Introduction

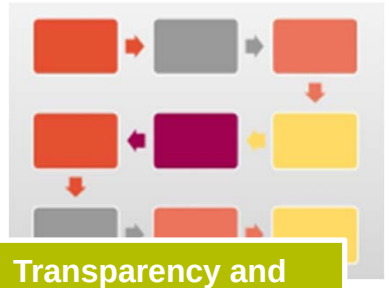
Introduction

- Bermuda Hospitals Board (BHB), comprised of King Edward VII Memorial Hospital (KEMH), Mid-Atlantic Wellness Institute and the Lamb-Foggo Urgent Care Centre, is mandated through legislation to provide quality acute and mental health care for Bermuda's resident population of approximately 67,000 people, as well as the many visitors to the island each year
- Given its relatively isolated geographic location, the Bermuda community needs a range of services far broader than would commonly be expected of a hospital serving a similar population base
- Like the health systems of many developed nations, Bermuda is facing a confluence of factors – driven by, among other things, rising costs and an aging population – that make efficient and effective healthcare a national imperative

Quality and Patient Safety

Equitable Access to Essential Healthcare

Affordability and Financial Sustainability



Transparency and Impartiality

Project Status: Where We Are in the Overall Process

Phase 1: Compensation and Performance Assessment	Phase 2: Develop Compensation Philosophy and Guiding Principles	Phase 3 :Design New Compensation Framework	Phase 4: Develop Implementation and Communication Strategy
☑ Collect and review internal information including organizational data, care delivery structure, and physician-level compensation and productivity[1] data ☑ Identify comparator market and confirm appropriate market data sources. ☑ Collect market TCC and productivity[1] data (clinical and administrative work effort) and apply weights and/or adjustments; include ratios of compensation to productivity[1] if possible ☑ Prepare detailed written report of findings including comparisons of BHB to market data. ***[1]We received limited productivity data in the form of billed charges which requires further analysis to conduct market comparisons***	☑ Review existing physician compensation governance documents[2] and employment agreements ☑ Prepare an initial draft compensation philosophy and guiding principles for BHB review and comment ☑ Provide advice and recommendations on proper structure and appropriate level standardization of BHB's employment agreements ***[2]BHB does not currently have a formal governance process for physician compensation***	☑ Building on information from previous phases, consider alternative compensation approaches that best suit BHB's unique needs ☑ *Develop market reference philosophy for physician compensation that is sustainable for the near future* ☑ Develop compensation straw models with a range of design alternatives by physician role/ specialty and across core elements of compensation ☑ Present straw models in a working session and make revisions based on input ★ **We are here...** Refine framework with additional detail and specific examples , as well as further examination of performance compensation framework and available productivity data and reports	**But we are not there yet…** TW provides high-level implementation and communication framework listing tasks and suggested timeframes BHB performs all work tasks with advice from TW on an ad hoc basis as needed

Today's Focus: How do we get from here to there?

Project to Date

- In mid-December 2012, Bermuda Hospitals Board (BHB) contracted with Towers Watson (TW) to assess its physician compensation program using comparative market data, to develop a compensation philosophy and guiding principles, and to develop a new compensation framework for BHB employed physicians
- At that time, BHB desired to implement a new physician compensation structure effective April 1, 2013
- BHB indicated a desire to develop a performance-based compensation framework; however several decision steps must occur before the framework can begin to be operationalized
- In Towers Watson's experience, projects of a similar nature typically take four to six months for development of the new framework and another six to twelve months for implementation
- Factors that organizations should consider when developing a production and/or performance-based physician compensation framework will be discussed throughout the presentation

Physician Compensation Philosophy and Strategy

Best Practices
Establish compensation committee to oversee physician compensation
Policies establishing review requirements • Review and approval of overall compensation plan • Triggers for committee-level review of specific individual arrangements
Develop governance documents and process • Compensation philosophy • Pre-approved ranges, thresholds, and parameters • Mix of base and incentive pay • Contract documents
Recruitment and retention policies • Signing and retention bonuses • Salary guarantees • Relocation expenses
Competitive benchmarking • Comparator market • Pay ranges and competitive positioning • Productivity expectations
Conduct program audit • Competitive market assessment • Alignment of pay and productivity • Document business factors to support current pay position

