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SYMPOSIUM: ALIGNING PHYSICIAN AND HOSPITAL INCENTIVES

Orthopaedic Surgeon-hospital Alignment at Geisinger Health System

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Abstract

Background There is broad recognition that the healthcare crisis in the United States is going to require a response and change in clinical practice. The management structure of Geisinger Health System is unique, and this has the potential to change the dynamics of surgeon-administration alignment.

Questions/purposes Our goal is to summarize and clarify the relationship between orthopaedic surgeons and the healthcare system at Geisinger, evaluate the positive and negative aspects, and consider which components may be reproducible.

Methods This overview arises from a review of management publications, discussions with orthopaedic attendings and administrators, and personal observations and comparison with my previous 15-year university-based practice.

Results The Geisinger Health System has always been physician-run. The overall efficiency and pragmatic approach found at Geisinger relies heavily on changing surgeon behavior to match what is optimal for the system rather than the individual. This approach appears to bring greater stability and more consistent outcomes, but only by removing what some see as the art of medicine and at the loss of perceived provider autonomy. Despite the rigid demands placed on the surgeon, the system remains adaptable to change and appears to retain faculty at a high rate.

Conclusions The Geisinger System is unique in its ability to control an insurance plan, multiple hospitals, and a large physician group. Through clear protocols and behavioral pressure, it demands surgeon alignment with the system as a whole and in return provides a stable work environment. It is not ideal for all surgeons and it is unclear whether it can be reproduced in a less structured setting.

Introduction

"As a nation we have embarked on a journey of sensibility and equity that has been too long delayed. The end of this journey is obscure, but before it is over and a new equilibrium established, the journey will engage nearly every person and institution in the country"—Francis Crosson and Laura Tollen [1].

Many analysts refer to a "healthcare crisis" in the United States in which the rising and unsustainable costs do not provide concomitant improvements in quality of care. Leading orthopaedic groups, including the American Academy of Orthopaedic Surgeons (AAOS) and subspecialty societies, have recognized that the healthcare crisis in the United States is going to require a response and change in clinical practice. An accountable care organization (ACO) is a group of providers who provide coordinated care, manage chronic disease, and strive to improve overall quality of care. In general, provider payment and system reimbursements are tied to quality metrics and managing overall healthcare expenditure. Page [7] commented, "Among the currently functioning integrated care systems in the United States are Kaiser Permanente, Intermountain Health Care, and Geisinger Health Systems. As

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the ACO model evolves, positive features from these systems may serve as a template to other organizations." It is the recognition that some systems are working and others failing that has led to a focused look at the fine details of different models, understanding that duplication is likely easier and more efficient than reinvention.

Nearly a century ago, Abigail Geisinger recruited Dr Harold Leighton Foss, who had earlier been an assistant to Dr William Mayo, as medical director to help organize and build a hospital in rural, central Pennsylvania (www.geisinger.org/about/history.html). What began as a regional resource has now grown into an integrated health delivery system incorporating six hospital sites, 39 independent office locations, a not-for-profit insurance plan, a basic science research program, and a multispecialty group practice than employs more than 900 primary and specialty physicians. The relationship between administration and physicians encompasses not only the hospital setting, but also includes elements relating to the insurance plan and the multispecialty group itself. The integrated delivery system created by these relationships has the potential to maximize quality of care while controlling total healthcare costs [1]. Although this situation is fairly uncommon in the United States, what is extremely rare is the management structure of Geisinger as a whole: it always has been and remains a physician-run organization.

Suchman et al. [9] in their article on organizational transformation of medical care described the traditional relationship between physicians and administrators: "Physicians tend to regard administrators as heartless, bottom-line-oriented, and insensitive to the needs of patients. Administrators see physicians as egotistical, sanctimonious, and lacking any capacity for teamwork." Although there are clear exceptions to this generalized, somewhat sarcastic statement, it does express, in simplistic terms, the emotional reactions often believed to be close to the truth. The management structure of Geisinger Health System, modeled after the Mayo Clinic, has always placed physician leadership in the senior-most positions, and this has the potential to change the dynamics of surgeon-administration alignment. The inclusion of residency training programs as well as the support for basic and applied scientific research adds to this somewhat unique environment.

