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

Currently, academic GIM leaders lack comprehensive, evidence-based guidance on how to structure their clinics, teams, and expectations to meet the evolving demands of modern primary care—while maintaining the sustainability and satisfaction of the primary care physician (PCP) role. Considerable variation exists in clinical care delivery models across academic settings, yet there are no national benchmarks that define optimal GIM structures, staffing models, or support systems.

To address these knowledge and evidence gaps, ten 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

Primary Care Practice National Survey

In late 2024, early 2025 – a survey was distributed to a sample of Division Chiefs across the country to gather information related to their team-based primary care models, managing of asynchronous work, and accounting for and compensating for the work of modern primary care.

The goals of this survey were to

- 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 the support of Research Assistants, Estelle Martin and Kiana Smith.

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.

Rush University Medical Center Qualitative Analysis

Key Exemplary Model: Inboxologist Covers Physician Inbox Messages During Business Hours

Exemplary Model #1: Inboxologist Covers Physician Inbox Messages During Business Hours

Quantifying and Organizing Work

At RUSH GIM, the inboxologist helps PCPs manage asynchronous work to prevent physician burnout.

The inboxologist does not have their own patient panel, but rather, covers 8 FTEs of physician in-baskets during business hours. This minimizes the need for physicians to manage their in-baskets while seeing patients. They will also cover in-baskets if physicians are on vacation.

Exemplary Model #2: Advanced Practice Providers (APPs) supporting physician large patient panels & MA support

Staffing

A dyad model is employed wherein Advanced Practice Providers (APPs), including nurse practitioners and physician assistants, support physicians managing large patient panels. Dyad APPs primarily handle patient visits that occur between scheduled physician appointments, focusing on urgent/immediate care for established patients and chronic condition follow up and management for hypertension, diabetes, etc. They also adjust medications for these conditions as needed. Experienced APPs may conduct transitional care and annual wellness visits to address care gaps, especially toward the end of the year. Their role is to extend the capacity of primary care physicians and improve patient access.

RUSH also utilizes a team-based primary care approach focused on medical assistant and physician partnerships. MAs have three primary responsibilities. First, they room patients, which includes performing depression screenings, administering vaccines, and addressing care gaps such as mammograms and A1c checks. For annual wellness visits, they complete the health risk assessments and prepare necessary visit documentation, including screenings for social determinants of health.

Second, MAs assist in managing the clinic's message pool. Nurses triage incoming messages to identify urgent issues, while MAs and clinic coordinators handle clerical and logistical matters.

Third, MAs generate care gap lists from Epic and proactively contact patients to schedule appointments aimed at closing these gaps.

GIM Practice Leader:

Laura J. Zimmermann, MD, MS, FACP is the Division Chief of General Internal Medicine at Rush University Medical Center in Chicago, IL. She is an Associate Professor in Internal Medicine and Family and Preventive Medicine. She also serves as Senior Medical Director for the Rush Health clinically integrated network. A primary care internist and board-certified lifestyle medicine physician, Dr. Zimmermann focuses on developing and implementing care models that improve clinical quality and reduce cardiometabolic risk in at-risk communities.

By the Numbers:

# of clinic overseen:	12-15
# of faculty:	65
# of residents:	90
cFTE:	32 hours
What constitutes full time:	Full time equivalent + teaching

Exemplary model #3: Blended Benchmark Compensation Model

Compensation

The compensation model in RUSH GIM uses benchmarks that align base salary with productivity. Benchmarks are based on a blend between AAMC and Sullivan-Cotter benchmarks. While the majority of PCP compensation is comprised of base salary, PCPs are also compensated for productivity above the RVU target based on base salary and are also eligible for an at-risk quality bonus based on clinical quality and utilization metrics. Those with education, research, and administrative time are also eligible for bonuses for these professional activities.

Tufts University School of Medicine Qualitative Analysis

Key Exemplary Model: Compensation Model

Exemplary Model #1: Compensation Model

Compensation

Dr. Schelling shared that Tufts will be implementing a new compensation model within the next six months, with a stronger emphasis on panel size. Under the new structure, the target panel size will increase from 1,800 to approximately 2,100 patients. While the weight of work RVU-based compensation will decrease, providers will receive a new stipend for exceeding panel size targets.

The current compensation model is mainly based on the number of weekly sessions completed by the physician. It also includes stipends for seniority, RVU production, inpatient service, and quality of care.

