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Pay for Performance: Benefits, Traps, and Pitfalls

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Disclosures

Neither I, Brent C. James, nor any family members, have any relevant financial relationships to be discussed, directly or indirectly, referred to or illustrated with or without recognition within the presentation.

I have no financial relationships beyond my employment at Intermountain Healthcare.

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Outline -

The good, the bad, and the ugly ...

1. ***Background theory: Large amounts of waste*** *(clinical and financial opportunity)* ***in care delivery***

2. ***Problems linking quality measures to financial incentives***

3. ***A different*** *(quality-based)* ***way of thinking about incentives in health care delivery***

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The idea of "patient-centered care"

- ***Institute of Medicine, 2001*** *(Crossing the Quality Chasm)*
- ***It's not "health care," but "disease treatment"***

  patients approach the care system around a health need

- ***Health care system typically organize around:***
  - *physicians*
  - *technologies (e.g., MRI scanner)*
  - *buildings (e.g., a hospital or clinic)*
- ***What if we instead organized around patients?***

  - condition-specific disease treatment processes

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Often called "continuum of care"

- ***Identifies patients before the disease starts***
  (primary prevention)
- ***Tracks them as the disease develops***
  (screening, detection)
- ***Follows them through treatment***
  (the complete care delivery process)
- ***To eventual resolution***
  (health problem resolution or patient death)

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Key concept: "Move upstream"

(a stronger version of "do it right the first time")

The idea of ***"preventive medicine"***
generalized broadly

Produces a similary broad definition of

waste

(anything that is not optimally value-adding from a patient's perspective)

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Bottom line strategy: eliminate waste

50+% of all resource expenditures in hospitals is quality-associated waste:

- *recovering from preventable foul-ups*
- *building unusable products*
- *providing unnecessary treatments*
- *simple inefficiency*

Andersen, C. 1991
James BC *et al*., 2006

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Process management is the key

- ***higher quality drives lower costs***
- ***under budget-based financing, all of the savings extend the resources available to the care delivery group***
- ***more than half of all resource savings will take the form of unused capacity*** *(fixed costs: empty hospital beds, empty clinic patient appointments, reduced procedure, imaging, and testing rates; all = higher productivity)*
- ***balanced by increasing demand***
  (Baby Boom; obesity; community growth; technological advances)

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Three ways to get a better number

1. ***Measure, manage and improve the system*** *- add front-line value*

2. ***Suboptimize*** *- make one area look better, but at the expense of other parts of the organization that are unknown, unmeasured, or outside of the goal's scope (shift limited resources to areas under the spotlight, thus damaging other, unmeasured areas)*

3. ***Game the number*** *-*
   - finesse the measurement system (manipulate the data)
   - "fire" problem patients

Deming:

- "as one attaches greater rewards or punishments to achieving a number, one gets increasing proportions of (2) and (3)"

- extrinsic rewards tend to destroy intrinsic motivation

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Shift resources under the spotlight

- *143 primary care practices implementing an electronic health record (EHR)*
- *71 practices randomized to receive data feedback w/ financial incentive, 72 receive data feedback alone*
- *compared 4 cardiovascular quality measures that received financial incentives, to 4 that did not*

	Quality performance
4 measures w/ financial incentives	***+22%***
4 measures w/o financial incentives	***-20%***

Ryan AM et al. The intended and unintended consequences of quality improvement interventions for small practices in a community-based electronic health record implementation project. Med Care 2014; 52(9):826-32 (Sep).

