Health Care System "In Pursuit of Excellence"
A Case Example

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Winchester Medical Center
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The Organization

Winchester Medical Center (WMC), located in Winchester, Virginia, is a 411-bed not-for-profit regional referral center providing tertiary services to 400,000 residents in a 16 county area of Northwestern Virginia and the Eastern Panhandle of West Virginia. WMC employs over 2,900 individuals, and has a medical staff of over 275 physicians who represent nearly every specialty.

WMC is one of the six hospitals of Valley Health System, which serves communities in Virginia, West Virginia and Maryland. The system's mission is to "serve their regional community by improving health."

The Initiative

Winchester Medical Center originally depended upon a traditional model for on-call physician services. The granting of attending staff privileges at the hospital carried the expectation that, in return for the privilege of using the hospital's resources, physicians would meet certain requirements. Those requirements included serving on hospital committees and providing on-call service. This model worked well in the organization for several decades.

However, WMC began to experience many of the same problems other hospitals faced nationwide with physician call coverage. With social and cultural changes and increasing economic pressures, some physicians dropped their attending privileges and the on-call burden that accompanied it. While those physicians saw a better work/life balance, the hospital experienced a shrinking attending staff with consequent gaps in the emergency room on-call roster.

WMC dealt with these changes as other hospitals have, with employed physicians, recruited physicians, a subsidized Hospitalist Program and call-pay to support the hospital's Level II Trauma Center.

The Hospitalist Program greatly relieved the internists of their on-call burden in the emergency room, but did not help most of the other physicians. It became necessary to pay the trauma surgeons, neurosurgeons and orthopedists to take trauma call. Shortages of certain specialists required "gap pay" to maintain the emergency room call roster from time to time. Eventually, WMC had a minority of the physicians on staff either being paid to take call or relieved of call by the subsidized Hospitalist Program, leading to disquiet and resentment among the remaining physicians taking call without compensation in the traditional model.

As the national and local debate over call pay continued to evolve, key hospital management and medical staff leadership initiated discussions aimed at finding a win/win solution for both the medical staff and WMC. That solution came in the form of the Attending Faculty Plan (AFP), which was formally established in January of 2006.

Developing the Attending Faculty Plan. The AFP is a hospital-funded 457(f) deferred compensation plan designed for members of the hospital's staff who have admitting privileges and who provide unassigned call. The framework for the AFP was developed to accomplish five goals:

1. Provide WMC's community with on-call physicians for unassigned patients in the emergency room.
2. Be of mutual long-term benefit to both the medical staff and hospital.
3. Involve the broader medical staff.
4. Be legally and financially sound.
5. Use hospital finances in a predictable, controlled manner.

Through the AFP, WMC was able to satisfy hospital and medical staff concerns alike while remaining in compliance with the myriad of regulatory statutes such as Stark, Anti-Kickback, Private Inurement and Excess Benefit Transactions. Legal counsel and benefits consulting expertise were engaged to ensure legal and tax compliance and to assist with program design, education/marketing and plan enrollment.

Key Elements of the AFP. The basic structure of the AFP includes the following:

- Physician participants in the AFP are obligated to sign a Personal Services Agreement on an annual basis (now an "evergreen" document) outlining the terms and conditions of membership. The AFP was designed to be voluntary, and lack of participation would not excuse members of the attending or associate staff from fulfilling their bylaws obligation to continue taking unassigned call for the emergency department.
- WMC agrees to annually determine a contribution to be made to the AFP. This contribution is very roughly based on the overall financial condition of WMC.
- Annual contributions by WMC do not exceed $4.5 million, and are not less than $2.5 million, to assist with budgeting this expense as well as to cap the liability for WMC.
- Per diem amounts are calculated for each specialty and annually tested to ensure per diems are within fair market value limits.
- Call compensation credits are calculated on a quarterly basis dependent upon the actual volume of call taken by physicians. The latter is tracked by the WMC emergency department.
- Call compensation is credited pre-tax into a 457(f) account. Each individual physician's account is credited a return indexed to mutual funds (those commonly available in most 401(K) or 403(b) plans) selected by the physician. Under this arrangement, the physician receives the benefit of dollar cost averaging and tax deferred growth.

- All monies deposited into the physician's account would remain the property of the AFP until the physician completes a pre-defined vesting period. At the conclusion of the vesting period, the physician owns the assets in the account, less any taxes due, which are removed from the corpus in the account.

AFP Organizational Structure. The organizational structure of the AFP consists of the following:

AFP Advisory Board: The AFP Advisory Board consists of seven voting members, four of whom originate from hospital board and management, and the remaining three from the WMC medical staff (as recommended by the WMC Medical Staff Executive Committee).

