Clinical Advisory Board

2007-2008 Clinical Executive Teleconference

Call Coverage Strategies

Best Practices for Securing Cost-Effective Call Coverage

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If you have any questions related to this study, upcoming publications, or other issues, please do not hesitate to contact the Clinical Advisory Board Staff. All comments and inquiries may be directed to Sruti Nataraja at natarajs@advisory.com.

With Sincere Appreciation

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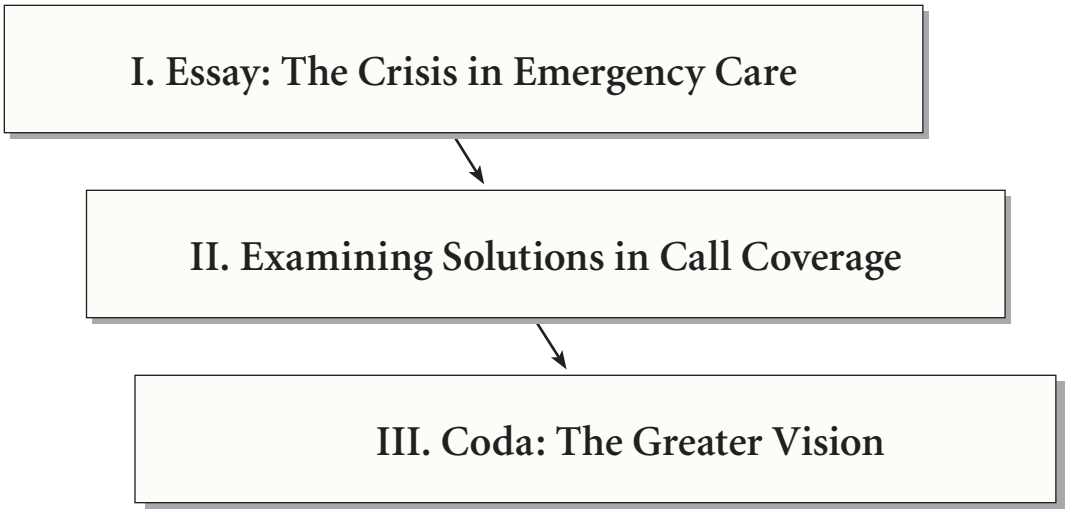
Roadmap for Discussion



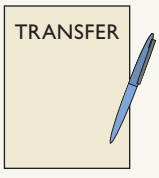
An Unfunded Mandate

Emergency Medical Treatment and Active Labor Act

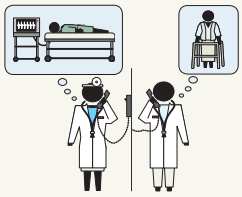
Highlights

- Hospitals participating in Medicare to provide medical screening examinations for all persons who present at the ER and request service, regardless of ability to pay
- If the person has an emergency medical condition, the hospital must treat or stabilize the person, or provide for an "appropriate" transfer to another facility
- Hospitals are required to maintain lists of physicians on-call who can provide further evaluation or stabilizing treatment to a patient with an emergency medical condition and establish policies and procedures for when a particular specialty is not available

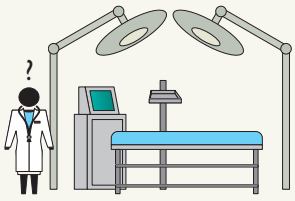
Physician EMTALA Violations



Knowingly signing a transfer form where benefits did not outweigh the risks



Intentionally misrepresenting an individual's risks or condition

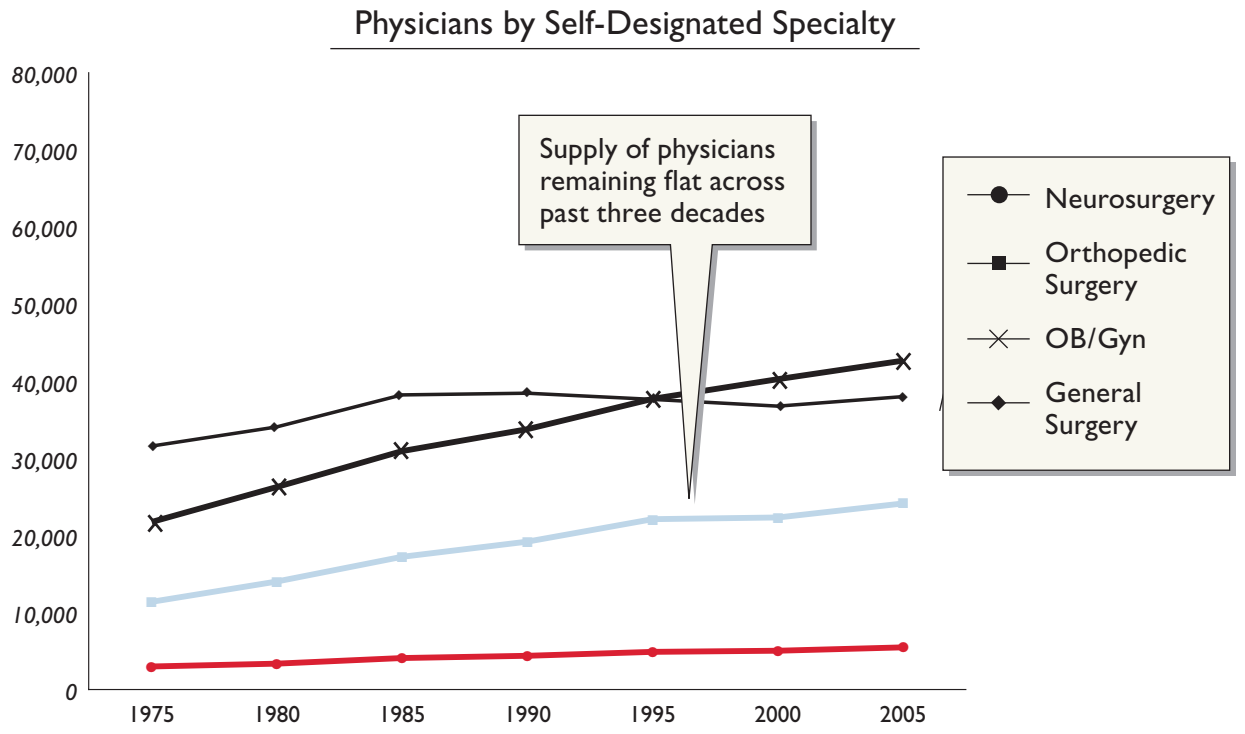


Refusing to appear within a reasonable time period, resulting in a patient's transfer

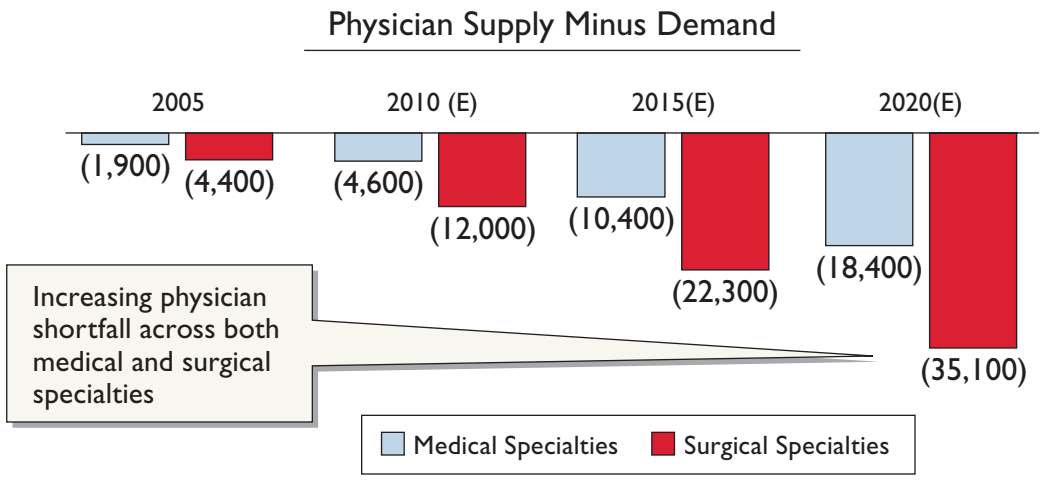
Up to $50,000 in civil penalties per inappropriate transfer; violations may result in exclusion from Medicaid and Medicare

Source: www.emtala.com, accessed October 8, 2007.

Absolute Physician Supply Constrained



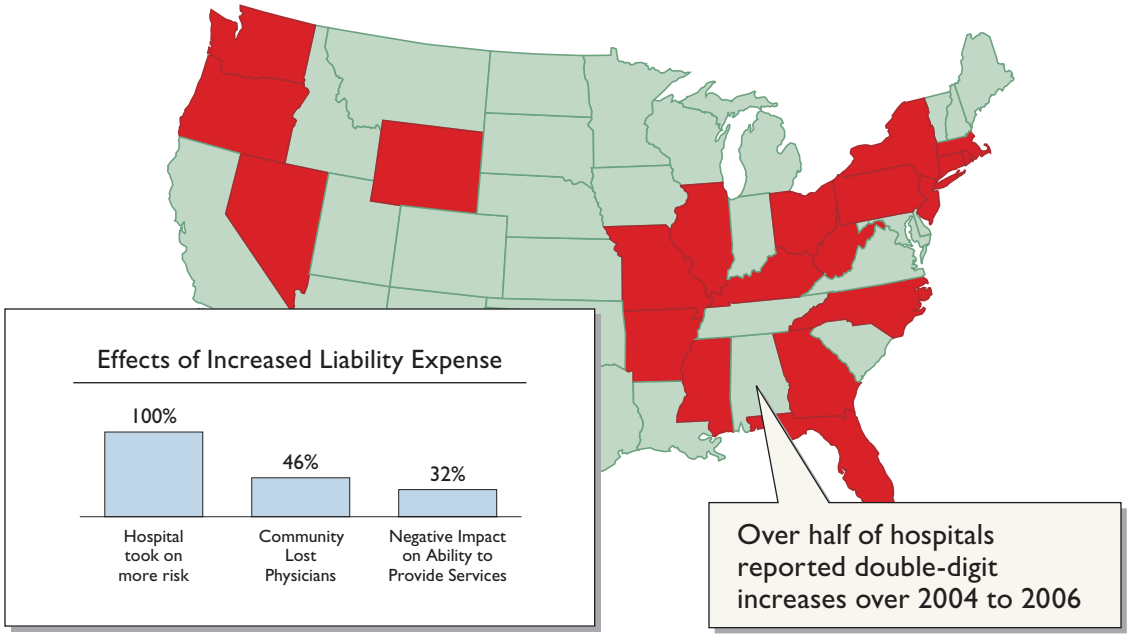
No End in Sight



Source: American Medical Association: Physician Characteristics and Distribution in the United States, 2007 edition; American College of Surgeons, "A Growing Crisis in Patient Access to Emergency Surgical Care," June 2006.

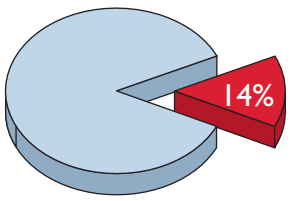
Changing Practices All Together

Malpractice Crisis States, 2006



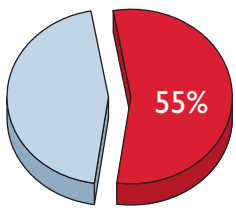
Impact of Liability Concerns by Specialty

Obstetrics



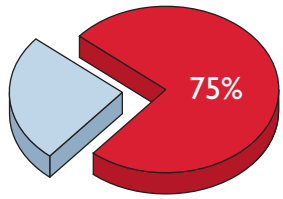
One in seven obstetricians stopped delivering babies

Orthopedics



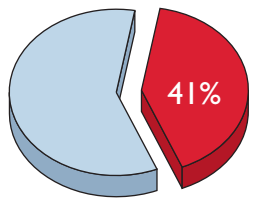
55 percent of orthopedic surgeons avoid 'high-risk' procedures

Neurosurgery



Three quarters of neurosurgeons no longer operate on children

Urology



41 percent of urologists refer 'high-risk' cases elsewhere

Source: AHA 2006 Survey of Hospital Leaders; M Glabman, "Specialist Shortage Shakes Emergency Rooms; More Hospitals Forced to Pay for Specialist Care, The Physician Executive, May-June 2005.

A New Physician Mentality

Previous Generation

- ☑ Saw ED call as a way to build practice
- ☑ Needed to take call to for hospital practice privileges
- ☑ Accepted longer work hours
- ☑ Saw call as part of responsibility to community

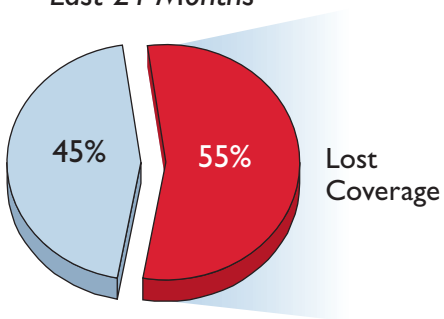
New Generation

- ☑ No longer reliant on the hospital to practice
- ☑ Often highly specialized, unable to take general cases
- ☑ Accustomed "shorter" to 80–hour work week limit
- ☑ Finds call unappealing for financial, litigious reasons

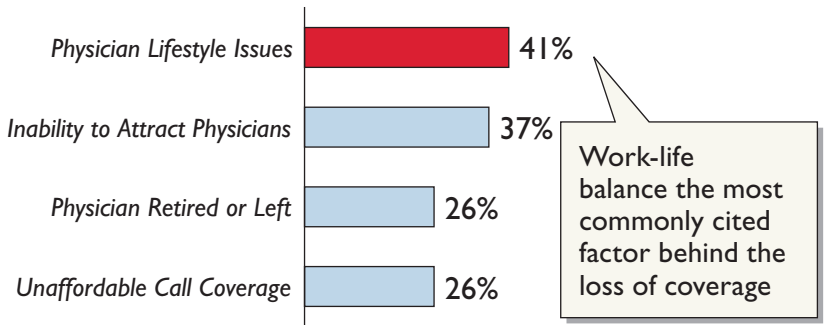
Quality of Life Ever More Important

Hospitals Reporting Gaps in ED Specialty Coverage

Last 24 Months



Factors in Loss of Coverage[1]

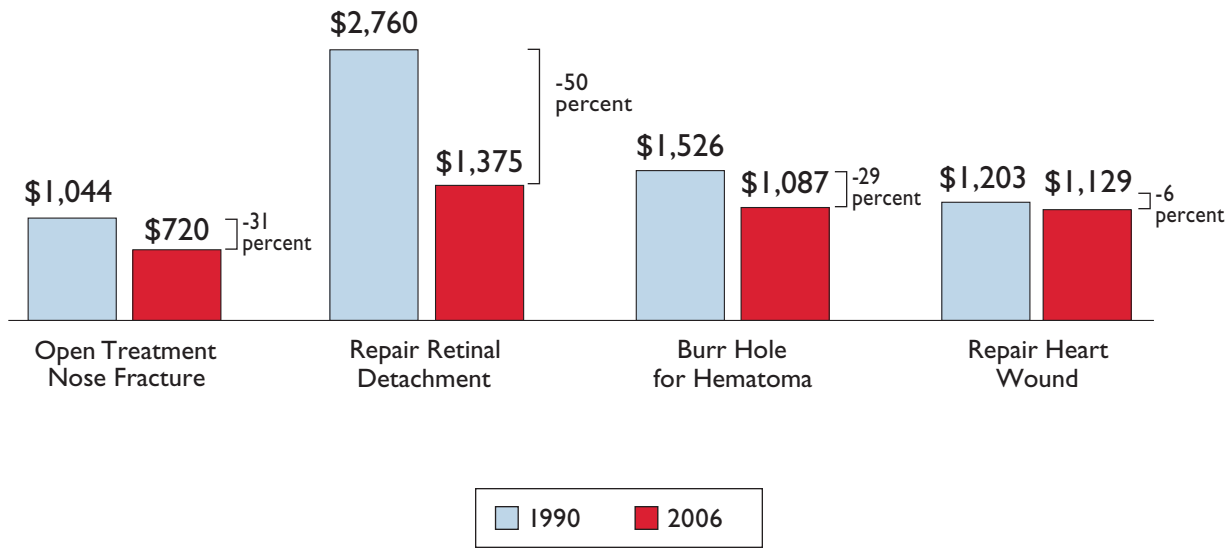


[1] Hospitals able to select multiple responses.

Source: AHA 2007 Survey of Hospital Leaders.

Call No Longer Financially Viable

Medicare Payments for Common Emergency Procedures



No Longer Affordable

"There is an estimated 200,000 physician shortfall in the next decade. This phenomenon is coupled with the continued decrease in reimbursement for physician services and the increased cost of living, malpractice premiums and costs of practice. Given these trends, physicians can no longer afford to take call."

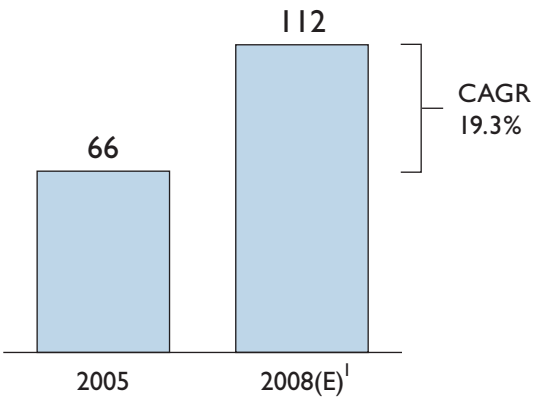
Chief Medical Officer
West Coast Health System

Source: American College of Surgeons, "A Growing Crisis in Patient Access to Emergency Surgical Care," June 2006; Clinical Advisory Board interviews and analysis.

Choosing to Practice Elsewhere

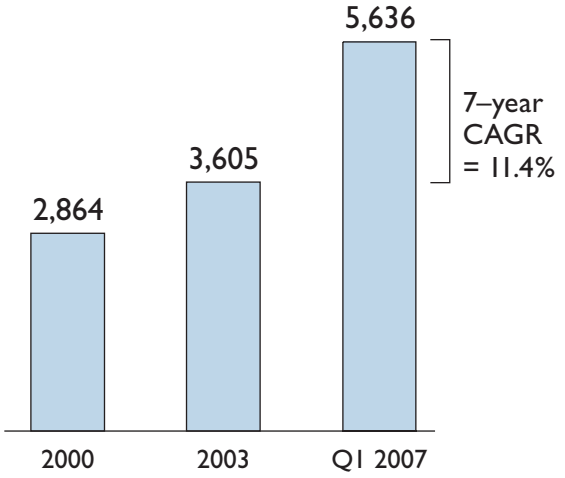
Number of Specialty Hospitals

2005–2008



Freestanding Ambulatory Surgery Centers

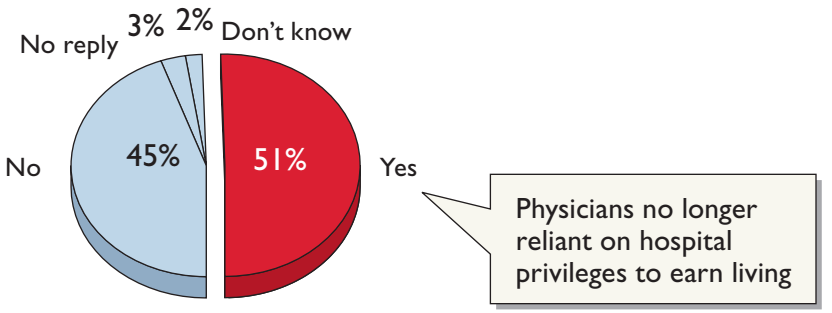
2000–2007



Impacting Hospital Call Coverage

"Over the last year, did any deficiencies in on-call coverage occur because specialists left your hospital (relinquished privileges) to pursue practice elsewhere?"

n=1,312



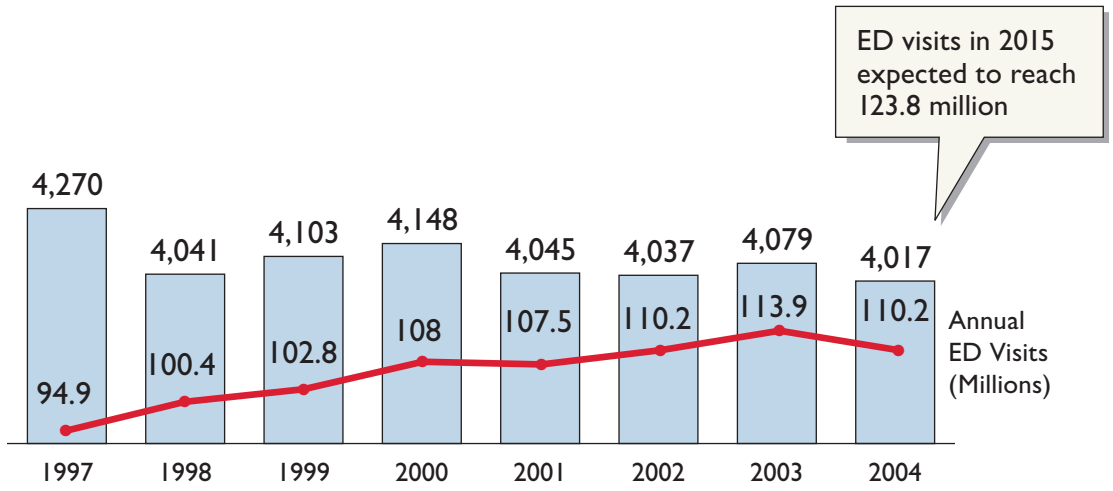
[1] Numbers do not sum to 100 percent due to rounding.

