Compensation Alignment

Faculty Clinical Performance

CEDARS-SINAI

LEADING THE QUEST

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About Cedars-Sinai

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- Cedars-Sinai is known for providing the highest quality patient care. Our dedication to excellence, compassion and innovation is rooted in the Judaic tradition and its devotion to the art and science of healing, which informs every aspect of our four-fold mission:
  - Leadership and excellence in delivering quality healthcare services
  - Expanding the horizons of medical knowledge through biomedical research
  - Educating and training physicians and other healthcare professionals
  - Striving to improve the health status of our community

- Since its inception in 1902, Cedars-Sinai has evolved to become the largest nonprofit hospital in the western United States – one that is internationally renowned for the best patient care modern medicine has to offer.

- By the numbers
  - 2,000 physicians in every clinical specialty
    - 440+/- FTE's employed faculty
  - 10,000 employees
  - 2,000 volunteers
  - 350 residents and fellows participating in over 60 graduate medical education programs

Goals for Today

- Provide a real time true story about changing culture
- Use the CSMC story as a platform to engage the group in a dialogue
- Offer some tangible examples about how to engage in changing physician behavior
- Identify some of the obstacles to a successful outcome
- Learn something from the experience of others in the audience

General Situation We Started With

- Over 10-years support for the CSMC academic enterprise from the medical center experienced a 4-fold increase
- The academic enterprise budget is ~80% +/- faculty salaries
- When analyzed we identified 33% +'- of faculty time was being allocated to activities that were entirely unfunded
- CSMC is among the highest cost providers in California
- Our faculty was used to hearing ***"Yes"*** for most things but there was little accountability

Underlying Principles : With assistance of Human Resources, Academic Affairs leadership and SullivanCotter [Consultants], develop a new compensation program that achieves the following:

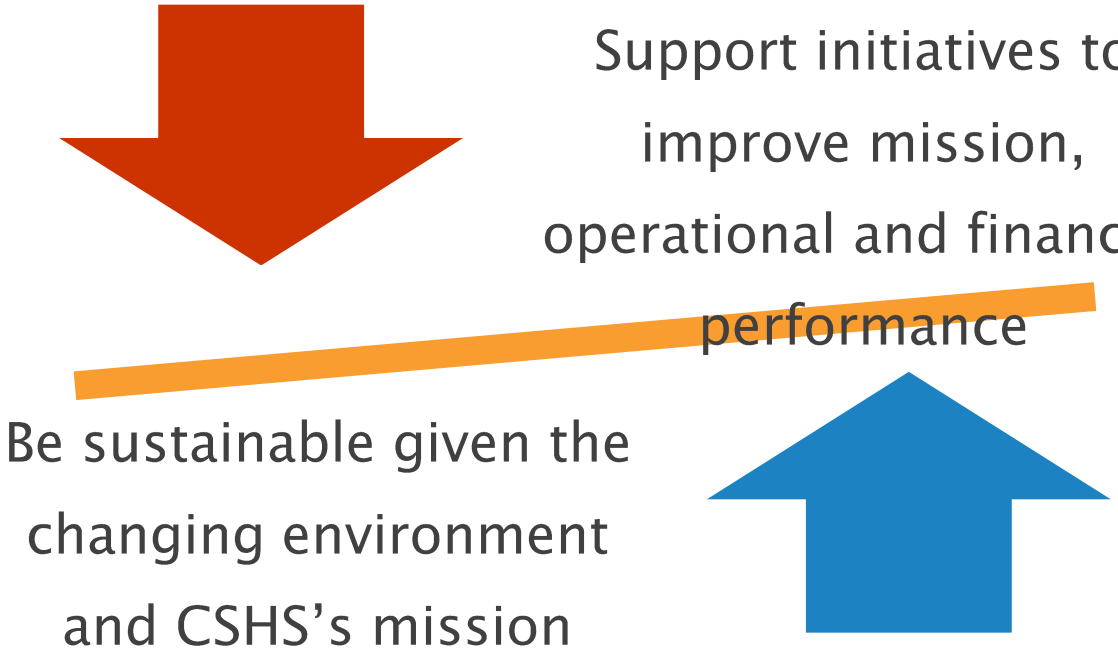
- Align total cash compensation [TCC] with productivity benchmarks, performance, CSMC mission, and values and apply appropriate geographic differentials

- Enable each Chair to manage the compensation and productivity program within the department, consistent with the common principles, established policies, and approved budget.

- Empower Academic Affairs and Human Resources to assist the Chairs in developing AND monitoring individual incentive plans, performance metrics, and other program components.

Initial Objective: Create a more structured compensation system that allows fair market value in the face of current conditions

- Cedars-Sinai Health System (CSHS) desired to enhance its compensation plan for faculty so that it would:

