

# Developing an Incentives Playbook: Aligning Influences in the Era of Reform



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The context in which physicians and other healthcare providers deliver care is transforming. In particular, the trend grows toward physician employment and provider consolidation. An important driver of these changes are payment reform policies aimed at shifting our fragmented healthcare system, currently built on fee-for-service reimbursement, to one that encourages integration and coordination while holding providers accountable for patient outcomes and costs. However, it is still not clear whether the changes in payments being tested actually do result in improved quality of care, better health outcomes, and lower costs for patients. Additionally, little systematic review is available on how to implement payment reforms, optimally, in real-world settings.

One issue that deserves more careful consideration involves potential disconnects between organizational and individual clinician incentives. That is, many payment reforms are targeted at organizations, such as accountable care organizations (ACOs), to which shared savings and various risk-based models are directed. However, within these organizations, the countless decisions made by physicians, nurses, and other frontline providers will predominantly determine organizational performance. These providers are often largely still being compensated by their organizations based on productivity. Thus, while bundled payment, shared savings and other reform initiatives may be reducing the proportion of payments linked to unfettered volume at the organizational level, their providers are still being paid more to do more. It seems more likely that payment and delivery reforms will achieve the greatest success when the financial incentives facing organizations are aligned with those of their frontline providers.

In order to achieve this alignment, hospital, ACO, and other

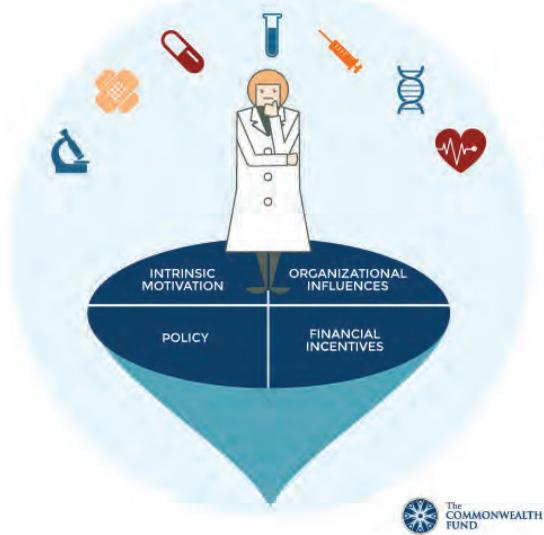
delivery system leaders must determine how to design effective financial incentives for their frontline providers. In addition, although financial incentives are often considered important in motivating behavior change, evidence on their use to drive quality improvement in healthcare has been mixed at best.<sup>1</sup> When internalizing payment reforms to the provider level, organizations may find that incentives are most effective when strategically packaged with nonfinancial influences that have also been shown to have a strong impact on provider behavior.

## Redesigning Financial Incentive Programs

A key strategy to try to improve provider performance has been the use of financial incentives. Certainly, the way in which providers are paid (eg, fee-for-service versus capitation, productivity bonuses versus profit-sharing) and the relative payment amounts for different services can influence what care is delivered. Over the years, many adjustments to those payments have been made to attempt to encourage care of higher quality. Intuitively, conclusion would be that explicitly paying more for something, such as higher-quality care, should lead to more of it. Yet, evidence demonstrating whether financial incentives drive healthcare quality improvement has been mixed. For example, research documenting financial incentive programs show limited evidence linking payment to patient outcomes and that incentives were more likely to improve productivity and financial performance than quality of care.<sup>1,2</sup>

One possible explanation for the underwhelming impact of financial incentives is that they may be too crudely or naïvely designed. In fact, we can learn from fields such as psychology and behavioral economics how to make incentives more salient to providers

### A HOST OF FACTORS INFLUENCE MILLIONS OF CARE DECISIONS EACH DAY



within the complex, time-scarce settings in which they deliver care. For example, substantial behavioral sciences research indicates that the size and timing of a reward plays a critical role in how an individual responds to it.<sup>3</sup> In general, larger rewards elicit greater effects, but many of the pay-for-performance programs in healthcare involve a relatively small proportion of provider reimbursement. Thus, linking a larger share of provider compensation to performance may lead to greater impacts.

