The American Hospital Association's
CENTER FOR HEALTHCARE GOVERNANCE™

The Health System-Physician Relationship Continuum:

What the Board Needs to Know

Monograph Series

About the Author

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The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information visit www.americangovernance.com.

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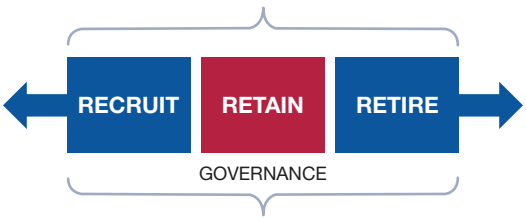
Overview

As payment models evolve, reimbursement is squeezed, patients become more sophisticated, and expectations for alignment become the rule rather than the exception, health systems and physicians must continue to find ways to develop sustainable working relationships that provide a highly reliable basis for future growth. Whether your organization employs physicians, or has owned practices, independent physicians, or a mix of all, it is important to apply collaborative strategies in appropriate ways to advance and deepen these critical relationships. Relationships with aligned independent physicians and what they look for the health system to provide will be different from those with employed physicians. Moreover, the perceptions of employed and independent physicians regarding which side of the fence is greener will continue to evolve.

Health System-Physician Relationship Continuum



This monograph will focus on the Board's role in plugging into how these processes are carried out within their organizations and on how the Board role is evolving. Among other things, we will address the characteristics of relationships among health care organizations and physicians that, if nurtured and respected, will enable the challenges of tomorrow to be more easily surmounted. Health care organizations should continually assess the physician relationship continuum—the ability to **recruit, retain, and retire** physicians—in a thoughtful, mutually beneficial, and collaborative manner that provides for effective on-boarding, retention, high-quality patient experiences and outcomes, clinical innovation, and transition of leadership.

Health System-Physician Relationship Dimensions

Throughout the continuum multiple relationship dimensions should be considered to ensure that the physician/health system relationship is robust and grounded on a solid foundation. Generally speaking these dimensions include:

1. **Transparency:** Transparency, as used in science, engineering, business, the humanities and in other social contexts, implies openness, communication, and accountability. Transparency means operating in a way that is easy for everyone to understand what others are doing or saying. It has been defined simply as "the perceived quality of intentionally shared information from a sender."[1]

[1] Schnackenberg, Andrew K.; Tomlinson, Edward C. (March 2014). "Organizational transparency: a new perspective on managing trust in organization-stakeholder relationships". Journal of Management (Sage). doi:10.1177/0149206314525202. Published online before print.

2. **Trust:** In the social sciences, the subtleties of trust are a subject of ongoing research. In sociology and psychology the degree to which one party trusts another is a measure of belief in the honesty, fairness, or benevolence of another party. The term "confidence" more appropriately describes a belief in the competence of another party. Based on the most recent research a failure in trust may be forgiven more easily if it is interpreted as a failure of competence rather than a lack of benevolence or honesty.

3. **Engagement:** Physician engagement is a characteristic of the relationship between an organization and its physicians. Engaged physicians are fully absorbed by and enthusiastic about their work measured by involvement, commitment, and productivity and take positive action to further the organization's reputation and interests.

4. **Expectations:** Expectation is defined as believing that something is going to happen or believing that something should be a certain way.

5. **Follow-through:** Follow-through is defined as the continuing of an action or task to its conclusion and involves organizing thoughts and activities well, taking time out to reflect, not operating in crisis mode, knowing who needs to be in the loop, and having a fundamental desire to complete things.

6. **Performance Evaluation:** An assessment of job-related actions and their outcomes within a particular position or setting, how and why achievement was above or below expectations.

7. **Succession Planning and Transition:** Transition refers to the process or period of changing from one state or condition to another. A change in condition is typically defined by the transfer in responsibility from one physician to another. Succession planning is a process for identifying and developing internal people with the potential to fill key leadership positions within the health system.

This monograph will discuss each phase of the relationship continuum and the impact or influence of the relationship dimensions, as well as address perspectives of physicians, executives, and boards. Questions to consider and tools for assessing your organization's relationship with physicians along the continuum also are included.

