



PURPOSE VS. PAYMENT: MOTIVATING CHANGE IN HEALTH CARE

2013 ABIM Foundation Forum

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A distinguished group of leaders from across the health care sector gathered at the **ABIM Foundation Forum** in August to consider a fundamental question facing anyone looking to improve our health care system: what motivates physicians and other clinicians to change how they practice? The question was framed in a dichotomous manner for participants, as a choice between intrinsic motivation—in which physicians improve in order to realize their own standards of professionalism and achieve their desire to become better doctors—and extrinsic motivation, in which improvement is driven primarily through a desire to gain financial rewards and/or avoid financial penalties.

Through their discussions over three days in plenary sessions, small groups and outside the formal meeting, the participants—including those who deliver care, those who pay for it and those who receive it—came to a consensus that motivation is far too complicated to attribute to any single factor or even set of factors. Armed with this understanding, they worked to create a roadmap for how systems, payers, physician organizations, standard-setting organizations and patients and their families can best motivate change to improve the quality of health care and to effectively steward the limited resources available.

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SETTING THE STAGE

The conference began with sessions designed to explore and provoke discussion about motivation. American Board of Internal Medicine and ABIM Foundation President and CEO Richard J. Baron, MD and ABIM Foundation Chair Donald E. Wesson, MD engaged in a dialogue about motivation at the meeting's outset, discussing achievements in their careers that had not been motivated by financial rewards, while also noting that a certain level of resources are necessary to practice medicine effectively and that the provision of those resources may be difficult to disentangle from financial incentives and rewards.

The Kimball Lecture, the Forum keynote address that honors former ABIM and ABIM Foundation President and CEO Harry Kimball, MD, was delivered by Ezekiel Emanuel, MD, PhD, Chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania. Dr. Emanuel offered two fundamental and conflicting precepts. First, our health care system—on which we spend approximately the entire gross domestic product of France—must change significantly to avoid a financial catastrophe for the nation and its people, and physicians are the only ones who can accomplish the needed changes. Second, physicians—like all people—are deeply resistant to change.

He also described two categories of problems the health system faces: (1) finding the motivation to change and (2) clearly defining the specific changes that should be implemented. Regarding the motivation to change, Dr. Emanuel discussed a few key aspects of human behavior that any effort to achieve systemic change must consider. First, information alone will not lead to change. In a phrase repeated many times over the ensuing days, he said that people need to hear something seven times before the information sinks in, and even then it may not motivate us to act. Second, people are highly social beings who care deeply about how they rank compared to their peers.

Third, we are poor decision-makers, easily paralyzed by having too many options. Fourth, we are highly loss averse, overvaluing what we have and undervaluing what we might gain from change. And fifth, mental energy is an expendable resource—the more we use it, the less we have in reserve.

Dr. Emanuel then applied these behavioral economics principles to physicians, suggesting the following practical steps for health systems, payers and other key stakeholders:

- Produce and distribute more reports comparing physicians to their peers to take advantage of doctors' competitiveness;
- Make it easier to do the right thing: structure care protocols with built-in nudges and defaults, from which real effort is required to deviate;
- Structure payment incentives to emphasize loss aversion, penalizing for failure to meet defined goals rather than rewarding for compliance;
- Showcase incremental improvements, recognizing the importance of even small victories;
- Prioritize physician buy-in and leadership in quality and cost control efforts;
- Emphasize management training in medical education; and,
- Guide physicians through needed transitions, such as through consultants who can provide step-by-step assistance and stories of relevant successful improvement efforts.

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Finally, he argued that all of these principles should be marshaled toward reaching a concrete and bold goal: by 2020, lower the growth rate of the health care sector to GDP plus zero percent, and for individual practices, lower the growth rate of the total cost of care per risk-adjusted patient to zero.

