

# The Pediatric Paycheck: Working Compensation Models

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# Private Pediatric Compensation Models

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

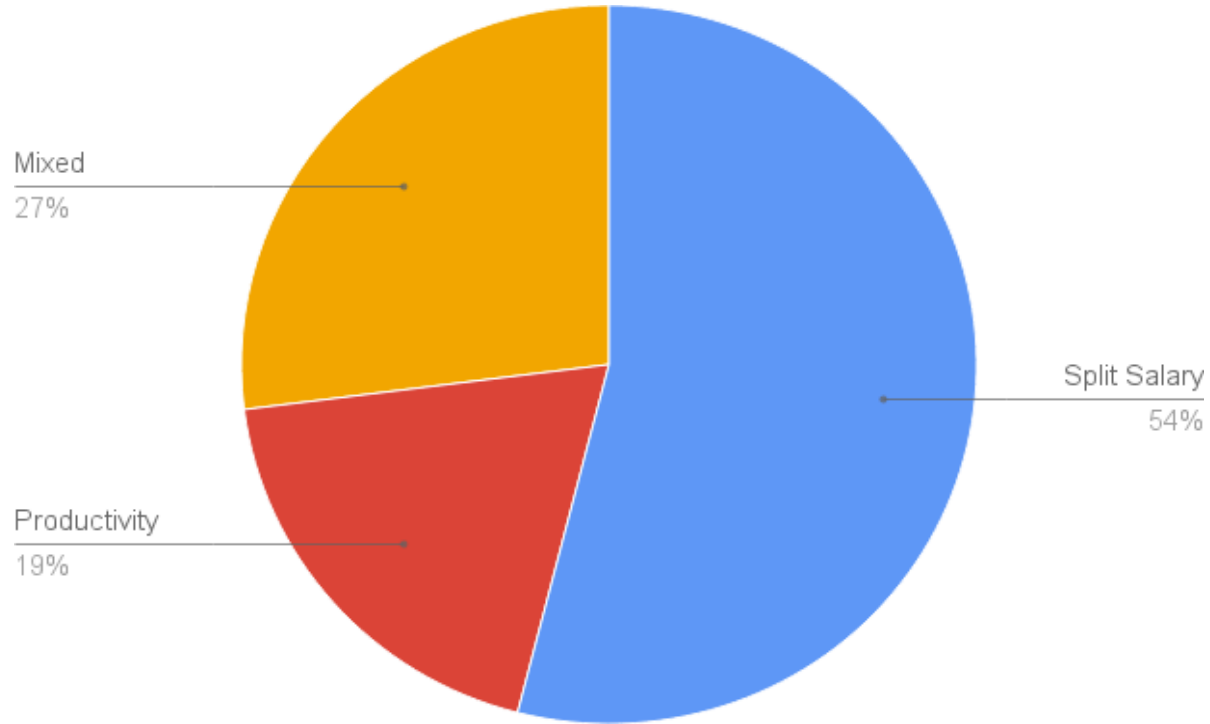


