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NOVEMBER 2014

Reforming Executive Compensation to Accelerate Change

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Intelligence Report Premium from HealthLeaders Media

Reforming Executive Compensation to Accelerate Change

This report outlines how organizations can best incentivize leaders to guide their organizations in new directions to meet evolving demands.

- How are organizations expanding their executive compensation incentives beyond financial and clinical production and toward reform-oriented goals?
- How is CMC Healthcare System balancing short-term losses for long-term gains in linking incentives to the building of a new imaging center?
- What special role must CEOs play in guiding both boards and executive teams to establish and accept compensation structures appropriate for new industry priorities?
- Why has Enloe Medical Center cut out all individual performance goals from executive compensation in favor of team goals, and what is the main thing it had to get right to make team goals work?



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PERSPECTIVE

The Impact of Healthcare's New Value-Based Environment on Recruitment, Retention, and Executive Compensation

As the transition from volume- to value-based care moves forward, healthcare providers continue to implement new strategies to navigate rapid regulatory changes and increasing market pressures. Executive compensation is one area under significant focus, particularly as reimbursements decline, operating margins narrow, and leadership turnover increases. As a result, providers are exploring opportunities to strengthen recruitment and retention, decrease risks, and maintain organizational momentum. This year's HealthLeaders Media Executive Compensation Survey demonstrates how some organizations are addressing executive compensation and the importance of aligning compensation packages to healthcare's new performance-based care model.

The evolution to value-based care delivery is ushering in a new set of realities for organizations, particularly the importance of recruiting, developing, and retaining innovative healthcare executives. This is an important area of emphasis for the healthcare industry in light of a survey released this year by the American College of Healthcare Executives that reported a record 20% turnover rate at the CEO level.

Adjusting executive compensation structures provides an opportunity for organizations to positively impact retention and decrease turnover. An overwhelming majority of executives surveyed for this HealthLeaders Media Intelligence Report identified the need for changes to executive compensation to

attract, retain, and engage leaders. In fact, 33% of executives said the compensation structure in their organization needed major enhancements, while 49% said only minor enhancements were needed.

Aligning executive compensation incentives more closely to value-based care will also drive increased engagement among healthcare executives. Many organizations are already adjusting compensation packages to reflect this change. Targets for incentive payments have changed over the years, with healthcare executives identifying the top four as operating margin, staff engagement and satisfaction, clinical performance, and cost containment. While some organizations are taking a proactive approach, others are slow to change. According to the survey, 43% of executives say their organization has not modified executive compensation incentives to reflect value-based purchasing.

Leadership development programs and succession planning are vital to recruitment and retention, as well as successfully addressing the trend of executive turnover. Unfortunately, this year's survey shows organizations can make significant improvements in this area. According to the survey, 46% of executives said they would have to leave their organization to advance their career, and half of them (23%) are currently looking at opportunities.

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Perspective (continued)

Healthcare executives seeking new career opportunities are finding the market has changed as the industry moves to bridge the gap between clinical and financial operations. Clinical integration and population health management are driving increasing demand for executives with clinical backgrounds. In this year's survey, while only 8% of respondents say that none of their executives has a clinical background, 44% say their organization is recruiting more such leaders. A clinical background will be essential as executive compensation incentives are expected to incorporate clinical performance parameters at an increasing rate in years to come. In fact, 76% of respondents expect their organization to emphasize patient satisfaction targets for executive incentives over the next three years. Readmission targets ranked second with 54%, and length of stay was a distant third coming in at 36%.

The shift to value-based care is drastically transforming the healthcare landscape, creating a period of both great opportunity and great risk for providers. Long-term success hinges on an organization's ability to recruit, develop, and retain high-performing executives. Embracing evolving executive compensation packages will play an integral part in an organization's future workforce recruitment and retention strategy.



Doug Smith
President and CEO
B. E. Smith
Lenexa, Kansas

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About the Premium and Buying Power Editions

This is a summary of the Premium edition of the report. In the full report, you'll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Mike Wiltermood, President and CEO of Enloe Medical Center in Chico, California, and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by CMC Healthcare System in Manchester, New Hampshire; Northern Westchester Hospital in Mount Kisco, New York; and Enloe Medical Center in Chico, California
- A list of Recommendations drawing on the data, insights, and analysis from this report
- Meeting Guide featuring questions to ask your team

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Methodology

The 2014 Executive Compensation Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In August 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 454 completed surveys are included in the analysis. The bases for the individual questions range from 428 to 454 depending on whether respondents had the knowledge to provide an answer to a given question. The margin of error for a sample size of 454 is +/-4.6% at the 95% confidence interval.

For the purpose of this survey, "executive" is defined as CEO and the CEO's direct reports. On the administrative side, the term *direct reports* often includes titles such as CFO, COO, and CIO. Chief quality officer, chief nursing officer, and chief medical officer are considered executives if the individuals filling those positions no longer have clinical responsibilities.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

Joseph Pepe, MD
President and CEO
CMC Healthcare System
Manchester, New Hampshire

Mike Wiltermood
President and CEO
Enloe Medical Center
Chico, California

Joel Seligman
President and CEO
Northern Westchester Hospital
Mount Kisco, New York

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Intelligence Report Senior Research Analyst

MICHAEL ZEIS
mzeis@healthleadersmedia.com

Vice President and Publisher

RAFAEL CARDOSO
rcardoso@healthleadersmedia.com

Editorial Director

EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor

BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director

ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager

ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor

DON COSTANZO
dcostanzo@healthleadersmedia.com

Intelligence Report Contributing Editor

RENÉ LETOURNEAU
rletourneau@healthleadersmedia.com

Intelligence Report Design and Layout

KEN NEWMAN
knewman@healthleadersmedia.com



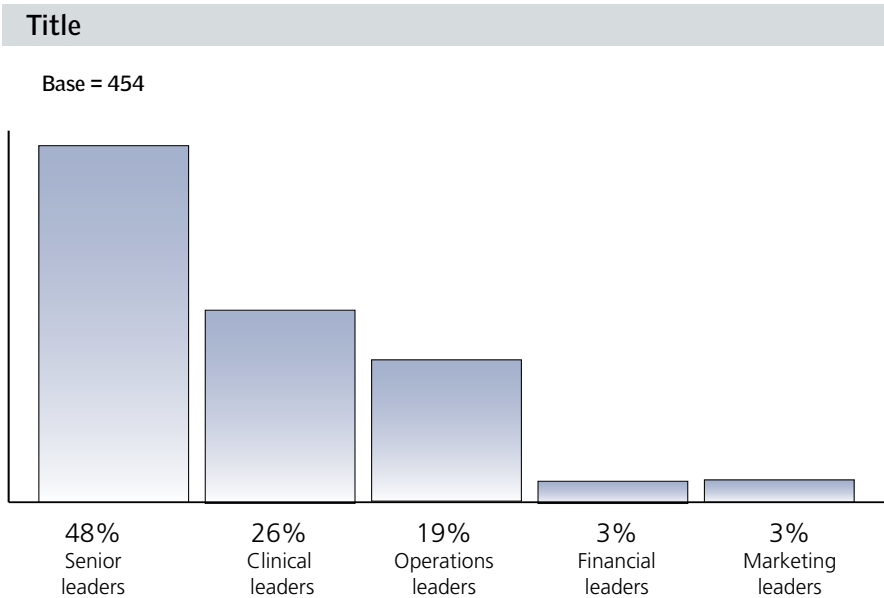
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Respondent Profile

Respondents represent titles from across the various functions at healthcare provider organizations.