The approaches discussed throughout this monograph will not solve every problem or eliminate tension completely, but they can reduce negative friction, and provide a roadmap for how to address effective on-boarding, compensation plan design, team cohesion, the fluidity of expectations in a fast-paced environment and other issues—in a consistent and respectful manner. These approaches, properly modified for institutional culture, will provide a springboard for meaningful collaboration.

Relationship Dimensions and the Board's Role

1. **Transparency:** Do our processes and procedures related to physician relationships reflect the importance of transparency?
2. **Trust:** How do we measure the level of trust that exists between the board, administration, and physicians? What can we do to strengthen it?
3. **Engagement:** Do we measure physician engagement? Are mission-critical physicians engaged?
4. **Expectations:** How do we set expectations for physicians? How do those expectations align with other key stakeholders within the health system?
5. **Follow-Through:** Are we seeing progress made toward our ultimate goals? Is the trend moving in the right direction? Are we on the same page?
6. **Performance Evaluation:** How do we gauge physician performance?
7. **Succession Planning and Transition:** Do we know the career arc of mission-critical physicians? Are we aware of our physician leadership bench strength?

An Optimal Physician/Health System Partnership

There are several key factors that drive development of an optimal partnership between a health system and its physicians. They relate to understanding a physician's value to the organization, how that value aligns with the strategies of the health system and the career goals of the physician, and ensuring that both of those factors are sustainable. These key drivers provide a context for optimizing the relationship at each stage of the continuum.

Recruitment and On-boarding: Getting off on the right foot

As the saying goes, "You never get a second chance to make a first impression," and many health system boards and executive teams seem to take that notion to heart when recruiting. Physicians often describe a recruitment process that is robust, well-coordinated, and welcoming; but afterward, as the relationship with their health system progresses, physicians perceive that the focus changes. It is essential for health care organizations to be clear upfront with physicians about what the organization expects and needs from them and why. Today's health care organizations need to be nimble, which means expectations also will

Elements included in an On-boarding Process	1. Strategy of the Health System and Service Line
	2. Orientation
	3. Role Clarification
	4. Near-term Objectives

Key Elements of the Physician Orientation Playbook	**90-day and 180-day Orientation:** Establish early milestones that can support early successes.
	IT Needs Assessment and Orientation: How does the health system expect the physician to operate within the information technology (IT) environment? Are exceptions considered?
	Revenue Cycle Optimization: What are the expectations of the physician to maximize revenue cycle?
	Credentialing and Contracting: Describe the credentialing process and current arrangements with payors (i.e. traditional fee for service, value-based purchasing, bundled payments).
	Marketing Integration: How is the service line marketed and what are the growth goals for the service line? What role, if any, does the physician play in furthering these efforts?
	Physician Mentoring: In order to optimize success, is there a physician mentor that can anwser questions regarding IT, patient access, clinical protocols, utilization, etc.?
	Key Points of Contact: Identify key contacts regarding service line management, human resource concerns, IT helpdesk, quality analytics, etc.
	Compensation Philosophy and Plan Mechanics: Provide overview documentation on the compensation philosophy, how the compensation plan operates, and when decisions can be expected.
	Incentive Compensation Plan Metrics: Describe the design of the incentive compensation plan, categories used, metrics and underlying data sources utilized.
	Performance Evaluation: Describe the other aspects of performance that are expected (i.e. behaviors, values, etc.), how they would be evaluated, and how often.

evolve. Health system leadership should engage physicians in this discussion at the start and ensure they share their needs and expectations of the relationship as well. Commit to ongoing transparency and emphasize the importance of sustaining alignment among mutual expectations and goals.

A comprehensive physician on-boarding process is essential to establishing trust, communication, and clear expectations at the outset and sets the tone for the relationship going forward. During these processes the board and management team should learn about physicians' expectations for involvement in clinical practice and administrative leadership, work/life balance, and what motivates each clinician. The health system also can describe its expectations for practice ramp-up and meeting productivity and quality goals, assess behavioral and cultural fit, and lay the groundwork for dealing with rapid change together.

