Compensation Alignment: The Journey to One Dartmouth-Hitchcock

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Chief Clinical Officer
Dartmouth-Hitchcock
1200 Physicians (50% AMC)

400 bed AMC + 5 group practices

Multiple compensation models

Risk-based 60% (ACO, self pay, employees)

40% of contracts with VBP components

Don’t do well at FFS
Issues with Old Compensation Plan

- Providers dissatisfied
- Multiple plans across system (equity, fairness)
- Not understandable or transparent
- Not market competitive
- Didn’t align with our strategic imperatives
- Disincentive to use Associate Providers
- Non-productivity measures not included
Phase 1
- Information gathering
- Goals and guiding principles
- Basic framework

Phase 2
- Details of plan
- 6 Workgroups
  - Allocation
  - Academics
  - Communication
  - Data and tool design
  - Model Design
  - Governance

Phase 3
- Launch
- Ongoing governance
D-H Guiding Principles

Implemented across Dartmouth-Hitchcock (One-DH)
- Across the Community Group Practices and DH-Lebanon
- Supporting Service Integration Across D-H
- Recruiting and Retaining the best

Allow us to pay for the type of work that is done
- Support our Research and Education missions
- Support important Administrative and Leadership roles

Encompass both Physicians & Associate Providers
- Removing barriers to Team Based Care
- Appropriate Compensation and Bonus for team based quality success

Facilitate our transition from Volume to Value
- Incorporate and expect achievement and exceeding national and organizational quality measures
- Transparent and understandable, aligned to strategic goals
Physician Compensation

Total clinical compensation (100%) includes the following:

- **Productivity** Expectations (85%)
- **Value Based** Measures (15%)*
  - Access (5%)
  - Quality (5%)
  - Patient Satisfaction (5%)

Target Salary, not percent of a percentile

**Expectation** of quality, access and patient satisfaction

- Not a quality bonus

*HCAHPS, HAC, CLABSI, CAUTI, VBP, Readmissions and more...
Clinical Compensation Models

Quality, Access, and Patient Satisfaction (Expectation)

4 Tier Model
Applies to physicians in sections measuring wRVUs

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<thead>
<tr>
<th>Tier</th>
<th>Min Production %ile</th>
<th>Max Production %ile</th>
<th>Market %ile</th>
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Pool Calculation

Physician Clinical Salary (tier) x Clinical FTE = Clinical Pool

15% Value

85% RVU
Quality, Access, and Patient Satisfaction (Expectation)

4 Tier Model
Applies to physicians in sections measuring wRVUs

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Pool Calculation

Physician Clinical Salary (tier) x Clinical FTE = Clinical Pool

Salary Model
Family Medicine, Geriatrics, Hospitalists, Pediatric Hospitalists, Internal Medicine, Pediatrics, Palliative Care, Pathology, Anesthesiology, and Emergency Medicine.

Pool calculated at the 50th percentile, regardless of production.
Compensation Model Determination

**Tier Based Model**

- **Able to directly control or influence work, productivity and volume?**
  - Yes
  - No

- **Work is shift based?**
- **Work requires in-house on-call presence and/or coverage of necessary services regardless of RVU opportunities?**
- **System measures outweigh RVU measures of productivity?**

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**Salary Model (Market Median)**

*Pool calculated at the 50th Market Percentile*
How are we paid?

Quality, Value and Utilization based Measures

60% Fee for Service

40% Value Based Contracts

CAHPS*, CLABSI, CAUTI, SSI, C. Difficile, Pressure Ulcers, Pneumothorax, DVT/PE, Sepsis, Wound dehiscence, Readmissions, ER Utilization, BP, HA1c, HEDIS OPPE and Others...

Where do these Quality Performance (Payments and Penalties), show up?

ACO Contracts
Value Based Purchasing
Hospital Readmission Reduction
Hospital Acquired Conditions
Outpatient Quality Reporting

Physicians and Associate Providers are integral to successfully attaining these measures.