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Cardiology, Chief of Neurology, Chief of Oncology, Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Inpatient Services, Dir. of Intensive Care Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt./MD), VP Nursing

Operations leaders | Chief Compliance Officer, Chief Purchasing Officer, Asst. Administrator, Chief Counsel, Dir. of Patient Safety, Dir. of Purchasing, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Financial leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Patient Financial Services, Director of RAC, Director of Reimbursement, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Type of organization

Base = 454

Hospital	44%
Health system	28%
Physician org	11%
Long-term care/SNF	7%
Health plan/insurer	4%
Ancillary, allied provider	4%
Government, education/academic	3%

Number of sites

Base = 125 (Health systems)

1–5	17%
6–20	32%
21+	51%

Number of beds

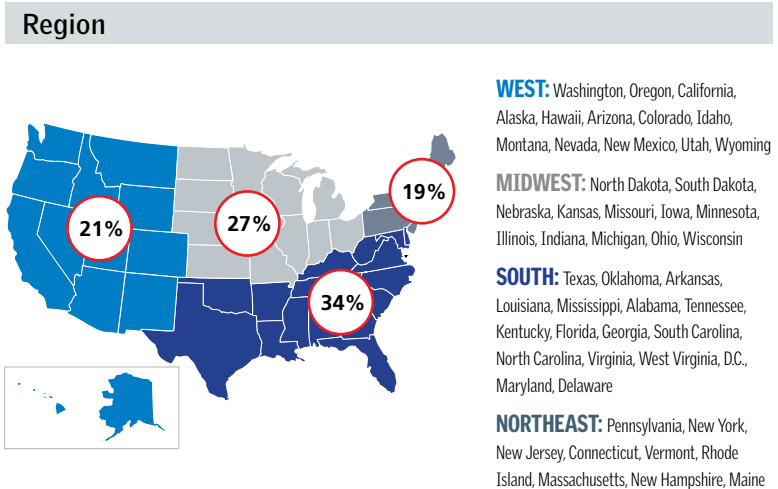
Base = 198 (Hospitals)

1–199	52%
200–499	31%
500+	17%

Number of physicians

Base = 50 (Physician organizations)

1–9	20%
10–49	32%
50+	48%



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ANALYSIS

Executive Compensation: Aligning Incentives With Mission

MICHAEL ZEIS

Because the healthcare industry is embarking on reform-prompted structural and financial overhauls, classic and comfortable production-based executive incentives are under scrutiny. Modifying executive compensation parameters is not easy, partly because moving in new strategic directions implies adopting new performance metrics. Compensation committees with a strong desire for stability may find that if they resist change, their strategic direction and their compensation packages will become misaligned at the top levels of the organization.

Joseph Pepe, MD, president and CEO of not-for-profit CMC Healthcare System in Manchester, New Hampshire, which includes the 330-licensed-bed Catholic Medical Center hospital, the New England Heart Institute, and several subsidiaries—is helping the CMC board take a new direction when updating executive compensation. “The compensation committee is looking at this now,” he says, “trying to find out what’s fair. They are used to focusing on what like institutions are doing. I’m trying to get them a little bit out of their comfort zones, suggesting that we look beyond overall revenue, although I think that is a consideration.

“Instead,” Pepe says, “we should look at what we want to achieve for the future. For example, if the future depends on the capabilities of improved

WHAT HEALTHCARE LEADERS ARE SAYING

“Qualitative goals include implementation of the payer strategy and payer partnerships, infrastructure built for population health management and high-risk management care delivery systems, new physician compensation and incentive systems, and development of new and innovative business structures.”

—President of a medium health system

“We are looking at relating compensation to reducing costs and length of stay, while improving outcomes and employee retention.”

—Vice president of finance for a small hospital

“Incentives overall tie to a fee-for-service world. Locally, margin targets are set, which incorporate the impact of population health and readmissions. In effect, there is no direct linkage, but rather there is an indirect linkage to both population health management and the trend away from acute care admissions.”

—Chief financial officer of a large health system

“The CEO receives incentives regardless of financial or quality outcomes. We still have a good old boy setup.”

—Chief nursing officer of a medium hospital

“There have been no changes. Compensation is still based on traditional metrics.”

—Chief medical officer of a large health system

“We’re adding goals, but overall financial targets are still expected.”

—CEO of a large health system

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Analysis (continued)

operational efficiency, clinical integration, quality outcomes, and care management, then why not develop metrics around these, so that there's incentive pay based on where we need to go in the future?"

Focus on mission and strategy. One-third (33%) of respondents to the *HealthLeaders Media Executive Compensation Survey* say that their organization's executive compensation structure needs major enhancements in order to attract, retain, and engage leaders. Joel Seligman, president and CEO of Northern Westchester Hospital, a not-for-profit 200-staffed-bed community hospital in Mount Kisco, New York, says, "That suggests to me that in a lot of places, variable compensation really isn't sensitive to organizational goals. And so that would suggest that there's a lot of opportunity for improvement out there."

In fact, 40% of executives say their organization's executive compensation packages are misaligned with their organization's strategies, which combines the 14% who say compensation is seriously misaligned and the 26% who describe it as slightly misaligned. Pepe identifies two possible consequences of such misalignment, and recognizes that a resolution must come from the very top.

"A significant percent of organizations may be at risk of either faltering on the progress of the organization or losing good executives due to misaligned compensation," he says. "The big question is how much of

this is the fault of the CEO and how much of this is the fault of the board's compensation committee."

Indeed, one of the tasks of the CEO is to take every opportunity to reinforce the organization's strategy with the executive team. Mike Wiltermood, president and CEO of Enloe Medical Center, a 200-staffed-bed nonprofit hospital in Chico, California, says, "We constantly try to address this at our team meetings, making sure that what we're talking about is relevant to our strategy."

Wiltermood, lead advisor for this report, explains the process at Enloe for ensuring that the board and the executive team both understand the organization's mission and strategy. "As part of our annual evaluation, each board member has a series of questions that they answer, and the executive staff also does the survey. They are asked specific questions about alignment between mission, vision, and values and our strategies. They are asked specifically if they feel that they line up."

"There are two forces involved. One is a push toward individual accountability—holding individuals responsible and rewarding or punishing them accordingly. The second force is about teams, and it is more powerful."

—Joel Seligman

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Analysis (continued)

Get my attention. Overall, survey respondents indicate that 9% of total executive compensation consists of cash incentive payments. Incentives are meant to help focus our energy. Some say that even a small incentive can make a big difference, but there is another point of view. Says Seligman, an advisor for this Intelligence Report, “I’ve read that if you’re giving me an opportunity to earn more by doing something better, it better be worth 10% of my salary or more, or you haven’t even got my attention. The 9% we see in the survey results is probably broken into two, three, four, five, or six different factors. It’s probably pretty withered down, so I wonder how effective those programs are at all.”

The proportion of compensation through cash incentives is higher among health systems (13%) than at hospitals (6%), but response to this question, including response by healthcare setting, has been fairly stable over time. Stability over time indicates that, overall, compensation committees probably feel that the levels of variable compensation are appropriate.

Individual and team goals. Incentives are split fairly evenly between individual goals (45%) and team goals (55%). Advisors expect more emphasis in the future on team goals, but do not expect a severe decrease in individual goals.

“There are two forces involved,” Seligman explains. “One is a push toward individual accountability—holding individuals responsible and rewarding or punishing them accordingly. The second force is about teams, and it is more powerful. I would expect that incentives will shift gradually toward being more team-based. This is about building a culture of teamwork and trust between people and process.”

As can be seen in the accompanying case study, incentive compensation for Enloe’s executives is based completely on team goals. (Data from our survey that does not appear as a chart in this report shows that 23% of respondents base cash incentives solely on team-based goals, while 15% base it exclusively on individual goals, and 22% split it, half for team, half for individual.) Says Wiltermood, “Our executives seem to resonate with and really like team goals, because we’ve got to help each other out. There are no silos. We communicate. Nobody withholds information, nobody is chasing down a personal goal to the detriment of the goals that we’ve set as

“We still live in a volume world and because of that, operating margin is still one of our metrics. But more and more we’re putting value metrics in our compensation packages.”

—Joseph Pepe, MD

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Analysis (continued)

a team. When you know that your success is built on the team as opposed to your individual effort, I think it does kind of change the collaboration.”

While 15% of respondents rely exclusively on individual goals, and 23% rely solely on team goals, the majority (62%) has some mix of team and individual goals. Still, it is prudent to monitor the mix closely. “If you get too myopic about an individual goal without being able to look as a team at the total impact that it’s having on an organization,” says Wiltermood, “you could potentially get into some trouble.”

Fondness for what we know. The objectives that are on top of the chart of individual incentive payments are the same as the items that are on the top of the team incentive chart—a mixture of financial objectives, clinical objectives, and staff engagement/satisfaction targets. “Individual goals and team goals aren’t very different anyway,” Seligman notes.

While staff engagement or satisfaction is relatively common as an executive incentive (47% have it as an individual goal, and 51% have staff engagement as a team goal), physician engagement is near the bottom of each chart, with 26%. Considering its importance, especially with care redesign efforts and the need for the industry to focus on improved outcomes and provider efficiency, one wonders why physician engagement isn’t part of variable compensation more

frequently. Seligman observes that physician engagement is difficult to measure.

“I think we gravitate toward things that are easier to measure and are readily available—we all know what operating results mean,” he says. “We do a physician satisfaction survey once every couple of years, and physicians don’t want to do them. Physician engagement is a tough one because generally you don’t have a regular flow of the kind of data that would be meaningful. And when you are talking about people’s bonuses, they want current data. They want frequent data.”

Pepe adds that there isn’t an agreed-upon definition for physician engagement, either. “It’s very difficult to define let alone measure physician engagement. Once we as an industry figure out how to define physician engagement, then we’ll monitor it.”

A majority sees that change is needed. Healthcare reform causes organizations to review their strategic direction. Organizations must

“Our executives seem to resonate with and really like team goals, because we’ve got to help each other out. There are no silos. We communicate.”

