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- Ridley GT, Skochelak SE, Farrell PM: Mission aligned management and allocation: A successfully implemented model of mission-based budgeting. *Acad Med* 77:124-129, 2002
- Ruedy J, MacDonald NE, MacDougall B: Ten-year experience with mission-based budgeting in the faculty of medicine of Dalhousie University. *Acad Med* 78:1121-1129, 2003
- Kennedy DW, Johnston E, Arnold E: Aligning academic and clinical missions through an integrated funds-flow allocation process. *Acad Med* 82:1172-1177, 2007
- Chinnis AS, Prescott JE: Mission-based management: Implications for emergency medicine. *Acad Emerg Med* 7:377-379, 2000
- Brigham EJ, Tellers CA, Rondinelli R: Academic survival through mission-based management. *Am J Phys Med Rehabil* 80:778-785, 2001
- Andreae MC, Freed GL: Using a productivity-based physician compensation program at an academic health center: A case study. *Acad Med* 77:894-899, 2002
- Family Practice Solutions Center: Benchmark methods: Benchmark development process. <https://www.facultypractice.org>
- Smith TJ, Girtman J, Riggins J: Why academic divisions of hematology/oncology are in trouble and some suggestions for resolution. *J Clin Oncol* 19:260-264, 2001
- Torras HW: Health Care Fraud and Abuse: A Physician's Guide to Compliance (ed 2). Chicago, IL, American Medical Association Press, 2003

Commentary: Observations on the University of California at Irvine Experience: Common Ground With Community Practices

By John Hennessy, CMPE

Holcombe et al¹ from the Division of Hematology/Oncology at the University of California at Irvine (UCI) take a prudent and thoughtful approach to developing a compensation program that will work not only for the physicians but also for the larger institution. This is an approach that is not unique to academic practice, so it may be used by community practices as well. Key elements of the UCI program are focused on what is important, what to measure, how to be transparent, and how to reward. Any system of recognizing and incentivizing performance within a practice will fall short if it does not have each of these measures.

The focus on and definition of mission are critical. UCI does not focus on what is getting done but instead on what ought to be done. In community practice, we too often focus on the patient in front of us and prepare for the one sitting in the exam room next door. In reality, for many of our practices, what we do has a much larger impact on our communities. We are often the interface between patients and large multicenter clinical trials, which continue to advance the practice of oncology. Even if we are not involved in formal teaching programs, we are in a continuous learning environment. Taking time to be thoughtful about what we do and how we do it contributes to every patient's experience, both today and tomorrow. In that sense, mission is less about a grand sweeping statement and more about what the organization aspires to do and become, as a favorable consequence of working together rather than of uncoordinated individual efforts.

UCI also defines all the elements that contribute to mission and recognizes them explicitly as critical to delivering the en-

tirety of care. There is clear acknowledgment that each element of delivering oncology care cannot stand on its own economically. We face this dilemma in community oncology regularly. Clinical research trials, whether industry trials or through cooperative groups, are often an economic drag on practices, but they are critical to ensuring our patients have access to the best care available. We also know that a practice needs leaders that will take time away from clinical care to focus on improving the administrative side of the practice. Without that focus, the practice would cease to exist. Although these activities do not directly generate high margins, without them, long-term margins would disappear.

UCI recognizes that measurement is key in any performance-based compensation model, but it extends that measurement to all contributions to the practice. UCI uses work relative value unit (wRVU) data to measure clinical activity. Although we can argue about whether this is a fair measurement of work, it is at least a consistent measure, when comparing similar practices. Those of us in multispecialty settings might be more challenged by this measurement tool, but other tools may be available. Community oncology practices can be hamstrung by the wRVU production model when practice economics are largely driven by infusion or other ancillary services. UCI is somewhat removed from the infusion suite, as are many of the academic practices surveyed, but community practices find this hard to ignore. How to integrate positive economic effects, or in some cases negative, into a physician compensation scheme in both a compliant and sound fashion remains a challenge for community practices.

Holcombe et al¹ point out that measuring nonclinical contribution, although less straightforward, is still a critical part of developing a complete compensation program. By setting the bar for measurement on the clinical side and also applying it to nonclinical services, a sense of fairness is created for both sides. Community practices can struggle to measure work that benefits the practice but may not generate direct revenue. This can create stress between high producers and those who may be effective in practice governance. The UCI model recognizes that both can be contributors, if not always equal contributors, to the success of the practice. The community practice must acknowledge not only that these activities are critical to the success of the practice but also that they are valuable to the practice and worthy of reward.

The authors discuss a compensation model that uses a base salary plus percentage incentive, using the terms “withheld” and “salary at risk.” These are probably interchangeable with terms like “bonus” and “reward.” Although in community practice, we might see models that range from pure socialism (ie, everything is shared) to 100% production (ie, “eat what you kill”), many practices use a mixed model of fixed compensation plus reward-based pay. Opportunities for incentive compensation might seem more limited compared with those in community practices because of the unique challenge of coordinating a patient care–focused model with a model that relies heavily on teaching. Many practices have to find a means of compensating physicians who do not spend the majority of their time in patient care, but execution of this tends to be a rarity compared with that in the academic setting. Holcombe et al¹ are explicit about the need for both those in clinical practice and those primarily not in clinical practice to have an understanding and appreciation for their partners’ work and relative compensation levels. Community practices would do well to ensure they have the same understanding, so those dedicating time to work on behalf of the practice are valued appropriately and not devalued because their productivity is unlike that of their partners.

Transparency is a critical component of this compensation plan. In many community practices, compensation and methodology can be a tightly guarded secret. The suggestion here is that openness creates a sense of fairness and equity. The buy-in concept discussed by the authors is made possible by this openness. The combination of fairness, equity, and buy-in is key to developing a compensation model that has the greater good—rather than a “what’s in it for me” attitude—as its focus. Some

attempts to adjust compensation within practices fail at this point. In almost any compensation adjustment, there will be winners and losers at the point of change. Successful practices will move beyond this as a group, understanding that by changing compensation, they allow all boats to rise with the tide, and even those who face an immediate downside stand to gain in the long run.

Holcombe et al¹ also note the importance of ensuring that incentive plans are funded. In community practices, we often use the model of splitting whatever is left over after expenses have been paid. We always count on there being money in that pile at the end of the month, but it is not common to set aside money monthly to ensure that long-term incentives are funded. And in difficult times, if there is such a set-aside effort, it can be the first program to be raided. Incentive plans can be successful, but failing to deliver the economic reward for performance, either to clinical or administrative staff, can make incentive plans completely ineffective. If people believe there are neither positive nor negative consequences for not meeting performance goals, entropy is a likely result.

Community practices can walk through the same process that UCI did and have a thoughtful dialogue about their existing compensation scheme or compensation schemes in general. However, the focus cannot be on merely dividing the existing pool differently. Winners and losers are most likely to be evenly divided, and the fear of being worse off with any change is a strong momentum killer. Compensation models should encourage and reward the growth of the practice clinically and economically. Meeting that standard may be the best test of a compensation model, whether in academic or community practice.

Accepted for publication on January 13, 2010.

Author’s Disclosures of Potential Conflicts of Interest

The author indicated no potential conflicts of interest.

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DOI: 10.1200/JOP.091079; posted online ahead of print at <http://jop.ascopubs.org> on February 19, 2010.

Reference

1. Holcombe RF, Hollinger KJ: Mission-focused, productivity-based model for sustainable support of academic hematology/oncology faculty and divisions. *J Oncol Pract* 6:74-79, 2010