We want to explicitly link Value, including Quality and Utilization Measures to compensation

*Consumer Assessment of Healthcare Providers and Systems
Linking Quality and Value Measures to Compensation

**Quality Measures**
- CAHPS*, CLABSI, CAUTI, SSI, C. Difficile, Pressure Ulcers, Pneumothorax, DVT/PE, Sepsis
- Wound dehiscence
- Readmissions
- ER Utilization, BP, HA1c, HEDIS and others…

**Access Measures**
- 3rd Available appt % Booked
- Utilization of OSC and Block Time

**Patient Based**
- Satisfaction Scores

**Value Domains**
- Quality 5%
- Access 5%
- Patient Experience 5%

**Benchmark Compensation**
(paid at 100%)
- 15% Value
- 85% Productivity

Local physician engagement in choosing measures is critical for Attribution to Compensation, these need to be Applicable, Measurable, Manageable and where appropriate, consistent with how we are Reimbursed

*Consumer Assessment of Healthcare Providers and Systems
What are some of the reported measures...we have 173 of them!

<table>
<thead>
<tr>
<th>Measure</th>
<th>Dept/Section</th>
<th>Domain</th>
<th>Location</th>
<th>Preventive and Screening</th>
<th>Service</th>
<th>VBP</th>
<th>IQR</th>
<th>OQR</th>
<th>HAC</th>
<th>HRRD</th>
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<td>All-Cause Unplanned Admissions for Patients with Diabetes</td>
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<td>Ambulatory</td>
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<td>OP - 12 The ability for providers with HIT to receive laboratory data</td>
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<td>X</td>
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<td>OP - 17 The ability to track clinical results between visits</td>
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<td>OP - 13 Cardiac imaging for pre-op risk assessment for non-cardiac</td>
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<td>OP - 30 Endo/Polyp Surveillance: Appropriate fu interval for patients</td>
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<td>Percent of POCs who successfully qualify for an EHR Program</td>
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<td>OP - 29 Endo/Polyp Surveillance: Appropriate fu interval for normal</td>
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<tr>
<td>HEDIS: Chlamydia Screening</td>
<td>Provider</td>
<td>Quality</td>
<td>Ambulatory</td>
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<tr>
<td>HEDIS: CDC HbA1c Good Control (&lt;8.0%)</td>
<td>Provider</td>
<td>Quality</td>
<td>Ambulatory</td>
<td>Primary Care</td>
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<tr>
<td>HEDIS: Comprehensive Diabetes Care: LDL-C screening</td>
<td>Provider</td>
<td>Quality</td>
<td>Ambulatory</td>
<td>Primary Care</td>
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<tr>
<td>Diabetes: A1C Testing</td>
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<td>Quality</td>
<td>Ambulatory</td>
<td>X Primary Care</td>
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<tr>
<td>HEDIS: Comprehensive Diabetes Care: Nephropath Monitoring</td>
<td>Provider</td>
<td>Quality</td>
<td>Ambulatory</td>
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<tr>
<td>HEDIS:  Cholesterol Management for Patients with Cardiovascular</td>
<td>Provider</td>
<td>Quality</td>
<td>Ambulatory</td>
<td>Primary Care</td>
<td>X</td>
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<tr>
<td>HEDIS: Use of Imaging Studies for Low Back Pain</td>
<td>Provider</td>
<td>Quality</td>
<td>Ambulatory</td>
<td>Primary Care</td>
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<tr>
<td>HEDIS: Annual Monitoring on Patients on Persistent Medications</td>
<td>Provider</td>
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<td>Ambulatory</td>
<td>Primary Care</td>
<td>X</td>
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Determining the right Value and Quality Measures

