

An Incentive Compensation System That Rewards Individual and Corporate Productivity

Deanna R. Willis, MD, MBA; Gaylen M. Kelton, MD;
Robert M. Saywell, Jr, PhD, MPH; Richard D. Kiovsky, MD

Introduction: *An economically mature health care market has led to increased cost competition. Subsequently, a perceived need for productivity-based physician compensation has developed. While some institutions have rewarded individual productivity based on specific facets of academic responsibility, such as teaching, research, and patient care, we chose to develop an incentive compensation system that rewards both individual and group productivity.* **Program Development:** *We developed a physician incentive compensation system that rewards individual and group productivity by capturing multiple aspects of work activity. Faculty members are given compensation value points for clinical productivity, scholarship activities, teaching activities, service activities, and achievement of the department's goals. The system was implemented in a graduated fashion in the Department of Family Medicine at Indiana University beginning July 1, 2000.* **Program Evaluation:** *In April 2003, all faculty physicians (n=18) participated in a survey about the compensation system. The majority of faculty view the system as a necessity for the department (72.2%); 35.2% were satisfied with the system overall; 35.3% were neutral; and 27.4% were dissatisfied or not sure of their overall satisfaction.* **Conclusions:** *A comprehensive physician incentive compensation system incorporating department goals can be designed and implemented in an academic setting.*

(Fam Med 2004;36(4):270-8.)

As health care and medical education markets change, medical schools across the country are experiencing a decrease in external funding and increased competition from other health care systems. As a result, many schools have developed systems for quantification of faculty productivity.¹

At Indiana University, clinical revenue is part of the faculty members' total compensation package. The clinical revenue of the department is directed to a practice plan corporation, which then pays clinical faculty members their practice plan compensation.

The National Physician Fee Schedule relative value units (RVUs) for valuation of clinical care² has become a common way to estimate clinical productivity. It does not, however, capture any of the other important activities of academic family medicine faculty. Several authors³⁻¹⁴ have described systems to quantify faculty activities in the categories of research, administration, patient care, and teaching. However, none of these systems link compensation to whether or not the depart-

mental goals are actually attained, which is something that business literature finds to be important.¹⁵

In 1999, because of increasing financial constraints, departmental leadership decided that a redistribution of compensation was necessary to make compensation more reflective of faculty productivity. The faculty agreed, believing that aligning individual efforts to achieve departmental success was important and would require strong faculty teamwork. Faculty further believed that a system that inadequately rewarded teamwork would jeopardize organizational success.

Program Development

A committee of departmental faculty members was established in November 1999 from a group of volunteers and appointees. This committee of faculty members from multiple faculty divisions met weekly for more than 1 year to develop the system.

Concepts

The committee believed that a compensation system should be equitable and easy to administer. For the system to serve as a true incentive, a significant portion of

income must be “at risk.” The committee defined “at-risk compensation” as compensation that is completely dependent on the measures of the incentive compensation system. The university would not allow the university salary of the faculty members to be at risk. Further, no university money for teaching, service, or research can be transferred to the practice plan. Instead, practice plan compensation is funded entirely by the clinical revenues of the department. Thus, to have adequate amounts of individual compensation at risk, the committee decided that the entire practice plan compensation would be earned under the new incentive compensation system. The committee realized, however, that the clinical revenues would be funding incentive compensation paid out for other academic activities such as teaching and scholarship. As a result, the committee decided that the total compensation paid out under the new system should be capped at the total amount of practice plan compensation paid the year before, so as not to jeopardize the financial stability of the practice plan. After the committee developed the system goals, the clinical faculty members voted to adopt those goals, as shown in Table 1.

Calculations

Each full-time faculty member has 440 half days of activity time annually. This is calculated as 52 weeks per year, minus 4 weeks for vacations and holidays and 2 weeks for professional development and continuing medical education.

