Integrated Healthcare Strategies
ARTHUR J. GALLAGHER & CO.

Aligning Executive, Physician and Staff Compensation with Population Health Goals

WILLIAM F. JESSEE, MD, FACMPE
Becker's Hospital Review
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Welcome

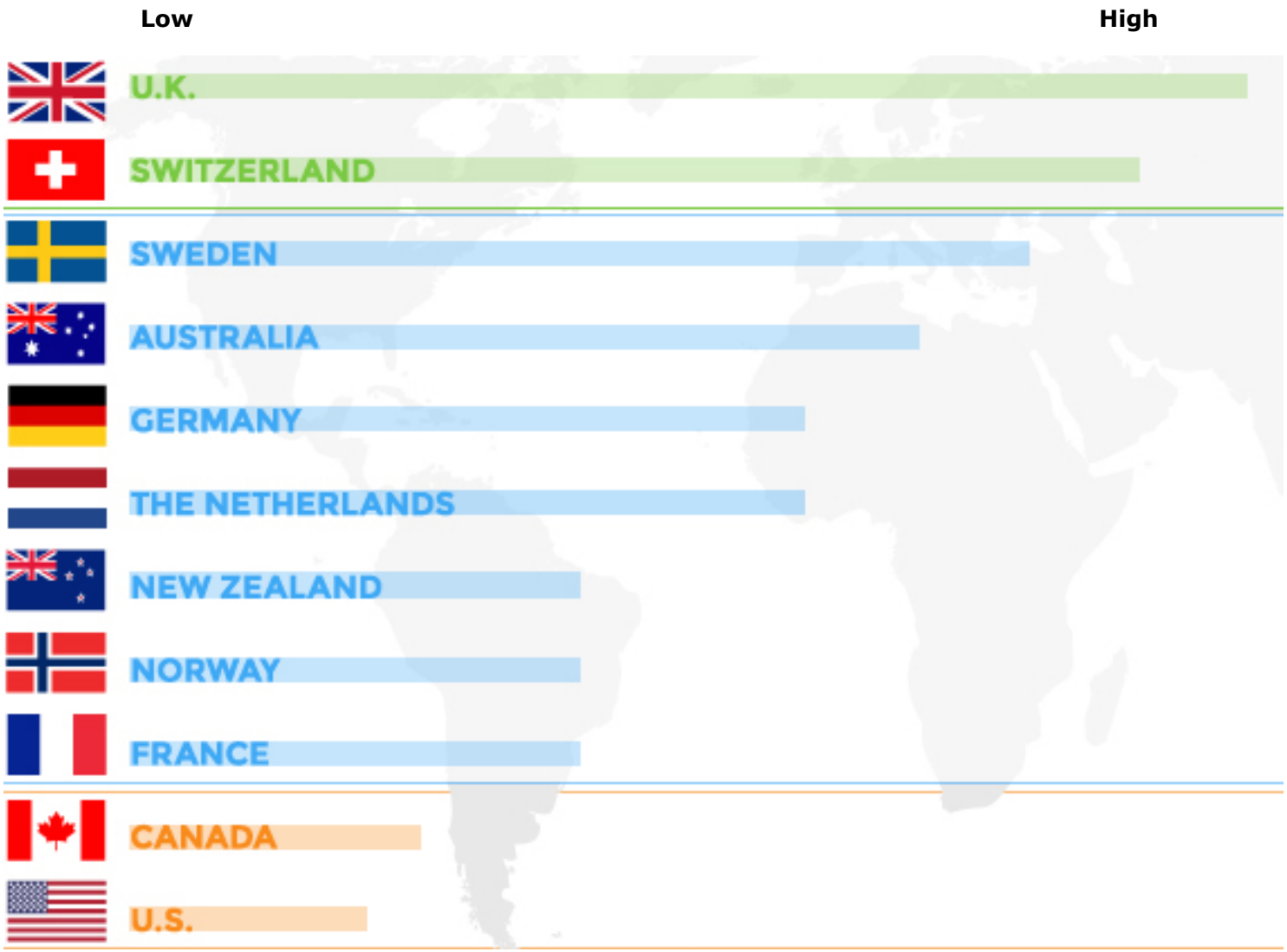
Today's Questions

1. What's really going on in the field with "population health management?"

2. To what extent should compensation of executives, physicians and staff be linked to success in improving population health?

