

2010 Military Health System Conference

Incentives, Motivation and Pay for Performance

Civilian and Military Lessons Learned

Sharing Knowledge: Achieving Breakthrough Performance

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Our Story



- MHS Pay for Performance Initiatives
- Kaiser Permanente Pay for Performance Initiatives
- What the science tells us about Pay for Performance
- Future Directions

What has the MHS tried?

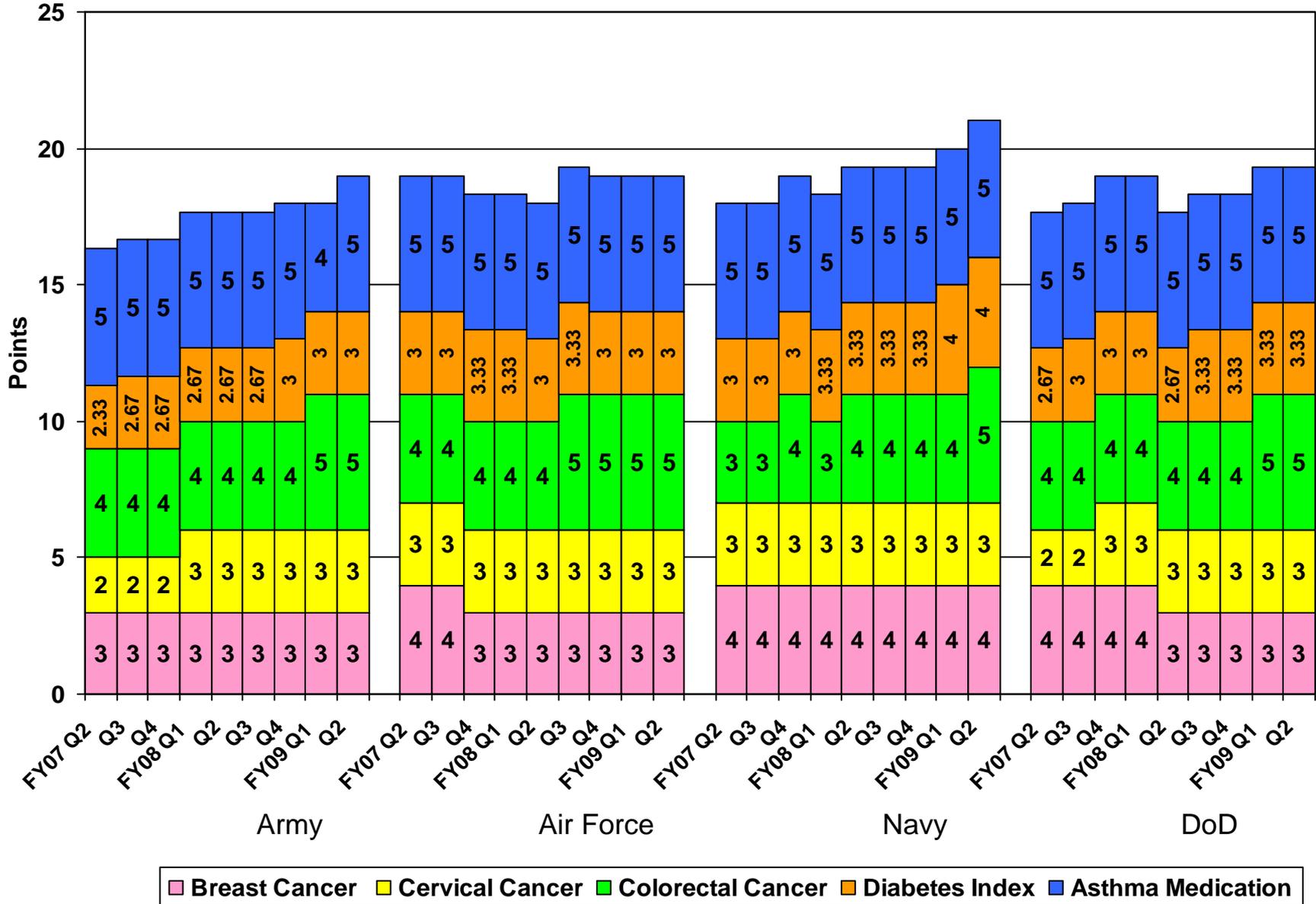


- Prospective Payment System (2005) – Basically a fee for service model that provides an incentive for increased clinical production
- Air Force Medical Service (AFMS) Business Plan (2005)
 - The business plan does not have a financial incentive tied to quality (HEDIS) measures, but these indicators are monitored regularly by the AFMS
- Army Performance-Based Adjustment Model (PBAM) (2007)
 - This initiative rewards improvement in quality by employing adjustments for meeting targets for performance
- Navy Performance Based Budget (PBB) (2008)
 - This initiative rewards improvement in quality by employing adjustments for meeting targets for performance

