
UW Health

Presentation Outline

UW Health

Who is UW Health

Primary Care Comp Plan

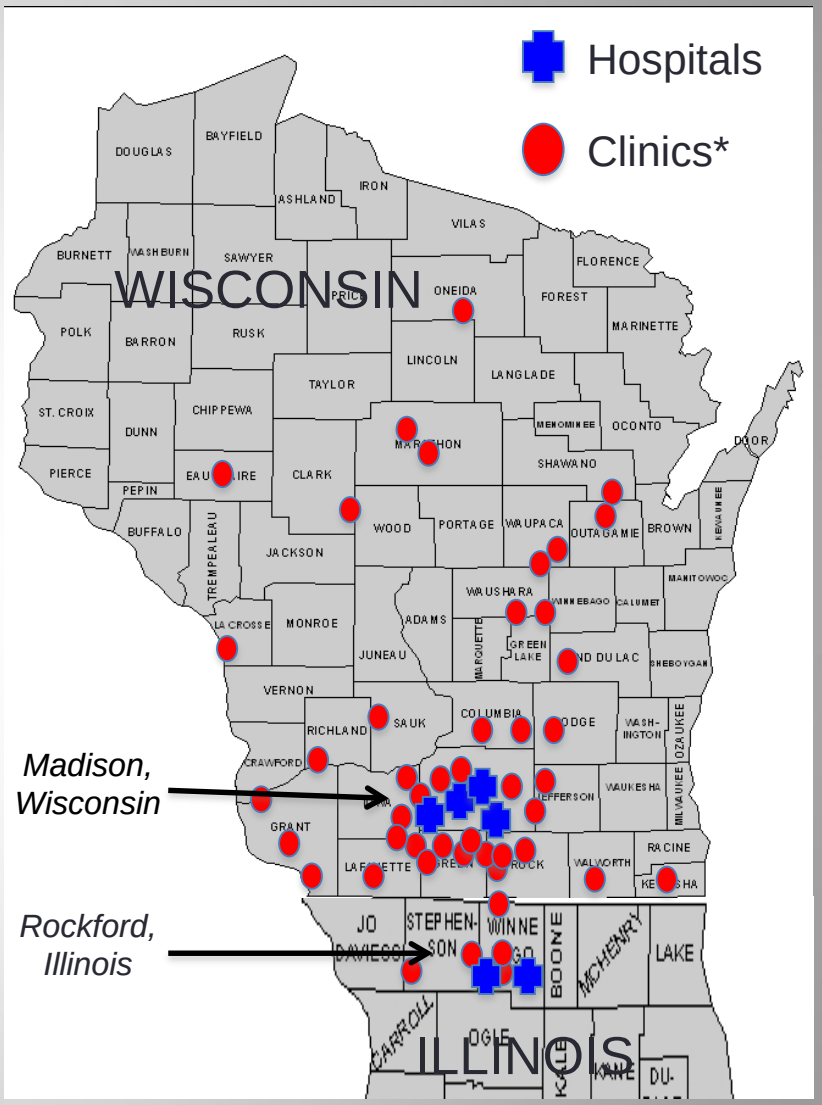
Who We Are

Current system components

- 6 hospitals with 1,093 beds
- Over 100 outpatient clinics
- 1,400+ employed physicians
- 180,000 member provider-owned HMO
- 14,000 employees

System financial indicators

- Revenues $3.2 billion
- Assets $3.4 billion



** Those not on a hospital campus*

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Significant 2015 Developments

UW Health Following Integration on July 1, 2015

UW Hospitals and Clinics Authority

UW Medical Foundation

These entities were integrated on July 1, 2015 through a sole corporate membership transaction.

Affiliation Agreement

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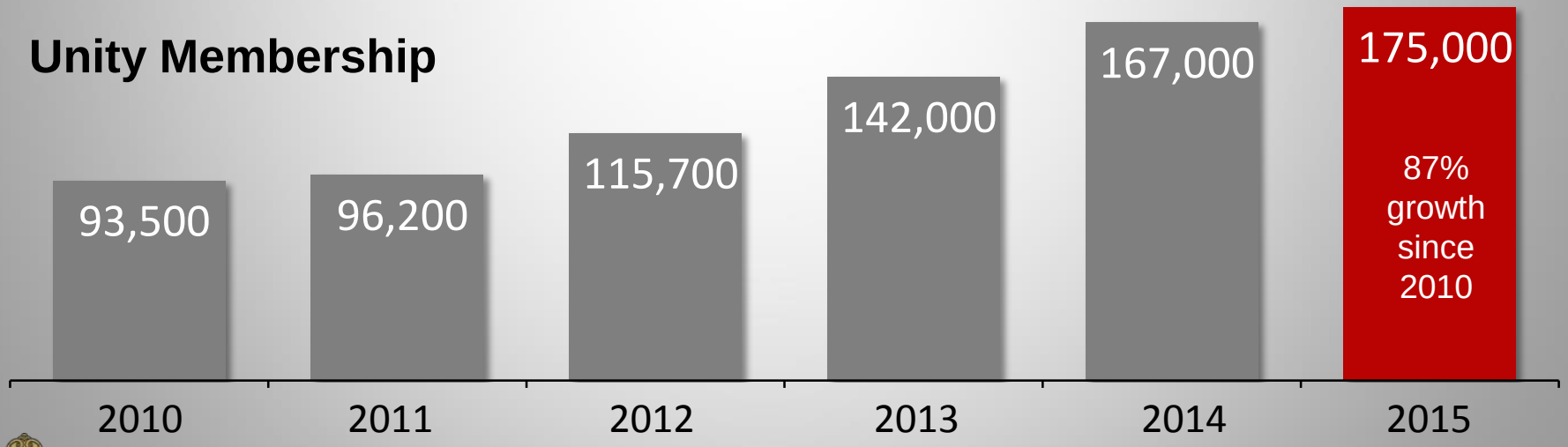
Jointly owned and consolidated.