Of the 440 half days each year, 220 are to be spent in revenue-generating activities. Revenue-generating activities include providing direct patient care, precepting patient care delivered by residents, and providing on-call coverage. The other 220 half days are spent in activities that do not generate revenue for the corporation (called non-revenue-generating activities). Faculty members are expected to participate at a minimum level in each non-revenue-generating activity category—including teaching, scholarship, and leadership. The allocation of the 220 non-revenue-generating activities half days is shown in Table 2. “Variable time” is time faculty members can choose to allocate at their own initiative.

The concept behind the time allocation is that each faculty member is given time to perform minimum expectations in each area. The faculty members are then given compensation for how productive they are during that time. To capture this productivity, we followed the relative value scale model set forth by Bardes,³ in which RVUs = hours x weight. The hours credit and weight for each activity were developed by the committee. The resulting RVUs per activity are presented in Table 3.

The compensation system defines teaching activities as all time spent with learners. Incentive compensation is paid-for activities such as mentoring medical students or delivering didactic lectures to residents. The compensation system rewards faculty members for the generation of scholarly work such as presentations, papers, grants, or book chapters.

The leadership category includes activities such as being the medical director of a clinic or director of a department division. Each leadership role was examined by the committee and given a relative value weight

Table 1

Goals for the Indiana University Department of Family Medicine Incentive Compensation System

<i>Goals</i>	<i>Measure of Evaluation</i>
(1) Maintain fiscal responsibility to the physician practice plan corporation and the department	Due to financial constraints, the total faculty compensation expense could not be more than the year before system implementation—unable to be measured other than having a zero variance from budget
(2) Capture the value of multiple facets of academic medicine	Faculty survey of perceived agreement with the weighted values for activity type
(3) Allow individual academic freedom	Faculty survey of perceived academic freedom
(4) Provide a productivity incentive for the faculty	Faculty survey of perceived motivation to pick higher weighted activities
(5) Allow for ease in reporting	Survey of faculty who complete the reports themselves

Table 2

Time Allocation Under the Indiana University Department of Family Medicine Incentive Compensation System*

Revenue-generating activities	220
Non-revenue-generating activities	
Scholarship	22
Meetings	44
Administrative	44
Teaching	22
“Variable time”	88
Subtotal non-revenue-generating activity time:	220
Total time:	440

* by half day of faculty time

and a standard number of hours time commitment. Administrative time allows time for patient care-related administrative activities (such as paperwork), but incentive compensation is not rewarded for these activities beyond the compensation given for patient care.

Categories

The measurement and reward for these individual activities and the corporate activities are captured by a five-category compensation system, named Categories A through E.

Category A captures the productivity of both revenue-generating and non-revenue-generating activities, as determined by the RVU points in Table 3. The dollar amount of compensation per RVU point for this category is set each year by the department chair. The initial dollar amount is based on an expected average RVU points for the faculty members. Table 4 shows a sample calculation of what a faculty physician's annual RVU point calculation for Category A might look like.

Category B is the clinical RVU productivity. This information is taken from the IDX front office management software system.² Due to the immaturity of data in our system (IDX was newly implemented) and the need to assess the reliability of the data, each faculty member was given a set dollar amount in Category B for the first 2 years. During the first 2 years, the clinical RVU productivity for faculty members was tracked but not linked to compensation. For the 2003–2004 academic year, the clinical RVU productivity is linked to compensation.

Category C is delivery room work. Since some faculty members of the Department of Family Medicine perform deliveries while other faculty members do not, Category C captures the economic value of that activity. Faculty members who perform deliveries are given a stipend under Category C to compensate them for providing this service. In addition to the stipend, each delivery that the fac-

Table 3

Indiana University Department of Family Medicine Relative Value Scale for Physician Compensation for 2001–2002

For any single activity:

$$\text{RVU points} = \text{relative value} \times \text{hours credit}$$

As per previous incentive compensation systems⁴ using the relative value x hours credit formula, hours credit are assigned by activity. Only activities titled "hour-for-hour reporting" are valued based on actual hours spent.

