Compensation Models for Primary Care
A Critical Review
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Disclaimer
Dr. Dubinsky has worked in the UK, Israeli, Kenyan, Japanese and Canadian (B.C., Ontario, Newfoundland) systems and has been at various times in salaried, FFS and APP models.

Agenda
- Payment Principles
- Payment Models – Pros/Cons
- P4P – A Critical Review
- Questions
**America @ Work Survey**
- 1,800 employees
- Pay 11th after:
  - Communication
  - Ability to challenge status quo
  - Opportunities for professional growth

**Kohn (1993)**
- Inadequate understanding of human motivation
- No study ever confirmed long term quality improvements
- Create a sense of community
- Democratize/consensualize decision making

**Herzberg’s Notion of Motivation (1959)**

“If you want people motivated to do a good job, give them a good job to do.”
1980’s
- Rising costs
- ↑ chronic disease prevalence
- ↑ utilization
- ↑ consumer demands
- ↑ demand for quality

USA
- March 2001 – “Crossing the Quality Chasm”
- IOM suggests:
  “evaluate payment options that more closely align compensation methods and quality improvement goals with input from private and public interests”

McGlynn et al NEJM (June 2003)
- Random sample (verbal, chart review)
- 12 metropolitan areas, approximately 13,000 patients
- 439 indicators
- Participants received 55% of recommended care including:
  - Preventative
  - Acute
  - Chronic
- Irrespective of socioeconomic status
- HUGE variation between conditions
  - 79% for cataracts
  - 10.5% for alcohol dependence
Payment of Health Professionals May Be For:

- Administrative Services
- Clinical Care

Administrative Services in Primary Care Departments/Facilities Include:

- Senior Leader (e.g. VP Medical, Chief of Staff, VP Nursing, VP Finance, etc.)
- Department Chief
- Committee Chairs
- Manager
- Director
- CEO/COO
- etc.

Physician Administrative Stipends

- Tax treatment
  - Risk to payer
- “Salary”
- +/- Incentive/bonus
Clinical Care

- Salary
- FFS
- Envelope funding
- Mixed

All +/- Incentives (P4P)

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Clinical Care

- Salary
  - Hourly, weekly annual
  - Fringe benefits, perquisites
  - Tax treatment
  - May be “bonused”

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Salary

**Benefits**
- Fixed
- Predictable
- Physician employee
- Ideal for marginalized
- May link to quality
- May link to productivity
- Annual (renewable of NOT!!)
- “Standard” for non-physician professionals

**Risks**
- Productivity
- Tax treatment
- Limited appeal to MD’s

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**FFS**

- May be visit, procedure based
- Sessional
- "Service" based
- Except for those with "private" license, not applicable to non-physicians

**Benefits**

- Incentivizes volume
- Tax treatment
- Politically palatable (to MD's)
- Can add incentives

**Risks**

- Incentivizes volume
- Incentivizes procedures
- Rewards procedurally oriented specialists
- No link to quality

**Envelope Funding**

- Capitation
- AFA
- APP (Alternative or Academic Payment Plan)
- May be individual, group, department, hospital or faculty based
- "Case based"
Envelope Funding

Benefits
- Funding guaranteed
- Appeals to contemporary trainees
- Can add incentives (group, system)
- Predictable
- Can be linked to productivity
- Ideal for “academic” centres
- May link to quality
- Lower billing costs (shadow billing)
- Can tailor services to patient/family/community need
- Easily (?) integrate non-physicians

Risks
- Funding guaranteed
- Group redistributes with no external controls
- Group dynamics/decision making
- Tax treatment
- Patient selection (FHN, FHO, etc.)

Mixed

Benefits
- As per envelope funding
- “Customized”
- Can incentivize some behaviours

Risks
- As per envelope funding
- Tax treatment

- e.g. ED AFA – hourly rate + volume
  + academics
  + committee work
  + etc.
Pay for Performance

An Iconoclast’s Questions

Who are we Paying?/Will we Pay?

- Hospitals
- Physicians
- Department Chiefs (all?)
- Diagnostic services
- Home care
- Administrators
- Nursing Staff
- PT/OT/RT
- SW
- Clerical Staff
- Dietary
- Housekeeping
- Boards
- etc.
What are we paying for?
i.e., What is performance?

Are we rewarding what is
OR
What should be?