Source: ACEP Survey of Emergency Department Directors, April 2006; Clinical Advisory Board interviews and analysis.

Demand Continuing to Rise

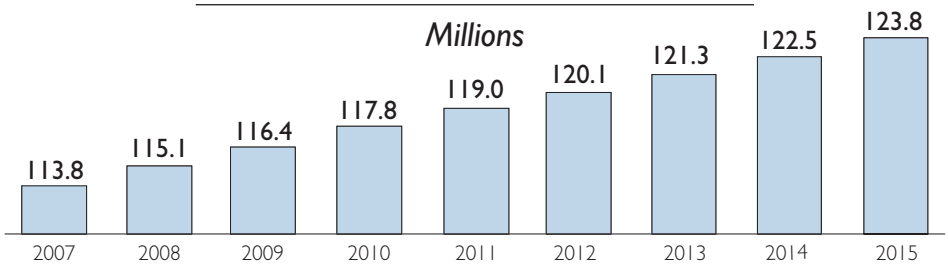
Number of Emergency Departments Compared to Number of Visits

1997–2004



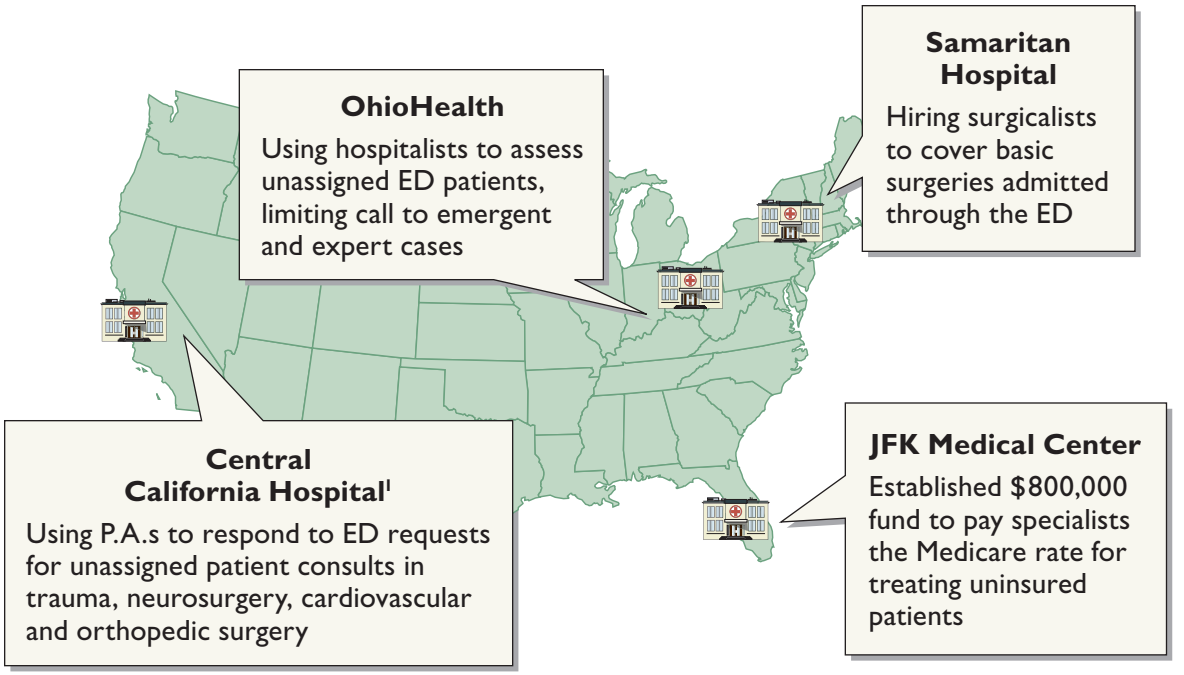
Capacity Cruch Only Expected to Worsen

Projected U.S. ED Visits, 2007–2015



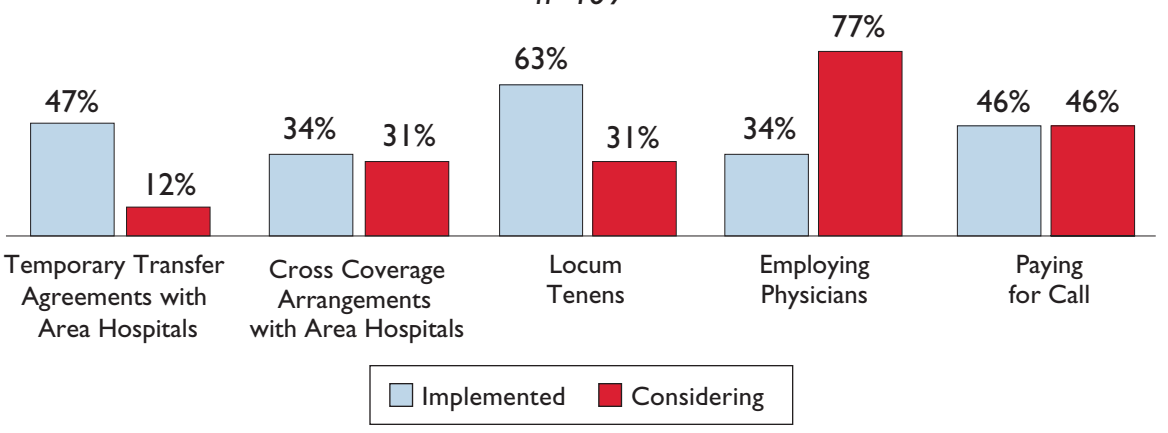
Source: AHA 2007 Survey of Hospital Leaders; AHA Statistics, 2005; MHAMCS, 1993–2003; "Improving Patient Flow and Throughput in California Hospitals Operating Room Services,"; Centers for Disease Control, National Hospital Ambulatory Care Survey: *ED Summary*; 1996–2006 Innovations Center Futures Database.

Taking Different Approaches



Adoption of On-Call Policies, 2006

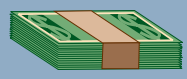
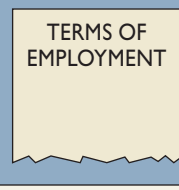
n=109



[1] Pseudonym.

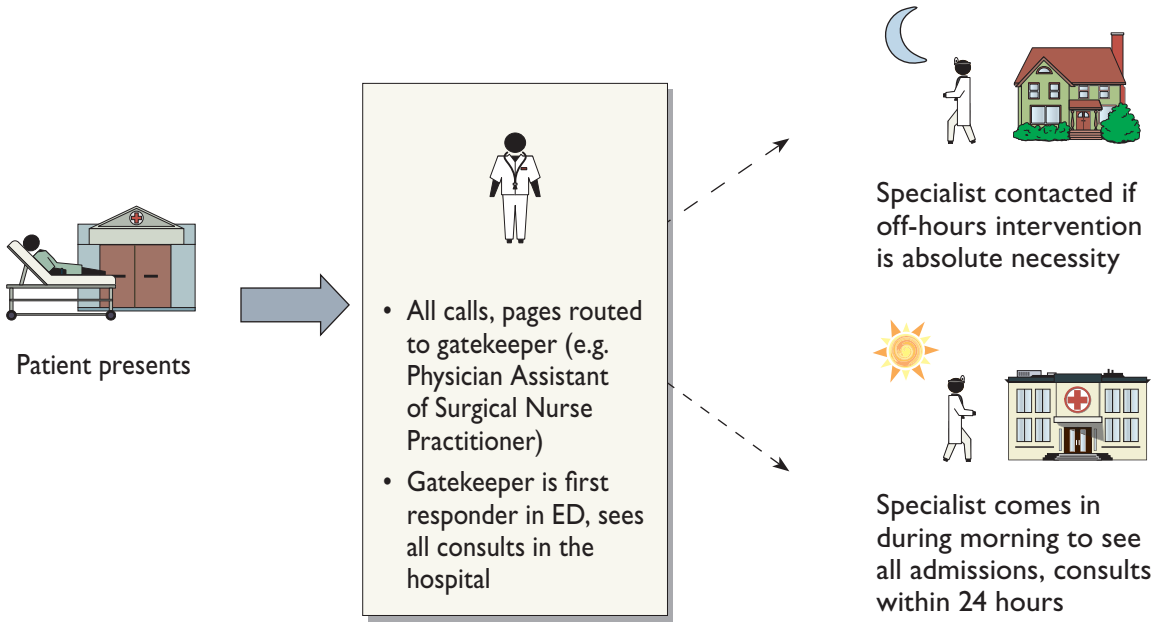
Source: "Hospitals offer financial incentives, reduce demands to persuade physicians to take call," HR Watch, June 23, 2006; California HealthCare Foundation, "On-Call Physicians at California Emergency Departments: Problems and Potential Solutions, January 2005; Sullivan and Cotter, "Physician On-Call Pay Survey Report," June 2006.

Addressing Largest Questions

	Alleviating Specialist Burden	Providing Financial Compensation	Employing versus Contracting	Increasing Number of Specialists
				
Key Questions	• What non-core activities can we offload from specialists? • How can I better leverage ED physicians? • What opportunities exist to leverage technology to ease call burden?	• How can I avoid running afoul of antikickback legislation? • What are the different models in paying for call? • How can I reverse course after starting to pay for call?	• When does it make sense to employ my physicians? • How can I best leverage employed physicians? • What specialties are increasingly open to employment?	• How can I increase my pool of specialists? • How can I share physicians across a system? • Have there been successful regionalization efforts?
Best Practices	#1 Non-Physician First Responders #2 ED Physician Skill-Building #3 Technology-Aided Specialist Consult	#4 Payment Model Overview #5 Deferred Compensation #6 Fee-for-Service Approach	#7 Call Coverage Specialist #8 OB Hospitalists #9 Surgical Hospitalist	#10 Homegrown Specialists #11 Inter-Hospital Regionalization

Source: Clinical Advisory Board interviews and analysis.

Non-Physician First Responders



Addressing EMTALA Concerns

"In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with another person to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, to determine whether or not an emergency medical condition exists. **The examinations must be conducted by individuals determined qualified by hospital bylaws or rules and regulations.**"

Emergency Medical Treatment and Labor Act
42 CFR 489.24(a)

Source: Clinical Advisory Board interviews and analysis; American Academy of Physician Assistants, www.aapa.org, accessed October 24, 2007.

Fully Utilizing ED Physicians

1

ED Director

Survey

1. What can we do specific to your specialty to help with call?
2. When you come in on call, what annoys you most?

2

- ED Director present at section meetings to discuss survey results
- Orthopod surveys reveal opportunity to improve handling of wrist fractures, inconsistent case set-up

3

- Hand surgeon scheduled to train ED physicians next month on basic wrist fracture repair
- Orthopods guaranteed same room every time called; tech deployed to ensure proper set-up

Case in Brief

Fitzpatrick Medical Center[1]

- A 200-bed short term acute care facility in the West
- Sent survey to all specialties participating in call; questions included what procedures ED physicians could take without direct back-up, biggest annoyances related to call
- Survey results discussed with each specialty at section meetings to outline concrete steps based on stated concerns

[1] Pseudonym.

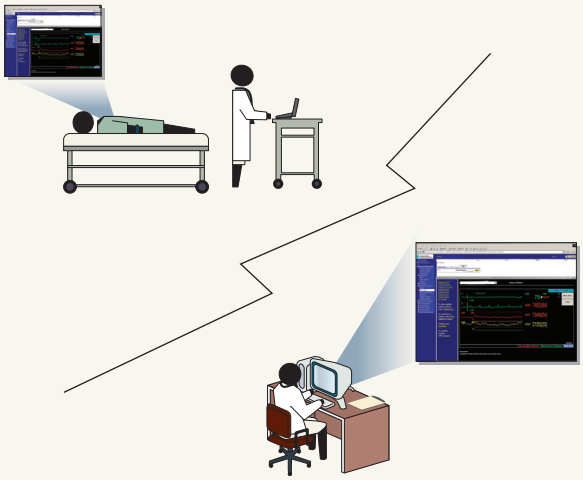
Source: Clinical Advisory Board interviews and analysis.

Technology Holding Promise

Live Video Streaming

Kaweah Delta Hospital

- 450-bed hospital in California
- Use TraceMaster application to feed live EKG data to EMR
- Physicians can view live feeds remotely

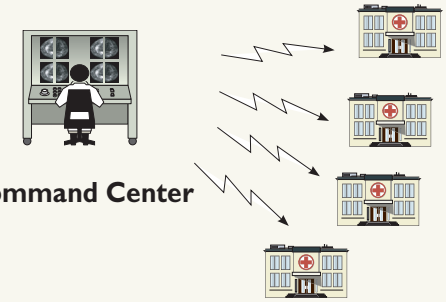


Physicians can keep tabs on inpatients without leaving the office, electronically entering or calling in instructions

Robotic Stroke Patient Assessment

Trinity Health

- 300-bed hospital in Michigan
- Launched Michigan Stroke Network
- Participating facilities consult with neurologist stationed at command center



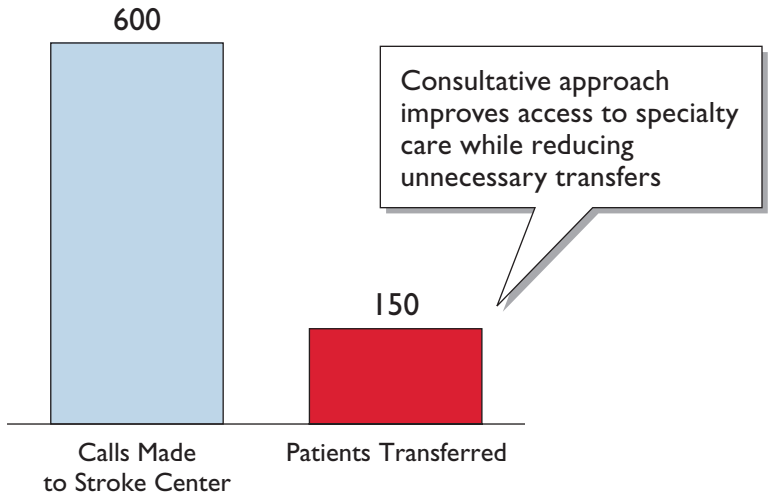
Command Center

Consults include review of imaging scans, patient examination with assistance from on-site physician

Source: Clinical Advisory Board interviews, Huff C., "On-Call? No Thanks", available at: http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/08AUG2007/0708HHN_FEA_Staffing&domain=HHNMAG, last accessed on October 10, 2007.

Impressive Early Results

Robotic Stroke Command Center Statistics



Not a Complete Solution

Hospitals and Health Networks

August 2007

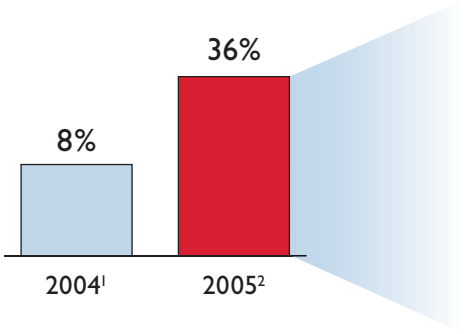
"Robotic support, despite its high-tech pizzazz, doesn't address the nub of the on-call problem: surgical coverage. In the AHA survey, surgeons dominated the top 11 specialties that hospitals were paying cash to cover: general surgery, neurosurgery, orthopedics, hand surgery and plastic surgery, among others. Neither can obstetrics be handled remotely. Ultimately, to do the procedure, someone has to show up."

Source: Huff C., "On-Call? No Thanks", available at: http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/08AUG2007/0708HHN_FEA_Staffing&domain=HHNMAG, last accessed on October 10, 2007.

Increasingly Paying for Call

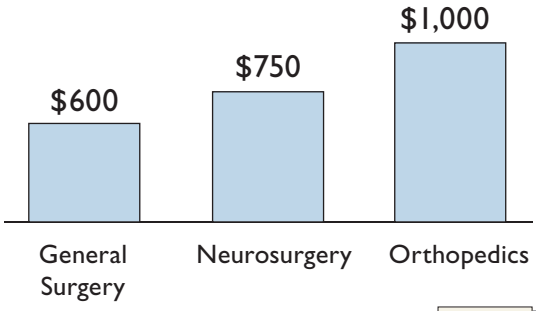
"Does your hospital pay stipends to any specialist physicians for providing on-call coverage?"

Percentage of Hospitals Answering 'Yes'



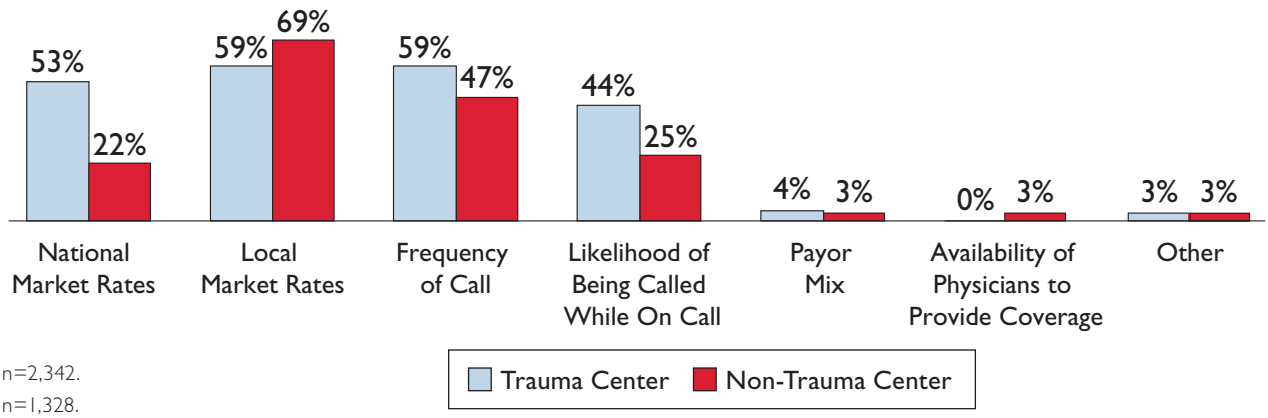
Stipend Rate, Top Three Specialties[3]

Median Daily Stipend, Unrestricted Call



Appendix

Variables Used to Determine Physician On-Call Pay Rates



[1] n=2,342.

[2] n=1,328.

[3] Based on AHA 2007 Survey of Hospital Leaders, "Percentage of Hospitals Reporting Payment for ED On-Call Coverage by Specialty."

Source: AHA 2007 Survey of Hospitals Leaders; 2006 ACEP Survey of Emergency Department Directors; Sullivan and Cotter, "Physician On-Call Pay Survey Report," June 2006.

Myriad Drawbacks to Stipend Approach

Immediate Taxation

- Stipend immediately subject to taxation
- Physician does not realize full value of payment

Short-Term Impact

- Physician sees no long-term impact of funds received
- Do not associate stipends with lifestyle benefits

Problems with Stipends

Vertical Pressure

- Specialties already receiving payment for call continuously demand higher rates

Horizontal Pressure

- New specialties also demanding payment for call
- Threaten to stop providing coverage if not paid

A Stop-Gap Measure at Best

"Stipends are not a long-term answer to the call-coverage problem. The amount the hospital is paying out continues will continue to increase to a point where it is no longer a sustainable solution."

Steve Worthy
Principal
MaxWorth Consulting

Source: Clinical Advisory Board interviews and analysis.

Recent Ruling Garnering Attention

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General, Washington, D.C. 20201

[*We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.*]

Issued: September 20, 2007

Posted: September 27, 2007

[Name and address redacted]

Re: OIG Advisory Opinion No. 07-10

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding the physicians' on-call coverage and uncompensated care arrangement employed by a medical center (the "Arrangement"). Specifically, you have inquired whether the

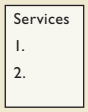
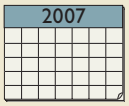
"Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that while **the Arrangement could potentially generate prohibited remuneration under the anti-kickback statue, if the requisite intent to induce or reward referrals of Federal health care program business were present, the Office of Inspector General ("OIG") will not impose administrative sanctions…**"

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that while the Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the Office of Inspector General ("OIG") will not impose administrative sanctions on [name redacted]

Understanding Safe Harbors

Safe Harbor Regulations

1 	The agreement is set out in writing and signed by both parties
2 	The agreement covers and specifies all of the services to be provided
3 	If the services are to be performed on a periodic, sporadic or part-time basis, the agreement exactly specifies the schedule, length, and charge for the performance intervals
4 	The agreement is not for less than one year
5 	The aggregate amount of compensation is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made by Medicare, Medicaid, or other Federal health care programs
6 	The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law
7 	The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services

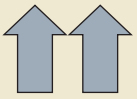
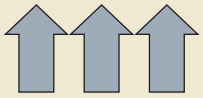
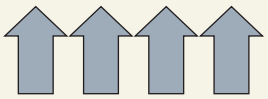
Staying within the Lines

"The general rule of thumb is that any remuneration flowing between and physicians should be at fair market value for actual and necessary items furnished or services rendered based upon arms-length transaction and should not take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties."

Source: Office of Inspector General, "OIG Advisory Opinion No. 07-10," September 27, 2007, available at: http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-10A.pdf, accessed October 30, 2007.

