Three Articles on Pay for Performance

Article 1: The Pitfalls of Linking Doctors’ Pay to Performance

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Not long ago, a colleague asked me for help in treating a patient with congestive heart failure who had just been transferred from another hospital.

When I looked over the medical chart, I noticed that the patient, in his early 60s, was receiving an intravenous antibiotic every day. No one seemed to know why. Apparently it had been started in the emergency room at the other hospital because doctors there thought he might have pneumonia.

But he did not appear to have pneumonia or any other infection. He had no fever. His white blood cell count was normal, and he wasn’t coughing up sputum. His chest X-ray did show a vague marking, but that was probably just fluid in the lungs from heart failure.

I ordered the antibiotic stopped — but not in time to prevent the patient from developing a severe diarrheal infection called C. difficile colitis, often caused by antibiotics. He became dehydrated. His temperature spiked to alarming levels. His white blood cell count almost tripled. In the end, with different antibiotics, the infection was brought under control, but not before the patient had spent almost two weeks in the hospital.

The case illustrates a problem all too common in hospitals today: patients receiving antibiotics without solid evidence of an infection. And part of the blame lies with a program meant to improve patient care.

The program is called pay for performance, P4P for short. Employers and insurers, including Medicare, have started about 100 such initiatives across the country. The general intent is to reward doctors for providing better care.

For example, doctors receive bonuses if they prescribe ACE inhibitor drugs to patients with congestive heart failure. Hospitals get bonuses if they administer antibiotics to pneumonia patients in a timely manner.

On the surface, this seems like a good idea: reward doctors and hospitals for quality, not just quantity. But even as it gains momentum, the initiative may be having untoward consequences.

To get an inkling of the potential problems, one simply has to look at another quality-improvement program: surgical report cards. In the early 1990s, report cards were issued on surgeons performing coronary bypasses. The idea was to improve the quality of cardiac surgery by pointing out deficiencies in hospitals and surgeons; those who did not measure up would be forced to improve.

But studies showed a very different result. A 2003 report by researchers at Northwestern and Stanford demonstrated there was a significant amount of “cherry-picking” of patients in states with mandatory report cards. In a survey in New York State, 63 percent of cardiac surgeons acknowledged that because of report cards, they were accepting only relatively healthy patients for heart bypass surgery. Fifty-nine percent of cardiologists said it had become harder to find a surgeon to operate on their most severely ill patients.
Whenever you try to legislate professional behavior, there are bound to be unintended consequences. With surgical report cards, surgeons’ numbers improved not only because of better performance but also because dying patients were not getting the operations they needed. Pay for performance is likely to have similar repercussions.

Consider the requirement from Medicare that antibiotics be administered to a pneumonia patient within six hours of arriving at the hospital. The trouble is that doctors often cannot diagnose pneumonia that quickly. You have to talk to and examine a patient and wait for blood tests, chest X-rays and so on.

Under P4P, there is pressure to treat even when the diagnosis isn’t firm, as was the case with my patient with heart failure. So more and more antibiotics are being used in emergency rooms today, despite all-too-evident dangers like antibiotic-resistant bacteria and antibiotic-associated infections.

I recently spoke with Dr. Charles Stimler, a senior health care quality consultant, about this problem. “We’re in a difficult situation,” he said. “We’re introducing these things without thinking, without looking at the consequences. Doctors who wrote care guidelines never expected them to become performance measures.”

And the guidelines could have a chilling effect. “What about hospitals that stray from the guidelines in an effort to do even better?” Dr. Stimler asked. “Should they be punished for trying to innovate? Will they have to take a hit financially until performance measures catch up with current research?”

The incentives for physicians raise problems too. Doctors are now being encouraged to voluntarily report to Medicare on 16 quality indicators, including prescribing aspirin and beta blocker drugs to patients who have suffered heart attacks and strict cholesterol and blood pressure control for diabetics. Those who perform well receive cash bonuses.

But what to do about complex patients with multiple medical problems? Forty-eight percent of Medicare beneficiaries over 65 have at least three chronic conditions. Twenty-one percent have five or more. P4P quality measures are focused on acute illness. It isn’t at all clear that they should be applied to elderly patients with multiple disorders who may have trouble keeping track of their medications.

With P4P doling out bonuses, many doctors have expressed concern that they will feel pressured to prescribe “mandated” drugs, even to elderly patients who may not benefit, and to cherry-pick patients who can comply with pay-for-performance measures.

And which doctor should be held responsible for meeting the quality guidelines? On average, Medicare patients see two primary-care physicians in any given year, and five specialists working in four practices. Care is widely dispersed, so it is difficult to assign responsibility to one doctor. If a doctor assumes responsibility for only a minority of her patients, then there is little financial incentive to participate in P4P. If she assumes too much responsibility, she may be unfairly blamed for any lapses in quality.