Approach and Methodology

Approach and Methodology

- TW approached this project as one that would potentially have significant impact on the future of health care delivery in Bermuda. We attempted to take into account the unique history, relationships, and other financial, cultural, and environmental issues to develop recommendations that can help guide BHB through a time of mounting pressure and challenges for meeting the health care needs of the people of Bermuda
- There are many unique aspects driving the market for physician services in Bermuda which must be considered before implementing changes that contemplate reducing income for physicians in highly-compensated, yet essential service lines, anesthesia and cardiology in particular
- TW's consulting team performed the following project steps;
  - Collect and review BHB internal data, including organizational and financial data and physician compensation data
  - Conduct market research and evaluate BHB's physician compensation program in terms of structure and market competitiveness.
  - Interview various BHB personnel to understand local market factors and drivers of physician pay at BHB

Approach and Methodology (cont'd)

- Towers Watson gathered and reviewed physician compensation market data from three markets. The comparative markets, data sources, and compensation drivers are noted below:
  - **United States: Composite regional and national benchmarks from three major physician compensation surveys**

The main drivers of US physician compensation levels are clinical specialty and production levels. Base salary levels are not reported in many of the US data sources; however, productivity data are reported

  - **United Kingdom: National Health Service (NHS) physician compensation data**

Base salary levels in the UK are primarily tenure-based with little variation due to clinical specialty or production levels. Additional incentives are available for off-hour work and high levels of quality. NHS market data report the range of base pay by classification but do not report actual total cash compensation (TCC) (inclusive of incentives) or productivity

  - **Canada: Benchmarks from the Canada National Physicians Salary Survey**

Canada physician compensation shows less specialty based variation as compared to the US market but more than the UK. Physician compensation in Canada is related to production with some reimbursements based on a fee-for-service methodology. Productivity data were not available

Approach and Methodology (cont'd)

- Competitive TCC market data benchmarks were developed based on blended data with a weight of 75% US national and 25% Canada market data
  - The higher US market data were used to reflect the higher Bermuda cost of living while the more level Canada data help smooth the specialty based variation present in the US data
  - US national market data were used as regional data are subject to greater variability year-to-year due to smaller sample sizes.
  - Given the variation in base salaries by specialty and the lack of TCC data, the NHS data were used only as a point of comparison to US and Canada data
- BHB base salary and TCC levels were compared to the competitive TCC market data benchmarks. For purposes of this analysis, BHB base salary levels include housing allowances as such allowances and other cash or in-kind benefits operate as supplemental income and can mask income disparities if not considered
- Available physician productivity data included billed charges data only which does not easily compare to market data; therefore, the analysis focused only on compensation
- Additional details about the Approach and Methodology may be found in the Interim Final Report dated April 13, 2013

Overall Findings

Overall Findings

Overall Finding #1

There is no governance structure or written physician compensation philosophy defining use of benchmarks, desired compensation positioning, or desired goals regarding pay mix (base pay, incentives, performance metrics, etc.)

- There are no uniform policies and practices guiding the provision of supplemental benefits such as rent allowances
- Rent payments and other cash or in-kind benefits operate as supplemental income and can mask income disparities if not considered when comparing total cash compensation and/or total compensation
- Annual expected work hours to be considered full-time (1.0 FTE) are not consistent across the organization or within clinical specialties; however, it is not uncommon for expected annual work hours to vary across specialties since physicians paid on a shift basis may have work hours tied to number, length, and type of shifts provided

Overall Findings

Overall Finding #2

The lack of a governance structure and compensation philosophy has resulted in actual compensation levels that do not consistently follow any particular market or rationale; rather compensation levels seem to have resulted from a series of "one-off" arrangements that occurred over time and under various leaderships