3. Where will the industry go from here—and how will we get there?

Overall Healthcare Ranking

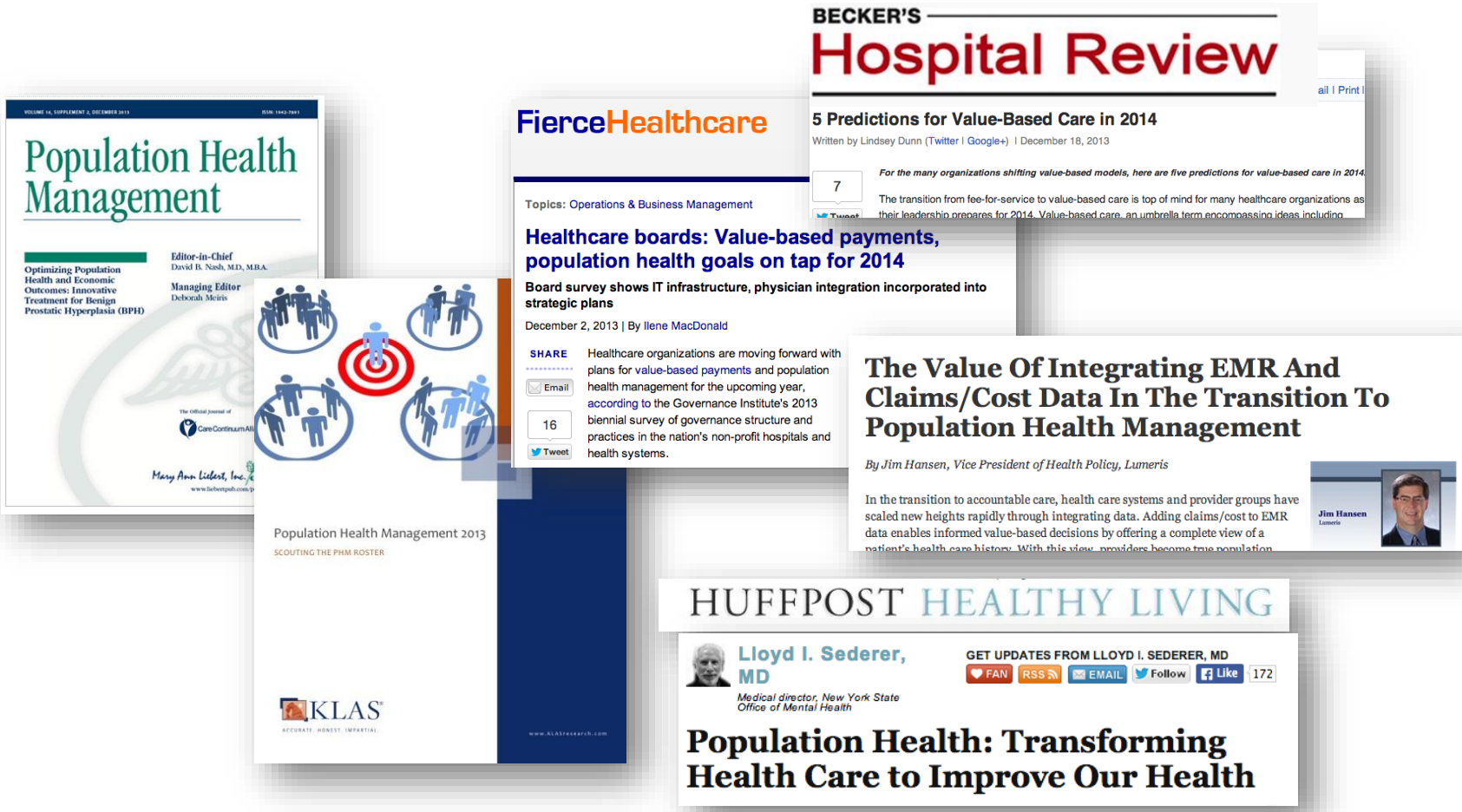


A recent study compared 11 nations on healthcare quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Source: K. Davis, K. Stremikis, D.Squires, and C. Schoen. Mirror, Mirror on the wall: How the Perfomarce of the U.S. Health Care System Compares Internationally, 2014 Update, the Commonwealth Fund, June 2014

Population Health Management

Stakeholders: PHM is the “way out” of the crisis



Proprietary and confidential

Some Definitions

“Population Health Management”