Nor is it clear that pay for performance will actually result in better care, because it may end up benefiting mainly those physicians who already meet the guidelines. If they can collect bonuses by maintaining the status quo, what is the incentive to improve?

Doctors have seldom been rewarded for excellence, at least not in any tangible way. In medical school, there were tests, board exams and lab practicals, but once you go into clinical practice, these traditional measures fall away. At first glance, pay for performance would seem to remedy
this problem. But first its deep flaws must be addressed before patient care is compromised in unexpected ways.

Research Note: Sandeep Jauhar, a cardiologist on Long Island, is the author of the memoir “Intern: A Doctor’s Initiation.”

**Article 2: Pay-for-Performance may Benefit Doctors Who Care for very Sick**

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Baylor College of Medicine
HOUSTON - (June 1, 2009) – Physicians who treat patients with multiple health problems will fare well under pay-for-performance, which bases physician reimbursement on the quality of care provided, said researchers at Baylor College of Medicine (www.bcm.edu) and the Michael E. DeBakey Veterans Affairs Medical Center in Houston (http://www.houston.va.gov/) in a report in the current issue of the journal *Circulation*.

When the researchers evaluated the high blood pressure treatment provided to patients who had other serious health condition, they found that such patients were more likely to receive high quality care than patients who had no co-existing health problems.

“Pay-for-performance raises a lot of fears and assumptions that the reimbursement will not be fair toward doctors who care for the sickest patients,” said Dr. Laura A. Petersen (http://www.hsrds.houston.med.va.gov/health-policy/petersenl.htm), the study’s lead author and director of the Houston VA Health Services Research and Development Center of Excellence and an associate professor of medicine at BCM. “What we found was that doctors do a good job of taking care of a lot of complex conditions, even better than they think they do.”

Petersen, who is also chief of Health Services Research at BCM, said the result surprised her.

“When a patient comes in with many problems, there is often less time to address any single one,” she said. She and her colleagues found, however, that physicians appear to identify the problems that present the most risk and deal with them effectively.

“This is good news and should be reassuring to doctors and health policy makers,” she said.

The research team chose to study high blood pressure because it is a common, symptomless problem that can have serious consequences, affecting the heart, brain and kidneys.

In their study, the researchers identified 141,609 patients with high blood pressure in a VA database. Of these 22,595 had no other serious health conditions; 70,098 had conditions that could be related to the high blood pressure (concordant), 12,283 other health conditions not related to high blood pressure (discordant) and 36,633 had both.

Blood pressure was controlled for 12,956 (57.3 percent) of patients with no other health conditions, 45,334 (64.7 percent) of those with concordant or related health conditions and 7,742 (63 percent) of those with other conditions not related to blood pressure. Of those with both concordant and discordant condition, 25,339 or 69.2 percent had blood pressure controlled.
The researchers noted that quality of care increased with the number of other conditions the patient had. In other words, the sicker the patient, the better the care, even after statistically controlling for the numbers of visits with a doctor.

"Our results should be reassuring for policy-makers who have faced criticism that performance measures, public reporting, and pay-for-performance initiatives may penalize health care providers of patients with multiple co-existing chronic conditions," they wrote.

Research Note:
Others who took part in this research include Drs. LeChauncy D. Woodard, Louise M. Henderson and Kenneth Pietz and Tracy H. Urech, all at the Houston Center for Quality of Care and Utilization Studies, a Health Services Research and Development Center of Excellence at the Michael E. DeBakey Veterans Affairs Medical Center and the Section for Health Services Research at BCM.
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This paper will be available at http://circ.ahajournals.org/
For more information on research at Baylor College of Medicine, please go to www.bcm.edu/fromthelab and www.bcm.edu/findings.

Article 3: Pay-for-Performance Doesn’t Always Pay Off

Martha Lagace
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Working Knowledge Paper
available at: http://hbswk.hbs.edu/item/3424.html

Executive Summary:

Paying your employees more for hitting specific targets may backfire, according to Harvard Business School (HBS) professor Michael Beer. As he learned in his study of thirteen pay-for-performance plans at Hewlett-Packard, the unspoken contract may make or break these programs.

What better way to drive people to work harder and more efficiently, you may ask, than to offer them a special carrot: more money for hitting specific company targets? The idea seems perfect. Managers want their employees to pull out the stops on Project X, for example. Employees, confident of their ability to reach if not surpass the goals, start banking on the extra money.

In practice, however, the process of connecting pay to performance may be far trickier that it at first appears, according to HBS professor Michael Beer.