Our goal is to attempt to summarize and clarify elements of the relationship between orthopaedic surgeons and the healthcare system at Geisinger by addressing the following issues: (1) surgeon-hospital alignment in the Geisinger academic medical center; (2) incentive plans and surgeon involvement in setting up those plans; and (3) downsides and risks associated with the Geisinger alignment model. We attempt to evaluate the success of the Geisinger System in providing a healthy professional working environment for the orthopaedic surgeon, comparing this system with other academic training programs, and evaluating the reproducibility at other locations.

Methods

Extensive discussion with current orthopaedic faculty, midlevel and senior administrators as well as a review of previously published articles relating to Geisinger Health System served as the basis for this review. PubMed served as the primary search engine, and only articles published in the last 5 years were evaluated as a result of the rapid changes evident in health care in general and Geisinger specifically. The search terms used included "Geisinger", "Hospital Physician Alignment", "Financial Incentives", and "Physician Quality Improvement". Over 100 citations were noted and six chosen appropriate for this review. In addition, appropriate text and nonpeer review literature are cited.

Surgeon-hospital Alignment at Geisinger

The details of the academic setting at Geisinger Medical Center (GMC) do not differ substantially from that of most institutions or departments with residency programs with two major exceptions: there is no dean and no universal publication requirements for retention. Because there is no promotion and tenure system, the individual providers rely on personal interest to drive academic pursuits. This has resulted in a mixed effort with some faculty more active than others in research opportunities. What does not vary to this degree, however, is the universal demand that all faculty actively participate in the education of the residents both in the operating room as well as the classroom. A common problem in any performance-based system that relies on either collections or Work Relative Value Unit (WRVU) totals as a measure of productivity is the time and effort that education and research demand from individuals. If the health system rewards its providers based on clinical volume or collections, how does it continue to encourage active participation in any educational/academic process?

The solution to this problem at Geisinger has been relatively simple: faculty who commit a major portion of their work effort to research and education can be designated as less than 1.0 (full-time) clinical full-time equivalent (FTE) and by doing so reduce their expected WRVU totals without reducing their salary and bonus structure. The remainder of their FTE is classified under either research or administrative effort depending on their role in the department. The specifics of incentive plans, discussed subsequently, allow for this adjustment on an individual yearly basis, and the perceived reward has been universally praised by the orthopaedic

faculty. That being said, every physician in the Department of Orthopaedics at Geisinger Medical Center has met or exceeded their WRVU expectations, demonstrating most surgeons teach because they choose to, not because they are reimbursed for it. In addition to the salary or WRVU credit for research time, the institution directly supports research effort through salary support of research personnel. The Department of Orthopaedics currently has five fully internally funded research individuals who coordinate and manage grant applications, institutional review board submissions, and study organization from inception through publication. Support for this research team comes to the Department of Orthopaedics as part of the yearly approved budget and is not dependent on external funding. Residents and fellows are encouraged to participate in all elements of the research process, and faculty are relieved of many of the more tedious tasks such as requests for institutional review board approval.

The process of pursuing clinical academic interests at GMC is facilitated by the advanced electronic medical record that has been used for over a decade. As an early adopter of electronic medical records, Geisinger has been able to track and focus on patient outcomes including elements relating to primary care, hospitalization, and surgical data. This in turn greatly simplifies clinical research in providing rapid and reliable access to patient information. The geographical setting and stable population of central Pennsylvania create an ideal environment for long-term studies. This same geographical isolation has another important effect on the academic faculty: there is no other nearby teaching environment available without major relocation. Unlike many other regional academic centers (ie, those in Philadelphia), which offer the option of moving from one academic setting to another, the relative isolation of Geisinger tends to promote long-term retention. This can, of course, be perceived as a negative if a surgeon is dissatisfied with their current position.