A physician recruitment and orientation manual or "playbook" should address key issues, such as those listed in the box on the botton of page 7, that physicians will need to understand to hit the ground running.

A specific, detailed playbook that outlines expectations and development milestones sets the stage for transparent communication and should help establish clear, mutual expectations about how the relationship should work for all parties. It also provides a set of issues around which ongoing assessment of the relationship can be conducted. Straightforward communication and the expectation of ongoing dialogue to reach and maintain alignment begin to build trust, which provides the foundation for future engagement.

The organization's executives will typically execute the physician recruitment and on-boarding process; however, boards and physicians each have their perspectives, interests, and roles to play in making the on-boarding process effective.

Recruitment and On-Boarding: The Board Perspective

Recruitment of high-quality clinicians is critical to support achievement of a health care organization's long-term strategies and goals. However, the level of board member involvement in this important process is mixed. In some organizations, the board has no or very little direct involvement with recruitment of physicians, but should that be the case? Board members can be deployed productively to help strengthen the physician recruitment and on-boarding process. First, they can help physicians understand that the organization's mission, vision, culture, strategy, and priorities are driven and supported by the board. Having board members affirm this during the physician recruitment and on-boarding process shows the value board members assign to the process and the importance they place on ensuring cultural fit between physicians and the health care organization.

The Board's Role: Recruitment and On-boarding

1. Ensuring the mission, vision, culture, and strategy are aligned, affirmed and communicated
2. Connecting with the community

Consider having board leadership, such as the chair of the board's compensation committee or quality committee, meet with candidates to help assess cultural fit and describe how physicians are critical to successful execution of system strategy. Board involvement can be very powerful in helping physicians understand their linkage and value to the organization.

Second, because board members are well connected to the community they can be a good resource for helping physicians and their families get acclimated to life in a new environment. Board members also can introduce physicians to community leaders, donors and other key supporters of the health system.

Recruitment and On-boarding: The Physician Perspective

A physician's willingness to share important needs and perspectives is critical to the long-term success of the health system-physician relationship. Effective on-boarding should give physicians answers to critical questions and the opportunity to establish common ground and alignment around key values and goals that can increase the probability of a successful, ongoing relationship.

More physicians than should, feel they do not have a voice in decision-making processes within health systems. An effective on-boarding process should enable physicians to surface the health system's approach to engagement, and both parties to assess whether the fit is right.

Through the recruitment process, physicians should seek to understand how the new relationship with the health system may be similar or different from their current or past experiences. For example, while some of the trade-offs between private practice and employment such as requirements to meet system productivity and quality goals may be clear, significant differences, such as the need

Questions to Consider: Recruitment and On-boarding

Board

1. What is the board's role in supporting and strengthening our physician recruitment and alignment process?
2. What is our physician recruitment and on-boarding process framework?
3. How does the board ensure that new physicians understand the importance of cultural, clinical, and strategic alignment with our health system?
4. How do we ensure key physician leaders are integrated into the community and support our organization's community mission and purpose?

Administration

1. What is driving our organization's need for specific physicians/specialties? How do we effectively express our expectations? (What is our expectations matrix: clinically, administratively, strategically, culturally, behaviorally?)
2. How do we assess whether individual physicians have the clinical and non-clinical qualifications we need to be successful? (References, leadership philosophy, cultural fit)
3. How will we evaluate the success of this recruitment in the first 90 days, 180 days, and thereafter?
4. What is our financial exposure if we choose poorly?

Physicians

1. How will this arrangement leverage my clinical and non-clinical strengths?
2. What are my expectations of the organization, and have I expressed them clearly?
3. Do I understand the organization's expectations?
4. How will my performance be assessed and measured? Do I understand the factors that animate the compensation and benefits program?
5. Do I see a long-term cultural fit with this organization?
6. Who are my points of contact (clinically, administratively, strategically) as I "learn the ropes" in my first 180 days?
7. How is this environment different or similar to environments within which I have worked in the past?
8. What does it mean for me if this relationship doesn't work out?

to pay Fair Market Value for compensation, may be difficult and frustrating for physicians to adapt to.