Following Dr. Emanuel’s remarks, there was considerable dialogue about whether his focus on reducing cost was overlooking the need to improve quality. He argued that the steps we need to take to reduce cost will also improve quality, while others contended that a focus on quality independent of cost was still deeply needed. Harvey Fineberg, MD, President of the Institute of Medicine, suggested that we need to focus on cost and quality “separately and together,” and not assume either will follow the other.

Also on the first day, the participants learned about transformation in another industry through remarks from an adviser to IBM’s president who was previously a top human resources executive and major purchaser of health care. He discussed IBM’s transformation from its beleaguered and endangered status in the early 1990s to a revitalized company. He also discussed the value of a crisis in focusing decision-making and enabling difficult transformations, and added that health care surely faces its own crisis now. Among other pieces of advice, he cautioned against “automating a mess,” instead stressing the necessity of fixing the underlying processes.

In his closing remarks, Dr. Fineberg built on the IBM executive’s comments about the health care crisis by arguing that although we have been talking about a crisis for half a century, we are now in “a near death experience.”

MOTIVATION IN PRACTICE

Craig Samitt, MD, President and Chief Executive Officer at Wisconsin’s Dean Clinic (Dean) at the time of his talk, discussed how Dean, one of the Midwest’s largest integrated health systems, motivated its physicians to improve care. He described how Dean had “had its foot in two canoes,” with 50 percent of its revenue coming through its own health plan (where Dean benefited from providing better care at a lower cost) and the other 50 percent coming through Medicare and private insurers, which paid for care on a fee-for-service basis (where Dean benefited from providing a higher volume of care). The system faced a choice between value and volume, and chose to pursue value—an undertaking that required significant physician persuasion.

Dr. Samitt described broad initial resistance among Dean’s physicians to the concept that a system could combine the highest quality and the lowest cost, or be the best for both patients and physicians. To help overcome this resistance, he stressed a vision that creates significant organizational pride and tapped into physicians’ intrinsic desire to be a highly qualified doctor – to be “the best.” He emphasized the importance of involving physicians as leaders in the process of improvement rather than simply dictating changes to them. Dean engaged physicians in LEAN improvement events, asking them to work as part of teams to solve problems.

Dean also relied heavily on transparency to advance change. For example, Dean showed its physicians unblinded data that revealed all of their practice patterns, as a form of peer pressure to encourage them to follow evidence-based practice. This was successful, as variation within the system decreased significantly. Physicians were also ranked by their patient satisfaction scores and the data was posted on Dean’s intranet site, thereby making information about specialists available to primary care physicians.

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Dean has now crossed the next frontier, launching the transition to compensating physicians based on their achievement of the Triple Aim. The system is seeking to create a “balanced scorecard” of incentives to avoid unintended consequences by compensating physicians on a range of factors, including improving patient experience (including quality), improving the health of populations and reducing cost. For example, payment for specialists will be linked to patient satisfaction measures, and primary care reimbursement could be linked in the future to appropriate referrals to specialists whose performance will now be available to them.

While Dr. Samitt described the incentives he implemented in a single system, Meredith Rosenthal, PhD, a professor of health economics and policy at Harvard, and a leading researcher on incentives in health care, shed light on what we know about how extrinsic motivators like public reporting and pay-for-performance (P4P) have fared across the health sector. At the outset, she described the appeal of these kinds of incentives for policymakers, who face a highly complex health care system and are eager to find levers to pull that will foster improvement.

Despite their surface appeal, Dr. Rosenthal said there is very little evidence that the P4P programs that have been launched thus far in the United States—such as Medicare’s nonpayment for hospital infections or its hospital P4P demonstration program—or the United Kingdom have had more than a modest impact. She considered reasons why these programs might not have achieved their desired impact, including project design that may have led to simply paying for the status quo, incentives that were too minimal to promote behavioral change, or incentivizing outcomes that providers simply do not know how to achieve. She also suggested that both political and market constraints influence the design of incentives and may render them less effective than they could be.