- SwedishAmerican Health System
- Unity Health Insurance
- Majority-Owned Joint Ventures
- Non-Consolidated Joint Ventures

Unity Health Plan Overview

- Provider-owned, Madison based, 21 county service area
- Top 50 Health Plan per US News & World Report and NCQA
- Gold Award from WELCOA (Wellness Council of America)
- 5 year member satisfaction score of 96.1%
- Announced merger with Gundersen Health Plan (70,000 members)



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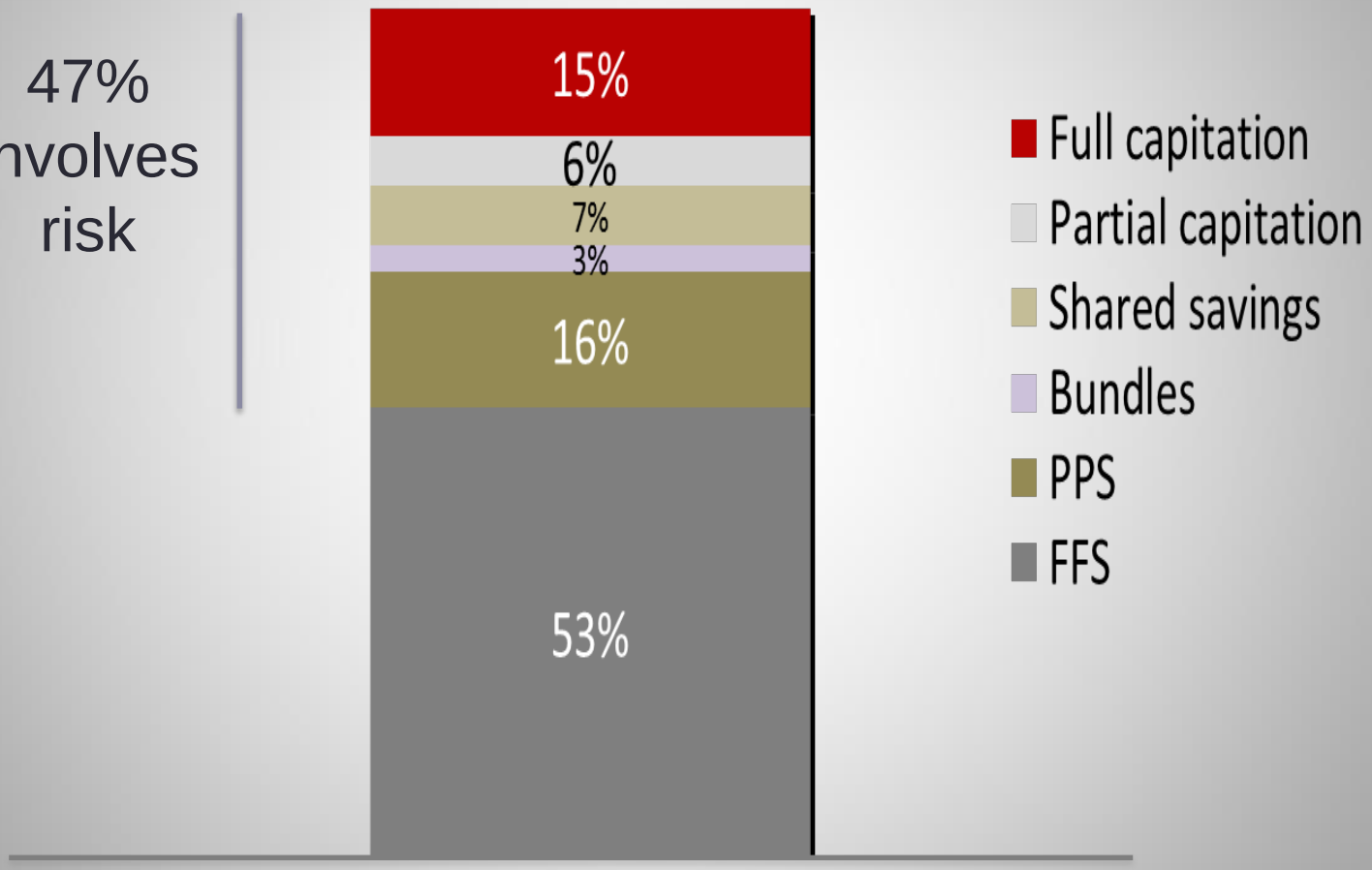
UW Health Net Revenues by Type

