

Dean's Council (DC)

June 16, 2008

Minutes

Present: Dr. Albertsen, Dr. Fortinsky, Dr. Gould, Dr. Jacob, Dr. Koeppen, Dr. Nissen, Dr. Simon

Excused: Dr. Arnold, Dr. Deckers, Dr. Egan, Mr. Gillon, Dr. Lalande, Dr. Loew, Dr. Pappano

Guest: Dr. Hepworth

The meeting was called to order at 4:42 p.m.

1. The minutes of the May 19, 2008 meeting were approved with one abstention.
2. Update on University Senate Unification Committee Meeting

At the last DC meeting, Dr. Jacob explained that in attempting to unify the faculty governance structures of the Health Center and Storrs campuses, the University Senate created a Unification Committee. Dr. Anne Hiskes, who chairs the committee, requested representation from the Health Center, and the DC agreed that Dr. Jacob should attend the first meeting to learn about the tasks to be addressed. They would then decide what ongoing representation was needed and how it would be chosen.

Dr. Jacob explained that the primary function of the University Senate and its various subcommittees is to manage undergraduate education. Each Senate meeting begins with a report by the President or Provost. In addition, the Senate Executive Committee meets regularly with the President and Provost. Minutes are taken for a portion of those meetings; part is conducted in executive session.

Because the Senate primarily deals with undergraduate education, DC agreed that it was not necessary to have representation from the School of Medicine on the Senate. However, they did agree that it would be useful to have representation on the Executive Committee. They also suggested that Provost Nicholls be asked to meet on a regular basis with faculty leadership from the Schools of Medicine (perhaps the Chairs of the Councils) and Dental Medicine. Dr. Jacob will convey these requests to Dr. Hiskes.

3. Education Council's Revised Operating Guidelines

At their June 11, 2008 meeting, the Education Council modified their operating guidelines by adding the following:

“Meetings of the Education Council are public, and may be attended by any interested individuals. These individuals may not participate in the business of the Council unless authorized by a majority vote of the Council membership.”

Individuals who would like to participate in the business of the Council have to contact Ms. Whalen or Dr. Koeppen for permission and would be allotted three minutes to speak. It was suggested that the guidelines also include the rule that EC is able to go into executive session if necessary. This will be added to the operating guidelines and sent back to Education Council for review and approval. If there is opposition to this addition, Dr. Koeppen will bring the issue back to the DC. Otherwise, the revised Education Council operating guidelines with the suggested addition were unanimously approved.

4. Clinical Faculty Merit Plan

Dr. Albertsen presented for approval the Clinical Faculty Merit Plan that was approved by the Clinical Council (the proposed plan is appended to the minutes). He explained that for various reasons, the previous plan was unsuccessful, and currently no process exists by which incentive payments for clinical productivity can be made. The proposed plan fills this void until the incoming Dean proposes an alternate plan. He explained that the plan is not an incentive plan; it is a merit plan with incentive in it. It parallels the mechanism used to increase salaries for education and research and provides an increase in clinical salary based on productivity and citizenship. The calculation used to determine merit payment is the provider's aggregated work RVUs divided by total salary and full benefits. This calculation creates a ratio of work RVUs which determines the clinical salary increase. The final calculations will be made and reviewed annually by the Executive Committee of the Clinical Merit Plan. If the plan is approved, salary increases would be payable on January 1, 2009, reflecting activity during the 2007/08 fiscal year. One of the major complaints with the previous plan was the inability to know the amount of incentive payments until payout. The proposed plan allows faculty to know what their incentive will be day to day; it also allows them to know their RVU ratio in real time.

The DC agreed with the principals of the plan but made the following suggestions.