In the upcoming model, the seniority stipend will be replaced with one based on academic rank, designed to encourage faculty to pursue academic promotion. Overall, the shift aims to expand patient panels and accommodate more patients in response to the ongoing decline in the number of practicing primary care physicians.

Exemplary Model #2: Nursing, Behavioral Health Personnel, and Pharmacy Assistance in the Primary Care Team

Staffing

Several unique roles compromise the primary care team. We highlight below three roles comprising the Tufts General Internal Medicine team and their functions and organization.

Nurses play a central role in the primary care team, managing a wide range of clinical care coordination tasks. They oversee all incoming phone calls and triage messages, to the appropriate team member—whether that's the front desk, the primary care provider, the pharmacist, or the social worker. Each floor has two dedicated desktop nurses, supported by five to ten floating nurses who assist with medication refills, transitions of care, case management, and specialized roles such as a nurse dedicated to diabetes management. Nurses also form the backbone of the care management team.

Four **behavior health personnel** support the primary care team by managing high-acuity cases, including patients experiencing suicidal thoughts, and facilitating warm hand-offs from other members of the care team for patients in crisis. They also assist with elder services, transportation, and financial concerns. In addition, the clinic has embedded psychiatric NPs who see patients directly, as well as one attending physician who conducts psychiatry-related visits alongside their resident.

Finally, **pharmacists** play a critical role in the Tufts GIM clinics. Pharmacists support prescribing by addressing questions about medication dosing, helping with medication adjustments for renal and geriatric dosing, and assisting with drug selection. Their scope also extends to patient counseling for weight management, smoking cessation, hypertension, and glycemic control. They work with patients both in-person and via telehealth, monitor medication adherence, and handle all prior authorizations on behalf of PCPs.

GIM Practice Leader:

Kimberly Schelling, MD, is Associate Chief of General Internal Medicine at Tufts Medical Center and the Tufts University School of Medicine, where she practices as an internal medicine physician. She completed her residency at Tufts Medical Center in 2008 and is an alumna of the Tufts University School of Medicine. She contributed to the field through publications in Hospital Practice and the American Journal of Infection Control. Her work has been widely cited, and she earned recognition from the National Committee for Quality Assurance's Patient-Centered Medical Home Recognition Program from 2013 to 2016.

By the Numbers:

# of clinic overseen:	5-6
# of faculty:	35
# of residents:	82
cFTE:	23
What constitutes full time:	Number of sessions per week

Exemplary Model #3: Reducing Message Burden Through Team Support

Quantifying and Organizing Work

At Tufts, the approach to managing asynchronous work is still evolving.

Nurses assist with asynchronous work by overseeing all incoming phone calls and portal messages (except for direct replies) and triage to the appropriate staff.

Physician assistants also assist in managing inbox messages during extended leaves.

One recent initiative has sought to minimize forwarding messages between team members, thereby reducing unnecessary message volume.

UAB School of Medicine Qualitative Analysis

Key Exemplary Model: MA Supported Pre-Visit Planning and Order Forms

Exemplary Model #1: MA Supported Pre-Visit Planning and Order Forms

Quantifying and Organizing Work

Each week, clinical medical assistants (MAs) look at which patients are scheduled for the next week. For these patients, they review previous physician notes and medical record "health maintenance sections," and determine any actions (e.g., labs, imaging tests) that are due.

For example, for each scheduled patient, the MA writes down the date of when the patient's last mammogram occurred and when it is next due. They highlight any lab tests that are due or any outstanding vaccines. This process of figuring out "what needs to happen" alleviates a tremendous amount of cognitive burden from the physician.

The UABMC GIM clinic additionally decided go "old-school" and return to physical paper physician order entry forms, which are printed for every visit. The form lists the most common labs, radiology tests, procedures (e.g., mammograms, colonoscopies), referrals, and diagnoses.

During a patient visit, physicians can check off relevant orders, then hand the form off to their MA. By the time the physician leaves the patient visit and finishes the patient notes, the orders have already been submitted by the MA and are awaiting final sign off from the physician.

According to Dr. Snyder, this workflow enables her physicians to efficiently move on to the next task in their schedule, as opposed to getting stuck "clicking" and putting in orders.

Exemplary Model #2: Triaging Asynchronous Work

Staffing

At the UABMC GIM clinic, RNs and the medical secretary play crucial roles in managing asynchronous work.

RNs and the medical secretary sit next to each other in clinic and work on handling the incoming message pool together.

RNs help with "in-between-clinic-visit" messages and symptom calls. They can do significant triage, so by the time the message reaches the physician, it has enough supporting information to allow the physician to quickly act-on the message.