“Improving the overall health status and lowering the cost of care for a specific population”

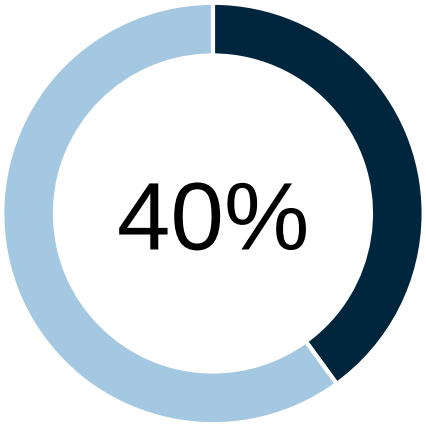
— Dr. David Nash, Dean of Jefferson School of Population Health and Rita Numerof, principal of Numerof & Associates

“Value-Driven Payment”

“Payment for health services based, at least in part, on measures of safety, quality, efficiency and patient satisfaction”

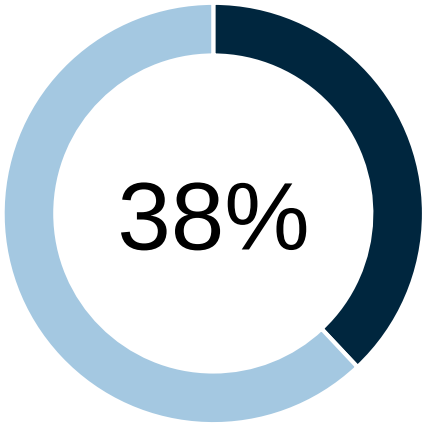
How much “Value-Driven Payment” is there?

Not a lot – yet.

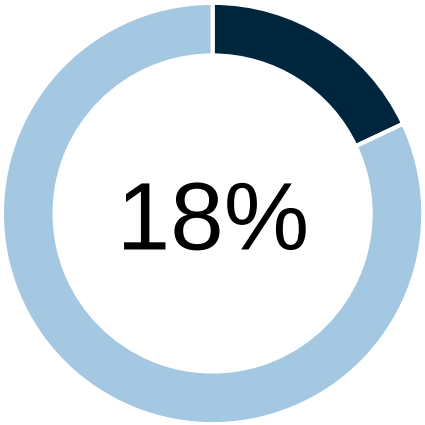


of **commercial insurance** payments were **at least partially** value-oriented, Nationwide in 2014*

