ACLGIM Hess Initiative Workgroup

Rebalance Primary Care Compensation to Align with Work

ACLGIM Association of Chiefs & Leaders of General Internal Medicine

Workgroup Goal

Identify how academic GIM practices across the United States approach design of practice structures, asynchronous work, patient panels, PCP compensation, and primary care teams.

Seeking Insight

At present, academic GIM leaders do not have sufficient information about how to structure their clinics, expectations, and teams to meet the demands of modern primary care while ensuring the sustainability of the primary care physician (PCP) role. There is substantial variation in the structure of clinical care delivery across practice settings but also a lack of nationwide benchmarks regarding optimal general internal medicine (GIM) structures and supports.

To begin addressing these knowledge and evidence gaps, four academic GIM practice leaders from across the country were asked to elucidate how their practice: 1) approaches PCP compensation, 2) staffs and structures the primary care team, and 3) quantifies and organizes primary care work.

Here's what we found.

University of Wisconsin Primary Care
Key Exemplary Model: Compensation Model — Interview Details: See page 2

University of California, San Francisco General Internal Medicine
Key Exemplary Model: One Touch Team — Interview Details: See page 3

Henry Ford Health Academic Internal Medicine
Key Exemplary Model: Team-Based Care — Interview Details: See page 4

University of Utah Primary Care Practices
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Primary Care Practice National Survey

These interview findings will inform the development of a national survey administered to academic GIM practices to systematically identify their practice structures, patient panel design approaches, compensation models, and team support for PCPs.

The goals of this survey are:

- Systematically identify how academic GIM practices across the United States approach design of practice structures, asynchronous work, patient panels, PCP compensation, and primary care teams.
- Develop an action-oriented best practice and benchmark resource to guide academic GIM leaders in their approach to practice structures, patient panels, PCP compensation, and primary care teams.

Lisa Rotenstein, MD, MBA, MSc, serves as the Principal Investigator of the study. She is an Assistant Professor of Medicine and general internist at the University of California at San Francisco and leads the Physicians Foundation Center for Physician Experience and Practice Excellence. Dr. Rotenstein oversees the project's design, conduct, data interpretation, and development of study products with support of **Estelle Martin,** Research Assistant.

The survey period will begin in late 2024. Interested in participating in this survey? Contact Jillian Gann at gannj@sgim.org.

University of Wisconsin Primary Care

Key Exemplary Model: Compensation Model

Exemplary Model #1: Compensation Model

Compensation

At the University of Wisconsin Primary Care, physician compensation is largely based on panel size. The health system provides a pool of money to each primary care specialty—general medicine, family medicine, or pediatrics—based on their number of medically-homed patients. Each additional patient attributed to a primary care specialty is associated with additional funds coming into that specialty. Thus, the monetary pool that comes into general internal medicine is determined by the following equation: # of medically homed patients x specialty specific patient attributed value.

Each specialty has its own panel benchmark per provider. The typical primary care panel size for a full-time clinical FTE is 1,800 patients. Within our system, having a larger panel size relative to one's clinical FTE increases earnings.

Given this arrangement with the health system, PCP compensation is comprised of the following components: 50% based on panel size; 35% based on clinical FTE; 25% based on RVU generation.

Wisconsin's innovative compensation model is supported by their capitated payment arrangement. To manage risk appropriately, UW physicians must provide the right care in the most cost-effective way.

Exemplary Model #2: Mature-to-Message Training Program

Staffing

The Division of General Internal Medicine at the University of Wisconsin offers a Mature-the-Message program which trains nurses to protocolize their approach to MyChart messaging, ultimately enabling nurses to tackle inbox messages more efficiently.

This training program supports UW Division of GIM's goal for 70% of MyChart messages to be answered by a nurse on a one-touch basis. If nurses cannot resolve the message, the patient will be scheduled for a telemedicine or face-to-face visit with a provider.

Exemplary Model #3: Home Grown Weighting Model

Quantifying and Organizing Work

UW GIM's panel system is home-grown and designed to measure the work that individual patients generate within the clinic. In this context, work is defined as:

- The number of interactions a medically homed patient collects in the UW system per year (ER touches, inpatient touches, number of clinic calls, number of refills, number of MyChart messages)
- Patient demographics (sex, age, insurance type, visit types) are entered into UW Health's statistical algorithm, which quantifies the work that specific demographic factors may be associated with differential work.

Together, the information about patients' annual interactions and how their demographic information may be associated with differential work informs the physician panel weighting system.

The panel target for UW GIM physicians is 1,800 patients modified per UW's weighting system, then prorated by their cFTE.

GIM Practice Leader:

Dr. Elizabeth Trowbridge is the Kenneth D. Skaar, MD, Chair of Primary Care and chief of the Division of General Internal Medicine within the Department of Medicine at University of Wisconsin Health. Dr. Trowbridge has been instrumental in the primary care redesign effort at UW Health and developed an innovative population-based compensation model for primary care.