<i>Activity</i>	<i>Relative Value</i>	<i>Hours Credit</i>
<u>Revenue-generating activity</u>		
Clinical		
Direct patient care (DPC)	3	4
Travel clinic	3	4
Sports medicine clinic	3	4
Teaching		
Office precepting	2	4
Specialty clinics (ie, coumadin)	2	4
Inpatient precepting	4	4
Procedure precepting	2	4
Nursing home precepting	3	4
One-on-one teaching (during DPC)	1	4
On call		
Weekend rounding inpatient	4	8
Night call (no additional "comp time" is given)	0.5	12
OB call (covered in stipend)	0	0
<u>Non-revenue-generating activity</u>		
Teaching		
Small-group lecture		
New	0.75	10
Repeat	0.75	4
Large-group lecture		
New	1	10
Repeat	1	4
ICM I or II	3	4
Resident advising	2	1
Medical student advising	2	1
One-on-one teaching (nonclinical setting)	2	1
<u>Scholarship/research</u>		
Grants**		
Grant new, funded, national		
First author	2 x grant fomula	200
Other author	Grant fomula	100
Grant new, funded, state/local		
First author	2 x grant fomula	100
Other author	Grant fomula	50
Grant, renewed		
First author	2 x grant fomula	20
Other author	Grant fomula	10
Grant written/submitted, nonfunded		
First author	0.4	100
Other author	0.4	50

Grant fomula

$$(\text{Grant \$ amount} \times 0.0001) / (\# \text{ authors} + 1) / (\# \text{ authors})$$

Where the first author gets twice the value of the other authors

(continued on next page)

Table 3
(continued)

Activity	Relative Value	Hours Credit
Publications		
Manuscript, peer reviewed, prestigious		
First author	1	100
Other author	1	50
Manuscript, peer reviewed		
First author	0.6	100
Other author	0.6	50
Manuscript, non-peer reviewed		
First author	0.2	50
Other author	0.2	25
Presentations (outside Indiana University Department of FM)		
National/state, new	2.5	10
National/state, repeat	1.5	10
Local	1	10
Media	—	—
Other		
Editorial Review Board (book/journal)	0.4	20
Board/committee, chair		
National	0.4	100
State/local	0.4	50
Board/committee, member		
National	0.4	50
State/local	0.2	25
Leadership		
Indiana University School of Medicine		
Admissions Committee	2	4
Curriculum Committee	2	1
Other school committee	2	1
Department		
Department chair	4	4
Vice chair	4	4
Committee		
Chair	2	1
Member	1	1
Faculty meeting	1	1
Division		
Director	4	4
Associate/clinic director	4	4
Hour-for-hour reporting:		
Curriculum development/administration	1	1
Committee		
Chair	2	1
Member	1	1
Recruitment interviews	2	1
Hospital		
Section		
Chief	2	1
Meeting	1	1
Indiana University Medical Group Board of Directors	2	1
Hospital Committee	1	1

**Funded research time and other salary savings time is paid at a rate of:
(relative value 3 x hours credit 4) per half day

RVU—relative value unit

ICM—Introduction to Clinical Medicine

ulty member supervises or performs results in additional compensation. Faculty members who do not provide obstetrical care do not receive compensation under Category C.

Category D is the category used at the chair's discretion. This category has the potential to be either a positive or a negative dollar amount. A negative dollar amount could be assessed in this category if a faculty member did not fulfill minimum responsibilities. Each faculty member holds an annual meeting with departmental leadership to determine these requirements.

Category D is funded by two mechanisms. The first mechanism is via a percentage of the compensation plan budget that is set aside annually as the chair's fund. This fund can be distributed at the discretion of the chair. The second mechanism is through any amount remaining from faculty members who have total productivity less than the expected average faculty productivity.