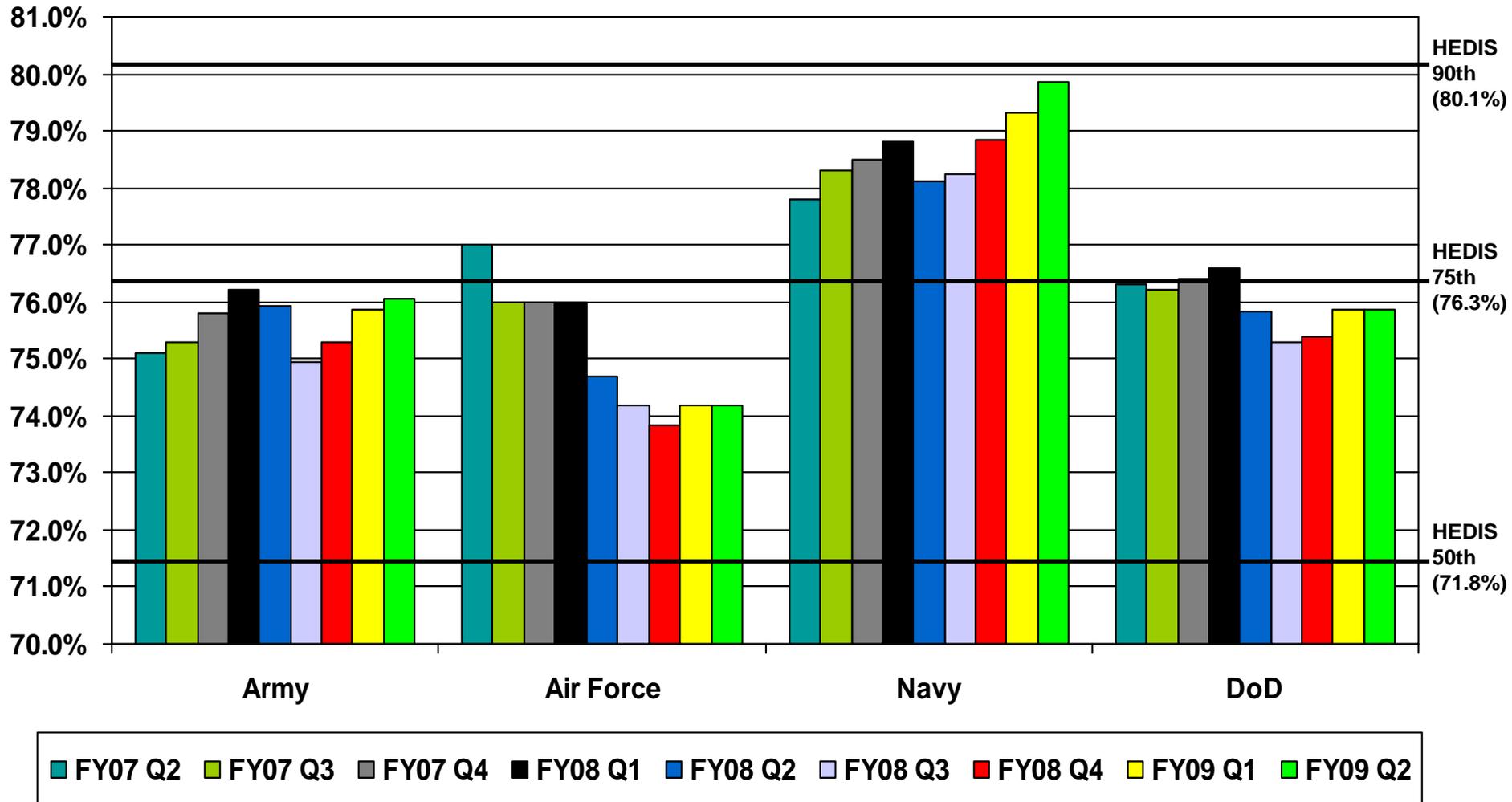
Ref: THE EFFECTS OF INCENTIVE PROGRAMS ON CLINICAL PRODUCTIVITY AND QUALITY By Heather M. Landon, Lt Col, USAF, MSC

