

Rewarding Improvement: Unintended Consequences of Pay-for-Performance

Jeffrey C. Bauer, PhD

The juxtaposition of this issue's two themes, process improvement and project management, makes perfect sense. Healthcare delivery does not change without purposeful planning, organizing, and implementing.

Decades of experience suggest the process of improving medical services must be managed if it is to happen at all. Left to their own devices, delivery systems and clinicians will perpetuate the traditional way of doing things, even when strong evidence suggests a different approach would produce lower costs or better quality.

We should not be surprised other industries are increasing the pressure on providers to improve healthcare. By the end of the 1990s, executives from many of the nation's largest corporations and public agencies had concluded they were wasting billions of dollars each year on a dysfunctional medical care delivery system. They believed the beneficiaries of their health plans were receiving uneven care and poor value.

Specifically, studies published by the Institute of Medicine convinced corporate and government leaders tens of thousands of deaths occur each year as the result of preventable

“Getting Health Care Right’ requires substantial investments in IT infrastructure for delivery systems and uncompensated time for practitioners who need to learn how to use the new tools and processes.”

errors. They formed The Leapfrog Group in 2000 as a sign of their serious intent to impose performance improvement on hospitals and physicians. The Leapfrog Group's slogan bluntly challenges providers to start managing for quality: “Informing Choices. Rewarding Excellence. Getting Health Care Right.”

Incentives for Managing Improvement

Other influential organizations, bearing familiar acronyms like NCQI,

IHI, AHRQ, and CMS, joined The Leapfrog Group in programs “to put their money where their mouth is.” Recognizing project management would not single-handedly improve the quality of healthcare, they decided to pay more money to healthcare organizations that adopted processes associated with better outcomes. The resulting policy is called pay-for-performance, or P4P.

In economic terms, P4P is a subsidy for the extra costs of performance improvement. “Getting Health Care Right” requires substantial investments in IT infrastructure for delivery systems and uncompensated time for practitioners who need to learn how to use the new tools and processes. Providers and practitioners who make the necessary investments in process improvement will generally lose money under the existing dysfunctional payment system. According to the theory and practice of P4P, a supplement in performance-based reimbursement covers providers' additional costs of quality in money and time.

The initial results of P4P are promising. Lives are being saved by process improvement programs that

THE H.I.I.T. FUTURIST

get the right medicines to more patients at appropriate times; get more diabetics tested for indicators that lead to better treatment that leads to lower incidence of long-term complications; get more pregnant women into programs that prevent birth complications; and achieve other benefits for the healthcare system.

P4P's approach aims to reverse the disincentives of the current healthcare system, which is prone to be inefficient and provide poor service. That's because a patient's current insurer is unlikely to benefit from prevention of medical problems that otherwise would be charged to some future payor. So the current disincentives continue to exist, even though significant amounts of disability and death could be reduced by increasing the emphasis on primary prevention of disease and prevention of complications.

The Other Side of the Coin

In light of gains already associated with process improvement projects, how could anyone raise questions about P4P? Indeed, it has attained a certain cachet of political correctness. Casting doubt on its value as a powerful force of health reform is likely to be seen as heresy.

However, three areas of concern suggest the need for critical thinking about unintended consequences. IT professionals need to understand these potential problems and to participate in efforts to minimize them.

First, a single-minded focus on payment-enhancing performance runs the risk of standardizing medical care in ways that are detrimental to some patients. For example, hospitals qualify for P4P by increasing the number of heart attack patients who promptly get an aspirin. However,

aspirin causes serious problems for some people. A timely aspirin for all patients with acute coronary problems may appear like world-class performance, but it likely causes more harm than good for at least a few patients. Performance improvement programs must be flexible, recognizing non-compliance is the best medicine for patients who cannot tolerate standardized treatment.

Second, the selection of best practices that merit P4P is based on peer-reviewed research literature. (Medical research is currently experiencing serious economic and ethical crises, but that's another story.) The "gold standard" of medical research is the randomized controlled trial in which everything except the experimental effect is held constant. This requirement suggests the most appropriate medical care for patients who have the single condition for which a study is controlled, but it can be problematic when a patient has two or more conditions. For example, P4P may reward a specific response to a patient's diabetes, but the intervention can be harmful if it interacts adversely with therapy for the patient's bipolar disorder. Editorials in leading medical journals now are raising legitimate questions about conflicts between best practices for patients with multiple morbidities.