Choosing a Model

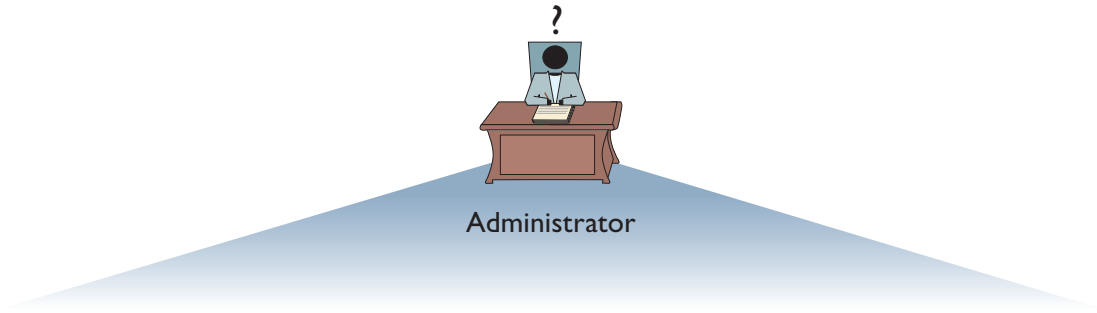
Payment Model Overview

Payment Method	Description	Complexity to Administer
Minimum Thresholds	Physicians do not qualify for a stipend until they have provided services past a pre-determined threshold (e.g. minimum number of call nights per month)	
Tiered Stipends	Specialties categorize into different stipend tiers based on relative burden or intensity of call; specialties with greater burden receive larger stipend amounts	
Guaranteed Reimbursement	Hospital guarantees certain level of payment for call services rendered, typically based on Medicare reimbursement rates; physicians turn over accounts receivable to billing administrator or third-party company	
Non-Qualified Deferred Compensation (457f)	Hospital credits deferred compensation account with pre-agreed upon stipend amount tied to medical staff membership over stipulated vesting period	

[1] Company-Owned Life Insurance.

Source: Clinical Advisory Board interviews and analysis.

Asking the Right Questions



Medical Staff Survey Questions

1. On what basis would you prefer to be paid?
a) Hourly rate
b) Per-diem
c) Annual rate
d) Productivity/Relative Value Units

2. What do you consider a reasonable compensation rate for:
a) Wearing a pager
b) Being called in to the hospital
c) Phone consultations

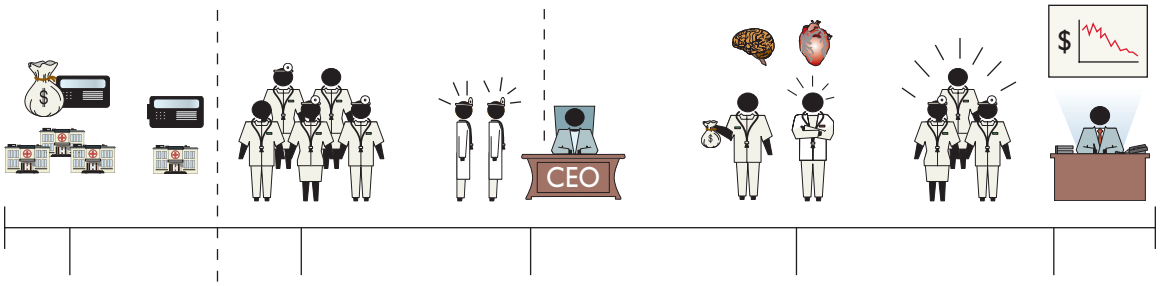
3. Would you consider a lower compensation rate should the hospital (check all that apply):
a) Hire dedicated Physician Assistants or Nurse Practitioners to help you take call
b) Increase the number of cases ED physicians are able to handle without backup
c) Extend a hospitalist program to take more call patients

4. How do you prefer funds to be distributed?
a) Monthly
b) Quarterly
c) Annually

5. Rank order the following payment approaches in order of preference (1 = Most Preferred):
__ Fee-for-service – Paid Medicare rate for services provided
__ Flat stipend – Paid one rate regardless of services provided while on call
__ Deferred compensation – Paid into a deferred account; funds grow tax-free until vesting date

Preempting Demands for Payment

Cash–for–Call Timeline



Local hospitals begin to pay specialists for call	Specialists begin to agitate for payment for call	One specialty threatens to pull all call coverage if demands not met	Other specialties see system as unfair, also demand payment	Hospital no longer able to afford payments; scrambles for new solution

Ideal Intervention Point

Typical Intervention Point

Case in Brief

Brady Community Hospital[1]

- A 400-bed, not-for-profit community hospital in the South
- Took proactive approach to paying for call by involving entire medical staff before demands for payment began
- Divided staff into per diem payment tiers based on liability risk, frequency of call and likelihood of actually being called by specialty
- Plan still in place two and a half years after implementation

[1] Pseudonym.

Source: Clinical Advisory Board Interviews and analysis.

Creating a Transparent System

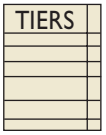
Emergency Call Advisory Committee

- Chiefs of staff, President and Vice President of medical staff, physician leaders
- Involved in brainstorming call coverage solutions

Physician Forums

- Forums open to all physicians, advertised in newsletters
- Surveys administered to test acceptance of proposed solutions

Call Burden Assessment



- Once per diem payment system established, all specialties ranked
- Ranking objective and all-inclusive

Process More Important than Outcome

"No one solution is a panacea. What is most important about our experience is not our system, but that we took a proactive approach to finding a solution before reaching a crisis point. By making sure physician needs were met early on, two and a half years later our system is still in place, we've had no EMTALA violations and no calls at night from ED physicians about not being able to find specialist coverage."

Vice President, Medical Affairs
Brady Community Hospital

Source: Clinical Advisory Board Interviews and analysis.

Reimbursing Through Future Payouts[1]

1 Crafting a Plan

- Hospital determines which physicians eligible to participate in plan
- Administrators set total annual budget for credits, determine specialty-specific credit amounts

2 Working with Physicians

- Physicians given copy of 457f plan
- Physicians sign professional services agreement; if broken, forfeit right to funds

3 Paying Out Credits

- When physician takes call, corresponding credit amount is deposited into 457f
- Physician able to invest allocated funds as desired

4 Watching Funds Grow

- Physician receives quarterly statement, watches earnings accrue tax-free
- Account not taxed until plan vests after pre-determined period of time

Typical Professional Services Agreement

Physician required to stay within community

Physician required to accept Medicare/ Medicaid patients

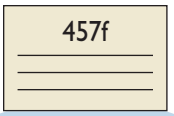
Physician required to take call

Physician not permitted to place financial stake in competing facility

[1] Call-Pay Solution™ using the deferred compensation platform is a registered trademark of MaxWorth Consulting.

Source: Clinical Advisory Board Interviews and analysis.

Examining the Intricacies



Advantages

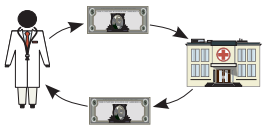
Antikickback Compliance

- Personal services agreement makes clear payment is in return for services
- Physician not required to refer patients to sponsoring hospital

ERISA[2] Limits

- Non-qualified plans not subject to ERISA
- Hospitals can selectively choose participants
- No limitations on contribution amount[3]

Sustainable Funding



- COLI[3] plan can be purchased by hospital on life of physician participant
- Upon physician passing, hospital is plan beneficiary[4]

Physician Security

- Rabbi trust ensures money cannot be revoked by hospital
- Hospital can remove surplus funds resulting from forfeitures

[1] Employment Retirement Income Security Act.

[2] Amount must be within reasonable limits to comply with Stark.

[3] Company-Owned Life Insurance.

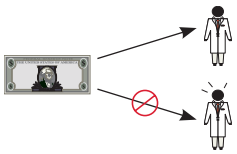
[4] Plan premiums covered by hospital; does not affect individually purchased plans.

Source: Clinical Advisory Board Interviews and analysis.

Case Study #1

Facing Specialist Discontent

Paying Case Selectively

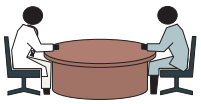


- Paying stipends only in trauma call[1]
- Also subsidizing hospitalist program for internal medicine call

Facing Increasing Pressure

- Specialties not receiving stipends complaining
- CEO receives letter from one specialty with call coverage cut-off date if not still paid

Brainstorming Solutions



- CEO and medical staff leader discuss solutions
- Contact legal consulting team to ask whether deferred compensation plans can be applied in call coverage

Case in Brief

Winchester Medical Center

- A 411-bed regional referral center, part of Valley Health in Winchester, Virginia
- Implemented deferred compensation plan in response to increasing pressure across specialists to reimburse for call

[1] Included ortho, neuro and general surgery.

Source: Clinical Advisory Board interviews and analysis.

Developing a Payment System

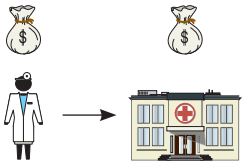
- Medical staff leaders formed focus group with department and section chairs, medical staff leaders
- Input used to develop plan

Program Details

Budget

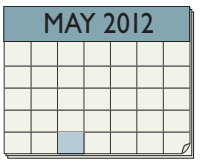
- Board set $2.5 to 4.5 M global budget for plan
- Hospital decides to fund plan through COLI policy

Forfeiture



- Physicians must stay within community, take unassigned call, participate with Medicare/Medicaid
- Participation in competing entity that requires a COPN causes forfeiture

Cliff vesting



- Plan vests five years out for current physicians, ten years out for new participants
- Physicians receive quarterly statements

Source: Clinical Advisory Board interviews and analysis.

Selecting Plan Participants

Call Committee

- Decided which physicians would be eligible for plan
- Included two ER physicians, a hospitalist, an internist, and a general surgeon

Call Burden Assessment

Specialty	Frequency	Intensity	Need	Liability Risk	Total Score
Orthopedics					
Urology					
General Surgery					
Neurology					
OB					

Scores summed to find overall call burden score; specialties ranked, divided into tiers according to level of burden

Each specialty graded based on four factors used to assess total burden of fall

APPENDIX

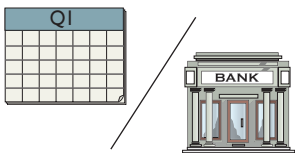
PAYMENT BASICS

Tiered Payments

Specialty	Burden
A	$$$
B	$
C	$$$$

Four tiers of payments based on relative burden of call

Data Tracking

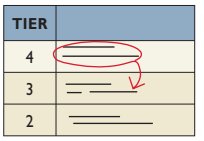


- ED and executive secretary maintain call roster; physicians confirm call credits
- Numbers double checked, sent to plan administrator

Quarterly Payout

Physicians paid per day of call; accounts credited quarterly

Credit Adjustments

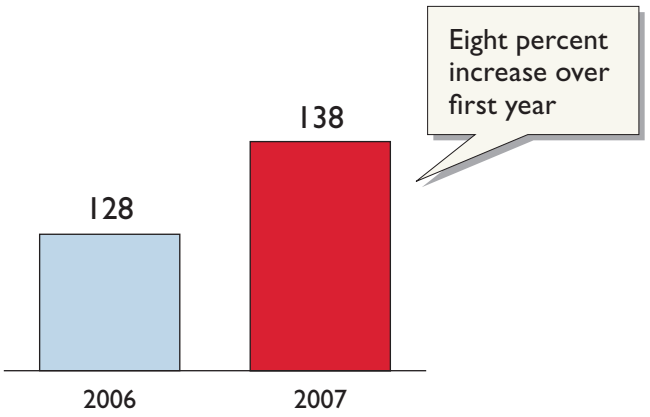


Hospital reserves right to move specialties between payment tiers where call burden changes

Source: Clinical Advisory Board interviews and analysis.

Improving Gaps in Coverage

Number of Physicians Participating in Plan



A Cost-Effective Strategy

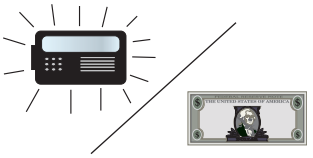
"Since the plan, we no longer pay for gap coverage. Ambulances are only on diversion in the event of a full ICU or disaster code, not because of lack of on-call specialty coverage."

Urologist
Winchester Medical Center

Source: Clinical Advisory Board interviews and analysis.

Case Study #2

Seeking Greater Physician Alignment

Growing Physician Discontent	Recognizing MD Efforts	Paying for Call
		
• Physicians feel hospital is failing to recognize their contribution to hospital's financial success • Some physicians considering own ASC	• Hospital seeks legal ways of compensating physicians • Physicians turn down participating bonds suggestion	• Deferred compensation allows additional income without risk of ASC investment • Physicians rewarded fair market value for services provided

Case in Brief

Southern Ohio Medical Center

- A 222-bed hospital in Portsmouth, Ohio seeing 79,000 emergency cases annually
- Implemented deferred compensation as means of improving physician relationship with hospital
- Tied program budget to percentage of hospital goals met to improve alignment

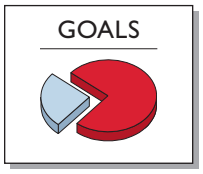
Source: Clinical Advisory Board interviews and analysis.

Calculating a Program Budget

Starting Budget

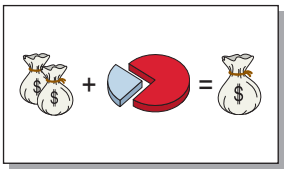
$1 M

Performance Factor



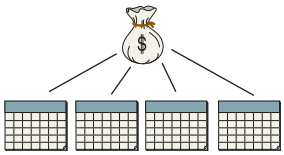
Hospital determines what percentage of organization goals were met

Actual Budget



Starting budget multiplied by performance factor to determine actual budget

Quarterly Budget



New total budget divided to calculate maximum quarterly payout

Risking Forfeiture of Funds

Personal Services Agreement Elements

Must take ED back-up call

Must respond within 30 minutes when called for an unassigned patient

Must accept Medicare and Medicaid

Must continue on active medical staff

Must not have ownership in competing facility

Source: Clinical Advisory Board interviews and analysis.

Presenting the Solution

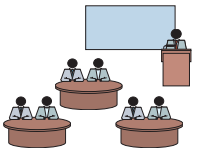
Medical Executive Committee

Medical staff leadership helps guide plan development

Choosing Eligible Physicians

- CFO in conjunction with MEC[1] choose eligible physicians based on call burden
- Physicians categorized into one of four payment tiers

Group Presentation



- Dinner held with eligible physicians to explain program
- Description of overall program layout

Individual Discussion

- Individual demonstration on expected earnings based on call logs
- Meetings arranged by legal consulting team

6 Months

Estimating Individual Contributions

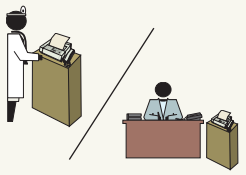
Tier	Credit per Day on Call	Intensity Need	Represented Specialties
1	1x	3x	Surgery, Orthopedics, Anesthesia
2	.75x	2.25x	Cardiology, Neurology, Obstetrics, Urology, Pulmonology
3	.50x	1.50x	ENT, Pediatrics, Gastroenterology, Oral Surgery, Radiology, Nephrology
4	.25x	.75x	Gynecology, Ophthalmology

[1] Medical Executive Committee

Source: Clinical Advisory Board interviews and analysis.

Calculating Quarterly Payouts

Tracking Call

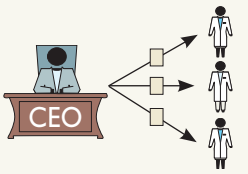


- Physicians fax call form to VP, Finance weekly
- Call form includes whether physician came in on 'off' hours, weekend or holiday, all patient names

Comparing Logs

- VP, Finance allocates two days at end of quarter to review forms
- Compares medical records log to physician forms to determine whether to include or exclude case

Generating Reports

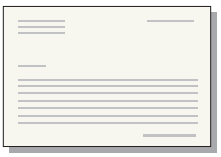


- Individual reports generated for all 35 physicians in plan
- Report details calculations behind credit amount based on template developed by IT department

Quarterly Report Breakdown

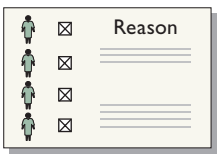
Vice President, Finance

Cover Page



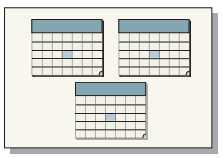
- Summary of number of weeks in quarter
- Week-by-week breakdown of cases covered
- Statement of total payout

Section One



Patient-by-patient breakdown of why or why not counted

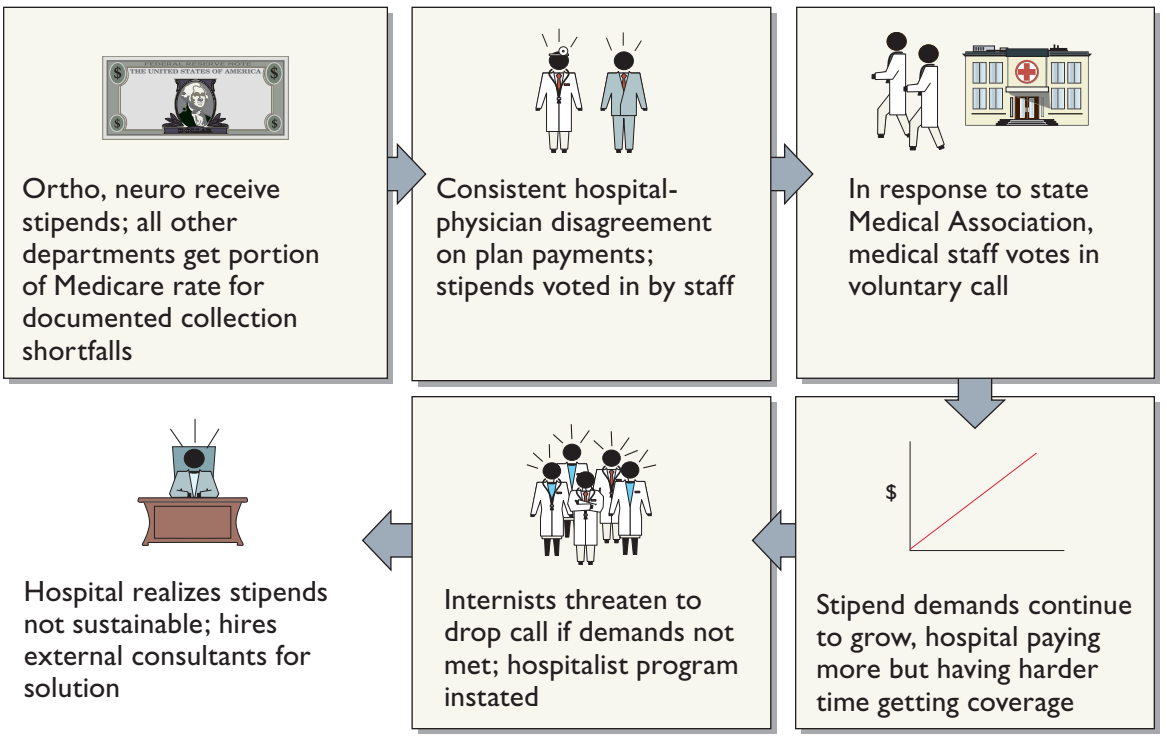
Section Two



- Includes all days in quarter, whether MD was on call, why day was or was not counted

Source: Clinical Advisory Board interviews and analysis.

A History of Call Strategies



Case in Brief

Favre Regional Medical Center[1]

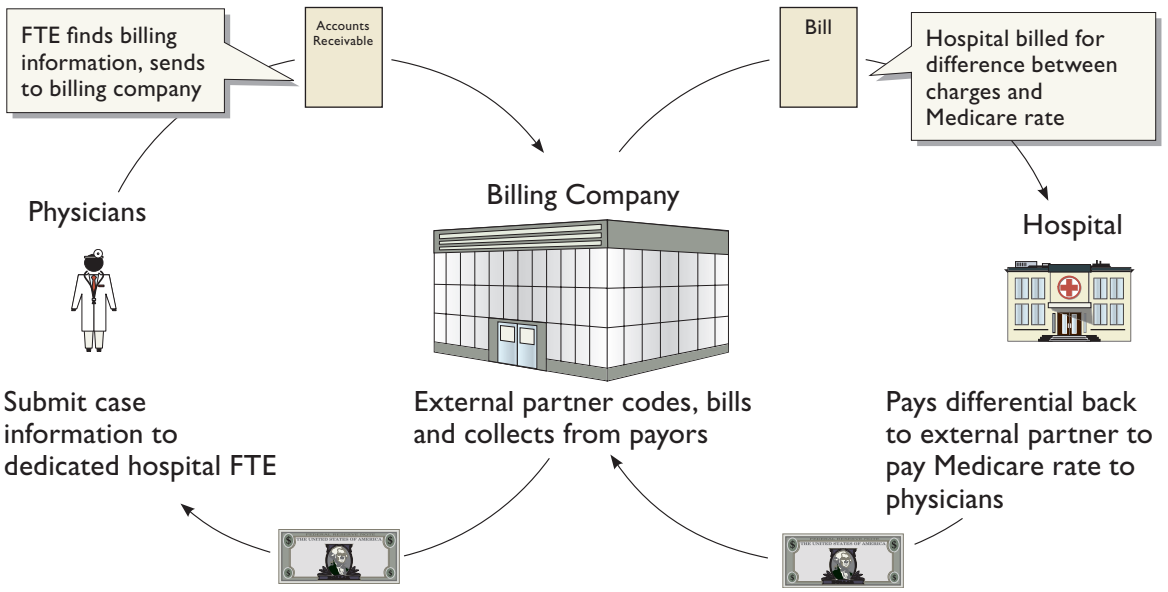
- A 400-bed hospital in the west assuming regional burden of high risk OB, neonatal care and trauma cases
- Facing demands for higher stipend rates across specialties, moved to fee-for-service approach at incremental cost of $200,000 over anticipated stipend inflation
- Physicians turn over accounts receivable regardless of payor to third-party billing company; third party codes, bills and collects from payors, charges hospital the difference to distribute Medicare rate to physicians
- Hospital pays billing party administrative fees on per-physician basis, billing company also paid percent of collections[2]

[1] Pseudonym.

