Dissertation

at

Aakash Healthcare

Dwarka, New Delhi.

"Framing Clinician Engagement Models and devising key negotiation strategies For Star Clinicians Across Various Specialities For Upcoming 230 Bedded Hospital In Dwarka, New Delhi"

by

Dr. Aditi Choubey

PG/15/003

Under the guidance of

Dr. Aashish Choudhary

Post Graduate Diploma in Hospital and Health Management

2015-17

International Institute of Health Management Research New Delhi

ACKNOWLEDGEMENT

I, Dr.Aditi Coubey, would like to extend my sincere and heartfelt obligation towards all the personages who have helped me in this endeavor. Without their active guidance, help, cooperation and encouragement, this dissertation would not have been possible.

I am highly obliged towards **Dr.Aashish Choudhry**, Managing Director, Aakash Healthcare for allowing me to pursue my Dissertation project from Aakash Healthcare, Dwarka, Delhi.

In this institute I have had the privilege to get to know many people who generously shared their

experiences and knowledge with me.

I wish to express my deep gratitude and regards to Dr. C.M Bhasin (COO), for conscientious guidance, constant supervision and encouragement to accomplish the project.

I wouldalso like to express my sincere gratitude to Dr.Reena Singh (Project head), Dr.Aishwarya Bakshi (AGM – Operations), Aakash Healthcare for being helpful and guiding me throughout my training and answering the queries that came along the way.

Furthermore, I would like to thank **Mr.Kanishak Gautam**, Deputy Manager - Hospital Operations, Aakash Healthcare for introducing me to the topic as well for the support on the way .

I am also very thankful to all the staff of Aakash healthcare for their attention towards my work and helpingme, which greatly added to my project. The administrative staff of the hospital has been veryhelpful to me and I would like to express my deep gratitude to all.

A special thanks to my Mentor **Dr. Pankaj Talreja** without whom this project would have been a distant reality.I am thankful for their aspiring guidance, invaluably constructive criticism and friendly advice during the project work.

Dr.Aditi choubey

ABBREVIATIONS

1	AHPL	Aakash healthcare private limited
2	COO	Chief operating officer
3	AGM	Assistant general manager
4	DM	Deputy manager
5	HIS	Hospital information system
6	OPD	Out patient department
7	IPD	Inpatient department
8	NICU	Neonal ICU
9	SICU	Surgical ICU
10	PICU	Pediatric ICU
11	MICU	Medical ICU
12	FT CONS.	full time consultant
13	CC	Courtesy consultant
14	VC	Visiting consultant
15	MG	Minimum guarantee
16	FFS	Fee for service
17	SA	Sustaining amount

AKASH HEALTH CARE- BACKGROUND

-WE CARE, HE CURES

Aakash Healthcare is a subsidiary of the Aakash Group, and is a state of the art healthcare facility and the first smart hospital in Dwarka.

Its patient-centric policy, erudite doctors and compassionate staff offer the best in class healthcare for everyone.

About Aakash Healthcare:

DrAashishChaudhry envisioned a smart orthopedic clinic for the people of Dwarka, New Delhi. In November 2011

Aakash Healthcare is a multi super specialty hospital, with state of the art infrastructure, path breaking technology, offering unrivalled healthcare services.

Dr. Aashish Chaudhry, the founder and Director of Aakash Healthcare, aims to make Aakash Healthcare the most preferred healthcare brand by providing compassionate, inexpensive, and world class healthcare services, with a talented team of doctors, and ultra modern technology, ensuring speedy recovery.

VISION, MISSION & CORE VALUES

VISION-To become the most desired healthcare brand by providing compassionate, caring and world class services with the help of talented team of doctors, professionals and latest technology.

MISSION- To achieve highest patient satisfaction index by delivering patient-centric, best healthcare services amongst the local and the extended community

COREVALUES-

Infrastructure Highlights

- 230 Beds in Phase 1.
- 70 Bedded Medical and Surgical Critical Care Unit.
- 24x7 Cardiac Emergency & Trauma Services.
- 15 Bedded Dialysis Unit
- Advanced Neonatal ICU.
- Ward Bed Options - Suite, Deluxe, Twin Sharing and Economy.
- 8 Modular OTs.
- Flat Panel Cath Lab.
- State-of-the-art diagnostic equipments that include - 3.0 Tesla MRI, 128 slice CT scan, Flat panel C-Arm, and 4-D Ultrasound to name a few.
- Automated Waste & Laundry Management System for efficient waste management.
- Pneumatic Tube System.

SCOPE OF SERVICES

KEY SPECIALITIES-

Orthopedics & Joint Replacement

Cardiology & Cardiac Surgery

Mother & Child

General & Minimal Access Surgery

Ophthalmology & Refractive Surgery

Nephrology

OTHER SPECIALITIES

- Anesthesiology & Pain Management
- Blood Bank & Transfusion Medicine
- Radiology
- Medical Oncology
- Neurology Interventional Radiology
- Endocrinology/Diabetes & Metabolic Disorders
- Pulmonology & Respiratory Medicine
- Hearing And Speech
- Lab Medicine
- ENT
- Gynaecology
- Surgical Oncology
- Neurosurgery
- Dental Sciences
- ER & Trauma
- Obstetrics Cosmetology & Plastic Surgery
- Urology
- Critical Care
- G I Surgery
- Preventive Health Check Up
- Rheumatology
- Mental Health & Behavioral Sciences
- Physiotherapy &Rehabilitation
- Gastroenterology &Hepatobilliary Sciences
- Dermatology
- Internal Medicine

HOSPITAL DEPARTMENTS AND SERVICES-

CLINICAL SERVICES	SUPPORT SERVICES	UTILITY SERVICES
• OUT PATIENT DEPARTMENT • INPATIENT DEPARTMENT • ACCIDENT AND EMERGENCY DEPARTMENT • INTENSIVE CARE UNIT • DAY CARE UNIT • OPERATION THEATRE	• RADIOLOGY • PATHOLOGY LAB • PHARMACY • BLOOD BANK	• LAUNDRY SERVICES • HOUSEKEEPING • FOOD AND BEVERAGES

BED MIX

Bed Mix	Type	Basement - I	Ground	First	Second	Third	Fourth	Fifth	Sixth	Total
Paying Beds	**Type**									
Economy	7 in 1						7	0	7	14
Economy	5 in 1						15	10	15	40
Triple Sharing	3 in 1						3	3	3	9
Twin Sharing	2 in 1						10	10	10	30
Single	1 in 1						8	8	8	24
Deluxe	1 in 1						1	1	1	3
Suite	1 in 1						1	1	1	3
Chemotherapy	5 in 1							5		5
MICU					15					15
ICU					8					8
SICU					11					11
PICU					6					6
NICU					21					21
CCU (Currently on hold)						7				7
Day-care Unit	5 in 1							5		5
Service Beds										
Dialysis Unit				10						10
Pre & Post Operative						8				8
A & E Unit			8							8
LDR						2				2
Endoscopy										0
Radiology		2								2
Cath Lab						2				2

INTRODUCTION

The Clinicians play a large role in the complex mechanisms of healthcare delivery. From providing frontline care to filling leadership positions, for making significant improvements in an organizations hospitals need clinicians to be on board

Healthcare Revolves Around Clinicians

Clinician's play a critical role in every aspect of healthcare Clinicians guide processes and decisions that are made inside and outside the hospital walls. Every strategy to fix problems in healthcare today revolves around the buy-in of one critical group—the Clinicians.