The absence of a university structure with all of the inherent academic administrative bureaucracy allows the Geisinger System to function more like a corporate structure. Although some faculty find this a less protective environment, it allows for greater adaptability and innovation in a constantly changing healthcare landscape. The specific goals of the system as a whole, each department, and each physician need to continually adapt to a vast array of issues, including new federal and private insurance regulations, new technologies, and changes in payer mix. "It is not important whether Geisinger's innovations are ideal, or even whether every innovation ultimately works," but instead that all professional staff is allowed "the organizational 'permission' to try, fail, learn from failure, and ultimately succeed" [8]. Institutional support is available for pilot projects and studies with the presumption that anything that might improve patient outcomes will ultimately benefit the entire system. In addition, the day-to-day management of musculoskeletal care is generally left to the department, allowing it to direct the majority of resources provided. The perception from some that the Geisinger System is too focused on cost, creating standardized treatment protocols, measuring outcomes, and potentially limiting the practice and art of medicine, is generally outweighed by the consistency this approach brings. The reality is that no one can successfully navigate without a clear strategic vision that is easily modified and centrally organized. It is the central organization that brings a high level of efficiency to GMC while at the same time creating the corporate structure that some surgeons find objectionable. The Health System must remain financially viable, especially at the hospital setting, and aligning provider goals with those of the institution is crucial to this goal.

Incentive Plans and Surgeon Involvement

Despite the fact that Geisinger Health System is a not-for-profit entity, the management goal is to provide high-quality, efficient care that can be sustained. Practically speaking, this means the system must maintain some degree of positive cash flow to allow for maintenance of facilities, unexpected losses, and expansion. From an orthopaedic perspective this necessitates recruitment of high-quality faculty, support of clinical practice, and a method of securing individual commitment to the systematic approach necessary to achieve predictable outcomes. This system-directed approach is not always well received from individual providers because the specific targets and demands can sometimes seem frivolous and a waste of time. The greatest perceived error in this system is a failure by the health system to communicate to each surgeon the rationale behind specific targets, goals, and demands. Targets and goals relate to diverse issues such as patient access, completion of documentation, surgical volume, and patient satisfaction. Providers are given little if any discretion about demands relating to clinical care, documentation, or directed clinical protocols. Surgeon salary relates to meeting the targets; specific examples of each, and administrative response, are discussed subsequently.

Each orthopaedic surgeon at GMC has two components to his or her salary: there is a base pay and an incentive pay. "A fundamental goal of Geisinger's compensation plan is to treat 20 percent of total physician compensation as variable and directly dependent on annual individual performance as well as annual group performance" [5]. The base pay begins at 30% to 40% of the national average income for orthopaedic surgeons and can increase with time or depend on the level of experience of a new hire. "Geisinger uses a proprietary survey as its first source to benchmark both

compensation and productivity…a physician's experience and specialty market rates are also considered in determining base salary" [5]. Tied to this base salary is a biannual incentive payment that is based on the provider meeting a predetermined set of goals, some clinical, some teaching, and some administrative (Appendix 1).

Twenty-five percent of the incentive is based on the surgeon meeting a WRVU target with very little bonus pay if the provider exceeds that target. As noted, all orthopaedic surgeons exceed the WRVU target, which is set at 60% of the national average for orthopaedic surgeons (currently 8400 WRVU/year). The faculty frequently asks why we exceed the work expectations, and the answer is fairly simple. First, we have chosen to practice in a busy tertiary referral center, and we welcome the high volume both for personal satisfaction as well as teaching purposes. Second, and perhaps just as important, the WRVU totals for a given year can serve as a basis for renegotiation of the base salary in coming years. The yearly contract process, which originates in the department and finishes with senior surgical administration, takes provider productivity into account and allows for changes in both expectations and rewards. Each surgeon is assigned to a specialty service and has near complete coverage by residents in the clinic as well as the operating room. In addition, each provider has his or her own Physician Assistant. Given vigorous electronic medical records with numerous updates, notes, discharge summaries, and orders required, the manpower available to the orthopaedic surgeons allows for a focus on research and medicine rather than paperwork.