—Mike Wiltermood

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Analysis (continued)

develop a new understanding of their financial foundation, and at the same time examine how to change their core deliverable: patient care.

More than one-fifth (21%) say their organization has made changes to its executive compensation strategies to address the financial realities of healthcare now. (But that includes 4% who say that the changes made were in the wrong direction! Just 17% describe the implemented changes as being in the right direction.) In addition to the 21% who have acted, Pepe notes the 50% who recognize that change is needed but have yet to devise a plan (35%) or implement it (15%).

“Combined, I see that 71% have changed executive compensation strategies or recognize a change has to occur,” Pepe says. “This tells me that it’s clear that the industry is taking this seriously, and the majority feel that financial reform is not just a fad or a fantasy.” He expresses concern for the 20% who say they have not changed executive compensation packages to address the financial realities of healthcare because they believe no change is needed. “Traditionally there are laggards,” he says, “and I worry that in this market those laggards may look more like a Borders bookstore in the future than like Amazon.”

Pepe sympathizes with the 35% who recognize change is needed but have no plan, particularly because of the difficulty of making projections in uncertain times. “In our market, a lot of organizations are going through

a transition process where they’re trying to come up with a new strategic plan that’s much different than the old strategic plan. The previous plan may have been a six-year strategic plan. Now if you go any more than three years, then you might as well be looking into a crystal ball.”

Performance metrics in play.

Probably because an organization’s overall mission and strategy have a degree of stability, the components of executive compensation packages are not subject to sudden shifts.

But over the past three years, higher percentages are saying that performance metrics are evolving. In our 2012 survey, 19% identified performance metrics as the aspect of their compensation package that has evolved the most in the previous two years. Answering the same question in this year’s survey, 27% say performance metrics have evolved the most.

“A significant percent of organizations may be at risk of either faltering on the progress of the organization or losing good executives due to misaligned compensation. The big question is how much of this is the fault of the CEO and how much of this is the fault of the board’s compensation committee.”

—Joseph Pepe, MD

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Analysis *(continued)*

Says Pepe, “Performance metrics are changing in two ways. One, they’re becoming less task-like and more quantitative. And they’re changing from volume to value metrics. What we’re trying to do at CMC is go toward the value metrics of physician alignment, with metrics such as mortality rates, readmission rates, integration, and so on. However, we still live in a volume world, and because of that, operating margin is still one of our metrics. But more and more we’re putting value metrics in our compensation packages.”

Although Pepe suggests that organizations are including value metrics more frequently, some are found close to the bottom of the list of clinical performance parameters that organizations expect to emphasize for executive incentives over the next three years. Patient satisfaction targets are mentioned most frequently, by 76%. Says Wiltermood, “Certainly everybody’s focus is on HCAHPS and readmissions. Those are things that have immediate financial consequences to us if we don’t manage them correctly.”

Other metrics covering activities that are probably very important to healthcare reform appear lower on the list. For instance, only 25% say that they will be emphasizing access-to-care targets over the next three years, and only 22% will be emphasizing care network expansion. Says Seligman, “This is not just new to us from a financial perspective. It’s completely new to us. Most hospitals haven’t had ambulatory care networks and prevention programs. Now these are new parts of our

structure and our scope. So I don’t think the metrics have caught up with the incentive plans yet. We don’t really agree on what good metrics are. One of the problems with executive compensation strategies is finding metrics that have some global relevance to them.”

Using access to care as an example, Seligman reminds us, as Pepe did, that if incentive parameters don’t match strategic objectives, progress toward the objectives may be impeded. “If there’s stuff we don’t measure,” he says, “we don’t improve. People may say that access to care is an important goal, but it’s kind of sad how hard it is to measure and how it looks like few people measure it well.” But the absence of metrics today should not impede the industry from making progress.

“Let’s look at how poorly or how well we’re measuring what is supposed to be a very important part of our mission. And then let’s work on it,”

“Combined, I see that 71% have changed executive compensation strategies or recognize a change has to occur. This tells me that it’s clear that the industry is taking this seriously, and the majority feel that financial reform is not just a fad or a fantasy.”

—Joseph Pepe, MD

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Analysis (continued)

Seligman says. “I’m a believer in looking for ways to track the important things as a way to ultimately improve them. So if we believe in our charitable mission of providing access for people, then I would challenge everyone to tell me how they do that.”

Incentives: Financial and beyond. Regardless of one’s approach, we should remember that the point is, indeed, to unite the executive team and by extension the whole organization in support of the mission. And as organizations revisit their mission statements and strategies in light of the requirements of healthcare reform, they are (or should be) revisiting their compensation packages, as well.

As Pepe notes, “In this time of change going from volume to value, you need staff engagement in order to make such a change. If you don’t have engagement, then change becomes quite difficult.” Some “classic” approaches to compensation may have to be abandoned or deemphasized. Pepe continues, “I think that the time has come where we actually reward people for metrics and stop rewarding them because they exist.”

Although Seligman recognizes that rewards based on financial performance are fundamental, he recognizes the need to look beyond. “At Northern Westchester Hospital, the incentive based on the financial performance of the hospital has represented about 25% of the calculation of everyone’s bonuses. That’s a meaningful number, and it’s not changing. But it’s not

40% or 50% or 60%, it’s 25%. Across the industry I think you’ll find the criteria for financial performance may be less prominent, or you’ll see incentives morphing from what had been our economic bottom line, our P&L, to financial metrics that are moving toward the idea of population health management.”

At Enloe, the simplicity of the balanced scorecard and an emphasis on team performance provide both engagement and focus in troubling economic times. Wiltermood says, “When times are tough financially, you have to try to maintain high employee morale at the same time you’re trying to find ways to balance the budget and cut costs. We try very hard to make sure that as we strive for improvement in one area, it doesn’t cost us in another area. Our compensation structure forces us to hold all those things up in front of us at all times, and I think that it’s been pretty effective for us.”

Executive compensation programs can be complex, especially as organizations add facets intending to allow their compensation programs to reflect industry trends, and as operating experience allows organizations

“If you get too myopic about an individual goal without being able to look as a team at the total impact that it’s having on an organization, you could potentially get into some trouble.”

—Mike Wiltermood

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Analysis (continued)

to add precision to their metrics. The advantages of such evolution are that attention can be targeted more accurately and executives can place more confidence in what will likely be more precise goals.

A possible disadvantage is that complexity can dilute our attention. Our survey shows that 9% of the value of executive compensation packages is in the form of incentives, which causes one advisor to wonder, considering that the 9% would likely be divided among a handful of performance metrics, whether we are providing sufficient reward to affect

behavior and effect change. In other words, we should ask ourselves whether the variety that often is the natural by-product of program enhancement actually distracts us instead of providing us more focus. Indeed, that is part of the balancing that comes with implementing executive compensation programs.

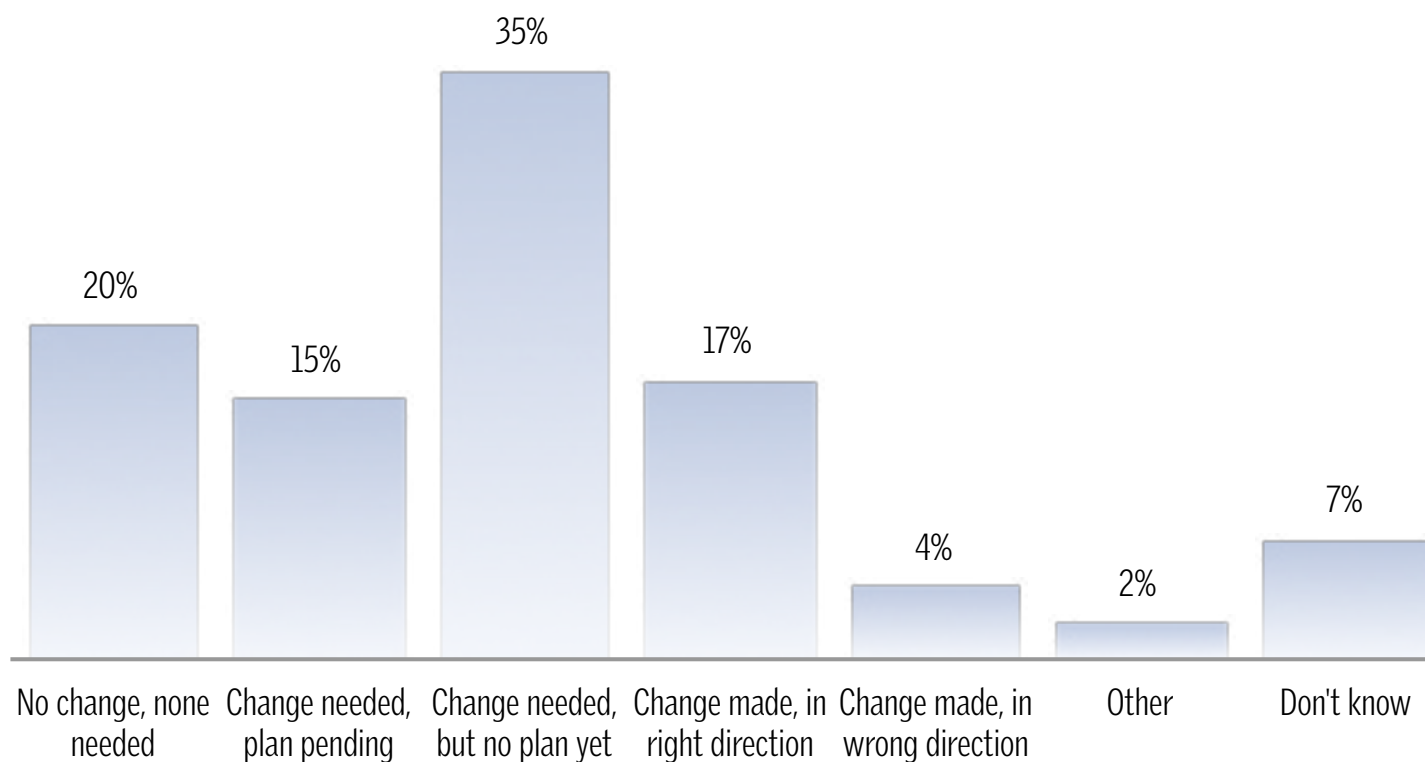
Michael Zeis is senior research analyst for HealthLeaders Media. He may be contacted at mzeis@healthleadersmedia.com.