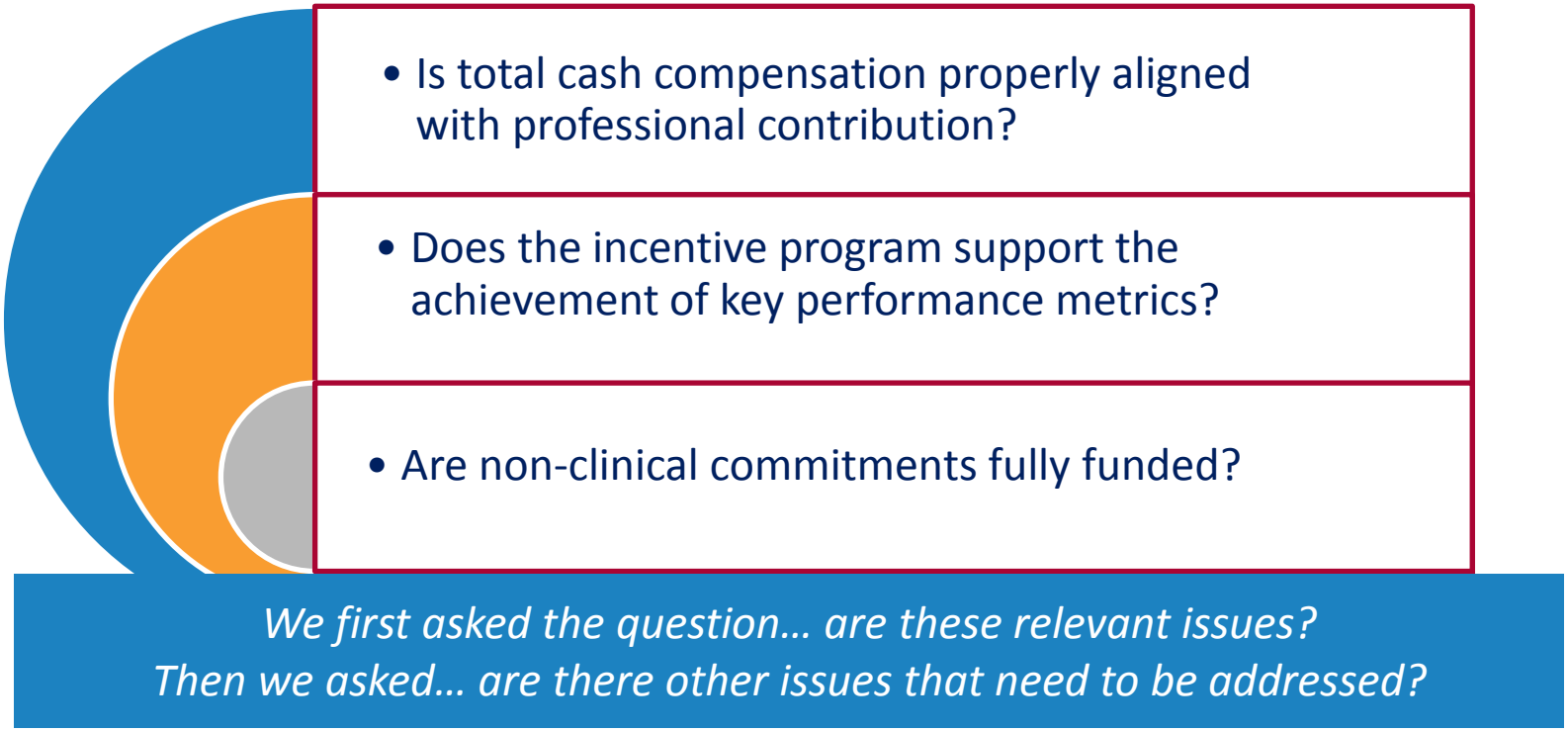


Faculty Plan in 2011 – Before New Plan Implementation

- The 2011 cash compensation plan for faculty featured the following:
  - Total cash compensation (TCC) targeted at competitive levels (geographic premium of 16% is applied) in relevant academic and clinical marketplaces
    - 79% of staff physicians had TCC below the 75th percentile with 14% between the 75th and 90th percentiles and 7% above the 90th percentile
- Base pay determined by physician rank, experience, production performance and contribution to the system
  - Merit increase grid of 0% to 4%
    - In FY 2011, the average increase was 2.9%, with departments ranging from 1.1% to 7.0%
- Incentive opportunity of 20%, based on clinical productivity, quality measures, teaching performance, and other measures including funded research, study groups, editorial boards, publications, speaking engagements, and meeting attendance
    - In FY 2011, the average incentive award was 11.7%, with departments ranging from 8.2% to 18.1%

Potential Issues – The world as we knew it was changing; A review of the current program seemed appropriate

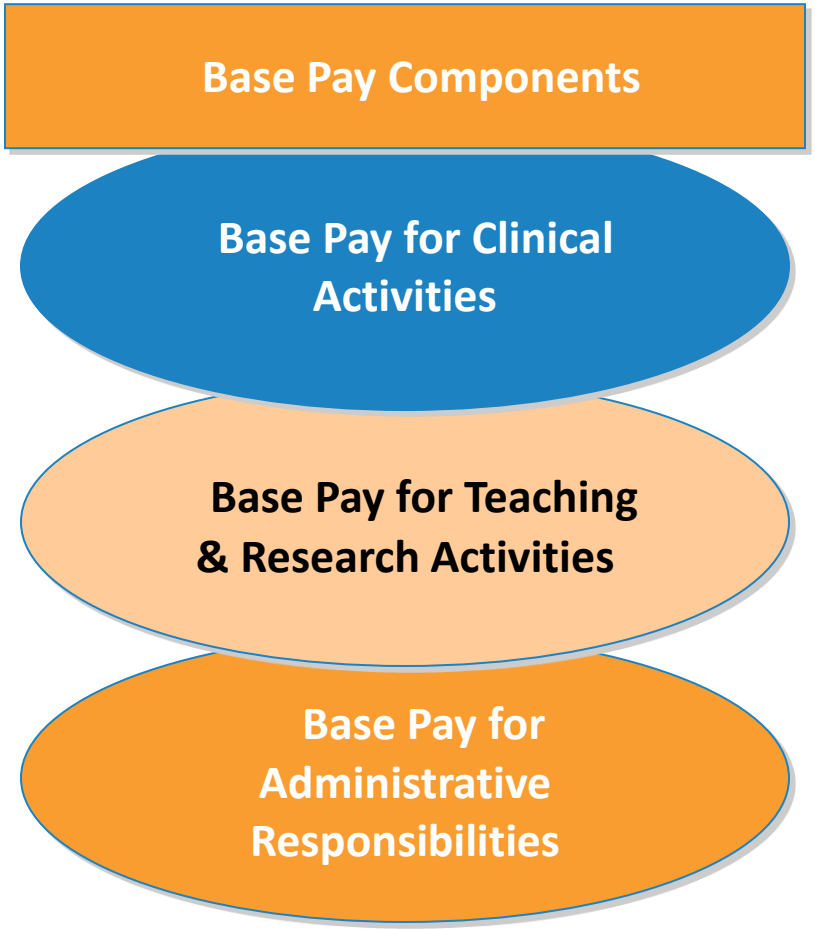
- Although many features of the current program were consistent with market practice, potential issues to review included:



