The Pediatric Paycheck: Working Compensation Models

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How can you ensure the fairest salary structure for your practice while upsetting as few people as possible and keep the practice healthy?
2008 Survey Details

- 2008, PCC Clients only
- More than 50 private pediatric practices across the country
- Average age of practice: 23 years
- Average size of practice: 3.9 FTE physicians
- ~10% solo, ~45% 2-5 physicians, ~45% 6+ physicians
- Average non-physician providers: 1
  - ~50% of practices use non-physician providers
  - Those practices average ~2 FTEs
2013 Survey Details

- 2013, more than 150 private pediatric practices across the country
- Average age of practice: 20 years
- Average size of practice: 5.9 FTE physicians
- ~12% solo, ~41% 2-5 physicians, ~31% 6+ physicians
- 54% employ “physician extenders”
- Average years in practice: 20
- 40% practice founders, 70% physician partners
2014 Survey Details

- 2014, more than 120 pediatric responses
- 50/50 Male / Female split
- 85% Owners
- 60% dependent children
- Focus on Work/Life Balance issues
2008 Survey Details, Compensation Models

- Split Salary: 54%
- Mixed: 27%
- Productivity: 19%

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2008 Survey Details, Productivity Measures

- Visits: 4.8%
- Charges: 41%
- Collections: 54.3%
2008 Survey Details, Distribution Timing

- **Annual**: 44.6%
- **Monthly**: 8.9%
- **Quarterly**: 16.8%
- **Other**: 29.7%
2013 Survey Details, Compensation Models

- Salary: 32.7%
- Productivity: 21.4%
- Mixed: 27.6%
- Other: 18.4%
2013 Survey Details, Productivity Measures

- Collections: 43.5%
- Charges: 21.7%
- RVUs: 10.9%
- wRVUs: 5.4%
- Visits: 13%
- Sessions: 5.4%
- Collections: 43.5%

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2013 Survey Details, Distribution Timing

- **Other**: 31.3%
- **Annual**: 33.3%
- **Quarterly**: 6.1%
- **Monthly**: 29.3%

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60% of practices who have non-partner physicians guarantee salaries for one or more years.

Nearly every non-physician provider is salary-based. Some exceptions.

25% of practices pay physicians for non-clinical duties (administration).

Of those who pay for admin, 38% pay based on time, 44% pay a flat-fee, 6% pay a percentage of salary. 13% use another method.

10% of practices use other measurements for incentives (patient satisfaction, peer review, community outreach, etc.).
90% of practices who have non-partner physicians guarantee salaries for one or more years. Nearly all are primarily salary-based.

95% of non-physician providers are salary-based (with bonuses).

58% of practices pay physicians for non-clinical duties (administration).

For those who pay for non-clinical duties, 70% pay for being Managing Director, 17% pay for negotiating work, 30% pay for clinical projects, 15% pay for H/R work, 26% pay for I/T work, 20% pay for being Medical Director, 11% pay for external professional work, and 25% find other things as well.

Nearly none use other measurements for incentives (patient satisfaction, peer review, community outreach, etc.).
79% report that they do not expect to change their compensation model in the next year. The average practice last changed its method almost 14 years ago (large deviation).

25% of all respondents report dissatisfaction with their existing compensation models.
15% expect to change models within the year, 24% within 1-2 years, 25% in more than 2 years, and 36% say...never.
The average practice last changed its method 9 years ago. (large deviation)
71% of all respondents report satisfaction with their existing compensation *models*.
66% of employed physicians reported satisfaction with their existing compensation *models*, though overall satisfaction is lower.
Correlations!

• The age and size of a practice have no correlation to the style of productivity measurement. [2008 and 2013]
• Mixed and productivity-base practices are more likely to have changed recently. Salary-based practices are less likely to have been changed recently. [2008 and 2013]
• Productivity-based practices are less likely to expect to make changes. Salary-based practices are more likely. [2008 and 2013]
• **Salary-based practices are less likely to be satisfied with their compensation while productivity-based practices are more likely.** [2008]
• Productivity-based practices have the highest satisfaction, especially when compared to practices they know. [2013]
Correlations, Part 2

- Larger practices are less likely to be satisfied. [2008]
- Larger practices have a higher compensation satisfaction. [2013]
- Older practices are less likely to be satisfied. [2008]
- The age of the practice doesn't affect satisfaction. [2013]
- **Satisfied practices are more likely to plan to make changes.** [2008]
- Practices who have recently changed are more likely to be satisfied. [2008]
- Productivity *model* (charges, collections, visits, etc.) does not have much effect on satisfaction. [2008 and 2013]
What do they really want?

Ranking of compensation objectives on a scale of 1-6 by employed physicians, 2013 Pediatric Compensation Model Survey, PCC.
Work / Life Balance

- Nights on call, lack of vacation, evening work contribute to workload imbalance
- Gender, practice ownership, dependent children do not change workload imbalance perception
Take Aways

- One compensation model does not fit all
- Review compensation for non-clinical work
- Call, evenings, vacation are leverage points
- Set practice goals, not individual goals
- Discuss these issues before it becomes dramatic
- Consistently review your system
- Use computer tools to measure productivity
- “Close Enough” is Good Enough!
Models
Real Life Example A

Group: 10 Pediatrician Practice  
Type: 30 years, large metro area  
Satisfied: Yes  
Last Changed: 1974

Compensation Style:  
- All partners straight salary.  
- All non-partners straight salary.  
- Partners evenly divide profits annually.  
- Non-partners receive subjective bonus.
Real Life Example B

Group: 6 Pediatrician Practice
Type: 25 years, large metro area
Satisfied: Yes
Last Changed: 2004

Compensation Style:
- Partner income based on collections.
- Partners receive 100% of collections after fixed and variable costs.
- Non-partners on guaranteed salary for two years, with incentives.
- Assessments made quarterly.
Real Life Example C

Group: 7 Pediatrician Practice
Type: 31 years, suburban
Satisfied: Yes
Last Changed: 2003

Compensation Style:
- Partner income based on *total visits*.
- Visit counts are estimated and post-cost income distributed monthly.
  Annual re-assessments.
- Non-partners are salaried.
Real Life Example D

Group: 11 Pediatrician Practice
Type: 25 years, suburban
Satisfied: No
Last Changed: 1990

Compensation Style:
- 50% Salary based on FTE, 50% based on collections.
- Fixed and variable costs based on FTE.
- Only one physician given admin bonus.
Real Life Example E

Group: 5 Pediatrician Practice
Type: 20 years, suburban
Satisfied: No
Last Changed: 1990

Compensation Style:
- All salary, some adjustment for FTE
- Two partners change of life...1/2 time, no salary cut?
Real Life Example F

Group: Large Pediatric group in MA
Challenges: Mixed population with significant Medicaid “Generations” of physicians
Challenge: Distribute income fairly while promoting practice health and supporting local health clinics

Solution:
• Create a Mixed Model
• Salary represents the smaller portion
• Office-specific “RVU” system assigns points to primary procedures; weight procedures that benefit the entire practice
• Assign values to non-clinical work (volunteering at local clinic)
• Pay 'bonuses' quarterly and examine the system annually
• Distribute management tasks among partners and rotate often
• Allow high producers to “pay” their social obligations by supporting the work of their partners in local clinics