

# Compensation Models: How to Incentivize but not Upset your Faculty TOO MUCH

John A. Ulatowski, MD, PhD, MBA  
Johns Hopkins University  
School of Medicine

# Disclosures

- We have a comp plan
- No other financial disclosures of relevance

# Do we have metrics?

- Clinical Productivity
- Educational Productivity
- Research/Discovery Productivity
- Administration Productivity
- Innovation ?

# Is “medicine” measuring itself?

- 14 articles AMCs (1995-2005) Depts. of Medicine
- Overall financial impact - 12 studies
  - 5/12 positive margin; 2 enhanced rev; 1 lower exp
- Effect on professional productivity - 8 studies
  - 20-30% increase in RVUs and funding over 1-3 yrs
- Quality of educational services - 3 studies
  - punctuality, enthusiasm, teach. effectiveness -no  $\Delta$
- Faculty satisfaction – 7 studies
  - 56-90% satisfaction with the plan

Andea et al. Health Care Manage Rev 31:251, 2006

# Can we Measure Clinical Productivity?

1. Clinical days per year
  - Normalized CD/yr\*
2. ASA Units/OR day
  - Normalized ASA Units/year
3. Time Units/OR day
  - Normalized TU/year

\*normalized to a full FTE or OR FTE

Each values certain types of product. > others

Abouleish et al. *Anesthesiology* 93:1506, 2000

# Measuring/Reporting something is important in any incentive plan

- Join national surveys on performance (SAAA)
- These are useful for benchmarking for
  - The department
  - Your Institution
- You can show your faculty how they are doing
  - Within the department
  - Between departments

# Prevalence and Characteristics of Academic Anesthesiology Programs

None (salary only)	29%	} 59% nil
Late/Call (only)	30%	
Shifts	20%	} 71% pos
Charges	11%	
Time	6%	
Other	3%	

Abouleish et al. *AnesthAnalg* 100:493, 2005

# What proportion of total comp is incentivized?

<u>% of Comp</u>	<u>% of Programs</u>	
< 10%	44%	} 90%
11-25%	46%	
>25%	10%	

Abouleish et al. AnesthAnalg 100:493, 2005

Does your dept have a formal comp plan, written and published internally?