Key Premises – The construct pursued reflects the emerging consensus RE: physician compensation in AMC's

- Revenue increases/expense reductions will likely be necessary to appropriately fund cash and total compensation for faculty physicians
- Funding of non-clinical activities and the AMC's ability to subsidize them will be challenged in the near term
- A compensation program focused primarily on wRVUs is not sustainable as there is no linkage to revenue, expense control and financial results
- Physician compensation is funded through identified sources:
  - Clinical income
  - Research funding
  - Institutional subsidies
  - Administrative service
  - External funding
- Physician compensation funding will need to vary based on departmental budget performance
- Chairs are in the best position to make physician compensation determinations following established group-wide principles and within established budgets

Base Pay Considerations



Key Considerations

- FTE allocation to each category of work should reflect:
  - Specific job responsibilities
  - Actual required time
- Each base pay component should be budgeted/funded
  - Reconciled with total funds actually available
  - Chairs may have unfunded/protected time included in approved department budget

Incentive Plan Considerations

Key Considerations

- Incentive funding must be included in the budget process
  - Payable if budget target is achieved/exceeded
  - Reduce/eliminate if budget target is not achieved
- Incentives must be distributed consistent with departmentally-established parameters
  - Performance metrics established on an individual basis
  - Performance metrics aligned with the group's strategic objectives

Time and Effort – Used to Allocate Expectations by Category of Work & Actual Reported Work Effort

Clinical work effort:

- Direct patient care activities.
- Resident supervision requiring direct patient care.
- Dictation and chart documentation.

Administrative work effort:

- Leadership positions (Program Director, Medical Director, In-Chief).
- Administrative duties which require physician expertise and are necessary to help the business needs of the department.
- The hours and outcomes should be specified for all administrative duties.

Teaching – Reflect all teaching activities that do not involve direct patient care

Research – identification of which research projects are funded and which are not.

- Chairs and Division directors are responsible for managing in accordance with set expectations and standards. There can be exceptions approved by Senior Leadership at the individual level. Department and/or division roll-up are approved annually and managed to that allocation.
  - Administration – 10% –[Target]
  - Teaching – 5% – [Target]
  - Research – whatever is funded (extramurally or institutionally)
  - Balance must be clinical

- Senior Leadership needs to agree on common understanding of duties falling into each effort category and ensure consistency in application of reporting effort.

Each major component of a physician's total work effort must be supported by the following information