- Actual BHB compensation levels do not align with either the US, Canada, or UK markets
  - Similar to the Canada market, there is little variation in base salary levels with the majority of BHB physicians having base salary levels between $245,000 and $275,000
  - Similar to the US market, certain specialties show a wide variation in TCC levels, due to participation in lucrative production-based incentive plans with some BHB physicians having close to 50% of TCC comprised of incentive compensation
- Nor do they always appear to follow expected patterns based on need of the specialty for basic hospital services (e.g., Emergency Department physicians appear to be below market median while geriatrics is above market median)
- Median actual BHB physician base salary and TCC levels and positioning relative to the market are shown on the next two slides

Overall Findings

- The competitive market TCC data and the aggregate market percentile positioning of BHB physician base salary and TCC relative to the market are shown below, by specialty:

Specialty	# of Docs	Competitive Market TCC Data (US/Canada Blend)				BHB Market Position	
		25th	50th	75th	90th	Base Salary Market Percentile [1]	TCC Market Percentile
Anaesthetics	8	$315,288	$372,665	$423,936	$503,724	83	91
Cardiology	3	$311,558	$395,592	$483,109	$604,232	64	90
Emergency	12	$238,600	$278,062	$325,795	$387,779	32	32
Endrocrinology	1	$172,804	$201,369	$246,061	$306,205	76	76
Geriatrics	1	$167,759	$197,909	$235,802	$272,799	93	93
Hospitalists	6	$197,529	$223,027	$259,268	$303,266	66	66
Infectious Diseases	1	$184,835	$218,891	$262,231	$320,989	77	77
Medical House Officer	13	$86,655	$96,295	$109,448	$124,395	63	77
Nephrology	2	$217,225	$259,992	$301,339	$381,771	64	93
Neurology	1	$207,409	$248,164	$293,024	$373,424	51	51
OB/GYN	7	$247,638	$297,170	$369,852	$466,065	36	77
Oncology	1	$275,626	$337,748	$414,282	$554,827	23	23
Pain Management [2]	2	$332,327	$372,665	$423,936	$503,724	98	100
Palliative Care	1	NA	NA	NA	NA	NA	NA
Pathology	3	$265,087	$323,654	$390,328	$481,790	29	29
Psychiatry	4	$176,782	$205,810	$247,235	$295,060	51	51
Radiology	5	$361,725	$414,693	$468,308	$557,150	20	52
Surgical House Officer	6	$90,526	$102,015	$114,966	$126,735	62	72
Overall Average						**58**	**68**

1 For purposes of this analysis, base salary includes annual housing subsidies

2 Anaesthesiologists providing pain medicine services have base salary levels benchmarked against Anaesthesiology and TCC benchmarked against Anaesthesiology Pain Medicine

Overall Findings

Overall Finding #3

With the exception of Performance Bonus Plans that utilize a “revenue less expense” methodology, productivity thresholds and work effort expectations are not clearly defined in relation to base salaries and TCC paid

- Benchmarking productivity is an important step in determining desired compensation positioning
  - Competitive assessment of clinical compensation is relational to productivity
  - Generally speaking, the level of compensation should be supported by a similar level of production
- Physician work relative value units (wRVUs) are commonly used to measure productivity because they are reliable, objective, and payer neutral, but other metrics such as billed charges, collections, patient encounters, etc., could also be used as valid productivity measures
- Compensation structures should consider whether a minimum threshold of productivity should be established or used as a trigger for further performance payments
- Physicians with both administrative and clinical roles must be assessed in relation to the relative work effort devoted to each; e.g., if a physician is expected work .25 FTE in an administrative role, what, if any, adjustments are made in clinical FTE and clinical salary

Overall Findings

Overall Finding #4

It is not clear that the Performance Bonus Plans incent the types and levels of performance that are important to BHB

- BHB's performance-based bonuses result in total cash compensation at the upper end of not only the US/Canada blended market data but also the higher US market data
- The "revenue less expense" formulas used to calculate the performance bonuses should be reviewed to ensure consistency with the current financial environment, equitability of bonus payments, and the ability to perform accurate comparisons to market data
- Although the reasons that certain providers in a service are excluded from the performance pools are not clear, the arrangement ultimately benefits those remaining in the pool since the costs of the excluded provider don't have to be covered by revenues
- Based on our consulting experience in the US market, the share of surplus allocated to the physicians is larger than we would typically see
- Separately identifying on-call time and related productivity payments would allow for more precise comparisons to market data