The remaining 75% of a surgeon's incentive pay is based on an individual productivity document, referred to as the back page. This document outlines the goals each provider must achieve above meeting the WRVU requirements. These goals are set on a yearly basis, some originating from within the department with the input of the provider (ie, research, publication, teaching, etc) and some are set by system administration. In general, these targets are easily reached, many are established with the individual's input but, on occasion, can be difficult to fully appreciate. For example, in 2011, each surgeon was given the goal of arriving in the operating room within 15 minutes of a ready-to-prep point as determined by the operating room nursing staff. Although this seems reasonable, ready to prep can be interpreted in many ways, the narrowest being the moment when anesthesia has the patient asleep. In complex spine cases, the application of neurologic monitoring can take an additional 20 to 25 minutes, and in many cases, the surgeon was not present until after all monitors had been applied. In those cases, the surgeon was marked as delinquent and, if they surpassed 5% of late arrivals, was subject to an incentive penalty as high as $5000. As a result of surgeon complaint, this goal was removed for the 2012 academic cycle, showing that the system remains fairly flexible. Another example of these goals is the newest target of 90% of discharge summaries completed and signed by any provider, including a resident or Physician Assistant, within 24 hours of actual patient discharge with the summary sent to primary care providers within 48 hours. The rationale for this target relates to new insurance regulations, which will soon penalize the hospital if the discharge summary is not completed, signed, and sent. The surgeons and their team are only responsible for the first part of this goal, and although one could argue that it is intrinsically unfair to the surgeon, who almost never actually does the discharge summary (resident and physician assistant responsibility), a more global viewpoint raises the following questions: "If one individual is not ultimately responsible for getting this done, who will make sure it is done?" and "What is the best way to incentivize and make sure the goal is accomplished?" From a clean, practical management perspective, penalizing the attending surgeon is, if nothing else, extremely effective. Additional targets or goals can include service line management, research and teaching, completion of computer-based courses (ie, hygiene, child abuse, and HIPPA), and satisfaction survey responses. As stated clearly by Dr Glenn Steele, President and CEO of Geisinger Health System, "Surgeons can make more money in other places. They come here to be part of changing health care." Whether each provider believes this or not, the system as it is structured encourages (or demands) certain behavior, depending on one's viewpoint. What cannot be argued is the effectiveness of this approach; good or bad, fair or unfair, each surgeon is aware of what they need to do to preserve all of their incentive pay.

From the perspective of the health system and hospital, "the major overarching goal for Geisinger Health System is to improve the quality and efficiency of its patient care, and Health Plan data consistently show that physicians employed by Geisinger under this compensation system are improving faster than other physicians" [5]. Geisinger has been a leader in implementing so-called "ProvenCare Methodology" [5] in multiple service lines, including diabetes care, coronary artery bypass graft surgery, and more recently THA/TKA. This concept revolves around defining proven treatment protocols and then demanding that providers follow the preset order plans, some of which can involve 50 to 60 steps, all of which must be completed. The protocols are organized through a multispecialty design process, and in the case of total joint arthroplasty, orthopaedic input was central and fundamental to the final product. The commitment and buy-in required from the providers to bring improved outcomes and cost savings to the system clearly require "aligning incentives to reward the creation of enhanced health care value" [8]. Data

collected by the system have shown consistent improvement in patient outcomes and cost savings, both far above national averages [5, 8]. Geisinger therefore openly strives to align the surgeon and the health system through its philosophical approach as well as its strict application of the incentive plans.