Definitions of the Expected Work Effort

- FTE (by mission area)
- Clinical blocks/sessions
- Hours per week/month

Academic Department Evaluation Tool

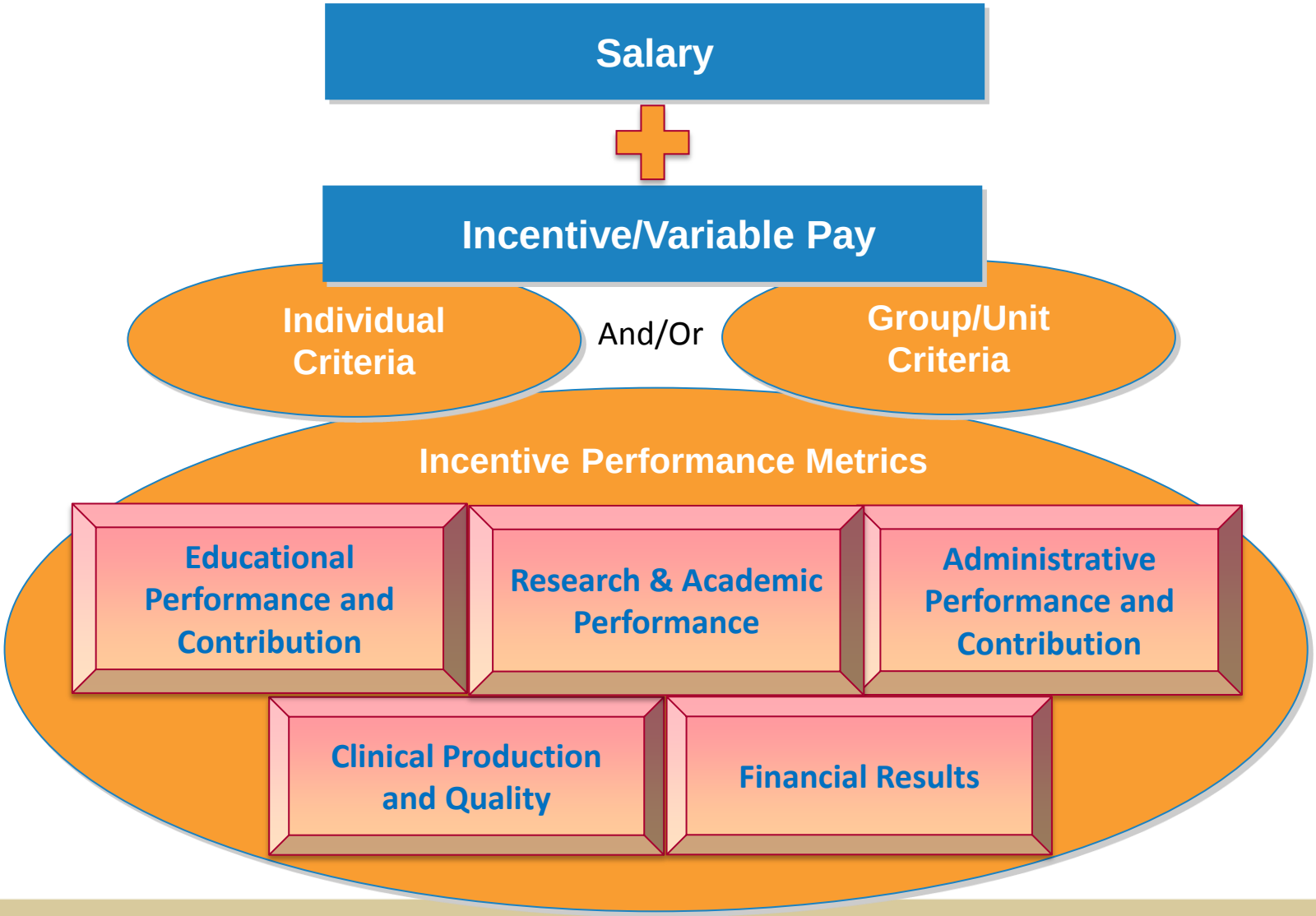
- Performance criteria/metrics
- Performance goals
- Tracking and reporting systems

Funding Sources

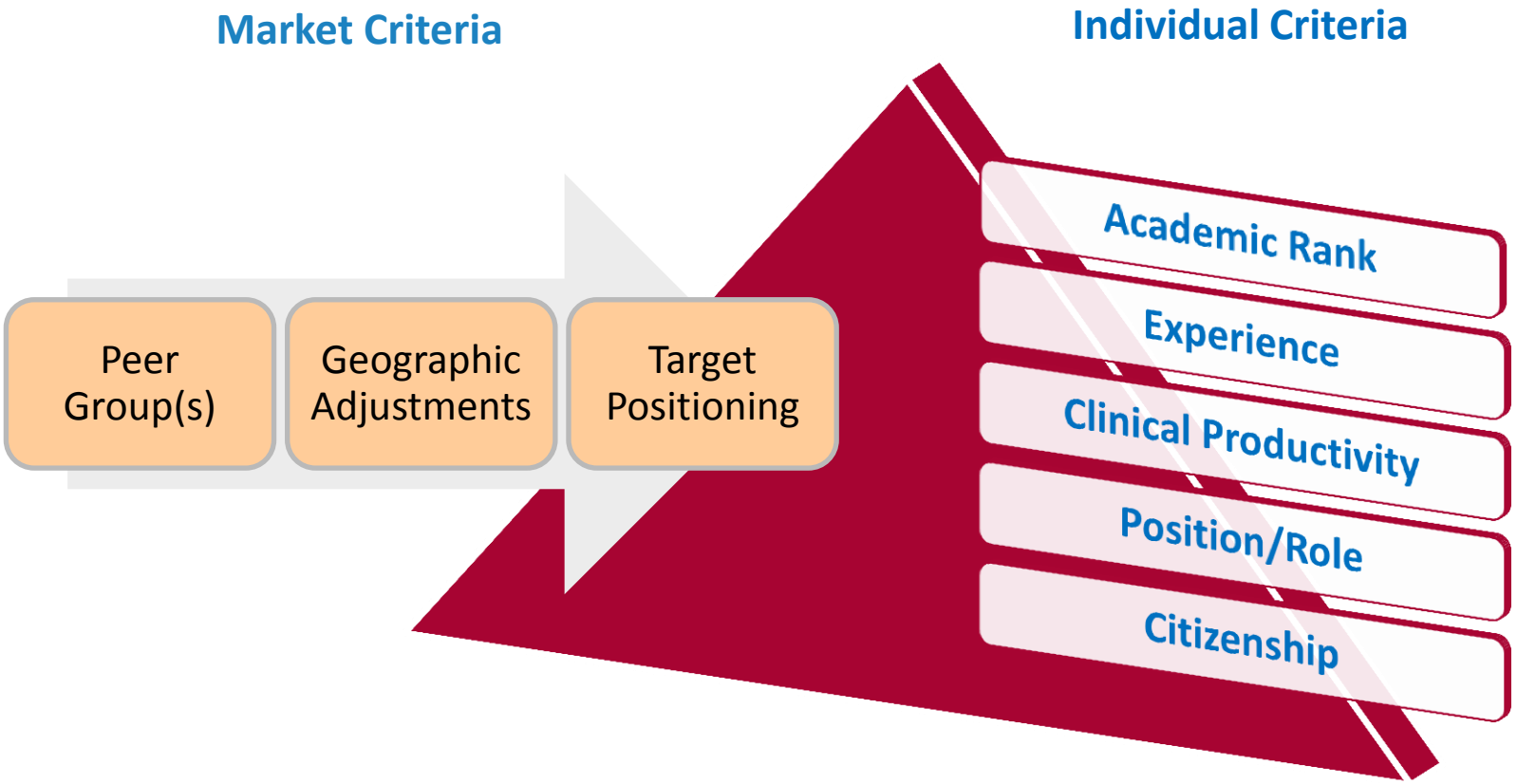
- Teaching: Funded by the medical school, or subsidized by the system
- Research: Funded by external grants or from departmental reserves, or subsidized by the system
- Administration: Funded by the provider/unit receiving the services
- Clinical: Funded by collections for professional services