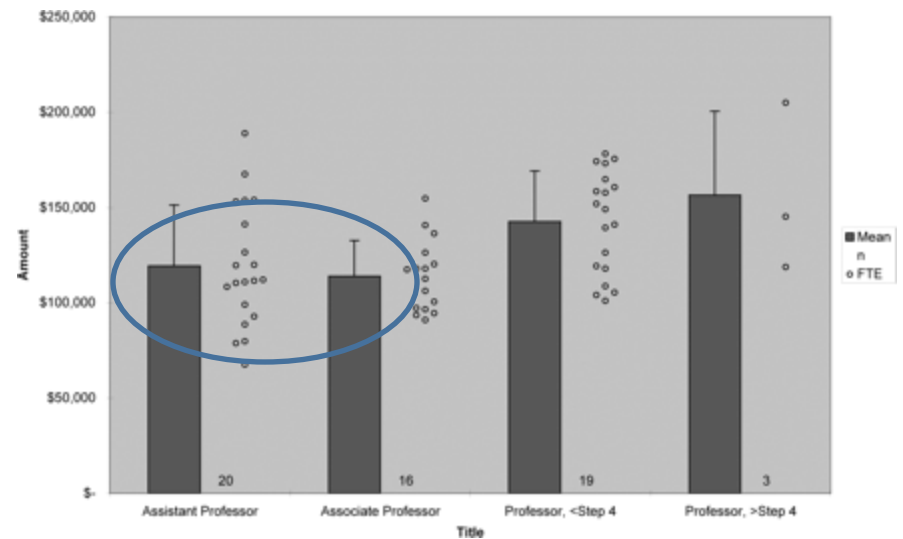
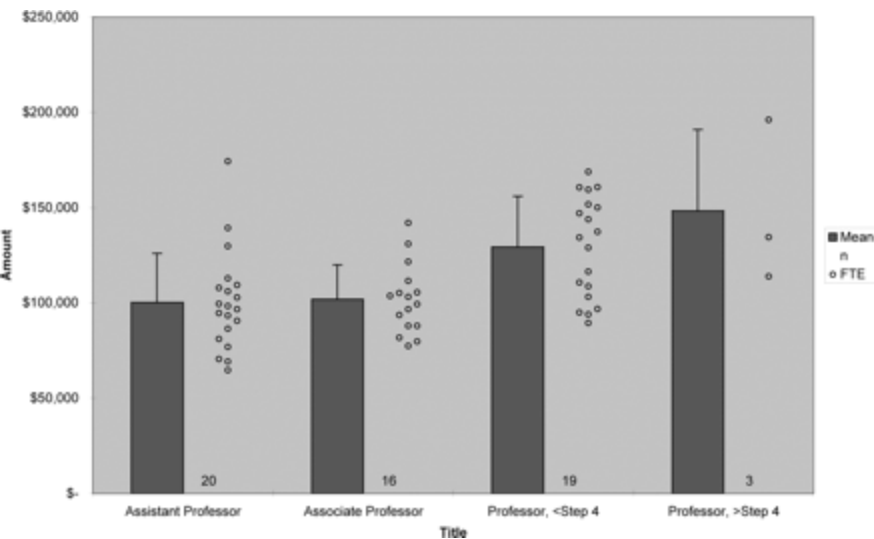
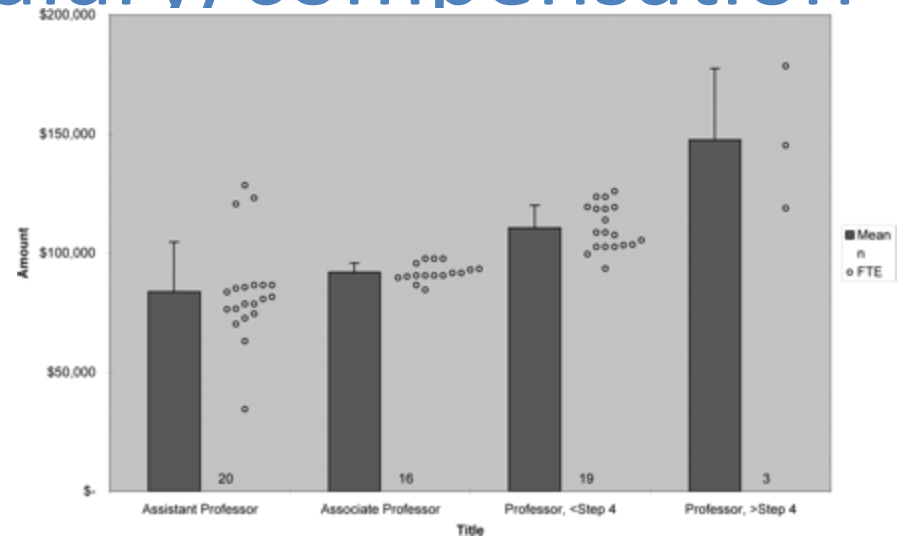
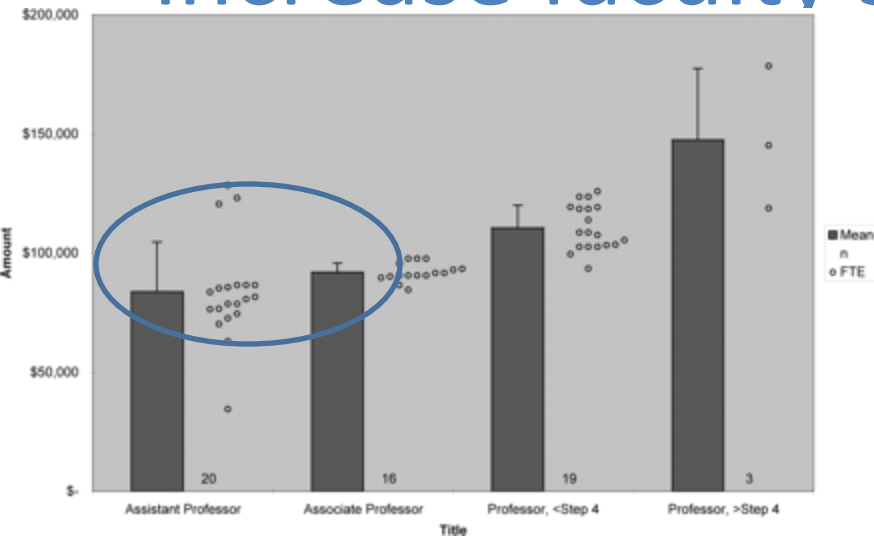
A. Yes

