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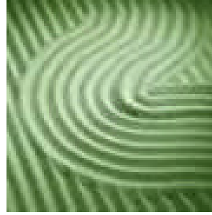

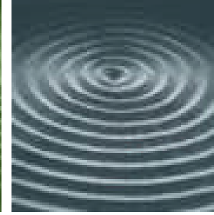

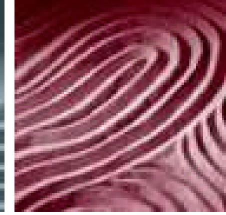

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Contractualizing physician relationships in a healthcare setting according to performance standards and objectives

Dr. Isser Dubinsky
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Any healthcare organization (whether acute, chronic, or long-term care, hospital or community based) must articulate its corporate and organizational goals before embarking on recruitment of physicians. The recruitment process should be based on the community's assessed need, not on defined "ratios" of service providers per population. Furthermore, the recruitment process should mirror the resources (both capital and operating) available to the institution, rather than reflecting physician needs for income, or oncall activities.

The need for service should be matched with a best practice model of service delivery. This will further assist in avoiding the recruitment of too many or too few health care professionals to the area, no matter which professional discipline they represent. Applying the best practice model helps the community determine more accurately not only the number of healthcare providers it needs, but also the infrastructure support necessary (including beds, capital equipment, and support staff) as well as clearly articulating the anticipated operating costs of the recruitment.

Once this mapping has occurred, the number of unfilled positions should be annotated. Those calculating this number should take into account not only current, but also future needs. This requires a detailed examination of the local demographic area, including plans for industrial expansion or plant closures, as well as an evaluation of potential regional affiliations for health service delivery.

Before undertaking the recruitment process, the organization must develop a comprehensive and clearly articulated job description. This should include not only the clinical requirements (including hours and types of service), but also the research commitment expected (including whether the individual recruited is to initiate, participate in, or co-ordinate research activity), teaching requirements (either bedside or didactic), and any other duties expected. These may include, for instance, committee work, program management, or leadership responsibilities. Each of these must be mentioned in the job description. Not only should the requirements be annotated, but there must be an articulation of the percentage of professional time to be spent in each of these pursuits.

A final component of determining the corporate/organizational goals is to articulate the necessary clinical, interpersonal, and administrative skills which will be necessary for the potential recruit to succeed.

As part of the recruitment and subsequent negotiation, the job expectation should be specifically outlined and matched directly to the requirements defined in the community-based needs assessment, the composition of the advertisements, and the articulation of the time commitment to each of the tasks inherent in the job (e.g. administration, teaching, research, and clinical care).

The clinical profile of the candidate must also be clearly defined. This must include a list of "core" competencies and a detailed list of all procedures germane to the candidate's discipline. Individuals should apply for each procedure specifically, and quantification of the numbers each procedure to be conducted on an annual basis should be specified,

along with the supports necessary (e.g. beds, outpatient clinics, laboratory and imaging procedures, office equipment, secretarial support, etc.)

The remuneration, including not only salary and benefits, but other forms of compensation, should be listed in detail. These may include provision of office space, secretarial support, parking and funding for such activities as continuing education. The length of the appointment should be stated, as should the expectations of the organization with regard to annual validation of credentials. It is suggested that it be made explicitly clear to physician recruits that an annual performance appraisal process is in place in the organization. Performance appraisal processes must reflect the specific job criteria as outlined above, and be explicitly clear to the recruit.

It is suggested that remuneration, particularly for non-clinical tasks, reflect not only the time to be spent in each endeavour, but also the quality with which the tasks are performed. A variety of compensation arrangements are in existence in the healthcare sector to reflect this philosophy. For instance, a department chief may receive a stipend at a fixed annual rate (with or without escalators over the term of the appointment), but be able to achieve further rewards if he or she is able to achieve previously agreed to corporate goals. These goals may include, for instance, the acquisition of incremental research funding, creating programmatic savings, or achieving further recruitment objectives.

Clearly, the physician performance appraisal should include an evaluation of performance in all areas related to the physician recruitment. Each of these should be assessed and reported to the physician and should reflect the initial job description, the interviewing process, and the initial process of credentialling. The performance appraisal should also evaluate the individual's participation in activities such as quality assurance, peer review, committee activity, and other components of the job definition as outlined and negotiated at the time of initial credentialling.

Undertaking such a process reflects the changing nature of the relationship between physicians and healthcare organizations. While the physician employee is a rarely encountered relationship, such individuals do exist, particularly in industry (such as biotechnology or pharmaceutical firms). These individuals, in general, receive compensation comprised of salary, plus benefits. Such individuals may recognize incremental compensation in the form of stock options, or other bonuses, based on either or both of individual or corporate performance.