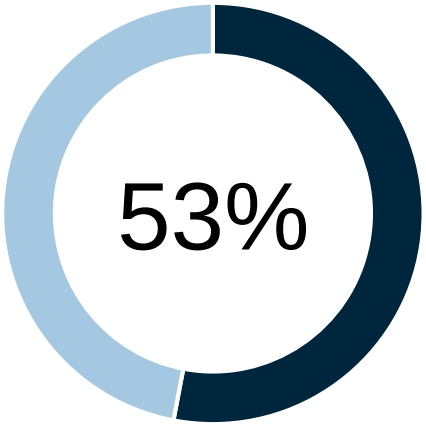
*That includes **shared savings, shared risk, partial or condition-specific capitation, FFS base plus P4P, bundled payments, full capitation (15%)**



of **hospital** payments included



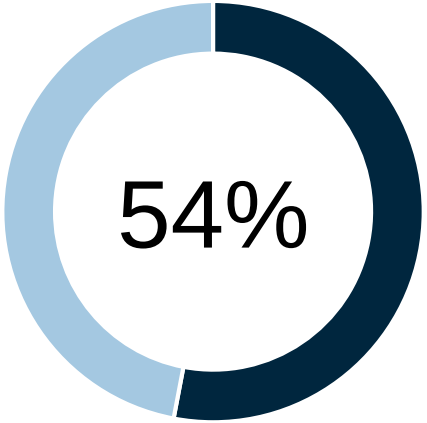
of **physician** payments included



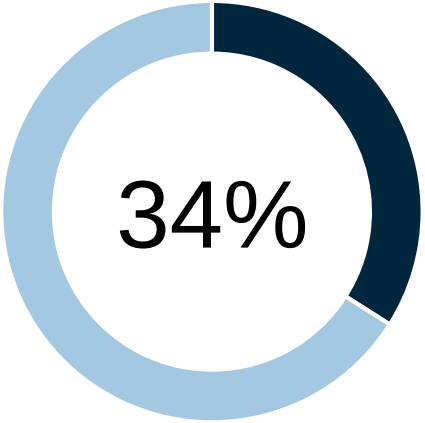
of those “value-driven” payments involved providers at risk

How much “Value-Driven Payment” is there?

And much of the “change” is from California payers, a state with long experience with capitation



of payments in California are at least partially “value-driven” (including 40.7% on full capitation) and **86%** of those payments place providers at risk*

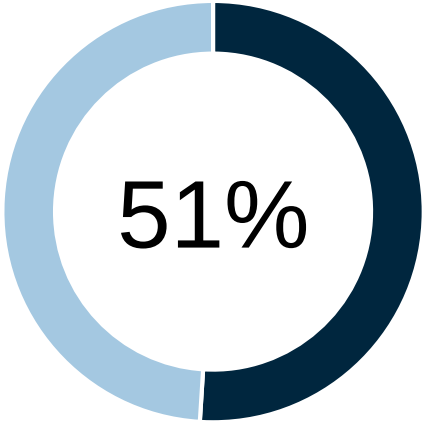


the prevalence of “value-driven payments” in the rest of the country (when you back out the California numbers)

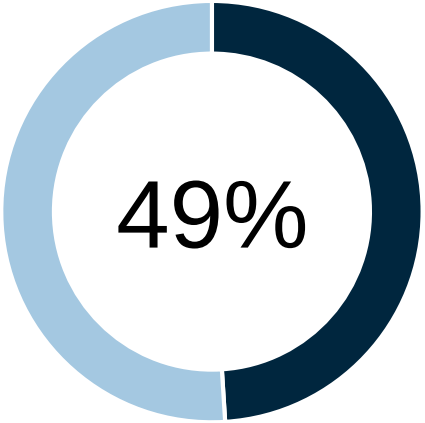
*Catalyst for Payment Reform, www.catalyzepaymentreform.org

How fast is fee-for-value coming?

