

Leading the Charge for Incentive-Based Physician Compensation

By Sheila Conant and Dr. Robert McCurren

Dr. Robert McCurren spoke with Sheila Conant about his passion for incentives. Dr. McCurren represents the future for incentive-based compensation and has implemented several successful strategies at the Henry Ford Wyandotte Hospital System where he is the Regional VP for Emergency Medicine Services. His solid experience with a charge-based compensation system provides valuable insight on how to create a win-win compensation plan using incentives.

Sending the Wrong Message

Like most physicians, Dr. McCurren was paid a straight hourly wage when he started his career as an ER doctor. Before long, he noticed that there was a growing sense of frustration amongst his colleagues with respect to compensation where everyone was paid exactly the same regardless of how hard or how productively they worked. That frustration was compounded by the fact that more patients were directed to the efficient, productive physicians fueling a vicious cycle of disparity. This kind of working environment promotes some degree of resentment against colleagues, not because of the natural differences in how people work, but because the differences are not recognized and appropriately compensated.

A consequence of this type of payment methodology is that there is a disincentive to work harder. “I don’t think that there is any question that incentives impact behavior,” says Dr. McCurren. “If you’re at the end of the shift and there are a few more patients to be seen, you have to decide if you are going to pick up another couple of cases at the end of the shift knowing that you’ll have to stay late and will get paid less and have less time to complete your other charts.”

Getting the Message Right

Dr. McCurren had his first experiences with incentives when he became the medical director at Wyandotte in 2005. He inherited a charge-based system that paid physicians a percentage of charges generated from each patient encounter. “It was a learning curve for me when I first got down there,” he said.

He initially had some concern about the system because he thought this kind of incentive payment placed too much emphasis on moving the patients through the ER without respect to patient satisfaction and the quality of care. As he developed an understanding of the charge-based compensation system, he realized his fears were unfounded. “Without knowing how the system worked, I shared concerns that a lot of people have about systems like this. I thought that the physicians might just care about moving the meat and wouldn’t worry about quality or patient satisfaction. I thought they might cherry-pick charts and that it was going to be a major problem. But it is amazing to me that, aside from maybe one or two individuals that would have been a problem under any system, 98% of the providers that I’ve worked with are not appreciably influenced by that at all. I’ve

never had a physician complain about cherry-picking. We never have people complain that people are hoarding charts trying to keep other people from seeing them, and we have never had a complaint from nursing or the administration or anyone that they feel that our system creates inappropriate physician behaviors.”

“So as I got to understand the system and saw how it impacted individual’s performance in the department, the benefits of it became very clear”, says Dr. McCurren. “There is no doubt in my mind that the compensation system definitely motivates people to bring up the productivity to the 2.5 or higher patients per hour which is consistently where the department tends to run there [at Wyandotte].”

His appreciation for the charge-based system was reinforced when he attended the [ACEP Emergency Department Directors Academy](#) around that same time. He attended a lecture on productivity-based pay systems that presented the pros and cons of different plans like fee for service, RVUs, and charges. Dr. McCurren said, “One of the things that the instructor said that struck everybody who was there was that it has been consistently shown that when you have a fairly heavily-weighted productivity based pay system, the productivity of the physicians in your department goes up anywhere from 20% to 30%. When you look at the general performance at Wyandotte at roughly 2.5 patients per hour compared to national benchmarks of 2 or less patients per hour, it’s right around the 20% to 30% range. It was definitely eye-opening. The numbers sure seem to fit.”

Dr. McCurren was further convinced of the merits of the system by the doctors in his department who universally seem to appreciate the system. “When I first became medical director at Wyandotte and we discussed how we were going to modify the system, one of the options on the table was to scrap the whole thing and go to a totally different system or a flat-hourly rate. I don’t think there was one person who wanted to go away from the system, and that doesn’t happen very often that you get a group of ER docs to agree to anything!”

The Wyandotte Charges-Based System

There were a few changes that he wanted to make. His goal was to modify some aspects of the plan to make it as transparent and fair as possible. With Dr. McCurren’s leadership, the Wyandotte doctors worked to gain a consensus to recognize seniority and to compensate, in a graduated fashion, based on experience and contribution to the group. They established a vesting period, built into the model, to accommodate physicians that were new to the charge-based system. They added a patient satisfaction component that modified the percentage of charges paid, keeping the productivity and patient satisfaction payments synchronized. He designed incentives to promote the behaviors that most contributed to efficiency, patient satisfaction, and quality for all aspects of ED operations.

