Clinical Compensation

Health Sciences Faculty Compensation

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Clinical Compensation is one source of total compensation and may have several components

- Clinical compensation is but one component of the HSCP. It may be nonexistent, the entirety of or a portion of combined X Y Z compensation
- There may be non-clinical sources for compensation (e.g. State FTE funding, research grants, teaching)
- Clinical compensation itself may contain a mix of several components:
  - CARE payment (wRVU driven)
  - Medical Directorships
  - Coverage payments
  - These are dependent upon the department/division compensation plan
Clinical Compensation has evolved significantly since the introduction of Resource Alignment

- Prior to RA2016, clinical compensation planning was left entirely to departments and was done without clear principles being employed.
- This ultimately led to some unfavorable situations:
  - Disconnect between clinical work and compensation
    - Cases of hard to justify compensation
    - Failure to be mindful of proper billing
  - Inconsistency and side deals
Resource Alignment ensured clinical compensation plans derived from basic principles

- Guiding principles in place for the development of plans included:
  - **Reward productivity** – tighten the correlation between work effort and compensation, provide an incentive for extra work and proper billing
  - **Transparent and faculty approved** – approved by department committee including representative faculty members, visible to all faculty
  - **Fair** – bring standardization to funding departments for things such as call coverage compensation and medical directorships
  - Each department has its own, customized plan, but all adhere to these principles and each must be approved by the Clinical Compensation Committee
Funds flow to the departments to create clinical compensation

- CARE payment is the largest source of clinical revenue to a department, and is taxed to fund operations and certain department determined compensation components (e.g. coverage, med directors)
- The funds available are then paid to faculty according to an approved compensation plan
The department commits to paying the Guaranteed, or Pre-Incentive comp each year. It may be readjusted year to year if faculty member does not achieve sufficient clinical revenues to fund.

Pre-Incentive comp should be readily achievable:

- Reasonable wRVU targets in line with history
- Startup funds to fill in for new faculty as their practice develops
Clinical Compensation Plan Common Framework (continued)

- Incentive compensation is almost always wRVU driven and is paid on a regular schedule (typically quarterly)
- Compensation per wRVU is dependent upon individual department plan details
- Non-wRVU clinical compensation (e.g. medical directorship, call coverage) passed through to physician as appropriate

Plans are customized for each department, sometimes by division. Individual plans can be complex, but should be transparent to participants and explainable by administrators
What kind of variations are out there?

- Adjustments for seniority (i.e. Assistant/Associate/Full Professor)
- Shared RVU pools to compensate for low-RVU portions of team practice
- Clinical Service Agreements providing large portion of Negotiated Comp
- Shift-based compensation
- And others……..