Modern Healthcare asked top healthcare leaders, and they answered



Rapidly

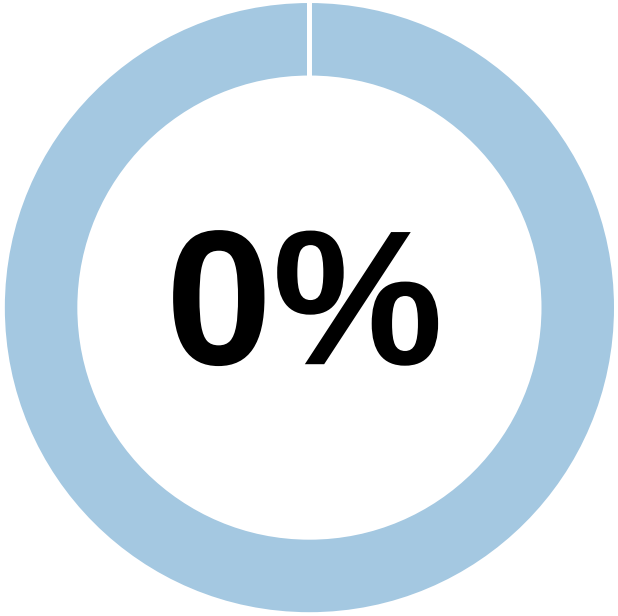


Slowly

*According to *Modern Healthcare* quarterly CEO Power Panel

How fast is fee-for-value coming?

So we can see there is some division regarding the pace of change, but there is one clear consensus…



of top US healthcare leaders* believe fee-for-value will ***NOT*** play a role in healthcare reimbursement.

*According to *Modern Healthcare* quarterly CEO Power Panel

Why would a value-driven payment system be better?

Rewards quality, safety, and efficiency

Encourages keeping people out of hospitals

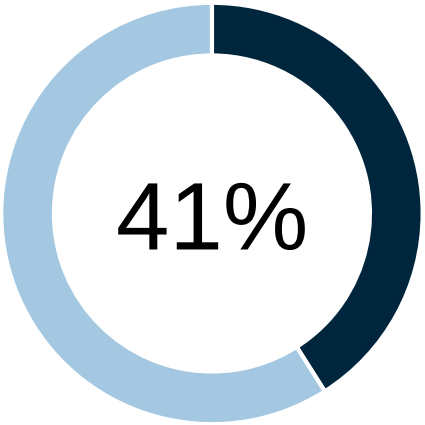
Encourages keeping people healthy ("population health")

Discourages waste

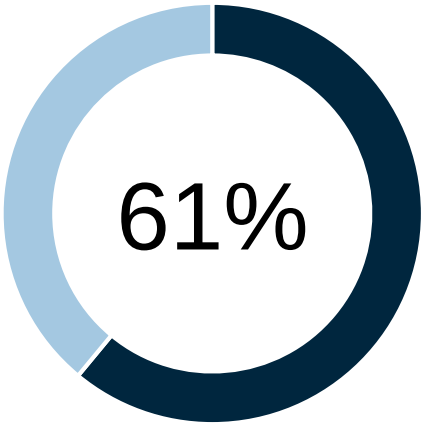
How much population health management activity is there?

Health Systems

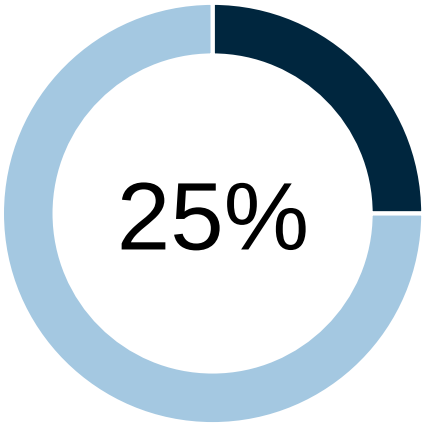
Health Plans



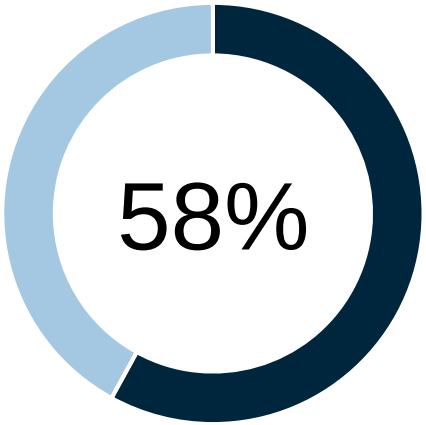
of **health systems** report having begun population health management – 88% plan to begin soon



of initiatives cover **commercial populations** – in addition to primary focus on Medicare and Medicaid population



of initiatives use **medical homes** – but 92% use **care managers** and 69% use **nurse practitioners**



of **health plans** actively engage in population health management

* 2014 Healthcare Benchmarks, Population Health Management, Healthcare Intelligence Network