- The Executive Committee of the Clinical Merit Plan consists of the members of the Compensation Plan Subcommittee of Clinical Council, who are appointed by the Chair of the Subcommittee. It was noted that all of the Councils and grievance committees are elected bodies, and it was felt that this committee should also be elected. It was decided that the Chair of the Subcommittee will nominate the membership, which will then be ratified by the Clinical Council, which is an elected body.
- One of the functions of the Executive Committee is to “serve as the primary appeals committee.” Because a Compensation Appeals Committee exists which reviews merit appeals, it was suggested that the Clinical Merit Plan be revised to state that the Executive Committee serves “as the committee for review and reconsideration based on factual information.”
- Incorporate the Compensation Plan’s ratings of not acceptable, marginal, acceptable, and superior performance into the table showing ratios and resulting salary increases.
- Revise for clarification the section of the plan that addresses “bumps” as follows: “Whenever a provider bumps with less than six weeks notice, s/he will complete a form attesting to the circumstances.”

A motion was made to accept the plan with the suggested changes. The motion was unanimously approved.

5. Old Business

Dr. Koeppen announced that Dr. Deckers has decided to not act on the Dean’s Council’s recommendations for the Department of Community Medicine and Health Care until the new Dean is in place. Dr. Babor has been notified of this decision.

The meeting was adjourned at 4:35 p.m. The next meeting will be held on Monday, July 21, from 3:30-5 p.m. in the Walker Academic Affairs Conference Room, AG-070.

Respectfully submitted,

Lynn Donatelli

CLINICAL FACULTY MERIT PLAN

Plan Overview

This is a merit plan. The plan provides a basis for increase to the individual's base salary annually. While the progress throughout the year will be computed and displayed on the Plan website, updated every two weeks, the final calculations will be made and reviewed by the Executive Committee of the Clinical Merit Plan annually.

The Executive Committee

The Executive Committee of the Clinical Merit Plan will consist of the members of the Compensation Plan Subcommittee of Clinical Council (C4, a subcommittee of the Clinical Council). The members of this subcommittee are appointed by the Chair of the subcommittee, who is a member of the Clinical Council. The duties of the executive committee are

- Review the plan annually for its fairness, consistency with financial reality, appropriateness, and proper application of the plan rules
- Oversee the function, deadlines, and accuracy of the plan
- Set the incentive payout amounts and frequency
- Review citizenship criteria and make adjustments to raises based on those measures in the context of the plan rules
- Serve as the primary appeals committee
- Determine citizenship criteria to be considered for the subsequent year

The committee will be referenced as **C4EC** in this document.

Appeals

The **C4EC** will hear appeals regarding:

- Errors in data
- Factors which cause data to be inaccurate
- Citizenship measures and their application

Appeals on other bases are heard by the Appeals Committee of the Compensation Plan.

Plan Design

The plan's design follows a basic principle that clinical faculty must generate collections that are in excess of their salary and full benefits cost in order to contribute to operating overhead. UMG's operating, that is non-physician overhead, varies in a range between 51% and 55% of net collected revenues. Thus, a faculty member who produces

collections of roughly twice his/her clinical salary and full benefits would “cover” the average practice overhead. In order to remain within STARK safe harbors, productivity calculations only consider work and the collections for services actually performed by the provider. Thus, “incident to” services, work performed by support staff and mid-level professionals but billed through the attending, is not included. A further affect of this approach is that portions of services identified as practice expense or the non-professional cost components are not included in the calculations.

The Calculation

Work Relative Value Units under the Resource-Based Value Unit System are aggregated for each provider during the reference period. That number is then divided by the faculty member’s total salary and full benefits (expressed in work-RVU equivalents¹). The overall calculation creates a ratio of work RVU’s as proxy for collections, compared to salary and benefits cost. This ratio becomes an index for the degree to which a faculty member covers their clinical salary cost, plus makes a contribution toward covering UMG overhead and adding to profitability.

A ratio of less than 1.0 would eliminate a provider from consideration for a base salary increase. For those who do qualify, there would be a 2.5% increase in the annual clinical portion of the salary with a ratio of 1.0, and an additional 0.5% salary increase for each 0.4 increment in the ratio above 1.0, until the salary increase is 5%. This is summarized below:

Ratio	Clinical Salary increase
<1.0	0
1.0-1.399	2.5%
1.4-1.799	3.0%
1.8-2.199	3.5%
2.2-2.599	4.0%
2.6-2.999	4.5%
3.0-3.399	5.0%
4.0-	5.0% and opportunity for incentive

In addition to the percentage increase based on this productivity measure, an additional 0.5% can be used as both an award and a penalty based on “citizenship” criteria, described in more detail below.

