ABSTRACT: 2017 ELAM Institutional Action Project Symposium

Project Title: WIPCOT; **WI**sconsin **P**rimary **C**are **CO**mpensation **T**oolkit.

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Background, Significance of project:

The role of Primary Care Physicians (PCP's) in the United Stated has shifted over the last 10 years from individual patient care to population- based care for a panel of patients. This shift has occurred without modifying how physicians are compensated for the additional work required under new models of care; including managing chronic disease registries, e-visits, telemedicine, and patient portals. Old compensation models based on volume-based care, such as Relative Value Units (RVUs), are not aligned with increasing value-based reimbursement for primary care physicians. Additionally, PCP panel sizes are not modified for clinic-based patient work, such as phone calls, medication refills, and post-hospital care. This misalignment of compensation, panel size and work expectations are one component of significant physician dissatisfaction and burnout.

UWSMPH has published successful examples of clinical compensation for academic general internal medicine (GIM) faculty and modified panel weighting systems that explicitly reward population-based care. The compensation model has resulted in a statistically significant increase in GIM physician satisfaction with their new plan as compared to RVU based plans in place for pediatric and family medicine physicians in the same institution. Other outcomes include increased retention of GIM physicians, increased percentage of providers accepting new patients from 19-48%, and a 3% decrease in RVU's.

Purpose/Objectives:

The first objective is to describe the development and implementation of the UWSMPH GIM compensation plan.

The second objective is to develop WIPCOT, a web-accessible toolkit based on the UWSMPH model. The tool kit will be comprised of tools and adaptable resources that will help to facilitate development and implementation of:

1. Population-based compensation plans that move away from RVU's toward panel management.
2. PCP panel weighting systems that can be adjusted for the care required outside of the actual visit.

Methods/Approach

There are several steps needed to develop WIPCOT. The current literature on compensation will be summarized so users understand the appropriate context for the toolkit. Development of the toolkit will include formulas for both compensation and panel sizing. These will include customizable data points such as: physician satisfaction with compensation plans, physician panel size, clinical RVU's, and patient access data

Outcomes and Evaluation Strategy:

1. Monitor use of the WIPCOT every 6 months through embedded links. These links will track the number of times the toolkit is accessed and by which institutions, with their permission.
2. Survey institutions who have accessed WIPCOT for implementation of new compensation plans.
3. Develop a multi-institution group to study new compensation models based on WIPCOT.

Conclusion with Statement of impact/potential impact:

The national movement to redesign Primary Care shows no signs of abating. Development of the WIPCOT toolkit has the potential to shift compensation models and PCP panel size weighting models to better align with the new work expectations and value based reimbursement of primary care physicians across the country. This should result in increased provider satisfaction and reduced physician burnout.

WIPCOT (Wisconsin Primary Care Compensation Toolkit)

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Background

- The role of Primary Care Physicians (PCP's) in the United Stated has shifted over the last 10 years from individual patient care to population-based care for a panel of patients. This shift has occurred without modifying how physicians are compensated for the additional work required under new models of care; including managing chronic disease registries, e-visits, telemedicine, and patient portals.
- Old compensation models based on volume-based care, such as Relative Value Units (RVUs), are not aligned with increasing value-based reimbursement for primary care physicians. Additionally, PCP panel sizes are not modified for clinic-based patient work, such as phone calls, medication refills, and post-hospital care.
- This misalignment of compensation, panel size and work expectations is one component of physician dissatisfaction.
- UWSMPH has published successful examples of clinical compensation for academic general internal medicine (GIM) faculty and modified panel weighting systems that explicitly reward population-based care. Outcomes include increased comparative physician satisfaction (Table 1), increased retention of GIM physicians, increased percentage of providers accepting new patients from 19-48%, and a 3% decrease in RVU's.
- UWSMPH now has a unified primary care compensation plan for General Internal Medicine, Pediatrics, and Family Medicine.

Purpose/Objectives

- Describe the development and implementation of the UWSMPH primary care compensation plan.
- Develop WIPCOT, a web-accessible toolkit based on the UWSMPH model. The toolkit will be comprised of tools and adaptable resources that will help to facilitate development and implementation of:

1. Population-based compensation plans that move away from RVU's toward panel management. (Figure 1)
2. PCP panel weighting systems that can be adjusted for the care required outside of the actual visit. (Table 2)

	Satisfied	Very Satisfied
Peds (RVU based)		
Structure	22%	0%
Salary	30%	4%
DFM (RVU based)		
Structure	20%	4%
Salary	24%	4%
GIM (Value based)		
Structure	42%	23%
Salary	32%	32%