**HEDIS Measures – What
have we seen as a result of
the P4P initiatives?**

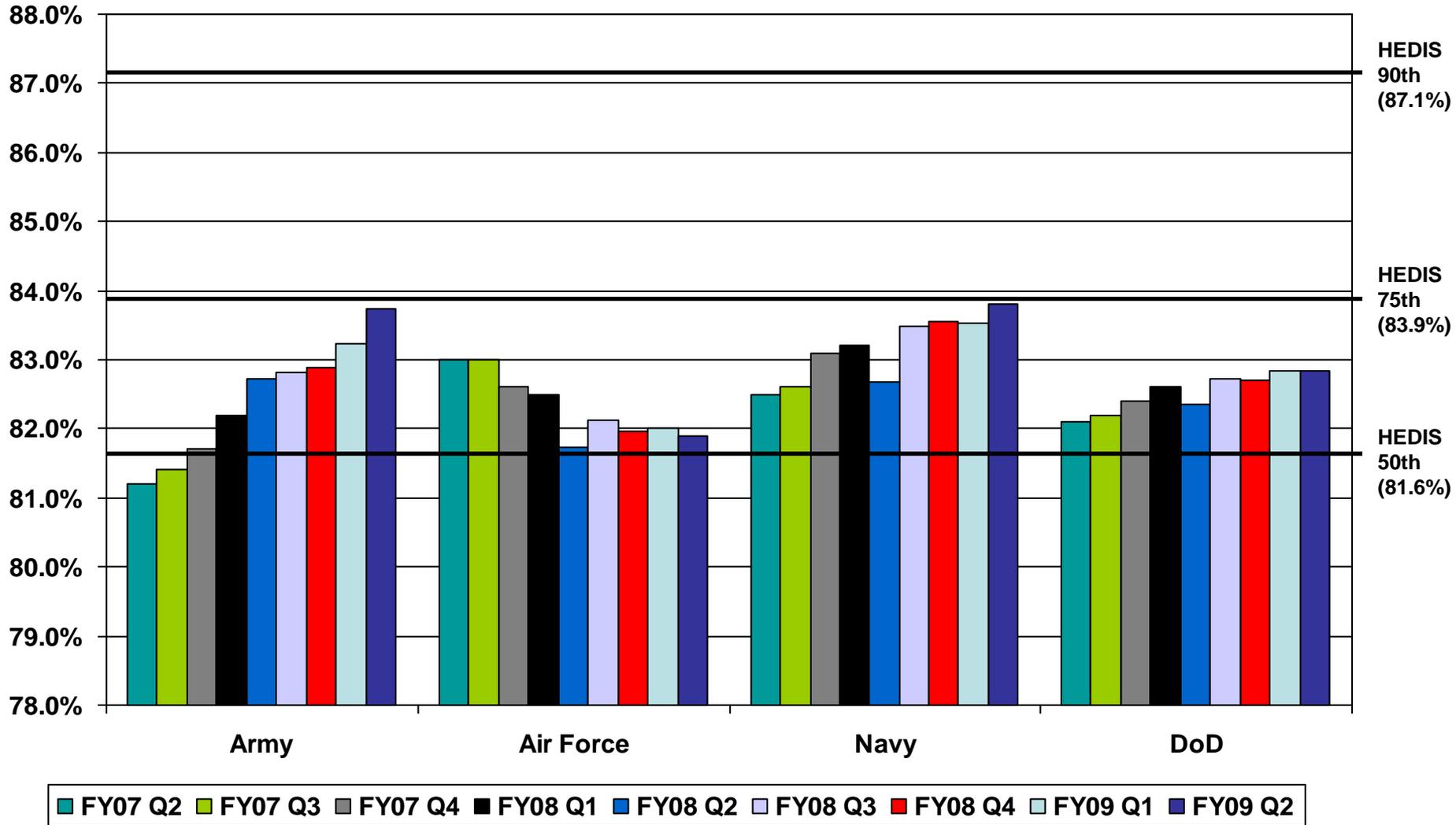
HEDIS Index Points



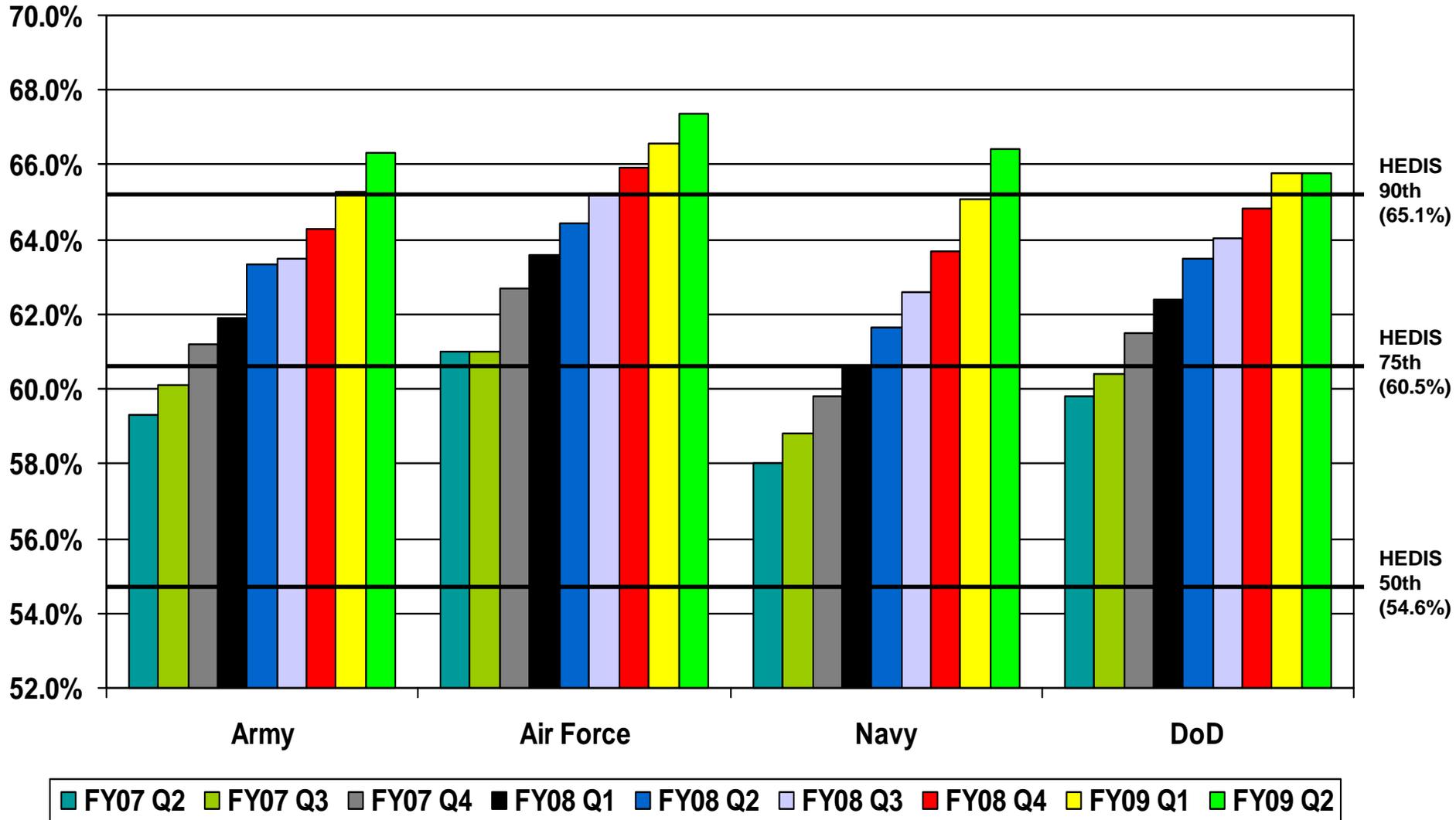
Breast Cancer Screening



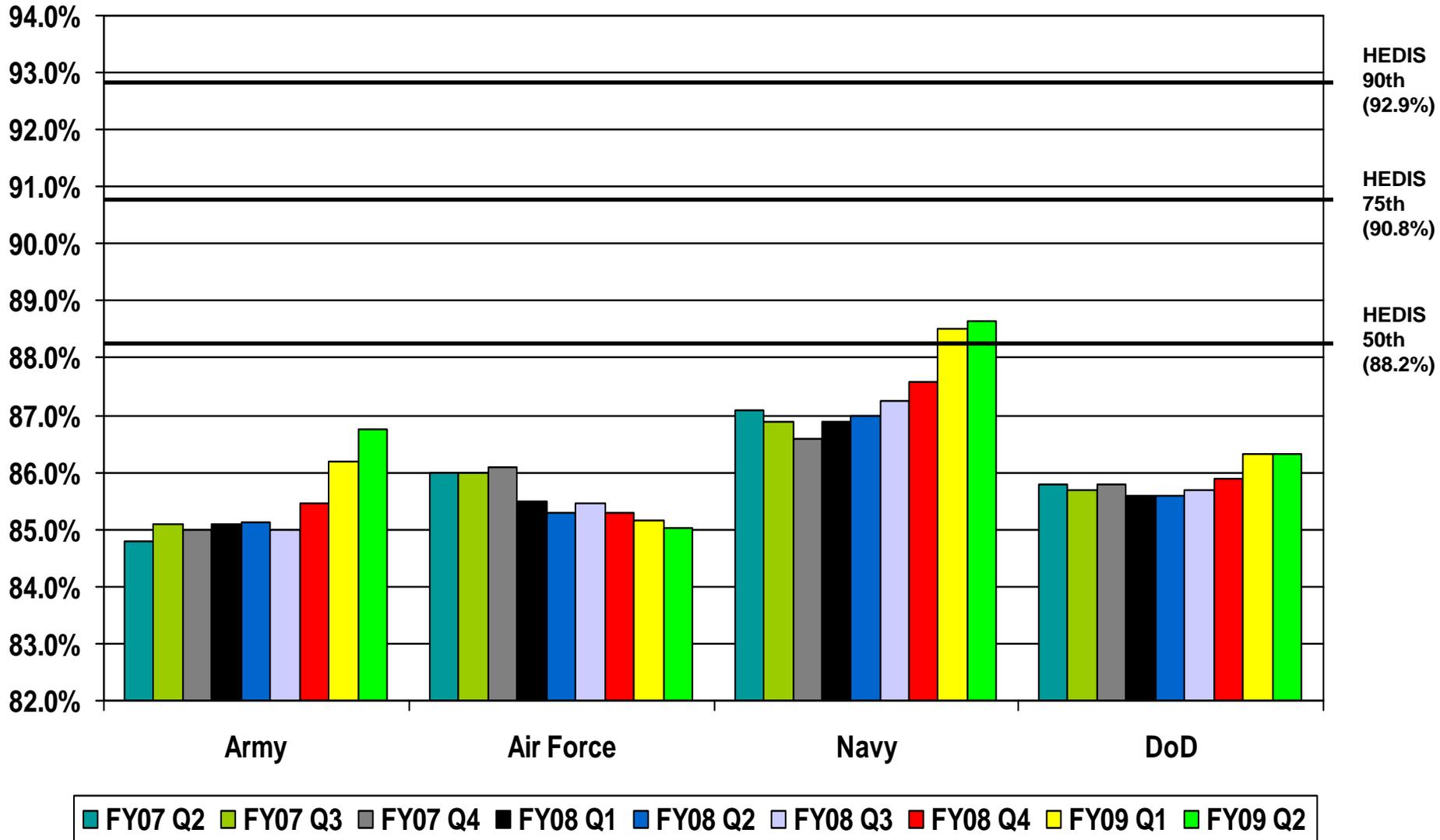
Cervical Cancer Screening



Colorectal Cancer Screening

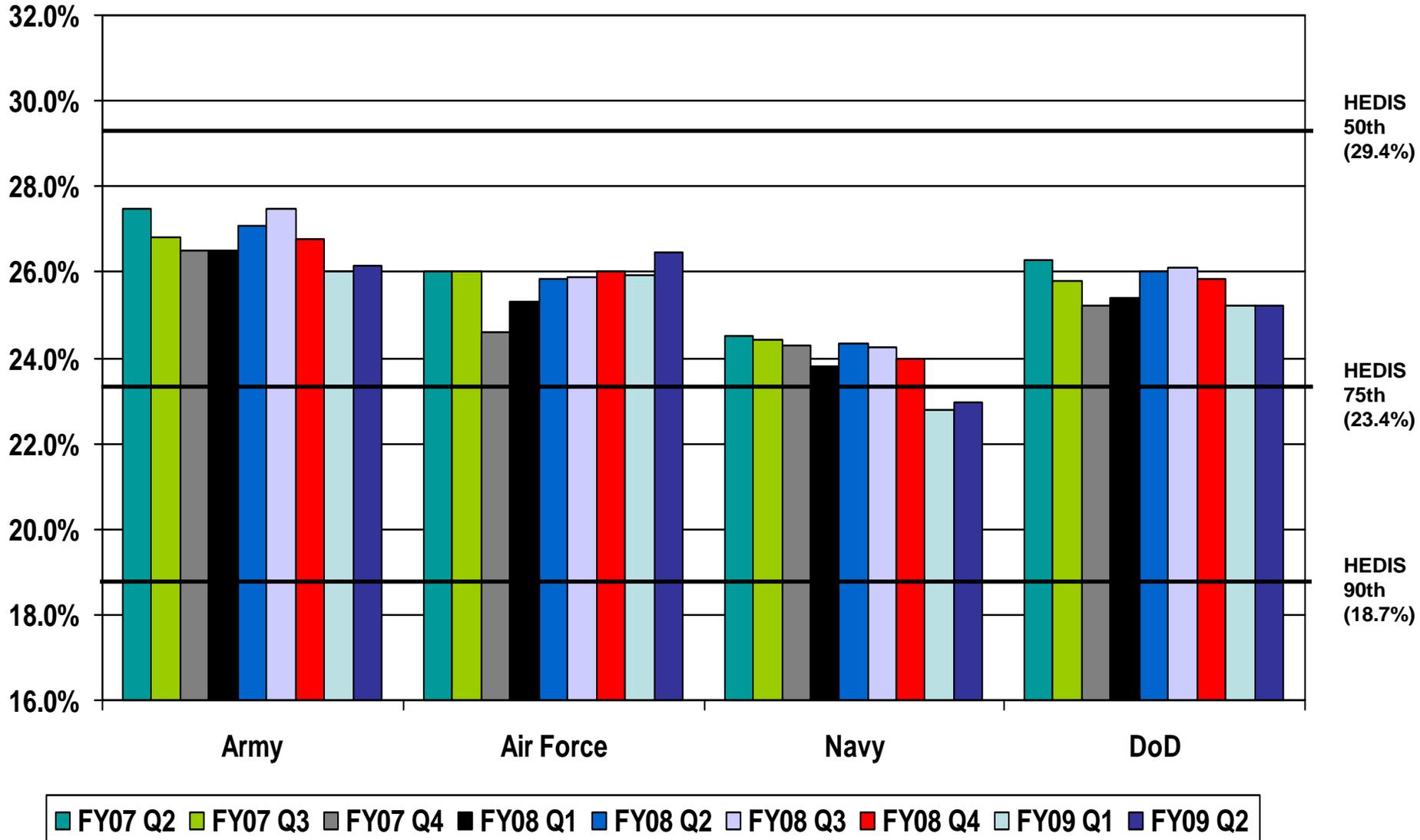


Diabetes A1c Screening

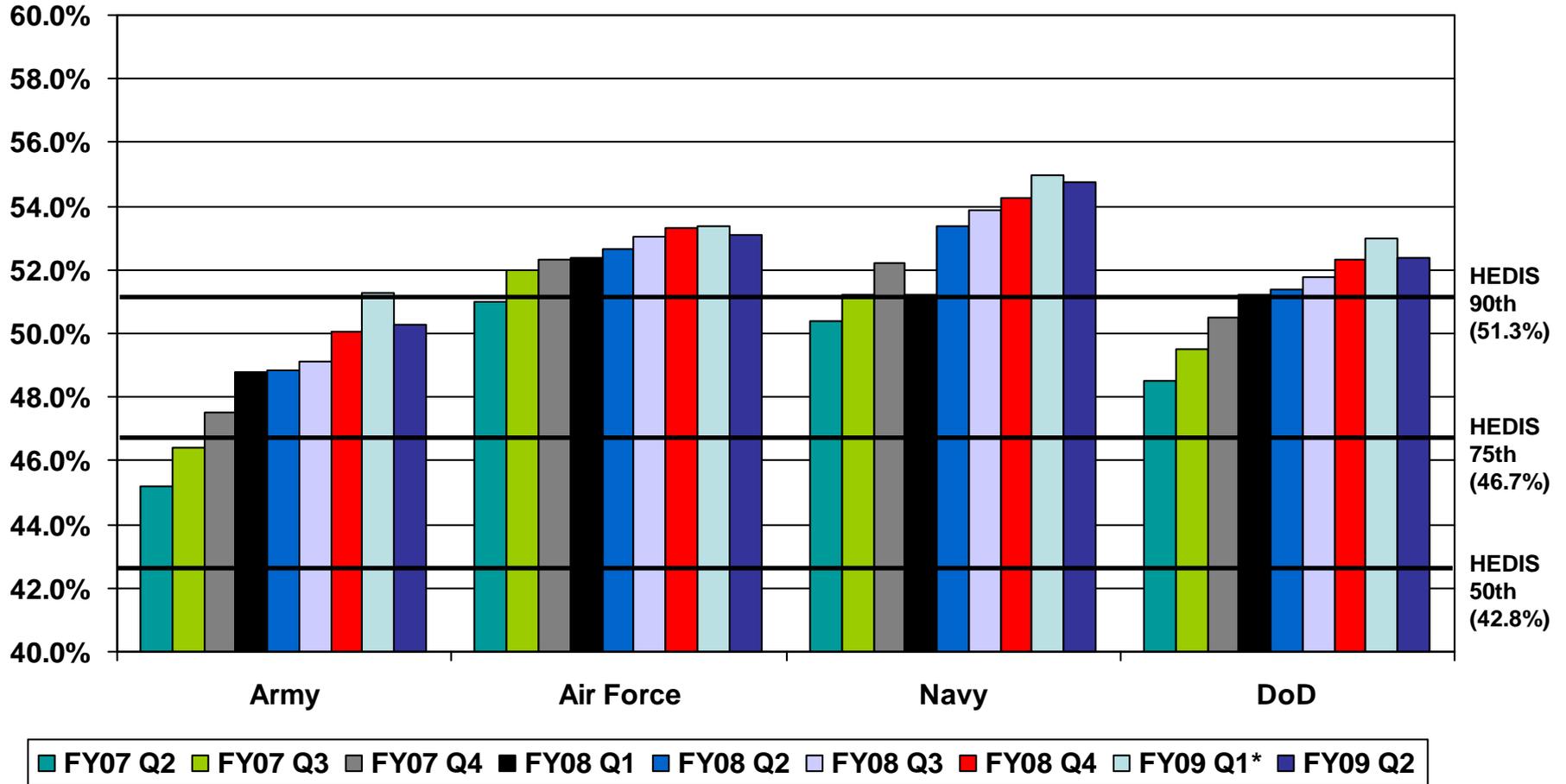


Diabetes A1c > 9 Control*

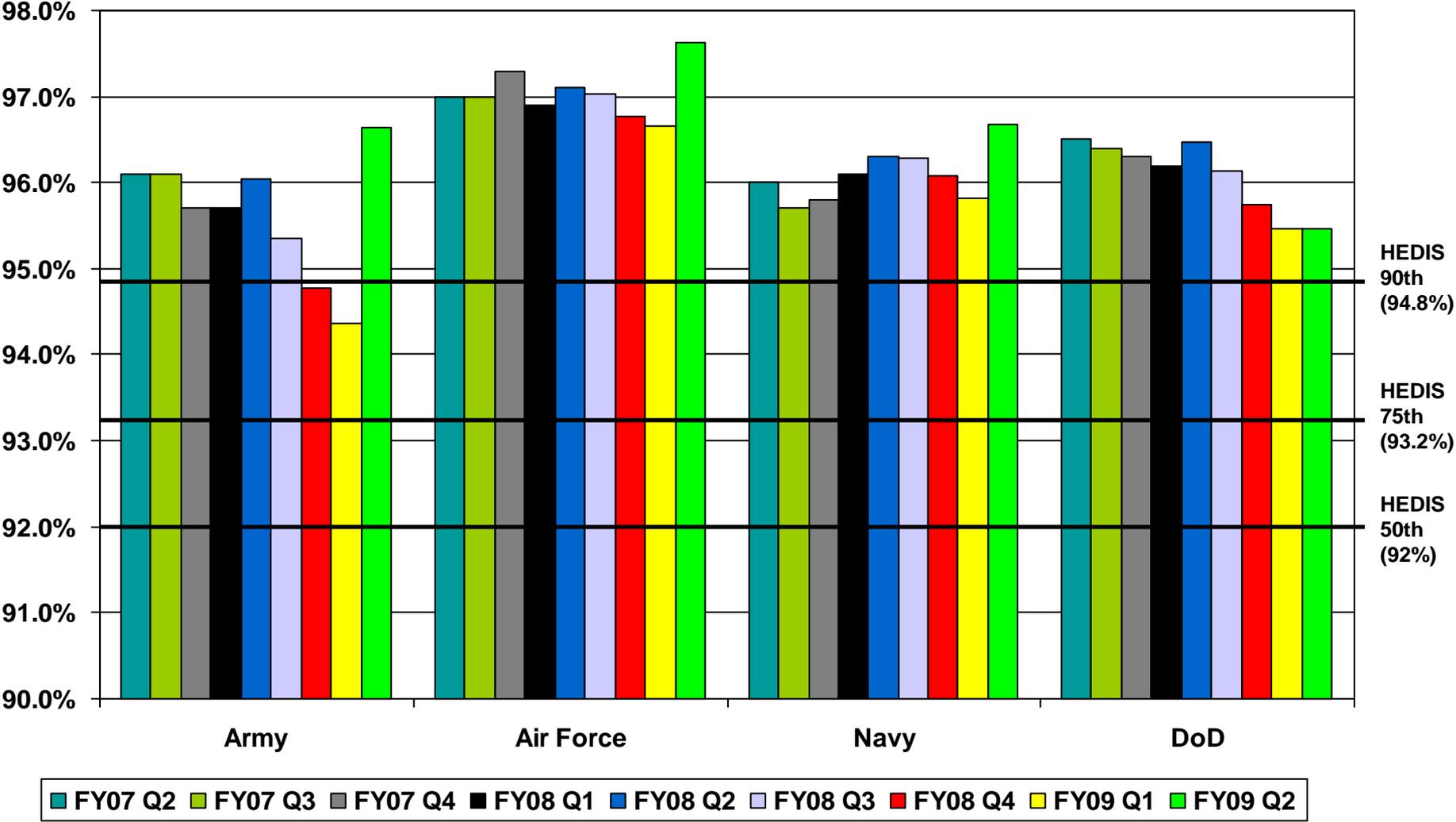
*A lower rates indicates better performance



Diabetes LDL < 100mg/dL



Asthma Medications





Use of Incentive Systems

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Three case studies



	Region 1*	Region 2	Region 3