Primary responsibilities of the AFP Advisory Board include, but are not limited to:

1. Review annual audited financial statements for WMC and approve annual funding of the AFP.
2. Receive an annual report from the AFP Call Committee outlining the specialties to be included in the AFP for each plan year and per diem amounts per specialty. The AFP Advisory Board can accept, reject or modify the recommendations of the AFP Call Committee.
3. Review the performance of the AFP third party administrator in managing the AFP assets and participant accounts, as well as the quality of ongoing plan enrollment and education.
4. Assess whether the allocation of AFP funds is fair and impartial to AFP participants, as well as to assess any factors that may have a bearing on specialties to be included, excluded and/or payments to be made. Factors to be considered would include physician supply shortages, strategic needs of WMC, etc.
5. Assess, on an ongoing basis, opportunities to expand the benefits of the AFP to its participants.
6. Submit final recommendations for review and approval to the Valley Health Board of Directors (parent corporation for WMC) to whom the AFP Advisory Board directly reports.

AFP Call Committee: The AFP Call Committee consists of five WMC physicians appointed by the WMC Medical Staff Executive Committee. The Chair of the AFP Call Committee is appointed by the medical staff president. Committee members are appointed to serve staggered three year terms and are eligible to serve a maximum of two terms. Current officers of the Medical Staff Executive Committee are not eligible to serve as members of the AFP Call Committee. By design, the AFP Call Committee is otherwise independent of the Medical Staff Executive Committee and reports exclusively to the AFP Advisory Board.

The AFP Call Committee is charged with integrating data related to unassigned call services by physician specialty, and making a recommendation to the AFP Advisory Board for fund distribution. The distribution of funds to each physician by category is determined according to selected criteria to include: intensity of service, frequency/number of calls, liability risk of specialty and hospital need for service. The committee annually solicits objective data as well as subjective input from the medical staff with respect to criteria for determining fund distribution.

The AFP Call Committee recommendations on fund distribution are independently assessed by an external consultant to ensure fair market value. Final recommendations of the committee are forwarded to the AFP Advisory Board for action.

The creation of the AFP Call Committee was important to the success of the program. WMC felt strongly that while funding of the program would be the hospital's responsibility, decisions on specialties to be included/excluded, as well as per diem calculations by specialty, should be decided by the AFP Call Committee based upon available funding each year. It was felt such an arrangement would improve objectivity of the process and minimize criticism of the hospital.

AFP Rating Scale. The AFP Call Committee developed a unique methodology adapted from the "Glasgow Coma Scale" to rate the criteria for inclusion in the AFP. All specialties providing unassigned call were rated as part of this process. The committee assigned specific values to each of the four criteria to be utilized as follows:

- Frequency of Service: Five points total.
- Intensity of Service: Four points total.
- Need for Service: Three points, plus one for community need.
- Liability Risk of Service: Three points.
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The AFP Call Committee assigned each specialty to be included in the AFP to a specific tier based upon their relative score on the Call Score.

TIERS

Tier 1	General Surgery	Tier 2	Cardiology
	Orthopedic Surgery		Neurology
	Anesthesia – 1st Call		Neurosurgery
			Obstetrics
			Urology
			Thoracic/Cardiovascular/Vascular Surgery

Tier 3	Otolaryngology	Tier 4	Gynecology
	Gastroenterology		Ophthalmology – General
	Pediatrics		Ophthalmology – Retina
	Oral Surgery		Neonatology
	Interventional Radiology		Plastic Surgery
	General Radiology		
	Anesthesia – 2nd Call		

AFP Per Diem Methodology. An equation was conceived by the AFP Call Committee in which the dollar values of call payment by tier could be determined each year. The formula adjusts for money available, number of physicians and specialties, and allows for adjustment of the distribution to meet physician expectations and hospital needs.

AFP Personal Services Agreement. The Personal Services Agreement (PSA) is the legal commitment between the AFP participant and WMC, and contains a number of eligibility requirements for participation and obligations of AFP participants, including:

1. AFP participants must sign and agree to the terms outlined in the PSA.
2. Participation is limited to those members of the WMC attending or associate staff who are actively taking unassigned call. Physicians who rely on Hospitalists for unassigned call and those physicians who do not take call (e.g. emergency room physicians) are excluded.
3. AFP participants must be actively participating in Federal Medicare and Virginia State Medicaid programs.
4. AFP participants must agree, as part of the PSA, not to compete substantially against WMC as follows:
1. Not to be employed by a competing hospital to WMC for more than $10,000 of annual W2 income (if annual income from a competing hospital is more than $10,000 the relationship is reviewed).
2. Not be an owner or shareholder in a competing venture(s) to WMC which would require State of Virginia Certificate of Public Need (COPN) approval.
5. AFP participants must agree to follow WMC's Charity Care Guidelines for services provided while taking unassigned call.
6. Non-participation in the AFP would not excuse AFP participants from their unassigned call responsibilities.