By the Numbers:

# of clinic overseen:	nine clinics
# of faculty:	85 physicians, 25 advanced practice providers
# of residents:	45 residents total
cFTE:	about 60
What constitutes full time:	44 weeks a year, 50 hours a week

"When we look at compensation models across academic institutions, we've been able to be innovative because we are capitated and our money comes into us based on how well we take care of a population of patients, not fee-for-service."

— Betsy Trowbridge

University of California, San Francisco General Internal Medicine

Key Exemplary Model: One Touch Team

Exemplary Model #1: One Touch Team

Staffing

The UCSF GIM One Touch Team was created after GIM leaders discovered that patient messages were touched 7-8 times, on average, before resolution. The One Touch Team now successfully resolves over 50% of clinical questions or referral messages routed to their respective clinic with just one touch. The team is staffed by 5 MAs, 1 LVN, 1 RN, and additionally features engagement from an "offline" NP, who handles a specific range of messages that come in via MyChart (e.g., referral renewal, urgent medication refills). Many messages previously populating clinician inboxes are now getting resolved early.

UCSF GIM continued to refine their message routing grid and created a list of "hot symptoms". Incoming messages with "hot-symptoms" are routed to RNs, while those without are converted to "warm hand-offs", where the team will schedule a billable telemedicine or in-person visit with an available NP.

Exemplary Model #2: Desktop Slots

Quantifying and Organizing Work

UCSF GIM maintains two administrative holds, known as "desktop slots," in their providers' clinic schedules. Faculty members use desktop slots to address straightforward items in the inbox, catch-up on work, or to book an additional patient into their schedule.

To accommodate for these administrative holds, UCSF GIM faculty transitioned from seeing 12 patients per half-day to templates that accommodate for 8-9 patients and the built-in desktop slots for asynchronous work.

Exemplary Model #3: Compensation

Compensation

UCSF's GIM physician compensation system is primarily modulated by RVU targets. The flow of funds from the health system to the GIM department is dependent on the department's productivity as compared to national MGMA benchmarks. Despite UCSF's RVU-based payment system, GIM physician compensation remains on a set salary scale.

While panel size does not directly influence compensation, it is tracked and managed by GIM. Over the past few years, UCSF GIM has shifted panel size targets to be determined by patient access, rather than risk-adjustment of a panel.

GIM Practice Leader:

Mitch Feldman, MD, MPhil, serves as chief of the UCSF Division of General Internal Medicine and the associate vice provost for UCSF Faculty Mentoring Program. As a practicing internal medicine physician, Dr. Feldman maintains a focus on health promotion and prevention

By the Numbers:

# of clinic overseen:	four clinics, all part of the same unified practice
# of faculty:	60
# of residents:	76
cFTE:	between 12.92 without fellows, 13.3 with fellows
What constitutes full time:	Eight half days (sessions are about 3 to 3.5 hours in length)

"One important lesson we've learned is that when you introduce innovations, it's crucial to follow up with continuous observation and refinement. For example, standardizing workflows for our flow managers and other staff on how to handle incoming messages consistently is vital."

— Mitchell Feldman

Outcomes

Between 2023 and 2024, the number of UCSG DGIM providers citing the in-basket as their primary work challenge dropped from 92 to 16.

Within the same time frame, when asked to rate how well their clinic implements appropriate in-basket workflows (1= strongly disagree --> 10 = strongly agree), providers' average response ratings rose 20.4%.

Finally, the One Touch Team experienced a 50% decrease in call volume after patient instructions to schedule an appointment for non-urgent medical symptoms were incorporated into the OTTs automated voicemail.

Henry Ford Health Academic Internal Medicine

Key Exemplary Model: Team-Based Care

Exemplary Model #1: Team-Based Care

Quantifying and Organizing Work

Henry Ford Medical Group Academic Internal Medicine (AIM) Clinic acknowledges that primary care comprises more tasks—prevention, acute condition management, chronic management—than a provider can deliver to a patient within a 30-minute visit slot, a couple times a year. Leadership thus began focusing on task-shifting, ensuring top-of-license care by all staff members. MAs maintain a set of tasks to prep the visit including screening for depression and teeing up health maintenance orders, nurses manage chronic diseases by protocol and perform patient education, and other personnel on the floor support behavioral health or diabetes management.

Almost all prescription refills are centralized and handled by nurses; refills are only sent to a physician if they deviate from refill protocol. Over 90% of prescriptions meeting safety protocols are refilled by the central nurse pool.

Exemplary Model #2: Non-Physician Onboarding Training

Staffing

Henry Ford Academic Internal Medicine Clinic has designed a robust recruiting, onboarding, and accountability program to ensure that every role meets a standard of performance and reliability. If a new staff member cannot meet those standards after a 6-week onboarding period, AIM helps them find another position within the health system that is more suited to their skills.

AIM is selective about the staff recruited to their clinic and ensures there is continuous and consistent training for staff after they have been onboarded. If performance issues arise, clinic nurses and MA leaders can provide individual staff coaching.