# of Physicians	6,462	6,736	843
# of Members	3,224,232	3,283,139	494,944
# of Primary Care Physicians	3,231 (approximate)	2,759	298
# of Specialty Care Physicians	3,231 (approximate)	3,977	545

*Region 1 includes OB/GYN as Primary care physicians, Regions 2 and 3 do not

Case #1 - Values



- Organization success
- Alignment of work to achieve goal
- Building pride for performance through transparency
- “All for one/one for all”
- Seen as fair
- Keep incentive \$ small 5 to 10% of salary
- Not hugely at risk

Opening the Gate to incentives



- Hitting the operating budget is the gate to other incentives
- Distributed @ facility level (local leader's autonomy with distribution)

Sample – Crossing the Quality Chasm



- Graphics on site.
- These include:
- **inpatient quality measures (AMI, heart failure, pneumonia, surgical infection prevention, sepsis);**
- **outpatient quality measures (cancer screening, osteoporosis management, cardiovascular health, medications for asthma, antidepressant medication management)**
- **patient safety measures (hospital acquired pressure ulcers, surgical never events, hospital acquired infections).**

Case 2 - Values



- Use of incentives to increase productivity/speed
- Use for recognition of individual performance
- Layered approach
- Small amount of \$ elevates attention (doesn't take much)
- Transparency – unblinded data

Levels



- Individual level
- Widget based production/speed, i.e. colonoscopies, cataracts
- Service
 - Patient communication
 - Bonding with Primary care provider
- Department level
- HEDIS measures
- Access awards to PC, SC
- Chief level
- HEDIS measures
- Inpatient measures
- Service: Access, use of Kp.org

Case 3



- Keep to small \$ (\$5 – 10,000)
- Good line of sight
- Flexible and fascile to needs
- Keep distance between UM and individual clinician

Individual



- Quality: HEDIS (screening, depression)
- Service: Access, time to 3rd, patient satisfaction
- Affordability: streamline processes, increase flow

When do incentives go wrong?



- System is not ready
- Data not transparent or not good
- Produces sub optimization
- Slippery slope – payment for all new work

When do they go right?

