MMA
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Physician Compensation

The work in improving access and optimizing primary Care delivery requires strategies to promote continuity and reduce wait times for and at services. As an inevitable consequence of the utilization of these strategies, the number of visits per patient per year will decrease. This will make your executive director nervous. On the other hand, if you can replace those “lost“ visits per patient per year with new visits from new patients, external to the practice, or with new visits from patients with unmet needs from inside the practice (e.g. women who need PAP smears), you can either break even or actually increase the number of total visits into the system, create opportunities for a more “mixed portfolio” of patients, pursue your mission of caring for the underserved, and improve clinical care.

Here is an extremely primitive view of the "best" in physician compensation:

Physician/clinician compensation

- Either partial or no fixed salary

System properties/requirements

- Have a defined panel and see your own patients.
- No waits. Do today’s work today. Work until done.

Variable reimbursements, based on reaching thresholds for:

- Panel size
- Continuity
- Patient satisfaction
- Selected clinical outcomes

I like having continuity (see your own, don't make them wait) and no wait times as a system property - an expectation that this is how we work. If we compensate on variable thresholds of delay, we get the provider bargaining issues – both the “I am different” bargain and the “I will forgo the optimum compensation for the privilege of letting my patients wait” bargain. You really want a non-variable system: “At our organization, patients don't wait. It is our brand, our culture.”

So I believe that continuity and no waits are a system property. If there are delays then we have to be able to explain the delays. The explanation always has a common theme - some variety in the ratio of demand to supply - either a permanent D>S mismatch, or a temporary mismatch caused by variation (increased demand or decreased supply). But the delay is explainable. Some explanations are acceptable while others are not (there are consequences to compensation, I suppose).

Then I would have thresholds for:

a. Patient satisfaction

b. Continuity - unless we can imbed this as system property. Continuity needs to be above random which means that a provider who is in the office 85% of the office time needs to have more than 85% continuity in order to get higher compensation.

c. Clinical care - selected clinical care components.

d. Panel - physicians with larger panels can get more compensation, but they have to be able to see their own patients, their patients can't wait, they must be satisfied, and the care must be good.

In my view, setting the no wait and continuity standard sets the tone. Otherwise we just get into debates about acceptable waits and we get into bargaining of wait time vs. some of the other parameters. So some physicians will let patients wait and hope to make up for that with the other measures (panel and continuity for example).