B. No

# Do you have an incentivize plan?

- A. None (salary only)
- B. Late/Call (only)
- C. Shift # based
- D. Charges
- E. Time
- F. Other

# Do clinical productivity incentives increase faculty salary/compensation



# Other Evidence of Salary Changes

**Table 7.** Mean Faculty Salary Ratios (Compared with 2001) by Rank Grouping in the Pre- and Postimplementation Periods

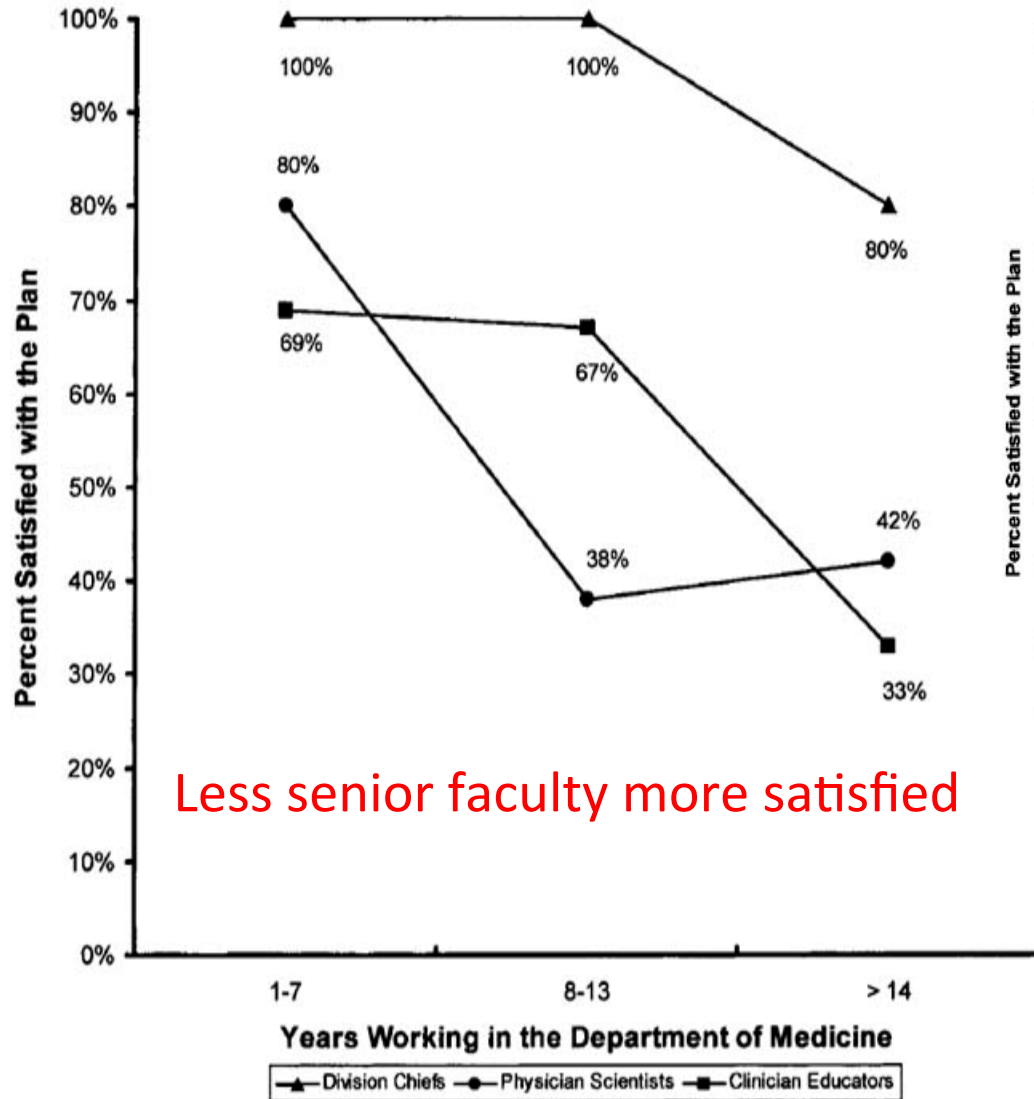
Rank grouping	Preimplementation (2003–2004)	Postimplementation (2006–2007) <sup>a</sup>
Instructors and assistant professors <sup>b</sup>	1.12	1.57
Associate and full professors	1.01	1.35

<sup>a</sup> Higher mean salary increase for postimplementation period compared with preimplementation across rank groupings ( $P < 0.0001$ ).