Third, care not qualifying for standards-based P4P is implicitly substandard. How much longer will corporate leaders and government officials be willing to pay anything at all for care that does not meet standards of best practice? Large corporations in The Leapfrog Group already specify the quality of materials and services they buy from their suppliers. They do not continue to purchase inputs that fail to provide expected value—healthcare IT profes-

JOURNAL OF HEALTHCARE INFORMATION MANAGEMENT

Richard D. Lang, EdD, Editor in Chief
Fran Perveiler, Vice President, Communications
Nancy Vitucci, Manager, Publications
Cari McLean, Coordinator, Communications

2006 HIMSS BOARD OF DIRECTORS

CHAIR George T. Hickman, CPHIMS, FHIMSS
Senior Vice President and Chief Information Officer
Albany Medical Center

VICE CHAIR Marion J. Ball, EdD, FCHIME, FHIMSS
Fellow, IBM Global Leadership Initiative
Center for Healthcare Management
Professor, Johns Hopkins School of Nursing

CHAIR ELECT John Wade, FCHIME, FHIMSS
Vice President/Chief Information Officer
Saint Luke's Health System

VICE CHAIR ELECT Victoria Bradley, RN,
CPHIMS, FHIMSS
Director of Patient Information
University of Kentucky Chandler Medical Center
University of Kentucky

Margret Amatayakul, RHIA, CHPS, FHIMSS
President
Margaret A. Consulting, LLC

Barry Chaiken, MD, MPH, FHIMSS
Associate Chief Medical Officer
BearingPoint, Inc.

Charles E. Christian, CIO, FCHIME, FHIMSS
Director, Information Systems/
Chief Information Officer
Good Samaritan Hospital

Ray Gensinger Jr., MD, CPHIMS, FHIMSS
Deputy Medical Director
Hennepin County Medical Center

John Hansmann, CPHIMS, FHIMSS
Regional Manager, Management Engineering
Intermountain Health Care

Liz Johnson, FHIMSS
Vice President, Clinical Informatics
Tenet Healthcare Corporation

Karen J. Ondo, FHIMSS
Executive Vice President, Business Solutions
KLAS Enterprises &
Principal Computer Systems Associates

Jay Srinivasan
Vice President, Emerging Technologies
University of Pittsburgh Medical Center

T H E H . I . T . F U T U R I S T

sionals do the same thing when they refuse to pay vendors that do not meet service level agreements. To add insult to injury, the plaintiff's bar is likely to start arguing healthcare not qualifying for P4P is evidence of medical malpractice.

Finally, the narrow focus on a few quality indicators may not really improve care at all, but only game the payment system. It's similar to the hazard that occurs when teachers focus efforts to improve performance on standardized tests—those efforts only may get in the way of students who might achieve real academic excellence.

For all these reasons, the growth of P4P potentially leads to its own disappearance. Corporate and government purchasers ultimately will shift from paying a little extra for demonstrably better care to not paying at all for

“How much longer will corporate leaders and government officials be willing to pay anything at all for care that does not meet standards of best practice?”

medical services that fail to live up to standards. Policymakers have crafted consumer-directed health plans to reinforce this trend.

The ongoing success of P4P also will intensify political support for the proposition healthcare reimbursement should reflect the true value of

medical care. Healthcare IT professionals will be drawn into this debate because they create and manage the data that will be used to decide who is paid in the future. They need to help their managerial and clinical colleagues realize P4P ultimately means all care needs to be good. The alternative is potentially no payment at all, as P4P moves from being the exception to being the rule.

About the Author

Jeffrey C. Bauer, PhD, a nationally recognized medical economist and health futurist, is a partner in the management consulting practice of ACS Healthcare Solutions, Dearborn, Michigan. See www.jeffbauerphd.com or contact him at jeff.bauer@acs-hcs.com.

Errata

The Winter 2006 issue of the *Journal of Healthcare Information Management* featured an article titled “Data Interchange Standards in Healthcare IT— Computable Semantic Interoperability: Now Possible but Still Difficult. Do We Really Need a Better Mousetrap?” by Charles N. Mead, MD, MSc.

On page 75, the article mistakenly noted that Health Level Seven (HL7) Version 3 does not allow top-down message definition. Version 3 does in fact allow use of a top-down methodology for defining each data interchange structure using only RIM elements bound to domain-specific values, i.e. a methodology in which optionality (e.g. HL7 V2 Z-segments) is not allowed.

The JHIM apologizes for the error.