Overall Findings

Overall Finding #5

BHB does not currently base any elements of physician compensation on quality, patient satisfaction, or other non-productivity based performance metrics

- All of the comparative markets considered for this analysis – UK, Canada, and US – are undergoing transformations that increase focus on quality, patient outcomes, cost of care, efficiency, etc.
- Health care spending had been on upward trajectory for many years and is expected to continue to increase as the population ages and costly chronic conditions become more prevalent
- Fee-for-service (FFS) payment systems essentially encourage volume over value; services are compensated regardless of their impact on patient health; FFS systems have little or no countervailing pressure to discourage the delivery of unnecessary services

Proposed Compensation Framework

Development of Pay Approaches

- As discussed in the Findings, BHB does not appear to utilize a defined or consistent approach when determining physician compensation levels
  - BHB pay levels and pay relationships do not consistently follow any of the competitive markets or reflect specific factors related to internal or external market conditions
  - Similar to the Canada market, there is little variation in base salary levels with the majority of BHB physicians having base salary levels between $245,000 and $275,000
  - Similar to the US market, certain specialties show a wide variation in TCC levels, due to participation in lucrative production-based incentive plans with some BHB physicians having close to 50% of TCC comprised of incentive compensation
- To address the lack of structure we developed pay approaches and plan mechanics based on quantitative and qualitative analyses utilizing:
  - Market data
  - Relationships in the competitive market data;
  - Type of clinical role;
  - Impact of clinical role on pay mix and performance metrics; and
  - Other emerging trends in physician compensation

Comparative compensation scales

Pay Grade	Specialty	# of Docs	US/Canada Blend TCC Market Data			
			25th	50th	75th	90th
	Medical House Officer	13	$86,655	$96,295	$109,448	$124,395
	Surgical House Officer	6	$90,526	$102,015	$114,966	$126,735
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	Radiology	5	$361,725	$414,693	$468,308	$557,150

Compensation Framework: General Guidelines

- The compensation framework should serve as a “roadmap” for determining pay mix and managing compensation levels:
  - Base salary levels should not fall below the minimum of the proposed salary range nor should they exceed the maximum of the range
  - Compensation should be supported by commensurate levels of production or work-effort (for shift based physicians such as Hospitalists or ED physicians)
  - Incentive opportunities should reflect the role
  - BHB should develop minimum thresholds of productivity or performance that must be achieved before physicians are eligible for incentives
  - BHB should consider capping maximum TCC at 125% of the Pay Range Maximum or the median ratio of TCC to production for physicians with transactional roles

BHB Decision Steps to Refine the Compensation Framework

- **Step 1:** Establish a formal governance process for physician compensation
- **Step 2:** Determine standards for positioning base salary and/or TCC levels within the pay ranges (between minimum and maximum); methods may vary based on clinical role and/or specialty and may include:
  - Lock-step market positioning – Ex: Pay all at the same point on the pay grade
  - Productivity-based – Ex: Target pay commensurate with productivity threshold
  - Value-based – Ex: Emphasis on quality, patient satisfaction, etc.
  - Local market factors – Ex: Vary market position based on BHB-defined importance or need
  - Other strategic considerations – Ex: Minimize disruptions or stepped transition to new framework
- **Step 3:** Determine the performance framework necessary to incent the desired physician behaviors
  - Pay mix could vary by clinical role
  - This step may involve determining the mix of fixed to variable compensation
  - Various methods may be used to establish funding mechanisms for variable compensation
    - Percentage of base salary
    - Withhold from target TCC
    - Vary allocation of surplus in performance bonus plans

Typical Compensation Plan Performance Categories

The basic plan structure must match organizational goals to clear and actionable measures