47% involves risk



*UW Health, Wisconsin Division, Data for FYE June 30, 2014

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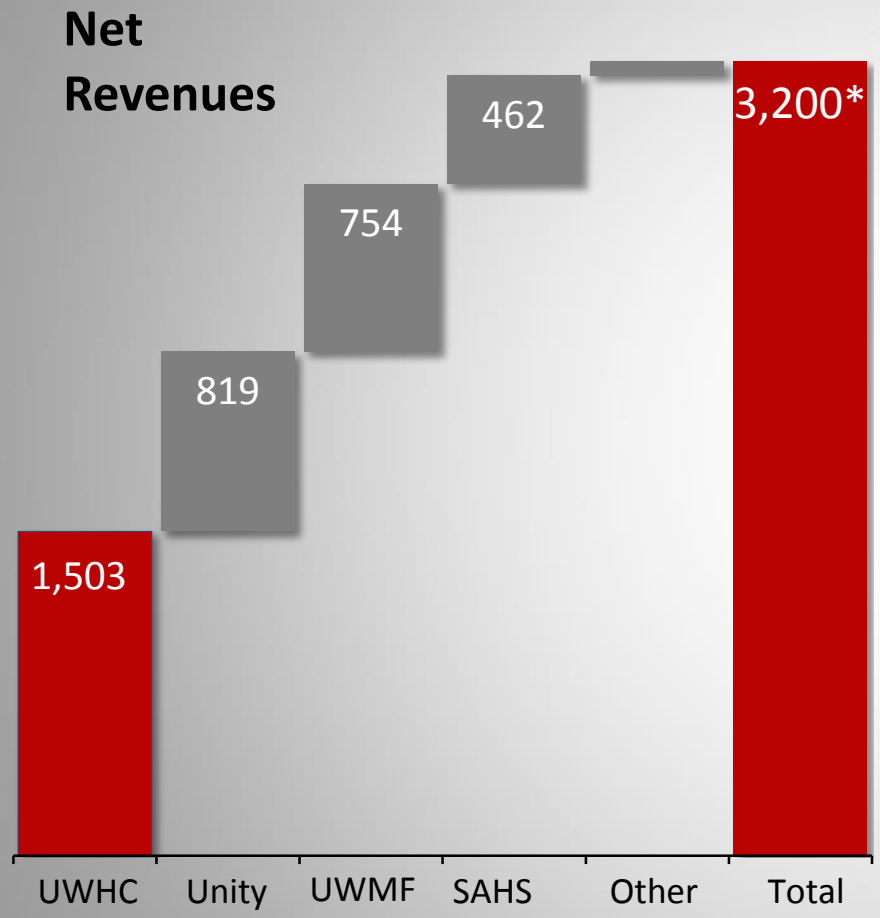
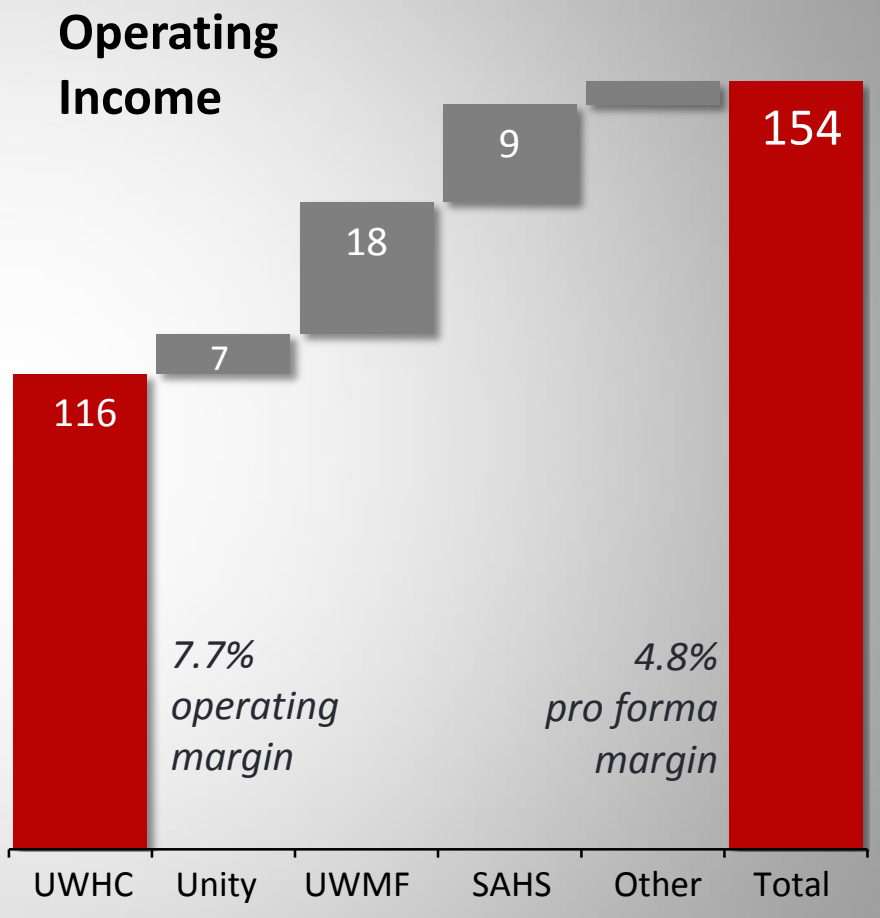
UW Health Income Statement Items