The final category is Category E, the corporate category. This is the category that captures the value of the department's goals and provides incentive for group activity. If the physicians' practice plan corporation meets the departmental goals for the year, then every faculty member receives the same predetermined amount of compensation in Category E. The amount of this category is set by the chair at the beginning of each academic year. The corporate goals are set and voted on by the corporation on an annual basis. Examples of corporate goals set by the practice plan corporation in past years include implementing patient satisfaction surveys at all clinical practice locations and the development of individual strategic scholarship plans for each departmental faculty member.

To provide ease of reporting, we use Microsoft Excel spreadsheets to capture revenue-generating

Table 4
Example of a Category A Calculation

	<i>Year to Date # of Half Days Completed</i>	<i>Year to Date # of Activities Completed (Not in Half Days)</i>	<i>Relative Value</i>	<i>Hours Credit</i>	<i>Total RVU Points</i>
	TIME	PRODUCTIVITY			
Revenue-generating activities (RGA)**	ELEMENT*	ELEMENT*			
Outpatient clinic	132		3	4	1,584
Nursing home	12		3	4	144
Inpatient care	80		4	4	1,280
Precepting residents	60		2	4	480
Flexible sigmoidoscopy clinic	12		2	4	96
Nasolaryngoscopy clinic	12		2	4	96
One-on-one teaching during direct patient care	40	1	4	160	
Weekend/holiday rounding		7	4	8	224
Night call		13	0.5	12	78
RGAs SUBTOTAL:		308			4,142
Scholarship*	44		0		0
New national presentations		2	2.5	10	50
Repeat state presentation		2	1.5	10	30
Editorial Review Board		1	0.4	20	8
Second author peer-reviewed manuscript		1	0.6	50	30
SCHOLARSHIP SUBTOTAL:	44				118
Teaching*	44		0		0
New large-group lecture		3	1	10	30
Repeat large-group lecture		6	1	4	24
Resident advising		6	2	1	12
Medical student advising		2	2	1	4
TEACHING SUBTOTAL:	44				70
Meetings*	44		0		0
Curriculum development		40	1	1	40
Hospital section meeting		6	1	1	6
Chair, Department Committee		6	2	1	12
School Committee		12	2	1	24
Department faculty meeting		12	1	1	12
Department committee member		12	1	1	12
MEETINGS SUBTOTAL:					106
Administration	0		0		0
TOTAL	440				4,436

RVU—relative value unit

* When calculating how a faculty member spends the 440 working half days each year, time is allowed for scholarship, teaching, and meetings. Time is set aside in each of these areas for faculty members to complete “productive” activities. However, the time element for each of these three areas is not attributed any relative value. Faculty members earn value in these categories based solely on the activities they perform during the allocated time (“productivity element”).

** In this example, the faculty member is using all of his/her variable time in “revenue-generating activities.”

activity automatically by linking them to scheduling spreadsheets. Individual faculty members review and validate this report on a monthly basis. They complete an electronic report of their academic time and other nonclinical activities and send that electronic report to the compensation system administrator.

Compensation

On a quarterly basis, each faculty member receives an individual compensation calculation, as shown in

Table 5. This report summarizes the total year-to-date compensation package for the individual and calculates an expected annual compensation value extrapolated from the year-to-date data. The quarterly distribution of this report allows faculty members the opportunity to readjust their activity level. The distribution also prevents faculty members from being surprised about their individual overproductivity or underproductivity at the end of the year.