CLINICIAN ENGAGEMENT

Clinician engagement is the process of bringing clinicians together with other healthcare stakeholders to continuously improve care and the patient experience.

Star clinician-

- Large patient base and OPD footfall.
- Popularity in catchment area
- Success rate.
- Years of Experience (10 to 12 yrs)

A star clinician can be identified by both the volume and quality of practice he/she has and his/her feedback and demand in the respective field of practice.

Star clinicians are usually senior consultants and above the cadre who handle both high volumes of cases and also treat/operate on complicated cases.

These are the most sought out doctors in their fraternity and are in high demand across the masses.

Star clinicians are considered those who has the capability of moving an entire patient base which numbers in lakhs, from one hospital to another based on the fact where the decide to settle and conduct their practice.

Stages of Clinician Engagement

1. Discover a Common Purpose

The idea of identifying a common purpose cannot be overemphasized. The entire purpose of why doctors became doctors is to care for—and improve the lives of—patients. This must be the primary focus of everything done at hospitals or facilities or anywhere that engages physicians. This is what drives the physician base.

2. Reframe Values and Beliefs

Physicians should be treated as partners with the hospital, not customers of it. Many times hospital administrators appease physicians because physicians are viewed as customers. By partnering with physicians, hospitals can ensure better care for patients, which is the key focus of clinicians.

3. Provide Support and Education

The development of project management skills in the clinicians can be provided by support and education; and not only for them, but for the rest of the staff as well. Physicians do not work well in an environment when there is a lack of understanding as to the strategy and purpose of the initiative.

4. Engage the Physician's Intellect

Showing physicians how they fit in to the process and why they are important to the success of the initiative will increase the level of engagement and support.

5. Build Trust

Building trust is the most important piece of the process. Communicate often and candidly. Address concerns and issues in a timely and obvious manner. Identify and overcome barriers to engagement. The administration and leadership within the organization must be very responsive.

6. Adopt an Engaging Style

Physicians want to be involved from the very beginning. Ask them how patient care can be improved. Because the underlying supposition is that improving patient care will allow for fewer mistakes, reduce waste, and provide patients the right care at the right time in the right place.

DOCTOR'S PRIVILEDGES-

Each hospital has its own set of rules, regulations and policies defining how doctor's can admit patients, and how they're allowed to treat patients.

The rules require doctors to submit application for their privileges. The application contains extensive information about the doctor's education, license and experience.

Different categories of privileges exist. These include

- Admitting privileges- allow a doctor to admit a patient to the hospital.
- Courtesy privileges- allow a doctor to occasionally admit or to visit and treat patients in the hospital.
- Surgical privileges- allow a doctor to perform surgery in the hospital's operating room or outpatient surgery area.
- OPD privileges.

REVIEW OF LITERATURE

FORTIS HEALTHCARE

DOCTOR ENGAGEMENT MODEL-

Fortis follows employee model for doctors in key sub-specialities by hiring them at high base salaries and offering them other incentives such as investments in their speciality, investment in outpatient diagnostic facility to serve as feeders and variable compensation.

A variable component of salary is calculated using a formula that factors success rate in various procedures, patient referrals, patient rapport, administrative responsibilities, and academic publications

Doctors are not allowed to have private practices and must treat all of there patients at Fortis facility.

High salaries are extended to doctors with the understanding that they will treat higher volume of patients.

Fortis efforts to hire star doctors for its hospital in any city may serve to pull in patients but may not maximize physician patient volumes.

Fortis does allow doctors in non-core specialties(dentistry and ophthalmology) and in multispecialty practices to maintain their own separate private practices and to consult at other hospitals. They are compensated on fee-for-service or revenue sharing basis.

APOLLO HOSPITALS

DOCTOR ENGAGEMENT MODEL-

Apollo has followed a traditional approach to working with its medical staff. Because the physicians have historically owned the majority of hospitals in India (e.g , the nursing homes of today),they may want to retain their autonomy and leadership position when they come to work in the corporate chains.

At APOLLO doctors are allowed to have their own practices and are paid for their professional services on a FFS basis by the patient (not by the hospital) . Apollo bills the patient for the cost of the equipment, facilities, and supplies. This removes the hospital from the doctor-patient relationship ant incentivizes doctors to be productive.

Apollo executives state they want to give doctors freedom to practice medicine; doctors are not evaluated on how much revenue their clinical department makes but rather on their clinical outcomes.

Earlier on, Apollo utilized a FFS model with guaranteed incomes, it then shifted to a model where doctors have to take equity(purchase a number of share) in Apollo's hospital; this equity model harkens back to the traditional model of physician ownership of hospitals. It also blends with Apollo's growth into new business lines that doctors can support and share in. Apollo has never used a salaried model.

Apollo does not promote the individual doctor. Apollo does market to specialists in a variety of ways to incent them to utilize the system. These include providing state of art technology, a comprehensive suite of clinical service, strong nursing support, assistance with academic research, good medical collegues, and its informal management of procurement. Apollo also holds appeal to doctors due to its continued profitability and prestige.

At the same time Apollo also charges fees to the specialist on its staff for the use of its examination rooms. In this manner, the chain avoids being a "physicians cooperative" that uses the hospitals for their own advantage free of charge.

Article 1- Physician Compensation Models: The Basics, the Pros, and the Cons

(Career Resources article posted on NEJM Career Center - *New England Journal of Medicine, September 2004)*

- **Straight salary/minimum-income guarantee or salary plus bonus/incentive.**

  Most often seen in large HMOs, academic settings, and large corporate- or physician-owned practices, these closely related models are perhaps the most straightforward, because the income level is set and physicians know how much they'll earn. When a bonus or incentive is added in, physicians should inquire about how, when, and under what conditions the sum is paid. The minimum-income guarantee, with or without bonus, is the most prevalent model today for new physicians starting out.

Pros and cons: These salary models are essentially worry-free for young physicians, so they offer a sense of security. But without the bonus component, which is usually based on the group's total earnings, they offer little long-term financial incentive if there is no "ownership track," and may ultimately either discourage entrepreneurship or support minimum-effort work standards.