[2] Third party billing company helps address Stark and antikickback concerns.

Source: Clinical Advisory Board interviews and analysis.

Adopting Productivity-Based Payment



Choosing the Right Partnership

Reliability

Risk lost payments if billing party is inefficient or physicians do not submit all ED call cases for billing

Registered

Provider number required to begin billing promptly, otherwise hospital risks disruptions in cash flow[1]

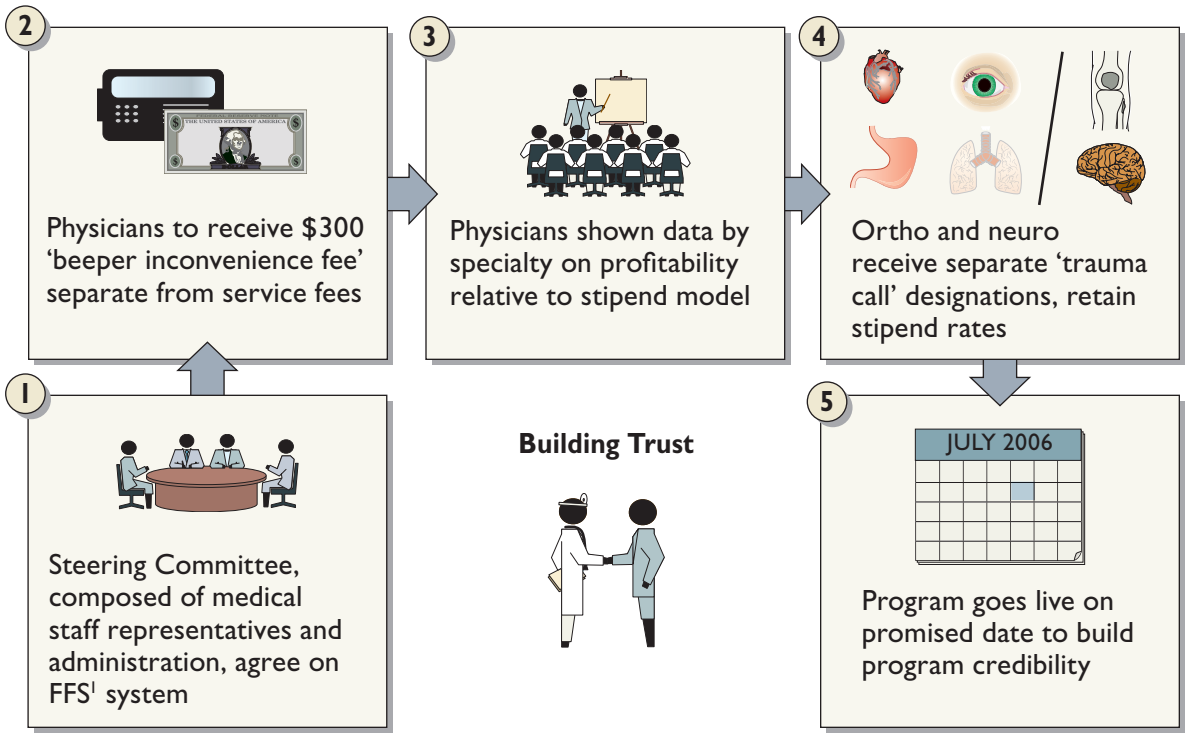
ED Experience

Few billing companies have ED on-call specific experience or are sufficiently comprehensive in scope of service

[1] Billing company must create group number for hospital.

Source: Clinical Advisory Board interviews and analysis.

Meeting Physician Concerns



(Finally) Getting It

"One day a surgeon would come to my office and say he made $10K in collections from taking call the previous week, and the next week that same surgeon would come by saying that we must have a better solution for reimbursing call because he was up all night with two unfunded patients. Administration really didn't understand how different the day-to-day experience was for physicians in taking call."

Administrator
Favre Regional Medical Center[2]

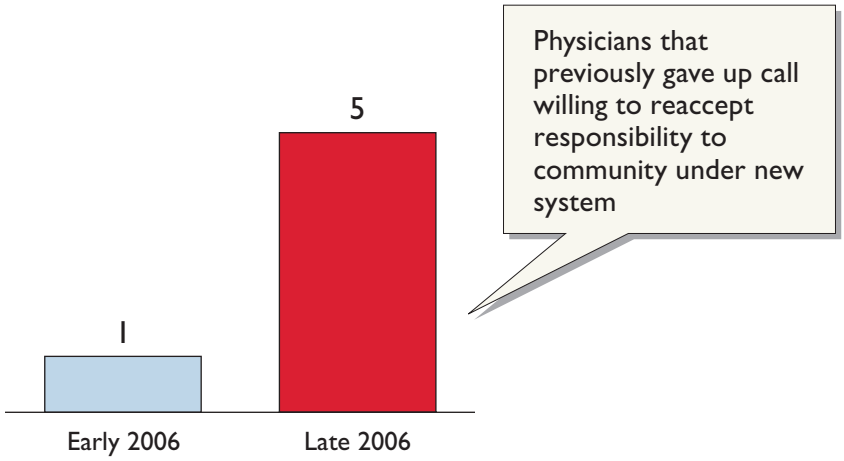
[1] Fee-for-service system.

[2] Pseudonym.

Source: Clinical Advisory Board interviews and analysis.

Satisfying All Parties

Number of Gastroenterologists Willing to Take Call



Running Like Clockwork

"I have not had one complaint from a physician about not getting paid correctly, and some of the physicians who had previously dropped out of call are back. When we started, the physicians were reluctant to trust the process or the outcome. We became proactive in working as partners with the medical staff leadership in arriving at a solution. There was growing peer pressure that everyone participate in call. They couldn't make an argument that there was differential treatment among specialties (which is a primary complaint with stipends). Nor could they make the argument that administration was creating a system, in a vacuum, that only benefited the hospital and not its doctors."

Administrator
Favre Regional Medical Center[1]

[1] Pseudonym.

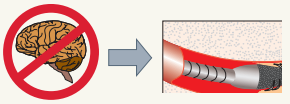
Source: Clinical Advisory Board interviews and analysis.

Confronting Gaps in Coverage

Neurosurgeon Economics Under Pressure

- Neurosurgeons making 25 percent less on cranial cases than spine cases[2]
- Suffering high malpractice premiums
- Reaching capacity constraints

Physicians Considering Defensive Practice Adjustments



- Surgeons carving out niche procedures
- Refusing some cranial and trauma cases
- Considering relocation

Health System Crafting Response

- Administrators examine opportunities to support neurosurgeon practice, maintain and grow neuro volume overall

Case in Brief

Colony Health System[1]

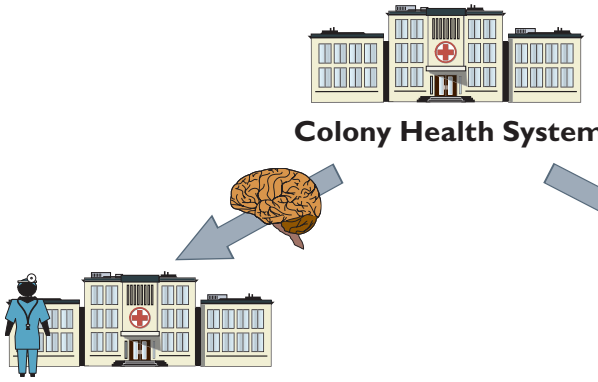
- A 265-bed community hospital located in the South
- Health system-affiliated independent neurosurgeons turning away cranial cases
- System employs a neurosurgeon to handle cranial, trauma and other "less desirable" cases, allowing hospital facilities to meet community need without putting undue burden on independent physicians

[1] Pseudonym.

[2] Per unit of time.

Source: Clinical Advisory Board interviews and analysis.

Parsing Out the Less Attractive Work



Employed Neurosurgeon

Takes cranial cases and other, less desirable neurosurgery cases

Freize[1] Neurosurgery

Focuses exclusively on spine

System Benefits

- ☑ Reduced medical staff tension
- ☑ Reduced transfer of cranial cases
- ☑ Improved overall care standard
- ☑ Enhanced cooperation in stroke center accreditation
- ☑ Potential for increased surgical capacity

Appendix

New Approach

"Independent physicians are focused on their own practices. They have rents to pay, equipment to purchase and staff to manage and are not really concerned about the hospital's success. We need the manpower to do the head work, and we also need to help private doctors deal with their income pressures right now."

Executive Medical Director, Quality and Performance Improvement
Colony Health System

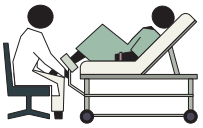
[1] Pseudonym.

Source: Clinical Advisory Board interviews and analysis.

Considering OB Hospitalists

- Midlife and mid-career
- Minimum of five to 15 years of private practice experience
- Often community physician prior to hospitalist role

Deliver and care for unassigned, uninsured, and emergent births



Round on all prepartum patients until patient's OB arrives to actually deliver baby

Serve as first assist on planned and emergency c-sections

Benefiting All Parties

Patient

- Prepartum care throughout labor
- Still have own physician deliver baby
- Uninsured patients have guaranteed access to a physician

Attending OB

- Does not have to leave office during day for call
- No longer has night call
- Still delivers patients' babies
- Does not have to deliver uninsured patients' babies

OB Hospitalist

- Only have to work one to two days per week
- Malpractice paid
- Can maintain private practice, research, and/or teaching
- Can afford to continue delivering babies

Hospital Administration

- Do not have to pay community OBs for call coverage
- Lower risk of lawsuits due to diminished severity escalation
- Can maintain labor and delivery service
- Potential financial gains

Source: Clinical Advisory Board interviews and analysis.

Practice Profiles: Seven Diverse Programs

Hospital	Year started	Number of physicians, practice organization	Jobs completed by OB hospitalists	Metrics of success
Branch Avenue Hospital[1]: 600-bed, not-for-profit teaching hospital in the South	2005	Four OB hospitalists provide 80% of coverage working in 12-hour rotations; remaining time covered by per diem physicians	• Care for all unassigned walk-in patients and transfers • Consult and provide support for unit nurses • Serve as general OB, managing, admitting, treating, and delivering high-risk patients in consultation with MFM • Serve on unit PI team	• Lawsuits or liability issues • Number of high-risk transfers • Number of uninsured served by hospital • Referring OB satisfaction • Number of referrals
Suitland Medical Center[1]: 600-bed, not-for-profit teaching hospital in the Northwest	2006	Four OB hospitalists—three hired and one locum—work alternating 24-hour shifts; if demand for services spikes, shifts are decreased to 12 hours	• Provide backup coverage in maternity clinic • Participate in staff and professional education • Conduct research	• OB satisfaction • Patient satisfaction • Number of high-risk transfers
Naylor Hospital[1]: 450-bed, not-for-profit community hospital in the West	2005	Four OB hospitalists work alternating 24-hour shifts	• Cover OB patients in the ED and after admission from the ED • Cover all unassigned and uninsured patients • Provide assistance to community OB deliveries as needed	• OB satisfaction • Volume of births
Southern Medical Center[1]: 400-bed, not-for-profit community hospital in the West	2005	Five OB hospitalists work alternating 24-hour shifts	• Provide prenatal and prepartum care for walk-in patients with no OB or PCP • Cover patients at over 20 weeks of pregnancy who enter through an outpatient OB clinic • Assist on high-risk deliveries and cesarean sections	• Number of high-risk patients seen • Patient satisfaction • Physician satisfaction
Congress Heights Hospital[1]: 150-bed, not-for-profit community hospital in the Northwest	2005	Four OB hospitalists complete 24-hour rotations	• Provide care for all patients on L&D unit until attending physician arrives • Provide inpatient management of perinatal patients, consulting with MFM physician when necessary • Lead continuing education case reviews • Serve as clinical leads on the unit by assisting nurses and staff • Teach attending physicians how to use EMR	• OB satisfaction • Number of referrals from family practice physicians and nurse midwives • Patient satisfaction scores • Percentage of calls covered by OB hospitalists • Number of high-risk transfers
Greenbelt Health[1]: 350-bed, for-profit hospital in the West	2007	Six OB hospitalists rotate 9:00 a.m.–5:00 p.m. and 5:00 p.m.–9:00 a.m. shifts	• Consult for community-based OBs if asked • Round on L&D, antepartum unit, mother and baby unit, and the ED • Serve as second assist on cesarean sections • Work closely with MFM physicians to generate a care plan	• Decrease in number of deliveries performed by nurses • Percentage reduction in need for OB call coverage • Number of OBs applying for fellowships (indicates desire to practice at hospital with OB hospitalists) • Nursing satisfaction scores • Patient satisfaction scores
L' Enfant Hospital[1]: 350-bed, not-for-profit community hospital in the West	2004	Five OB hospitalists work alternating 24-hour shifts	• Care for unassigned and uninsured OB/GYN patients arriving through the ED • Cover emergency cases for community obstetricians • Assist with complicated deliveries or cesarean sections • Ensure complete and accurate coding and billing • Serve on hospitalist leadership team	• OB satisfaction • Patient satisfaction • Ease of hiring OB nurses

[1] Pseudonym.

Source: Clinical Advisory Board interviews and analysis.

Surgical Hospitalists Increasing

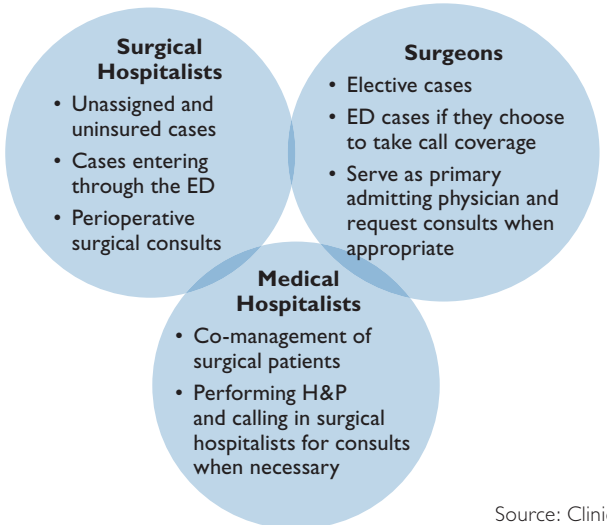
Surgical Duties

- Provide unassigned ED consult services and perform surgery on those patients as required
- Respond to ED for patient evaluation in timely manner
- Provides surgical consultative services to staff physicians—medical and surgical—on inpatients to include H&Ps, surgical evaluations, and post-op care
- Performs procedures, including central line insertions, chest tube insertions, and cut-downs requested by ordering physician
- Provide surgical first assist for surgical subspecialists as required

Non-surgical Duties

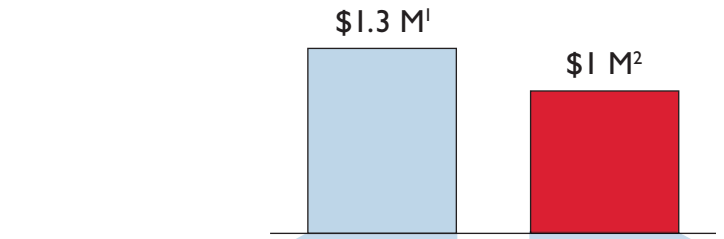
- Generates on-time starts, length of stays, and hospital charges that are at or below level of non-hospitalist surgeons
- Facilitate communication and interaction between patients, families, peers, and ancillary staff
- Ensures that patients and families are informed of clinical management care plans
- Participate in wound care clinic four hours per week

Preventing Overlap in Duties



Source: Clinical Advisory Board interviews and analysis.

Evaluating ROI and Applicability



Band-Aid Solution

- Little value-add for financial output
- Can never pay enough to make some physicians happy
- Could cannibalize elective margins

Investing for the Long Haul

- 24/7/365 coverage
- Able to more efficiently treat uninsured and unassigned
- Faster time to treatment and reduced LOS

Case in Brief

Anne Arundel Medical Center

- A 265-bed community hospital in Maryland
- Implemented surgical hospitalist program in 2006
- Employ four surgeons who cover the ED, unassigned patients, and procedures

[1] Assumption: $3,500 call coverage payment per night x 365 nights per year.

[2] Assumption: $250,000 salary x 4 surgeons.

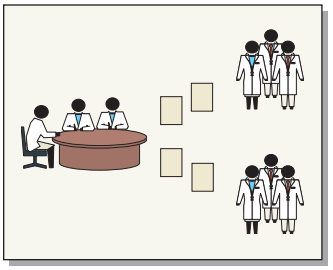
Source: "2005–2006 Physician Compensation Review," *Modern Healthcare*, available at: http://www.modernhealthcare.com, accessed March 9, 2007; Clinical Advisory Board interviews and analysis.

Stipends Not Meeting Needs

Seeking a Solution

- Hospital already paying straight stipends for call coverage
- Neurosurgeons still reluctant to take call
- Medical Executive Committee makes recommendation to CEO to contract with one group for all neuro call

Putting Out an RFP



- Request for proposal entered
- Contract offers exclusive right to cover all emergency neuro patients
- Hospital guarantees fixed income to group who wins contract

Selecting a Group

- Medical Executive Committee responsible for decision
- Three-physician group interested and trained in neuro trauma care chosen

Case in Brief

Scripps Memorial La Jolla

- A 293-bed hospital in La Jolla, California; one of San Diego County's six designated trauma centers
- Put out a request for proposal for all neurosurgery call
- Contracted group receives guaranteed income from hospital in return for seeing all emergency neurosurgery and neurology patients

Source: Clinical Advisory Board interviews and analysis.

Advantages to Exclusive Contract

Physician Benefits

- Guaranteed income gives reassurance that group will maintain profitability
- Fixed income allows group to establish an accurate budget
- Physicians interested in trauma patients satisfy intellectual needs

Hospital Benefits

- Hospital able to relieve existing neurosurgical physicians of call duties
- Assured consistent ED coverage and compliance with ACOS[1] standards
- Hospital able to establish and enforce fixed program budget

A Sustainable Solution

"We are now in the fourth or fifth year of our program. The group we chose has made the model work and the guaranteed income has even helped them to retain and recruit new surgeons."

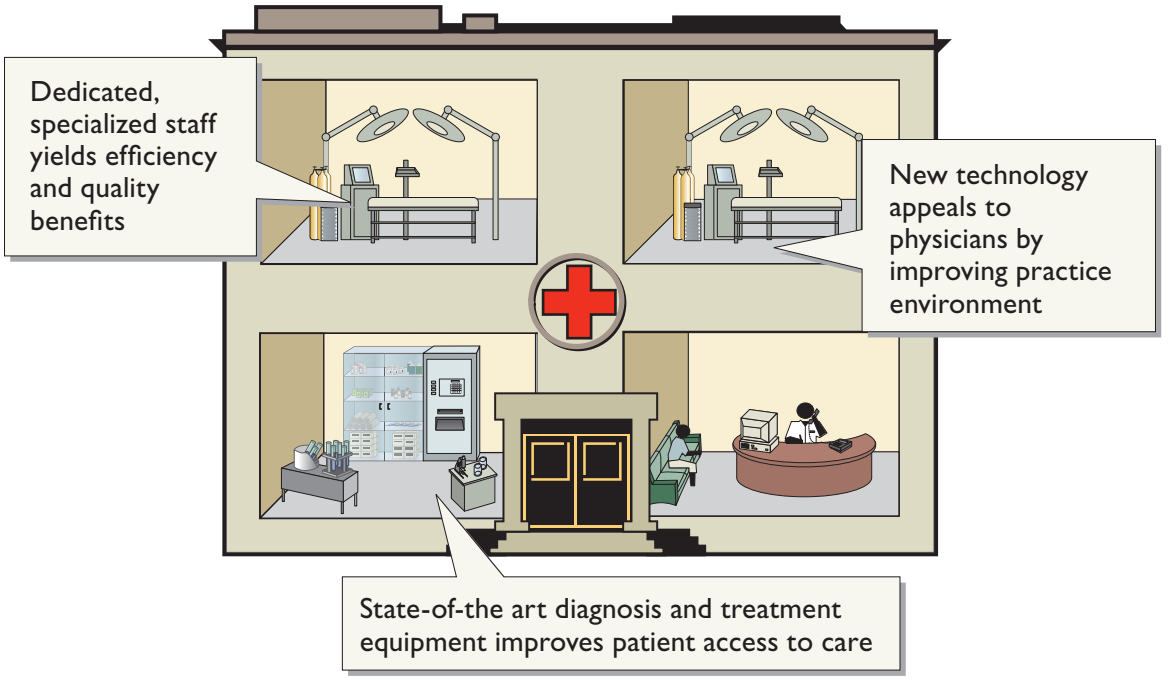
Chief Medical Officer
Scripps Health System

[1] American College of Surgeons.

Source: Clinical Advisory Board interviews and analysis.

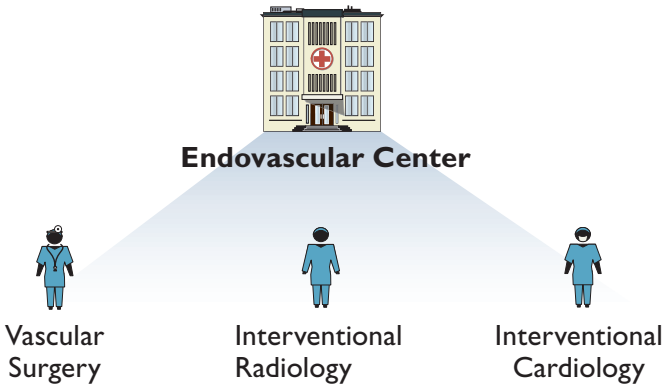
Appealing to Physician Interests

Specialty Center Advantages



Source: Clinical Advisory Board interviews and analysis.