Table 5

Example of a Quarterly Individual Compensation Summary

Faculty Name: XXXXXXXXXXXXXX

Current closing date: June 30

Line A	RVU activities	RVUs to date	0	Annualized Line A compensation:	\$0.00
		\$/RVU	\$x.xx		
		Line A compensation to date			
Line B	Clinical productivity	Clinical RVUs to date	0.00	Annualized Line B compensation:	\$0.00
		\$/RVU	\$0.00		
		Line B compensation to date	\$0.00		
Line C	Maternity care	Maternity care stipend to date:	\$0.00	Yearly maternity care stipend:	\$0.00
		Deliveries to date	0.00		
		\$/delivery	\$xxx.xx	Delivery compensation to date:	\$0.00
		Delivery compensation to date	\$0.00		
Line D	Director discretion				\$0.00
Line E	Corporate			Corporate only paid if goals met	\$0.00
				\$xxxx.xx to be paid as 12th check if corporate goals met	
Projected annualized compensation		Current compensation due	\$0.00		\$0.00
Compensation paid to date		Usual monthly compensation:			
		Number of months paid to date:	0		
		Monthly compensation paid to date:	\$0.00		
		Delivery compensation paid to date:	\$0.00		
		Total compensation paid to date:	\$0.00		
Reconciliation projections:	Current compensation due:	\$0.00	Projected annualized compensation:	\$0.00	
	Total compensation paid to date:	\$0.00	Monthly compensation paid through 11th check	\$0.00	
	Net current reconciliation	\$0.00	12th check may be \$xxxx, may be zero	\$0.00	
			13th check July 31—reconciliation check	\$0.00	

RVU—relative value unit

Throughout the year, one twelfth of the average expected compensation in categories A and B is distributed monthly for the first 11 months. The Category C stipend is paid out at a rate of one twelfth per month for the first 11 months. Obstetrical delivery compensation is paid out monthly as deliveries occur.

By June 30 each year, the chair determines whether or not the corporate goals were met. If the corporate goals were met, then Category E is paid out during the month of July. A final calculation is performed, by the system administrator, based on June activity submis-

sions. The amount paid out during the previous 11 months is subtracted from the annual compensation due, and the residual is distributed in the month of July.

During development of the compensation system, frequent reports were made to the physician practice plan corporation. At significant stages in development, such as assigning values to activities, the system was taken to the corporation for a vote of support before work continued. On completion of the framework development, the system was approved by a vote of the corporation.

Program Evaluation

Two years after the new incentive compensation was implemented, a faculty survey was performed, and the committee evaluated the system's ability to meet its stated goals. All 18 physician faculty members completed the anonymous satisfaction survey. The survey included questions seeking the faculty's opinion of the value and effect of the RVU system on both the department and the individual. Most responses were based on a 5-point Likert scale ranging from "strongly agree" to "strongly disagree" and included a "not sure" option. The survey was submitted to an external (nondepartmental) statistical analyst who compiled the data and distributed aggregate results to the committee.

Overall Satisfaction

The majority of physician faculty members (72.2%) reported that they view the incentive compensation system as a necessity for the department, as reported in Table 6. One third (35.3%) of the 17 faculty responding to the question reported that they were satisfied overall with the incentive compensation system that we are using. Another one third (35.3%) reported that they were neutral, and 29.4% reported that they were dissatisfied with the incentive compensation system. Seven of the 18 respondents (38.9%) answered "yes" to the question about the incentive compensation system being a personal nuisance. Six of those seven also viewed incentive compensation, in general, as not helpful in the health care industry.

Meeting Goals

The first goal of the compensation incentive system was to maintain fiscal responsibility to the physician practice plan corporation and the department. At the initiation of the new compensation system, the corporation asked that the total practice plan compensation for all physicians not exceed the total amount distributed the year before. The total practice plan compensation for all physicians has remained within budget since its implementation. The new compensation system has redistributed that compensation in an objective manner as guided by the new system (Figure 1).

The second goal was to capture the value of multiple facets of academic medicine. The relative weighting of activity value allows the opportunity for faculty members to excel in multiple areas. Sixteen of the faculty who responded (88.9%) agreed with the committee's assignments of weighted values for clinical activities, 29.4% agreed with the scholarship weightings, 35.3% agreed with the weightings for teaching activities, and 35.3% agreed with the leadership weightings (Table 6).