For public reporting, she said that the evidence of success is mixed to negative. There is little evidence to suggest that public reporting helps consumers, either because the information is delivered the wrong way or because patients don’t receive the data at the right time. On the provider side, hospitals whose performance was reported publicly did engage in more quality improvement activities, although there is no evidence that those particular activities were successful.

Overall, Dr. Rosenthal said despite the somewhat thin current evidence base, theory and field experience have led her to conclude that there should be a role for financial incentives in the health care system, but an incentives-based solution alone will not be sufficient to transform care. She characterized the evidence about P4P by saying that “all [its] problematic features are well-identified and hard to deny, but it’s not clear the alternatives are any better.” By contrast, efforts to incentivize physicians and systems by affecting consumer demand—such as through public reporting—are much more speculative.

In his remarks bringing the day to a close, Mark Smith, MD, President and Chief Executive Officer of the California HealthCare Foundation, suggested a tension between the remarks of Drs. Samitt and Rosenthal. While Dr. Rosenthal described the thin evidence linking incentives to changed behavior, Dr. Samitt presented a health system in which actors responded quickly and meaningfully to changed incentives. To reconcile their presentations, he suggested that we may have not given incentives sufficient time to work or that many of the incentive programs that have been instituted are too weak to deliver results. He also proposed that we likely overrate the importance of financial incentives and underrate incentives related to improved quality of life for physicians. For example, a change that results in relieving doctors of some of their after-hours paperwork and gets them home for dinner with their family could have a significant impact.



Dr. Smith concluded with his optimistic take on the challenges the health system faces, suggesting that the creation of a system that provides better, safer and cheaper care is within sight. The old debates about whether physicians should operate based on protocols, and whether their performance should be measured and reported, have largely been resolved. Now we are debating how these goals can best be accomplished, and although the issues raised in that debate are far from trivial, the main hurdle has been overcome.

FIXING THE SYSTEM

On the Forum's final day, Maureen Bisognano, President and Chief Executive Officer of the Institute for Healthcare Improvement, spoke about how we can build effective structures to provide the best care at the lowest cost while also restoring joy in the practice of medicine for physicians and other clinicians. She shared stories of patients, including the difficulties faced by a patient whose wheelchair had a flat tire. While the patient's physician commendably dedicated significant time and effort in responding to the patient's individual problem, ultimately prescribing a spare tire, Bisognano called for a health care system that focused on solving the problem for all patients using wheelchairs. She said this required a change in what we value in clinicians (i.e., innovation) and how we train them—to reward the development of systemic solutions rather than an exclusive focus on the problems of the patient in front of them. She suggested that this system-level focus would also increase physicians' job satisfaction by allowing them to feel they were making a greater difference and ultimately allow for a better work-life balance, although some participants questioned whether systemic responsibilities would instead impose an unwanted burden.

Participant Recommendations

This goal of achieving systemic change was mirrored by participant activities during the Forum. First, participants spent significant portions of the meeting's first two days divided into five groups, each working to propose ways to improve the health system by focusing on specific system actors (i.e., government and private payers, professional standard-setting organizations, physician organizations, integrated health systems and group practices, and patients and families). Some of the most intriguing of their recommendations included:

- Move to global payment to accelerate accountability and optimize resource allocation.
- Provide price transparency at the point of service, including information about physician ownership of ancillary services.
- Continuously disclose Triple Aim performance scores, with peer comparisons, at all levels of aggregation, including individual clinicians.
- Develop national transformation resources through a public/private partnership (like the regional extension centers) that reaches out to practices, including smaller organizations with fewer resources.
- Incorporate stewardship knowledge, skills and attitudes into residency review criteria as well as professional Certification and Maintenance of Certification products and activities.
- Use ABMS Maintenance of Certification as a primary tool to educate physicians without prior quality improvement experience.

- Medical societies and other physician organizations should play a more active role in developing and disseminating improvement tools and bringing them to the point of care to assist physicians in meeting the imperative to deliver better value.
- Every delivery system should have an organizational charter that defines appropriate behaviors and their relationship to population health.
- Create a national or regional trusted resource that provides patients with specific strategies that enable them to be activated and engaged in achieving the Triple Aim.
- Encourage specialty societies and journals to include patients in their meetings and on their boards.