CURRENT COMPENSATION INCENTIVES

Current Compensation Incentives

Executive Compensation

- Growing portion of pay at risk
- Rewards for cost-effectiveness, quality, patient satisfaction
- Also for profitability, volume, and growth

Physician Compensation

- Large portion of pay at risk in most practices
- Primary driver is still volume (wRVUs, collections)
- System-owned practices introducing rewards for quality, patient satisfaction, etc.
  - 70% of our physician comp clients have developed plans placing 10-25% of income at risk based on a blend of volume, quality metrics, patient satisfaction, “citizenship,” organizational financial performance

Current Compensation Incentives

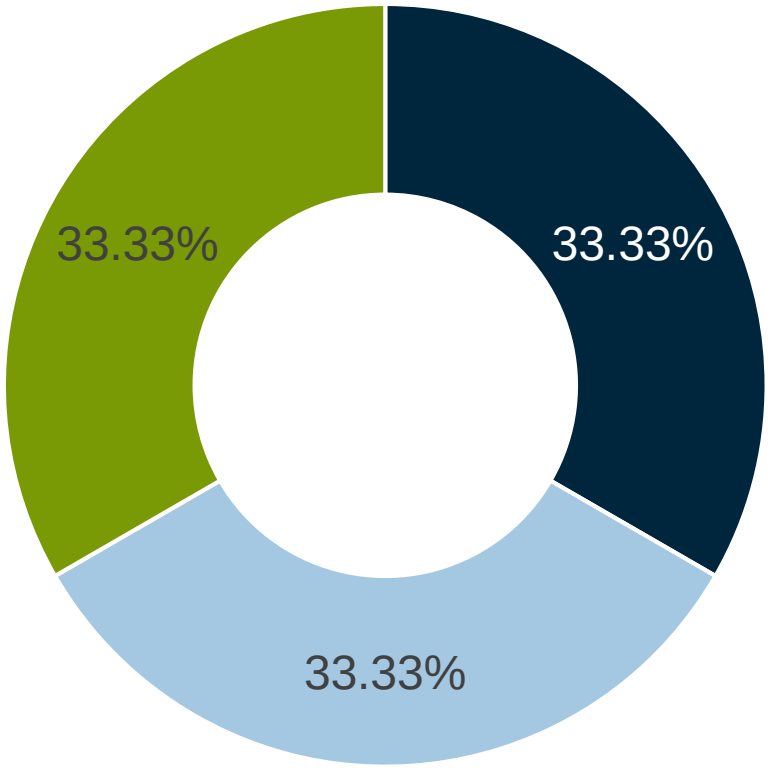
Staff Compensation

- Incentive compensation still the exception rather than the rule
- Gainsharing programs reward cost-effectiveness and/or patient satisfaction and/or quality
- Home health nurses often paid per visit, sometimes straight salary
- NPs and PAs typically paid salaries with no variable pay

SOME CREATIVE INCENTIVE EXAMPLES

Incentive Example – Unity Point (Iowa)