Placing a Price on Entry



Program Logistics

- Shared access during daytime
- Shared call responsibility for pre-defined procedures
- Non-participating physicians not permitted to practice in endovascular center

Program Benefits

- Improved interspecialty call coordination, larger physician pool
- Turf war management
- Easy to implement triage nurse to direct call cases appropriately between specialties

Case in Brief

Manning Clinic[1]

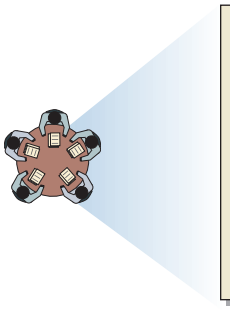
- A multispecialty clinic in the Western United States
- In the business plan stage of developing an endovascular program to meet demand for minimally invasive treatments
- Physicians will be permitted to opt in or out of plan—only those opting in will be credentialed for core procedures

[1] Pseudonym.

Source: Clinical Advisory Board interviews and analysis.

Identifying Potential Clinical Shortfalls

"Where is CV Going?"



Future Direction of Clinical Innovation

- ☑ Robotic MI valve
- ☑ Video-assisted atrial fibrillation
- ☑ Endovascular thoracic aortic procedures

"Do We Have the Expertise?"

Potential Services	Hosp A	Hosp B	Hosp C
Valve (aortic, mitrial)	Yes	Yes	Yes
Lone A Fib[1] (VATS[2])	No	No	No
Cardiac Ablation	No	Yes	No
VAD[3]	No	No	No
LVRS[4]	No	No	No

Charting a Course for Cardiovascular Strategy

- Executive work group spends three months reviewing trends
- Part of system initiative to ensure clinical readiness for long-term growth
- Group observes procedures becoming more technological, more specialized

Uncovering Gaps in Staff Skill Set

- Some priority investment areas lack medical staff experts
- Relying on recruiting for emerging subspecialties (now and in future) deemed "unrealistic"
- Working group shares findings with medical staff

Case in Brief

Burr Health System[5]

- Three-hospital health system, located in the East
- "Clinical champion" program designed to provide ongoing education to medical staff, avoid need to recruit amid specialist shortage
- One clinical champion established, future champions planned for congenital heart repair, robotic MI valve, advanced heart failure, standalone MI atrial fibrillation ablation

[1] Lone atrial fibrillation.

[2] Video-assisted thorascopic surgery.

[3] Ventricular assist device.

[4] Left ventricular reduction surgery.

[5] Pseudonym.

Source: Medical Group Management Association (MGMA), Physicians Compensation and Production Survey 2006 Report; Clinical Advisory Board interviews and analysis.

Expanding Specialty Services

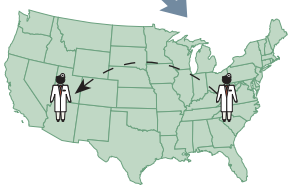
The Making of a (Endovascular Thoracic Aortic Aneurysm Repair) Champion

Staff Surgeon Volunteer

- Cardiac surgeon agrees to learn system-designated clinical priority area
- System pays travel, fellowship fees, benefits and full salary

Sharing Skills Across Medical Staff

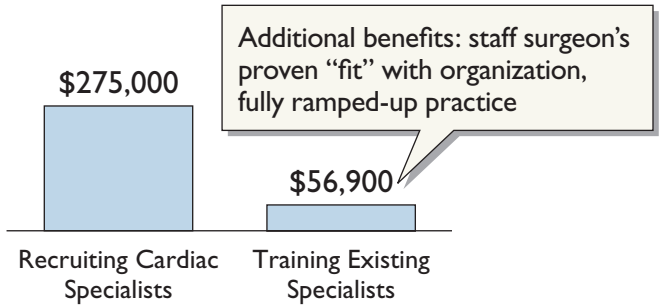
- Upon return, surgeon works with staff interventional cardiologists to learn related catheter techniques for percutaneous valve procedures
- Teaches other staff surgeons interested in new procedure skills



Travel for Education

Spends one month at mini- fellowship in thoracic aortic surgery

Cost Comparison, Recruitment Versus Training[1]



Training the Sounder Investment

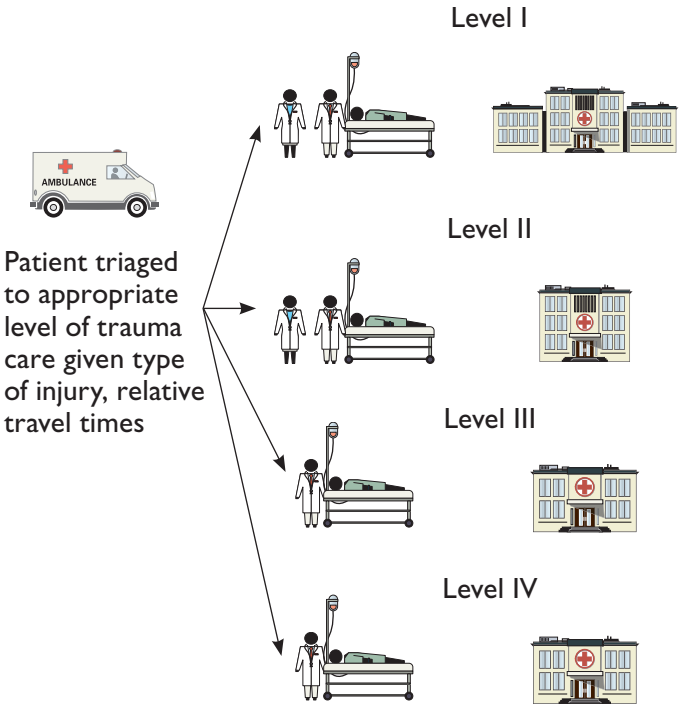
"It's a substantial upfront cost, but will be completely worthwhile in another three to five years when the physician shortage becomes even more pronounced, making subspecialist recruitment even harder."

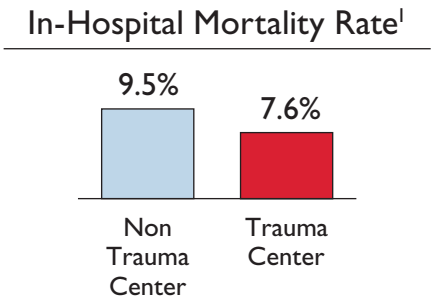
Medical Director, Heart Institute
Burr Health System

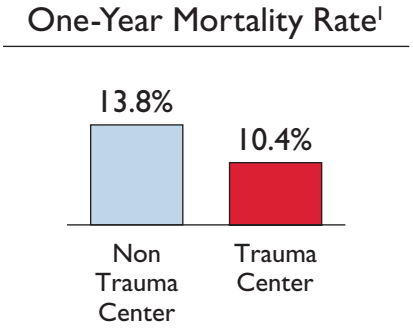
[1] For recruitment costs, assumes 2005 50th percentile starting salary for a cardiovascular surgeon ($250,000), costs for candidate sourcing, site visit, relocation, and cost of a recruiter's time over average time-to-fill period. For training costs, includes 3 months of living expenses, approximate tuition ($50,000) and transportation.

Source: Clinical Advisory Board interviews and analysis.

Already Regionalizing Trauma Care





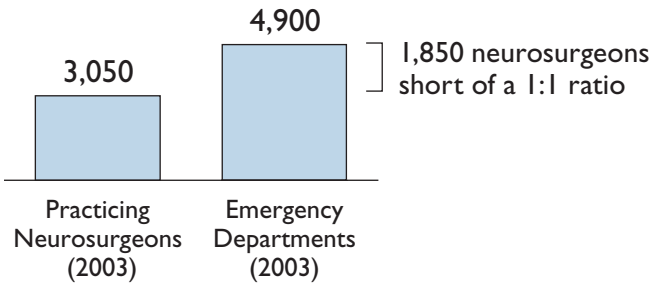


[1] Adjusted for differences in case mix.

Source: EJ MacKenzie et al, "A national evaluation of the effect of trauma center care on mortality," New England Journal of Medicine 2006 January 26, 354(4):366-78; Institute of Medicine, "Future of Emergency Care," Prepublication Copy.

A Logical Solution to Call Coverage

Number of Neurosurgeons to Number of Emergency Departments



Source: Institute of Medicine, "Future of Emergency Care," Prepublication Copy.

Sharing District Resources

Palm Beach, FL

- Emergency Department Management Group (EDMG) formed spring 2004
- Goal of finding regional solutions to limited availability of specialists taking call

Program Details

Regionalization

- High costs of maintaining call coverage would be concentrated in a few high volume hospitals where volumes make full-time on call feasible
- County hospitals would pay 'subscription fee' to support call at designated hospital

Coordination

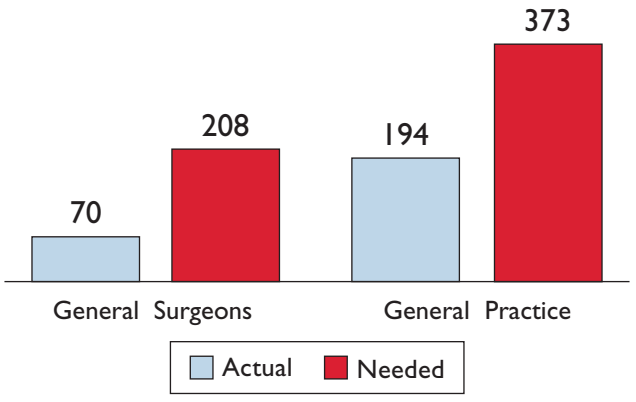
- Developing a web-based, electronic ED call schedule so EMS can track which specialists are available where, triage appropriately

Accountability

- Quality assurance program to be developed to measure system performance

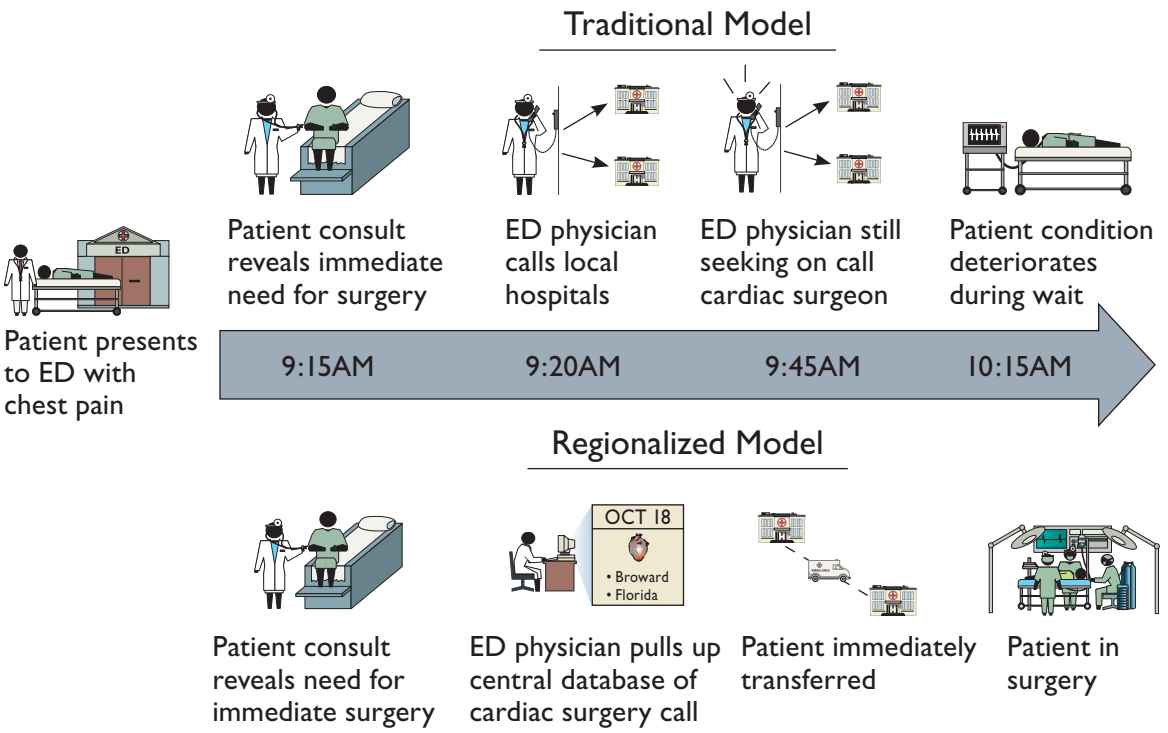
Preempting Severe Specialist Shortage

Five-Year Specialist Forecast, Palm Beach County



Source: P Pensa, "Physician Shortage Worsening; Aging Doctors, Unfavorable Conditions Cited in Study," South Florida Sun-Sentinel, March 27, 2007.

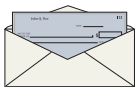
Providing Faster Access to Care



Source: Institute of Medicine, "Future of Emergency Medicine," Prepublication copy.

Controlling Frequent Fliers

Take calls from patient to evaluate acute care needs and direct to most appropriate care setting

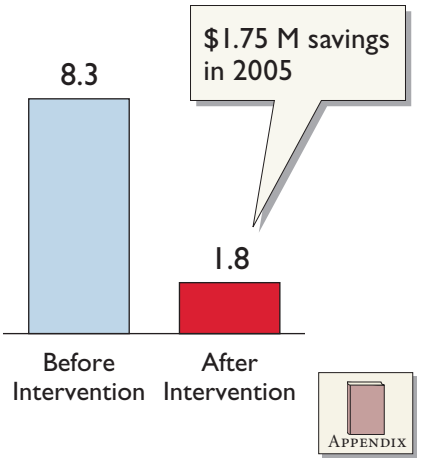


Help pay for medical equipment and medication when necessary

Refer stable patients to Seton's Community Clinics to manage chronic conditions

ED Visits per 'Frequent Flier'

Over Six-Month Period



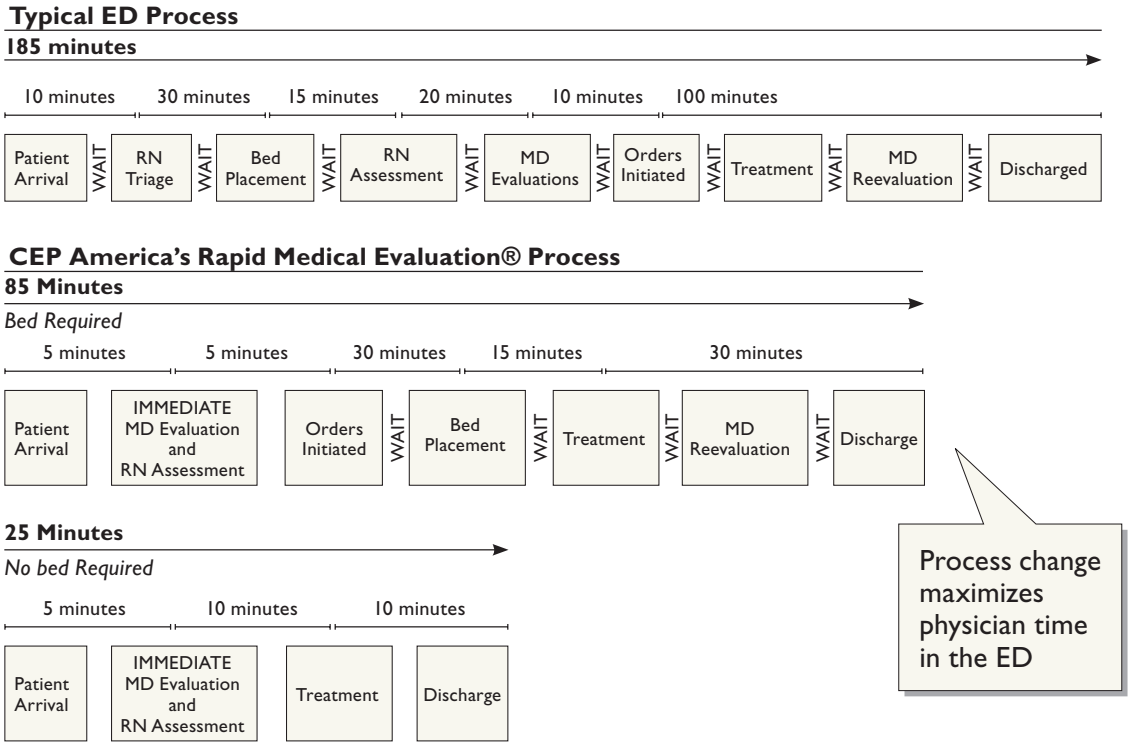
Case in Brief

Seton Family of Hospitals

- A six-hospital health system in Texas
- Analyzed ED visits, discovered many underfunded patients with limited access to care were using ED for routine visits
- Dedicated case manager to target 'frequent flier' population, defined as: 1) Patients with six or more ED visits per year; or 2) Patients with three or more inpatient visits per year

Source: Clinical Advisory Board interviews and analysis.

Reenvisioning the Care Process



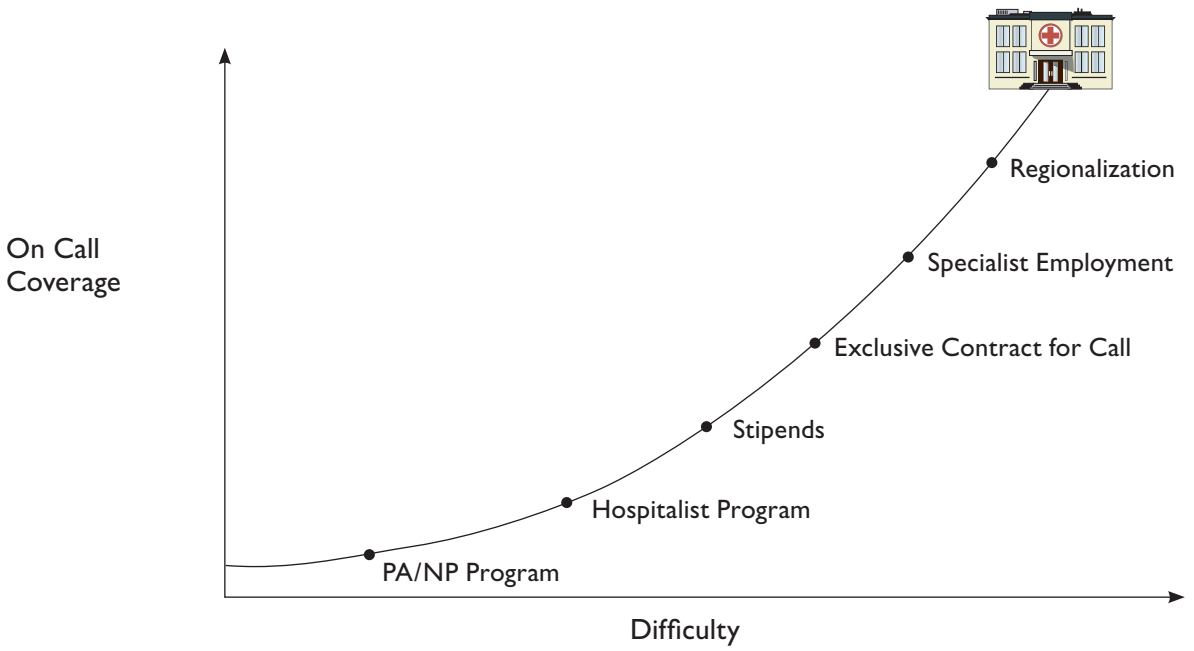
Company in Brief

CEP America
EMERGENCY PHYSICIAN PARTNERS

- A physician partnership with 900+ MDs, 350+ PA/NPs
- Covers 60 emergency departments, 2,500,000+ patients, private, public, trauma, teaching and community hospitals
- Reducing time to provider in ED using parallel processing concepts; Rapid Medical Evaluation (RME) consists of immediate bedding and placing a provider at triage

Source: Clinical Advisory Board interviews and analysis.

A Continuum of Solutions



Metrics of Success

Diversions

Ambulance diversions due to lack of on-call coverage

Recruitment/Retention

Ability to recruit new surgeons, retain those threatening to leave

Coverage

Percentage of specialties with on-call coverage or number of gaps

Sustainability

Frequency of plan revisions, annual budget inflation rate

Key Takeaways

1. In securing call coverage, no one solution is a panacea. Instead, hospitals should work proactively with their medical staffs to find a mutually beneficial approach that best speaks to the physician and administrator concerns at that specific organization. The process should be objective, transparent and inclusive of all specialties and should occur before the situation reaches a breaking point.

2. In working with physicians to find a solution, the hospital must recognize the burden call coverage places on physicians – both from a quality of life perspective and a financial perspective. Recognizing physician contributions and emphasizing the obligation to patients will help align party goals. However, where hospitals choose to implement a pay for call system, they should be mindful to stay in line with antikickback statutes.

3. While hospitals can employ a variety of tactics to improve their coverage situation, ultimately these will not solve for the absolute physician shortage we are experiencing. Hospitals will increasingly need to find system-level or regional solutions to better leverage existing specialists across multiple sites.

4. Lastly, an inability to secure adequate call coverage is symptomatic of a much larger problem, that is, poor hospital-physician alignment. Hospitals must ultimately seek measures that go beyond solving the call coverage problem to create a physician-friendly ED.