Amounts by entity ($MM) – FYE June 30, 2015**





*After elimination entries

** Combined by management, combined amounts unaudited

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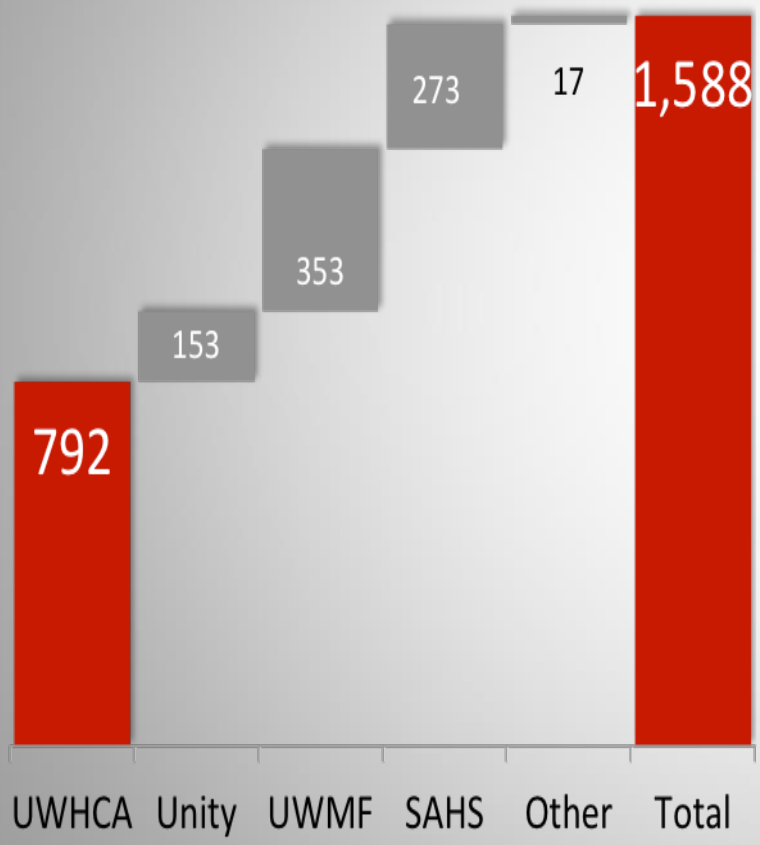
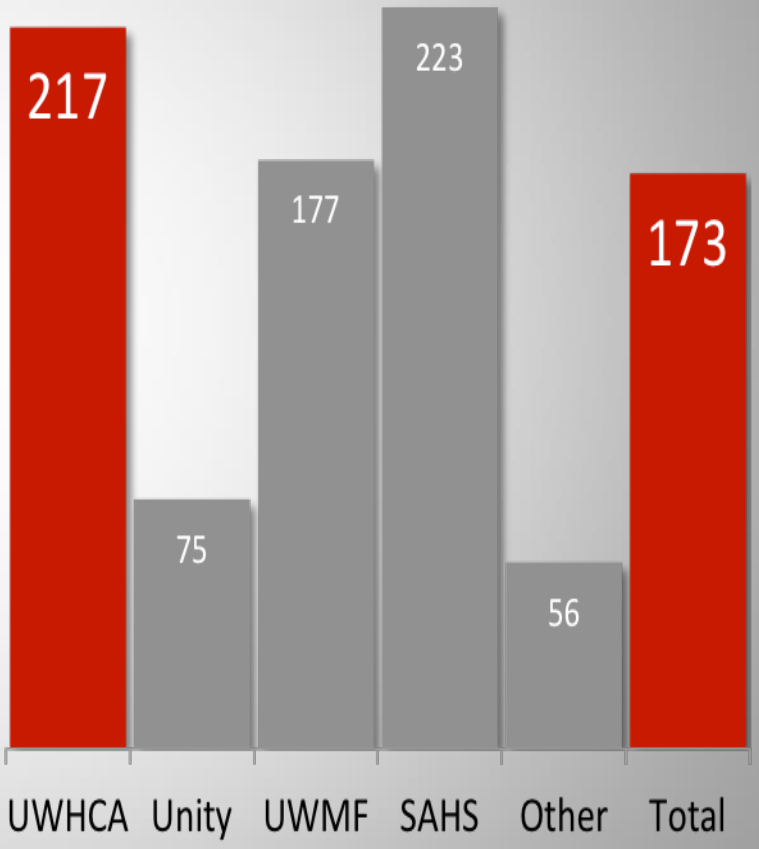
UW Health Balance Sheet Items

Amounts by entity ($MM) – FYE June 30, 2015

Unrestricted Cash and Investments ($MM)



Days Cash on Hand



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Historical Plans

- UWMF principle of market pay for market work
- Market represented by participation in national benchmark surveys for both compensation and work RVU (AMGA, MGMA, SullivanCotter)
- Productivity-driven formulas – RVU based
- Individual plans for each UWSMPH Department
- Metrics utilized = BM weighted median work RVU and compensation
- Variation in how Departments applied market definition
- Each plan required ⅔ vote of faculty to make changes

Impetus For Change

- Loss of physicians to hospitalist roles and others to competitor hospital/medical group
- PCP compensation drifting below market
- Physician burnout
- Changing work of primary care – expanding volume of non face-to-face work not recognized with RVU
- Difficulty recruiting – expected shortages of PC MDs
- 2 years of GIM residents with no interest in primary care
- Poor access
- Health Care Reform –value equation
- Perception of “Hamster Wheel” with existing productivity drivers

Organizational Response

- UW Health Primary Care Redesign initiative
- New model of care delivery based on patient centered, team-based care focused on population management and health
- Emphasis on value rather than volume of care provided
- Value = $\frac{\text{Quality (care and service)}}{\text{Cost}}$
- Work toward PCMH recognition

CEO Statement

A complete and functional Primary Care System will require 3 key elements:

1. An agreement between physicians and the organization about physician responsibility
2. Responsibility of the organization to provide the resources and environment that allows physicians and Care Teams to fulfill their responsibilities in an efficient and satisfying way
3. A fair and rational compensation plan

"Redesign is an enterprise-wide initiative which represents an extraordinary opportunity and a clear and urgent imperative to transform the way that primary care clinicians work in the service of their patients"

