

Creating Incentives for Accountability in Patient Care

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POLICY FORUM

Creating Incentives for Accountability in Patient Care

William Bond, MD, MS

“If we all put one of our lunch items in a pool, then we can sell them, and we’ll split the profit.” This must be heard in middle school lunchrooms across the country every year. The corporation usually lasts a few days and may end in a lunchroom brawl, but generally nobody dies or becomes permanently injured. As we consider the market for lunchroom dessert pastries, it highlights the many differences between health care and other goods. With pastries, we know the price on offer and the price if we bought the pastry at the competing corner store. We know our classmate is driven by the profit motive and is unlikely to share the income with his mother who packed the lunch. The profits are visible; the coins are easily seen, counted, and distributed. Thus, there is transparency in any gain sharing.

Of course in health care, we as the patient are not sure we want a pastry, we’re not told the price of the pastry, we’re not sure if the pastry is good for us, whether evidence exists that the pastry is beneficial, or whether the doctor is motivated to sell or withhold the pastry based on our well-being or his or her profit. Additionally, the doctor or practice might have avoided our lunch table all together, because we’re the poor kids or the kids who were likely to have a bad outcome after eating the pastry.

Thus in health care we have knowledge asymmetry, agency problems, lack of price transparency, and biased selection of patients, to name just a few issues. Adding to that complexity, Medicare, private insurers, and employers have now argued for incentives to increase care quality, decrease utilization, and improve overall outcomes [1]. Clearly patients, payers, and clinicians respond to incentives, and incentives in any system are challenging to orchestrate and can lead to distortions in the market. Consider the well described regional variation in health care utilization that is in part driven by the fee-for-service system [2, 3]. Any overly large incentive may distort the market or lead to unethical choices in the offering of services.

Structuring Incentives Effectively for Teams and Organizations

Here we consider the impact of an incentive distributed on a team of providers, rather than simply on the individual physician. For any incentive to have an impact it must first be understood. In an era when incentives may be tied to clinician-, group-, and network-level performance, this should not be taken for granted. My multispecialty group within an integrated delivery system recently mandated an online training module to explain the incentive system and its impact on physician and advanced practice clinician salaries. As noted in informal discussions with colleagues, this module was felt to be appropriate and generally appreciated by

clinicians. Building an understanding of incentives for team members such as medical assistants with lower levels of baseline education, however, poses additional challenges. These team members may have difficulty understanding percentages, holdbacks, quintiles of performance, budget trigger points, and other terminology routinely used to justify or withhold incentives.

Without understanding, we cannot reach the goal of *aligning* incentives across the team. The focus of strategic alignment has traditionally been the relationship between physician incentives and those of an integrated health system [1]. However, within the integrated system, many team members such as nurses and medical assistants have key roles to play in meeting practice goals, but under current incentive structures receive little if any performance-based compensation. Some of the neglect may simply be a historical artifact of organizational structures, with nurses paid under a different reporting silo than doctors. Barriers may also be created by nursing union rules that inhibit trials of productivity-based pay or shared-risk models. In aggregate, more attention should be paid to incentives for other team members who play key roles in overall clinical productivity.

This is especially worth considering because the marginal impact of an incentive for any actor in the health care system will depend in part on its relationship to existing salary and wealth. Thus, reason would suggest that a \$5,000 bonus payout would be far more meaningful to a nurse making \$60,000 than to a physician making \$200,000. Incentives for lower-paid members of the team might actually yield significant productivity gains with smaller increases in cost than physician incentives. While executives may have 20 percent or more of their annual pay based on performance-based incentives, there are no authoritative guidelines or evidence about safe maximums or effective minimums of incentives for health care team members.

Furthermore, practice models can be set up so that performance markers must be met at the individual level, group level, and health network level. Whether these markers function independently—that is, when the individual performance marker is hit, the incentive for that marker is paid—or whether they are tied triggers—so that all marker levels must be hit for any reward to be had—must be carefully considered. Linking nothing to individual performance could be very frustrating, but linking all incentives to higher organizational level performance could be exceptionally demotivating. Reward structures demanding continuous progress can also be demotivating—most improvements in quality or cost are likely to plateau over time, and such incentives would lead to more effort for less marginal gain. Markers that target improvement over time may favor the clinician or team, while changes in absolute number may favor the hospital or health network, which typically receives and distributes the incentive [4].

Systems would do well to consider the balance of incentive between the inpatient and outpatient settings and between providers and staff. Likewise, markers that target improvement over time may favor the physician or team, whereas changes in

absolute numbers may favor the hospital or health network that typically receives and distributes the incentive [4].

What Behavior Is Being Incentivized?