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FIGURE 1 | Exec Comp Strategy Addressing Financial Realities Now

Q | Which of the following best describes how your organization's executive compensation strategy is addressing the financial realities of healthcare now?

Total responses



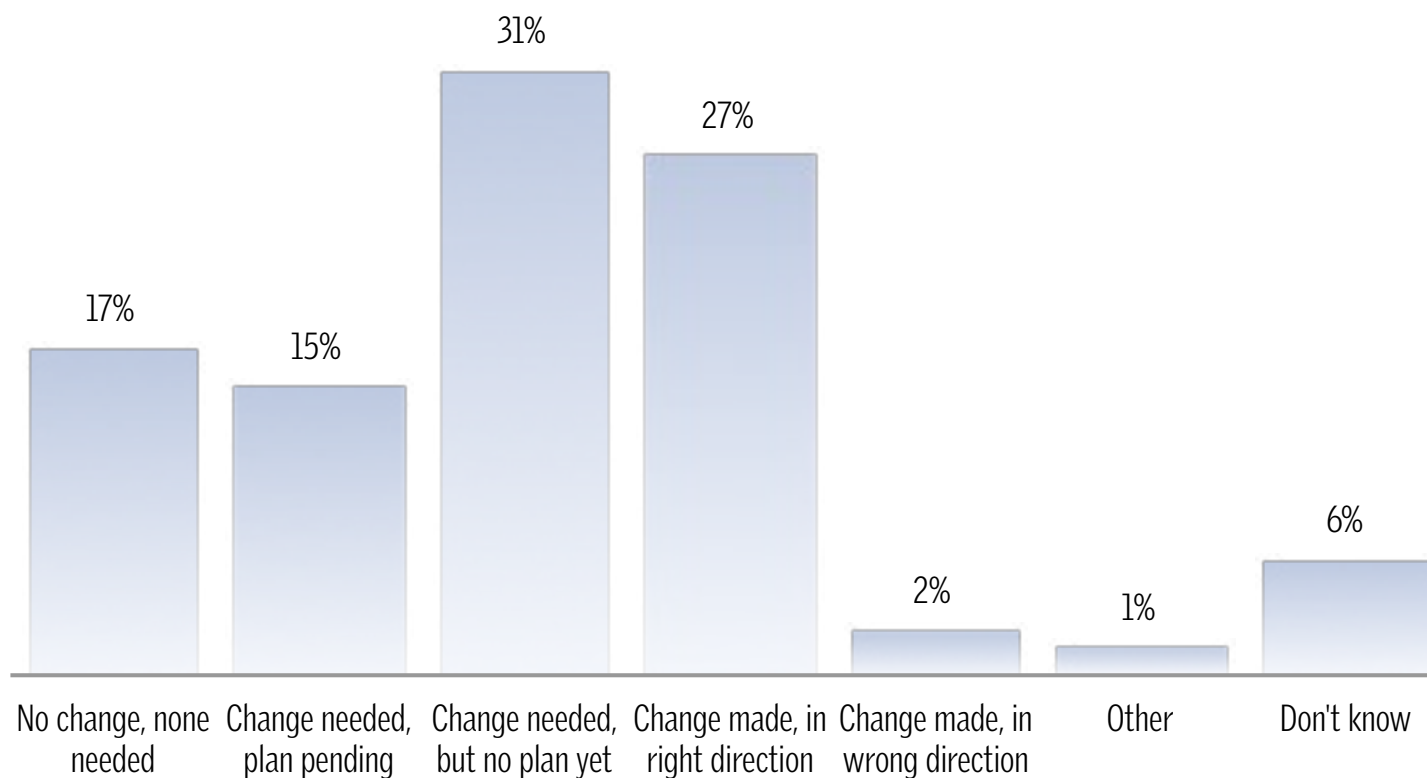
Base = 454

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FIGURE 2 | Exec Comp Strategy Addressing Patient Care Objectives

Q | Which of the following best describes how your organization's executive compensation strategy is addressing the patient care objectives of healthcare now?

Total responses



Base = 454

PREMIUM REPORT SAMPLE CHART [Click here to order!](#)**FIGURE 3 | Modifying Team Incentives for Shift to Value-Based Purchasing**

Q | In consideration of the shift from fee-for-service to value-based purchasing, has your organization modified its group or team incentives for executive compensation packages, or is it expected to do so?

Click on these
icons to dig deeper.

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FIGURE 3 *(continued)* | **Modifying Team Incentives for Shift to Value-Based Purchasing**

Q | In consideration of the shift from fee-for-service to value-based purchasing, has your organization modified its group or team incentives for executive compensation packages, or is it expected to do so?

Who controls the money? [Click on the icons to learn how they think](#)

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- Indicates the type of goods or services the respondent is involved in purchasing
- Indicates the role of the respondent in making purchasing decisions
- Indicates the total dollar amount the respondent influences

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FOLLOW-UP: METHODS FOR MODIFYING AND REASONS FOR NOT MODIFYING

Q | In consideration of the shift from fee-for-service to value-based purchasing, has your organization modified its group or team incentives for executive compensation packages, or is it expected to do so?

If yes, in what way?

System transformation

- The overall compensation methodology for the C-suite has changed to include a heavier “subjective” and qualitative component. This component includes strategies critical to transform the health system over the next five years with annual objectives and results.

Continuum

- Beginning to expand administrative roles to expand beyond acute care and be responsible for the coordinated continuum of care in a collaborative manner. Incentives are being developed that require collaboration and success to be achieved across the continuum.

Scale

- Counting covered lives as a measure of success with clinical outcomes.

Outcomes

- Greater focus on quality outcomes; not just on filling beds.
- Looking at ways to replace the WRVU model with a quality-based model.

Financial

- Looking at yearly performance measures for at-risk compensation.
- Revenue targets for divisions are tied to some value-based contracts.

Patient experience, patient care, patient focus

- A percentage of incentive compensation is tied to performance on a composite hospital VBP composite score. Includes patient experience of care, clinical process of care, and outcomes.
- Annual bonus structure has been historically based on profit only (actual vs. budget). For this year, several other measures were added including more patient-focused measures.
- Moving from production and financial success toward patient satisfaction, clinical outcomes, as well as goal achievement.

Exec staff reduction, comp adjustments

- Discontinued bonus plans, decreased benefits packages, canceled the IRA.
- Salaries were reduced anywhere from 20% to 40% in all executive positions.

If no, why not?

Metrics

- Adequate metrics have not been identified.
- Measurement is still difficult and the incentive plans are tied to measurable outcomes.

Compensation change not needed

- Attitude is that current executive staff will inherently understand and be able to guide transition to ACO model—not necessarily a good presumption in my opinion.
- Still not convinced it is necessary and still too much driven by fee-for-service.

Board/management unaware

- Board’s lack of understanding of changes.
- Lack progressive thought on this.
- Old guard culture/mentality.

Compensation cannot/will not change

- Annual performance objectives change, but comp plan does not.
- Board directive [is] to make no changes. Board has held salaries flat with no increase over that past five years and no other incentives. Board still wants to link bonus to financials that are based on volume not value.
- We are not changing the current plan, it has been built into the compensation formula for a decade.