Should we be paying for what is
EXPECTED?
Definition of Pay for Performance (P4P)

“Models that offer financial rewards to providers who achieve or exceed specified quality benchmarks.” Mathematica Inc., 2009
- May be paid to individuals, groups or institutions
- Measure with benchmarks OR relative comparisons

Structure of Reward System

- Relative performance in agreed on quality measures
- Absolute performance
- Performance improvement over time
- Can “measure” achievements in structure, process or outcome

Proposed Benefits

- Increase quality
- Eliminate under/over use
- Avoid rewarding “poor quality”
- Align financial reward with improved outcomes
Potential Problems

- Narrow clinical focus
- Incentives too small
- A diversity of models and lack of rigorous evaluation
- Evidence of both positive and negative outcomes
- Outcomes highly dependent on patient behaviour, other providers
- Attribution of improvements
- “Cherry picking”

Competing Values

- Physician rankings differ significantly from other stakeholders
- Physicians vs. ED staff vs. other providers vs. patient/community

<table>
<thead>
<tr>
<th>Patients</th>
<th>Administrators</th>
<th>Physicians</th>
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<tbody>
<tr>
<td>- Courtesy</td>
<td>- Competence</td>
<td>- Technical skill</td>
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<tr>
<td>- Communication</td>
<td>- Collaboration</td>
<td>- Competence</td>
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<td>- Responsiveness</td>
<td>- Customer focus</td>
<td>- Clinical outcomes</td>
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Jun, Peterson, Zaldin (1998)
Values

Dictated by:
- Data availability
- Appeal to “multiple users”

Values

- High correlation – nurses and managers
- Low correlation – home care with all others:
  - Prehospital
  - Managers
  - Physicians
  - Nurses

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<tr>
<th>RN’s</th>
<th>Managers</th>
<th>Home Care</th>
<th>Pre-hospital</th>
<th>MD’s</th>
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<tbody>
<tr>
<td>• Care processes</td>
<td>• Care processes</td>
<td>• ESI linkage to community</td>
<td>• Ambulance indicators</td>
<td>• Critical care processes</td>
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<tr>
<td>• Capacity</td>
<td>• Capacity</td>
<td>• Critical care processes</td>
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<td>• Patient satisfaction</td>
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<td>• Utilization</td>
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Outcomes

- Relatively few rigorous evaluations
- Evidence of “association” between P4P and improved care and outcomes, at best!

- 9 physician programs, 6 focused on DM
- 7 offered bonuses for quality benchmarks
- 2 returned “withheld” funds
- NB – no comparison groups, “volunteer” bias
- At least one quality measure improved in each program
UK P4P

- Introduced 2004
- $3.2 Billion USD incremental over 3 years
- Planned to increase FP income by 25%
- 146 indicators
- 10 diseases, organization of care, patient “experience”
- Sliding scale of points
  - % of patients with disease reviewed/year
    - e.g., 20 points if review 70% of asthmatics/year
- Maximum 1050 points – approximately $140,000 USD

Campbell et al, NEJM, July 2007

- Does P4P have additional benefit over CDM and introduction of “national standards”?
- Analyzed changes in quality of care – linear or not?
- “Rate of improvement” in indicators accelerated after introduction of $ incentives for asthma, DM, NOT IHD.

Campbell et al, NEJM, July 2009

- Followed previous cohort to 2007
- Once “target” reached, improvement slowed
- “Quality of care decreased for conditions with no incentives *
- Continuity of care decreased
- ? Thresholds too low
- ? Lack of incentives to improve beyond “threshold”
UK P4P - Family Medicine

Doran et al, NEJM, July 2006

- 8,105 family practitioners
- One year
- Metrics:
  - Reported achievement (% receiving)
  - Population achievement (proportion of total patients with a condition receiving)
  - Exception reporting (achieving high scores by classifying patients as ineligible)

Doran et al - Results

- Net achievement 83.4% of targets, 97% of points (75% anticipated)
- Socioeconomics*
- Practice factors (size, MD age, venue of MD education)*
- Exception reporting high (>15%) in 1% of practices*

* moderate, significant effects

Doran et al – Observations/Cautions

- Need to add staff
- Increase use/demand for EMR
- Gaming did occur
- MB to factor in/out co-existing conditions (e.g., cholesterol in terminally ill patients)
- 91% had A1C measured BUT up to 93-94% of US patients in groups with NO incentive; 64% in groups with P4P
- Similar data for lipid testing, eye exams, flu vaccine
- ? Targets too low (UK has increased minimum and maximum thresholds)
- ? Misreporting
- Varying rates of exception reporting by disease (hypothyroidism low, mental health high)
- EXPENSIVE
- LARGE MD INCOME INCENTIVES
USA - HMO

Rosenthal etc, NEJM, November 2, 2006

- Surveyed 252 HMOs
- >50% use P4P
- 90% of those for MDs
- 38% for hospitals
- "Targets" included:
  - BP control (31%)
  - DM care (87%)
  - Cholesterol management (62%)
- Bonus average ranges <5% (35%) - ≥5% (30%)
- Bonus rewards:
  - Top performers (32%)
  - Achieve target (62%)
  - "Improvements" (20%)