# 2014 Survey Details

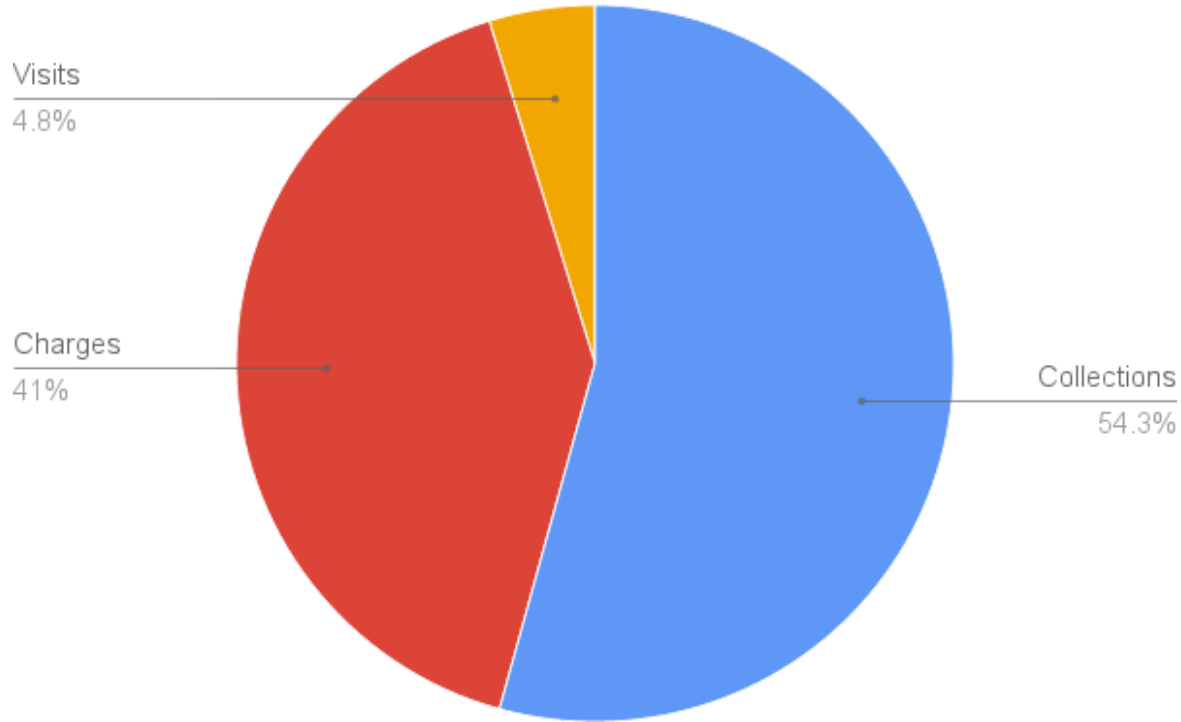
- 2014, more than 120 pediatric responses
- 50/50 Male / Female split
- 85% Owners
- 60% dependent children
- Focus on Work/Life Balance issues



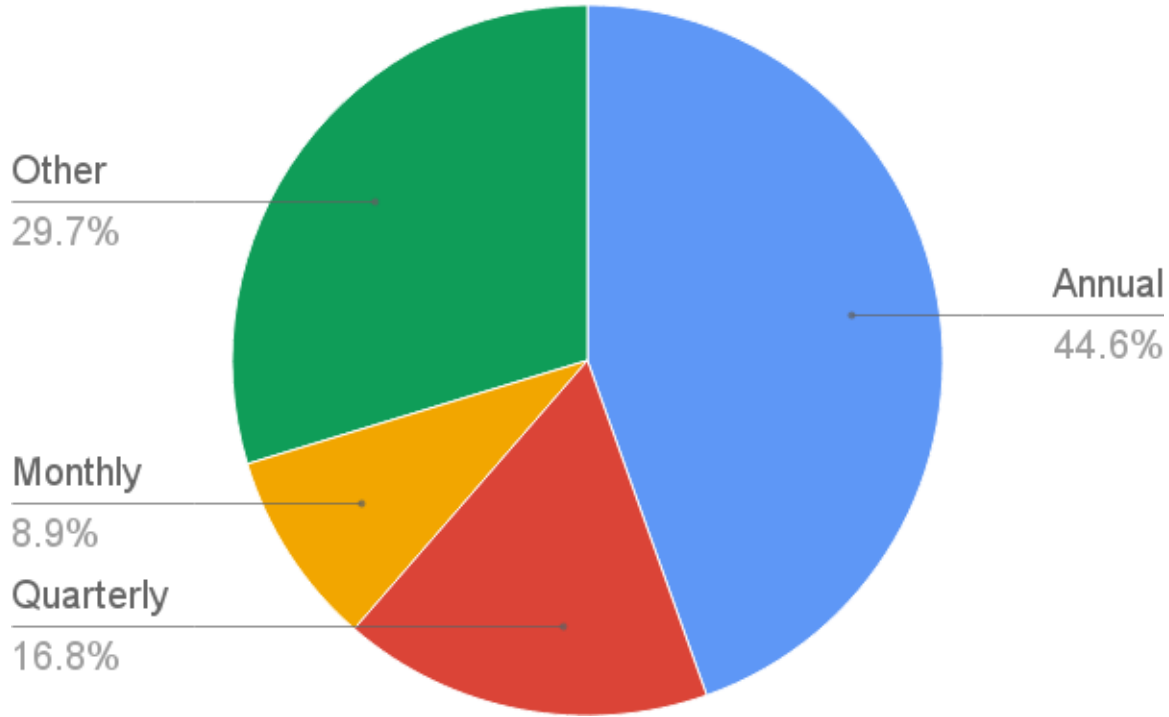
# 2008 Survey Details, Compensation Models