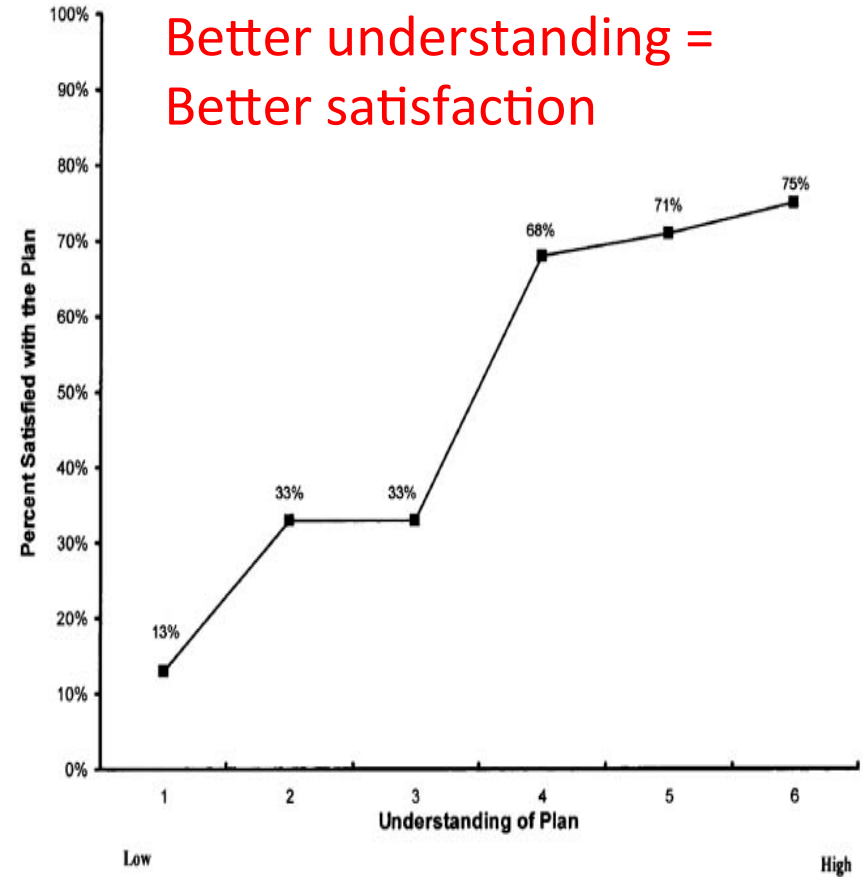
<sup>b</sup> Higher mean salary increase for instructors/assistant professors compared with associate and full professors across periods ( $P < 0.001$ ).

**Reich et al. AnesthAnalg 107:1981, 2008**

# Satisfaction with “a plan”



Less senior faculty more satisfied



Better understanding =  
Better satisfaction

Tarquinio et al. Acad Med 2003

# Implications

- Clinical productivity incentives can increase comp
- More for junior faculty salaries (pay off debts, build personal equity, increased retention)
- Close the gap between junior and senior faculty (may have grant salary support, may be already be receiving significant non-monetary incentives, wish less CDs/call)
- There may be different rates of satisfaction

# So...not to upset your faculty too much

- Explain the plan, re-explain it and write it down
- Make it transparent, does not have to be simple
- Make it equitable; equal opportunity
  - JHU statement on the annual salary sheet “would you like to know more about how your salary was derived?” yes/no
- Explain what is likely to happen (senior, junior)
- Show the data
- Get faculty feedback over time
- Revisit the goals regular intervals
- Modify the plan to fit the need(s)

# Do clinical productivity incentives Effect other academic activities

Miller and Cohen...in the discussion (qualitative)

- “residency flourished”
- Highly ranked Med Student rotation
- Faculty acknowledged as outstanding teachers
- Grant funding increased