The medical secretary typically addresses routine refills and proposes them to the physician. They also handle paperwork requests by retrieving records—which are printed for physician viewing—then subsequently scanned into the patient's chart. The secretary manages all asynchronous clinic paperwork, including paperwork related to home health orders and diabetic supplies. According to Dr. Snyder, the clinic's secretary is "worth her weight in gold"!

While MAs are not heavily involved in screening patient messages, they step-in when the RNs are short staffed. In these instances, MAs will call the patients to gather more information, then type up this information for the physicians to return to.

GIM Practice Leader:

Erin Snyder, MD, who received her medical degree at UAB School of Medicine in 2003 and has been a professor at the UAB School of Medicine since 2006, currently serves as the Associate Director of Clinical Services.

By the Numbers:

# of clinic overseen:	1-3
# of faculty:	8
# of residents:	31-40
cFTE:	1
What constitutes full time:	Number of sessions per week

Exemplary Model #3: Compensation ModelTheme: Compensation

Compensation

The compensation for clinical work within UAB Primary Care (of which UAB GIM is one clinic) is determined by a formula which includes 1) arrived patients per session, 2) panel size, and 3) utilization of a partner APP. There is no fixed component to the compensation package.

Arrived patients per session comprise 70% of the package; physicians received one point per returned patient, 2 points per new patient, and 1.5 points for a visit + wellness exam.

Patient panel size comprises 20% of the package; for every 10 patients (adjusted by age and gender) a physician adds to their patient panel, their compensation bumps up a tier.

The last 10% of the package is based on how busy a physician's advanced practice provider (APP) partners are. This was initially built into physician compensation to incentivize physician-APP teams.

However, Dr. Snyder shared that UAB Primary Care is changing their compensation model, since they have identified some of the model's downsides, which include a strong incentive to see new patients and maximize panel size. This has been detrimental to faculty wellness and sustainability. It has also made it harder for Dr. Snyder and her colleagues to take care of the patients of physicians who leave.

Outcomes

The UAB GIM clinic has been recognized as a top-performing clinic, consistently reaching the highest benchmark for Net Promoter Score over the past four years. During this time, 97% or more of patients reported that they would recommend the clinic to others, highlighting its sustained excellence in patient care and satisfaction.

University of Miami Qualitative Analysis

Key Exemplary Model: The Patient Navigator & Pharmacist

Exemplary Model #1: The Patient Navigator & Pharmacist

Staffing

The University of Miami General Internal Medicine (UMiami GIM) Division faculty mainly provides care at two sites–one at the University of Miami and one at Jackson Memorial Hospital. Below we highlight one unique team member from each location.

At the University of Miami GIM clinic, patient navigators assist patients covered by Medicare Advantage health insurance with follow-up care, ensure they attend appropriate appointments and help to close quality care gaps. They work closely with providers to coordinate external follow-up for patients with complex needs, helping to improve continuity and reduce unnecessary utilization.

At the Jackson clinic, a pharmacist is present on-site about half of the time but always remains available virtually. The pharmacist supports chronic disease management for high-need and complex patients and provides device education (e.g., inhalers, insulin). They also assist as needed with disease-specific medication adherence education, prescription assistance programs, co-pay assistance cards, formulary decision-making, coordination of specialty medications, telehealth and phone follow-up for patients at high risk for readmission, and drug information resources. Dr. Taldone emphasizes the value of having a pharmacist accessible during clinic sessions, noting that their expertise enhances clinical decision-making and that residents consistently report positive learning experiences from their interactions. The pharmacist's presence has also contributed to strong collaborative relationships within the care team.

Exemplary Model #2: Team-Based Asynchronous Workflow

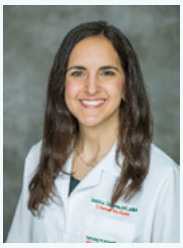
Quantifying and Organizing Work

Several roles currently contribute to asynchronous work at the University of Miami GIM clinics.

Nurses contribute significantly to asynchronous care through triage, and the program is actively working to finalize nursing protocols. Nursing staff on the UM side play a central role in intervisit care, primarily by calling patients to inform them of laboratory results, triaging symptoms, and escalating urgent issues to attending physicians. A nurse manager oversees both the family medicine and internal medicine clinic, while each clinic also has a dedicated nurse who spends about 90% of their time on triage, managing in-basket messages, providing phone counseling, and escalating care, when necessary, in addition to supporting clinic operations. This dedicated nurse supports all clinical faculty (CTFEs) working within the clinic.