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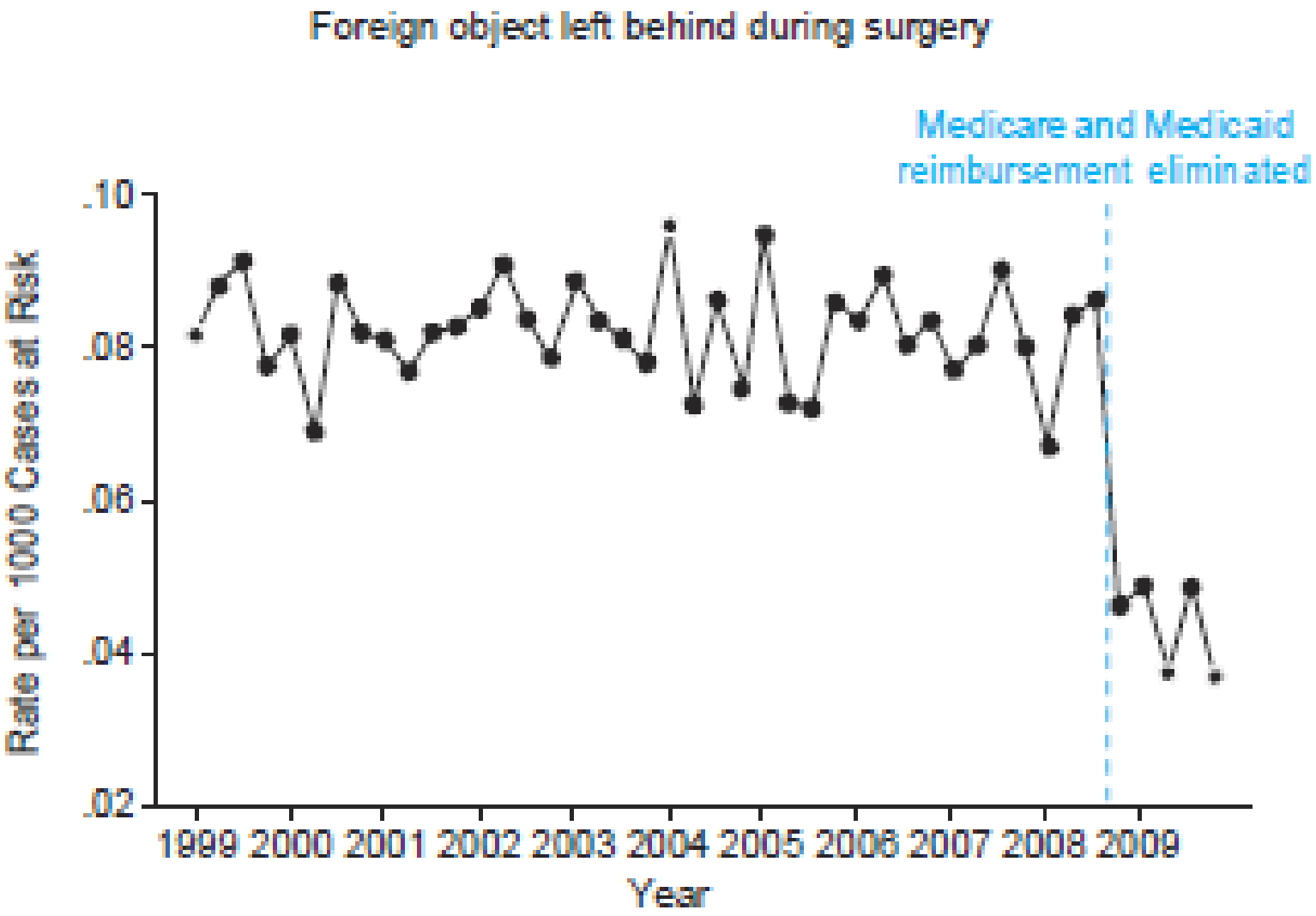
Game the number: P4P = P4Metric



Farmer SA, Black B, Bonow RO. Tension between qaulity measurement, public quality reporting, and pay for performance. JAMA 2013; 309(4):349-50 (Jan 23/30).

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Drive by Dan Pink

- ***Algorithmic tasks: every step fully predefined***
  - just execute against a completely specified plan
- ***Heuristic tasks: high complexity, can't fully predefine*** *- requires "on the fly" adjustment, thought, creativity*
- ***Tightly linked to workforce eduction level***
  - high education level = high heuristic task load

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Strong evidence *- multiple replications,different settings*

- ***For algorithmic tasks, financial incentives work as predicted:***

  financial incentives drive better performance

- ***For heuristic tasks, the opposite happens:***

  financial incentives = worse performance!

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Drive by Dan Pink

The financial incentive conundrum:

- ***pay fairly*** *- pay enough to "take money off the table";*
- ***so that people are thinking about the work and the patient, not about money***

Functional definition of health professionalism:

- ***Autonomy*** *- self-direction; ability to adjust to each patient's need*
- ***Mastery*** *- personal and professional excellence*
- ***Purpose*** *- doing things that make a real difference*

(See: https://www.youtube.com/watch?v=u6XAPnuFjJc)

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No good deed goes unpunished

- *Neonates > 33 weeks gestational age who develop respiratory distress syndrome*
- *Treat at birth hospital with nasal CPAP (prevents alveolar collapse), oxygen, +/- surfactant*
- *Transport to NICU declines from 78% to 18%.*
- *Financial impact (NOI; ~110 patients per year; raw $):*

	Before	After	Net
Integrated health plan	900,599	512,120	388,479
Medicaid	652,103	373,735	278,368
Other commerical payers	429,101	223,215	205,886
Payer total	1,981,803	1,109,070	872,733
Birth hospital	84,244	553,479	469,235
Transport (staff only)	22,199	- 27,222	- 49,421
Tertiary (NICU) hospital	958,467	209,829	-748,638
Delivery system total	1,064,910	736,086	-328,824

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Better has no limit ...

an old Yiddish proverb

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