Don’t know how to proceed

- Not decided on a direction [that will be] equitable for nonclinical departments.
- Not sure what to do.
- Unsure how to structure.

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FIGURE 4 | Outlook for Career Advancement

Q | Which of the following best describes the outlook for your career advancement?

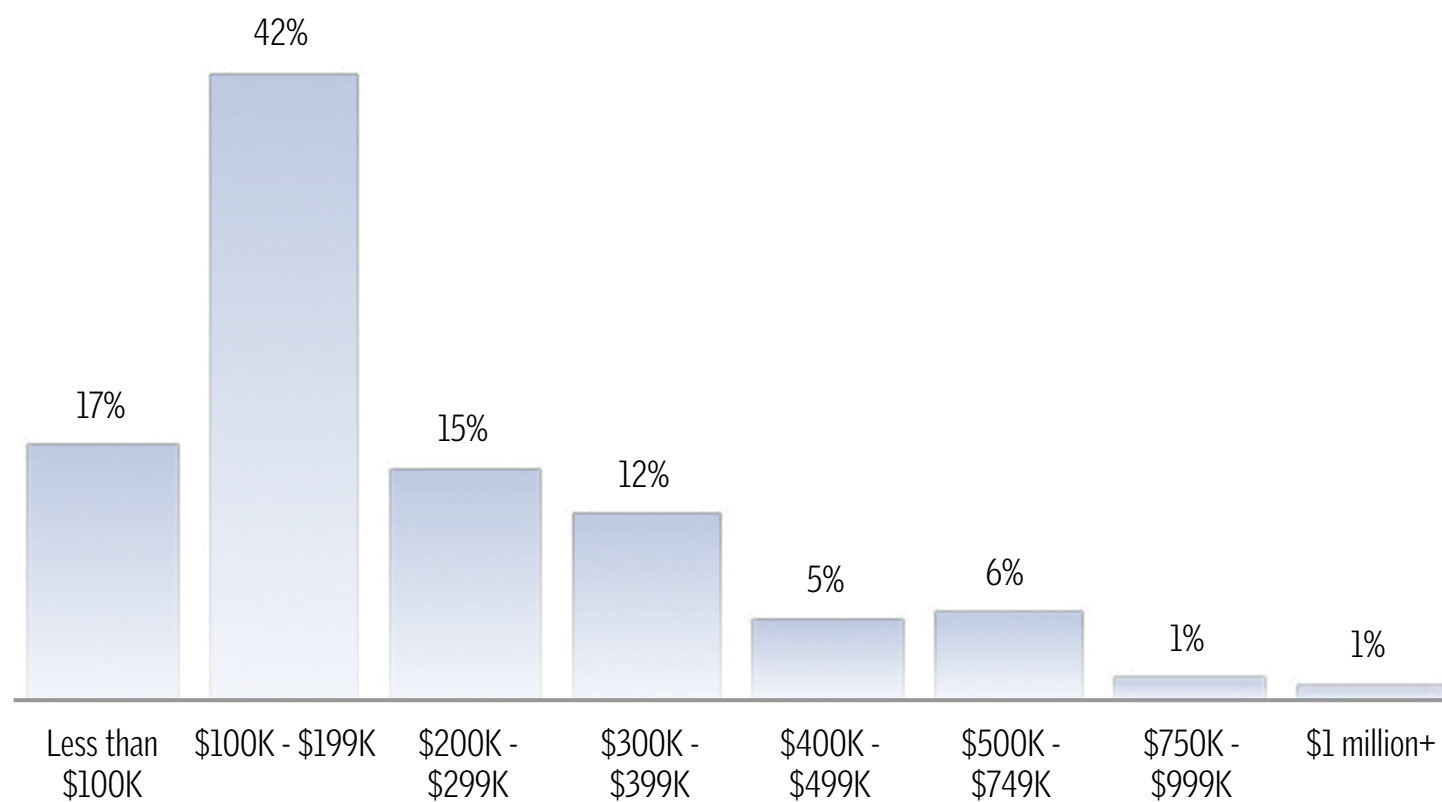


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FIGURE 5 | Total Compensation

Q | Which range does your total compensation package fall into? Include cash compensation, non-cash compensation, and deferred compensation.

Total responses

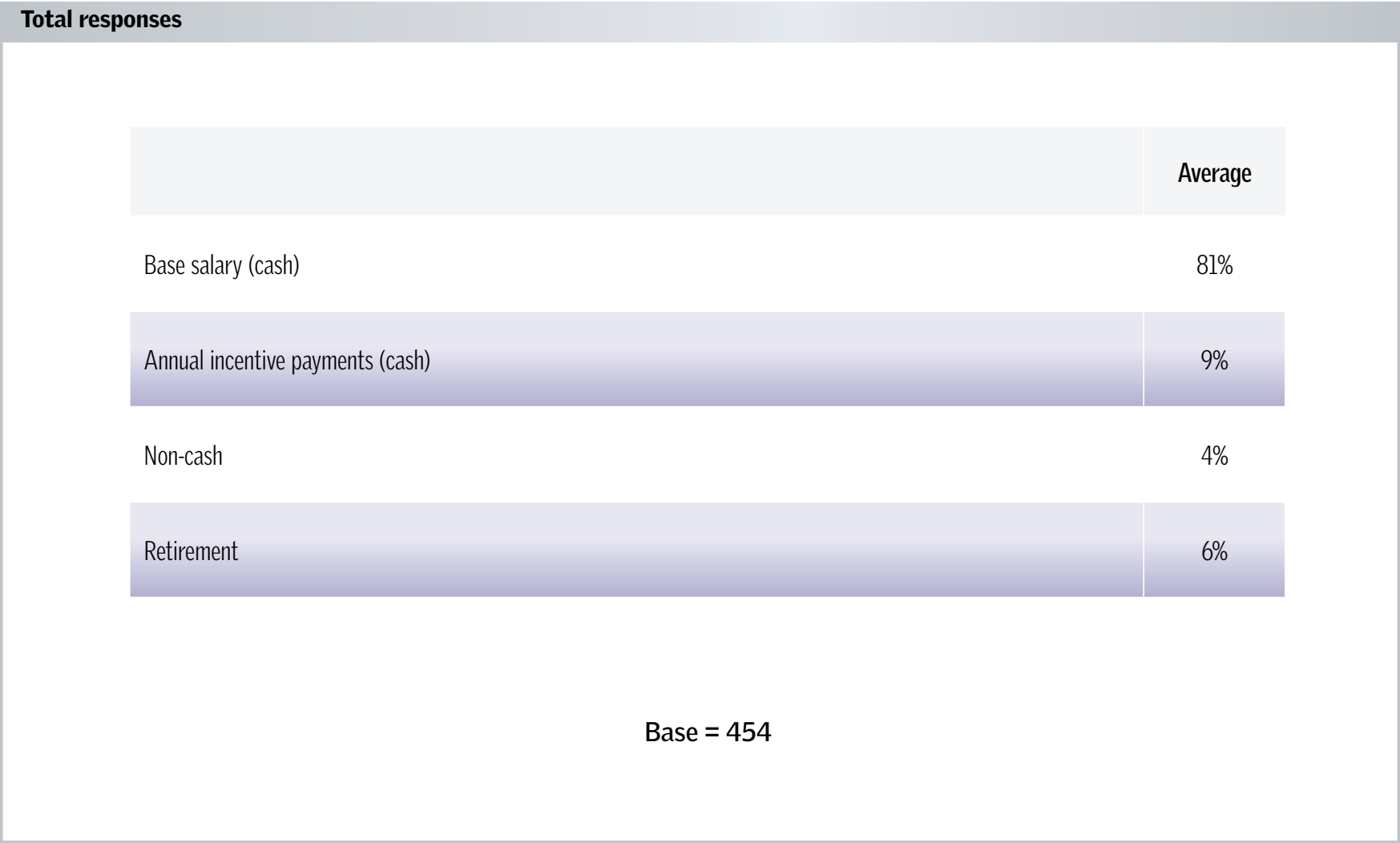


Base = 454

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FIGURE 6 | Allocation of Total Compensation

Q | In the current fiscal year, how is your compensation divided among cash compensation, non-cash compensation, and retirement?



PREMIUM REPORT SAMPLE CHART [Click here to order!](#)

FIGURE 7 | Average Individual and Team Incentive Split

Q | How are your incentives split between individual and team goals? (Among those with annual cash incentive)

Click on these
icons to dig deeper.