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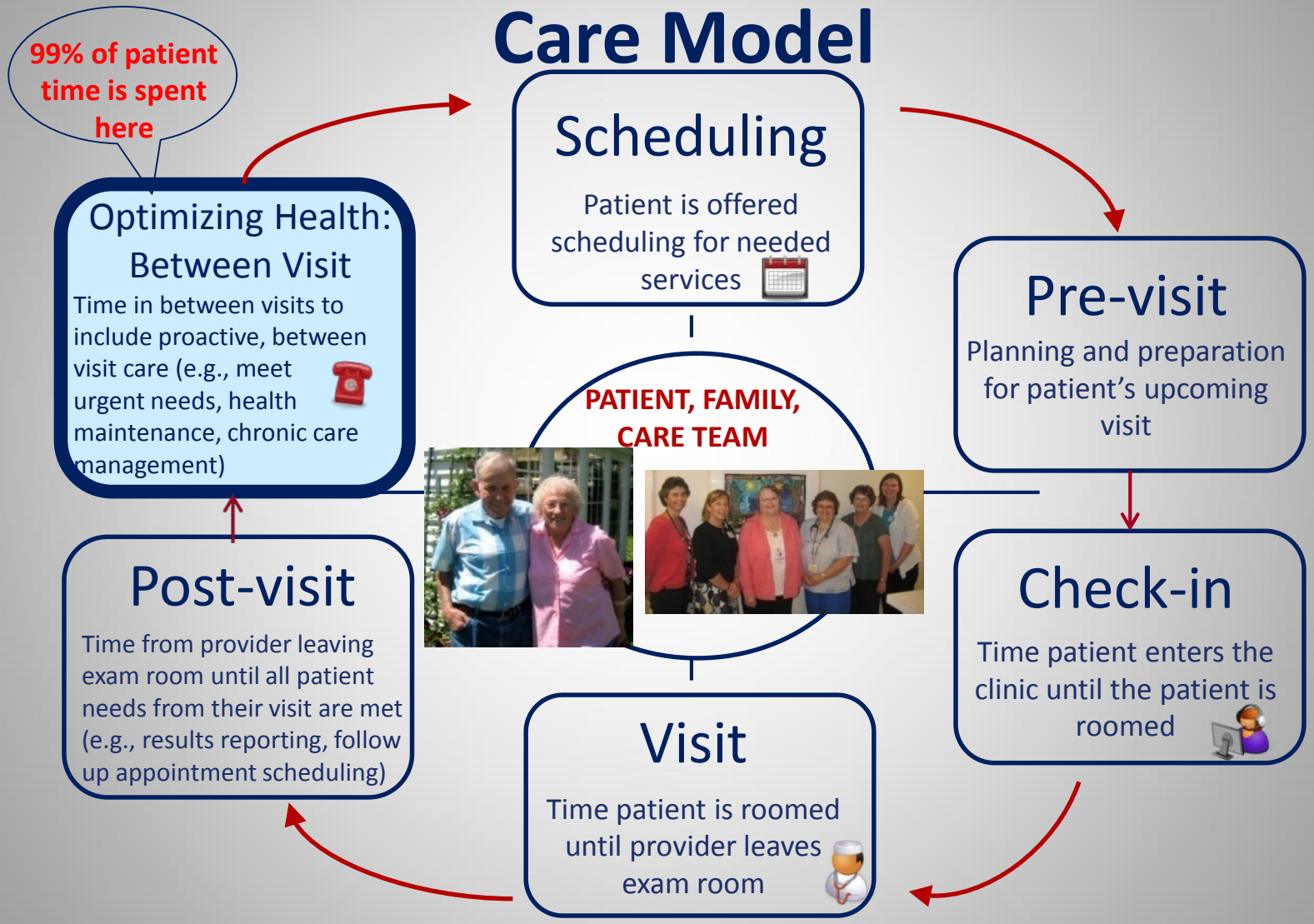
Primary Care Redesign (2008 – 2014)

- Strategic priority
- Physician led, team-based care
- Standardized care model across all sites with defined, standardized, trained staff roles
- Expanded roles for APP
- Pay for value (P4P agreements with HMOs, MSSP, MU)
- PCMH recognition
- EPIC optimization
- Compensation plan based on management of populations rather than units of work (RVU/visits, etc.)

Standardized Care Model



Source: Adapted from Health Partners

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Time Savings from Building Robust Teams

(from Bodenheimer, Health Affairs 11/2013)

EXHIBIT 1

Estimated Primary Care Physician Time Savings

Type of care	Percent of physician's time in traditional practice	Estimated percent of physician's work that can be reallocated to nonclinicians	Estimated percent of physician's time saved
Preventive	17	60	10
Chronic	37	25	9
Acute	46	10	5
Total	100	—[a]	24

SOURCES KS Yarnall et al., Note 14 in text; J Altschuler et al., Note 16 in text. [a]Not applicable.

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Compensation Leadership Group

- Medical Director for Operations
- Clinical Vice Chairs General Internal Medicine, Family Medicine, General Pediatrics
- Department physician reps
- CFO
- Department Administrators Medicine, Family Medicine, Pediatrics
- Finance Department staff

Primary Care Compensation Plan

Principles

- Support evolution of the redesign of the primary care delivery system model
- **One plan** for all primary care physicians
- Focus on **clinical compensation**
- Support physician led, **team-based care**
- Base on **size of the population** cared for (weighted panels)
- Allow structured customization at the specialty level to promote innovation and recognize unique differences
- Retain **market sensitivity** → move to leading edge
- **Recognize all work** done on behalf of a patient population
- Provide **stability/predictability** to compensation – lean toward salary-type system
- Incorporate **value** metrics (focus on areas MDs can and should control)
  - Quality of service
  - Quality of care
  - Health of population
  - Costs of care
- **Understandable, equitable, transparent**

Standardized Job Expectations - Compact

- Population management
- Clinical FTE defined/standardized
- Face-to-face and non face-to-face hours
- “Citizenship” – Department defined
- Care team leadership
- Quality improvement

Basic Plan

- Available compensation dollars are based on size of individual physician and site physician team panels
- Market basis defined by weighted external specialty specific median compensation
- Median market compensation linked to 1800 weighted active panel
- Site pool of dollars allocated based on work done on behalf of all patients of the site
- Incentives/cost sharing for incorporation of APP on care teams
- Dollars at risk for meeting standard job expectations
- Incentive pool funded by organization for outcomes of panel management/population health (Quality)

Component Definitions

Benchmark Median Specialty Compensation

Annually derived from weighted average of three national surveys recognized by UWMF (AMGA, MGMA, SullivanCotter)

Target Weighted Panel Size

Derived from review of limited market information and historical activity of our patients

Panel Weighting

Based on age, sex, payer and three year historical activity at PCP sites – derived from data on 360,000 patients – reported monthly to all physicians – adjusted every 6 months for compensation calculation