These differences should be raised during the recruitment process so all parties go into the relationship with eyes wide-open. Both the system and physicians should ensure these conversations take place.

Retention

While recruitment and on-boarding provide the first opportunities to express what is important to both the health system and physicians and to lay a strong foundation for an ongoing relationship, retention is based on how those values are expressed and animated in practice. Retention strategies often include a flexible work schedule for physicians, greater administrative support, greater continuing education, child care assistance, select benefits, providing continuity of process and expectations, and ensuring the physician has a voice in decision-making. Long-term rewards and recognition through a variety of methods also help align clinicians with the perspectives of the organization's executives and board.

The Board's Role: Retention

1. Understanding the compensation plan and key personnel

Health systems can begin by creating a system-wide retention matrix that identifies mission-critical physicians and assesses the risk to the organization if these physicians leave (see Appendix pages 18 and 19). "Mission critical" may be defined in several ways. This designation may reflect a dearth of physicians available for a specific sub-specialty or community need; it may be assigned to a physician who has shown tremendous talent in building a critical program, or another who has provided leadership in navigating change among physicians, clinical staff, and administration.

This matrix should provide the board with a quick snapshot of top talent and associated risks and the opportunity to ask questions about transition and succession plans. The matrix should be monitored by a board committee and shared with the board at least annually.

Compensation Plan Design and Benefits

Compensation, benefits, and just plain listening can have a tremendous impact on retention. Physicians should be involved in the design of the physician compensation plan and prepared in advance to do so. Physicians are often generally unaware of the variety of applicable legislation, regulations, and public reporting requirements associated with Stark laws, Anti-kickback rules, the False Claims Act, imposition of intermediate sanctions, and the IRS Form 990, or are insensitive to the consequences of non-compliance. For example, some see the need for physician compensation to comply with Fair Market Value requirements primarily as a pretext for the health system to reduce compensation arrangements.

> I only have so many years of significant earning potential. I need to make sure that the health system leverages my skills for our mutual best interest. Often times I feel like we are at cross-purposes or not on the same page. It's a trust issue.
>
> Invasive Interventional Cardiologist

Educating physicians about applicable regulations, market evolution, and public reporting is critical to the ability of a health system and physicians to productively work together to redesign compensation models and metrics and develop a regulation-sensitive compensation plan.

Compensation levels and approaches are sensitive topics. Physicians' perceptions that

a health system is trying to "save a buck" by paying them less money only raises red flags and erodes trust. Addressing these perceptions directly and transparently builds the trust essential for meaningful collaboration.

Questions that must be answered when designing or redesigning a compensation plan include:

1. How do we define our market? Locally, regionally, nationally?
2. What elements of our current plan work well or should be changed?
3. How do we balance guaranteed compensation with performance-based compensation?
4. How do we determine the appropriate metrics for performance-based compensation?
5. How do we ensure the physician compensation plan and its performance metrics support achievement of the organization's strategic plan?
6. What is the role of medical directorships and clinical oversight responsibilities and how are they valued?
7. What other intangible factors should be considered?

Ultimately the board, executive, and physician leadership should approve plan design. An annual compensation plan review can ensure the plan remains current and provides opportunities to course-correct as circumstances change.

A clearly defined physician compensation governance structure and work plan for compensation oversight should identify the responsibilities of the board and board committees, administrative leadership, and physician leaders (see Appendix pages 20 and 21). Questions that should be addressed include:

1. What group(s) are tasked with overseeing the plan(s) and providing input into any suggested modifications?
2. How will productivity and non-productivity metrics and achievement levels be established?
3. When will plan changes be put into effect?
4. Who has approval authority for plan changes?

Answers to these questions will depend on the organization's compensation philosophy, leadership structure and culture, and economic realities. Environmental factors such as declining reimbursement, greater focus on population health, and evolving personal and generational dynamics also will likely come into play. It is imperative that the board, executive leadership, and physicians share an understanding of the challenges and the contributions, skills, and talents required to surmount them, as shown in the case example on page 12.