Non-clinical assignments and FTE allocations that can not be fully funded should be evaluated for reduction or elimination

Physician Compensation Model



Salary Guidelines – The salary plan should include defined ranges/ guidelines for each clinical specialty based on considerations as illustrated below



Sample Salary Guidelines

Salary Tier 1	Salary Tier 2	Salary Tier 3
Salary Range from 85% of P25 Market Value for Assistant Professor up to P25 Market Value for Assistant Professor[1]	Salary Range from P25 Market Value for Assistant Professor up to P75 Market Value for Associate Professor[1]	Salary Range from P25 Market Value for Professor up to P75 Market Value for Professor[1]
	The salary range for Tier 2 will be divided into four or five pay/productivity levels	The salary ranges for Tiers 2 and 3 may overlap
[1] Market data should be adjusted by the 16% geographic premium		
Less than 2 years since completion of training	Academic rank of Assistant or Associate Professor	Academic rank of Professor
	Board certified/eligible	Board certified
	Meets basic teaching performance expectations	Distinguished record of teaching, research, academic and/or service performance
	Meets basic service and citizenship expectations	Demonstrated record of leadership contribution to the group/unit, the practice, or the System
	Clinical productivity meets/exceeds minimum performance threshold for the Tier	
	Meets other performance critieria, if any, established by the Department or the System	Meets other performance critieria, if any, established by the Department or the System

Physicians should be placed into a salary tier and paid within the designated tier based on teaching, research, and academic standing using criteria defined by CSHS with appropriate levels of Chair discretion

Incentive Plan Considerations: How Do We Best Evaluate Performance Above and Beyond the Basics of the Position?

Incentive Based on Educational, Research, Academic and/or Administrative Performance Criteria

- Based on educational, research, academic and/or administrative performance goals
  - Goals should be weighted on the physician's work effort allocation
  - Teaching and Administration should be budgeted at 10% or 15% of salary and funded if the group/unit budget is achieved
- Can be supplemented by incremental funding if the unit exceeds budget
  - Should be capped at 20% or 25% of salary

Incentive Based on Individual or Group/Unit Productivity

- Can be based on either individual or group productivity; incentive = $ per wRVU or % of Net Collections
  - Payable for productivity – defined threshold which reflects the salary and clinical FTE of the physician(s)
  - Funded based on group productivity and distributed based on individual work effort or productivity
- Funding should be based on the expected net income or budget of the group/unit
- No cap, as long as quality and compliance standards are achieved

Clinical Faculty Compensation Program

- The program strengthens the linkage between clinical performance, accountability and compensation.
  - Individual physicians are accountable and rewarded on the basis of both *individual and departmental/divisional* clinical performance- including productivity , as well as academic performance
    - Incentive awards will align with % clinical effort expected (*i.e., for a faculty member who is .5 clinical FTE, 50% of incentive is a function of clinical performance*)
    - Individual faculty compensation and clinical productivity benchmark percentiles are aligned to clinical performance percentiles
  - Chairs and Division Directors are accountable and rewarded on the basis of *departmental/divisional clinical performance* goals and budgets, as well as academic performance

- **Benchmarks**:
  - Compensation: National AAMC data (with an adjustment of 16% to account for Cedars' market).
  - Clinical Productivity: Faculty Practice Solutions Center ("FPSC") data *(UHC/AAMC)*

Measuring Performance: Its all about establishing clear and measurable goals with realistic metrics

- Performance based on mix of:
  - Individual clinical productivity
    - *Departmental flexibility if more advantageous to identify some group clinical performance goals vs. all individual goals*
  - Departmental / Division goals, including professional services collections

- Clinical performance metrics will include more than one measure. Metrics *may* include:
  - Work RVUs
  - Payer Mix
  - Volume (i.e., number of visits and/or procedures)
  - % of salary supported with professional services collections

- Other metrics may include:
  - Citizenship (using EMR properly, completing documentation within set timeframes, etc.)
  - Financial – meeting Dept./Div. collections *and* expense budget targets

Incentive Compensation – Additional criteria may need to be added beyond individual performance connected to base salary

- Department **incentive funding and distribution criteria:**
  - Based on Department meeting financial targets/budgets
  - Proportional to productivity, revenues, wRVUS, clinical outcomes, quality measures, etc.
  - Achievement of defined, measurable indicators of clinical, academic, and service performance and productivity at the department level (chairs will develop a matrix of indicators prior to implementation of this plan)
  - Chairs will be accountable for managing to roll-up on individual performance metrics (i.e. research, wRVU's and collections).

- Individual "citizenship" criteria, common to all departments.

- Performance criteria
  - Goals and targets set annually
  - Developed by the Chair and approved by the Vice Dean of Academic Affairs.
  - Based on the achievement of defined, measurable indicators of clinical, academic, and research performance.