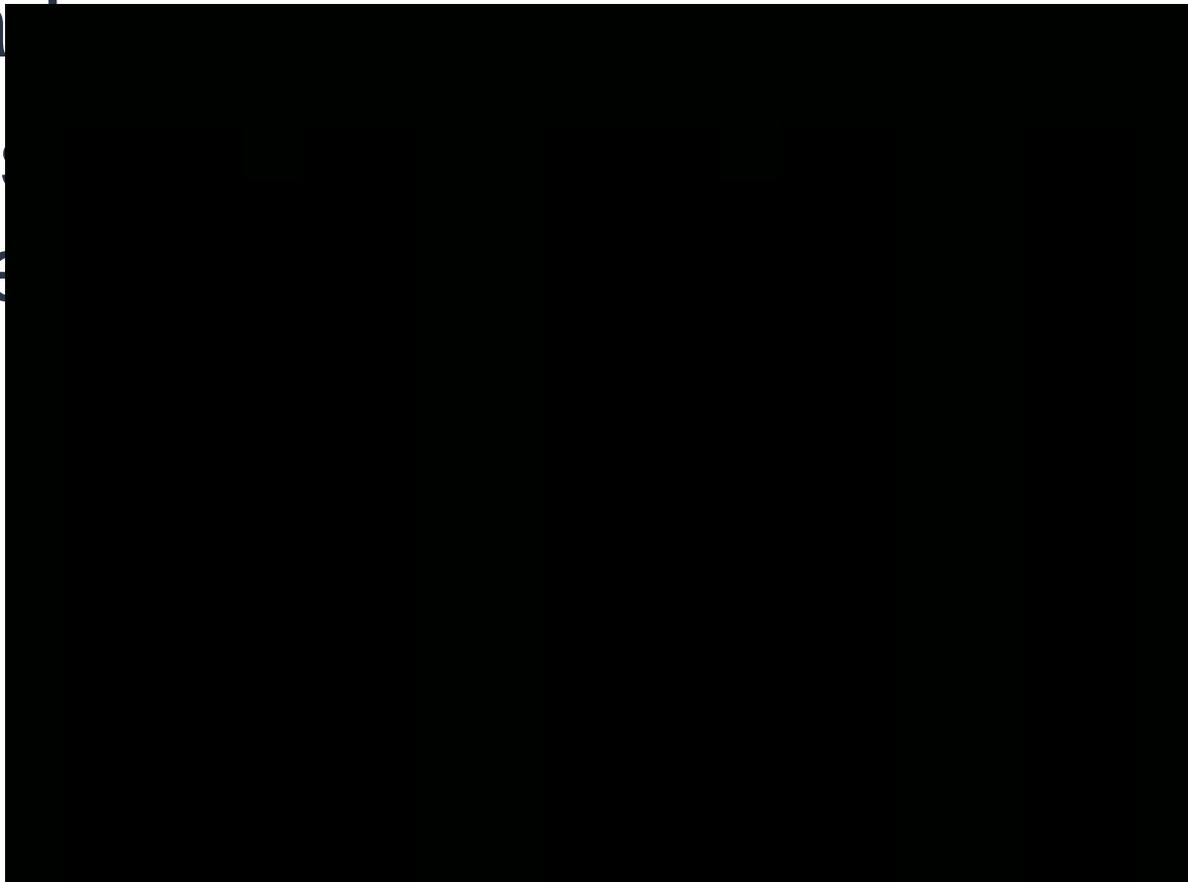


- Low amount of \$ to create focus – 5 to 10K
- Straight/simple process to increase immunization rates, cancer screening
- Increase transparency, pride, able to influence goal

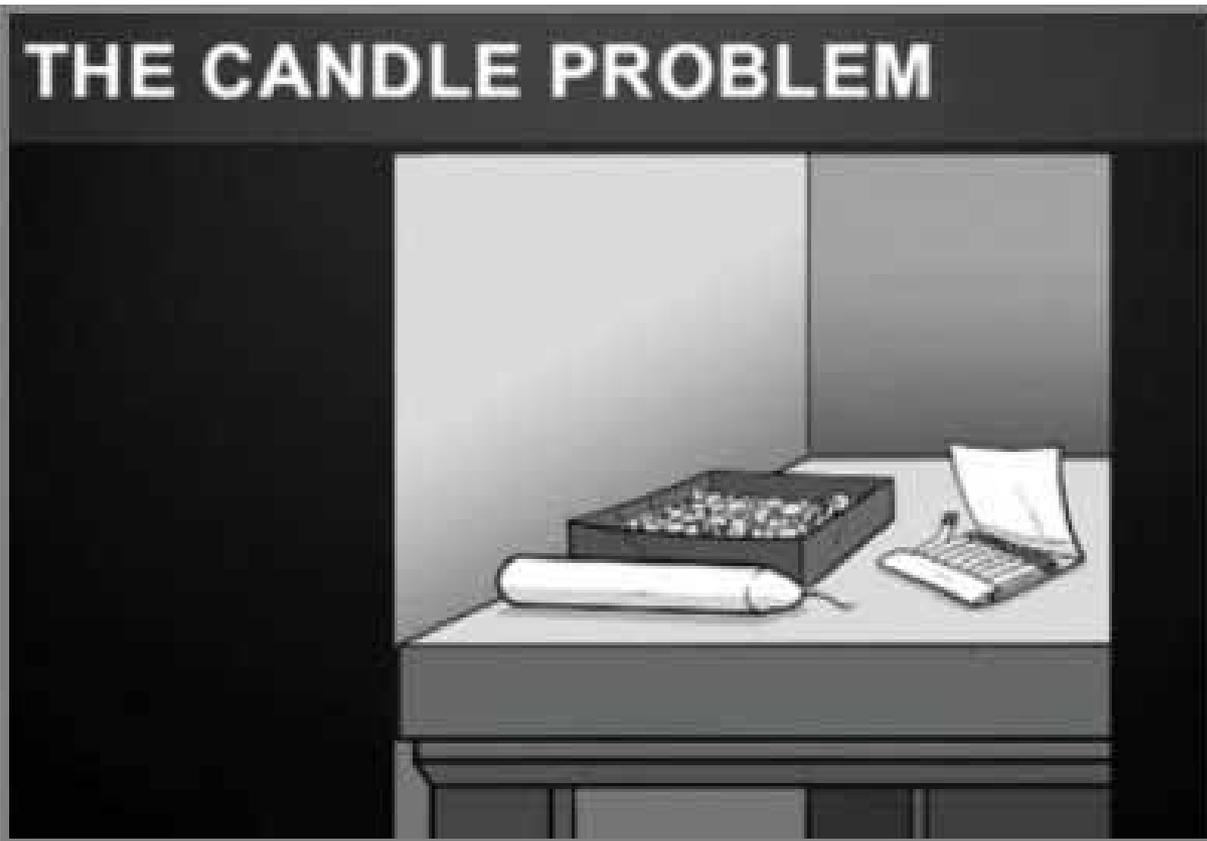
What else motivates?