Which behaviors are encouraged by an incentive system are obviously worth considering as well. Ethical questions arise if the incentive becomes so strong that it creates selection bias within practices. By selection bias we mean potentially noncompliant or simply less healthy patients may be excluded so that the practice doesn't look bad on performance measures. There is some evidence that this happened in the National Health Service [5] which created the need for "exception reporting" allowing some patients to be left out of the incentive calculation. This was also found in Taiwan when there was "cherry-picking" with regard to which patients were chosen to be included in the performance tracking for diabetes [6]. In part, the success of the health maintenance organization (HMO) model, the system in which the provider shares the most risk for cost of care, stems from the fact that most non-Medicaid HMO patients are working individuals (or their families) with insurance, and thus the model excludes many high risk, high complexity patients. In the new ACO model, which is close to the HMO model in terms of shared risk and reward, team members may become complicit in patient selection bias if they are encouraged by strong financial incentives.

There are several solutions to problematic incentives. The Acute Care Episode (ACE) demonstration project capped provider bonuses at 25 percent of physicians' Medicare rate so that incentives would not be designed to grow or reduce patient volumes but to reward clear cost savings [7]. Another idea is to have some team members off any incentive plan, whether that incentive is to share cost savings or increase productivity. These team members can then serve as conflict-of-interest mediators and be available at the practice or integrated delivery system level. The idea is similar to appointing court judges so they can serve without need for reelection and are thus less beholden to stakeholders.

More work should be done to consider systems of arbitration that would mediate conflicts between those trying to decrease utilization and patients/advocates who feel that more care or diagnostic efforts are warranted [8]. Many such issues might be avoided by training physicians and educating patients in a shared decision-making process. Helping patients understand that the choice to recommend for or against testing is based on evidence rather than one doctor's opinion may lead to evidence-based care with less resource use and fewer adverse events [9]. Designing insurance schemes that motivate patients to both understand and choose value-added care will be another ongoing challenge [2].

Beyond Financial Incentives

We must also acknowledge that financial incentives are only one factor affecting clinician behavior [10]. For an extensive review of the effectiveness of financial incentives in changing health care professional behaviors, see the Cochrane Review on this topic by Flodgren et al. [11]. Recent qualitative work by Bitton et al.

demonstrates both a method to study practice change and some of the impacts noted during practice change across multiple settings. Through a series of site visits and interviews they explored methods that were used to encourage change, including the role of consultants, team and staff restructuring, change fatigue, and the effects of compensation changes [12]. They found specific contextual factors in each practice that influenced the willingness to change a primary care practice to a patient-centered home model. In this case change to a PCMH meant shifting from a fee-for-service model to a capitated payment model that paid both the physicians and care team. It would be worthwhile to consider their research questions and methods before rolling out an incentive scheme, because the exploration of site-specific change barriers may allow for targeted and more successful change efforts.

In another ethnographic approach, Magrath et al. note that monetary and quality incentives might crowd out other sources of motivation such as intrinsic motivation, might undermine the social relationship with patients, and might have detrimental effects on teamwork by fostering competition or envy [13]. Nonfinancial incentives might include reward and recognition, but individuals may also be motivated by control over lifestyle and work flexibility. At the larger organizational level, characteristics such as organizational justice have been correlated with better performance [14]. Organizational justice, while manifested by fair policies and procedures, is ultimately rooted in ethically sound practice, professionalism, and model behavior. Thus, it is best to pay attention to both culture and nonmonetary incentives. Effective efforts to improve culture might include leadership development, accountability for highly professional behaviors, and fostering a focus on the patient.

In the end, the incentives of the U.S. health care system have to change to bring about system reform. For better or worse, the primary mechanisms of incentive reimbursement in accountable care organizations (ACOs) are likely to include bundled payments for episodes of care and pay-for-performance in the near future. Bundled payments should reward successful transitions of care efforts and appropriate reductions in utilization. Historically, however, capturing the value of managing complexity at the individual or practice level has been challenging. Utilization risk may force providers to reflect more carefully on care patterns beyond the individual patient and consider efforts such as those of the National Institute for Clinical Excellence (NICE) in the U.K. and “Choosing Wisely,” an effort of the American Board of Internal Medicine to deter low value practices through dissemination of evidence [15]. Already some have shown promising results with the ACO model focused on better coordination of care [16]. However, demanding accountability from clinicians and care teams when they may be hampered by incompletely orchestrated care delivery systems and fragmented electronic health records could be disheartening.

In conclusion, incentives and their distribution across the team and care settings must be carefully considered. Financial incentives should be considered as just one factor in clinician behavior change [10, 17-20]. Incentive targets should be agreed upon by

external stakeholders (patients, insurers, employers, and quality and safety leaders) and practice stakeholders (physicians, advanced practice clinicians, nurses, staff, and community or transitional care coordinators). The team will need education on the incentives, with periodic reinforcement and a process for indoctrinating new team members during orientation. The team's performance must be frequently fed back to its members and the team should use performance improvement methods to come up with collaborative ways to move toward performance goals.

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Further Reading

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