Goals For Compensation Of Clinical Faculty

Total Cash Compensation (TCC) = Base Salary + Incentives

- **Goals**:
  - Increase proportion of TCC paid from incentives – Over time, allows for greater incentive for clinical performance
  - Substantially reduce if not totally eliminate all unfunded time
  - Minimize use of internal funding in favor of external sources

- **Method For Achieving Goals:**
  - Hold base salaries constant (no merit increases) in FY 14
  - Increase incentive pool by what would have been merit pool %
  - Clinical incentives to be paid twice annually (goal is after 6 months and at year end)

Method For Achieving Productivity Goals [Continued]

Productivity increases will occur in two ways:

1. *Increasing the amount of time available to provide clinical care*
2. *Increasing the clinical productivity benchmark percentile goal*

- Limit "un-funded" time for administration and teaching to 15% (dept'l aggregate)
  Average admin + teaching (all departments)
  - FY12: 35% (actual)
  - FY13: 28% (estimated based on YTD)
  - FY14: 15% (proposed)

- Research time must be funded
- Balance is clinical time

- Faculty clinical time will be set and monitored annually via the following:
  - Expectations set at time of hire (documented on "Fact Sheet")
  - Annual Evaluations
  - Faculty contract renewals

Increasing Clinical Productivity Benchmark

- Increase clinical productivity
  - *Current average across all departments (based on 6 mo data for FY 13) C-S faculty are at the 26th percentile*

	Median	65th Percentile	> 65th Percentile
FY 14	Meets	Exceeds	
FY 15		Meets	Exceeds

  - Unlike many university settings, C-S has a unique balance between faculty and attending physicians
    - C-S leadership has made institutional decisions that have historically set "boundaries" for faculty practice patterns (e.g., MFM & deliveries, GI and routine scopes) which may limit ability of a faculty physician to increase clinical volume.

Next Steps: Faculty Communication Plan

- Approval by senior management
- Use faculty open forum to begin introducing concepts regarding productivity
- Additional details immediately after to be provided at individual Departmental and/or Division Faculty Meetings
  - Department, Divisional, Individual Dashboards provided and explained to faculty
  - Provide monthly reports to individual faculty
    - Reviewed with them by chair/division director
- **Communications – Present new plan including**:
  - Vision / Need for Change
  - Benchmark: move from median to 65th within two years
  - Performance based on mix of individual productivity and departmental / division budget goals
  - Base salaries held constant in FY 14
  - Incentive pool fund will be increased with dollars form merit pool
  - Monthly reports

Lessons Learned

- It is all about ***changing culture*** and how people think
  - Cultural Change, especially involving physicians and their compensation are among the most difficult to affect

- None of this will happen without ***transparency***
  - Without real transparency and disclosure of information it will be difficult to ever get anyone to come along, especially highly intelligent and well trainee

- Identify opportunities to enable ***system governance***
  - The best way to enforce behavior is to have physicians involved in the process

Lessons Learned (cont'd)

- Provide ***education*** regarding clinical and benchmark data
  - Review sample individual dashboard reports
  - Arrange for individual meetings with faculty to:
    - Review their dashboard report and answer questions
    - Discuss what it will take for them to achieve goals (i.e., number of clinics, visits)
  - Provide mentoring for Division leaders regarding changing expectations for their roles (holding faculty accountable to productivity goals, etc.)

Sample Physician Report

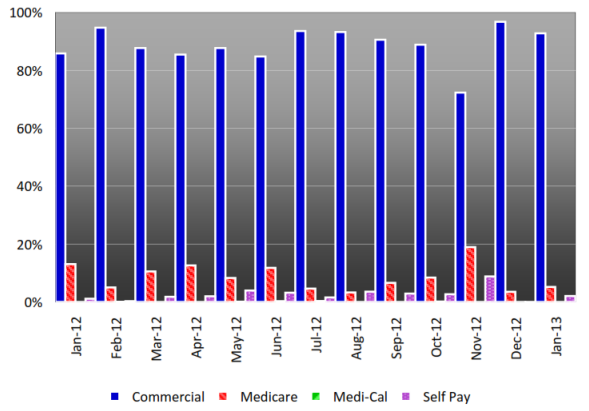
FTE Overview

Metric	Expectation	T&E YTD	FTE Status
cFTE	70%	77%	1.00
Admin FTE	10%	12%	
Research FTE	0%	0%	
Teaching FTE	20%	11%	
Sessions/ Week	6.0	N/A	