The third goal was to allow academic freedom. The system allows faculty members the flexibility to choose what activities they wish to pursue within the framework of the system. Table 6 illustrates that nine respon-

Table 6
Physician Compensation System
Evaluation Responses (n=18)

	#	%
Compensation system is a necessity for the department.		
Yes	13	72.2
No	5	27.8
How satisfied are you with the RVU system that we are using?*		
Strongly satisfied	3	17.6
Satisfied	3	17.6
Neutral	6	35.3
Dissatisfied	4	23.5
Strongly dissatisfied	1	3.9
In general, incentive compensation is helpful to the health care industry.		
Strongly agree	1	5.6
Agree	11	61.1
Neutral	2	11.1
Disagree	3	16.7
Strongly disagree	1	5.6
The compensation system is a personal nuisance.		
Yes	7	38.9
No	11	61.1
What is your perception of the RVU weightings for each category?		
Clinical activities*		
Overvalued (5)	7	41.1
(4)	9	52.9
Just right (3)	1	5.9
(2)	0	0.0
Undervalued (1)	0	0.0
Scholarship activities**		
Overvalued (5)	2	13.3
(4)	3	20.0
Just right (3)	6	40.0
(2)	4	26.7
Undervalued (1)	0	0.0
Teaching activities**		
Overvalued (5)	3	20.0
(4)	3	20.0
Just right (3)	7	46.7
(2)	1	0.7
Undervalued (1)	1	0.7
Leadership activities**		
Overvalued (5)	0	0.0
(4)	6	40.0
Just right (3)	6	40.0
(2)	1	6.7
Undervalued (1)	2	13.3

(continued on next page)

Table 6
(continued)

	#	%
In general, the compensation system promotes individual freedom.***		
Strongly agree	2	14.3
Agree	3	21.4
Neutral	1	7.1
Disagree	5	35.7
Strongly disagree	3	21.4
When choosing how to spend my work time, I consider the RVU system value for that activity compared to other activities.*		
Strongly agree	2	11.8
Agree	9	52.9
Neutral	3	17.6
Disagree	2	11.8
Strongly disagree	1	5.9
The monthly submissions are easy to report.*		
Strongly agree	4	23.5
Agree	6	35.3
Neutral	3	17.6
Disagree	3	17.6
Strongly disagree	1	5.9

RVU—relative value unit

- * Indicates one missing response
- ** Indicates three missing responses
- *** Indicates four missing responses

dents (52.9%) disagreed that the system promotes their individual freedom, which supports the committee’s perception that this component of the system has not been adequately implemented.

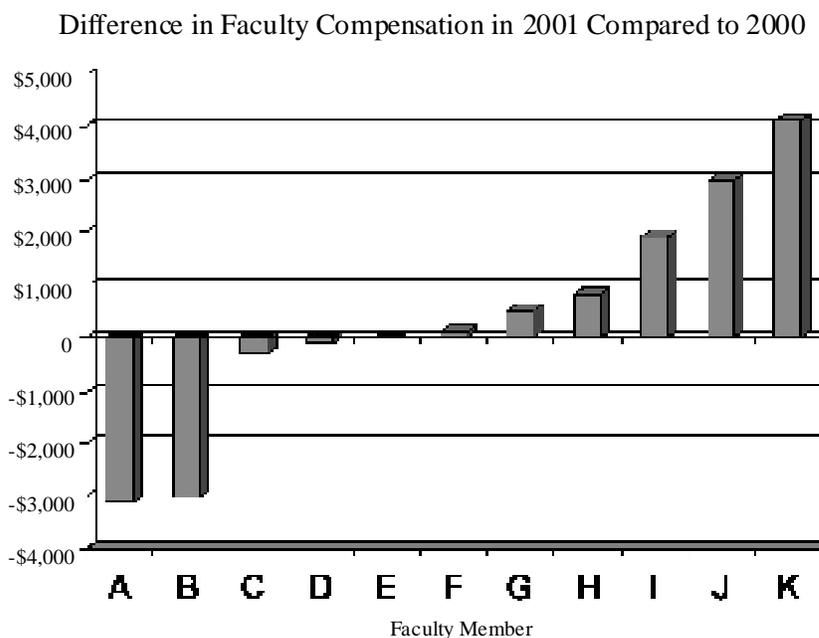
The final goal of the system was to allow for ease of reporting faculty activity and to provide a productivity incentive to the faculty. Two thirds (64.7%) of the faculty responding reported that they consider the compensation system value of one activity compared to another when they choose how to spend their work time (Table 6). Two faculty members report that they use their assistant to submit the reports. When those two faculty are excluded, 10 (66.6%) of those responding agree that the monthly submissions are easy to complete (Table 6). The one faculty member who disagreed that the submissions are easy to complete was also one of the four who reported being uncomfortable with using Microsoft Excel. One faculty member commented that now when a scheduled responsibility is cancelled, there is a financial consequence to that cancellation and that it is much easier to find another faculty member to trade or cover scheduled activities. The medical director of the residency program has reported significant improvement in faculty willingness to fill the call schedule.