Miller and Cohen. *AnesthAnalg* 101:195, 2005

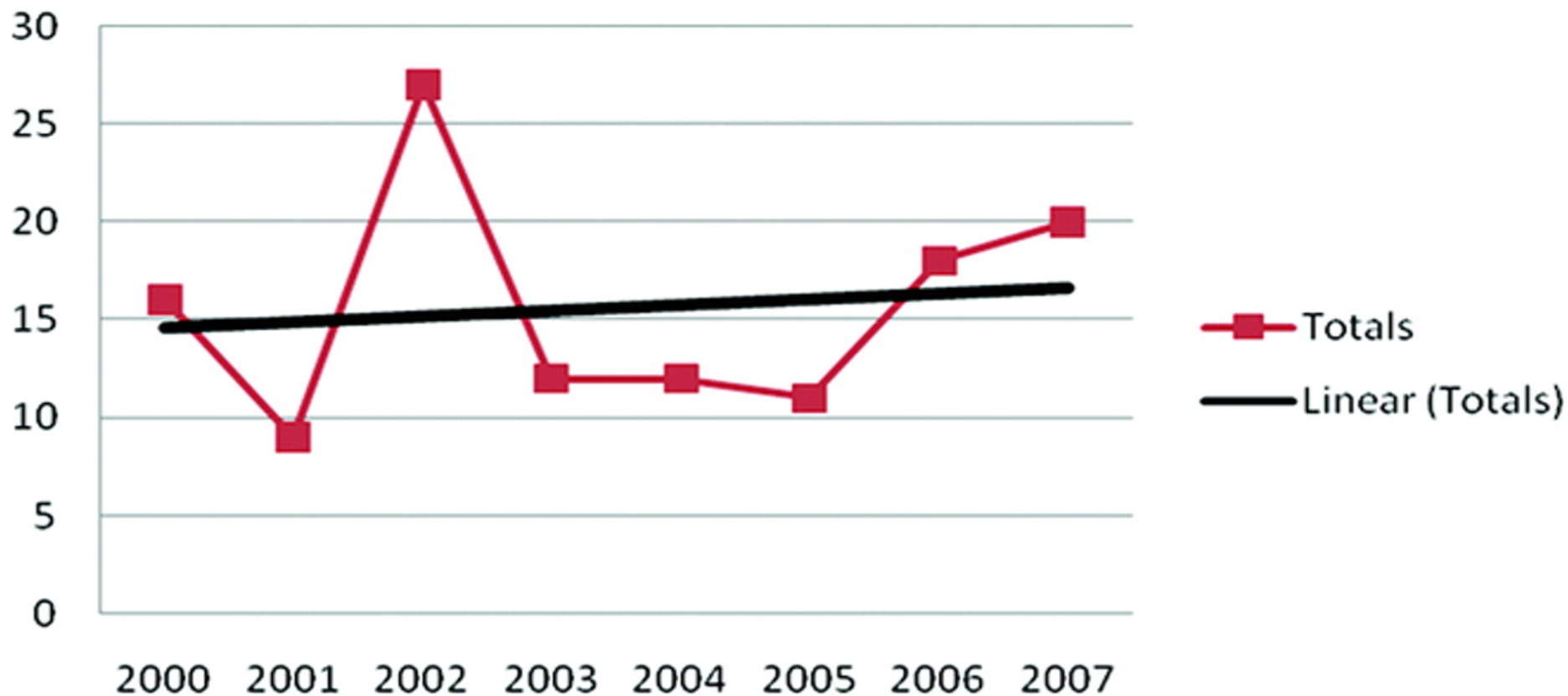
# Implications

- Junior faculty do more clinical time (CDs, Late/Call)
- Perhaps this will improve in OR teaching/exposure
- Will it distract from quality teaching?
- Are they the ones getting the grants?
- Senior faculty doing more

## Long term implications

- Less non-OR teaching and other academic time
- Will this shrink the academic core in departments?
- Especially in research and long term faculty growth
- ???