# 2008 Survey Details, Productivity Measures

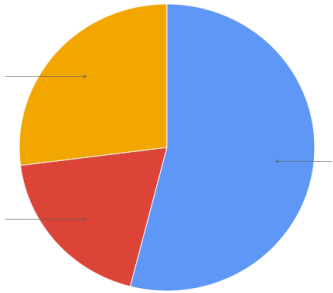
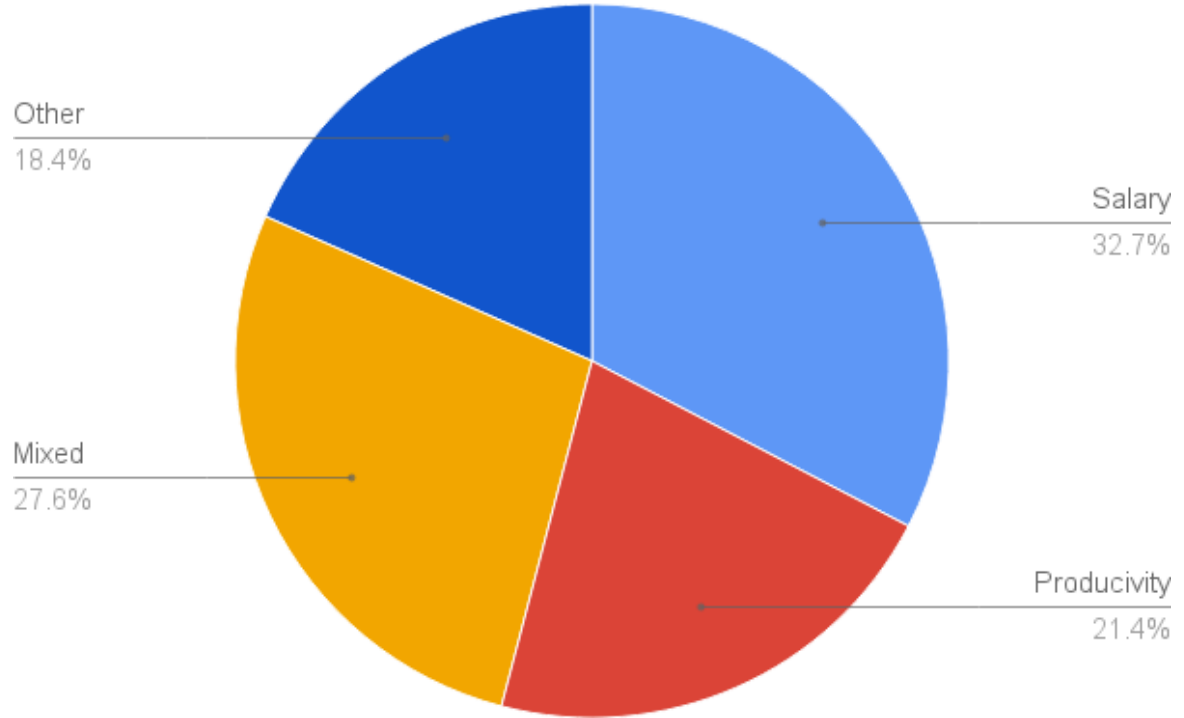