Finally, in the cases of extremely high productivity, an incentive can be paid. The quantification of ‘very high productivity’ and the amount of the incentive and the

¹ The provider’s individual conversion factor is the provider’s historical actual dollars collected for direct patient care divided by the provider’s work RVUs for direct patient care for the same time period. The median conversion factor for the practice is computed for the same historical time period. If the practice median is higher than the individual’s factor, the practice median is assigned as the individual’s factor instead.

frequency of payout will be decided by the executive committee, basing its decision on budgeted amount available for incentive.

An additional positive feature of the plan is that since it is not dependent on collections for its calculations, providers will be able to know how they are performing in much closer to real time rather than waiting several months for billings to be converted into collections.

Additional Components of Proposed Plan

Administrative and Clinical Contract Dollars

Many faculty generate revenue in non-patient care activities, as medical directors or advisors, in quality assurance activities etc. These administrative activities represent time that is not available for patient care, and in the plan these dollars for “administrative contracts” are deducted from the provider’s salary and benefits cost.

In contrast, clinical contracts reflect payment for patient care services but at a negotiated or flat rate. These dollars are considered in the plan as being no different than other clinical activity. RVU’s are assigned to these collections based on the provider’s conversion factor for direct patient care.

Clinical FTE

The clinical FTE is the amount of salary charged to UMG relative to total salary. In this plan, the denominator amplification effect of very low clinical FTEs is nullified by requiring that any FTE below 25% be considered to be 25%. For example, a provider who is only charged for 10% of the salary cost to UMG, but who may actually work one full day, or 20%, appears to be dramatically productive. The rationale for the 25% minimum is that the overhead as a percentage of collections is actually much higher for providers who practice for very small percentages of their time.

Citizenship Measures

C4EC annually reviews each provider for the provider’s contributions to the efficiency and attractiveness of the practice. The assumption is that each provider is a reasonable and proper member of the clinical community. The citizenship measures would be ‘average’ for them and there is no impact on the merit raise. However, sometimes behavior is not reasonable for the practice; the C4EC, using the citizenship measures, may reduce a provider’s raise by 0.5%² if appropriate. When the provider’s contribution to the practice is unusually positive, based on the measures, the C4EC may add 0.5% to the provider’s increase.³

² If the provider’s ratio is 1.0-1.399, the reduction would result in no increase, rather than a 2.0% increase.

³ If the provider’s ratio is below 0.95, no increase may be added. If it is between .95 and .999, a 2.0% increase is allowed

1. Each clinic session has a budgeted number of hours. The individual's presence in the session time should equal the budgeted time. Note that for clinicians who have a heavy commitment to clinical session time (FTE is greater than 85%), then one session can be allowed within that FTE for administrative work.
2. Bumps: A bump is considered a sudden and unanticipated rescheduling of patients due to the inability of the provider to be present. The operational policy on bumping is that six week's notice must be given before a clinic is changed or canceled, and the patients who are bumped must be seen within two weeks or earlier from the bump. Whenever a provider bumps, s/he will complete a form attesting to the circumstances. C4EC will track bumping as a measure of citizenship, and unjustifiable bumping will be considered unfavorably.
3. Operative note dictation within 24 hours is required by State regulations, by CMS conditions of participation, and by Joint Commission standards. If at any time 5% of any clinician's volume is delinquent in dictation, the delinquencies will be considered a negative impact on citizenship.
4. Incomplete charts that result in financial compromise: If the compromise is more than 2% of the clinician's salary, this will be considered as a negative citizenship measure.
5. The committee will review the performance survey completed by the office staff and reviewed by the office manager. This rating may be used to provide a positive increment to the raise but cannot be used to lower the increase.
6. Access measures: A target is to have 80% of new patients seen within 30 days of the request. Achievement of this target will be considered a positive citizenship measure.