Each of the above six requirements established the necessary "substantial risk of forfeiture" for AFP participants to enhance compliance with federal regulations governing such hospital-physician arrangements.

AFP Vesting Schedule. AFP participants have the ability to control where their deemed accounts are invested. Additionally, each AFP participant is assigned a vesting period as follows:

- AFP participants under 60 years of age have a five year minimum vesting schedule. Participants over 60 may choose shorter vest periods.
- AFP participants can select a longer vesting period to control when funds are distributed to maximize compounding and delay tax liability.
- AFP participants are vested in the event of death, permanent disability or the attainment of age 60.
- Importantly, any physician who stopped taking call (e.g. changed medical staff privileges to Courtesy Staff or resigned from the staff) would lose all monies which have not yet vested, thereby further creating a substantial risk of forfeiture for the physician. These forfeited funds would remain in the AFP, and would be used to reduce the WMC contribution into the AFP for the succeeding year.

The Role of the Board of Trustees. The involvement of Winchester Medical Center's Board of Trustees was essential to the success of the plan's implementation. The plan was presented to the board as a project developed jointly by the administration and medical staff. The leaders' understanding of the challenges and their willingness to work closely with the physicians ensured a smooth transition and helped to garner board support. Although the Board had some initial concerns about the pay for call concept, they were willing to support the plan because it implements the concept in a manageable, controlled manner without runaway costs and annual pay renegotiations.

The plan is owned and embraced by the system Board, and overall responsibility lies with the system Board; however, oversight of the plan is delegated to an Advisory Board. The Advisory Board includes the Board Chairman, CEO, senior management and physicians, and is committed to ensuring the plan succeeds. The commitment of the Advisory Board to ensuring the plan's success has led to important program adjustments that have strengthened physician support, compliance, and other critical changes.

Challenges Encountered the Role of Consultants. The most difficult part of implementation was overcoming physician mistrust of the hospital, as well as board concerns related to changing to a pay for call system. The transition required trust from both groups to ensure success.

Development of the program took approximately 18 months. The complexity of the plan design requires frequent attention. MaxWorth Consulting Group provides ongoing assistance with many unique challenges relating to physician issues, continuing education for new and current physician participants, and the overall management of all strategic alliances included in the administration plan functionality and funding.

In addition, Dr. Thomas Oliver played an instrumental role in the program's development and implementation as the medical staff President at the time. Dr. Oliver has assumed the role of medical staff liaison for the program. This vital role has allowed the medical staff to leverage Dr. Oliver's knowledge and expertise in the details of the program.

Potential Future Changes.

In the future, Winchester Medical Center may consider adding quality measures to the program, either using quality measures to impact provider payment or including quality measures in the risk of forfeiture criteria. In addition, it may be beneficial to roll in legacy cash call pay programs.

Impact

Approximately 50% of the entire medical staff was eligible for participation; WMC received almost 100% enrollment in the plan. To date, the AFP has been widely accepted and positively embraced by the medical staff as a whole. In exchange for the financial recognition by WMC of physicians actively caring for unassigned patients, WMC received a commitment from AFP participants to assume unassigned call for an extended period; avoided future physician-hospital competition; and further satisfied its community mission by requiring AFP participants to follow WMC's Charity Care Guidelines, as well as actively participate in federal Medicare and Virginia Medicaid.

Since 2006, nearly 30 hospitals have joined Winchester in implementing a version of the AFP model, with an average of one new hospital per month adopting the solution. Hospitals implementing the solution have varied in size, including large and small single hospitals, as well as systems.

Value

The AFP will help to secure the future viability of Winchester Medical Center by capping annual contributions to the AFP at pre-set levels and utilizing corporate-owned life insurance (COLI) as a hedge against future AFP funding liability and operating costs. This form of life insurance is "balance sheet friendly" and creates a recovery vehicle for the expenses associated with paying for call. Over time, because of the feature of this funding approach, the hospital receives the death benefits, which can be used to help offset the investment in physician call compensation. There is no other approach that will actually reimburse the hospital for paying for call.

WMC has also made available to participants a group long term disability plan. The AFP has proven to be a novel model for addressing the problems of unassigned Emergency Department call responsibility that will also strengthen hospital-physician relations and better align WMC interests.

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