Primary Care Panels

- Local HMOs required all patients to be aligned with a PCP
- Internally required PCP designation for all patients
- Developed internal panel weighting process utilizing age, sex, payer (Medicare, Medicaid) historical 3-year activity at PCP sites – utilized data on 360,000 patients
- Active panel defined as visit or procedure anywhere in UW Health in previous 3 years

Panel-Based Target Compensation

Individual Physician

Weighted MD panel x benchmark median comp

1800

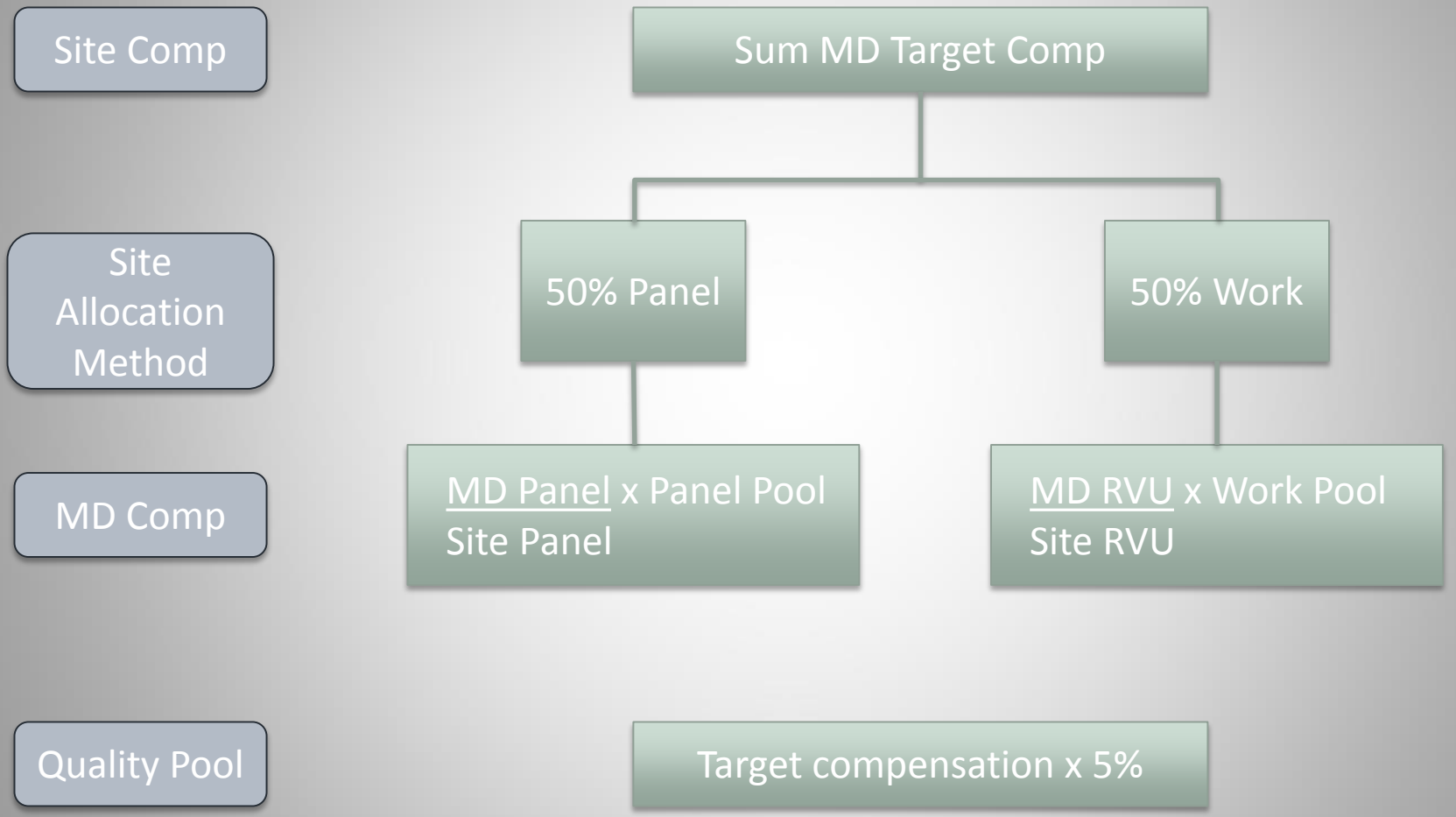
Site/Care Team Compensation Pool

Sum of site individual MD target compensation