Patient Satisfaction

Overall	Recommend
In Development	

Provider Payor Mix Trend

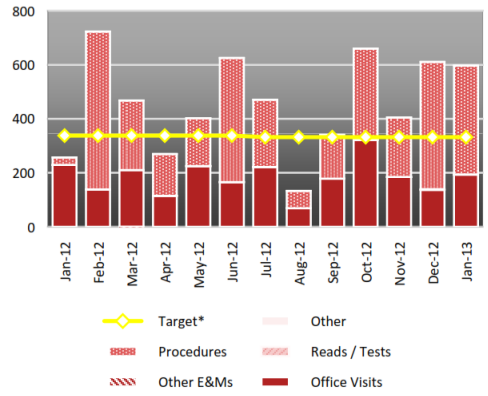


Higher Commercial and Lower Government are Favorable

Key Statistics

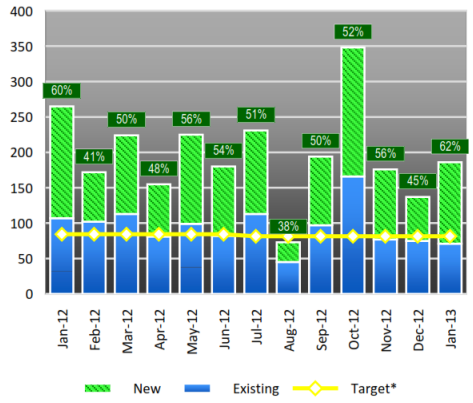
Metric	Current Month	Prior-Year Month	YTD	Prior YTD	YTD Goal	FPSC YTD Mean
wRVUs	597	257	3,216	2,665	TBD	3,323
Office Visits	186	265	1,345	1,235	TBD	814
Charge Lag	23.1	24.3	19.0	18.7	TBD	N/A
Next 3rd	2.8	0.0	7.0	0.0	TBD	N/A
Collections	$52,099	$32,226	$254,692	$229,567	TBD	N/A
Total Charges	$135,011	$96,221	$701,459	$641,946	TBD	N/A

wRVUs by Month



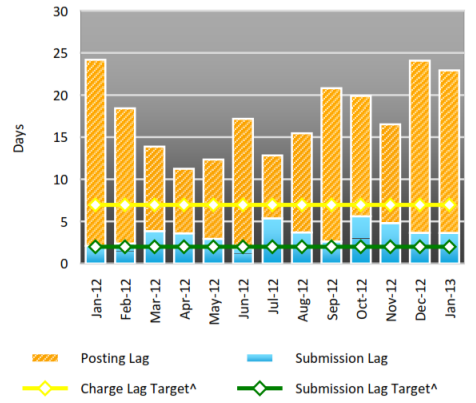
Higher wRVUs are Favorable

Patient Visits by Month



Higher Visits are Favorable

Average Professional Charge Lag



Lower Days are Favorable

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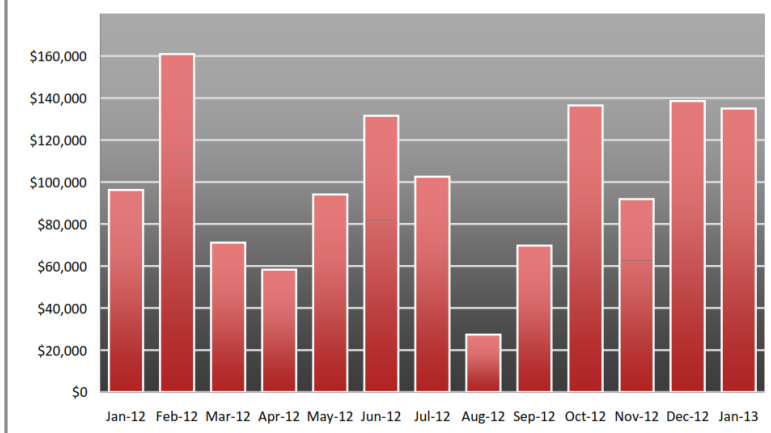
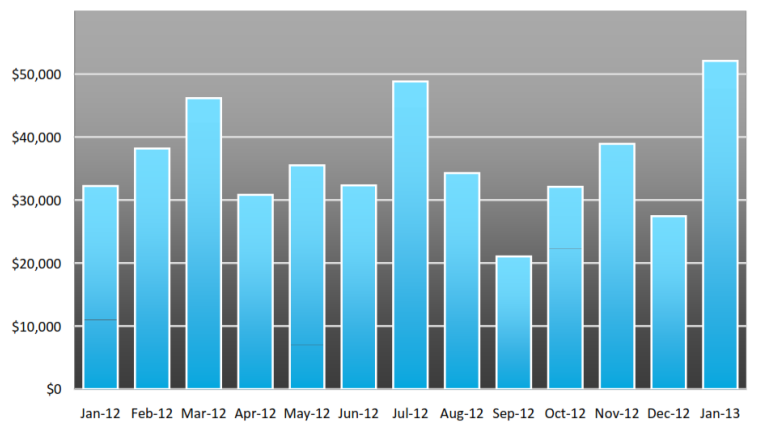
Sample Physician Report