In addition, there are often long lag times between when care is delivered and when rewards are given, largely due to delays in the requisite data collection for calculating performance measures. To reduce the lag times and improve saliency, organizations may find it advantageous to provide rewards to providers before a performance period with the potential to take some or all of it away if performance standards are not met.<sup>4</sup> This strategy also leverages research indicating that people will try harder to avoid losses than to reap potential gains of equal value.<sup>4</sup>

Another research-based suggestion is to make financial incentives more psychologically striking by decoupling them from usual compensation.<sup>5</sup> This might be accomplished by showing incentive payments as a separate line item on a pay stub.<sup>4</sup> One organization, Advocate Physician Partners, has even experimented with handing out incentive bonuses in person at regularly scheduled quality improvement meetings.

Experimenting much more with the timing, frequency, size, and other characteristics of financial incentives, including how to link them to specific performance measures, will help determine the most effective designs. Drawing from the substantial related research in other industries, such as finance, can help accelerate the process. Additionally, a wide array of payment reforms are currently being tested, ranging from bonus payments embedded in the fee-

for-service system to global payment systems. The insights gained from past, present, and future research should help make important contributions to the redesign of financial motivators that must simultaneously encourage better coordination among diverse providers and ensure that each one believes in the the significance of—and receives the benefits from—their work.

### The Value of Nonfinancial Influences

When considering the mixed evidence on the effectiveness of financial incentives and payment and delivery reform initiatives in general, it is evident that there are other factors aside from money that influence behaviors. In particular, most current financial incentive programs are predicated on money being the primary driver of the decisions people make, which may not be the case for healthcare providers. Moreover, many barriers to high-quality care are not financial.

#### *Financial incentives versus intrinsic motivation and medical professionalism*

While financial incentives almost inevitably influence behavior, a culture centered on monetary motivation risks underestimating the inherent value of a healthcare provider's likely intrinsic motivation: the desire to do a challenging job well for the satisfaction of it and to positively impact the lives of others.<sup>6</sup> Intrinsic motivation also relates to one's desire to meet goals and garner the respect of peers. A large body of cognitive and social psychology research shows that for challenging tasks, incentive programs that detail behaviors tied to financial rewards (particularly marginal rewards) may "crowd out" behaviors that individuals would otherwise do without any reward at all, potentially producing a negative effect.<sup>7</sup> An evaluation of a financial incentive program in the United Kingdom provides an example of how this crowd out effect may materialize in a healthcare context. Some participants raised concerns that the program may have incentivized "studying to the test," while placing less emphasis on areas of care not tied to metrics, especially doctor-patient interactions.<sup>8</sup>

In some cases, medical professionalism and a provider's intrinsic motivation have been found to be a greater positive influence than financial incentives. For example, peer comparisons have effectively driven performance in Pennsylvania, where the introduction of quality report cards for cardiac surgeons across the state had quadruple the effect on surgeons' performance than did profit incentives.<sup>9</sup>

Even something as seemingly simple as putting one's goals in writing can help leverage intrinsic motivation to become a better performer. When physicians signed and posted a "commitment letter" in their examination rooms to decrease the use of inappropriate prescribing of antibiotics, such prescriptions decreased by almost 20% in some Southern California primary care settings.<sup>10</sup>

More research could determine whether and how financial and nonfinancial motivating factors can be used in tandem to generate even better results. Many payers are already preparing performance reports for providers as part of various payment reform and public reporting efforts.<sup>11</sup> These programs present a natural opportunity to push the knowledge base on how peer comparison reports and goal-setting might be used to improve provider performance on a

large scale.