Downsides and Risk of the Geisinger System

The greatest downside to the system outlined here, as perceived by orthopaedic surgeons, is a sense of loss of autonomy and the centralization of authority. The benefit to patients in terms of efficiency, cost containment, and quality outcomes may not be appreciated by the clinical provider who is focused more on his or her own day-to-day activities and practice demands. Some surgeons, who have never experienced practicing in a university environment, compare their situation with those in private practice and reasonably conclude that the Geisinger System is large, bulky, and much slower to respond and change. Although this is undoubtedly true, it remains relatively nimble in comparison to most universities. The financial incentive system, as outlined here, can also be seen as a downside in that the incentive for working beyond expectation does not really exist, and some providers believe this takes control of individual income away. In addition, the ancillary income derived from radiology, in-office physical therapy, and durable medical goods is not available to any providers at GMC, much like most university settings. There is no question this is the reality, but the positive aspect is that the system removes the risk of major change or loss in income experienced by those in private practice. The year-to-year contracts used at GMC can theoretically put a surgeon at risk of being terminated, although this has never been the practice. Gratuitous or random termination would obviously undermine any trust and cooperative spirit that exists and would make future recruitment impossible. When asked about this issue, Dr Glenn Steele responded, "We would put ourselves out of business…no one would want to work for us" (personal communication). On that basis, most of the faculty looks at the yearly contract as either a neutral or positive process; either nothing changes or the surgeon is afforded the opportunity to petition for a new incentive plan.

Discussion

This review attempts to evaluate the success of the Geisinger System in providing a healthy professional working environment, compare this system with other academic training programs, and evaluate the reproducibility at other locations. Based on the data available from Geisinger, internal administrative evaluation, and perhaps most importantly feedback from the orthopaedic providers, one can get an overall sense of how the system functions in relation to the surgeon. A comprehensive evaluation, including aspects relating to patient outcomes, patient satisfaction, and overall efficiency, is beyond the scope and purpose of this review. Although the fundamental question addressed is whether the surgeon-hospital alignment at Geisinger is good for the surgeon, this review summarizes and clarifies elements of the relationship between orthopaedic surgeons and the healthcare system at Geisinger by addressing the following issues: (1) surgeon-hospital alignment in the Geisinger academic medical center; (2) incentive plans and surgeon involvement in setting up those plans; and (3) downsides and risks associated with the Geisinger alignment model.

This review is limited by several factors. First, it is based primarily on the experience of the author (DSH) rather than any rigorous scientific process, although the opinions and input of the entire orthopaedic faculty were obtained. This faculty input was most helpful in evaluating the risks and weaknesses of the Geisinger System because it provided broader insight and significantly greater historical perspective. A second weakness is that the review reflects the view of orthopaedic surgeons, not surgeons or physicians in general. It is distinctly possible that other subspecialties or generalists receive less support from the Geisinger System and may not share the opinions, both positive and negative, expressed by the orthopaedic faculty. The clinical and financial success at Geisinger has been well documented, as discussed, but employee satisfaction, specifically physician satisfaction, has never been formally studied. As health systems reinvent and redesign themselves, it would be of great benefit to all providers to incorporate a formal method of measuring and responding to elements of both satisfaction and dissatisfaction on a continuing basis. A healthy organization can only remain that way if providers can be retained.