# 2008 Survey Details, Distribution Timing

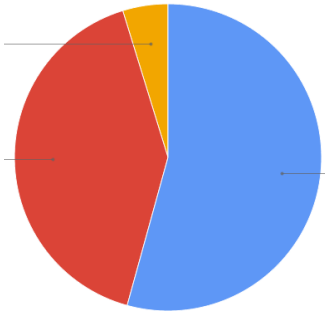
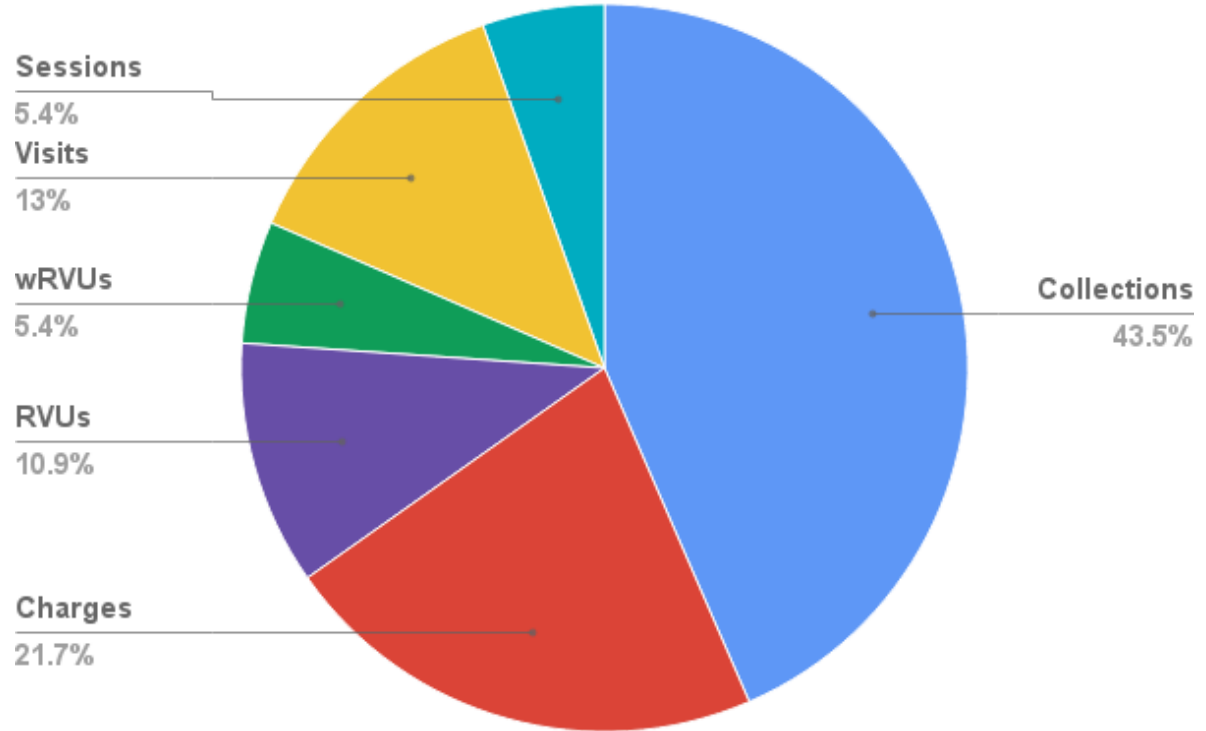




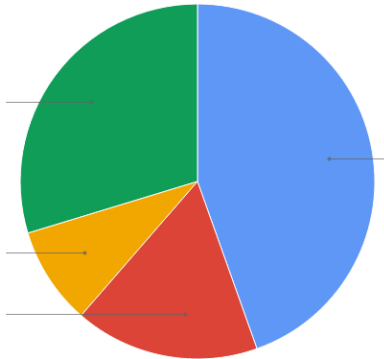
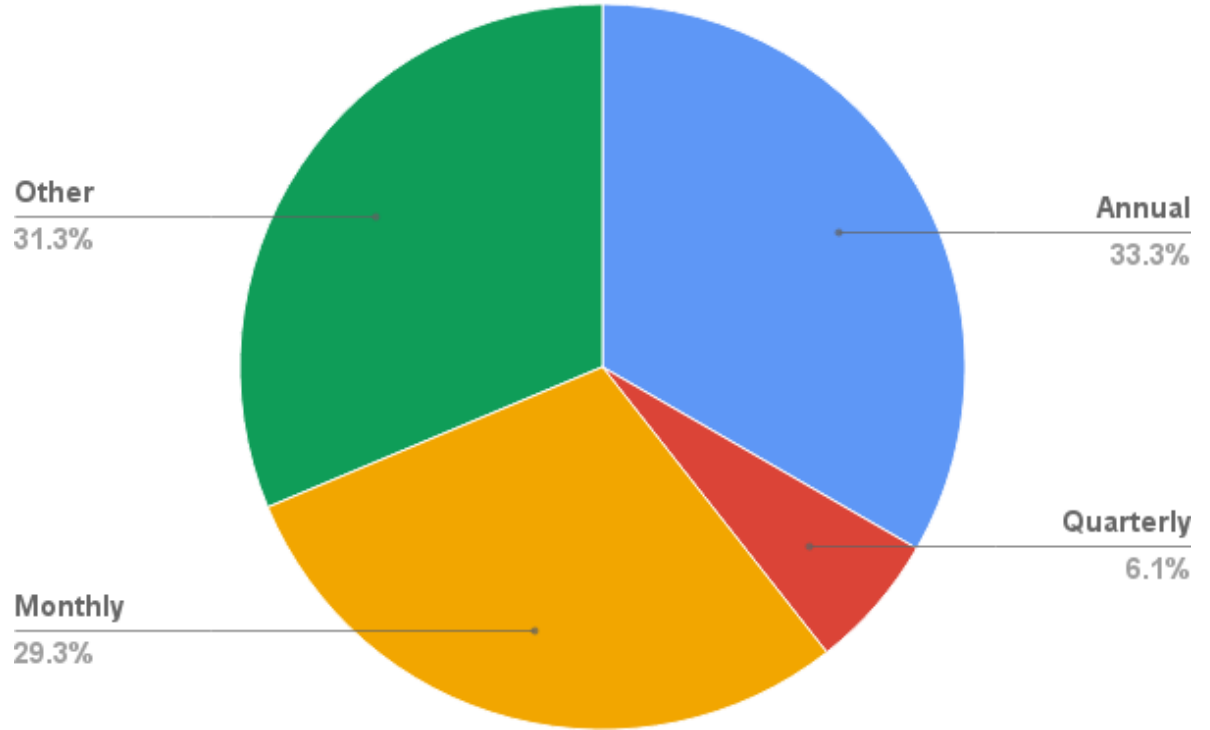
# 2013 Survey Details, Compensation Models