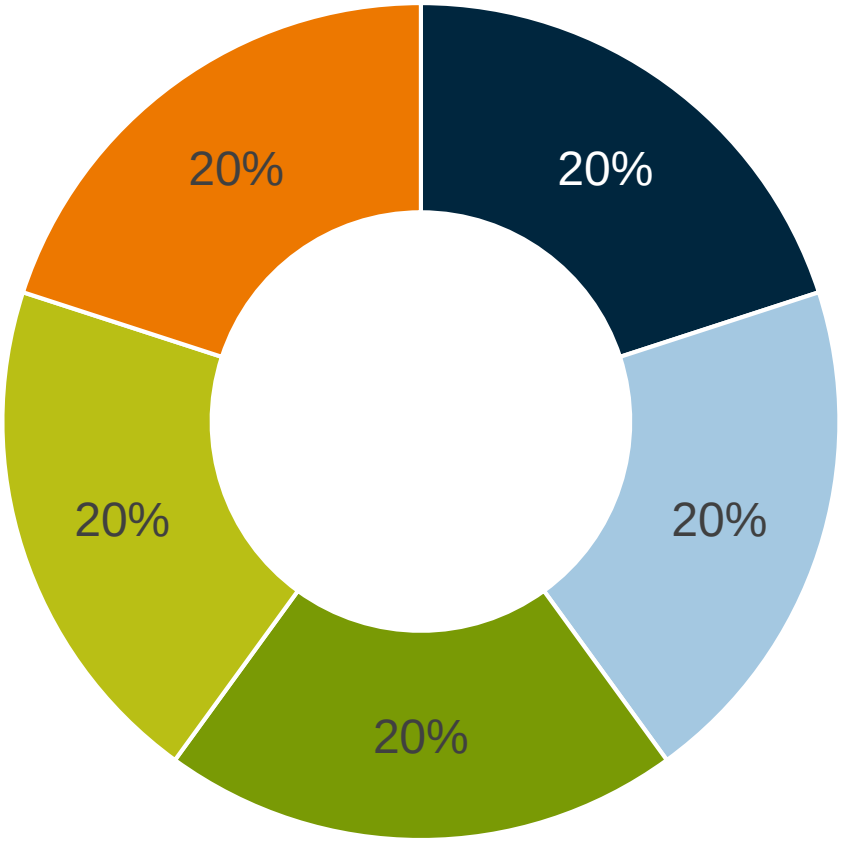
PCP Compensation:



- Value Metrics
- Base Salary
- Production (Half based on panel size, half on wRVUs)

Incentive Example – Trinity Health

Execs have 10% or higher pay at risk, with incentive based on:



- HAI & Readmission Rates
- Lowered Rates of Smoking & Pediatric Obesity
- Patient Satisfaction Scores
- Workforce Engagement
- Financial Performance

Incentive Example – Henry Ford Health System

Executive incentives based on:

- Hypertension control
- Lowered HAI and readmission rates
- Deployment of new patient portal

Incentive Example – Mercy Health

Executive comp linked to:

- Performance in Medicare bundled payment program for joint replacements
- Ease of getting PCP appointments
- Preventing readmissions
- Screening / referral for opioid abuse

WHAT NEEDS TO CHANGE?

What Needs to Change?

If we are serious about managing population health, we need:

- A **cultural transformation**, from treating illness to managing health
- **An economic model that rewards (providers, patients) for keeping people OUT of inpatient care**
- Extensive **integration** of clinicians into hospitals and health systems
- Robust **data and analytical tools** to allow managers and clinicians to better manage the health of people they serve
- Greatly improved communication and coordination among care providers
- Better **alignment** of executive, physician, and staff compensation with population health goals

What Needs to Change?

The Bottom Line

Healthcare increasingly **demands** measurable performance (on measures of safety, quality, efficiency, and patient satisfaction)

Performance **requires** alignment, engagement, and integration of the work force—and a **culture** committed to performance

Performance-based incentive compensation can be a valuable tool—but a strong **performance management system** is even more important and essential to managing the changes needed

Discussion

Integrated Healthcare Strategies
a division of Gallagher Benefit Services, Inc.
801 West 47th Street, Suite 300
Kansas City, MO 64112