- **Equality/equal shares.**

  This model, considered the easiest from an administrative standpoint, is based purely on economics: after expenses, the remaining revenues are allocated equally among the group's physicians.

Pros and cons: On the plus side, this structure discourages over-utilization and doesn't require complex mathematical formulas. The possible downsides are that the model presumes all physicians are equally skilled, equally productive, and most importantly perhaps, equally

motivated to work in the group's best financial interest. That means "high producers" have little long-term incentive and low producers may be allowed to ride on the financial coattails of the more productive physicians. Nonetheless, many single-specialty groups adopt this model on the premise that all services, even those for which reimbursements are lower, are valuable and necessary to a group seeking to operate a full-service practice.

- **Production- or productivity-based compensation.**

  This model, with its myriad variations, can be fairly complicated. Essentially, physicians are paid a percentage of either billings or collections, or they are paid based on the resource-based relative value scale (RBRVS) units assigned to procedures or patient-visit types. The overhead costs of the practice — both fixed and variable — are allocated among the physicians.

Pros and cons: The possible advantage of this model is that it both encourages and rewards extra effort by individual physicians. In that also lies the potential downside: it can create a competitive intragroup environment that some physicians might not find appealing or that can deter citizenship. The productivity model and relative overhead allocation can also be difficult to manage administratively and politically. "Physicians need to understand their personal objectives. If they're interested in a very collegial environment, they might not want to be in a group where each physician is paid on his or her own production, because that will be pretty competitive," says Cornett.

Physicians should also determine whether their earnings in a productivity-based scheme will be based on their billings or on collections. If earnings are collections based, it behooves the physician to determine what percentage of billings the group typically collects, as well as how quickly — or slowly — reimbursement is received.

Patient mix also comes in to the picture in productivity-based compensation, so it's advisable to inquire about relative percentages of commercially insured, Medicare/Medicaid insured, and uninsured patients seen in the practice, as well as how new patients are assigned. For example, a physician whose patient base consisted primarily of Medicare or Medicaid patients would earn less than a counterpart whose patient base was primarily commercially insured, as Medicare/Medicaid reimbursement tends to be the lower of the two.

- **Capitation or productivity plus capitation.**

  The concept of capitation — prepaid health care premiums allocated to contracted provider groups for all coverage or specialty-services coverage of a defined enrollee population — became prevalent in the late 1980s and early 1990s. Capitation is still present in certain HMO-intensive markets, such as California, Minnesota, and the Northeast. Translated into a compensation model, capitation involves distribution of health plan payments among physicians in a nearly equal manner or based on some type of formula.

Pros and cons. On the plus side, capitation rewards groups, and in turn those groups' individual physicians, who deliver cost-efficient, effective care. However, from an economic standpoint, capitation-based income is dependent on marketplace factors and a group's negotiating prowess, which means that overall income levels may wax or wane from one year to the next. In addition, because global capitation contracts may entail providing all services to a group of patients, a high percentage of catastrophic diagnoses may negatively affect the group's bottom line, and therefore individual physicians' income levels.

On a final note, regardless of the compensation model in place at the hiring practice or entity, young physicians should calculate their living expenses and monthly personal budgets based on the compensation amount that is guaranteed. It's not advisable to count on a year-end bonus, even if it looks likely, because unforeseen factors could affect whether the bonus actually materializes.

Article-2 Physician partnership to lead healthcare organization & picking the right model for your market –pwc

(STRATEGY &)

Author- Gary Ahlquist (senior partner with STRATEGY & based in Chicago), Ross Nelson et al.

To make integrated delivery networks succeed, health systems will need to align with physicians. Physicians exert the greatest control over patient referrals and thus downstream patient volumes and are the 'face' of organization.

- **Four models to align with physicians**

Health systems can use four potential models to align interests and engage physicians

Affiliation:

Health systems give admitting privileges to physicians and may appoint medical directors to lead service lines in an administrative capacity. The affiliation model is easy to implement, and physician

Source: Strategy& analysis
Leaders can typically balance clinical aspects of care transformation more effectively than administrators. The governance is collegial, in that physicians tend to be more responsive to physician leaders. However, this model can have a limited impact on cost and quality.

Partnership:

In this model — which may be structured as clinical co management agreements, gain-sharing arrangements, or joint ventures — physicians form a separate legal entity for a contractual stake or ownership across a given service line. In exchange, the health system pays some combination of performance bonuses and/or shared savings. As with the affiliation model, partnerships are relatively easy to implement, and organizations can align incentives around the most variable and costly portion of care delivery.

There are challenges to this model, however. Partnerships represent a partial transformation at best, and any potential gains in cost and quality may still be limited by the practice preferences of physicians. Partnerships also have the potential to create a two-tiered system, alienating clinicians who are not part of the agreement. And they often do not emphasize coordination with other aspects of care delivery (such as post-acute services), which may hinder the health system's ability to succeed with new payment models.

Employment:

In most states, health systems can employ physicians, either directly or through a separate physician-led but hospital-controlled legal entity. In this arrangement, compensation often consists of a base salary and financial incentives that are linked to productivity and/or quality metrics. Although it is more difficult to implement, the employment model allows the health system to respond more quickly and effectively to evolving market conditions. In addition, organizations can get an exemption from the Stark Law (which requires that patients get a range of options for follow-up treatment after they leave the hospital), allowing them to gain patient volume by controlling such referrals from the doctors they employ.

Another advantage involves care protocols; employed physicians are more easily influenced to follow standard procedures, and are typically more loyal to the health system where they work.

And this model is increasingly attractive to younger physicians, who tend to be less entrepreneurial and are more interested in a work–life balance.

One drawback to the employment model, however, is that some evidence shows reduced productivity among employed physicians. Therefore, achieving goals such as an overall cost reduction of 25 percent may be difficult with a physician employment model. Similarly, though physicians are more likely to follow care protocols, higher quality is not always guaranteed. Financially, in the current fee-for-service model, the impact of employing physicians can at times be negative — compensation and overhead can outpace revenue, even including the incremental downstream impact of controlling referrals.

Clinically integrated networks:

In the fourth alignment model, health systems have a high degree of interdependence and cooperation with their physicians to control quality, outcomes, and costs. The integrated model is effectively "employment-plus": a tightly governed relationship that allows for differentiated performance in outcomes and quality, a differentiated experience for patients, and tailored value propositions for payers and employers. It applies strong governance and integration along clinical and operational dimensions to reinforce best practices among the staff and thus improve physician productivity. However, clinical integration is challenging and time-consuming to implement. It requires complex mechanisms for tracking risk and utilization and allocating rewards

Article-3 **Pros & Cons of Physician Compensation Models** **by Judy Wilson**

Equal sharing:

This model is simple to arrange administratively and it would discourage over utilization as each partner would get the same amount. Those would be pros to this type of plan. Some of the cons for this type of model are there would be no incentive to produce more productivity as each physician is going to get the same amount of money either way. It would also penalize any physician that is a high producer and allow lower producers to just float along with the same pay.