Many participants were enthusiastic about the first of these recommendations, with Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC), suggesting that global payment offered transformative potential to improve professionalism. The existing fee-for-service system, he said, “creates rigidities in the system that impede the free flow of resources based on clinical judgment.” This would be eliminated by the adoption of a global payment system that would free physicians to provide the best care for their patients within the overall resource constraint established by global payment, unrestricted by the rigid rules of fee-for-service payment. Looked at in this way, global payment establishes a framework for implementing *Medical Professionalism in the New Millennium: A Physician Charter*, with clinicians caring for individual patients while also assuming responsibilities as stewards of funds for a defined population.

TACKLING SPECIFIC PROBLEMS

The second activity designed to engage participants in pursuing systemic change occurred on the Forum’s last day, when participants organized themselves into eight groups designed to address particular problems facing the health system. Some potential initiatives, which teams are currently working to advance, are described below:

- **Social Determinants of Health and the Role of Physicians in Addressing Them**

This group will seek to advance the recognition by physicians and physicians-in-training of the importance of social factors that influence health and the need for physicians to play a role in addressing them. Strategies include promoting the inclusion of information about social factors affecting health in patients’ electronic health records and integrating instruction about health disparities and advocacy in medical education.

- **People-Driven Health Care**

This group will look to promote better patient engagement in health care through the development of marketing materials, engaging patients through social media and promoting the creation of a patient engagement practice assessment for physicians that includes a menu of strategies to engage patients.



- **Quick Response Teams to Address Federal Rules**

This group will seek to create an organized group that can review and comment on federal rules from the perspective of physicians who are interested in promoting evidence-based coverage decisions by federal agencies.

- **Medical Education**

This group will articulate the vision of the idealized physician, and the ideal care and learning systems that are necessary to achieve that vision. Among other things, the group will consider how to harmonize efforts of professional organizations focusing on elements of high-value care, and how to engage students, residents and recent graduates in creating a rating system for high-value learning and care environments similar to the “conflict of interest scorecard” pioneered by the American Medical Students Association.

- **Organizational Professionalism**

This group promoted the creation of a charter that would define the professional responsibilities of health care organizations such as hospitals and health systems, recommending that the ABIM Foundation lead the effort.

CONCLUSIONS AND NEXT STEPS

The case for change was perhaps made most effectively near the meeting’s end by David Johnson, MD, Chairman of the Department of Internal Medicine at the University of Texas Southwestern Medical Center, Chair of the American Board of Internal Medicine Board of Directors and member of the ABIM Foundation Board of Trustees. Dr. Johnson addressed the group not in his official capacity, but as the parent of an adult child with significant health problems. He said that despite his credentials, it is “virtually impossible to get the care my daughter needs” and that the health care system will be fixed when he can take his daughter to the front door of her clinic and not have to walk every step of the way with her to ensure she gets the care she needs.

David Blumenthal, MD, President of the Commonwealth Fund, followed with concluding thoughts. He said that one clear conclusion from the Forum was that we “need not and should not choose between intrinsic motivation and external reward.” Both are critical for motivating and guiding change, but neither is sufficient in an environment where human behavior, organizations, human biology, measurement and public policy are all so complicated. He pointed to the need for greater efforts to understand how behavioral economics applies to providers, for health systems to do a better job of supporting professionalism, and for the system to find a way to truly engage consumers—an area where he believes we have made little headway. He called upon participants to remember that successful change strategies will almost always be multi-modal, involving culture, leadership, vision, recruiting, training and other factors.

With these thoughts in mind, participants left the Forum energized to use all levers at their disposal to motivate change in their own institutions. We hope that all participants benefited from the discussions at the Forum and will play an active role in improving the health care system in the coming year.

ABIM FOUNDATION MISSION STATEMENT

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