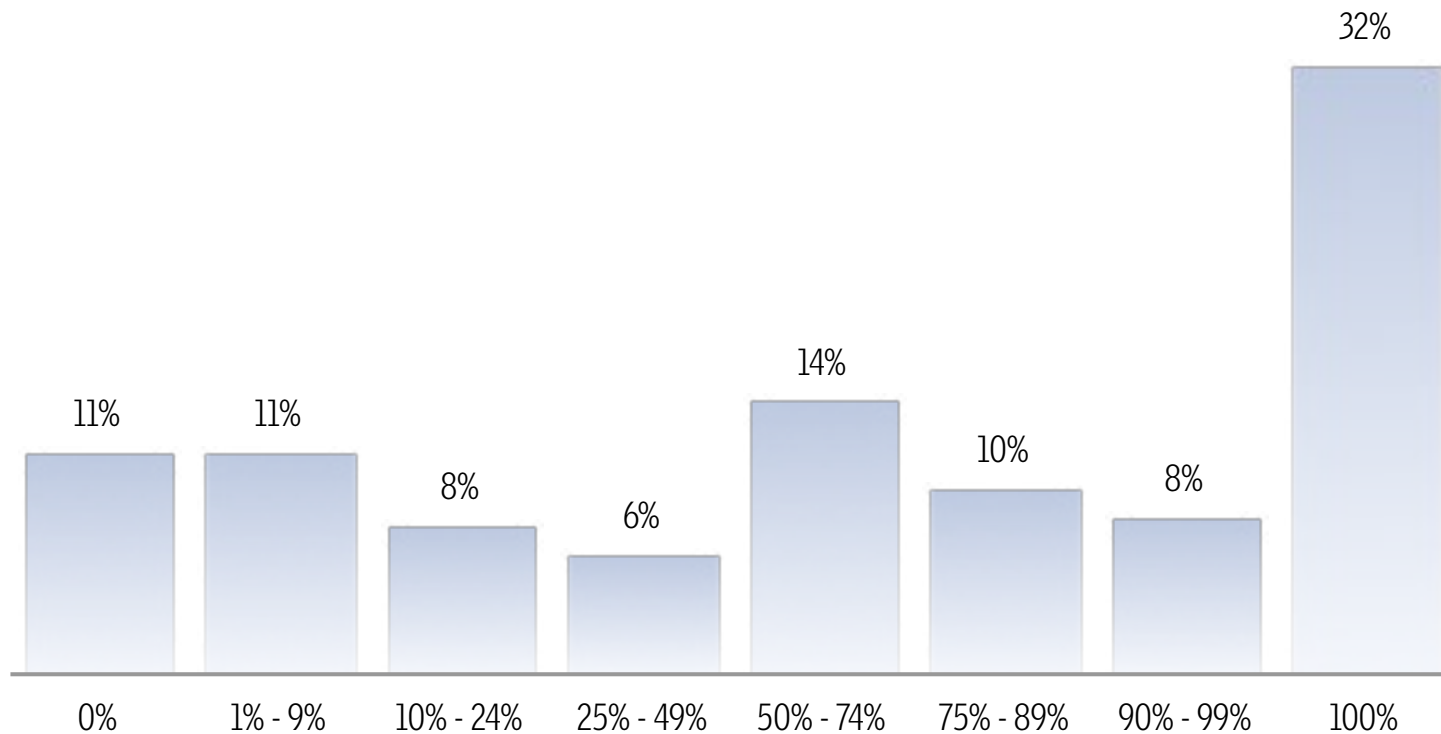
DATA SEGMENTATION TOOL

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FIGURE 8 | Percentage of Potential Incentive Awarded Last Year

Q | What percentage of your total potential incentive payment was actually awarded to you by your organization last year?
(Among those with annual cash incentive)

Total responses



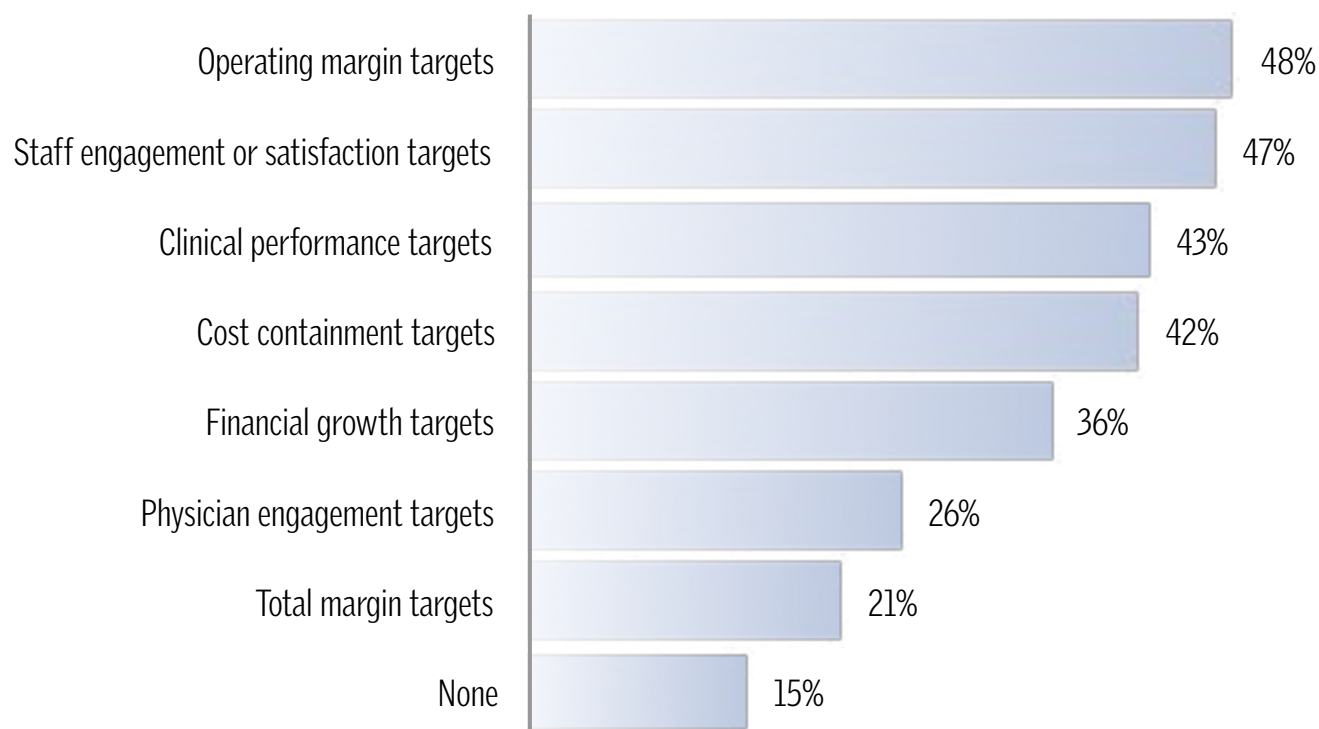
Base = 262

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FIGURE 9 | Basis for Individual Incentive Payments

Q | Which of the following general categories serve as a basis for your current individual incentive payments? (Among those with annual cash incentive)