# Annual Index Medicus Publications

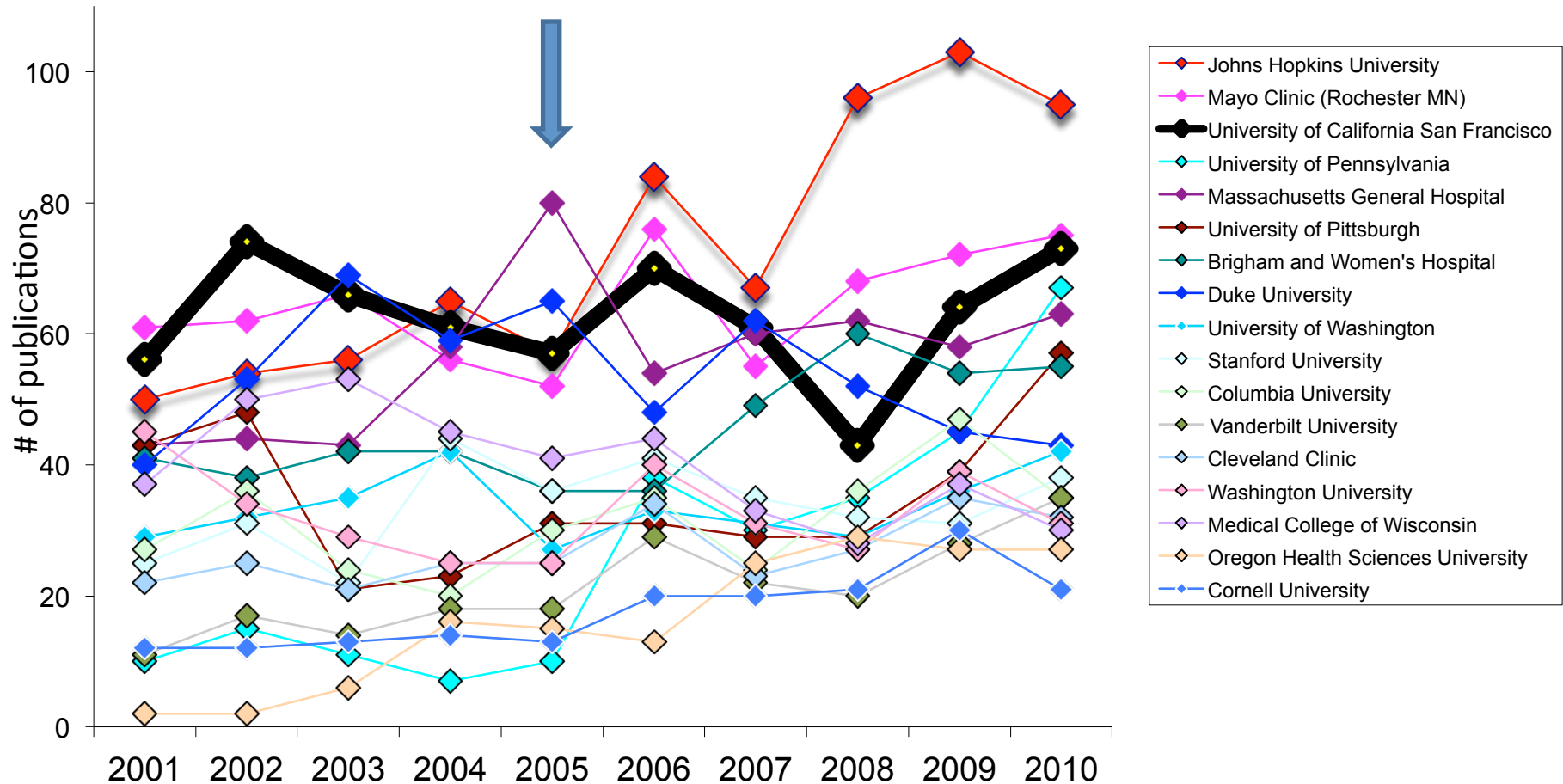


Who is doing the writing?

Junior or Senior? Good or bad?