Traditionally, physician compensation has been derived from a combination of fee for service OHIP derived income, along with fee for service non OHIP derived income (such as from WSIB or private payers). Physicians have traditionally paid for their own overhead, and provided their hospital "contribution" free. The marketplace, however, has changed considerably. Increasingly, physicians are being recruited to management positions in hospitals, or other healthcare organizations. They may be serving as vice presidents, chiefs of staff, department chiefs, or program managers.

Depending on the size of an organization, a physician vice president may subserve this function on a full-time basis. In this capacity, he or she will generally receive an annual salary, perhaps augmented by fee for service income if, indeed, they continue to maintain a part-time clinical practice. In addition to the salary, individuals will oftentimes be eligible for other benefits, such as provincially negotiated pension plans. They may receive fringe benefits, which may be extensive, including medical and dental benefits, disability insurance, life insurance, etc.

Oftentimes, these individuals are able to increase their base compensation as a consequence of job performance, the acquisition of extra training, (such as obtaining an MBA or MHA) or on the basis of previously negotiated annual increments in income. It is crucial that such appointees have a clear understanding of the performance evaluation process, and its potential impact on their compensation.

Physicians serving as Chiefs of Staff, or Chairs of MAC, have frequently provided such services for minimal or no compensation. Increasingly, such individuals are required to devote a significant amount of their professional time (up to and including full-time) to such appointments. They may receive between 25 and 100% of their total annual income in return for their management functions. They generally will be appointed for a period of time which may span from 3 to 5 years, with, generally, one renewal allowed.

Again, reflective of the changing nature of the physician hospital relationship, such individuals will have a contract which, ideally, will include terms of reference, clear delineation of a performance appraisal process, and a set of goals and objectives which will reflect not only the performance appraisal process, but oftentimes the individual's compensation package.

Department chiefs have, in many cases, also provided such services as a "contribution" to the healthcare institution to which they are appointed. In light of the increasing responsibility which accrues to department chiefs, such individuals are now almost inevitably compensated for their contribution. Compensation may range from as little as $5,000 to $10,000 to in excess of $150,000, depending on the size of the hospital, and the complexity of the clinical service. Appointments, again, are frequently of 3 to 5 years in duration, with one renewal allowed. It is suggested that such appointments should be contractualized, including explicit reference to and/or inclusion of the hospital by-laws, goals and objectives, and performance appraisal process as they impact on the role of department chief. Again, compensation may be on a sliding scale reflecting the individual's ability to achieve previously agreed upon corporate goals and objectives.

Historically, physicians who participated in administrative activities, and who did <u>not</u> hold a concomitant management position at the hospital, provided such service as a "component" of their clinical appointment. Increasingly, however, physicians have been receiving compensation for participation in activities such as committee work. In many cases this, also, may be rewarded on an hourly basis, with stipends ranging from $50 to $150 per hour for such activity. If, indeed, institutions are compensating physicians for participation in committee or other activity, it clearly subserves the interests of the

organization to establish performance criteria which will become the basis of continuing compensation.

It should be mentioned that the nature of physicians/"employer" relationship in the non-institutional sector is also in evolution. For instance, the FHN and FHG arrangements in Ontario, as well as physician compensation schemes in Alberta and B.C., provide for lump sums of money to be paid for the provision of after hours services. These may form either part of the contract for the provision of this service, or alternatively be "shift based". Such agreements are generally reflected in an annual contract, with explicit terms for service guarantees and performance measurement.

In other settings, either groups or individuals may engage in a contract with an agency, pharmaceutical firm, or other private venture (such as an air transport service). Again, there is often contractualization of the relationship, with an explicit annotation of the services to be offered, the remuneration to be provided, and the criteria upon which performance will be measured.

In summary, the relationship between physicians, hospitals, and other healthcare employers is in a period of significant evolution. Increasingly, in return for the granting of privileges, hospitals are seeking to delineate specific job performance criteria, and compensation schemes which reflect achievement of those clinical goals. For physicians who engage in administrative, research, or teaching activity, there is also increasing formulization of the relationship. Oftentimes, the compensation offered will reflect not only the time commitment, but the quality with which the task is completed, and its congruence with corporate strategies.

For this collaborative relationship to be both effective and efficient, it is necessary for hospitals to develop recruitment and appointment strategies which are clearly reflective of both community and organizational need. A performance appraisal process must be created which is viewed as being objective, transparent, and equitable. Only by being exhaustive, in both establishing the terms of appointment and contracting for it, can the needs and goals of both parties be realized.