Exemplary Model #3: Compensation

Compensation

AIM utilizes specialty-specific benchmarking to calibrate their RVU targets. However, the medical group maintains a salary model for their physicians, provided that the physicians achieve a minimum RVU target of around 70% national average. According to Dr. Willens, the physicians in his primary care clinic often exceed this minimum requirement due to the team model that includes residents and hospital patient care.

Patients are empaneled to faculty and consistent residents share their assigned preceptor's panel. This makes for additional patient access to their PCP with residents.

When lead time, such as time to next available appointment with a resident, is longer than 2-4 weeks, an additional group of residents may be assigned to the attending's panel.

GIM Practice Leader:

David Willens, MD, serves as Henry Ford Medical Group's Division Head of General Internal Medicine and Vice Chair of Quality and Safety for the Department of Medicine. Dr. Willens previously served as the Director of Ambulatory Quality and Medical Education within the same division. As a practicing internal medicine physician, Dr. Willens is guided by his experience as a specialist in population health and quality improvement.

By the Numbers:

# of clinic overseen:	one clinic, but there are 33 primary care clinics within the institution
# of faculty:	20 in AIM clinic
# of residents:	136
cFTE:	15
What constitutes full time:	36 patient contact hours a week

"Fundamentally, you cannot possibly expect a physician alone to do all of the roles, and you have to invest in the infrastructure to create a team that is highly functional. The same way a football team practices 40 hours a week for a 2-hour game, you've got to step back and do some redesigns."

— David Willens

Outcomes

AIM's HEDIS quality rankings moved from last among 33 primary clinics to middle, an outstanding ranking for a medically and socioeconomically complex patient population.

In recognition of leading practices serving our Detroit patients, achieved safety-net patient-centered medical home designation from Blue-Cross Blue Shield of Michigan.

AIM recruited seven former-chief IM residents out of ten new-physicians hired over past 10 years, an unprecedented achievement in their GIM history.

Maintain rapid responses to patients' calls and messages primarily with staff via top-of-license recruitment, screening, onboarding and accountability management and clear role definitions and daily management procedures. 70-75 % of patient calls and messages are resolved by nurses and MAs without being forwarded to physicians.

Clinical activity generated positive financial contribution margins for 5 of the last 7 years.

University of Utah Primary Care Practices

Key Exemplary Model: Expanded MA Protocols

Exemplary Model #1: Expanded MA Triage Strategy

Quantifying and Organizing Work

At the University of Utah's primary care practices, Medical Assistants (MAs) take on a relatively expansive role. Inbox messages are not sent directly to the physician, rather, they are directed to an MA triaging pool. Messages relating to factual questions —such as lab opening hours—or straightforward refill requests are addressed by MAs.

These practices have additionally developed and instituted standardized MA protocols to triage routine and less complex medical complaints. For example, if a patient writes in with urinary symptoms, MAs might first direct the patient to do a urine sample. However, these protocols have not been implemented across all practices and are still in the process of being studied and disseminated.

Exemplary Model #2: Push towards synchronous visits

Staffing

Within University of Utah's Division of GIM, MAs are strongly encouraged to convert more complex MyChart patient messages into clinic visits, rather than handling them asynchronously. Often, asynchronous care is not medically appropriate for MyChart management; either an exam is necessary, or clinicians need more information from the patient.

Dr. Conroy dissuades her fellow faculty from feeling pressure to provide medical care or advice purely through the portal, unless the patient is seeking very simple care.

Because Utah primarily operates in a fee-for-service model, practices don't generate any revenue without a patient visit and currently do not bill for MyChart message responses.

Exemplary model #3: Compensation

Compensation

At the University of Utah, the General Internal Medicine clinics operate within a 100% fee-for-service model. Despite this, faculty PCPs in these clinics are on a guaranteed annual salary; additional clinical incentive pay—distributed yearly—constitutes a very small percentage of physicians' total compensation. This payment approach contrasts with other models within the same University of Utah health system, where physician compensation is directly tied to the number of patients seen, and the revenue generated, by the clinician. Providers are also compensated at the same level for teaching sessions and UME and GME roles.

GIM Practice Leader:

Molly Conroy, MD, MPH, is the Chief of the Division of General Internal Medicine and the John Rex and Alice C. Winder Presidential Endowed Chair in Internal Medicine, University of Utah School of Medicine. She also serves as the Director of Primary Care Integration for the University of Utah Medical Group.

By the Numbers:

# of clinic overseen:	17 primary care clinics in institution, oversees the 3 General Internal medicine clinics
# of faculty:	25
# of residents:	30-40
cFTE:	14.3
What constitutes full time:	Eight half-day sessions, which total 32 hours of direct patient care each week

"For less complex and more routine medical complaints, there is now a playbook that the MAs can follow to triage those requests."

— Molly Conroy

Outcomes

UU DGIM has been able to successfully recruit and retain primary care faculty over the past 5 years and is also starting a Primary Care Internal Medicine Track in the 2024-25 AY. Provider satisfaction rates are higher than U Health and national averages.