Discussion

We have demonstrated that an incentive compensation system that incorporates departmental goals can be implemented in academic family medicine. The majority of physician faculty members of the department perceived a need for an incentive compensation system. The system we have designed has fair acceptance; however, it is imperative that we evaluate the reasons why five faculty members are dissatisfied with the system.

Limited financial and physician manpower resources appear to have influenced our successful system implementation. The chair can still direct faculty time and resources on an individual and contractual basis. However, because of a shortage of faculty members brought about by financial constraints, this individual freedom has not been able to be fully utilized. For some of

Figure 1



The figure is a graphical representation of the difference in faculty compensation between the 2 years, ie, one faculty member made \$3,000 less in 2001 than in 2000, and another faculty member made \$4,000 more in 2001 than in 2000.

the faculty members in the residency division, their variable time is used to cover additional residency teaching activities. The real benefit of the system in this instance is its ability to identify exactly where physician manpower is needed. Finding mechanisms to restore variable time for all faculty members may be essential to promote individual freedom, something that is deemed important to professional career satisfaction. Additionally, generating a financial cushion, so that not every physician member of the department is held to one half of the revenue-generating activities, is important for both individual and academic freedom.

One of the main limitations of this system is that it rewards only quantity of work done, rather than both quantity and quality. To provide proper incentive to faculty, the system must be adapted to incorporate quality of work in addition to quantity. The other limitation of the system is that the incoming revenue streams to the department cannot be directly linked to the incentive compensation program. An additional, but less significant, limitation is that not all activities are captured by the system. For example, one faculty member is the director of one of nine new core curriculum areas for the entire school of medicine. At the time the compensation system was developed, these nine curricular areas did not exist. As a result, the compensation system does not yet capture this activity. This is an example of why the committee must continually evaluate new and unique activities that the faculty report.

An additional benefit to the department from the system was noted as well—providing an effective monitor of the activities of the most valuable departmental resource, its physicians. The department is now able to document every half day of activity for all of the clinical faculty members and can demonstrate the work effort in clinical, scholarship, and teaching activities to the dean. A second unexpected benefit of the incentive compensation system is that the residency program wanted to increase the number of outpatient preceptors in resident continuity clinics. Using the data from this system, the department was able to obtain an exact number of half-day preceptor sessions that would be needed to provide the additional staffing. Lastly, it serves as a valuable strategic planning tool for the department by providing concrete information about how physician time is allocated to each activity.

We are currently in the process of evaluating factors that are related to faculty dissatisfaction with the incentive compensation system. In the future, we would

like to evaluate the effect of the new system on corporate success. Eventually, we plan to expand the system to cover the entire department so that all clinical and nonclinical faculty members are incorporated into the incentive compensation system.

Acknowledgments: The authors would like to acknowledge Terrell W. Zollinger, DrPH, for his assistance with the faculty satisfaction survey development and Michael J. Przybylski, PhD, for his assistance with data compilation and analysis.