Charges by Month



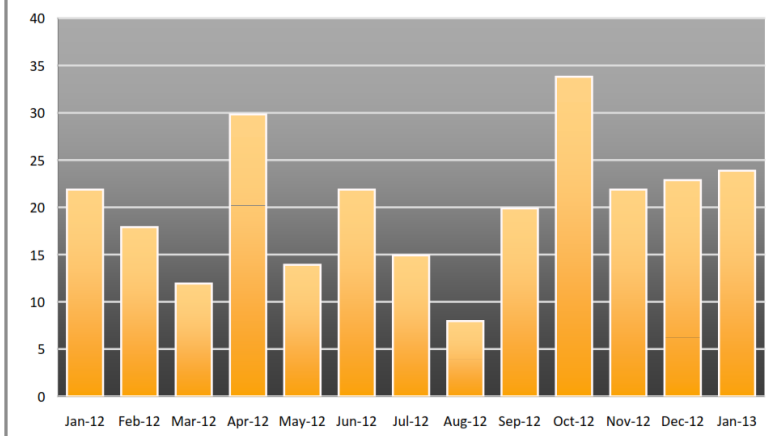
Higher Charges are Favorable

Collections by Month



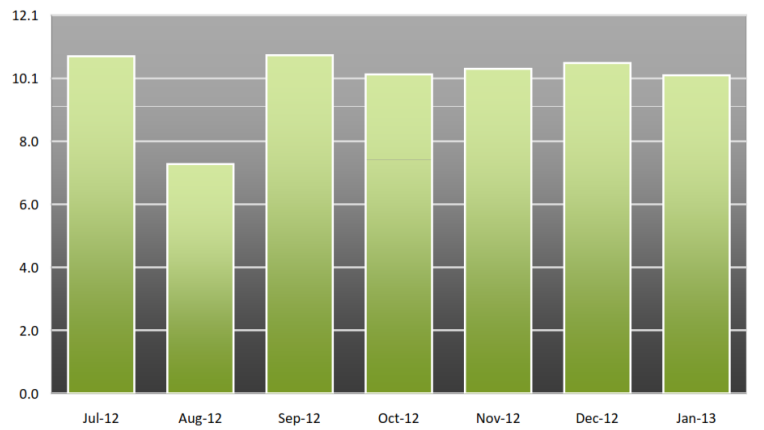
Higher Collections are Favorable

Procedures by Month



Higher Procedures are Favorable

Visits per Session



Sample Physician Report

Top 10 Procedures Based on Quantity

CPT Code	CPT Code Description	Total Units
99024	POSTOP F/U VISIT INCLD GLOBAL SERV	763
99203	OFFIC/OUTPT E&M NEW MOD SEVER 30MIN	631
99212	OFFICE/OUTPT	627
99202	OFFIC/OUTPT E&M NEW LOW-MOD 20MIN	584
99211	OFFIC/OUTPT E&M ESTAB 5 MIN	242
99213	OFFIC/OUTPT E&M ESTAB LOW-MOD 15MIN	201
99201	OFFIC/OUTPT E&M NEW MINOR 10MIN	112
99243	OFFIC CONS NEW/ESTAB MOD 40 MIN	92
28270	CAPSULOT; MTP JT-1-EA JT (SEP PRO)	27
28300	OSTEOTOMY; CALCAN W/WO INT FIXA	26

Scheduling Statistics

Appt Type	CM	YTD
Completed	77%	72%
Cancelled	9%	11%
Rescheduled	10%	12%
No Show	2%	4%
Other	2%	1%
Total	100%	100%

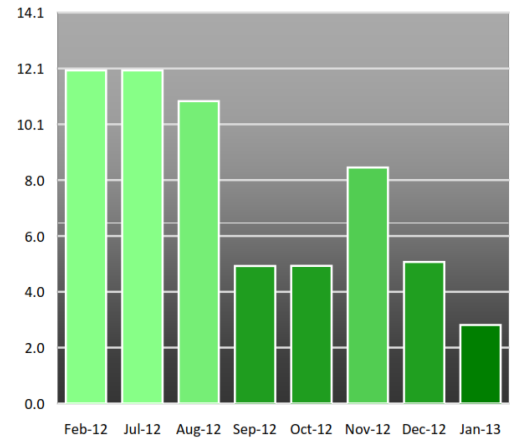
In Development

In Development

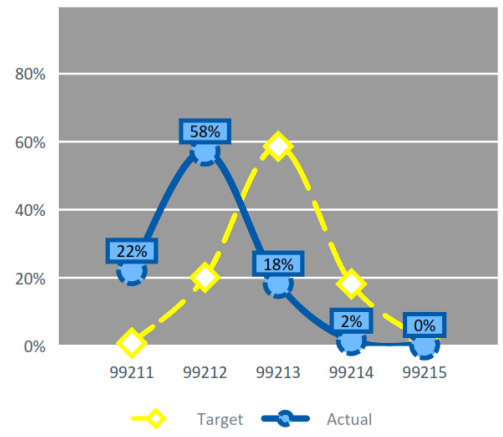
Top 10 Procedures Based on wRVUs

CPT Code	CPT Code Description	Total wRVUs
99203	OFFIC/OUTPT E&M NEW MOD SEVER 30MIN	896
99202	OFFIC/OUTPT E&M NEW LOW-MOD 20MIN	543
99212	OFFICE/OUTPT	301
99213	OFFIC/OUTPT E&M ESTAB LOW-MOD 15MIN	195
28300	OSTEOTOMY; CALCAN W/WO INT FIXA	185
29891	ARTHROS ANK SURG; EXC DEFEC TAL/TIB	174
99243	OFFIC CONS NEW/ESTAB MOD 40 MIN	173
27698	SUTURE 2ND REPR TORN LIG ANK COLLAT	163
27691	TRANSF/TRANSPL SNGL TENDON; DEEP	152
27870	ARTHRODESIS ANK ANY METHD	146

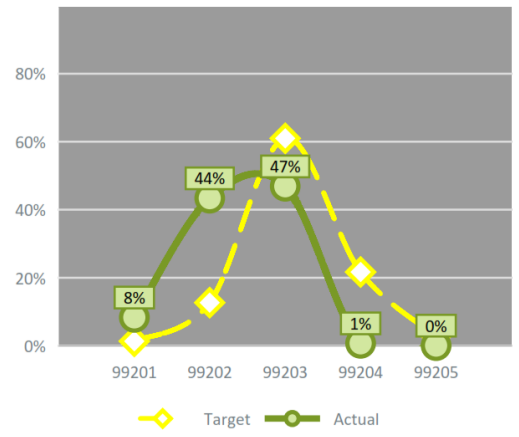
Days to 3rd Next Available Appointment



Established Patient Coding Distribution



New Patient Coding Distribution



Questions

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