Incentives based on charges provide a powerful motivator. Although there is a strong relationship between the charge and the RVU associated with a procedure, money is easily understood by everyone. And even though a charge and a RVU are conceptually the same, when a physician is in touch with the charge generated from seeing a patient, their association for pay doesn’t need to go through the RVU conversion. “I think it’s valuable for physicians to see what charges are being generated. It’s a transparent system. I mean, anyone could figure out what an RVU meant. If you told someone that you generated 100 RVUs for a shift, they could figure out what the dollar amount was anyway, so why not just give them the dollar amount instead of the RVUs?”

Basing pay on collections has the potential for unintended behaviors. “The two reasons I tell people we do charges rather than collections are that one, we want to eliminate the lag period between when you see the patient and collections. No one wants to wait three months for their first paycheck when they start. The tighter we can correlate your shifts and the patients you see to your paycheck, we think the better it is for everyone. The second is that I think there would be problems with people cherry-picking to avoid seeing those patients that they know have no insurance or are underinsured.”

In a charge-based system, the collection of charges doesn't impact physician pay. “It doesn't matter at all whether we get paid a dollar for that patient you see, you're going to generate a charge and still get paid a certain percentage for seeing that patient, regardless. The message is clear that when there are more patients to be seen at the end of the shift, seeing more patients will generate a charge versus the potential of earning nothing using a collections or fee-for-service model. “That's the way we want the system to work.”

A fan of [Open Book Financing](#), Dr. McCurren feels that, “ When this kind of transparency is part of the business model, and the more that everyone is involved in the big picture and understands the finances behind everything, the more engaged they're going to be, the more valued they're going to feel, the more sense of fairness there is in the organization, and I think ultimately that that is what we all want to achieve.”

Key Points to Ponder

There are some common issues that must be faced when implementing any incentive payment system.

Providers that are new to the system need a more predictable compensation method until they can establish a baseline productivity level. “After a year, they're at their baseline productivity. They have reached a plateau at that point and are ready to jump into the program fully with everyone,” suggests Dr. McCurren. “One of the challenges when you adopt a system like this is that you have to be very clear in your mind how it works, and you have to be able to clearly articulate to prospective physicians so they can understand what they're getting into. But the system really sells itself. The discussion that I have with applicants is that most people want a situation where they are rewarded for working harder. It aligns incentives in almost every area of ED operations. We want people to code well, we want people to document their procedures, and we want people to sign their charts when they're done.”

The culture of the group makes a dramatic shift from employee-centered to stakeholder. The discussion between a manager and employee is much different when a provider is paid based on productivity rather than paid hourly. A manager may emphasize the behaviors that they expect, but with a productivity-based system where the desired behaviors are integrated with the model, “It changes that whole dynamic, and it really does decrease the problems that you have with managing some of the difficult physician issues that you have with some people who struggle with documentation and signing the charts.”

For an incentive payment to be effective, it needs to be timely. Productivity-based bonus payments paid on a quarterly basis are not as effective as regular payments made every pay period. Dr. McCurren notes that “The problem with those [kinds of payments] is too much separation between the individual patient, the individual chart and charges, and your compensation when you have a pooled RVU total or average.” Timely payments are entirely tied to getting high-quality, accurate data. “The statements that we give our physicians each pay period show that on your evening shift on June 13th you saw 22

patients. Hence your total charges were, say, \$3000, and your percentage is this and this is what your check is. Our physicians know how many patients they saw, and they're really able to make that direct correlation in their head on how that impacts their paycheck. And it does impact physician behavior. It impacts my behavior. I mean, when I'm at Wyandotte there's no question that if I'm at the end of the shift, even if things aren't terribly backed up, if there are a couple of fairly low acuity patients that I know that I can move through pretty quickly, I know that I'm going to be rewarded if I do a little bit of extra work instead of finishing my email or doing the rest of the charts that I may not have finished. But I know that it's worth my while to step up and see those patients. We know from lots of information about how ED flow works that a few patients can make a huge difference in the long run, particularly when you're dealing with limited resources and departments that are challenged by physical space like Wyandotte. You know, having physicians that are continuing to work through the end of their shift helps a lot."