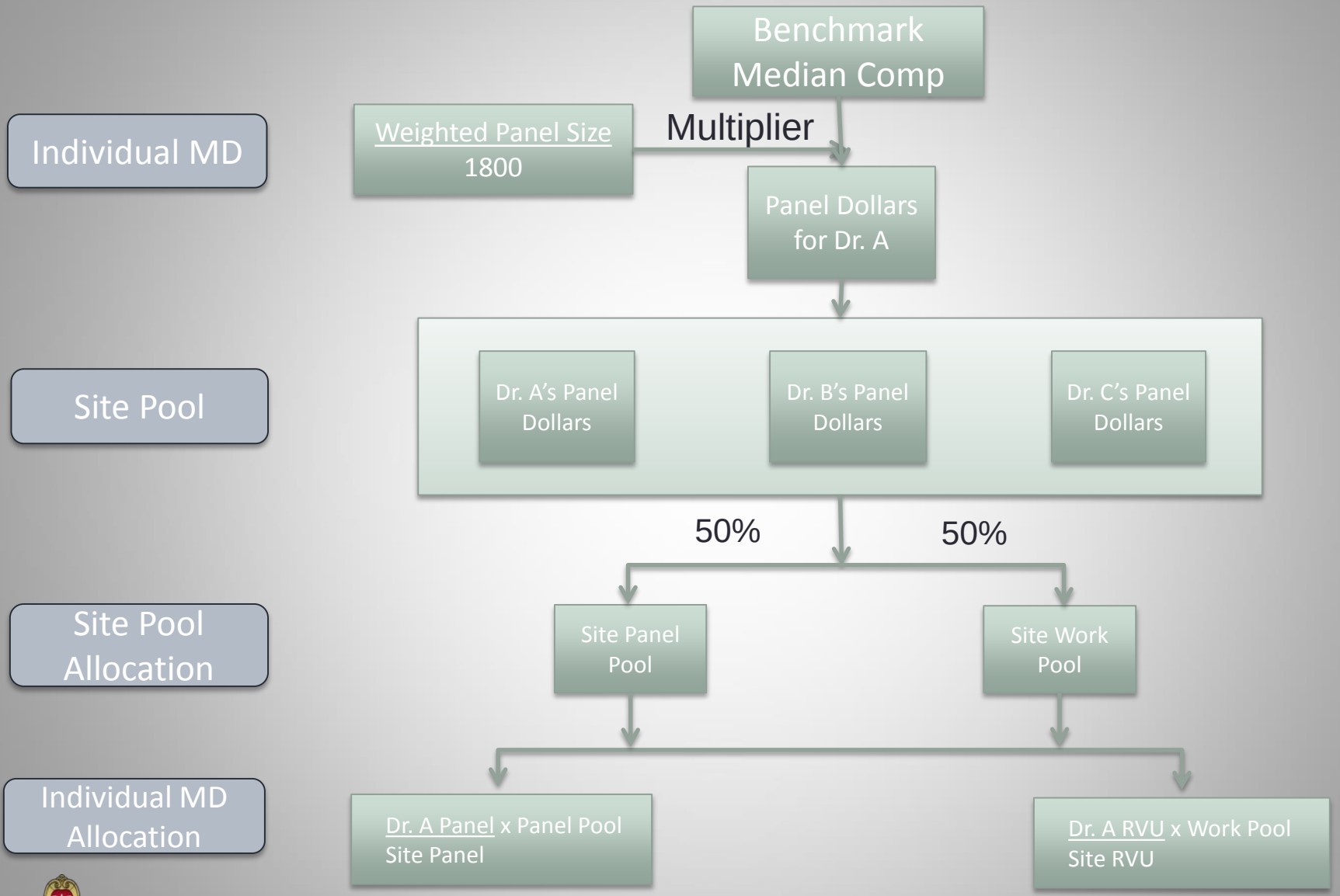
Allocation of Site Pool

- Flexibility for Department/sites to determine allocation based on how work is shared – expected to evolve as experience gained
- Initial guideline → base a portion on size of personal panel and remainder on individual contribution to meeting overall care needs of site panel population
- Emphasizes individual and site physicians expectation of attracting and retaining a population of patients as well as quality of the care provided for that population
- Initial proxy for work = $\frac{\text{individual site work RVU}}{\text{total site work RVU}}$