Performance Evaluation Process

Performance evaluation is an opportunity to assess whether mutual expectations are being met and to reinforce strengths and minimize weaknesses. Evaluation is best supported by a framework of ongoing communication about environmental issues affecting the organization and clinicians that may have an impact on overall performance and compensation.

Elements included in a Performance Evaluation Process	1. Timing
	2. Participants
	3. Evaluation Criteria
	4. Data Collection and Reporting
	5. Follow-up

An effective performance evaluation process engages system executives and physicians in constructive conversation aimed at gaining agreement on strengths, and on areas, goals, and timeframes for improvement.

A thorough, thoughtful process that focuses on continuous improvement and provides for consistent, meaningful feedback can be an important element of a health system's physician retention strategy.

Case Example

The following example shows how the strategies and approaches discussed here were applied in a situation where Fair Market Value was a concern for physicians in a particular specialty and the physician compensation model was outdated.

The first step was educating the board's physician compensation committee about the status of the physician compensation plan, physicians' concerns about changes to the plan, and the circumstances that created the current situation. Previously, the committee had not delved into these issues as deeply.

Once they understood the issues, the board sent a strong message that the specialty should be maintained for the health and well-being of the community.

With board support to address the problem, the next step was to educate and talk through the issues and concerns with the clinicians. Despite some heated exchanges, it was comforting for the clinicians to know that the board had made it clear that their program must survive and thrive. This helped clinicians conclude that management was not trying to disadvantage them. Sharing data about the issues also appealed to the physicians' problem-solving orientation.

Multiple meetings, modeling, and remodeling resulted in adjustments to the model that:

- maintained characteristics of the plan that were most valuable to the clinicians;
- brought the plan into alignment with other specialties within the health system; and
- mitigated concerns about Fair Market Value while avoiding a reduction in the overall competitiveness of the compensation and benefit structure.

Trust also began to be rebuilt through this process. Physicians became more engaged in solving the problem because the system's motives were no longer being questioned. Conversations became focused on:

- the growth of the service line,
- how to increase patient access,
- how to assist system leadership in ensuring performance measurements were accurate, e.g., tracking wRVUs (weighted Relative Value Units) effectively, and
- achieving an overall understanding that the model will continue to change.

Continued transparency and engagement around issues as they arise will be important, but not nearly as important as how management and physicians follow-through on the commitments and expectations established through this process. The board is pleased that the organization's relationship with these physicians and their compensation plan are on solid footing and expects periodic progress reports.

Performance Areas for Consideration:

1. Clinical Effectiveness
2. Quality of Care and Patient Experience
3. Leadership
4. Administrative Duties
5. Resource Utilization

The process begins with identifying the less tangible aspects of performance to be evaluated.

Performance areas may include the ability for the physician to embrace change or work effectively as part of a multi-dimensional team including physicians, nurses, administration, and others.

Questions to Consider: Compensation and Performance Evaluation

Board

1. How should we be involved in the oversight of physician compensation? Do we have a committee designated for such oversight?
2. Do we know whether our compensation plan is aligned with our strategy?
3. Are physicians being recognized economically when the health system achieves its goals?
4. Should our compensation plan reflect the evolution of reimbursement (i.e., fee-for-service, bundled payments)?
5. Is our compensation plan an asset in the recruitment of physicians?
6. How effective is our process for evaluating physician performance?
7. How do we identify the mission-critical physicians in our organization?
8. Are we aware of our approach to physician engagement and retention?

Administration

1. Is the process for governing physician compensation clear?
2. Does the compensation balance guaranteed compensation with performance-based compensation?
3. Does the physician compensation plan and its performance metrics support achievement of the organization's strategic plan?
4. Have we given the physicians a voice in the compensation plan design process?
5. How do we ensure that our organization's strategy and the expectations of both the system and physicians are incorporated into our evaluation program? How do we evaluate the efficacy of our processes?
6. How do we comprehensively evaluate all aspects of critical performance (i.e., clinical quality, patient experience, leadership, relationships, ability to advance critical initiatives)?
7. How do we effectively assess those clinicians that are most critical to be retained? What makes their retention critical?
8. How do we learn what we need to know about group or individual dynamics regarding clinician retention that could impact our decision-making? Are we trying to use a hammer instead of a scalpel?