Productivity:

This would encourage professional effort and complement a governed economic system. Those two things would definitely be pro for this type of model. Cons of this type of model could cause inter-group competition. There would be substantially more to do on the accounting management side for this type of model. It could also cause, and more than likely, encourage over utilization. You would see physicians less likely to be willing to do anything that was not directly related to patient care.

Salary:

This type of model is the easiest to administer but, could in-debt the corporation if salaries are set too high depending on the income that is being received. It also might cause physicians to not step out of their safety zone to think of other ways to expand the practice.

Salary plus bonuses:

This type does encourage the physicians to increase their income by their performance for the bonus at the end of the year. It also offers security, because they are guaranteed a salary and if they do really well they will also receive a bonus. Those are all very good pros for this type of model. It could put some of the income at risk depending on a physicians' subjective measurements. What would warrant a bonus, other than increase monies coming into the practice? Physicians may have a minimum work standard and it could possible become the norm for the practice.

RATIONALE FOR THE STUDY

Clinicians are the key drivers to the successful functioning, profitability & business of hospital.

Good mix of doctors contribute to the brand building of the hospital & to provide the right mix

of medical and surgical care to patients we need a multidisciplinary team.

This team will form the basis of care for all patients availing out patient and inpatient services of the facility

Also, the team will set the pitch of standard of care and services provided by the hospital and hence should be done after proper research & due diligence.

In this study we are devising the engagement model for clinicians and trying to narrow down on number of doctors per specialty who will act as the key drivers for hospital business growth plan.

OBJECTIVES

GENERAL OBJECTIVE-

Framing clinician engagement models and devising key negotiation strategies for star clinicians across various specialties for an upcoming 230 bedded multi super specialty hospital in Dwarka, New Delhi.

SPECIFIC OBJECTIVE-

a) Identify the need and feasibility of a multi super specialty hospital in the given territory.
b) Prioritize the specialty mix in lines with the Healthcare needs of the market.
c) Shortlist the specialties which need to be driven by star consultants.
d) To define doctor's banding as per prevailing market practices.
e) To draft Clinician engagement models and give the numbers and matrix of clinical team required on board to go live.
f) To device key negotiation strategies for getting star clinicians on board.

RESEARCH METHODOLOGY

TYPE OF STUDY- Descriptive study

AREA OF STUDY- Aakash healthcare

STUDY PERIOD- 3 months (1^{st}feb- 30^{th}april)

TYPE OF DATA- primary and secondary, qualitative.

MODE OF DATA COLLECTION-

- Review of existing models.
- Informal interviews with organization staff

RESULT

CLINICIAN ENGAGEMENT MODELS-

1) FULL TIME

Model Type	Full Time	Tenure	Long term (2 or more years)
Model Details	▪ Doctor works on a full time engagement with a hospital.	**Pros**	▪ FTs provide complete coverage to the hospital. ▪ Responsible for setting up, development and performance of the specialty/ department. ▪ High degree of ownership and responsibilities. ▪ Both parties look for long term association.
Model Preferred for Specialties	▪ Super specialties like Cardiac, Neuro, Ortho and Onco ▪ Basic specialties like General medicine., general surgery, Gynec & Obs, Gastro, Neonatology, Pediatrics, anesthesiology and diagnostics.	**Cons**	▪ Hospital can have limited number of FTs i.e. 1 or 2 generally (mid-size hosp) ▪ Fixed Cost to the hospital irrespective of revenue generated in the initials years of operations.
Exclusivity	▪ Yes	**Preferred Payout Model**	New Hospital 1. Fixed payout 2. Minimum Guarantee and incentive 3. Minimum Guarantee or Incentive (whichever is higher) 4. MG + Retaining Fees/ Sustaining Allowance + Fees for Services Mature Hospitals 1. Minimum Guarantee and incentive 2. Minimum Guarantee or Incentive (whichever is higher)
Practice in Other Hosp	▪ Not permitted	**Own Clinic**	▪ Not permitted

2) PART TIME/VISITING

Model Type	Part Time/ Visiting	**Tenure**	No Lock in period
Model Details	▪ Doctor has part time association of 1 to 4 hours with a hospital are termed as part time consultants. ▪ Doctor visits a hospital less frequently or as required on call visit are termed as visiting consultants. ▪ Doctors have OP and IPD rights.	**Pros**	▪ Preferred model wherein a hospital does not intend to invest heavily in FTs. ▪ Association is mainly on FFS model, hence no fixed cost to the hospital.
Model Preferred for Specialties	▪ Super specialties like Cardiac, Neuro, Ortho and Onco ▪ Non-core specialties like ENT, Dermatology, Infectious diseases, Hematology, psychiatry, plastic surgery, etc.	**Cons**	▪ Doctor visits multiple hospitals and/or own clinic. ▪ No restrictions in terms of competitor or multiple engagement. ▪ OPD/ IPD availability to a hospital is as per the doctor's schedule & availability. ▪ Possibility of patient and revenue leakage. ▪ Low degree of ownership in developing the specialty department.
Exclusivity	▪ No	**Preferred Payout Model**	New Hospital 1. Fees for Services 2. Fees for Services and Minimum Guarantee (whichever higher) Mature Hospitals 1. Fees for Services
Practice in Other Hosp	▪ Permitted	**Own Clinic**	▪ Permitted

3) COURTESY/EMPANELLED-

Model Type	Empanelled Consultant	**Tenure**	No Lock in period
Model Details	▪ Doctors are empanelled with a hospital and have IP and Surgical rights, as applicable. ▪ Do not have OPD engagement.	**Pros**	▪ This works with doctors having their own clinics. ▪ Association is mainly on FFS model, hence no fixed cost to the hospital.
Model Preferred for Specialties	▪ Super specialties like Cardiac, Neuro, Ortho and Onco ▪ Non-core specialties like ENT, Dermatology, Infectious diseases, Hematology, psychiatry, plastic surgery, etc.	**Cons**	▪ Doctor visits multiple hospitals and/or own clinic. ▪ No restrictions in terms of competitor or multiple engagement. ▪ Low degree of ownership in developing the specialty department.
Exclusivity	▪ No	**Preferred Payout Model**	New Hospital 1. Fees for Services 2. Fees for Services and Minimum Guarantee (whichever higher) Mature Hospitals 1. Fees for Services
Practice in Other Hosp	▪ Permitted	**Own Clinic**	▪ Permitted