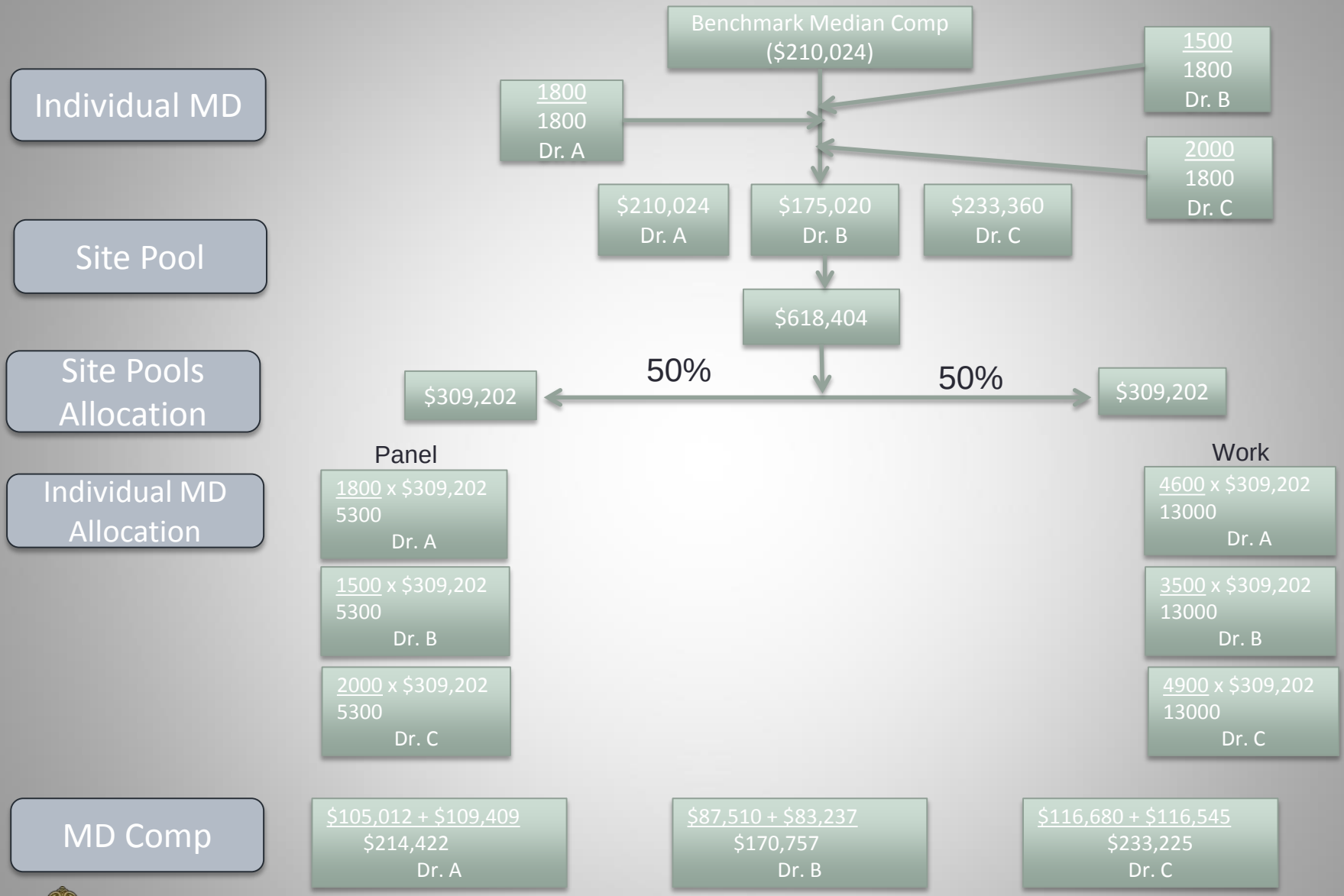
Site Allocation



Comp Plan Flow Chart



Family Medicine Example



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Department Options – Site Allocation

Internal Medicine

50% personal panel 25% FTE 25% MD RVU/site RVU

Family Medicine

50% personal panel 50% MD RVU/site RVU

Family Medicine Resident Clinics

4 clinics – pool all panels

80% MD FTE/all site FTE 20% MD RVU/all site RVU

Pediatrics

25% personal panel 75% MD RVU/site RVU

At Risk

- 5% withhold on panel-based compensation
- Annual performance review linked to achievement of Department specific metrics linked to standard job expectations (MD compact)
- Expectation that all can earn the withhold at end of year
- Availability of compensation pool guaranteed by organization

Modifications

- Utilized to deal with special or unique situations which cannot be adequately recognized in the core plan
- All are subject to ongoing review and modification as plan evolves and environment changes and do not require a vote to change the core plan
- Examples include physicians who perform unique procedures, FM participation in OB, coverage of hospital care for newborns by pediatricians, expense of APP

APP

- Estimate that the presence of a 1.0 FTE APP allows a team to care for an additional 900 patients
- Site with APP charged with 50% of salary and benefits of APP
- Expense phased in over 3 years when APP is added to a site to allow for practice growth
- Requires about 500-600 patients added to panel to cover the cost of APP
- Incents teams to effectively incorporate APP on teams – optimize utilization of physicians – reduce long-term costs of excess physician recruitment

Quality

- 5% (additional) pool of base compensation set aside by organization
- Linked to quality (service and care), health outcomes, and costs of care
- Specific metrics defined by Quality Council and Operations Council
- Revised annually
- Metrics retired as performance reaches targets

FY2014 Quality Metrics

MEASURES FOR FY2014 QUALITY PORTION (5%) OF PRIMARY CARE PHYSICIAN COMPENSATION PLAN

Specialty	Domain	Weight	Measure	Goal	Payment Threshold
GIM	Access	1%	Avatar Appointment Availability: "An appointment was available when needed"	77.0%[a]	72.0%[a]
	Service	1%	Avatar Physician Communication: "My doctor explained my illness or treatment in a way I could understand"	92.2%[a]	87.2%[a]
	Health Outcomes	1%	Diabetes All-or-None Outcome Measure (Optimal Results) – WCHQ	31.37%[b]	21.84%[b]
	Health Outcomes	1%	Uncomplicated Hypertension: Blood Pressure Control – WCHQ	84.12%[b]	74.91%[b]
	Population Health	1%	Adult Pneumococcal Vaccination – WCHQ	89.65%[b]	80.85%[b]
DFM	Access	1%	Avatar Appointment Availability: "An appointment was available when needed"	77.0%[a]	72.0%[a]
	Service	1%	Avatar Physician Communication: "My doctor explained my illness or treatment in a way I could understand"	92.2%[a]	87.2%[a]
	Health Outcomes	1%	Diabetes All-or-None Outcome Measure (Optimal Results) – WCHQ	31.37%[b]	21.84%[b]
	Health Outcomes	1%	Uncomplicated Hypertension: Blood Pressure Control – WCHQ	84.12%[b]	74.91%[b]
	Population Health	0.5%	Adult Pneumococcal Vaccination – WCHQ	89.65%[b]	80.85%[b]
	Pediatric Health	0.5%	Childhood Immunization (Up to Date for Children 0-2 years)	85.0%[c]	N/A[d]

FY2014 Quality Metrics

Specialty	Domain	Weight	Measure	Goal	Payment Threshold
GPAM	Access	1%	Avatar Appointment Availability: "An appointment was available when needed"	77.0%[a]	72.0%[a]
	Service	1%	Avatar Physician Communication: "My doctor explained my illness or treatment in a way I could understand"	92.2%[a]	87.2%[a]
	Pediatric Health	1%	Childhood Immunization (Up to Date for Children 0-2 years)	85.0%[b]	N/A[c]
	Pediatric Health	1%	Asthma Control Testing (ACT) – 3 part measure		
			0.5% for overall ACT Rate – [Sub-Measure 1]	65.0%[b]	N/A[d]
			0.25% for percent of patients in control (of those tested) – [Sub-Measure 2]	N/A[e]	
			0.25% for % of asthma patients who had <19 on one test followed by a second test >19 – [Sub-Measure 3]	N/A[e]	
	Pediatric Health	0.5%	Lead Screening Rate	95.0%[f]	N/A[d]
	Pediatric Health	0.5%	MCHAT Screening Rate	90.0%[f]	N/A[d]

Future

- Increase % allocated to value/quality
- Adopt site care team modifications to work allocation
- Define cost (delivery system and care) measures for value metrics
- Ongoing refinements to panel weighting
- Education/communication
- Specialty compensation changes

Questions?