Having a reliable system that can be directly tied to the billing company, the data management, and all the way to payroll that the physicians can trust is critical. High-quality data is essential to implementing any productivity-based system. "You can't implement a system like this without doing the modeling up front," says Dr. McCurren. "I need to know the financial impact of [a change], from a budgetary standpoint, because you can't make a huge change without having a good understanding of what the impact's going to be. So the quality of data, the transparency of the data, those are all critical features. Also it's important that it is nimble enough to be able to make fine-tune adjustments in some form or fashion as you need to, because there are variables that come up that you have to address." For example, when there is an increase in the fee schedule charges are immediately increased but that increase does not necessarily significantly increase collections.

Advice for First-Timers

One of the biggest fears for implementing a productivity-based system is that it may create unhappiness. Some providers might earn less money. Some may work the plan too vigorously. Some may leave to seek employment elsewhere.

It's inevitable with this type of compensation system that there is going to be a range of pay aligned with each provider's own productivity level. So it's important to be careful when selecting a guaranteed minimum hourly. "I think that in this day and age you do have to have that as part of the system. Most people are not going to be happy if they come in and it's a rare slow shift that they make something far below what they typically would on a shift. But you have to set [the guaranteed minimum amount per hour] low enough that people are going to consistently be getting into the charges system and not just getting guaranteed hourly on a half or more of their shifts. So that's where you have to do a fair amount of modeling to figure out where that break-even point is." With a guaranteed minimum per hour, the amount of money earned is under the direct control of each provider.

The goal of an incentive-based compensation system is to improve efficiency and productivity. "That's another very important element or dynamic that comes into the discussions with the group when you have a system like this that's not there if pay is guaranteed. People become active in business decisions like how you staff and run the group. They will frequently make decisions that are entirely different than if they're simply getting paid an amount per hour. So there is the ability to decrease in some way your total physician hours when you implement a system like this. You can eliminate some overlap, eliminate some people from signing in for overtime when they're just staying and finishing charts. Or if you simply increase productivity by anywhere close to 20-30% by reducing LBE's because you see

patients sooner, quicker, and through the system faster, all of those things, the pot grows and there may not be any losers in the system.”

“Probably the biggest obstacle and hurdle to people implementing this is fear. It’s not just the fear that people are going to jump ship, it’s just the huge amount of investment in time and energy that it takes to explain to people, to do the modeling, to show people, to reassure, to deal with the people that are unhappy the first few months as you’re learning how the system works. It takes work, and you have to be prepared to make that leap, but I think it’s worth the investment. I think it makes everyone happier. It makes your life easier and it makes the doc’s life better.”

The Big ROI Question

Dr. McCurren gives this insight regarding the return on his investment. “You could pretty easily show the impact side-by-side if you changed your productivity by 20%. It would be more complicated if you needed to include more significant changes in staffing patterns where it forced you to cross a threshold where you had to add a whole other shift. But you could do some group calculations that would quickly get way into the millions of dollars in additional revenue if you were able to convert sites to incentive-based plans and realize gains of 15 to 20% in productivity.”

“There’s a great hunger out there for incentives. I have medical directors who contact me all the time. They hear about what we do there, and they think it’s great. But, it is important to note that with any system like this that there are local influences and variables and politics that are always going to influence what system is best for any one department. Now, I think a charge-based system can work almost anywhere with changing a few different variables in the equation to account for those things. And I still remain convinced that our system is the best.”



About Sheila Conant:

Ms. Conant is the Chief Executive Officer of COREmatica. Since 1999, she has worked with incentive compensation systems for health care providers. Prior to COREmatica, Ms. Conant owned an information technology consulting firm developing software solutions for companies in many industries including health care.



About Dr. Robert McCurren:

Dr. McCurren is the Regional Vice President for Henry Ford Wyandotte Hospital's Emergency Department, Fast Track, Pediatric Emergency Center, Hospitalist Program, and the freestanding Center for Health Services location. He is also Regional Vice President for St. Joseph Health System in Tawas, MI; Grayling, MI; Cadillac, MI; and Nanticoke Hospital in Seaford, DE. Board certified through the American Board of Emergency Medicine, Dr. McCurren has served on countless committees including Chair of the Difficult Airway Committee. Dr. McCurren was awarded the 2008 Callahan Award, the highest award a physician can receive. Dr. McCurren achieved independent department status for Emergency Medicine at Henry Ford Wyandotte Hospital. He became a member of the EPMG Board of Directors in September, 2008.