USA - Hospitals

Lindenauer et al, NEJM, February 1, 2007

- Measured changes in adherence over 2 years
- 10 “individual”, 4 “composite” measures of quality
- Compared 613 P4P hospitals with 406 “controls” (public reporting)

Results

- P4P greater improvement in composite measures
  - CHF
  - AMI
  - CAP
- Greatest "improvement" (16.1%) in poor performers
- Lowest "improvement" (1.9%) in high performers
- P4P hospitals’ improvement modestly greater than controls
- Financial incentive added 2.6 – 4.1% higher "performance"
**Outcomes**

**Petersen et al, Ann. Int. Medicine, 2006**
- 17 evaluations of MD P4P programs
- Randomized studies found no effect of incentives
- One study showed negative effect on sickest patients

**Outcomes**

**Christianson et al, 2008**
- 21 Australian EDs
- Wait time and ambulance bypass
- Required “payback” if targets not met
- 2 of 3 measures improved, sustained for 3 years

**Outcomes**

**Lindenauer et al, NEJM, 2007**
- Improvements in composite performance over 2 years
- Most bonus $ went to highest performers at baseline
Hirth et al. Health Research and Educational Trust (2009)

- Examined effect of P4P when multiple providers affect outcome (dialysis)

  “The type of provider to which incentives are targeted is likely to influence what specific investments are made to improve performance.”

Raube Proquest (2009)

- Obstacles to QI in P4P system identified as:
  - Inadequate IT support
  - Changing MD behaviour
  - MD’s want a 5-10% incentive
  - “Economic incentives are not sufficient to produce quality and cost-efficiency improvements”

Vina et al, Hospital Medicine (2009)

- More “top performers” use:
  - Order sets
  - Pathways
  - Multidisciplinary teams
  - High levels of organizational support
  - Innovative, “progressive” care models
  - Condition-specific physician champions
  - Resource (IT, HP) improvements
Pay for Performance in the ED

Ensuring Pay for Performance Works in the ED

- Consensus on the measures
- Consensus across interest groups
- Evidence-based, reliable, valid
- Relevant
- “Controlled” by ED
- Current
- Tested/validated measures

ACEP potential problems

- Lack of information
- Lack of follow up
- Ensure incentives match practice environment
- Work load of reporting
  - “Whose ‘performance’ are we measuring?”
    - Clerical
    - Nursing
    - ED Physicians
    - DI
    - Lab
    - Consultants
    - etc.
USA

- Launched Physician Voluntary Reporting Program (PVRP) 2006
- 2007 commenced voluntary reporting of 3-5 quality measures/MD
- ACEP developed/AMA approved measures:
  - ECG for non-traumatic chest pain
  - ECG for syncope
  - VS for CAP
  - Assess O2 sat for CAP (81%)
  - Assess mental status for CAP
  - Empiric ABX for CAP (74%)

Other ED approved metrics

- ASA < 4 hours after arrival with MI (92%)
- Beta blockers for AMI (65%)
- Domain of CCU/ICU/cardiology

ED P4P

Vancouver Coastal

- Goal: Increased % of patients meeting target ED transit times (4 hours I → III, 2 hours IV, V)
- Process:
  - Process redesign
  - $100 pp < target time
  - $600 pp to bed < 10 hours
- Results:
  - 21% increase in target achieved
  - Increase by 2 FTEs
  - "Only through an integrated hospital wide effort…could times be reduced"
ED P4P

Ontario
- "Wait Times Strategy", "Pay for Results"
- Increase access, decrease wait times
- Rewards for decrease wait time / decrease admit time / decrease offload delays
- ??? If targets reflect “quality”
- Provides $ to meet target
  - $82 Million 09/10

Suggested Future
- Explicit job/role descriptions
- Compensate at/near top of market
- Set explicit performance criteria
- Compensation system transparent
- Formal compensation philosophy
- Internal relativity of physician leader compensation
- If bonusing, set criteria, weighting
- Need programs to be coordinated

My 20 questions
- Are (the) targets appropriate?
- Does (should) the money matter?
- Should individual performance be reported?
- Should individuals be “rewarded”?
- Are the measures appropriate/accurate/relevant/feasible?
My 20 questions, continued

- Can we avoid unintended consequences (e.g., frail elderly)?
- Is P4P a long or short term strategy?
- Will this create shared accountability/responsibility?
- How (or can we) ensure comprehensive/accurate data?
- How can (or should) we avoid rewarding poor performers?
- Should we only reward the top decile/quartile?
- Should there be penalties?

2 BIG QUESTIONS

1. Are we paying for:
   - Quality?
   - Meeting a threshold?
   - Improvement?
   - Doing what we should have done already?

2. Are we (at risk of) incenting short term $ gains vs. sustainable system change?

YOUR QUESTIONS