Typical Plan Goals	Incentive	Performance Metrics	Availability of Measurement at BHB
Reward a high level of clinical activity that will result in increased revenues and/or improved patient access.	Production	Charges, net patient revenues, RVUs, panel size, visits/encounters, and office hours/availability.	Billed charges available now; other measures may be developed over time
Encourage cost-effective and clinically appropriate care.	Resource utilization/ Efficiency/ Medical Management/ Quality	ALOS, inpatient days per thousand population, ambulatory visits per thousand population, and selective utilization rates (e.g., ER visits, MRIs, off-island transfers).	Feasible with clinical input and systems support
Acknowledge a patient-oriented focus and the importance of patient satisfaction to enrollment growth.	Patient Satisfaction	Patient satisfaction surveys, patient complaints and compliments, and panel retention.	Patient Satisfaction Surveys
Reward the performance of nonclinical activities that benefit the organization.	Group Citizenship	Governance participation, committee participation, peer review, specific work group outcomes, and staff surveys.	Feasible with clinical input and systems support

BHB should assess the availability of credible performance data
In order to ensure the success of the performance plan

Performance Compensation Framework

Other Considerations:

- BHB desires to include measures of productivity and performance in the compensation framework; however, we were unable to gain a clear understanding of the availability of performance data at the department or individual physician level
- Furthermore, measures of productivity are important for benchmarking physician compensation in relation to productivity, e.g., TCC per wRVU, TCC per collections, etc.
  - While wRVU and collections data are not currently available, we understand that billed charges data are available and the necessary reports can be produced on a physician-level basis
  - Billed charges do not reflect actual collections; however, it may be possible to "adjust" gross charges data to approximate actual collections levels for benchmarking purposes
- In addition to measures of productivity performance, BHB should articulate the overall clinical strategy with linkage to specific physician behaviors and performance metrics

Roadmap to Performance-Driven Compensation Framework

Build organizational competencies to measure performance and provide resources and education to physicians that will support performance achievement

Performance-Based Compensation Challenges

- There must be a strong **governance process** in place to review and approve metrics and targets

Key Question: Who governs the process?

- Incorporating performance metrics into the physician compensation plan increases the **complexity** of the planning process and the need for **resources**
  - Resources to coordinate research, data collection, and reporting
  - Resources to manage increasingly sophisticated compensation plan metrics

Key Question: Who manages the process?

- Conduct honest assessment of **organizational readiness**
  - **Capability** to define and measure performance
  - **Culture** to structure incentives to reward good performance and penalize poor performance
- Consider **physician readiness**
  - Do individuals have the **competencies** to meet performance expectations?
  - Does the organization have the **tools** to help them meet performance expectations?

Key Question: Not are we ready, but how do we get ready?

Performance-Based Compensation Challenges (cont'd)

- Availability of data
  - The medical record (EMR/EHR) is the gold standard of complete and accurate information when measuring quality
  - Other sources include patient surveys, testing results, provider self-report, and administrative data
  - Access to data needed to measure performance? Who has it? How often do we need it? How will we get it?
- Sufficiency of data
  - Difficult to obtain valid measures for an individual physician
  - Use aggregated measures or composite score to combine performance results across multiple measures in a category
  - May need to use team or department performance metrics
  - Are "gap filler" mechanisms needed while new processes and reports are under construction?
- Performance standards and benchmarks
  - Who are we comparing ourselves to?
  - Industry benchmarks vs. internal benchmarks
  - Attainment vs. improvement

Performance-Based Compensation Challenges (cont'd)

- Physician performance goals must be linked to organizational goals
  - Articulate a clear connection between system-wide objectives and physician performance
  - Define the physician performance that needs to be improved and how improvement will benefit BHB
- Consider utilizing a trial or shadow period to ensure valid data and tracking abilities prior to attaching metrics to compensation
  - Allow adequate time for development of individual and organizational competencies
  - Stepped transition to mitigate the potential impact of sudden disruptions to physician income

Administrative Compensation Framework

Administrative roles:

- Determine whether administrative duties are performed in addition to their clinical responsibilities, or whether clinical work effort is reduced given administrative responsibilities
  - If clinical work effort decreases due to administrative duties, base salary levels must be adjusted to reflect decreased clinical role
- Define a methodology for determining administrative pay, keeping in mind that pay for similar roles should be comparable; options include
  - Factor of clinical base salary
  - Flat annual stipend
- Consider establishing minimum staffing ratios and/or other scope metrics to support director level roles
- Work effort may vary based on role expectations (e.g., department chief vs. division director)
- Consider having physicians log time associated with performance of administrative duties
- Conform and communicate administrative titles