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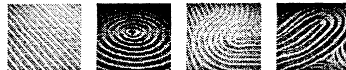
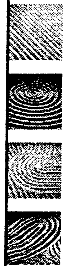
CONTRACTUALIZING PHYSICIAN RELATIONSHIPS IN A HEALTHCARE SETTING ACCORDING TO PERFORMANCE STANDARDS AND OBJECTIVES



INTRODUCTION

- articulating corporate/organizational goals
- performance evaluations
- the changing physician/hospital relationship
- achieving a collaborative arrangement



1) ARTICULATING CORPORATE/ORGANIZATIONAL GOALS

- must begin prior to recruitment

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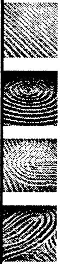

- Includes community needs assessment
  - clinical volumes
  - on call/after hours
  *NB norms
  - regional models (existing, planned)
  - demographic changes

what Δ's are happening in the comm'y.?

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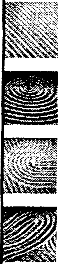

- Include organization's resource issues
  - capital costs
  - operating ~~op~~ costs.

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- must reflect best practice
  - current
  - projected

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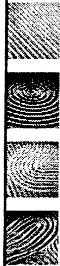

- Must be developed for administrative roles eg. department chief, chief of staff, committee chairs
- should reflect corporate strategic/planning processes
- should be quantified, where possible

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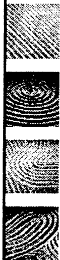
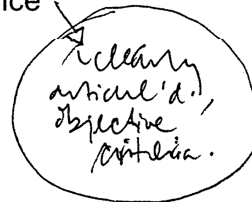
2) PERFORMANCE EVALUATION



- increasingly part of physician/institution interface
- must reflect recruitment/credentialling process
- must reflect mutually agreed upon corporate goals
- must reflect clinical / administrative / teaching / research performance



- must include affective components
  - attitudes
  - relationships
  - collegiality

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PERFORMANCE EVALUATION

- Initial (app. 6 mos)
- subsequent (annual)
  - oral and written
  - by appointment
  - bi-directional
  - written summary with action plans →

- Performance specific
  - clinical - quantity and quality
  - admin
  - teaching
  - research
  - other

PERFORMANCE EVALUATION

CRITERIA <u>MUST</u>

- match recruitment
  credentialling
  contracting
  » quantity
  » quality
  » other

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3) THE CHANGING PHYSICIAN/HOSPITAL RELATIONSHIP

- moving from independent provider of clinical services to contractual arrangement for a variety of services on a continuum

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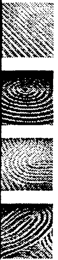
INCLUDES

- employee
- senior management
  (CEO, VP Medical, CofS)
- program leader
- department leader

* may be part or full time



COMPENSATION

- Salary
- salary and clinical
- “contract”
- “contract” with incentives
- benefits

SALARY

- industry
  - may be augmented by options, bonus etc.
  - *ie performance (individual/corporate)
- generally “standard” benefits

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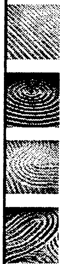

“CONTRACT” and FFS

- e.g. VP Medical
- FFS for clinical
- “contract” (=T5) for admin

  or
- “salary” (=T4)

*NB differences

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- 3 - 5 year terms
- annual contract with performance criteria
- 1 contract with renewal criteria (performance based)
- may be base + fixed to corporate goals
  + sliding scale
  + step increments (merit)
- base incentives (e.g. obtain MBA)
- MUST REFLECT RECRUITMENT/CONTRACT

FFS AND "STIPEND"

- FFS may have hard, soft, no cap
  (NB relative merits)
- STIPEND may be "salary"
  or
  "contract"
- typically Dept. Chief
  - 3 to 5 years, 1 or multiple contracts
- linked to admin. tasks

STIPEND MAY BE

- fixed
- sliding scale
- fixed and bonus

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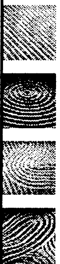

- Should be linked to performance
  - clinical goals
  - admin. performance
  - other
- MUST REFLECT RECRUITMENT/CONTRACT

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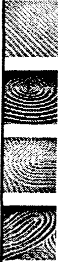

HOURLY STIPENDS

- Increasingly for committee work
- 0 →parking space→$150/hr
- MUST BE LINKED to PERFORMANCE
  - individual vs. team vs. both
- CRITERIA to be clear, mutually agreed, objective, contracted

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OTHER

- FHN
- FHG
- HOCC
- AFTER HOURS (e.g. BC, Alta.)

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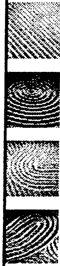
4) ACHIEVING A COLLABORATIVE RELATIONSHIP



- A new and evolving art
- keys
  - quantification of need
  - establishing corporate
    - goals
    - priorities
    - strategic objectives
    - financial plan
- recruitment/credentialling
- communication
- x cultural understanding
- performance appraisal

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