*Local physician engagement in choosing measures is critical*

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<thead>
<tr>
<th>Access</th>
<th>Quality</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Booked</td>
<td>3rd Available appointment</td>
<td>Reduced ED utilization</td>
</tr>
<tr>
<td>Provider Specific Outcomes</td>
<td>Disease specific measures</td>
<td>Improved Contracting Performance</td>
</tr>
<tr>
<td>Provider based experience</td>
<td>Sectional satisfaction</td>
<td>Service line measures</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Ob-Gyn</th>
<th>Radiology</th>
<th>General Surgery</th>
<th>GI</th>
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<th>Cards</th>
<th>Rheum</th>
<th>Hosp Med</th>
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*Consumer Assessment of Healthcare Providers and Systems*
## Constructing Value Measures for each area

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<td><strong>Quality</strong></td>
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<tr>
<td><strong>Patient Experience</strong></td>
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</table>

### General Surgery
- % Booked Utilization of OR/OSC

### Primary Care
- % Booked New PCP
- Weekend appts

### Cardiology
- % Booked 3rd Available External referrals

### Quality
- CAUTI, CLABSI, Postop wound dehiscence
- Handwashing 4W
- Screening Composite (Pioneer focus)
  - [Ha1c, BP, Colo, BMI], HEDIS measures
- Mortality and readmission for AMI
  - and HF, BB after MI
- Handwashing 4E, CVCC

### Patient Experience
- Communication with Doctors Satisfaction scores
- Patient Rating of Doctors Satisfaction Scores
- Shared Decision Making
- Communication with Doctors Satisfaction scores

*Consumer Assessment of Healthcare Providers and Systems*
Department – Quality/Financial
Physician – Quality/ Productivity
Physician Summary View
Transitioning Towards One D-H

- **Individual Locations**: Productivity tiers determined by each individual location and sometimes providers. *Current Practice*
- **Academic Medical Center and CGP**: Productivity tiers determined by AMC and combined CGP locations
- **All Locations Combined**: Productivity tiers determined by all locations combined based on Service and Specialty (One D-H)
Clinical Compensation

cFTE x salary
(based on system tier performance)

Modified by patient sat, quality, access

<table>
<thead>
<tr>
<th>Physician</th>
<th>cFTE</th>
<th>Measure 1 (50%)</th>
<th>Measure 2 (25%)</th>
<th>Measure 3 (25%)</th>
<th>Weighted Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (Manch)</td>
<td>1.0</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td>B (Manch)</td>
<td>1.0</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>C (Leb)</td>
<td>0.8</td>
<td>7</td>
<td>7</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>D (Leb)</td>
<td>0.5</td>
<td>8</td>
<td>8</td>
<td>9</td>
<td>33</td>
</tr>
<tr>
<td>E (Leb)</td>
<td>0.9</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>F (Keene)</td>
<td>1.0</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>29</td>
</tr>
<tr>
<td>G (Keene)</td>
<td>0.8</td>
<td>7</td>
<td>6</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6.0</td>
<td>6.4</td>
<td>7.4</td>
<td>8.0</td>
<td>28.3</td>
</tr>
</tbody>
</table>
Sub-allocation of pools

Each site receives pool based on relative performance of providers at the location

Local input to distribute pool for site

Move toward system-wide service lines
Physician Clinical Compensation Models

Expectations of Quality, Access, and Patient Experience
Value Based Measures are 15% of total compensation, reviewed every 6 months

<table>
<thead>
<tr>
<th>Tier</th>
<th>Min Prod %ile</th>
<th>Max Prod %ile</th>
<th>Market Percentile</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>40</td>
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<td>41</td>
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<td>3</td>
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<tr>
<td>4</td>
<td>81</td>
<td>100</td>
<td>90&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Tier Based Model

Salary Model
Typically, Primary Care, Emergency and Hospital based specialties are compensated at a median salary and not a production based
Calculated at the 50<sup>th</sup> Market Percentile

Clinical Compensation Pool Calculation = FTE x Market Rate

Individual clinical Performance Determines Local Sub-allocation

Keene
Manchester
Lebanon

15% Value
85% Productivity

Local Leader Input
Physician without an academic role, 100% clinical

Clinical Comp Pool

- $cFTE \times$ salary based on tier
- Pool developed across DH
- Modified by patient sat, quality, access