Table 1: WI Primary Care Physician Satisfaction Survey

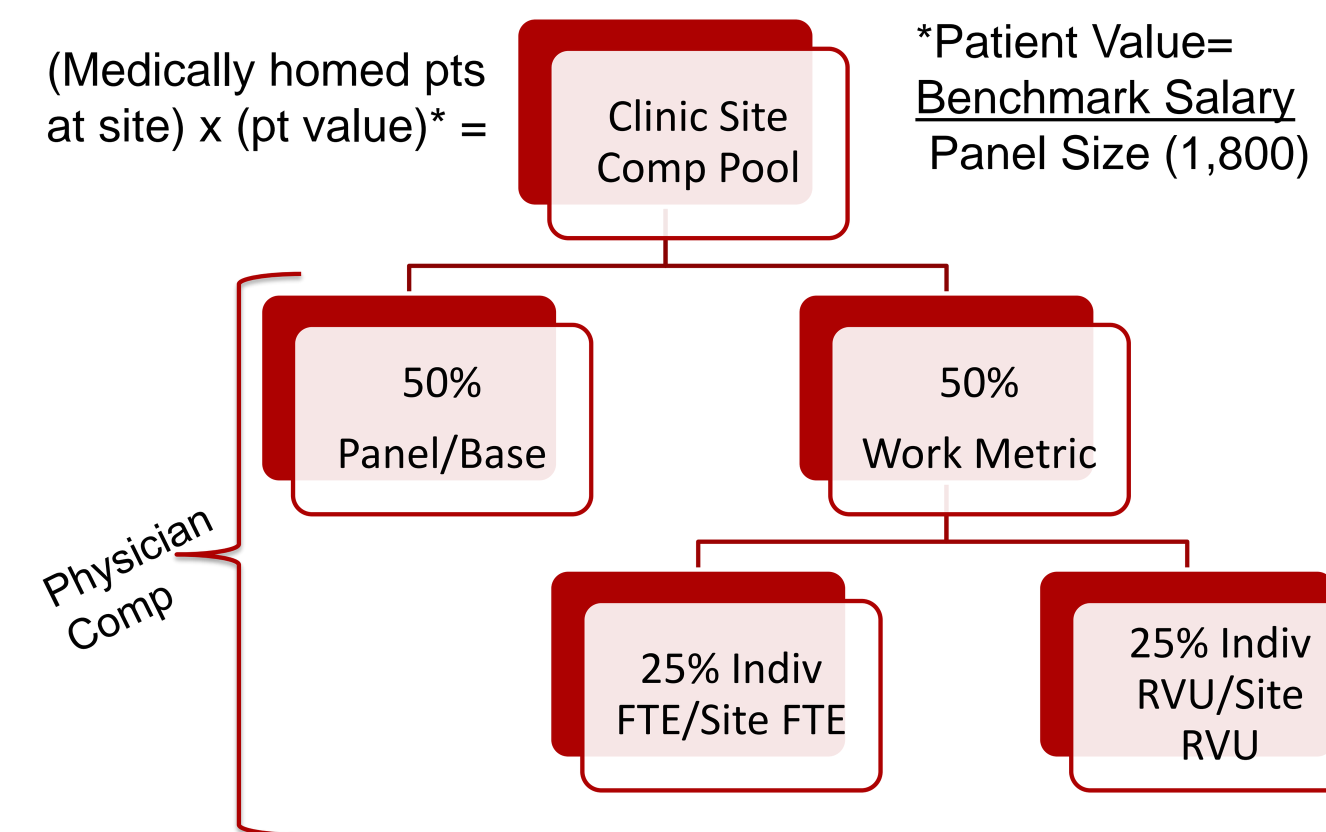

Figure 1: WI Primary Care Compensation Plan

Female	Weighting
Medicaid 0-3	1.44
Medicaid 4-14	0.78
Medicaid 15-39	1.20
Medicaid 40-59	1.45
Medicaid 60-74	1.57
Medicaid ≥ 75	1.71
Medicare 0-3	0.00
Medicare 4-14	2.62
Medicare 15-39	1.82
Medicare 40-59	2.22
Medicare 60-74	1.17
Medicare ≥ 75	1.98
Other 0-3	1.55
Other 4-14	0.82
Other 15-39	0.81
Other 40-59	1.00
Other 60-74	1.21
Other ≥ 75	1.09

Male	Weighting
Medicaid 0-3	1.51
Medicaid 4-14	0.85
Medicaid 15-39	0.69
Medicaid 40-59	1.13
Medicaid 60-74	1.42
Medicaid ≥ 75	1.04
Medicare 0-3	0.00
Medicare 4-14	0.00
Medicare 15-39	1.15
Medicare 40-59	1.65
Medicare 60-74	1.52
Medicare ≥ 75	1.89
Other 0-3	1.65
Other 4-14	0.84
Other 15-39	0.53
Other 40-59	0.80
Other 60-74	1.12
Other ≥ 75	1.33

Table 2: WI Modified Patient Panel Weighting System

Methods/Approach

1. The toolkit will be launched mid-June 2017 on the UWSMPH Health Innovation Program (HIP) Exchange

www.hipexchange.org

2. The toolkit will include:

- current literature on compensation
- successful implementation strategies
- formulas for compensation with customizable data points
- formulas for panel sizing

Outcomes/Evaluation Strategy

1. Monitor use of the WIPCOT every 6 months through embedded links. These links will track the number of times the toolkit is accessed and by which institutions.
2. Survey institutions who have accessed WIPCOT for implementation of new compensation plans or panel modification plans.
3. Develop a multi-institution group to study new compensation models based on WIPCOT.

Discussion

The UWSMPH population-based compensation plan has demonstrated that moving away from a volume based compensation plan has the potential to increase provider satisfaction, retain physicians, and improve access. This plan allows time for physicians to focus on non face to face work such as chronic disease management and should lead to improved quality of care, decreased provider burnout, and improved patient safety The flexibility of this plan allows institutions to incentivize needs of the institution, such as access, through compensation.

Discussion cont'd

We have observed that physicians respond quickly to compensation incentive changes.
Institutions with Medicare Shared Savings Plans and highly capitated reimbursement models have clear reasons to move to this type of value based plan.
Institutions with volume based reimbursements will find the initial value proposition more difficult.

Summary/Next Steps

The national movement to redesign Primary Care shows no signs of abating. Development of the WIPCOT toolkit has the potential to shift compensation models and PCP panel size weighting models to better align with the new work expectations and value based reimbursement of primary care physicians across the country.

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