Physicians

1. Does the compensation plan reflect the market appropriately?
2. Was I involved in the discussions related to the compensation plan design?
3. Do I feel that guaranteed and performance-based compensation are balanced?
4. Have I been a part of the conversation about designing the performance evaluation process? Do I understand why each component of the process is important?
5. Have I openly shared my perspective in measuring the right elements?
6. Has the health system been clear about what success looks like and my role in contributing to it?
7. Have I been clear about what retention factors (compensation, participation in decision-making, leadership development opportunities, etc.) are important to me?

Once performance areas are identified, a collection method for performance data should be determined and complete confidentiality maintained. This should become part of a regular review process that follows a given schedule (i.e., annually or bi-annually) and is conducted around an anniversary date or other performance period.

Once completed, the results of the self-evaluation and other stakeholder input should be compiled and discussed. This type of process provides for constructive feedback in a structured manner that allows for successes to be recognized and weaknesses to surface and be thoughtfully considered. For example, if a physician is scoring well on resource utilization, the method the physician uses to produce that result can be replicated more broadly, or physicians that perform less effectively can use that physician as a resource for improvement. Over time, progress and trends can be tracked and results used if difficult decisions need to be made, or unique retention elements justified. These results also can help in determining which clinicians are critical to retain.

Retirement, Succession and Transition

Effective transition and succession of clinical leadership is an often-overlooked aspect of the health system-physician relationship continuum. If your organization has been successful in building a regionally or nationally recognized clinical program, what steps are underway to ensure the program maintains its stature and momentum as program leadership changes? What if something untoward suddenly occurs to the individual that represents the spirit of the program? Health care organizations need to effectively plan for these transitions and engage physicians in the succession process.

Preparation should focus on both unplanned and planned transitions.

Unplanned Transitions

Boards and system executives should ensure that a plan is in place to address emergency or unplanned transitions of clinical program leadership. The plan should include appointment of interim leadership, clinical coverage, a communication plan, the steps to be implemented in finding a suitable replacement, and how to manage the ripple effect that typically occurs among other program staff.

While such plans are usually not widely disseminated, the board should be aware that a plan is in place for each critical service line, and that each plan is reviewed and renewed annually.

Planned Transition

In planning for a transition in clinical program leadership, health systems need to assess what has made the program successful and what will be required of program leadership for success going forward. Is the future program leader's personality critical? How important was the clinical pedigree and reputation of the founder to the program's success? In the future should the program focus on growth? Efficiency? What leadership capabilities will be critical for meeting program goals? How do we prepare for a smooth transition?

A succession plan for each critical service line should address the current physician leader's career trajectory and the bench strength of colleagues, their interest in leadership, and whether their interests align favorably with the health system's (see Appendix page 22).

The Board's Role: Succession Planning and Transition

1. Identification of Critical Service Lines
2. Identification of Physician Leadership Roles and Individuals
3. Awareness of the Service Line Risk Profile
4. Overview of Unplanned and Planned Succession Plans

Questions to Consider: Retirement, Succession, and Transition

Board

1. Are we aware of the key personnel within our critical service lines?
2. Do we have a plan to address the sudden departure of key physician(s)?
3. Are we knowledgeable about our physician risk profile (i.e., age, lifestyle change, opportunity)?

Administration

1. Where are we at greatest risk if we lost key physician talent?
2. What is the glide path for an incumbent planning for retirement, and what role, if any, should he or she play after the transition occurs?
3. How do we assess the qualities we need in future leadership?
4. How do we ensure that we keep existing talent with the potential to fill future leadership roles?
5. Are we aware of potential points of failure in our plan?
6. How did we execute against the plan, and how can we improve our process in the future?

Physicians

1. Do I anticipate a change in my status over the next several years?
2. Am I prepared for the transition?
3. If so, would I wish to remain involved in a different capacity?
4. Is there anyone that can succeed me in the event of an emergency?
5. If not, how do we address that?
6. Is the service line prepared for transition and potential disruption?