Appendix

Companion Materials

Auditing Call Strategy

Calculating Stipend Amounts

Employment Worksheets

Physician–Friendly ED Tactics

Tool #1: Call Coverage Opportunity Assessment

Worksheet Objective

The purpose of this worksheet is to aid organizations in assessing the adequacy of their current call coverage strategy as a whole, then identify individual components that hold the greatest opportunity for improvement. The more 'yes' answers that exist, the larger the potential to improve in that area. Organizations should consider this sheet a diagnostic assessment of areas where call coverage programs may fall short, then target improvement efforts towards those areas with the largest shortcomings.

Hospital Call Coverage Strategy Assessment	YES	NO
Is the paging system failing during different shifts?	_____	_____
Is the hospital regularly failing to meet or nearly failing to meet EMTALA requirements?	_____	_____
Is lack of specialist coverage the primary reason for ED diversions?	_____	_____
Are ED physicians currently struggling to find available on-call specialists?	_____	_____
Are specialists currently defecting or reducing services due to call obligations?	_____	_____
Is there an effective transfer mechanism in place for patients needing a higher level of care for any reason?	_____	_____
Do you lack regular review of transfer patients by performance improvement and peer review processes?	_____	_____
Does the hospital lack a call ladder system?	_____	_____

Hospital Contracts Assessment	YES	NO
Can the hospital put more pressure on health plans for more timely payments?		
Do you lack appropriate transfer agreements?		
Are there remaining opportunities to contract with a hospitalist group to reduce call burden?		
Are there remaining opportunities to provide an exclusive contract for call coverage where gaps in care exist?		

Physician Education	YES	NO
Do physicians lack clear understanding of EMTALA rules and interpretations?		
Do ED physicians lack knowledge of specialists' preferred method of contact by time of day?		
Do ED physicians lack knowledge of each physician's scope of practice?		
Are expectations for call poorly defined or stated (e.g. coverage conditions, response times, etc)?		
Has transfer criteria not been approved from administration and medical staff?		

On-Call Logistics	YES	NO
Could the call roster be more accessible/clear for physicians?		
Could the hospital further take advantage of services with clinical overlap?		
Are systems lacking to obtain continuous feedback from on-call physicians?		
Do you currently lack systems to handle complaints from on-call physicians in an expeditious manner?		
Do you lack mechanisms to resolve conflicts between ED and on-call physicians?		
Do you lack appropriate mechanisms to periodically review call strategy effectiveness?		
Are current physicians complaining about their call burden?		

Tool #2: Tactic Relevance Assessment

Worksheet Objective

The purpose of this worksheet is to help organizations determine which strategies may be most relevant to their specific institution based on factors such as culture and biggest barrier to securing specialist coverage. The more 'yes' answers each strategy receives, the higher the likelihood of that strategy being potentially relevant at an individual institution.

Specialist Recruitment	YES	NO
Is the absolute number of physicians on staff the largest barrier to specialty coverage?	_____	_____
Have medical staff bylaws already been amended to mandate call for all physicians in a specialty where gaps in coverage occur?	_____	_____
Are physicians reaching the physical limit of call coverage provided per physician?	_____	_____
Are physicians considering relinquishing medical staff privileges or subspecializing due to unsustainable call burden?	_____	_____

Specialist Employment	YES	NO
Are you currently paying more for call in a specialty than the market rate of a specialist salary?	_____	_____
Are specialists in your area open to employment?	_____	_____
Are specialists struggling to remain profitable in private practice (due to local volumes, payor mix, malpractice liability, etc)?	_____	_____
Does legislation in your state permit physician employment?	_____	_____
Does your organization have mechanisms in place to represent physician priorities and have a good relationship with existing staff?	_____	_____

Exclusive Call Contract	YES	NO
Is your organization willing to set aside a budget for a coverage program?	_____	_____
Are private practice physician groups in your area struggling with overhead costs or having difficulty with a highly variable income climate?	_____	_____
Are there multiple private practices in your local market in the specialty whose services you wish to recruit?	_____	_____
Is your hospital already paying stipends and looking to change your call coverage approach?	_____	_____

Deferred Compensation	YES	NO
Has your organization not yet moved to paying for call?	_____	_____
Have most or all of your physicians refrained from financially investing in competing facilities thus far?	_____	_____
Is your organization willing/able to set aside a budget for such a program based on expected payouts for current call burden?	_____	_____
Does your organization have an administrator able to track and distribute call credits quarterly?	_____	_____
Does your organization have a strong relationship with physicians and good prospects for long-term financial health?	_____	_____

Specialist Relief Workers	YES	NO
Could specialist burden in specialties where the greatest barrier to coverage is the absolute number of physicians be reduced through better triage?	_____	_____
Does your organization have a hospitalist program in place but does not yet have 24/7 ED hospitalist coverage?	_____	_____
Are on-call specialists currently frustrated by unnecessary ED consults?	_____	_____
Are there remaining on-call duties that could be handled by Nurse Practitioners or Physician Assistants?	_____	_____
Would alleviating the call burden increase the number of specialists willing to take call or the amount of call they are willing to take?	_____	_____

Tool #3: Specialty Call Intensity Matrix

Worksheet Objective

The purpose of this worksheet is to help organizations who are planning to pay for call rank specialties by relative call burden to determine which specialties will receive higher payments. Hospitals are encouraged to customize this form as needed.

Intensity Ranking Process

1.	List all specialties currently needed for call coverage and the global program budget the hospital is willing to set aside on an annual basis
2.	Choose the number of payment tiers that physicians will fall into, the parameters of each tier, and the payment rate a physician in each tier will receive based on total program budget
3.	For each specialty, use ED call logs and medical records to determine as accurately as possible the number of days per year spent on call, the number of times actually called in to the hospital, and the approximate number of follow-up visits per patient seen while on call by specialty
4.	Calculate the relative intensity or burden of call for each specialty; rank specialties in descending order and divide the list into tiers based on calculated rankings
5.	Establish a system for tracking call provided and distributing call payments on a per-physician basis
6.	Review call intensity regularly to determine whether changes in call burden merit moving a specialty to a different tier and assess any necessary changes in program budget

$$\frac{\text{Number of Days on Call per Year}}{\text{Number of Physicians in Specialty}} + \frac{\text{Days Called per Year}}{\text{Number of Physicians in Specialty}} + \frac{\text{Average Number of Follow-Up Visits}^{1} \times \text{Average Number of Patients Admitted}}{\text{Number of Physicians in Specialty}} = \text{Call Intensity}$$

Specialty	Average Number of Days on Call (Per Physician)	Average Number of Days Called (Per Physician)	Post-Call Follow-Up Burden (Per Physician)	Call Intensity

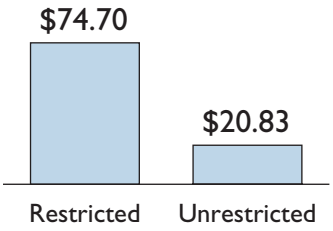
[1] Per ED patient per specialty.

National Stipend

Median Equated

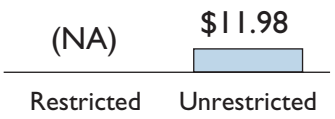
Anesthesiology

n=23



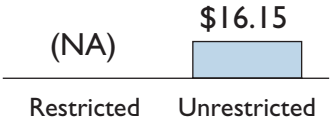
Cardiology

n=9



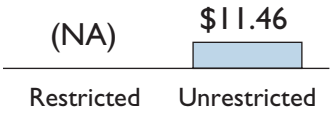
Cardiothoracic Surgery

n=6



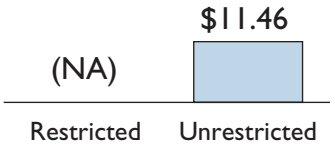
Gastroenterology

n=7



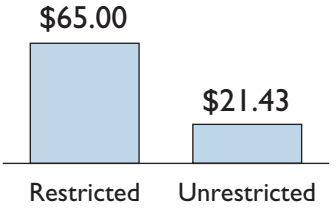
General Surgery

n=18



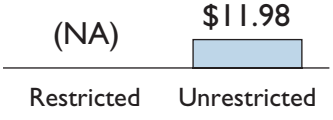
Neonatology

n=10



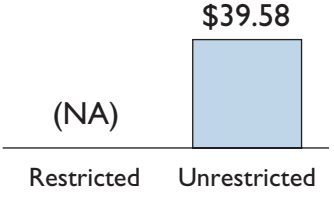
Neurology

n=7



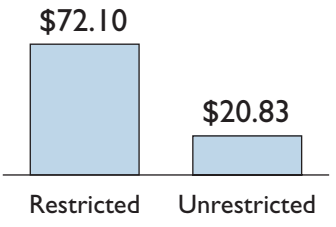
Neurosurgery

n=28



OB/Gyn

n=33

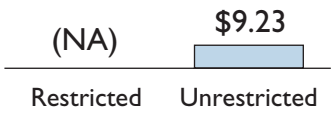


Benchmarks

Hourly Rate

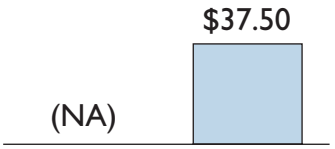
Ophthalmology

n=13



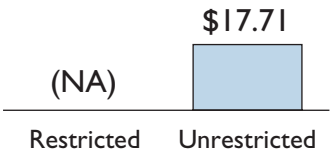
Orthopedic Surgery

n=35



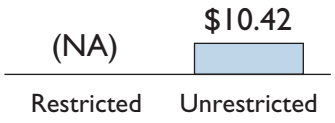
Orthopedic Surgery–Hand

n=8



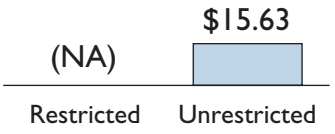
Pediatrics

n=7



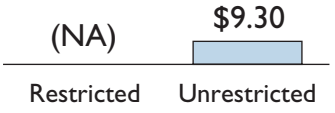
Plastic Surgery

n=13



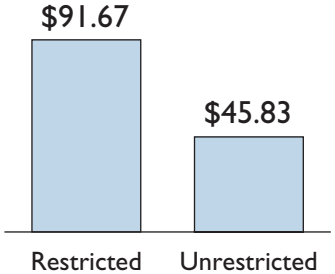
Psychiatry

n=16



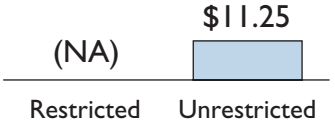
Trauma Surgery

n=30



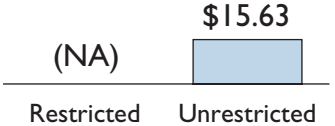
Urology

n=4



Vascular Surgery

n=9



Source: Sullivan and Cotter, "Physician On-Call Pay Survey Report 2006," June 2006..

Tool #5: Physician Employment Toolkit

Specialist Employment Evaluation Toolkit: Overview

Objective

This toolkit assists members in planning and evaluating specialist employment opportunities, as well as executing recruitment, contract development, and performance-audit functions for employed physician roles.

Key Questions Answered

- How can we determine the costs, benefits, and net financial impact of employing a particular physician?
- Under what circumstances might we pursue specialist employment despite a negative financial projection for the hospital?
- How can we determine which physicians within any given specialty will perform well in an employment role?
- How can we ensure employment arrangements remain in compliance with applicable state and federal regulation?
- What features can we include in employment contracts to maximize sustainability and financial upside to the hospital?
- How should we evaluate performance of employment initiatives over time?

Key Participants

- Chief Executive Officer
- Chief Financial Officer
- Vice President/Director of Strategic Planning
- Chief Medical Officer
- Planning and Decision Support Staff
- Financial Analyst(s)

Time to Complete

Total Time	Data Collection	Data Entry and Calculations
2 months	1 month	3–4 days

Worksheets Included

Part I: Evaluating Employment Business Case

- Initial Investment Worksheet
- Pro Forma Cash Flow Worksheet
- Discounted Cost-Benefit Worksheet
- Net Present Value Calculation
- Strategic "Fit" Assessment Worksheet

Part II: Evaluating Employment Candidacy

- Attribute Selection Worksheet
- Behavioral Interview Guide
- Professional Qualification "Red Flag" Questions
- Staff and Peer Evaluation Survey

Part III: Crafting the Employment Contract

- Key Contract Terms
- Compensation Structure Guide
- Productivity Measure Guide
- Primer on Employment-Related Legislation

Part IV: Auditing Performance of Employment Initiatives

- Performance Indicator Compendium
- Performance Dashboard Template

Initial Investment Worksheet

Purpose: This worksheet calculates the total initial investment costs associated with employing a physician. This is the first step in conducting a systematic, quantitative cost-benefit assessment of a specialist employment opportunity.

Instructions:

- Complete the worksheet for each employment candidate. Though only typical start-up expenses are listed, space is provided for additional entries; include all one-time expenses incurred in the employment of a physician.
- Report anticipated expenses precisely, where possible. If an expense cannot be reported precisely, a defensible methodology for estimating the expense should be used and recorded for consistency in future assessments.
- Sum all expenses to Total Initial Investment.

Category	Estimation Methodology	Expense
Candidate Search		
Advertisements (creative and placement costs)		
Search Agency Fees		
Professional Consulting Fees		
Recruitment/HR Staff Hours		
Candidate Screening Process		
Candidate Travel Expenses		
Candidate Lodging Expenses		
Welcome Meals / Events		
Recruitment/HR Staff Hours		
Other Visit Expenses		
Practice Acquisition		
Real Estate Purchase		
Medical Equipment Purchases		
Office Equipment Purchases		
Professional Consulting Fees		
Legal Fees		
Recruitment/HR Staff Hours		
Other One-Time Expenses		
	Total Initial Investment:	

Next Step

Carry forward Total Initial Investment value to Net Present Value Calculation, p. 231, to account for the initial one-time costs of physician employment.

Pro Forma Cash Flow Worksheet

Purpose: This worksheet projects cash inflows and outflows for an employed physician across a three-year period.

Instructions:

- Complete the worksheet for each employment candidate. Use estimated procedural volume, case mix, and reimbursement rates to project Gross Patient Revenue for the physician.
- Enter Adjustment and Expenditure line items as negative numbers.
- Sum all line items for Recurrent Income to project Net Operation Revenue.
- Sum all line items for Recurrent Expenditure to project Total Operating Expense.
- Sum Net Operating Revenue and Total Operating Expense to project Net Cash Flow.

Line Item	Year 1	Year 2	Year 3
Recurrent Income			
Gross Patient Revenue			
Adjustments			
Other Revenue[1]			
Net Operating Revenue			
Recurrent Expenditure			
Salaries and Bonus			
Benefits			
Malpractice Insurance			
Marketing			
Medical Equipment Purchase / Repair			
Practice Leasing Fee			
Administrative			
Other _____			
Total Operating Expense			
Net Cash Flow			

Next Steps

Carry forward Net Operation Revenue and Total Operating Expense values to Discounted Cost-Benefit Worksheet, p. 230. Carry forward Net Cash Flow value to Net Present Value Calculation, p. 231, to determine ongoing costs and revenues associated with employing the physician.

[1] Other Revenue should reflect revenues likely generated by physician employment but not elsewhere recorded. For example, if the candidate will specialize in less-profitable cases to improve the procedure mix of community-based physicians, elective-procedure revenue from independent medical staff might increase as a direct result. The effect of employment on revenue may also be negative. It is important to consider employment's impact on revenue beyond revenue the employed physician generates personally.

Discounted Cost-Benefit Worksheet

Purpose: This worksheet calculates the present value of cash flow for each employment candidate. The results allow a cost-benefit analysis for physician employment that accounts for the time-value of money.

Instructions: Complete the worksheet for each employment candidate. Collect the Annual Operating Expense and Annual Operating Revenue figures from the Pro Forma Cash Flow Worksheet and insert in the appropriate cells of the cost-benefit worksheet.

Key Definitions:

- **Discount Rate:** The rate of return offered by alternative investments. Expected cash flows in the future should be discounted by the "cost of capital." Unless advised otherwise by the Finance Department, use a discount rate between 4% and 7%. It is also recommended to run the calculation twice using different rates (to reflect varying risk levels). (i)
- **Discount Factor:** The ratio that will be used to adjust costs and benefits by the discount rate. (C)

Year 1: $\frac{1}{1+i}$ Year 2: $\frac{1}{(1+i)^2}$ Year 3: $\frac{1}{(1+i)^3}$

- **Discounted Costs:** The present value of recurrent costs during the term of employment. (D) = (A) x (C)
- **Discounted Benefits:** The present value of recurrent revenues during the term of employment. (E) = (B) x (C)
- **Discounted Net Benefit:** The total discounted benefits minus the total discounted costs. (F) = (E) + (D)
- **Benefit/Cost Ratio:** The total discounted benefits divided by the total discounted costs. (G) = (E) / (D)

Note on Usage: Opportunities with a benefit/cost ratio greater than one have greater financial benefits than costs. The higher the ratio, the greater the benefits relative to the costs. The ratio could also be interpreted as the incremental benefit generated per dollar spent. For example, a ratio of 1.50 for employing a neurosurgeon means that each dollar spent on employment generates $1.50 of operating revenue.

	Year 1	Year 2	Year 3	Total
(A) Annual Total Operating Expense				
(B) Annual Net Operating Revenue				
(C) Discount Factor				
(D) Discounted Costs				
(E) Discounted Benefits				
(F) Discounted Net Benefit				
(G) Benefit/Cost Ratio				

Net Present Value Calculation

Purpose: This worksheet calculates the net present value (NPV) of the employment proposal, taking into account the required, pre-employment investments and the discounted cash flows across the expected term of employment. The projections allow members to estimate in advance whether employing a physician will be financially beneficial.

Instructions: Complete the worksheet for each employment candidate.

Key Definitions:

- **Net Cash Flow:** Transfer the figures from Pro Forma Cash Flow Worksheet. (A)
- **Discount Factor:** Transfer the figures from Pro Forma Cash Flow Worksheet. (B)
- **Discounted Net Cash Flow:** The present value of net cash flow over the term of employment. (C) = (A) x (B)
- **Total Present Value[1]:** The sum of the all Discounted Net Cash Flow over the term of employment. (D)
- **Total Initial Investment:** Transfer the figure from Initial Investment Worksheet. (E)
- **Net Present Value:** The Total Present Value minus the Total Initial Investment. (F) = (D) – (E)

Notes on Usage:

- A positive NPV indicates that the proposed employment will generate positive future streams of cash flow and should be accepted on financial merits. If the NPV is negative, then the project probably should be rejected unless the non-financial benefits overwhelm the financial concerns.
- This tool can be used to compare employment candidates with one another—or to compare employment strategy as a whole against other physician alignment strategies—on the basis of financial returns. There may be other compelling reasons to accept or reject an employment proposal—such as likely impact on quality of care, recruitment/retention of existing medical staff, and local competitive position—which are not accounted for in this tool. Members may still consider employing the physician(s) when the NPV is negative, especially as a means to confront the following scenarios and conditions:

☑ Threat of program closure
☑ Threat of key medical staff defection
☑ Substantial coverage shortfall (in ED and community)
☑ Significant decline in overall clinical quality
☑ Potential patient safety concerns
☑ Continued loss of market share in profitable services

Total Present Value Calculation:

	Year 1	Year 2	Year 3	Total
(A) Net Cash Flow				
(B) Discount Factor				
(C) Discounted Net Cash Flow				(D)

Net Present Value Calculation:

(D) Total Present Value	
(E) Total Initial Investment	
(F) Net Present Value	

[1] If medical equipment or other physical assets were purchased during the term of employment, Total Present Value should include the depreciated value of the assets

Strategic "Fit" Assessment Worksheet

Purpose: This worksheet assesses the strength of each employment proposal based on quantitative considerations from a traditional cost-benefit analysis, as well as qualitative considerations from a traditional Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis. The worksheet weighs important strategic implications not typically captured in the financial assessment of an employment proposal, and allows comparison of competing proposals according to objective criteria.

Instructions:

- Complete the worksheet for each employment initiative under evaluation, scoring the initiative for all eight criteria and adding the scores to arrive at a total score.
- If evaluating multiple employment initiatives—or evaluating one employment initiative relative to competing strategic investment opportunities—compare total scores to determine which initiative is most aligned with organizational priorities.

Notes on Usage:

- This worksheet should supplement—not replace—other methods of evaluating an employment initiative.
- Criteria, scoring guidelines, and point allocation on the worksheet are offered as suggestions; members are encouraged to customize the scoring tool to reflect their unique strategic priorities and market dynamics.
- Scores near or above 75 (using current criteria and scoring guidelines) represent a strong fit between the proposal and hospital strategy; this threshold may be used to evaluate the strategic merits of a solitary proposal.