There is little doubt that Geisinger succeeds in providing a stable, rewarding practice setting, recognizing that the environment is not perfect or ideally suited to all personalities. The concept of alignment involves adjusting parts or people until they are in the proper relative position and this can be extremely difficult to do, especially when varied personalities are involved. In addition, the determination of proper position can vary depending on individual perspectives and values. Many surgeons do not like being coerced, either by peer pressure or financial means, and would rather not be part of a group, cooperative structure. The financial stability of Geisinger, however, is crucial to its ability to provide clinical, educational, and research support, and this stability depends on controlling patient costs, patient behavior, and physician

behavior. "Geisinger's unpublished recruitment and retention data indicate that its physicians seem to approve of this system….current annual turnover is 4–5 percent, compared to 6 percent or more in the 2010 American Medical Group Association survey" [5]. These data, in conjunction with the financial stability at Geisinger, would suggest successful physician/hospital alignment has been achieved. The trifecta of control over medical staff, hospital, and insurance plan remains somewhat rare in the United States, however, and it is this near complete control of healthcare delivery that allows Geisinger to be as successful as it is. Many academic and private hospital environments will guarantee salary and clinical support, but the level of buy-in and cooperative effort obtained varies greatly. The reality, good or bad, of the Geisinger System is that it does not permit a noncooperative, independent approach. You are rewarded fairly with clearly defined goals. Failure to meet those goals results in a penalty. This is the nature of a team effort.

Based on personal experience and that of faculty who have practiced in university settings, there appears to be little day-to-day difference between GMC and the average academic practice. Residents are omnipresent, conferences are a daily occurrence, peer review is rigorous, and teaching remains a primary focus. Although the department is growing and evolving toward more rigorous academic goals, the lack of a promotion and retention process makes it almost impossible to conceive a situation in which a successful clinician and educator would be asked to leave. One could argue that this removes the incentive to do research and publish, but, having experienced both environments, I would disagree with this conclusion. Any surgeon who expends energy on teaching, writing, or research does so primarily because they are interested and excited by the process, not because it is demanded of them. The goal of the training program remains focused on producing well-rounded, clinically proficient, critically thinking residents who will provide excellent patient care.

The design and flexibility of the incentive plans at Geisinger remain fairly unique, especially in academic medical centers. Fair and reasonable salaries combined with realistic work demands and excellent ancillary support combine to create what most perceive as an excellent lifestyle. Without doubt there are other systems that provide clinical support for the surgeon as well as control of the hospital setting or the insurance plan, but few that allow the degree of physician input and direction into the incentive plans seen at GMC. The more typical organization rewards surgeons based on volume or collections without incorporating quality or outcome measures. This type of system fails to recognize that the integration of providers, sustainability, and the ability to change and respond to new challenges remain critical elements to any successful strategy. Intermountain Health Care has shown savings in excess of USD 50 million a year from a single protocol directed at improving labor and delivery care, a demonstration of the power of a fully implemented change in medical practice that was formulated and accepted by the physicians in a centrally organized system [3]. The apparent success of physician alignment at Geisinger, linking up to 20% of physician compensation to strategic goals, is further supported by reports of a drop in clinical quality indicators at Kaiser Permanente when financial incentives were removed [6]. These recent reports do not support the concept that physicians are self-centered and only focused on money, but rather recognize the reality of being human. In their discussion on pay-for-performance programs, Lansky et al. [4] report, "In most P4P programs to date, the proportion of total physician compensation tied to quality performance has been in the 1%–3% range, and many argue 10% to 20% of payment must be linked to quality to trigger changes in clinical practice." It is "impossible to compare Geisinger's compensation system with those of other integrated delivery organizations, the details of which are generally kept confidential," but "Geisinger has increased its clinical services revenue by more than ten percentage points annually during the last ten years through a combination of growth in the number of clinicians and increases in their productivity" [5]. The leadership at Geisinger clearly believes in "the teachings from behavioral economics such as prospect theory, which describes how modest financial incentives can produce a disproportionately large impact" [5]. Unless other healthcare organizations structure themselves similarly, it seems unlikely they will be able to achieve the same alignment with and commitment from their orthopaedic surgeons.