BHB should standardize, define and document expected work effort for all physician administrative roles (department chiefs, division directors and other administrative roles)

Next Steps

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Next Steps

- Finalize Compensation Philosophy and Guiding Principles
- Refine clinical compensation framework based on BHB decision steps
- Confirm status and timing of organizational plans to operationalize tracking and measurement of clinical quality and efficiency
- Develop process to define performance measures for standards for physicians

Implementation and Transition Steps

- **Transition Plan**
  - Develop Communication and Implementation Strategy
  - Develop Process Road Map for Performance Measurement
  - Compensation philosophy, policies and procedures and other plan documentation
- **Identify multidisciplinary project team to coordinate implementation**
  - Data collection
  - Performance measurement
  - Benchmarking
  - Develop performance dashboards
  - Performance improvement
- **Establish timetable for drafting new physician agreements**

Sample Clinical Performance Metrics

Illustration/Example

Patient Satisfaction	Citizenship
Press Ganey	Completed medical records
Peer-peer review	Follow standards of behavior
Peer-staff review	Follow policies and procedures
Other survey tools	EHR/EMR adoption
Telephone surveys	Meeting attendance
Financial	**Stewardship**
Reduce overhead or other expenses	Administrative responsibilities (not associated with a formal job)
Target revenue	Committee participation
Target NOI	Quality/protocol development
Denied claims	Teaching and research
Financial	Leveraging technology (e.g., EMR adoption, CPOE

Sample Clinical Performance Metrics (cont'd)

Illustration/Example

Efficiency / Care Management	Quality / Outcomes
Care coordination	Preventive health screenings
Post-discharge follow-up	Clinical process measures
Chronic disease management (diabetes, asthma, etc.)	Clinical outcomes (e.g. diabetes A1c control >9), blood pressure control >140/90, cholesterol control LDL <100)
Resource utilization (e.g., OR utilization, room utilization, scheduling accuracy, length of stay)	Preventable admissions / readmission rates
Response time, wait time, access measures	Patient Safety

Sample Primary Care Performance Metrics

Illustration/Example

Growth/ Care Management	Quality/ Outcomes
Patient access (e.g., appointment availability)	Preventive health screenings
Panel size	Process measures
New patient visits	Outcomes (e.g. diabetes A1c control >9), blood pressure control >140/90, cholesterol control LDL <100)
Completed health risk assessments	Core measures
Care coordination	Preventable admissions/ readmission rates
Chronic disease management (diabetes, asthma, etc.)	Chronic disease management (diabetes, asthma, etc.)
Post-discharge follow-up	External (ACO, payers, etc.)

Sample Primary Care Performance Metrics (cont'd)

Illustration/Example

Patient Satisfaction	Citizenship
Press Ganey	Completed medical records
Peer-peer review	Follow standards of behavior
Peer-staff review	Follow policies and procedures
Telephone surveys	EHR/EMR adoption
	Meeting attendance
Financial	**Stewardship**
Reduce overhead or other expenses	Administrative responsibilities (not associated with a formal job)
Target revenue	Committee participation
Target NOI	Quality/protocol development
Denied claims	Teaching and research

Illustration/Example

Sample Administrative Performance Objectives

- Performance objectives of clinical leaders (department chief/division director) should aim to:
  - Enhance the quality and efficiency of patient care
  - Remove unnecessary duplication of effort
  - Training and development of junior physicians and other staff
  - Involvement in quality improvement processes
  - Assure shared responsibility throughout the department or service
  - Ensure the supporting resources needed
  - Regularly monitor progress.
- The nature of a clinical leader's performance objectives may depend in part on his or her role and specialty, but should include objectives relating to:
- Objectives may refer to protocols, policies, procedures and work standards, e.g.,
  - Quality
  - Activity and efficiency
  - Clinical outcomes
  - Clinical standards
  - Management of resources
  - Service development
  - Multi-disciplinary collaboration