PAYOUT MODELS-

Fixed Payout	▪ Fixed amount paid every month irrespective of revenue generated by the clinician. ▪ YoY increase of 10 to 20 % based on the performance of the doctor.	Not Applicable	Not Applicable
Minimum Guarantee and Incentive	▪ Fixed amount is paid as minimum guarantee. ▪ A Base Target (BT) is set as a multiplier of MG e.g. 1 to 3 times. ▪ A doctor is paid incentive in the range of 50% to 80%. ▪ In case doctor's professional fees revenue is more than BT, incentive is paid on additional amount as per the incentive percentage.	Not Applicable	Not Applicable
Fees for Service or Minimum Guarantee (whichever is higher)	▪ Fixed amount is decided as minimum guarantee and Fees for Service payout in the range of 70% to 90%. ▪ Per month MG is paid to the consultant every month and on quarterly basis average FFS per month is calculated. ▪ Incase FFS is equal or less then MG, MG is paid to the consultant. ▪ In case FFS is more than MG amount, FFS amount is paid to the consultant.	▪ Initially when patient volume is low, hospital provide fixed amount per OPD visit to a consultant to cover up his overheads and traveling charges and ensure long association with the hospital when FFS amount is very low.	▪ Not Applicable
Fees for Services	▪ Fees for Service payout in the range of 70% to 90%.	Fees for Service payout in the range of 70% to 90%.	Fees for Service payout in the range of 70% to 90% only
MG and Sustaining Amount + Fees for Services	▪ Fixed amount is paid as minimum guarantee. ▪ Additional Fixed amount called as an investment / sustaining amount is paid over and above MG for fixed period (6 to 18 months). ▪ A Base Target (BT=MG+SA) is set as a multiplier of MG e.g. 1 to 3 times. ▪ In case doctor's professional fees revenue is more than BT, incentive is paid in the range of 50% to 80% on additional amount.	Not Applicable	Not Applicable
Fees for Service or Minimum Guarantee + Sustaining Amount (whichever is higher)	▪ Per month MG and SA is paid to the consultant every month and on quarterly basis average FFS per month is calculated. ▪ Incase FFS is equal or less than MG+SA, MG+SA is paid to the consultant. ▪ In case FFS is more than MG+SA amount, FFS amount is paid to the consultant.	Not Applicable	Not Applicable
Revenue Sharing	▪ CAPEX investment by the hospital. ▪ Consultant (individual/ team/ company) manages the department and shares the revenue with the hospital between 10 to 30% depending on specialty.	Not Applicable	Not Applicable
Equity Model/ Partnership Model	▪ Consultant individual or company set up clinical department with CAPEX investment and shares the profit from the department depending on the equity contribution.	Not Applicable	Not Applicable

DISSCUSSION

- **TO IDENTIFY THE NEED AND FEASIBILITY OF A MULTI SUPER SPECIALTY HOSPITAL IN THE GIVEN TERRITORY.**

- Dwarka is a neighborhood of Delhi and is located in the district of South West Delhi in India.
- Dwarka is the largest residential suburb in Asia, with a total of 1718 residential enclaves, and a net population of 1,100,000.

Location:

- The sub-city is located in South-West Delhi in the vicinity of Gurgaon and international airport.
- It is bounded by Uttam Nagar, Vasant Kunj, Vikas Puri, Najafgarh, Bijwasan, Palam vihar, Vasant Vihar, Janakpuri and Delhi cantonment.
- It is at a short distance from Gurgaon.

Connectivity to Catchment areas:

- Dwarka has a robust and well connected road network. The sub city will be connected to the mother city by 4 major roads from all directions.
- The sub city is well connected by metro rail with the city centre and other major parts of the city.
- Connected to Indira Gandhi International Airport Terminal 3.
- The sub city is now connected through metro rail to Noida (UP) and Anand Vihar and Ghaziabad
- Dwarka is expected to be connected to Gurgaon by metro in the near future due to its close proximity to the NCR town.

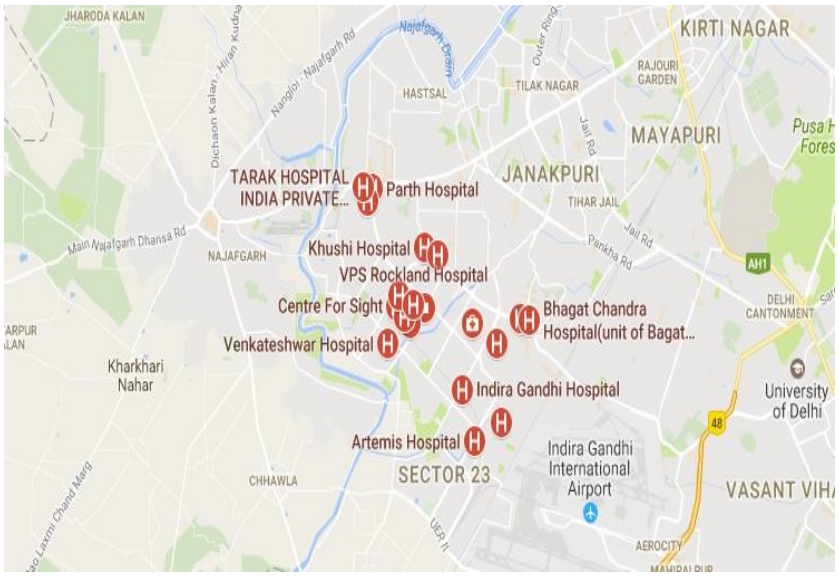
Demographic Details:

Dwarka Sub City:

S.No.	Description	2011
1	Area	56.48 km^2
2	Total Population	1,100,000
3	Population Density	19,000/km^2