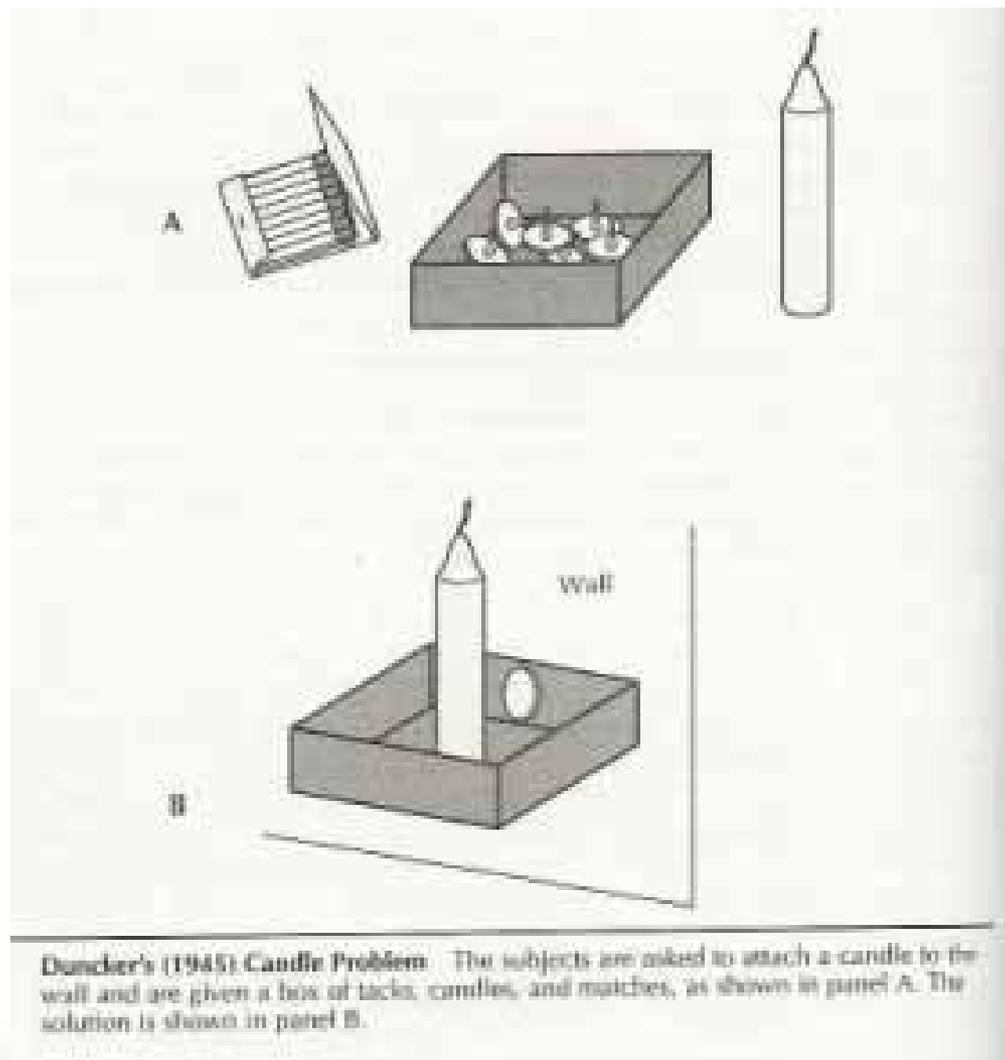
- The health
- The mission
contributes
- Pride



Motivating People – One Finding



Motivating People – One Finding



Motivating People – Summary of the Science



- What are the lessons?
 - Financial rewards are frequently counter productive
 - Intrinsic motivation is more powerful than extrinsic motivation
 - To maximum intrinsic motivation, focus on autonomy, mastery, purpose
- What should we do?
 - Pay people a fair amount
 - Use “if then” rewards only for simple mechanical activities (not creative ones)
 - Encourage peer to peer “now that” rewards – they must be a surprise
 - Focus on individual and team learning and mastery
 - Regularly emphasize the purpose of the organization
- References
 - Drive – The Surprising Truth About What Motivates Us – Daniel Pink (Also, see TED.COM (Dan Pink))
 - One More Time- How do you motivate People? – Frederick Herzberg (Harvard Business Review 2003)
 - The Three Signs of a Miserable Job: A Fable for Managers (And Their Employees) - Patrick Lencioni
 - Outliers – Malcolm Gladwell

Strengths and Weaknesses of P4P: In the context of the science of motivation



- Strength –
 - Provides tangible evidence to all concerning “what is important”
 - Proven success in improving HEDIS (civilian and military)
 - Can be applied across an entire enterprise
- Weakness
 - Only works for simple activities that do not require creativity
 - HEDIS and IMR vs. Satisfaction and Access
 - May reduce overall productivity
 - May result in unintended consequences
 - Focus on a few outcomes but, ignore other, more important ones
 - Linking activities to financial reward can remove other incentives (think of allowance and chores)

How Can We Use This Learning



- Next Week
 - Be skeptical of simple answers that are totally focused on financial incentives and “if then” rewards
 - Be reassured that what you learned in leadership training actually matters
 - Communication, increasing levels of responsibility, mission/purpose, teamwork
 - Use measures primarily for improvement, not for judgment
- Over the next several years, for those making policy
 - Move away from strict fee for service
 - Find a way to incentivize value creation (quadruple aim), but consider more than just financial incentives or “if then” approaches
 - Pilot test before going live across the MHS

Additional References on P4P in Medicine



- American Academy of Family Physicians. "Pay-for-Performance." <http://aafp.org/online/en/home/policy/policies/p/payforperformance.html>
- American Medical Association. "Guidelines for Pay-for-Performance Programs." <http://www.ama-assn.org/ama1/pub/upload/mm/368/guidelines4pay62705.pdf>.
- Doran, Tim, Catherine Fullwood, David Reeves, Hugh Gravelle, and Martin Roland. "Exclusion of Patients from Pay-for-Performance Targets by English Physicians." *The New England Journal of Medicine* 359, no. 3 (17 July 2008): 274.
- Dudley, R. Adams, and Meredith B. Rosenthal. *Pay for Performance: A Decision Guide for Purchasers*. AHRQ Publication No. 06-0047. Rockville, MD: Agency for Healthcare Research and Quality, April 2006.
- Epstein, Arnold M., Thomas H. Lee, and Mary Beth Hamel. "Paying Physicians for High-Quality Care." *The New England Journal of Medicine* 350, no. 4 (22 January 2004): 406-410.
- Joint Commission on Accreditation of Healthcare Organizations. "Principles for the Construct of Pay-for-Performance Programs." <http://www.jointcommission.org/PublicPolicy/pay.htm>.
- *Rachel M. Werner and R. Adams Dudley: Making The 'Pay' Matter In Pay-For-Performance: Implications For Payment Strategies No one P4P payment type is best, and each offers different incentives for improving quality. HEALTH AFFAIRS ~ Volume 28, Number 5, 1498-1510*