Performance against clinical measures vs. group

Individual Compensation

What about academic physicians?
**Clinical Compensation**

- cFTE x salary (based on system tier performance)
  - Modified by patient sat, quality, access

**Clinical Compensation Pool**

- 10% of median salary (using academic cFTEs) distributed based on academic measures (rank, productivity)
- 100% of salary distributed based on clinical performance
- 90% of salary distributed based on clinical performance

---

**Academic Productivity**

- Academic physician career is different than non-academic
- Expectation of scholarly output and teaching
- A percentage of clinical dollars in each section/department in the AMC distributed based on academic performance
- Accountability framework for academic work at the individual, section and department level being developed
Physician with academic role, 100% clinical

<table>
<thead>
<tr>
<th>Clinical Comp Pool</th>
<th>Academic Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>cFTE x salary based on tier</td>
<td>10% x academic cFTE x salary based on tier</td>
</tr>
<tr>
<td>- Pool developed across DH</td>
<td></td>
</tr>
<tr>
<td>- Modified by patient sat, quality, access</td>
<td></td>
</tr>
</tbody>
</table>

**Performance against clinical measures vs. group**

**Academic performance**

**Individual Compensation**
Physician with academic role, 50% clinical

**Clinical Comp**
- cFTE x salary based on tier
  - Pool developed across DH
  - Modified by patient sat, quality, access

**Academic Component**
- 10% x academic cFTE x salary based on tier

**Section Chief, 20%**
- aFTE x salary based on tier (clinical role) or admin rate (admin role)

**NIH Research 30%**
- Research grant/contract dollars

**Individual Compensation**
- Performance against clinical measures vs. group
- Academic performance
- Modified by performance in role
- Direct dollars in grant + DH make whole

DH make-whole
**Activity Reporting Tool**

**Authority:** Chief Medical Officer

**Management:** Activity Reporting / Provider Services

**ACTIVITY REPORTING TOOL**

**Compliance Concerns**
- Medicare Part A
- NIH Reporting
- VA WRJ, VT.
- Federal Grant Billing

**Clinical FTE**
- Compensation Plans
- Per Diems & Var. Contracts
- Data Warehouse Output
- Hires, Terms, & Leaves

**Operations & Finance**
- Research Management
- Corporate Accounting
- Transparent Non-Clinical Time
- Budget & Analyst

**Dartmouth-Hitchcock**

**A CULTURE OF CARING**
Name: [Name Hidden]  

Department: Inf Disease & Intl Health  
FTE: 1

FTE: 1

Your activity has been signed and recorded. Thank you.

As part of your employment with D-H, you are confirming the following activity for the month below...

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
<th>Type</th>
<th>FTE</th>
<th>% activity</th>
<th>Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-H Federal Reporting</td>
<td></td>
<td></td>
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<tr>
<td>Intensive Care Nursery</td>
<td></td>
<td>A&amp;S</td>
<td>0.1</td>
<td>10</td>
<td>10%</td>
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<tr>
<td>Other Reporting</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Clinical Services, Catholic Medical Center, Special Care Nursery</td>
<td></td>
<td>Contract</td>
<td>0.5</td>
<td>50</td>
<td>50%</td>
</tr>
<tr>
<td>Prog Dir Pedi Neonatology</td>
<td></td>
<td>GME</td>
<td>0.2</td>
<td>20</td>
<td>20%</td>
</tr>
<tr>
<td>Clinical Time</td>
<td></td>
<td>Clinical Time</td>
<td>0.2</td>
<td>20</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>Total:</td>
<td>1</td>
<td>100</td>
<td>100%</td>
</tr>
</tbody>
</table>

I agree that the above report is an accurate certification of activity spent in the period noted at the top. If there is any deviation that equates to more than 5%, the employee will note the change in the grey 'verify' column and the official report will reflect that difference.