We had a clinical leader and highly regarded, well-trained, eager young physicians. With proper retention planning we were able to transition our clinical leader out of practice and maintain his energy and institutional knowledge. We made transition and succession a cultural cornerstone for administration and clinicians.

President and CEO of a mid-sized health system

Conclusion

Sector evolution will continue to challenge boards, administration, and physicians to think differently about how they relate to one another, how they face ever more difficult problems, and how they can capitalize on opportunities together. Each health system will decide how best to address these topics in order to ensure that relationships remain strong, purpose and roles remain clear, and all interested parties remain aligned. Alignment cannot and will not be optimized without intentional focus.

Boards have evolved over time to focus on and enhance their awareness and knowledge of issues such as finance, quality, strategy, philanthropy, and board member recruitment. These efforts have been made because the board, led by visionary leaders, recognized the need to adapt to changing dynamics. The topics discussed in this monograph may seem to take a backseat to myriad other concerns today. However, paying attention to these topics can catapult an organization to a stronger foundation of trust, collaboration, and appreciation of the value of engagement. Avoiding them, and the mistrust, misalignment, and miscommunication that can occur as a result, often leads to mistakes; and for many health systems the margin of error is getting thinner. In health care's current state of rapid change, attending to the health system-physician relationship continuum will offer opportunities to adapt together and move more nimbly through an uncertain, but fast-approaching future.

Appendix

PHYSICIAN RETIREMENT TIMETABLE

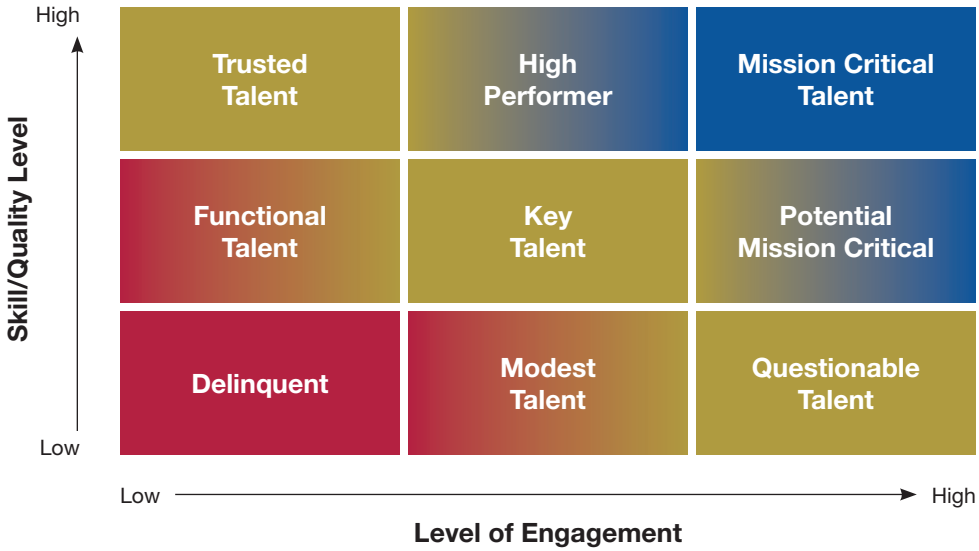
Sample Health System

Name/Title	Age	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Dr. Lisa Blue Chief of Cardiology	63	63	64	**65**								
Dr. Cindy Green Chief of Orthopedics	59						65	66	**67**			
Dr. Bruce White Chief of Neurology	54									63	64	65
Dr. Donna Black Orthopedic Surgeon	41											
Dr. Dan Turquoise General Surgeon	64				68	69	**70**					
Dr. Doug Yellow General Surgeon	64	64	65	**66**								
Dr. Tim Purple Interventional Cardiologist	57			60	61	**62**						

Notes:

PHYSICIAN RETIREMENT TIMETABLE: TALENT ASSESSMENT GRID

Sample Health System



SAMPLE HEALTH SYSTEM PHYSICIAN COMPENSATION GOVERNANCE RESPONSIBILITIES OUTLINE

It is imperative that, with Sample Physician Group (SPG) established and operating, the governance responsibilities for overseeing the physician compensation and performance program are clear. There are annual responsibilities for the Sample Health System (SHS) Executive and Physician Performance and Compensation Committee of the board and the SPG Compensation Committee. This document is intended to clarify the responsibilities for both groups.