As he discovered when he examined programs in pay-for-performance that were discontinued at Hewlett-Packard, these programs may indeed have an upside—but there is a potential downside lurking, too. The HP experience was eye-opening as well as sobering. Thirteen separate units of the company—at different types of sites, in different states—launched pay-for-performance plans in the early 1990s. Within three years, all had dropped them.
In a recent talk to HBS faculty and in two working papers, which he co-authored with Nancy Katz and Mark D. Cannon, respectively, Beer explained why implementing these pay schemes can be so complicated. Clearly, there has been an increase in pay-for-performance all over the United States and increasingly all over the world, he said. But his conclusions on the rocky process of conception, design, and implementation may benefit managers who like the idea but who want to avoid the same miscalculations that HP experienced.

An ideal laboratory

In the early 90s, Hewlett-Packard seemed a perfect setting for innovations in pay. A so-called "built-to-last" company, it was highly decentralized and enjoyed a sense of mutual trust, high commitment, and wide use of management by objectives. The workforce was salaried and the merit system was based on peer comparisons at the salaried level. There were no executive bonuses. Stock options were awarded as recognition. But there was also a lot of pressure in the company, said Beer. Managers of thirteen units took the initiative of appealing to headquarters to try something new to spur on their employees.

According to Beer, managers in many companies look to pay-for-performance for good reasons. They expect that it will attract and motivate people. They expect performance standards will outweigh the costs of whatever incentives they put in place. They also want protection against business exigencies: should the market go south, they don't want to be permanently stuck with new costs.

The vast majority of employees, in general, also want pay-for-performance, Beer said. While they may not think their current pay system is unfair, they do think pay-for-performance is an opportunity to make it more fair. They think they can outperform whatever pay they get; they usually assume they will benefit in terms of higher pay.

In his working paper co-authored with Mark D. Cannon of Vanderbilt University, Promise and Peril in Implementing Pay-for-Performance: A Report on Thirteen Natural Experiments, Beer also outlined the controversies surrounding traditional pay versus pay-for-performance. Some scholars assert that pay becomes an entitlement, and an employee's pay is based on her level and not her actual performance. Others, including HBS professor Teresa M. Amabile, contend that pay-for-performance can cast a pall over self-esteem, teamwork, and creativity, Beer and Cannon wrote.

I think there is an implicit negotiation going on between what management wants and expects, and what employees want and expect.
—HBS professor Michael Beer

"Other scholars have argued that the real problem is that incentives work too well. Specifically, they motivate employees to focus excessively on doing what they need to do to gain rewards, sometimes at the expense of doing other things that would help the organization," Beer and Cannon continued.

"I think there is an implicit negotiation going on between what management wants and expects," observed Beer in his talk to HBS faculty. This implicit negotiation is "embedded" in the context of pay-for-performance, but often goes undisputed and unacknowledged, he suggested. Misunderstandings about goals are the result. Pay-for-performance may also have a natural life cycle that managers are unaware of, he said.

Problems in San Diego

One HP unit that threw the matter into relief was HP's San Diego site. The experiment in pay-for-performance began naturally enough, driven by a transition to self-managed teams in production.
Managers launched a program of team goals coupled with team-based pay with three possible levels of reward. Managers reckoned that 90 percent of teams could reach Level 1, 50 percent could reach Level 2, and 10-15 percent Level 3.

For the first six months, everyone loved the new system. The majority of teams hit Levels 2 and 3. And, said Beer, because the payout was greater than expected, management adjusted the goals upward. Then the complaints began.

The teams were frustrated that factors out of their control, such as the delivery of parts, affected their work. The high-performance teams often refused to admit people whom they thought to be below their level of expertise, leading to disparities among the teams. There was reduced mobility between teams, preventing the transfer of learning across teams. Employees built their lifestyles around the higher level of pay, and were angry when they could not achieve it consistently.

Managers for their part felt they were spending too much time reengineering the pay system. They concluded that it did not motivate employees to work harder or, perhaps more importantly, to learn. It was also hard to maintain consistency of pay across the larger site. Managers also grappled with the question of sustaining pay-for-performance over time.

There were clear short-term benefits but also clear longer-run costs, Beer suggested, including the cost of constant redesign and negotiation of the system. Other HP units ran into similar difficulties.

As he and Cannon wrote in their paper, "The most striking finding from these pay-for-performance experiments is the size of the gap between managers’ expectations of benefits and the reality that they experienced in terms of costs."

Going forward

Were the results due to unique circumstances at HP? The answer is yes and no, Beer and Cannon wrote. "HP's culture is one that historically placed more emphasis on management that builds commitment rather than on monetary incentives. Clearly they would be more prone to abandon programs that threatened trust and commitment." Similar programs at low-commitment companies might have succeeded where HP failed.

Financial rewards in a fast-changing business environment could undermine a company's ability to build trust and commitment unless management and employees have an honest discussion of their mutual expectations, they added. This is "very difficult to do."

Going forward, Beer suggested that managers recognize pay-for-performance not just in instrumental terms—as a carrot, perhaps—but as a larger exercise in fairness and justice within the organization. "Do not proceed until both sides understand what they are getting into."