Clicking 'SIGN' will constitute your legally binding digital signature.
Signed by:

ELECTRONICALLY SIGNED

For questions or issues with this form, please contact Brian Smoker, Activity Manager at: x3-1206, or Brian.M.Smoker@hitchcock.org.

Instructions
Step: #1. Please review your professional activity spent.
Step: #2. VERIFY or CORRECT the percentage by typing the appropriate amount, per D-H Activity Reporting Policy.
Management Dashboard Monthly View

(Red = FTE outside General Surgery. Blue = FTE within General Surgery)
Quality, Access, and Patient Satisfaction (Expectation)

4 Tier Model
Applies to physicians in sections measuring wRVUs

<table>
<thead>
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<th>Tier</th>
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<td>90</td>
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Salary Model
Family Medicine, Geriatrics, Hospitalists, Pediatric Hospitalists, Internal Medicine, Pediatrics, Palliative Care, Pathology, Anesthesiology, and Emergency Medicine.

Pool calculated at the 50th percentile, regardless of production

Pool Calculation
Physician Clinical Salary (tier) x Clinical FTE = Clinical Pool
Linking Quality and Value Measures to Compensation

**Quality Measures**
- CAHPS*, CLABSI, CAUTI, SSI, C. Difficile, Pressure Ulcers, Pneumothorax, DVT/PE, Sepsis
- Wound dehiscence
- Readmissions
- ER Utilization, BP, HA1c, HEDIS and others...

**Access Measures**
- 3rd Available appt % Booked
- Utilization of OSC and Block Time

**Patient Based**
- Satisfaction Scores

**Value Domains**
- **Quality 5%**
- **Access 5%**
- **Patient Experience 5%**

**Benchmark Compensation (paid at 100%)**
- **15% Value**
- **85% Productivity**

*For Attribution to Compensation, these need to be Applicable, Measurable, Manageable and where appropriate, consistent with how we are Reimbursed*

*Consumer Assessment of Healthcare Providers and Systems*
Constructing Value Measures for Each Area

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*Consumer Assessment of Healthcare Providers and Systems*
Physician – Quality/ Productivity
Transitioning Towards One D-H

Individual Locations
- Productivity tiers determined by each individual location and sometimes providers. *Current Practice*

Academic Medical Center and CGP
- Productivity tiers determined by AMC and combined CGP locations

All Locations Combined
- Productivity tiers determined by all locations combined based on Service and Specialty (One D-H)
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Clinical Compensation Pool Calculation = FTE x Market Rate

Individual clinical Performance Determines Local Sub-allocation

Sub-pool
- Keene: 0.9
- Manchester: 1.0
- Lebanon: 0.6

Local Leader Input

15% Value
85% Productivity
**Academic Productivity**

- Academic physician career is different than non-academic
- Expectation of scholarly output and teaching
- A percentage of clinical dollars in each section/department in the AMC distributed based on academic performance
- Accountability framework for academic work at the individual, section and department level being developed

**Clinical Compensation**

cFTE x salary (based on system tier performance)

*Modified by patient sat, quality, access*

**Clinical Compensation Pool**

10% of median salary (using academic cFTEs) distributed based on academic measures (rank, productivity)

**Clinical Pool**

90% of salary, 100% of salary distributed based on clinical performance

**Faculty**

10% of median salary (using academic cFTEs) distributed based on academic measures (rank, productivity)

**Non-Faculty**
D-H Guiding Principles

Implemented across Dartmouth-Hitchcock (One-DH)

- Across the Community Group Practices and DH-Lebanon
- Supporting Service Integration Across D-H
- Recruiting and Retaining the best

Allow us to pay for the type of work that is done

- Support our Research and Education missions
- Support important Administrative and Leadership roles

Encompass both Physicians & Associate Providers

- Removing barriers to Team Based Care
- Appropriate Compensation and Bonus for team based quality success

Facilitate our transition from Volume to Value

- Incorporate and expect achievement and exceeding national and organizational quality measures
- Transparent and understandable, aligned to strategic goals
New Compensation Plan

Alignment ● Integration ● Simplicity