Prescription requests are initially screened by clerical staff and then routed to the nurse practitioner or physician who last saw the patient, or to the patient's primary care provider.

GIM Practice Leader:



Sabrina Taldone, MD, MBA, serves as Chief of the Division of General Internal Medicine, Associate Chief Medical Officer of Ambulatory Services, and Chief Medical Director of the Primary Care Service Line at the University of Miami, where she is also Associate Professor of Clinical Medicine. A UM alumna, she earned both her medical and MBA degrees and completed her residency and Chief Residency at UM/Jackson Memorial Hospital. Dr. Taldone's leadership spans clinical operations and medical education; she was recently appointed Associate Dean of Clinical Affairs.

By the Numbers:

# of clinic overseen:	1-3
# of faculty:	20
# of residents:	63
cFTE:	7.2
What constitutes full time:	Number of sessions per week

Residents also play a role in managing in-basket messages, and the program employs a block scheduling model to ensure residents have dedicated time to engage in intervisit tasks, which serves as an important component of developing competency in this area outside of direct clinic sessions.

Exemplary Model #3: Compensation

Compensation

The compensation model at University of Miami GIM includes a fixed salary component tied to meeting an RVU target, adjusted for clinical FTE, with additional productivity bonuses available beyond that. Providers become eligible for bonuses based on RVU productivity in excess of their RVU target.

Dr. Taldone notes that the model effectively rewards high-performing providers who consistently see a high volume of patients. However, it can be challenging in instances where factors beyond a provider's control, such as patient no-shows, impact productivity. Looking ahead, Dr. Taldone expresses interest in evolving the model to include a blended compensation structure that also recognizes and supports intervisit care activities.

Outcomes

The University of Miami GIM currently tracks outcomes through an annual faculty and staff engagement survey. In 2024, 89.7% of respondents agreed with the statement, "My work gives me a sense of personal accomplishment." The division is currently exploring additional strategies to capture more granular data in the future.

University of Pittsburgh Qualitative Analysis

Key Exemplary Model: The Patient Navigator & Pharmacist

Exemplary Model #1: Intervisit Care Team

Staffing

Clinics in the University of Pittsburgh's General Internal Medicine Division are supported by both intervisit care teams and clinical care teams. These teams function independently.

The exact structure of the intervisit care team varies across University of Pittsburgh GIM sites, with some roles shared across sites. In general, it is comprised of nurses, a prior authorization team, pharmacists, and secretarial staff.

- Nurses on the intervisit care team are responsible for triaging incoming calls and messages, communicating with patients regarding concerns, and relaying messages back to providers, as appropriate.
- The prior authorization team, who is staffed by nurses, manages all prior approval requests.
- Both GIMO and Shea Medical Center (two of the GIM clinics) benefit from a clinical pharmacy team that supports patients with complex medication needs. They assist with anticoagulation management for patients on Warfarin, provide medication education, and help address any polypharmacy challenges when reviewing medication lists.
- Secretarial staff on the intervisit care team facilitate form completion. They place forms into Adobe, route them to providers, and then send them to the final recipient after providers have completed the form. This team also helps patients with administrative issues, scheduling appointments, or other services, etc.
- Certified diabetes care and education specialists will work with patients between visits to problem solve around their diabetes and adjust medications.

In contrast, the clinic care team is composed of frontline staff responsible for in-person patient care and operational support. This includes administrative staff who assist with checking patients in, front desk staff that manage registration and billing, medical assistants (MAs) who room patients, and floor nurses who handle procedures such as injections, iron infusions, dressing changes, and walk-in patient crises. In addition to assisting with intervisit care, the clinical pharmacist and certified diabetes care and education specialists see patients in person in the office, often in conjunction with a visit with physicians or APPs.

Exemplary Model #2: Value-Based Coordinator Theme: Quantifying and

Quantifying and Organizing Work

Across all clinic sites, a value-based coordinator plays a key role in supporting asynchronous work associated with performance on value-based contracts. She focuses on closing care gaps and facilitating patient outreach by creating lists of patients discharged from the hospital or ED within the last seven days. These patients receive phone calls from licensed healthcare workers who facilitate post-discharge care. The value-based care coordinator also assists with Hierarchical Condition Coding and works with pharmacists to close quality care gaps. The presence of this role is facilitated by the fact that 60% of the University of Pittsburgh GIM's patients are covered by a single payor with strong value-based incentives.

