Compensation for Managing Population Health

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As the healthcare delivery system shifts its focus from “volume” to “value,” it must also change the way executives and physician leaders are paid. This is the reason why I was so intrigued by a recent report from The Governance Institute. A service of the National Research Corporation, The Governance Institute regularly publishes a wide variety of white papers meant largely for hospital board members. Its winter 2015 white paper, “Aligning Physician and Executive Compensation with Population Health Management,”1 deserves broader recognition, which prompted me to write this editorial.

Led by experts Don Seymour and William F. Jessee, MD, the report is based on the findings of a study of 44 integrated delivery systems. It reviewed the current practices of these 44 systems with regard to executive and physician compensation that aligns with the goals of a value-based delivery system. Some key takeaways from their findings are worth a closer look.

In the private, for-profit sector, executive compensation is typically tied to achievement of the overarching goals of the organization. The goals are either set by the chief executive officer or the board of directors. The majority of executives are accustomed to having their compensation organized in such a fashion and expect to be rewarded if the organization thrives.

For physicians, even those in leadership positions in large delivery systems, this is not typically the case. Physicians have been historically rewarded for productivity and have been driven, in fact, by the mantra of “more is better,” with income incentives attached to growth in the volume of services offered. Once we recognize this conundrum, we can begin to better understand how best to align physician leader compensation with population health management.

According to Mr Seymour and colleagues, in the 44 systems in their study, the organizations with a long history of delivering clinical services at economic risk—either through managed care arrangements, capitated contracts, or sophisticated pay-for-performance programs—have used a series of different measures to promote population-based care.1

In closed systems such as Ochsner Health System, Kaiser Permanente, and others, there is a long history of just this kind of payment process. However, in the typical evolving integrated delivery system paradigm, with a traditional hospital at its core, there may not be any organizational precedent for rewarding physician leaders (in particular) based on organizational goals or on population-based goals. In this latter group, according to Mr Seymour and colleagues, new measures are emerging that tie compensation to performance.1

These measures include clinical quality, patient experience and satisfaction, and cost-effectiveness. “The metrics used most frequently are those linked to reimbursement, such as those used in Medicare’s Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, the Hospital-Acquired Condition Reduction Program, the Shared Savings Program, or the Bundled Payments for Care Improvement Initiative. Some are borrowed from measurement sets developed or endorsed by national organizations, such as the National Committee for Quality Assurance (NCQA) with its Healthcare Effectiveness Data and Information Set (HEDIS) measures.”1

Still other measures are now being drawn from specific accountable care organization (ACO) contracts in many new Centers for Medicare & Medicaid Services (CMS)-derived measures for ACO work. These include chronic disease management, adoption of medical homes, integration of advanced practice providers, and improving care in the community.

The authors predict that there will be further alignment of executive compensation, potentially with the goals of Healthy People 2020. I found this to be most intriguing. Healthy People 2020 “provides a comprehensive set of 10-year national goals and objectives for improving the health of all Americans. Healthy People 2020 contains 42 topic areas with more than 1,200 objectives. A smaller set of Healthy People 2020 objectives, called Leading Health Indicators (LHIs), have been selected to communicate high-priority health issues and actions that can be taken to address them.”2
Among the leading health indicators that are clearly of a population improvement nature are measures such as access to health services and reduction in injury due to violence, substance abuse, and tobacco use. Therefore, the authors envision a day when these population-based measures, through the leading health indicators and Healthy People 2020, may serve as a cornerstone for physician executive compensation and achieve the goals of improving the health of the US population.

Juxtapose these kinds of measures with the traditional measures noted earlier that principally were intended to drive growth through volume. We are in a new world order. How might a typical evolving integrated delivery system begin this journey of linking compensation to population-based metrics? Mr. Seymour and colleagues believe that there are several paths to success, which could include partnering with a payer that knows how to manage population health, partnering with another system to share the start-up costs and learn from one another, begin with a company’s self-insured employees, and focusing early on on certain chronic diseases, such as congestive heart failure.1

More advanced systems may need to do some additional work, such as benchmarking against other similarly developed systems across the country. The authors recommend looking at systems such as Ascension, among others. (I would add to their list Trinity in Livonia, MI, and Mercy Health in Cincinnati, OH.) They also believe that organizations should “establish physician clinical integration committees to work through the issues that you will undoubtedly encounter around data and clinical care management,” and “assess the current level of engagement of both staff and physicians and determine whether you have the right people to manage through the change that will be required.”1

The Governance Institute’s report lists significant roadblocks to this process. I will not enumerate all of them here, but certainly issues such as lack of resources, lack of expertise in risk management, and inappropriate end-of-life care are potential clinical roadblocks to a successful implementation of population-based compensation. This makes sense, of course. If we cannot make critical clinical decisions about end-of-life care, how can we ever hope to make higher-level decisions linking compensation to the overarching goals of our entire organization?

I was impressed by this report, and I must have read it 3 times to fully glean the central messages. It seems to me that the journey from “volume to value,” most especially as it relates to our pocketbooks, is going to be fraught with challenges. Although organizations such as The Joint Commission, CMS, the National Quality Forum, and others create all kinds of new measures, connecting these measures to take-home pay will involve blazing some new paths. If your organization has reached a higher level of maturity in aligning physician and executive compensation with population health management, and you are not currently a managed care plan, I would very much like to hear from you! I am confident our colleagues across the country would also like to know about your journey.

As always, I am interested in your views, and you can reach me via e-mail at david.nash@jefferson.edu.

References