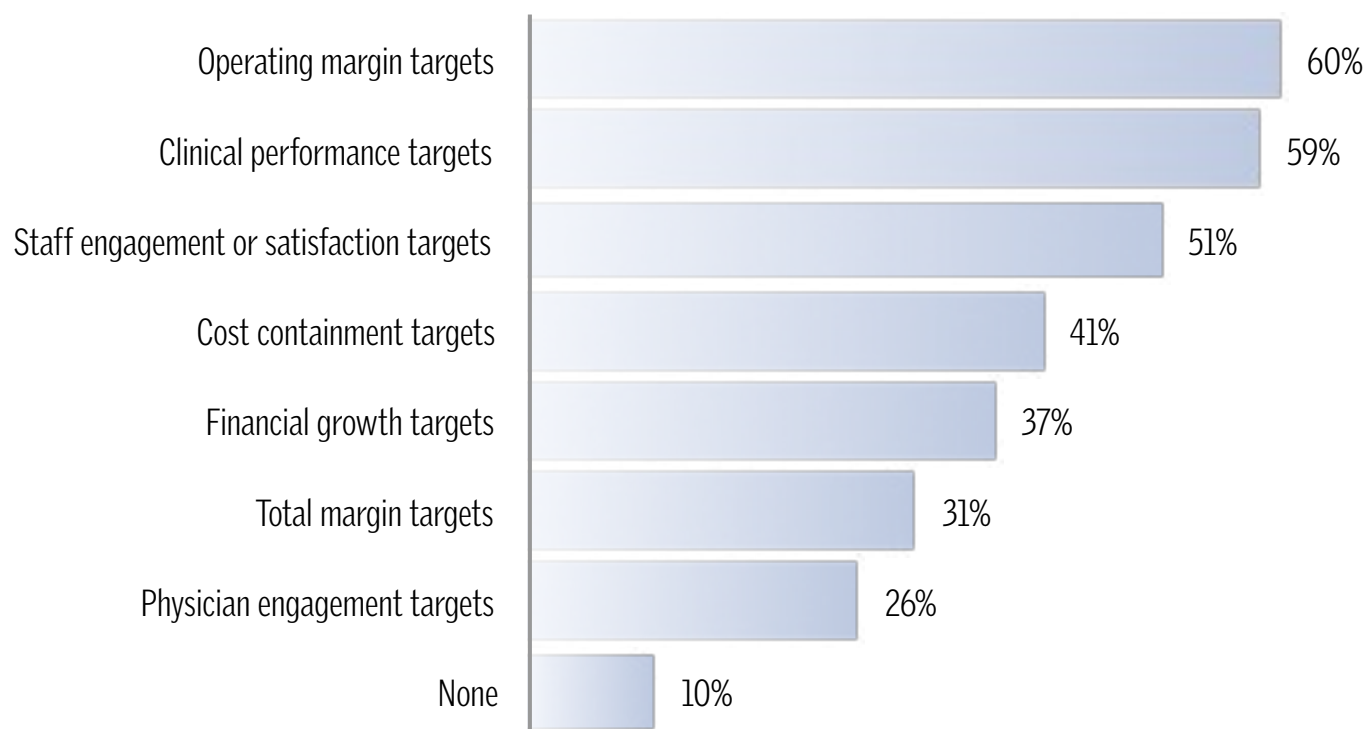
Total responses



Base = 262, Multi-Response

[Click here to learn more and order the PREMIUM EDITION: case studies, actionable strategies, further segmentation](#)**FIGURE 10 | Basis for Team Incentive Payments**

Q | Which of the following general categories serve as a basis for your current team incentive payments? (Among those with annual cash incentive)

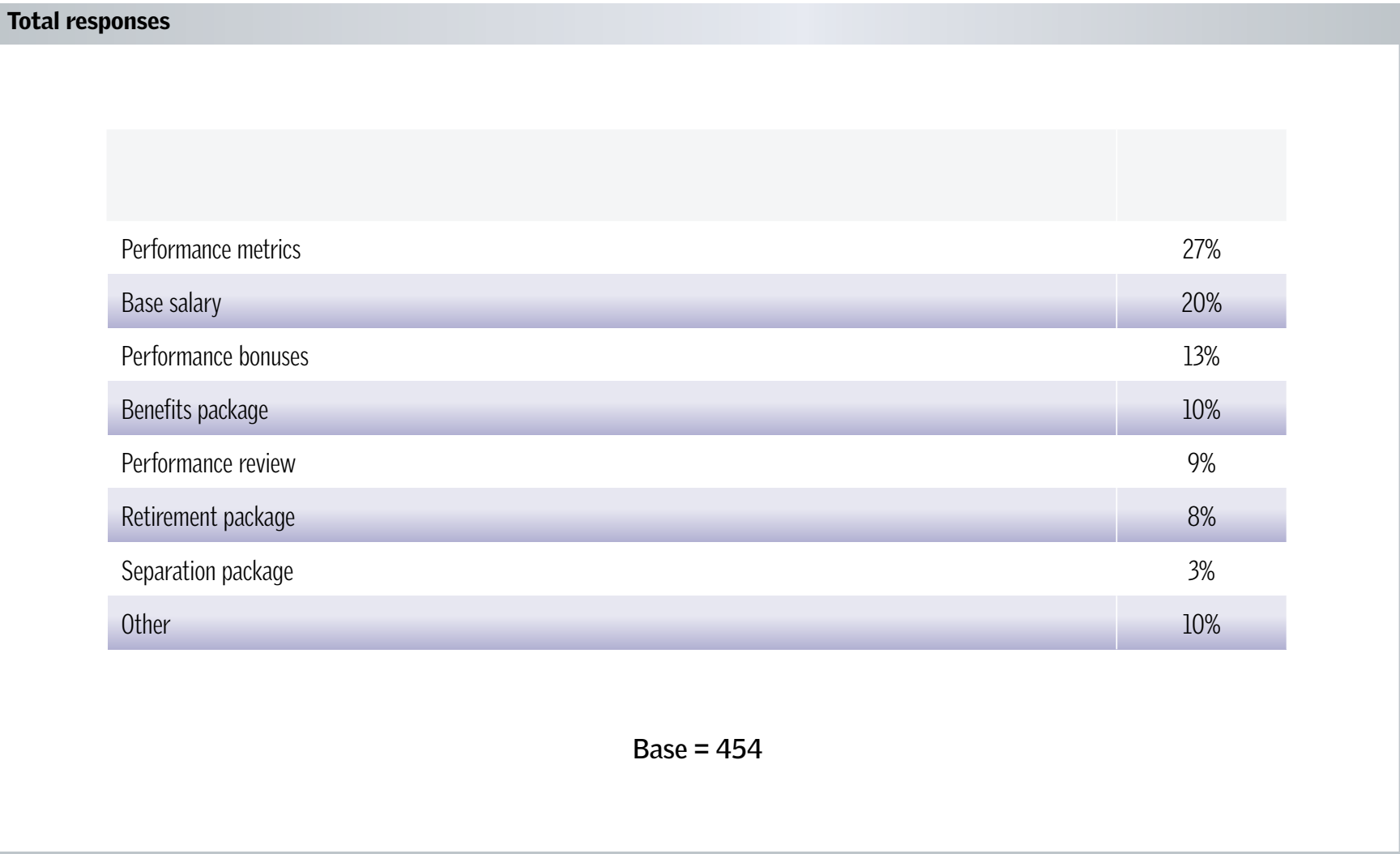
Total responses

Base = 262, Multi-Response

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FIGURE 11 | Most Evolved Aspect of Exec Comp Past Two Years

Q | Which aspect of executive compensation has evolved most at your organization over the past two years?

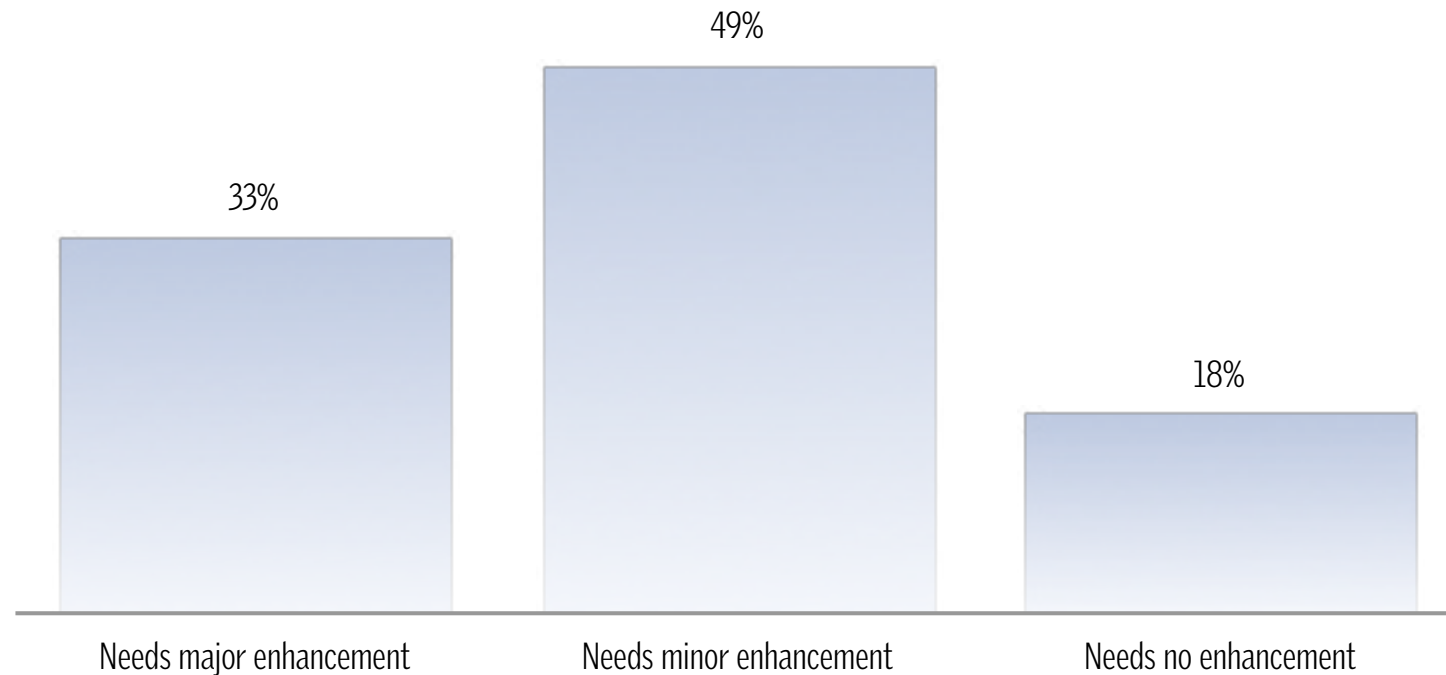


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FIGURE 12 | Outlook for Exec Comp Structure

Q | To attract, retain, and engage leaders, what is the outlook for executive compensation structure at your organization?