# 2013 Survey Details, Productivity Measures



# 2013 Survey Details, Distribution Timing



# 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]**



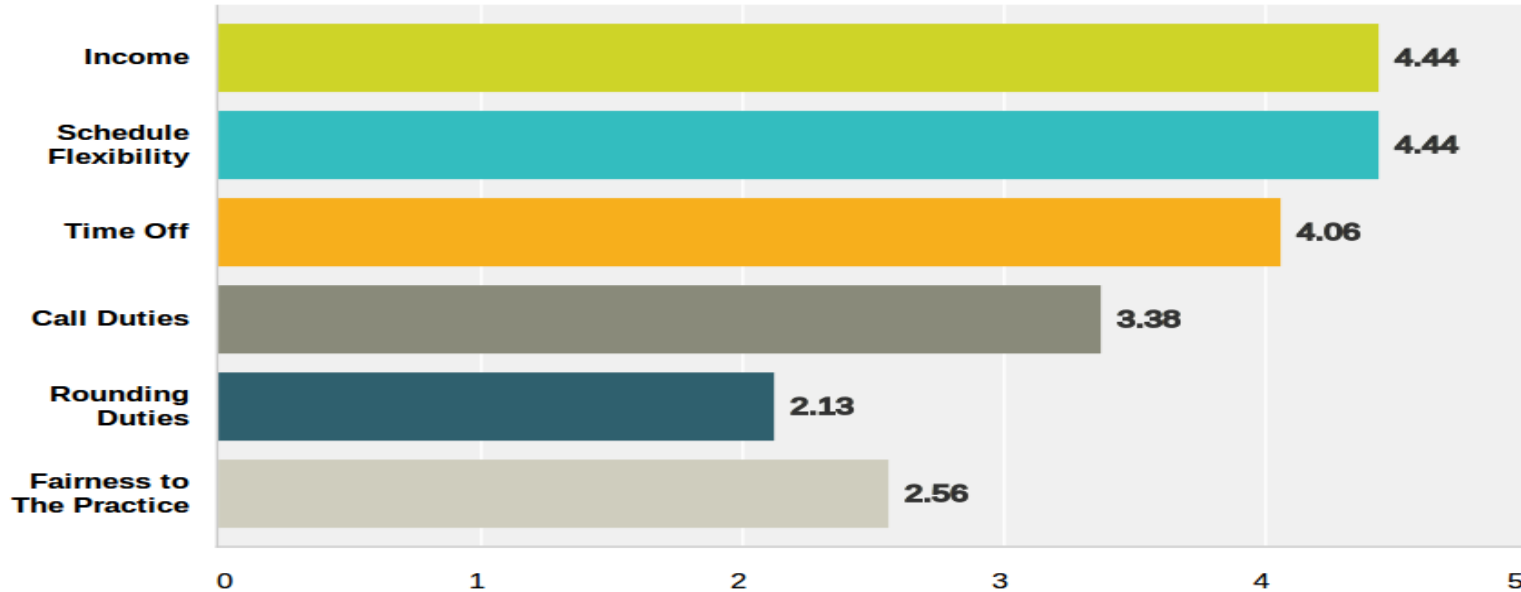


# Correlations, Part 2

- 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.



# 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