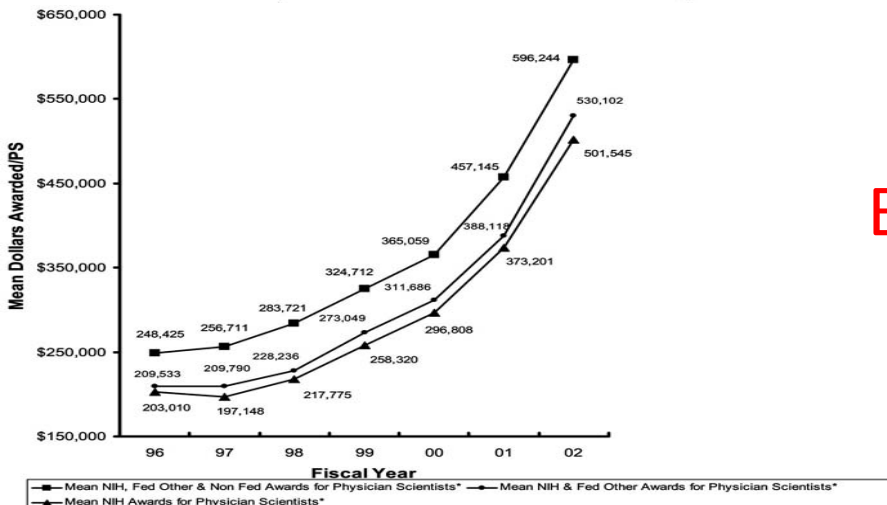
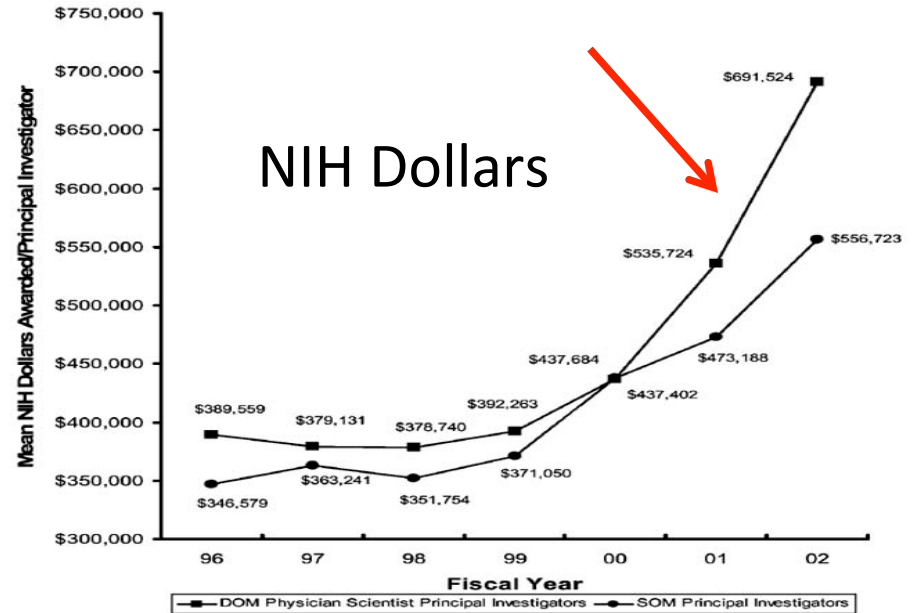
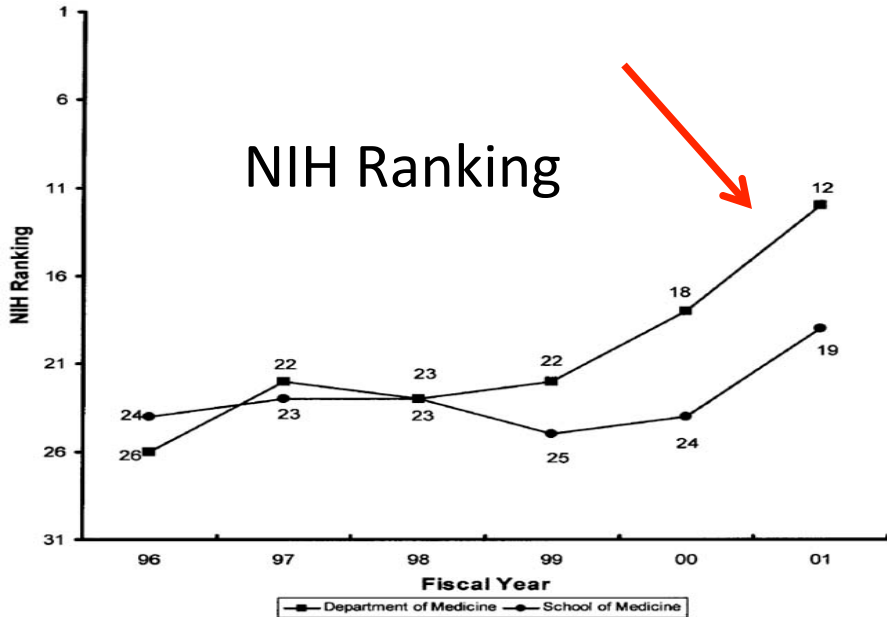
Reich et al. *AnesthAnalg* 107:1981, 2008

