The Pediatric Paycheck: Working Compensation Models

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PCC Pediatric EHR Solutions

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Private Pediatric Compensation Models

Historically, PCC has examined ways to improve the revenue factors that affect physician salaries: coding patterns, systemized pricing, preventive care, insurance negotiations, and more.

Ultimately, however, the story continues long after you have maximized your revenue and reduced your expenses...what do you do with all that extra money?!

In a private practice, discussions about provider salaries are often uncomfortable and almost always dissatisfying.

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, Part 2

- 54% of practices use salary as the only method for physician compensation (with or without evenly distributed bonuses).
  19% use pure productivity models.
  27% use a 'mixed' model.

- 57% of productivity-based practices pay based on collections.
  43% pay on billed charges.
  5% count visits.

- Practices who pay bonuses pay them annually 45%, quarterly 17%, monthly 9%, and 'other' 30% of the time.

- Bonuses are distributed evenly 31% of the time, are based on productivity 29% of the time, or use some other method (40%).

2013 Survey Details, Part 2

- 32% of practices use “equal salary” for physician compensation (with or without evenly distributed bonuses).
  21% use pure productivity models.
  27% use a 'mixed' model.
  18% use “other” - or largely explanations of a “salary” model.

- 40% of productivity-based practices pay based on collections.
  20% pay on billed charges.
  10% pay on RVUs, 5% on wRVUs.
  12% pay on total visits, 5% on sessions.

- Practices who pay bonuses pay them annually 33%, quarterly 6%, monthly 29%, and 'other' 31% of the time.

2008 Survey Details, Part 3

- 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.).

2013 Survey Details, Part 3

- 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.).

2008 Survey Details, Part 4

- 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.**

2013 Survey Details, Part 4

- 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]

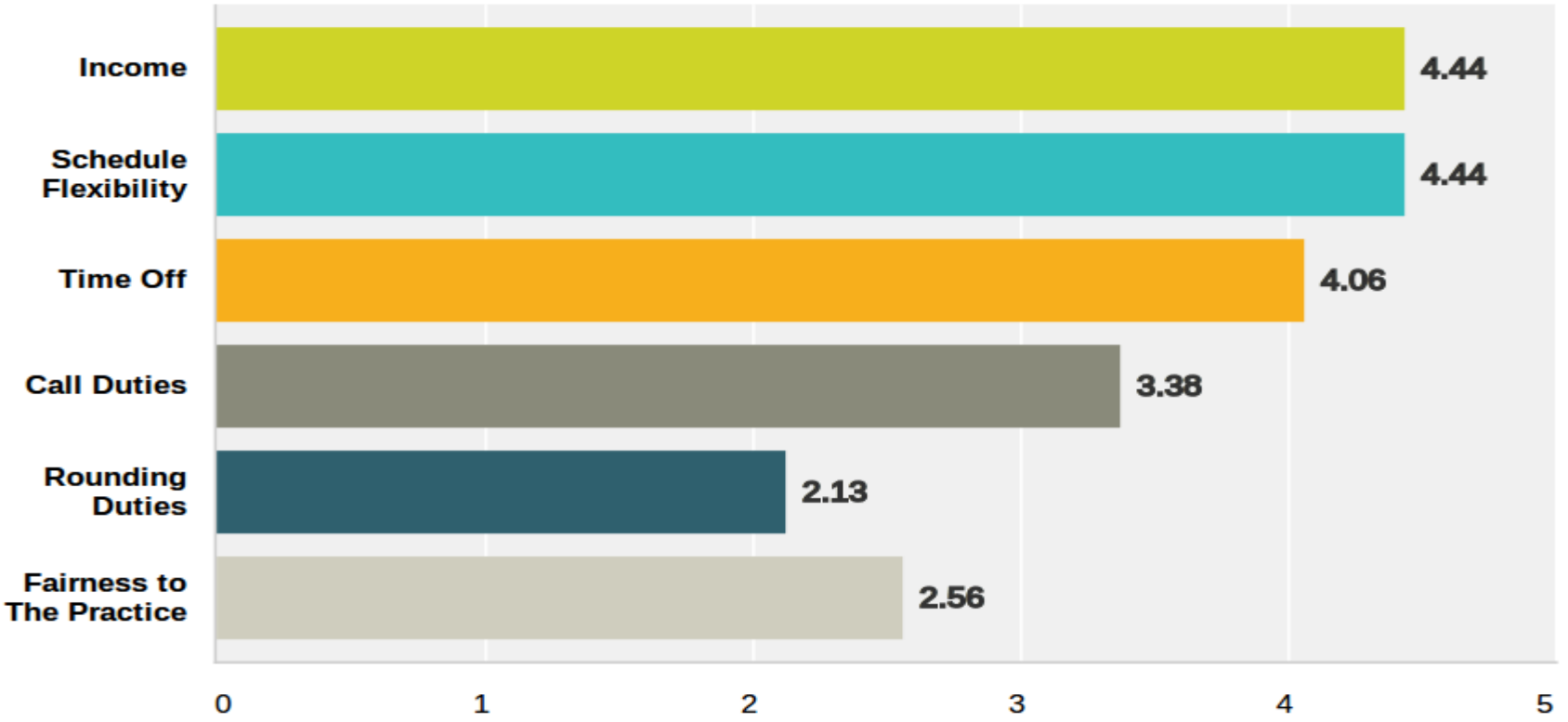
- Older practices are less likely to be satisfied. [2008]
  The age of the practice doesn't affect satisfaction. [2013]

- **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.

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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