Corresponding Author: Address correspondence to Dr Willis, Indiana University, Department of Family Medicine, 1110 W Michigan, Long Hospital, Suite 200, Indianapolis, IN 46202. 317-278-0300. Fax: 317-274-4444. drwillis@iupui.edu.

REFERENCES

1. Jones RF, Mallon WT. How do medical schools use measurement systems to track faculty activity and productivity in teaching? *Acad Med* 2002;7:115-23.
2. Centers for Medicare and Medicaid Services, Washington, DC. National physician fee schedule relative value units. <http://cms.hhs.gov/providers/pufdownload/default.asp#pfsrelative>. Accessed October 1, 2002.
3. Bardes CL, Hayes JG, Falcone DJ, et al. Measuring teaching: a relative value scale in teaching. *Teach Learn Med* 1998;10(1):40-3.
4. Hilton C, Fisher W, Lopez A, Sanders C. A relative value-based system for calculating faculty productivity in teaching, research, administration, and patient care. *Acad Med* 1997;72(9):787-93.
5. Andrae M, Freed G. A new paradigm in academic health centers: productivity-based physician compensation. *Med Group Manage J* 2001;48(3):44-54.
6. Andrae MC, Freed GL. Using a productivity-based physician compensation program at an academic health center: a case study. *Acad Med* 2002;77(9):894-9.
7. Brandt TL, Romme CR, LaRusso NF, Lindor KD. A novel incentive system for faculty in an academic medical center. *Ann Intern Med* 2002;137(9):738-43.
8. Cohen JR, Fox S. Developing a new faculty practice plan with a model for funds flow between the hospital and the plan. *Acad Med* 2003;78(2):119-24.
9. O'Brodivich H, Pleinys R, Laxer R, Tallett S, Rosenblum N, Sankorsak C. Evaluation of a peer-reviewed career development and compensation program for physicians at an academic health science center. *Pediatrics* 2003;111(1):26-31.
10. Glass KP, Pieper LE, Berlin MF. Incentive-based physician compensation models. *Journal of Ambulatory Care Management* 1999;22(3):36-46.
11. Johnston MAC, Gifford RH. A model for distributing teaching funds to faculty. *Acad Med* 1996;71:138-40.
12. Scheid DC, Hamm RM, Crawford SA. Measuring academic production. *Fam Med* 2002;34(1):34-44.
13. Sussman AJ, Fairchild DG, Coblyn J, Brennan TA. Primary care compensation at an academic medical center: a model for the mixed-payer environment. *Acad Med* 2001;76(7):693-9.
14. Yeh MM, Cahill DF. Quantifying physician teaching productivity using clinical relative value units. *J Gen Intern Med* 1999;14:617-21.
15. Liccione WJ. Effective goal setting: a prerequisite for compensation plans with incentive value. *Compensation and Benefits Management* 1997;13(7):19.

Rewards are in the midst of a transition from the strictly standardized to the highly personalized. Companies at the forefront of this wave are creating rewards programs that are delivered more continuously, aligned more closely with individual preferences, and based more fully on an employee's whole contribution to the team and the organization. These companies understand that effective rewards programs require a personal relationship with each worker. First, employees respond favorably to agile compensation programs that provide raises, bonuses, or other incentives more often than the traditional once-a-year rewards system. And companies have a strong incentive to implement these programs. Reward system contains all components of organisation, that includes people, processes, rules and procedures, alongside the decision-making activities, which involved the the process in allocating compensation and benefits to employees, in trade for his or her contribution to the business (Griffin and Moorhead, 2009). Specifically, productivity can be increased adopting incentives like piece rates. Lazear and Oyer (2009) additionally debated studies which displayed that even nevertheless incentives worked, in a way that they had a good result on outcomes, they didn't work consistently each time and from time to time even had unintentional and unwanted results. Reward system play a vital role in Human resource department of any business and it is the same in Microsoft as well.