# Pub Med Publications Attributed to 'Anesthesiology' Departments, 2001 - 2010



Publications associated with Anesthesia/Anesthesiology Departments were identified using PubMed. Although this approach will miss some publications (those with independent corresponding addresses), this should affect all Institutions equally

# A Dept of Medicine Experience



But who is getting the grants?

# Faculty Response to Incentives

- Fair: Clin-Educators (68%) Phys-Scientists (58%)
- 50% less time on teaching
- 67% less time on committees (admin)

# Teaching Evaluations

Scale 1-4	<u>FY 2000</u>	<u>FY 2002</u>
Punctuality	3.6	3.7
Enthusiasm	3.6	3.8
Effectiveness	3.5	3.8

Tarquinio et al. Acad Med 2003

# Do you pay for academic activities?

A. Yes

B. No

# Academic activities pay?

- A. Base pay
- B. Incentive

# Academic Metrics

- Teaching
  - Amount
  - Evaluation scores
  - Publications
  - Education research
- Research
  - Grants
  - Grant submissions
  - Publications
  - Peer review

SOM support

Grant \$\$

National and International Recognition  
Promotion and Base Increment

Reich et al. *AnesthAnalg* 107:1981, 2008

# Administrative Metrics

- Hardest to build as part of an academic portfolio
- National recognition
- Not necessarily accepted in discovery
- Requires prime time
- Can be career building link to health service and comparative effectiveness research; safety and quality
- Can be supported by hospitals

# So...not to upset your faculty TOO MUCH

- Look for innovative ways to support academic
  - work and time
- SOM teaching programs with salary support
  - simulation
- Seek tuition remission programs for degrees
  - M. Ed., MBA and MHA, MPH
- Seek key national positions for them

# Incentive Programs

## Effect on Quality of Care

- Building literature on periop metrics
- Little in the literature on patient quality
- Recent Cochrane Review in Primary Care
  - “The **use of financial incentives** to reward PCPs for improving the quality of primary healthcare services **is growing**. However, there is **insufficient evidence to support** or not support the **use** of financial incentives **to improve the quality** of primary health care.”

**Sivey et al. Cochrane Library Issue 9 Sept 2011**

# So... not to upset your faculty TOO Much

- “They are making me do it.”
- External reporting requirements
  - SSI, antibiotic timing and redosing
- Internal standards of practice
  - ACLS, Hand Hygiene, hospital protocols
- National/State standards of practice
  - ASA (PONV prophylaxis), MOCA, MOSL

# So... not to upset your faculty TOO Much

- “We need to do this for ourselves.”
- External reporting requirements
  - We should define the important metrics
- Internal standards of practice
  - Will be necessary to justify salary support
  - Value added to the patient
- Financial opportunity partnering with Hosp.
  - Cost reduction, revenue enhancement, safety metrics and customer satisfaction

Do you include quality measures in your base comp or incentive plans?

A. Base

B. Incentive

C. Both

# Components of an Incentive Plan

Incentivize everything? Nothing?

- Establish an expected performance
  - At or below - non incentive
- Unrestricted bonus pool
  - More feasible with clinical and grant revenue
- Should be non-competitive
  - Mission focused and team reward
- Variable component; not and all or none target
  - Scale, perhaps \$\$ more for highest performance

Lubarsky. *AnesthAnalg* 100:490, 2005

# Build a positive environment

## Building Trust

- Transparent
- Keep your promises and show the data
- Measure satisfaction
- Pay supplements regularly (monthly; quarterly)
- Modify your risk:reward ratio (% base comp)
- Start with easy wins, raise the bar over time
- Do not incentivize what they cannot achieve
- Create synergies (Faculty, CRNAs, Residents)