There is no doubt that the system at Geisinger is not perfectly designed for all orthopaedic surgeons, but the individual and professional risk is extremely low. Combined with a salary plan that is competitive, excellent ancillary support, and the stability inherent in controlling a successful insurance plan as well as financially stable hospitals, the package as a whole has great appeal. The greatest perceived downsides appear to be a loss of autonomy and the need of the individual to align themselves with the systematic approach required for financial stability and quality control. This is especially true given the current uncertainty surrounding medical and surgical practice. The situation was well summarized by Dr Atul Gawande in *The New Yorker*, in his article looking at "Big Medicine," and the value and quality that is often seen in more structured, reproducible systems. He related medicine to the food industry and pointed out the great benefits of The Cheesecake Factory restaurant chain in terms of consistency, high quality, and fair pricing: "We've let health-care systems provide us with greasy spoon fare at four-star prices, and the results have been

ruinous. The Cheesecake Factory model represents our best prospect for change. Some will see danger in this. Many will see hope. And that's probably the way it should be" [2].

A critical look at new ACOs and transformational healthcare systems has shown mixed results. Reform requires buy-in and active participation, and this in turn demands physician/hospital alignment and incentive programs that are perceived as fair and are financially sustainable. Only time and critical analysis will determine which models work best and which will survive. "Patients won't just look for the best specialists anymore; they'll look for the best system" [2]. Creating this system is extremely difficult and filled with resistance from every aspect of medicine. It requires the right faculty, physician-led administration, integrated insurance plans, and the freedom to evolve. It may exist in one small town in rural Pennsylvania.

Appendix 1. Fiscal 2013 incentive goals for *Enter name of physician*. Listed below are your incentive goals for Fiscal 2013. Each goal accounts for a proportion of the total incentive. The relative weight of each is expressed as a percentage of the total. Your clinical work unit leader can discuss the measurement tools used and provide you with interim measures, as available. Nothing in this plan or application is designed to substitute for individual sound medical judgment based on clinical presentation.

GOALS	March 2013 % weighting	September 2013 % weighting
1. FINANCIAL PERFORMANCE (25% of total annual available incentive) Goal will measure physician work effort and work-effort performance will be measured as follows: 0% awarded for work effort below the 50th percentile 50% awarded for work effort at or above the 50th percentile but below the 60th percentile 100% awarded for work effort at or above the 60th percentile but below the 70th percentile* 110% awarded for work effort at or above the 70th percentile but below the 80th percentile* 120% awarded for work effort at or above the 80th percentile* **If your Clinical Work Unit achieves its Fiscal 2013 annual budget, an additional 10% will be added to the financial performance incentive and will be payable in September 2013.*	**25%** **Assesses Calendar 2012 Performance (January 1, 2012, through December 31, 2012)**	**25%** **Assess Fiscal Year 2013 Performance (July 1, 2012, through June 30, 2013)**
2. QUALITY (40% of total annual available incentive)		
2a Completion of open encounters within 30 days—no more than 10 per 6-month period	***5%***	***5%***
2b Enter specific quality goals	***Enter %***	***Enter %***
2c Enter specific quality goals	***Enter %***	***Enter %***
2d Enter specific quality goals	***Enter %***	***Enter %***
2e Enter specific quality goals	***Enter %***	***Enter %***
3. INNOVATION		
3a Enter specific goals	***Enter %***	***Enter %***
3b Enter specific goals	***Enter %***	***Enter %***
3c Enter specific goals	***Enter %***	***Enter %***
3d Enter specific goals	***Enter %***	***Enter %***
4. MARKET LEADERSHIP		
4a Enter specific goals	***Enter %***	***Enter %***
4b Enter specific goals	***Enter %***	***Enter %***
4c Enter specific goals	***Enter %***	***Enter %***
4d Enter specific goals	***Enter %***	***Enter %***
5. THE GEISINGER FAMILY		
5a Enter specific goals	***Enter %***	***Enter %***
5b Enter specific goals	***Enter %***	***Enter %***
5c Enter specific goals	***Enter %***	***Enter %***
5d Enter specific goals	***Enter %***	***Enter %***

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