SAMPLE HEALTH SYSTEM — EXECUTIVE AND PHYSICIAN PERFORMANCE AND COMPENSATION COMMITTEE

1. Approve the Physician Compensation Philosophy document
2. Review compensation for physicians that exceeds the XX percentile in total cash compensation and the XX percentile compensation per wRVU.
3. Oversight and review of physician compensation arrangements, including:
    a. Select physician compensation arrangements such as (new and/or renewals)
        i. Medical Director contracts
        ii. Professional services contracts
        iii. Physician employment contracts
        iv. Hospital-based physician contracts
        v. Physician recruitment contracts
        vi. On-call/call coverage
        vii. Locum arrangements with entities (other than a commercial locum tenens firm)
        viii. Medical staff leadership compensation
        ix. Clinical research compensation
        x. Teaching stipends

SAMPLE PHYSICIAN GROUP — COMPENSATION COMMITTEE

1. Establish an annual work plan and corresponding timeline
2. Review Physician Compensation Philosophy document to reaffirm or recommend modifications to the SHS board committee
3. Consideration of modifications to compensation model(s) including Fair Market Value analysis (if required)
    a. Review Part A (Individual Clinical Productivity) and Part B (Organizational Incentives)
    b. Identify rationale for modifications
    c. Prepare analysis to support modifications
    d. Review impact of proposed modifications prior to finalizing recommended changes to the SHS board committee
4. Mid-Year Analysis of Compensation Model focusing on actual compensation levels, goals, outcomes, and productivity compared to philosophy, model and expected results.

See the sample timeline for conducting the processes for both committees on page 21 to organize the annual work related to physician compensation.

SAMPLE PHYSICIAN COMPENSATION COMMITTEE WORK PLAN

PHYSICIAN GROUP COMMITTEE WORK

January

- Mid-Year Analysis of Compensation Model focusing on actual compensation levels, goals, outcomes, and productivity compared to philosophy and model

February

- Review of mid-year results with Physician Steering Committee
- Begin discussion with Sample Physician Group (SPG) Compensation Committee to determine whether adjustments to philosophy or model are recommended

March/April

- Consideration of compensation model modifications including Fair Market Value analysis, (if required)
- Identify rationale for modifications
- Analysis for support of modifications or groundwork for upcoming fiscal year (FY) plan model without modifications; setting incentive targets and rebalancing survey data

May

- Review modifications and/or FY model with SPG committee for approval
- Sample Health System (SHS) board committee: Review of compensation model(s) or modifications to physician compensation models

July 1

- Current model or revised implemented for FY

HEALTH SYSTEM COMMITTEE WORK

September

- Administration collects data regarding committee oversight parameters

November

Committee meets to review and reaffirm, or adopt modifications to:

1. Physician compensation philosophy
2. Committee charter
3. Review of physicians under the committee oversight parameters
4. Education on prior FY and trending

PHYSICIAN SUCCESSION BENCH STRENGTH

Sample Health System

Name/Title	Age	Yrs of Service	Date of Hire in Position	Years in Position	Retirement Time Frame	Emergency Replacement	In Development	Future Prospects
Dr. Lisa Blue Chief of Cardiology	63	12	1/1/09	6	2-3 years			
Dr. Cindy Green Chief of Orthopedics	59	10	6/21/09	6	5-6 years			
Dr. Bruce White Chief of Neurology	54	21	1/7/07	8	>10 years			
Dr. Donna Black Orthopedic Surgeon	41	13	2/7/03	12	>10 years			
Dr. Dan Turquoise General Surgeon	64	13	12/9/07	7	2-3 years			
Dr. Doug Yellow General Surgeon	64	33	6/21/82	33	>10 years			
Dr. Tim Purple Interventional Cardiologist	57	29	10/1/98	16	6-8 years			

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