Criteria	Score	≥ $1 M	$600 K – $999 K	$0 – $599 K	<$0
What is the risk-adjusted net present value of this strategy?		20 points	15 points	7 points	0 points
		Strong Position	**Moderate Position**	**Weak Position**	
Is the hospital competitively positioned to execute and benefit from this strategy now?		15 points	5 points	0 points	
		Yes, large opportunity	**Yes, small opportunity**	**No**	
Does the initiative create a new revenue stream for the institution?		15 points	5 points	0 points	
		Yes, large opportunity	**Yes, small opportunity**	**No**	
Does the venture protect existing business from departing the institution?		15 points	5 points	0 points	
		Yes, >10%	**Yes, 0–10%**	**No**	
Does the initiative increase contribution income from a high-priority procedure/ service line?		15 points	5 points	0 points	
		Substantially	**Moderately**	**Not at all**	
Does the initiative increase competitive position, expand geographic presence, or extend brand recognition for a high-priority service line?		10 points	7 points	0 points	
		Substantially	**Moderately**	**Not at all**	
Does the initiative advance clinical quality, service quality, and/or operational excellence?		10 points	5 points	0 points	
		Substantially	**Moderately**	**Not at all**	
Does the initiative strengthen or create strategic alliances/physician "alignment"?		5 points	2 points	0 points	
Total					

Attribute Selection Worksheet

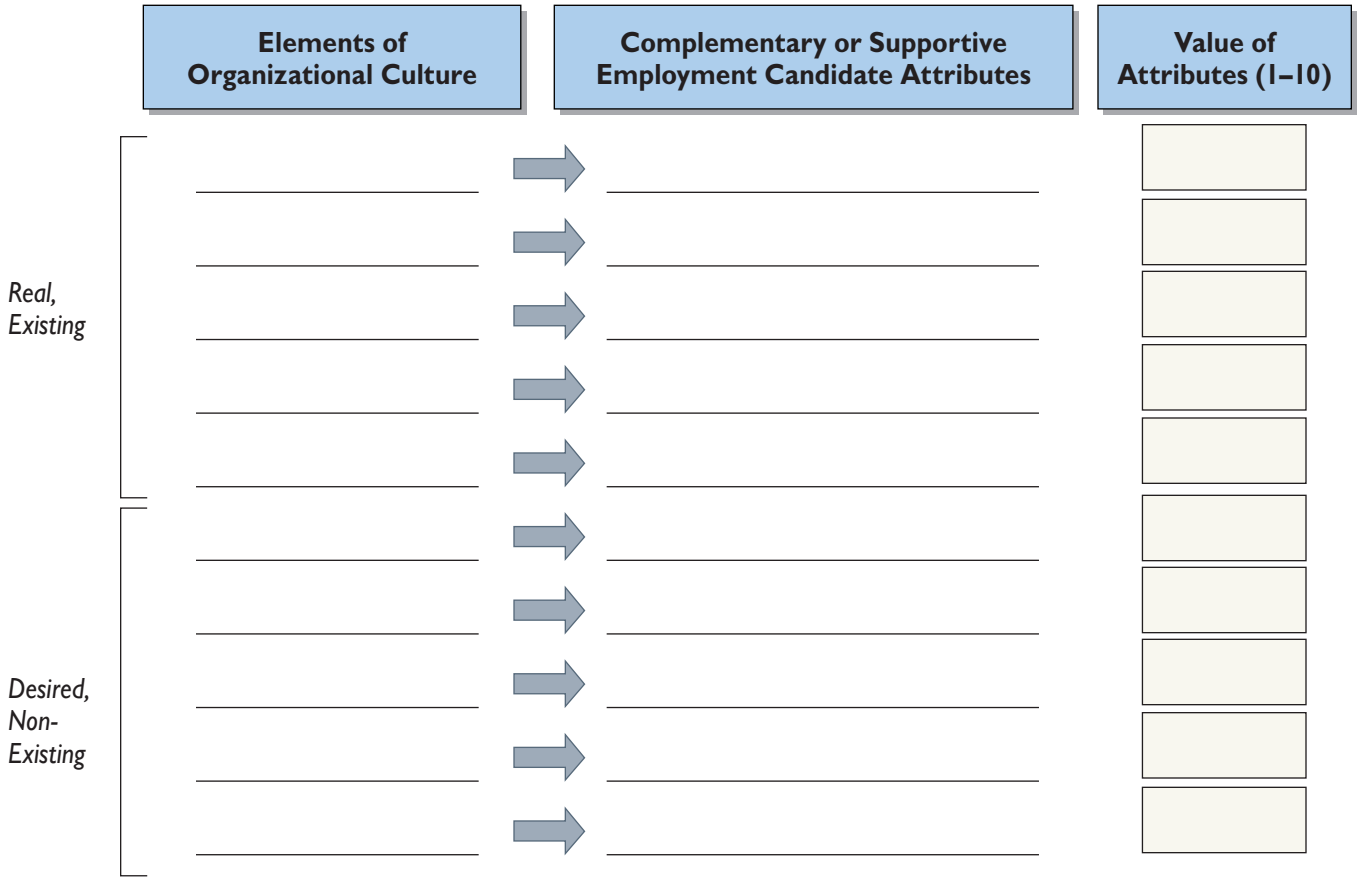
Purpose: This exercise identifies the attributes of a candidate who will fit best in the employed physician role by determining which employee characteristics are most supportive of the hospital's overarching philosophy and strategy.

Instructions:

- List key elements—both real and desired—of the hospital's organizational culture and strategic priorities.
- List key attributes of hospital employees and medical staff members who make positive contributions to the organizational culture and consistently advance the hospital's strategic priorities.
- Assign to each attribute a value, from 1 to 10, reflecting the importance that an employment candidate possess the attribute. A value of 1 represents least importance and value of 10 represents greatest importance.
- Consider all attributes in screening processes for potential new employees, giving most weight to those attributes receiving higher values.

Notes on Usage:

- The "real" elements of organizational culture should accurately reflect the work environment, even if these elements are not considered positive; accuracy is important in this exercise, as employment candidates must be capable of operating within the existing workplace.
- Members may distinguish between essential and preferred characteristics of employees. Essential characteristics include those attributes that are required for a candidate to be considered for employment; if an essential characteristic is not exhibited by a candidate, the physician should—under no circumstances—be offered a contract. For example, "commitment to clinical excellence" will be considered essential for most members.



Behavioral Interview Guide

Purpose: This guide helps evaluate whether a physician being considered for employment will thrive in the employment context. Sample behavioral interview questions are designed to determine both how well the physician is likely to adapt to an employment contract, and how well the physician is likely to fit within the organizational culture.

Instructions:

- Use the guide as a template for behavioral interview questions during interviews with employment candidates.
- Build upon the suggested Evaluation Criteria with the Complementary Employment Candidate Attributes identified in the previous exercise. Then supplement the guide with additional interview questions and Elements of Desired Response to isolate the physician characteristics and aptitudes that represent ideal candidacy for employment.
- Track the frequency with which the candidate responses include elements of desired response.

Behavioral Interview Guide

Evaluation Criteria	Sample Questions	Elements of Desired Response
Readiness for Integration	• Describe why you might consider employment. And why now? • Pretend you joined our hospital and it's a year from now. You are happy. Why is that? • What are your biggest concerns about becoming an employed physician?	• Recognizes differences between being in private practice and being an employed physician • Shows enthusiasm or openness to joining the hospital on a full-time basis • Describes perceived benefits of hospital employment clearly, providing evidence for cooperation on hospital initiatives
Long–term Commitment to Community	• Describe why you choose this community as a place for work and residence. • What do you feel are the most important contributions you have made to your practice and community during the last 1–2 years (if applicable)? Why did you get involved? • Describe the level of your involvement in your community.	• Shows clear commitment to and interest in the community in the long run • Demonstrates sufficient support circle rooted in the community • Feels responsible for the well-being of community members
Personality	• What do those who work with you like best about you? Least? • What do you think are the most important qualities of being a doctor other than clinical excellence? • Tell me about what you like to do when you are not working. What is important to you? What do you do to relax?	• Shows appropriate level of self-confidence and trustworthiness • Maintains a well-rounded view of the physician role • Values productivity • Seeks opportunities for involvement in broader staff initiatives • Demonstrates ability in conducting self-care and relieving stress
Professional Conduct	• Describe a time when you disagreed with an organizational policy/procedure. What was the policy/procedure and what did you do to resolve the conflict? • Describe the last time you had a conflict with staff members and nurses. What happened and how did you resolved it? • Describe the last difficult patient you encountered. How did you handle the situation?	• Respects divergent viewpoints and is able to work calmly through conflicts using logic and communication • Understands, interprets and consistently applies the organization's policies and procedures • Communicates with staff members and nurses in a cooperative, positive fashion • Promotes collaboration and teamwork • Conducts self in a manner that fosters patient satisfaction, trust and loyalty to the practice/institution
_____	• _____ • _____ • _____	• _____ • _____ • _____

Professional Qualification "Red Flag" Questions

Purpose: This checklist scrutinizes an employment candidate's professional qualifications. A detailed examination of past performance lapses and disciplinary actions is necessary to eliminate from consideration those candidates who pose a threat to clinical quality or medical staff relations.

Instructions: Research the following key questions and answer by placing check marks in the appropriate columns. Any unexplained "yes" response suggests questionable professional qualifications and should be interpreted as a serious obstacle to employment. If comparing multiple candidates, the candidates with fewer "yes" responses are likely to carry less liability.

Questions for Evaluation		Yes	No
#1	Has the candidate ever been subject to any disciplinary action (such as admonition, reprimand, suspension, reduction, or termination of privileges) by any medical institution?	☐	☐
#2	Has the candidate ever been subject to any disciplinary action by any regulatory agency?	☐	☐
#3	Has the candidate ever been subject to any disciplinary action by any professional society?	☐	☐
#4	Has the candidate's request for professional status (such as medical license, clinical privileges, hospital staff membership, or employment) ever been denied?	☐	☐
#5	Has the candidate's professional status ever been investigated, reduced or placed under supervision?	☐	☐
#6	Has there ever been evidence of a pattern of deficiencies regarding the candidate's clinical ability or knowledge?	☐	☐
#7	Does the candidate have any mental or physical illness that have or could potentially impair ability to exercise all or any of the professional duties (both administrative and clinical)?	☐	☐
#8	Does the candidate have any substance (including drugs and alcohol) addiction that have or could potentially impair ability to exercise all or any of the professional duties (both administrative and clinical)?	☐	☐
#9	Has the candidate ever been involved in a claim for professional negligence, settled or pending?	☐	☐
#10	Has the candidate ever been involved in any other claims, lawsuits, criminal activities, or investigations that affect professional relationships or qualifications?	☐	☐
	Total	____	____
	(tally responses above)		

Staff and Peer Evaluation Survey

Purpose: This worksheet facilitates the assessment of an employment candidate's qualifications from the perspective of the hospital staff members and peer physicians with whom the candidate interacts (or has interacted).

Instructions:

- Staple a self-addressed, stamped envelope to 10 copies of the evaluation worksheet.
- Instruct the candidate to distribute the worksheet among peer physicians and clinical support staff (especially nurses) with whom he/she interacts most frequently in a professional context—regardless of whether these individuals work at your facility. Reviewers should be asked to complete and mail the form within one week.
- When you have received all responses, review qualitative feedback and tally the scores on each worksheet related to the physician's performance and behavior. Average the scores to get an overall performance score.
- Weigh responses to determine the degree of "fit" of the candidate within the organizational culture.

Notes on Usage:

- This tool should supplement, not replace, the other candidate screening tools.
- Members should allow for possible bias in evaluations from family members, friends, and business partners.
- Members may choose to eliminate the top and bottom scores from the assessment as outliers to reduce risk of bias.
- The tool is less applicable to/for physicians who are just completing medical training.
- The closer the total score is to 100, the more favorable the peer review and the better the potential fit of the physician within the organization.

Staff and Peer Evaluation Survey

Candidate Name: _____ Reviewer Name (Title): _____

Candidate Specialty: _____ Reviewer Specialty/Department: _____

Reviewer Place of Work _____

Reviewer Contact Information _____

- How long—and in what capacity—have you known the candidate? _____
- During what time period did you have the opportunity to directly observe the candidate's practice of medicine?

  From: _____ To: _____

  _____

- Describe any strengths observed with regard to the candidate's manner of practice and adherence to ethical standards:

  _____

  _____

- Describe any weaknesses observed with regard to the candidate's manner of practice and adherence to ethical standards in light of his/her level of training, experience, and background. Circle a grade for the candidate's performance in each category along the scale. (1 being Poor, 10 being Superior.)

  _____

  _____

Clinical Ability

Medical Knowledge in Specialty	1	2	3	4	5	6	7	8	9	10
Clinical Technical Competence	1	2	3	4	5	6	7	8	9	10
Professional Judgment	1	2	3	4	5	6	7	8	9	10
Ethical Conduct	1	2	3	4	5	6	7	8	9	10

Professional Conduct

Physician-Administration Relationship	1	2	3	4	5	6	7	8	9	10
Physician-Patient Relationship	1	2	3	4	5	6	7	8	9	10
Physician-Colleague Relationship	1	2	3	4	5	6	7	8	9	10
Physician-Staff Relationship	1	2	3	4	5	6	7	8	9	10
Attendance at Meetings	1	2	3	4	5	6	7	8	9	10
Involvement in Hospital Committees	1	2	3	4	5	6	7	8	9	10

Key Contract Terms

Purpose: This tool lists key sections and provisions that should be at least considered for—and ideally integrated into—employment contracts to maximize upside of physician employment.

Instructions:

- Read through contractual elements listed in this tool with legal counsel, and any parties responsible for the organization's employment of physicians, specifically the structuring or negotiation of employment contracts; for example, the Vice President of Human Resources, the Chief Financial Officer, and Chief Medical Officer.
- Check the box in each section once you have considered the corresponding features and updated or added to the language of employment contracts (as appropriate).

☐ Section: Compensation

Description: This section documents key considerations related to physician salary and benefits.

Key Features/Clauses of Best-Practice Contract:

- **Compensation Plan:** The contract should contain a clear description of the amount of annual base compensation, eligibility for bonus compensation, and means of payment (monthly, weekly, etc). It is common for institutions to attach an exhibit outlining this information. If the contract has a multiyear term, whether and to what extent the employee physician's compensation will change in subsequent years should also be addressed.
- **"No Remuneration for Referrals" Term:** Both parties must agree that compensation levels are at fair market value and that nothing in the contract is intended to encourage or permit any remuneration for induced referrals. This protects both parties from self-referral/anti-kickback legal liability.
- **Benefits:** Common benefits include family health insurance, dental insurance, life insurance, an allowance for continuing medical education (CME), paid time off or vacation and sick pay, short-term disability insurance, long-term disability insurance, annual allowance for professional dues and subscriptions, and retirement plans.
- **Professional Liability Coverage and Tail Coverage:** The employer typically covers medical malpractice coverage during the term of employment. While many institutions do not provide tail coverage for physician's previous practice (and require the physician to present a certificate of insurance as evidence of the physician coverage before commencing employment), the party responsible for tail coverage for periods before and after the employment term should be addressed in this section to avoid future confusion.

Note: Some institutions, especially those in rural areas, offer physician relocation incentives. Both parties should review such incentives carefully to ensure that they are permitted under federal law and are clearly articulated in the contract.

☐ Section: Ownership of Assets

Description: This section covers the assets that the institutions and the physicians bring to the employment agreement and specifies the ownership of those assets throughout the employment term and after the termination of employment term.

Key Features/Clauses of Best-Practice Contract:

- **Medical Records, Charts and Files:** All records and files concerning patients of the institution should belong to and remain the property of the institution. However, the contract should include language to provide reasonable physician access to the records if access is necessary for defense in professional investigations such as malpractice action, a credential committee investigation, or a Board of Medical Practice inquiry.
- **Research:** If the physician performs research, publishes books, or publishes papers during work time or after hours during the employment term, the research results, the written materials, or resulting patents should be the property of the institution.
- **Physical Assets:** The contract should specify ownership of all physical assets including equipment, supplies in the period after termination of employment.

Key Contract Terms

❑ Section: Term and Termination

Description: This section clarifies the duration of employment and denotes explicit events that could trigger termination of the employment contract by either the institution or the physician, both with cause and without cause.

Key Features/Clauses of Best-Practice Contract:

- **Duration:** The contract should have a starting and ending date, and should specify whether the contract is automatically renewed at the ending date. Typically, the initial term is set at two years, with clauses for termination.
- **Market Condition Clause:** This clause allows the institution to respond and adjust to changes impacting all health care providers. This clause could give the institution the exclusive right to reassign the physician to a different department or facility, alter the physician's work schedule, and make any other changes in the conditions of the physician's employment according to the needs of the organization. A less aggressive version of the clause allows for renegotiation of the contract. The contract should have language dealing with potential dispute-resolution methods such as mediation or arbitration should disputes arise.
- **Termination For Cause:** Termination-for-cause provisions allow the institution to immediately terminate the physician's employment if certain events occur, and are based on a variety of reasons related to job qualification or performance (also include lack of fitness to practice medicine) and conviction of felony.
- **Termination Without Cause:** Most institutions include without-cause termination clause in the contract to maintain flexibility for both parties. This provision states that the employment contract may be terminated by either party for no specific reason by providing prior written notice to the other party within a specified timeframe, which is usually 90 days.

❑ Section: Employee/Employer Responsibilities

Description: This section details responsibilities of both the institution and the physician, including professional duties and decision powers over future purchase of assets and staffing.

Key Features/Clauses of Best-Practice Contract:

- **Physician Responsibilities:** A complete job description for the physician might be included to articulate professional requirements and expectations. Details such as the number of hours the physician is expected to work, particular hours or days that the physician will work, and call coverage obligations should be specified. In addition to professional responsibilities, this section typically includes the institution's expectation of physician cooperation with strategic and operational initiatives (i.e. completion of any billing and collection paperwork, participation in quality improvement projects, etc.).
- **Performance Evaluation:** The contract may include the general evaluation criteria, such as quality of medical services provided, frequency of patient complaints, productivity in terms of patients seen per day, and contributions to the institution's operations (including committee work, teaching duties, or community activities), in addition to frequency of the evaluation process.
- **Institution's Responsibilities:** The institution might provide and/or purchase office space, support staff, supplies and establish payment rates with payers. Most institutions also reimburse professional expenses incurred by the physician.

Key Contract Terms

❑ Section: Non-Compete/Non-Solicitation Covenants

Description: This section, also known as Restrictive Covenants, contains provisions designed to protect the business interest of the institution by preventing the physician from competing with the institution in a specific geographic area (usually a radius of between five and 50 miles) for a specific period of time (usually one or two years.)

Key Features/Clauses of Best-Practice Contract:

- **Outside Employment or Moonlighting:** The contract should contain language to detail conditions (if any) under which allowance for outside practice is to be approved during the term of employment and to clarify whether compensation from such activities belongs to the institution or the physician.
- **Non-Compete Clause:** This clause prohibits the physician from directly or indirectly providing services substantially similar to those provided at the institution in competition for patients or revenues in the same general locale for a specific period of time following termination of employment.
- **Non-Solicitation Clause:** This clause prohibits the physician from soliciting patients and other employees of the institution for a specific period of time following termination of employment. Some institutions use this clause as a substitute for a non-compete agreement while others include this in addition to the non-complete clause.

Note: While enforceability of non-competition covenants varies by state, a clause that restricts competition is enforceable only if the terms are clearly drafted and reasonable. For example, a non-compete area within a radius of 25 miles may be appropriate for a neurosurgeon in the rural setting but not appropriate nor fair for a primary care physician in the urban environment.

Compensation Structure Guide

Purpose: This guide is an overview of major compensation methodologies for employed physicians. The guide is meant to help members evaluate each compensation model on its benefits and drawbacks—especially those related to productivity— to decide which best suits hospital and physician needs.

Instructions: Review the outlined compensation structures—weighing benefits and drawbacks of each—and select the structure most appropriate for the employment proposal at hand.

	Compensation Structure			
	Flat Rate	**Salary Plus Bonus**	**Salary Plus Percentage of Collections Minus Cost**	**100% Productivity**
Description	Physician paid annual salary regardless of productivity	Predominantly flat salary with bonus opportunity based on quality and/or productivity measures	Predominantly flat salary supplemented by significant bonus dependent on practice profitability	Income based solely on amount of patient services rendered
Sample Terms	75th percentile annual compensation reported for specialty in national surveys (MGMA, AMGA, etc.)	70–90 percent flat salary; 10–30 percent bonus determined by physician performance on productivity and/or quality measures	70 percent flat salary; 30 percent bonus paid if net profit achieved from practice	Compensation based on practice revenues less practice costs
Pros	• Easier to recruit new physicians with guaranteed income • Easy to implement and manage compensation	• Focuses physician attention on patient care and/or productivity • Offers physician with less profitable payer mix significant financial security	• Physician at risk for payer mix • Promotes physician attention to practice costs	• Rewards greater productivity and patient volume • Maintains private practice compensation model
Cons	• No rewards for physician behavior • Hospital *may* pay more than physicians net in private practice • Physicians often less productive	• Too little money devoted to incentives to meaningfully affect physician behavior • Hospital assumes risk for payer mix	• Significant effort required to accurately measure practice cost • Practice cost allocation contentious between hospital and physicians	• Does not compensate for time spent on non-clinical, indirect care tasks (e.g., guideline development) • Requires that physicians trust hospital managers
Strategic Rationale	Recommended for short-term use when transitioning physicians into new market	Recommended for specialists whose payer mix is heavily weighted toward managed care, though whose services are necessary for coverage *Example: Less profitable specialists including internal medicine, OB/Gyn, pediatrics*	Recommended for in-demand specialists who are typically financially successful in the community *Example: Profitable specialists including CT surgery, general surgery, endocrinology*	Recommended for entrepreneurial physicians to align with the hospital in growth areas *Example: Most profitable specialists including neurosurgeons, cardiologists, and uro-gynocologists*

Productivity Measure Guide

Purpose: This guide provides an overview of productivity measures that can be used to determine variable compensation for employed physicians. The measure(s) used to determine variable pay should reflect performance against goals of strategic primacy to the hospital—such as volume or net revenue—and should also lie within the control of the employed physician.

Instructions: Review the outlined productivity measures—weighing benefits and drawbacks of each—and select a measure (or measures) to be used in compensation scheme.

Notes on Usage:

- Only well-defined, quantifiable measures should serve as the basis for productivity-based pay.
- Productivity incentives may vary among employed physicians due to personal and professional differences, as well as program-specific hospital priorities.