#### *The role of organizational culture*

Healthcare groups with a strong organizational culture may more effectively foster the intrinsic motivation of physicians and ensure provider “buy-in” when a new incentive program is being developed. In fact, an organization’s culture has an impact beyond programs concerned with finances. For example, one study found that hospitals with the lowest acute myocardial infarction mortality rates were generally characterized by a strong organizational culture, including a clear, mutual mission among employees and leadership; support for quality improvement; highly involved senior leadership teams; and nonpunitive problem-solving approaches.<sup>12</sup> Unsurprisingly, case studies of high-performing delivery systems consistently find that strong leadership and a supportive culture are key contributors to success in payment and delivery reform efforts.

By espousing the qualities that organizations look for in their providers, such as accountability, inter-professional cooperation and self-motivation, organizations can reinforce behavior associated with high-quality care.<sup>13</sup> Creating a supportive culture in this era can be complicated by the fact that many physicians have worked in solo or small group practices, essentially self-employed and reimbursed under fee-for-service. As physicians move to group and salaried settings, earning potentials may decrease, schedules may become fixed, and many more of their practice decisions (eg, referral patterns and treatment choices) may be questioned. Organizations will need to engage their clinicians in ways that encourage higher-quality care, while not promoting the automatic practice of protocols that do not consider patients’ individual needs.

Also, as integrated health systems increasingly bring together diverse practices to achieve overarching goals, it will be crucial for organizations to promote a culture in which medical professionalism is highly valued, and providers and leadership share a common vision.

#### *Motivation is not everything: operational influences*

The increasing complexity of regulations and financial incentives within the healthcare delivery system requires deliberate attention to promoting environments that encourage effective professional behavior. However, within organizations, even well-designed motivating influences can only go so far. Additional, negative factors—such as provider fatigue, poor team planning, poorly designed work flow, knowledge gaps, memory lapses, and overreliance on decision making based on “rules of thumb”—may negatively influence provider behavior despite the presence of a well thought out financial incentive.<sup>14</sup>

In short, the practice of medicine is complex and fraught with uncertainty, making occasional errors essentially unavoidable even for the most well-intentioned clinician. Thus, constantly rethinking processes of care to reduce the potential for error is crucial.<sup>15</sup> To address cognitive shortcomings and optimize caregiving, for instance, organizations may implement decision-support tools that check and alert clinicians in ways that they find beneficial. In addition, quality improvement teams may identify a range of process improvements

that involve minimal additional resources such as checklists, reorganization of provider teams, and the redesign of physician schedules. Payment reform can help justify and support such efforts, and improved operations management can help ensure that payment reform goals are met.

#### **Need for Synergistic Approaches to Provider Incentives**

The need to align organizational and individual provider incentives will likely increase in the future. The number of physicians employed by a hospital or hospital-owned practice increased significantly in 5 years, from 16 percent in 2007 to 29 percent in 2012.<sup>16</sup> Supported by the Affordable Care Act, the formation of ACOs is accelerating this trend. The ACO model’s dependence on individual provider behavior to meet organization wide goals exemplifies the importance of leveraging organizational influences to reduce barriers to high-quality care, and moving forward, we can research and learn from the experiences of the Pioneer ACO sites: In those that have improved, what organizational forces have been present that may have led to positive results? We have certainly learned from the implementation of payment reform programs to date that the evidence on their effectiveness is mixed. However, mixed evidence does not necessarily equate to ineffectiveness. Rather, opportunities abound for further learning, to discover which types of providers and services will find which financial incentives most effective. Even within a particular payment reform program, performances will vary widely; further investigation into the characteristics of the providers and organizations with the best results could inform providers in other locations and support future efforts to design the best financial incentives, especially when combined with nonfinancial influences to optimize the probability of success.

A goal of such investigation could be identifying a “playbook” of incremental interventions that can be used to improve provider performance at all levels. Even better, many of these interventions—eg, tweaks to pay stubs or current performance reporting systems—are likely to be low-cost and easily compatible with current working paradigms. While any single intervention may have relatively minor impact, over time, the combination of various incremental steps could lead to significant strides in improving the quality of care while reducing costs to patients—all while creating a more satisfying experience for both patients and providers.

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