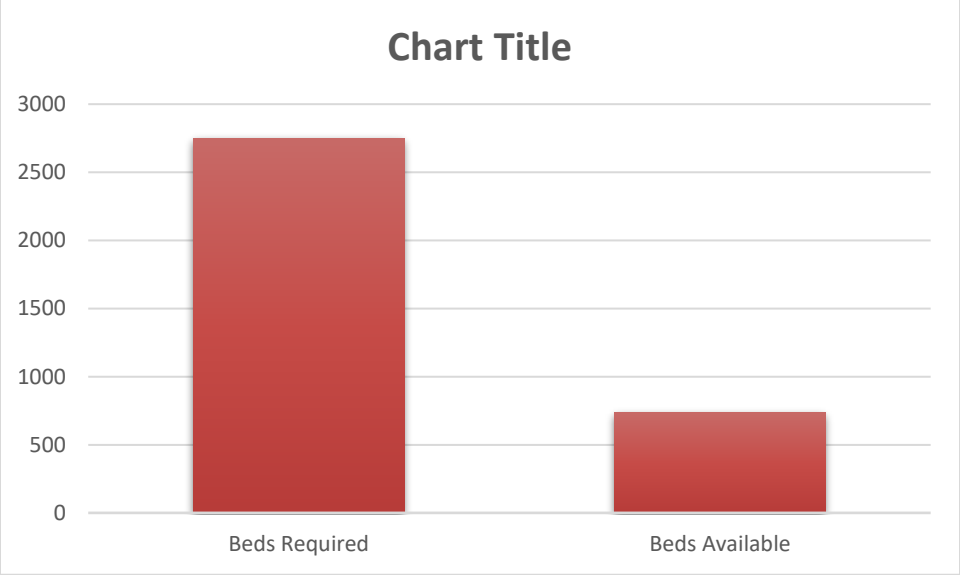
Medical facilities in Dwarka, Delhi

Serial No.	Name	No. of Beds
1	**Venkateshwar**	**325**
2	**Rockland**	**103**
3	**Maharaja Agrasen**	**80**
4	**Bhagat Chandra**	**85**
5	**Artemis**	**40**
6	**Rescue Hospital**	**50**
7	**Shree Hospital**	**20**
8	**Lifeline Hospital**	**20**
9	**Shree Sai Hospital**	**4**
10	**Ravi Nursing Home**	**4**
11	**Gee Bee Nursing Home**	**3**
12	**Dr. Nanda's Eye Care**	**2**



Observation:

Considering the WHO bed requirement norm, Dwarka has a severe bed deficit – approximately 700 beds available against the required 2,750.



- **Prioritize the specialty mix in lines with the Healthcare needs of the market.**

- The top multi-specialty hospitals in Dwarka have three to four leading specialties the drive majority of volumes and help position the respective hospitals.

Specialty Focus	**Hospitals**			
	Artemis	**Ayushman**	**Rockland**	**Venkateshwar**
Top 3	Orthopaedics	Orthopaedics	Orthopaedics	Orthopaedics
	Gynaecology	Gynaecology	General Surgery	Cardio Thoracic and Vascular Surgery
	Cardiology	Medicine	Cardiology	Gastroenterology
Other key Specialties	Nephrology	Cardiology	Oncology	Critical Care
	Gastroenterology	Nephrology	Gastroenterology	Interventional Cardiology
	paediatrics	Gastroenterology	Nephrology	Medical Oncology
	Neurology	Paediatrics	Urology	Neurosurgery
	Ophthalmology	Neurology	Plastic and Cosmetic Surgery	Neurology and Paediatric

				Neurology
• T	Dentistry	Ophthalmology	GI Surgery	Surgical Oncology
h	Dermatology	Dentistry	Critical Care	Urology and Nephrology
e	Cosmetic and Plastic Surgery	Endoscopic Surgery	Radiology	Pulmonology and Sleep Medicine
t	Endoscopic Surgery	ENT	Endocrinology	Ophthalmology
o	ENT	Urology		Physiotherapy
	Urology			Rheumatology
p	Physiotherapy			Respiratory Medicine

four hospitals all have Orthopedics amongst the top three specialties.

- While all hospitals have most of the facilities, there is no clear focus on specialties like-
    - Mother and Child Care
    - Oncology
    - Geriatrics
    - Dermatology
    - Nephrology/Urology
- After analyzing the current market status in terms of the availability of specialties, the following key specialties are recommended for Aakash Healthcare-

- At the time of startup-
  - Specialty Orthopedics
  - Mother and child
  - Neurosurgery
  - Critical Care
  - Nephrology
- In the later stages of Operations-
  - Interventional Cardiology
  - Cardiac Surgery
  - IVF
  - Gastroenterology
  - Oncology
  - Endocrinology
  - Transplant Medicine

- A specialty mix focusing on super specialty and a set of other specialties is recommended for Aakash Healthcare

- To Shortlist the specialties which need to be driven by star consultants.

➢ KEY SPECIALITIES that will be driven by star clinicians-

- Orthopedics & Joint Replacement
- Cardiology & Cardiac Surgery
- Mother & Child
- General & Minimal Access Surgery
- Ophthalmology & Refractive Surgery
- Nephrology
- Internal medicine.

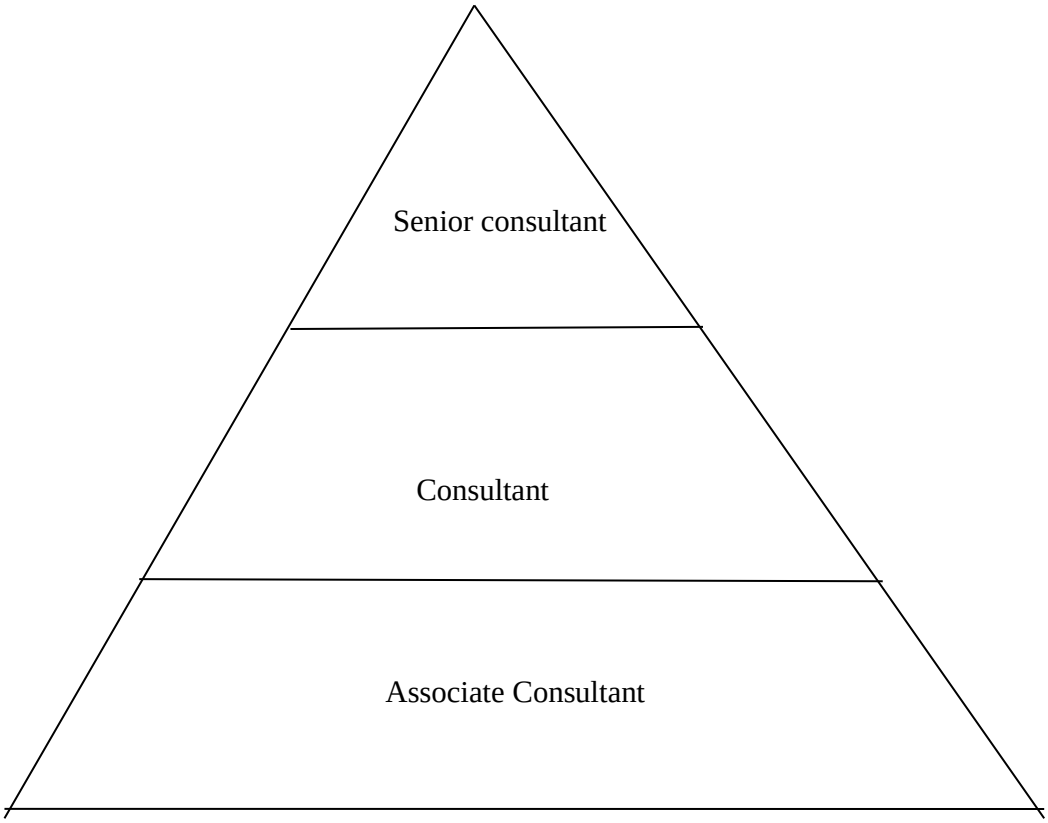
➢ OTHER SPECIALITIES

- Anesthesiology & Pain Management .
- Blood Bank & Transfusion Medicine
- Radiology
- Medical Oncology
- Neurology Interventional Radiology
- Endocrinology/Diabetes & Metabolic Disorders
- Pulmonology & Respiratory Medicine
- Hearing And Speech
- Lab Medicine
- ENT
- Surgical Oncology
- Neurosurgery
- Dental Sciences