	Productivity Measure				
	Patient Encounters	**Gross Charges**	**Net Revenues**	**Net Revenues Minus Expenses**	**Relative Value Units**
Description	Number of documented, face-to-face encounters between physician and patients per unit of time	Gross patient charges billed at established rates prior to any adjustments (charitable, contractual, employee discounts, bad debt, or other)	Actual dollar amount collected that is attributed to a physician for professional services; based on gross charges minus contractual adjustments and any bad debt	Total collections minus all costs incurred by the physician in revenue-generating activities	Work component of the Resource-Based Relative Value Scale (RBRVS) which reflects the time, skill, effort, and judgment involved in performing clinical services
Pros	• Easily tracked and measured • Benchmarking data widely available • Provides incentive to maximize patient visits	• Easily tracked and measured • Benchmarking data widely available • Provides incentive to maximize payer mix, case mix, volume	• Provides incentive to maximize payer mix, case mix, volume • Provides more accurate reflection of hospital income generated by physician	• Best alignment with system incentives • Exposes physician to market forces in private practice-like environment	• Accounts for skill required and time spent in patient care • Provides incentive to maximize case mix, time in patient care
Cons	• Does not reflect level of technical complexity • Does not reflect payer mix, case mix, revenue, or profit	• Does not reflect adjustments to charges or costs of care • Requires significant modification if fee schedules are changed	• Does not reflect costs of care • Benchmarks not widely available	• Depends on system ability to accurately track costs on physician level • Physicians need to have trust in system administrative and cost-allocation efforts	• Requires accurate coding at high level of detail • Does not reflect payer mix • Benchmarks not widely available

Source: Clinical Advisory Board interviews and analysis.

Primer on Employment-Related Legislation

Purpose: This guide provides a brief overview of key federal legislation governing the structure and incentive models of physician employment contracts. The guide is by no means exhaustive, and members are encouraged to consult legal counsel concerning the structure of all physician employment contracts.

Instructions: Review outlined legislation and consider implications for employment-related strategies— employment contract structure in particular— to ensure compliance.

Key Stark Law Considerations

42 USC §1395nn / 42 CFR 411.357 (c)

Rationale: Prohibits physician referrals to entities with which they have a financial relationship

Penalty: Civil penalties up to $15,000 per service plus twice the reimbursement claimed; may be excluded from participating in Medicare and Medicaid

Employment-Related Provisions in Brief:

✓ Statute contains special exceptions for employed physicians

✓ Employment contracts must be for specifically identifiable service

✓ Incentive pay generally permitted for personal productivity—not departmental productivity

✓ May not take into account volume or value of referrals to hospital or department

✓ Employment contract must be commercially reasonable, with salary at fair market value

✓ Statute strictly interpreted; "inadvertent" violations prosecuted

✓ Limited CMS guidance available via case law or advisory opinions

Relative Risk in Physician Employment ●●○○○

Key Anti Kickback Considerations

42 USC §1320a-7b(b) / 42 CFR 1001.952(i)

Rationale: Prohibits direct and/or indirect incentives which could induce a health care provider to generate Medicare or Medicaid referrals to a particular hospital

Penalty: Felony; $25,000 criminal fines, five years in prison; up to $50,000 civil fine, exclusion from participation in any federal health care program

Employment-Related Provisions in Brief:

✓ Statute contains broad exception for all "bona fide" employees

✓ Fair-market salary not expressly required

✓ Payments based on RVUs generally acceptable

✓ Employment offers involving the purchase of a physician practice must be focused on value of assets—not future income stream

✓ Successful prosecution of an institution must show "intent" to violate; a higher standard than Stark

Relative Risk in Physician Employment ●○○○○

Primer on Employment-Related Legislation

Key Gainsharing Considerations

42 USC §1320a-7a(b)(1) &(2)

Rationale: Prevents hospital inducements to physicians that could: 1) effectively reduce patient services; 2) promote "cherry picking;" 3) promote unfair competition and referrals

Penalty: Civil monetary penalty of up to $2,000 per patient, loss of right to be participating provider

Employment-Related Provisions in Brief:

✓ Has been interpreted to prohibit providing physicians with a percentage of hospital costs savings, bonuses for use of less costly supplies

✓ Extremely narrow exceptions

✓ Limited number of programs approved by OIG to date

✓ Hospitals reluctant to implement gainsharing programs given limited number of narrow rulings

✓ Legislation currently under consideration to expressly permit gainsharing under statutorily defined circumstances

Relative Risk in Physician Employment ●●●●○

Key 501(c)3 Status Considerations

Treasury Regulation §53.4958

Rationale: Ensures that non-profit entities do not end-run their favorable tax status by directing excessive monies to key stakeholders

Penalty: Loss of non profit status, IRS fines

Employment-Related Provisions in Brief:

✓ Prohibits private inurement to employees based upon hospital net earnings

✓ Permits incentive compensation if structured around 12 statutory safeguards

✓ Applies to employees exercising substantial influence over organization

✓ Employees may receive pay only for work actually performed

✓ Compensation standards judged by a "reasonable for industry" standard

✓ IRS perceived as less restrictive than CMS

Relative Risk in Physician Employment ●○○○○

Legal Disclaimer

The above overview should not be relied upon as legal authority. The Advisory Board does not provide legal advice and recommends that all members obtain counsel from a licensed attorney prior to entering into any employment arrangements or contracts.

Performance Indicator Compendium

Purpose: This catalog provides a menu of critical performance indicators for employed physicians. A select subset of indicators may be used to create a robust performance dashboard for tracking and modifying the performance of employed physicians—as well as physician strategy in general—over time.

Instructions:

- Select 10 to 15 metrics from the catalog to track; selected metrics should reflect key strategic priorities of the institution as well as operating indicators of critical importance (e.g., malpractice insurance costs).
- Add and customize metrics as appropriate

Note on Usage: Financial performance and productivity indicators are the most important metrics to monitor, as they reflect the ultimate financial sustainability of physician employment.

Metric	Suggested Frequency	Rationale for Inclusion on Employment Dashboard
Financial Performance and Productivity		
Physician salary, wages, and benefits as a percentage of operating expense	Quarterly	Places total compensation expense in context of overall operating expenses
Physician salary, wages and benefits as a percentage of operating revenue	Quarterly	Places total compensation expense in context of institution's financial ability to provide compensation
Total malpractice insurance costs	Quarterly	Key financial and quality measure for employed physicians
Total benefit expense per employed physician	Monthly	Easy measure for communicating benefit costs to physicians and senior board members
Gross charges billed per employed physician	Monthly	Basic physician productivity indicator
Net revenue per employed physician	Monthly	Productivity indicator accounting for contractual adjustments
Operating revenue per employed physician	Monthly	Productivity indicator accounting for contractual adjustments and operating expenses
Operating margin from employed physicians	Monthly	Profitability indicator summarizing the overall financial state of employment strategy
Supply cost per employed physician	Monthly	Tracks medical supply cost and highlights over- and underutilization
Physician employment budget as a percentage of total operating expense	Quarterly	Provides context for institutional investment in physician employment
Budget expense per employed physician	Quarterly	Measures employment budget efficiency and tracks costs per physician
Physician employment budget variance	Monthly	Gap-to-target measure clearly communicates if meeting or exceeding budget on employed physicians
Recruiting cost per employed physician	Quarterly	Examines cost-effectiveness of recruiting; may indicate need to identify more cost-effective recruiting methods

Performance Indicator Compendium

Metric	Suggested Frequency	Rationale for Inclusion on Employment Dashboard
Service and Quality Performance		
Employed physician satisfaction scores	Semi-annually/ Annually	Leading indicator for duration of employment arrangements
Patient satisfaction scores	Semi-annually/ Annually	Tracks employed physicians' impact on patient satisfaction
Staff satisfaction scores	Semi-annually/ Annually	Tracks employed physicians' ability to work with staff and nurses
Peer review scores	Annually	Tracks employed physicians' ability to work cooperatively with the larger medical staff
Severity-adjusted average length of stay (ALOS)	Quarterly	Key financial and productivity indicator
Total unadjusted mortality associated with employed physicians	Quarterly	Major focus of consumers, insurers, and public health agencies on the local and national level
Nosocomial infection rate of employed physicians	Quarterly	Nosocomial (facility-acquired) infections have a significant impact on cost and quality of care; tracking infection rates identifies potential problems in the surgical practice for selected procedures
14- and 31-day readmission rate associated with employed physicians	Quarterly	Unscheduled readmissions for same or related condition have significant impact on cost, quality of care, and patient wellness
Medication errors of employed physicians	Quarterly	Though less costly on an individual basis than nosocomial infections, medication errors are more common and suggest communication breakdowns among clinical staff
Patient falls associated with employed physicians	Quarterly	Proxy for quality of care; patient falls also affect the cost of care provided

Performance Dashboard Template

Purpose: This dashboard template provides a framework for tracking the performance of employed physicians, as well as the effectiveness of employment initiatives as means to achieve overarching strategic goals, on an ongoing basis. The performance dashboard should distill key financial and operating indicators to create a "snapshot" of the overall health of employment initiatives, and provide early warning of potential performance downturns that warrant corrective action.

Instructions:

- Select a set of performance indicators from the Performance Indicator Compendium. Measures should map to overarching organizational strategies, and reflect key financial and operational targets for physician and organizational performance. List indicators down the left-hand column.
- Limit the list of indicators to 10 to 15 metrics with limited redundancy to facilitate "big picture" awareness.
- Complete the remainder of the dashboard.
- Update "Current Performance" (and where possible, "Independent Physician Performance") monthly, and compare to Independent Physician Performance, Short-Term Goals, and Long-Term Goals.
- Discuss with key strategy leaders the ramifications for performance above and below target levels, including the potential for exiting, altering, or expanding employment initiatives to enhance organizational performance.
- Update dashboard metrics and targets as needed—notably, when system strategy and market dynamics change.

Key Definitions:

- **Remedial Action Threshold:** The "trigger point," or quantifiable performance level that, when transgressed, initiates immediate corrective action. The threshold may be "fixed" or "relative." Fixed targets are unchanging and provide an objective indication of performance and rate of improvement (or deterioration) across time. Fixed targets are most critical for indicators for which there is a distinct and indisputable performance level that must be met, such as an operating margin. Relative targets are variable and often measure deviation from mean performance. Relative targets work best for indicators that measure trends, such as patient or staff satisfaction
- **Independent Physician Performance:** Performance of non-employed physicians, included to provide perspective and to act as benchmark.

Notes on Usage:

- Indicators listed in the template that follows are for illustrative purposes only. Members are encouraged to select and track the indicators that best reflect the strategic goals and operating indicators that the employment initiative is meant to advance. The mix of metrics selected will likely be unique to the institution. See Performance Indicator Compendium.
- Include specific performance targets which, when crossed, trigger immediate action.
- Incorporate industry-wide and institution-specific physician performance benchmarks, where possible, to ensure that employment of physicians continues to be strategically sound over time.

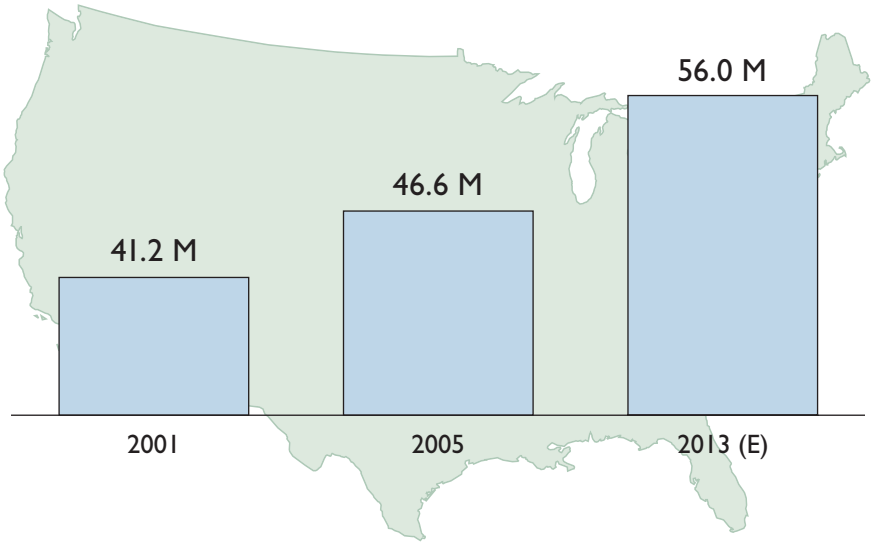
Performance Dashboard Template

Month / Year:_____

Performance Dashboard: Employed Physicians						
Indicators	**Current Performance**	**Baseline Performance**	**Independent Physician Performance**	**Remedial Action Threshold**	**Short-Term Goal (Performance target/deadline)**	**Long-Term Goal (Performance target /deadline)**
Financial Performance and Productivity						
Physician employment budget as a percentage of total operating expense			N/A			
Physician employment budget variance			N/A			
Physician salary, wages, and benefits as a percentage of operating expense			N/A			
Total malpractice insurance costs			N/A			
Operating revenue per employed physician						
Operating margin from employed physicians						
Supply cost per employed physician						
Service and Quality Performance						
Patient satisfaction						
Severity-adjusted average length of stay						
Nosocomial infection rate						

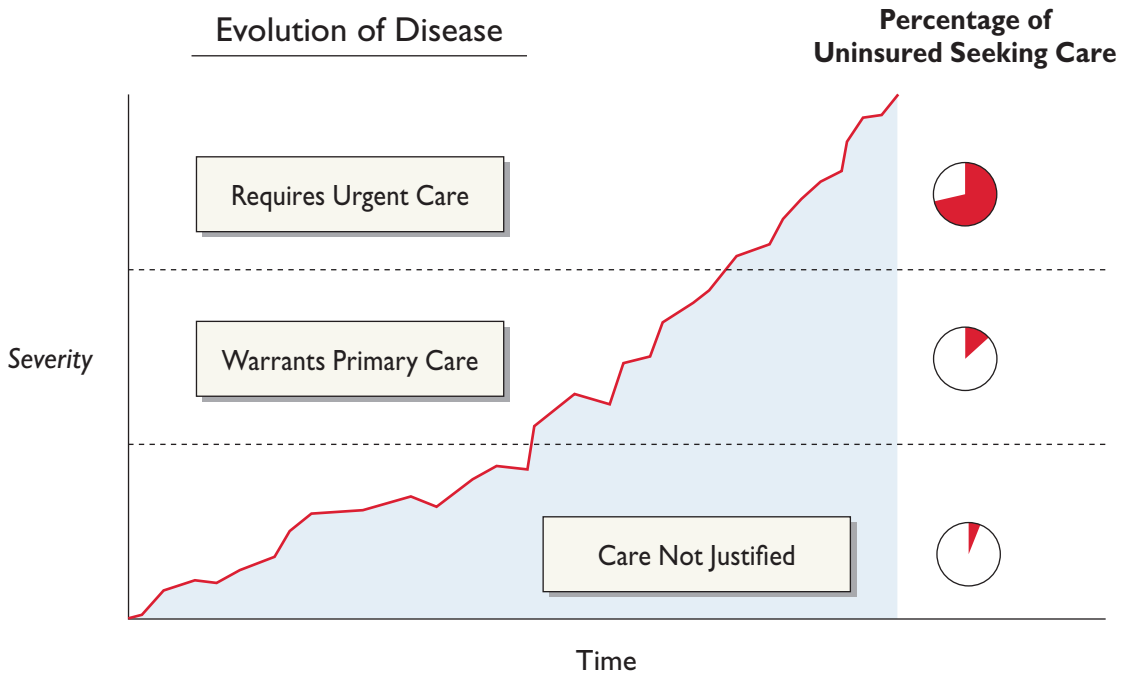
An Ever-Expanding Burden

Number of Uninsured in the United States



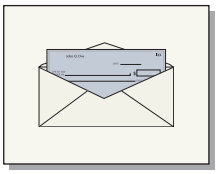
Source: US Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," available at: http://www.census.gov/prod/2006pubs/p60-231.pdf, accessed March 9, 2007; Gilmer T, et al., "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs Web Exclusive*, April 5, 2005, available at: http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=uninsured+2013&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT, accessed March 9, 2007.

Frequenting the ED



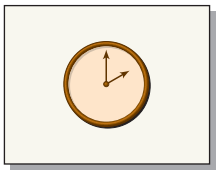
Can You Really Blame Them?

Deterrents to Seeking Primary Care



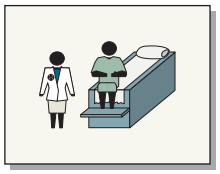
Expense

Without insurance to cover the cost of treatment, uninsured unlikely to be able to afford medical care



Time

Treatment options for uninsured are often over-crowded, resulting in very long wait times



Fear of the Unknown

Patients with poor primary care suffer from worse diagnoses, encouraging them to accept the relative comfort of ignorance

Source: Clinical Advisory Board interviews and analysis.

Motivated by Rising Costs

Case in Brief

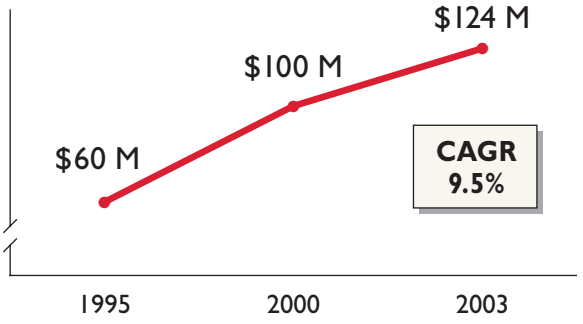
Seton Family of Hospitals

- 1,040-bed, six-hospital system in Texas
- Workgroup created to address rising unfunded patient costs

Indigent Care Workgroup

- Diagnosis and Therapeutics Directors
- Access Director
- Billing Director
- Hospital VP
- Health Plan Director

Unfunded Patient Costs



Source: Clinical Advisory Board interviews and analysis.

Frequent Fliers Target ED

A Snapshot of One Frequent Visitor

Five ED visits in less than two months

Mr. Peters		
Date	**Diagnosis**	**Location**
2/2/04	Acute URI	Hospital A ED
2/20/04	Bronchitis	Hospital B ED
3/9/04	Backache	Hospital B ED
3/11/04	Lumbago, Hypertension	Hospital B ED
3/11/04	Skin Disturbance	Hospital A ED

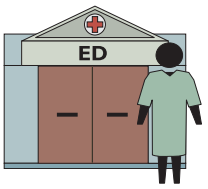
Path of Least Resistance

"When we looked at the patients who were frequenting our emergency rooms, we found that many underfunded patients with limited access to care were taking the path of least resistance by coming to our hospitals, where the barriers to care were the lowest."

Diana Resnik, VP of Community Care
Seton Family of Hospitals

Source: Clinical Advisory Board interviews and analysis.

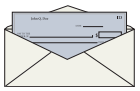
Directing Resources to the Most Needy



Identifying Frequent Fliers

- ☑ Patients with six or more ED visits per year
- ☑ Patients with three or more inpatient visits per year

Take calls from patient to evaluate acute care needs and direct to most appropriate care setting

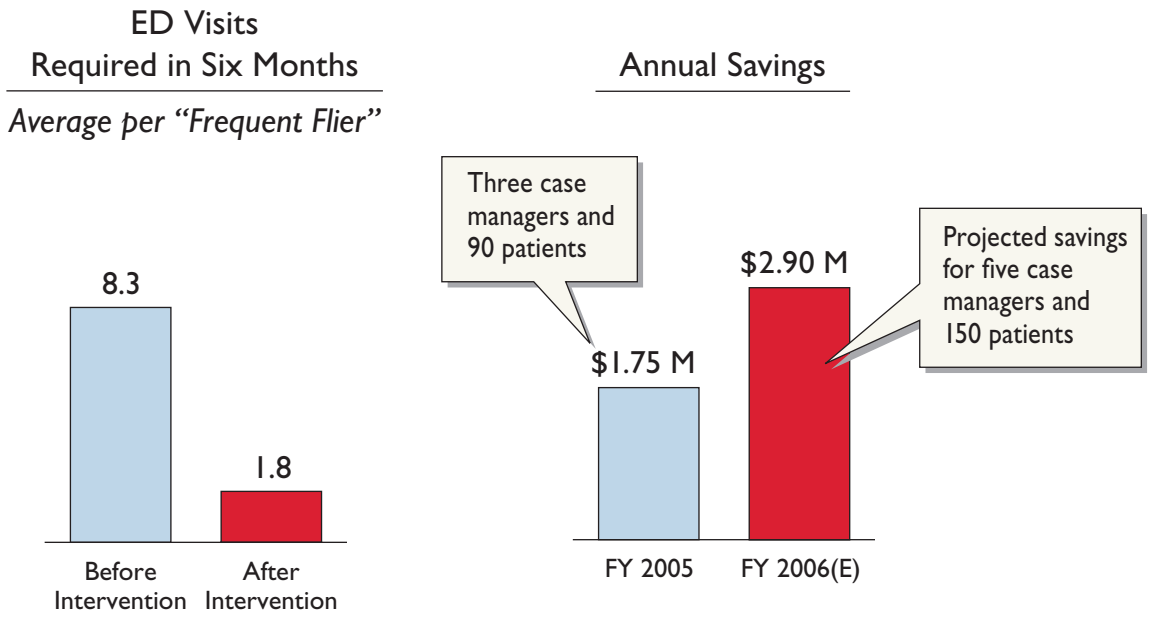


Help pay for medical equipment and medication when necessary

Refer stable patients to Seton's Community Clinics to manage chronic conditions

Source: Clinical Advisory Board interviews and analysis.

Reducing Visits and Costs



Source: Clinical Advisory Board interviews and analysis.