GIM Practice Leader:

Jane Liebschutz, MD, MPH, is a Professor of Medicine and Chief of the Division of General Internal Medicine at the University of Pittsburgh. A primary care physician and substance abuse researcher, she is board certified in internal medicine and addiction medicine.

Gary Fischer, MD is a Professor of Medicine with a secondary appointment in Biomedical Informatics. He completed his residency in primary care internal medicine at Massachusetts General Hospital. He is also Medical Director for the Ambulatory eRecord and Program Director for the UPMC/Pitt Clinical Informatics Fellowship.

By the Numbers:

# of clinic overseen:	7
# of faculty:	56
# of residents:	208
cFTE:	16.3
What constitutes full time:	Number of sessions per week (8 four-hour sessions)

Exemplary Model #3: Compensation Model

Compensation

Initially, the University of Pittsburgh's GIM division used a shift-based compensation model that tied compensation to the number of hours worked per month. However, this approach was eventually reconsidered, as it did not differentiate between providers who saw a higher volume of patients per session and those who saw fewer. Without an incentive for greater panel size or clinical volume, this model was seen as unfair to those providers who saw more patients.

The current compensation model has four main components. These include the number of four-hour sessions completed by the physician, the number of patients seen per session, panel size, and the proportion of new patients seen. This helps compensate for a combination of panel management, patients seen in clinic, and new patients seen, all of which are important, but which may be emphasized by different providers (e.g., newer providers or those who don't have a full panel may be more likely to see new visits, which take more time). Providers with larger panels may have a greater workload related to intervisit care, and thus the panel size component of the model accounts for that.

According to Dr. Liebschutz, this revised model has been effective because it allows providers to choose their preferred workload while offering incentives for higher patient-facing work.

VCU School of Medicine Qualitative Analysis

Key Exemplary Model: Integrated Care Team

Exemplary Model #1: Integrated Care Team

Staffing

The primary care team at VCU GIM includes various roles that each serve distinct, but complementary functions in patient care. These include medical assistants, licensed practical nurses, registered nurses, and advanced care providers.

Medical assistants have recently assumed a larger role in the outpatient setting. Their core responsibilities include rooming patients, taking vital signs, and administering vaccines and in-clinic medications. As they gain experience, MAs begin to take on more advanced tasks, such as managing medication refill requests. In these cases, they review medications against the patient's medication list and then forward an electronic proposal to the prescribing clinician for approval.

Licensed practical nurses have roles largely similar to medical assistants at VCU.

Registered nurses focus primarily on patient assessment and triage. They manage incoming calls and messages, speak directly with patients, and determine whether a visit is necessary. When appropriate, they also relay messages to providers for action on issues that can be resolved without an appointment.

Advanced practice providers (APPs) primarily function as billing clinicians, stepping in to see patients when a physician is unavailable. In rare cases, they maintain relatively small, less complex patient panels and help extend physician capacity when needed.

Exemplary Model #2: Protected Time and Team Support for Asynchronous CareTheme: Quantifying and

Quantifying and Organizing Work

At VCU, time for asynchronous work is built directly into providers' clinical schedules. For example, physicians who practice outpatient medicine full-time are scheduled for eight patient-facing sessions each week (equivalent to four full days of clinic) and receive one day of administrative time. This non-clinical day is intended for catching up on clinical tasks, addressing in-basket messages, and following up on lab results. However, Dr. Kushinka notes that many physicians still find the volume of asynchronous work exceeds the allotted time, and the division continues to explore strategies to reduce this burden.

To help offset the workload, other team members contribute to managing asynchronous tasks. Front desk staff handle paperwork, ensuring it is sorted and routed to the appropriate provider. Pharmacy technicians play a particularly critical role by managing prior authorizations—contacting insurance companies, completing required paperwork, and securing approvals. According to Dr. Kushinka, having pharmacy technicians in this role has been especially valuable in alleviating the prior authorization burden for physicians.

GIM Practice Leader:

Jeffrey Kushinka, MD is Chief of General Internal Medicine and Associate Professor of Medicine at the VCU School of Medicine, where he has been on faculty since 2006 following his residency and Chief Residency in Internal Medicine. A graduate of the University of Richmond with a degree in Physics and the VCU School of Medicine, he has built his career around clinical administration, education, and evidence-based medicine.

By the Numbers:

# of clinic overseen:	1-3
# of faculty:	20
# of residents:	41-50
cFTE:	10
What constitutes full time:	Number of sessions per week, 10 sessions, 8 patient-facing sessions and 2 administrative sessions