- ER & Trauma
- Cosmetology & Plastic Surgery
- Urology
- Critical Care
- G I Surgery
- Preventive Health Check Up
- Rheumatology
- Mental Health & Behavioral Sciences
- Physiotherapy & Rehabilition
- Gastroenterology & Hepatobilliary Sciences
- Dermatology

- To define doctor's banding as per prevailing market practices.

DOCTOR'S BANDING-



SENIOR CONSULTANT-

Consultant with more than 10 years of experience with moderate patient base.

CONSULTANT-

Consultant is the title of senior hospital based physician or surgeon who has completed all of his or her specialist register in their chosen specialty. Clinician with more than 5 years of experience

ASSOCIATE CONSULTANT –

An associate specialist or consultant is one who is appointed to permanent position in middle ranks.

The main difference between an associate consultant and consultant is that an associate consultant is more on a for-hire role, generally called in to look at specific patients with one common specific ailment

Associate specialist can be part time or work across many hospitals.

They will generally perform less management duties and perform more time on patient care

- To Draft Clinician engagement models and propose the numbers and matrix of clinical team required on board to go live.

Clinician Engagement Models

FULL TIME	PART TIME/VISITING	COURTESY
• DOCTOR WORK ON THE FULL TIME ENGAGEMENT WITH THE HOSPITAL	• DORTOR HAS PART TIME ASSOCIATION OF 1-4 HOURS WITH THE HOSPITAL	• DOCTORS ARE EMPANELLED WITH THE HOSPITAL AND HAVE IP AND SURGICAL RIGHTS.

1. FULL TIME

- Doctor works on a full time engagement with hospital
- Practice in other hospital is not permitted also practice in own clinic is not encouraged.
- Tenure of engagement is long term (2 or more years).
- This model is preferred for following specialties-
    - Superspecialties like cardiology, neurology, orthopedics, and oncology.

- And basic specialties like General Medicine, General surgery, gynecology & Obstetrics, Gastroenterology, Neonatology, Pediatrics, Anesthesiology & Diagnostics.

PROS-

1. FT's provide complete coverage to the hospital.
2. Responsible for setting up, development and performance of the specialty/department.
3. High degree of ownership and responsibilities.
4. Both parties look for long time association.

CONS-

1. hospital can have limited number of FT's i.e 1 or 2 generally (mid-size hospital)
2. fixed cost to the hospital irrespective of revenue generated in the initial years of operations.

Visiting consultant model

- Also called as part time consultant.
- In this model, doctor having part time association for 1 to 4 hours with the hospital are termed as part time consultants
- Doctors' visits a hospital less frequently or as required on call visit are termed as visiting consultant.
- Doctors have the OPD and IPD rights
- Practice in other hospital and own clinic is permitted.
- This model is preferred for super specialties like cardiology, neurology, orthopedics and oncology.
- Also, for the non-core specialties like ENT, Dermatology, Hematology, Psychiatry, Plastic surgery etc.

PROS-

1. Preferred model wherein hospital does not intend to invest heavily on FT's.

2. Association is mainly on FFS model , hence no fixed cost to the hospital.

CONS-

1. Doctor visits multiple hospitals and/or clinic.
2. No restrictions in term of competitor or multiple engagement.
3. OPD/IPD availability to a hospital is as per the doctor's schedule and availability.
4. Possibility of patient and revenue leakage.
5. Low degree of ownership in developing the speciality department.

COURTESY CONSULTANT MODEL-

- Doctors are empanelled with a hospital and have IPD and Surgical rights.
- Doctor's do not have OPD engagement.
- Doctor's are permitted to practice in other hospitals and own clinic.
- This model is preferred for the superspecialties like cardiology, Neurology, Orthopedics and Oncology.
- Also, for the non-core specialties like ENT, Dermatology, Hematology, Psychiatry, Plastic surgery, etc.

PROS-

1. This works with doctor's having there own clinic.
2. Association is mainly on FFS model, hence no fixed cost to the hospital.

CONS-

1. Doctor visits multiple hospital and /or clinic.
2. No restriction in terms of competitor or multiple engagements.
3. Low degree of ownership in developing the specialty department.

DOCTOR PAYOUT MODELS

-FIXED PAYOUT-

Fixed amount paid every month irrrespective of revenue generated by the clinician.

YOY increase of 10-20% based on the performance if doctor.

Preferred in case of full time consultants.

- MINIMUM GAURANTEE AND INCENTIVE-

  Fixed amount is paid as minimum gaurantee

  A fixed target is set as multiplier of MG e.g 1 to 3 times

  A doctor is paid incentive in term of 50 to 80%

  In case Doctor's professional fees revenue is more than BT, incentive is paid on additional amount as per the incentive percentage.

  This model is preffered for FT's

- FEE FOR SERVICE OR MINIMUM GAURANTEE (whichever is higher)
  - FT's

  Fixed amount is decided as minimum gaurantee and Fees for service payout in the range of 70% to 90%.

  Per month MG is paid to the consultant every month and on quaterly basis , average FFS per month is calculated.

  In case FFS is equal or less then MG, MG is paid to the consultant.

  In case FFS is more than MG amount, FFS amount is paid to the consultant.

VISITING /PART TIME-

Initially when patient volume is low, hospital provide fixed amount per OPD visit to the consultant to cover up his overheads and travelling charges and ensure long association with the hospital , when FFS amount is very low.

- Not applicable for courtesy consultant.

- FEE FOR SERVICES-

  Fee for services payout in the range of 70% to 90%

  Applicable in case of FT's, Part time/visiting consultant, Courtesy consultant.

- MG & SUSTAINING AMOUNT + FEE FOR SERVICES

  Fixed amount is paid as MG.

  Additional fixed amount called as an investment/sustaining amount is paid over and above MG for fixed period (6 to 18 months)

  A base target (BT= MG+SA) is set as a multiplier of MG e.g 1 to 3 times

  In case doctor's professional fees revenue is more than BT, incentive is paid in the range of 50% to 80% on additional amount.