Total responses

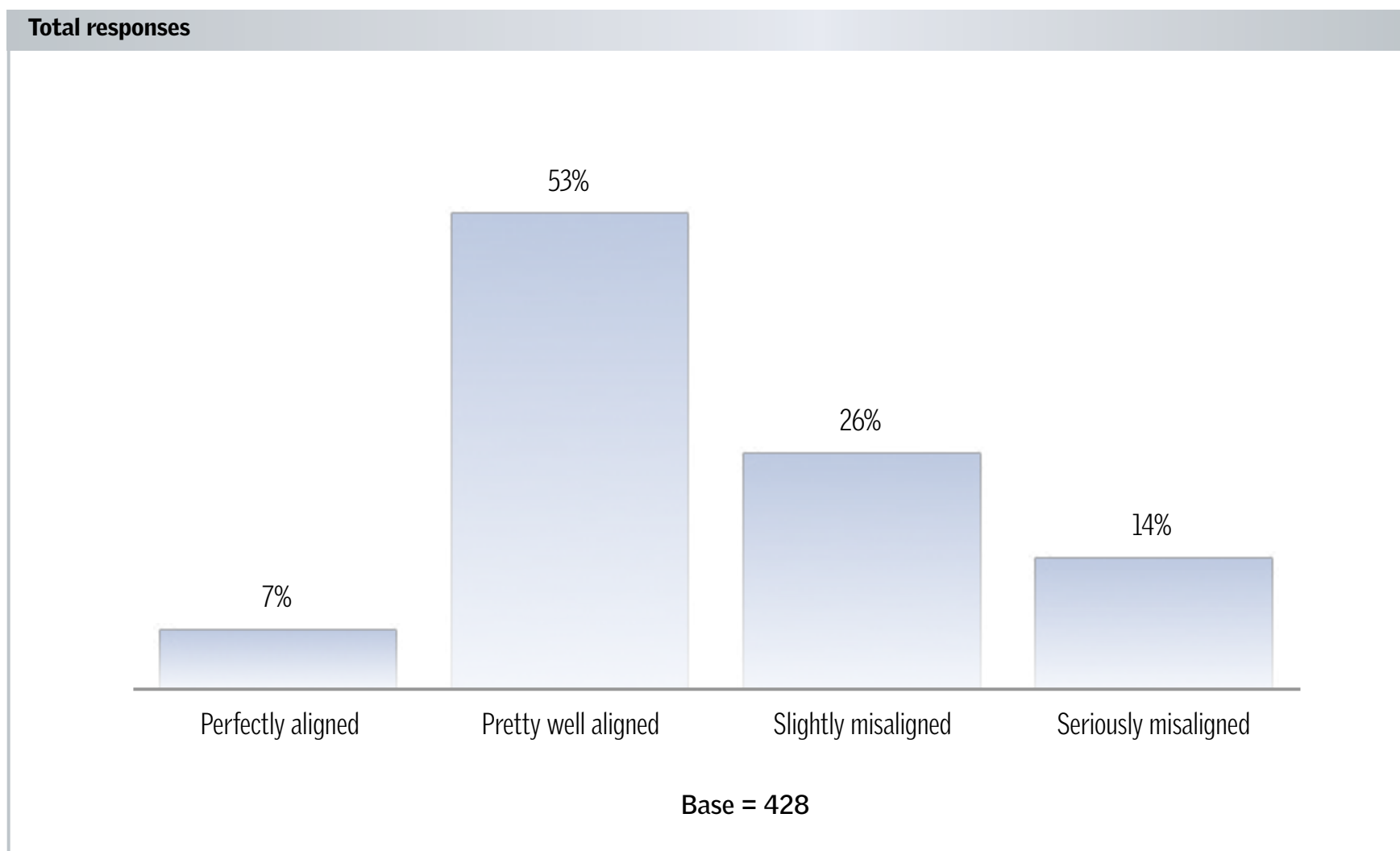


Base = 454

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FIGURE 13 | Exec Comp Alignment With Organization's Strategies

Q | How closely are your organization's executive compensation packages aligned with your organization's strategies?

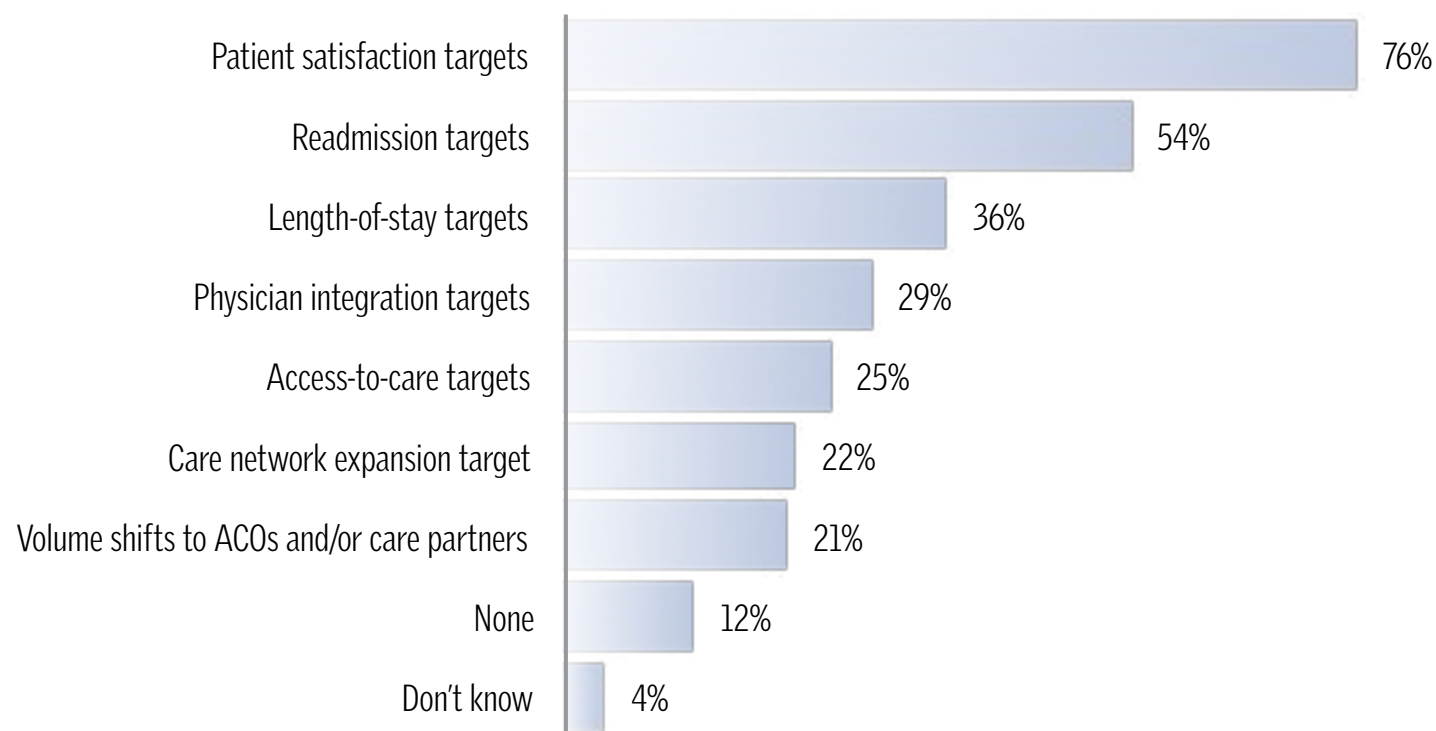


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FIGURE 14 | Clinical Performance Incentives Next Three Years

Q | Which of the following clinical performance parameters do you expect your organization to emphasize for individual executive incentives over the next three years?

Total responses



Base = 454, Multi-Response

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FIGURE 15 | Executives With Clinical Backgrounds

Q | What best describes your organization’s practice with respect to having executives with clinical backgrounds?

Total responses

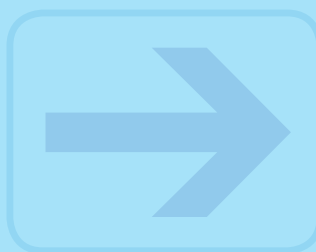
None have; not considered needed	7%
None have; but seeking such executives	1%
Some have; no more needed	31%
Some have; seeking more	35%
Most have; no more needed	15%
Most have; seeking more	8%
All have; subject to change	1%
All have; not subject to change	3%

Base = 437

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