- FEES FOR SERVICE OR MINIMUM GUARANTEE + SUSTAINING AMOUNT (whichever is higher)

  Per month MG and SA is paid to the consultant every month and on quaterly basis average FFS per month is calculated.

  In case FFS is more than MG+ SA amount, FFS amount is paid to the consultant.

- REVENUE SHARING-

  CAPEX investment by the hospital.

  Consultant (individual/team/company) manages the department and shares the revenue with the hospital between 10 to 30 % depending upon specialty.

  This model is preferred in case of FT's.

- EQUITY MODEL/ PARTNERSHIP MODEL-

Consultant individual or company set up clinical department with CAPEX investment and shares the profit from the department depending on the equity contribution. Preferred in case of FT's.

DOCTOR MIX-

- KEY SPECIALTIES

S. No.	Key Specialities	Sr. Consultant		Consultant		Associate Consultant		Total Numbers
		Numbers	Model	Numbers	Model	Numbers	Model	
1	Orthopaedics & Joint Replacement	1	FT	2	FT	4	FT	7
2	Minimal Access Surgery	2	FT	1	VC	4	FT	7
3	Opthalmology	2	FT	1	VC	1	FT	4
4	Mother & Child	2	FT	1	CC	5	FT	8
5	Cardiac Sciences / CTVS	2	FT	2	CC + FT	4	FT	8
6	Nephrology	1	FT	2	CC + FT	2	FT	5
7	Internal Medicine	2	FT	2	VC + CC	5	FT	9

Full Time Consultant	FT
Visiting Consultant	VC
Courtsey Consultant	CC
Star Consultant	

➢ OTHER SPECIALTIES

S. No.	Other Specialties	Sr. Consultant		Consultant		Associate Consultant		Total Numbers
		Numbers	Model	Numbers	Model	Numbers	Model	
1	Anesthesiology & Pain Management	1	FT	2	FT	5	FT	8
2	Blood Bank & Transfusion Medicine	1	FT	0		1	FT	2
3	Critical Care	1	FT	1	FT	4	FT	6
4	Dental Sciences	0	NA	2	FT			2
5	Dermatology	0	NA	1	FT			1
6	Endocrinology	1	FT	1	VC			2
7	ENT	1	FT	2	VC			3
8	ER & Trauma	0	NA	1	FT	6	FT	7
9	G I Surgery	1	FT	1	VC			2
10	Gastroenterology & Hepatobilliary Sciences	1	FT	1	FT			2
11	Gynaecology	2	FT	2	FT + CC	2	CC	6
12	Lab Medicine	1	FT	2	FT	3	FT	6
13	Medical Oncology	1	FT	0		0		1
14	Mental Health & Behavioral Sciences	0	NA	1	VC			1
15	Neurology	1	FT	1	VC	1	FT	3
16	Neurosurgery	2	FT + CC	1	VC			3
17	Physiotherapy & Rehabilition	0	NA	1	FT	4	FT	5
18	Plastic Surgery	2	FT + VC			1	FT	3
19	Preventive Health Check Up	0	NA	1	FT			1
20	Pulmonology & Respiratory Medicine	1	VC	1	VC			2
21	Radiology	1	FT	2	FT	4	FT	7
22	Rheumatology	0	NA	1	VC			1
23	Surgical Oncology	1	CC	1	VC			2
24	Urology	1	FT	1	VC			2

Full Time Consultant	**FT**
Visiting Consultant	**VC**
Courtsey Consultant	**CC**
Star Consultant	

- To device key negotiation strategies for getting star clinicians on board.

1. Dedicated OT's for Star surgeons.
2. Dedicated OPD's for Star clinicians.
3. Single unit model for star consultant.
4. Higher MG's to ensure support during lean periods.
5. Provision of existing team movement/relocation of their choice from their current practice to our facility.
6. Arrangement of OPD slots and call days based on the preferences and models proposed by star clinicians.

CONCLUSION

In order to contain cost and operate the facility with minimum load on liquidity, I recommend that the engagement of all clinicians shall not be a full time retainer ship

The doctors/clinicians who are on full time basis can be engaged FFS or MG model

Other than full time consultant, the hospital shall adopt the strategy of VC and CC and empanel them to ensure full time availability of doctors during out patient hours and also inward drainage of patient base of VC and CC.

Getting star clinicians on board will bring high patient foot falls and improve the visibility of facility amongst the common masses.

Hence, it is suggested that the models recommended for clinician engagement shall be followed.

RECOMMENDATIONS

Before Selecting a Doctor and Engagement Model

1. Doctor's background should be checked in terms of clinical outcome.

2. Ethics- in terms of exclusivity, commitment to the organization should be considered

3. Past employment record and reason for separation should be taken into account.

4. Last contract/s Term and Conditions – payout, MG, separation, and other contractual bindings should be taken into consideration

5. Attitude towards the organization and developing the department should be prime focus

6. Team player qualities has to be analysed

7. Patient base , reach and popularity of the clinician should be considered

8. Lock in period / commitment has to be finalized

9. Comparative of candidate/s and prevalent payouts.

REFERENCES

1. https://www.healthcatalyst.com/proven-physician-engagement-strategies
2. https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdf
3. https://www.strategyand.pwc.com/media/file/Strategyand_Physician-Partnership-Healthcare-Transformation.pdf
4. http://www.nejmcareercenter.org/article/physician-compensation-models-the-basics-the-pros-and-the-cons/
5. http://www.mgma.com/Libraries/Assets/Store/Books/8652-excerpt.pdf Strategies for Value-Based Physician Compensation Authors: Jeffrey B. Milburn, MBA, CMPE, and Mary Maurar, MLS
6. https://www.sullivancotter.com/wp-content/uploads/2016/03/Value-Based-Physician-Compensation-final-hfm-Magazine.pdfCASE STUDY by Brian Bunkers Mark Koch Jeanie Lubinsky Jeffrey A. Weisz Brian Whited
7. http://www.bdcadvisors.com/roadmap-for-physician-compensation-in-a-value-based-world/
8. http://www.physicianspractice.com/mgma15/how-develop-physician-compensation-plan
9. https://www.aapc.com/blog/34988-physician-compensation-models/
10. http://www.aafp.org/careers/hunting/compensation.html
11. https://cph.uiowa.edu/ruralhealthvalue/files/RHV%20Physician%20Engagement%20Primer.pdf
    Physician Engagement – A Primer for Healthcare Leaders A. Clinton MacKinney, MD, MS
12. http://www.freedassociates.com/insights/point-of-view/developing-successful-physician-engagement-strategy/
13. https://www.healthcatalyst.com/proven-physician-engagement-strategies

THANK YOU