

# **Attitudes on Incentives Survey Tool: Overview of a Validated Measurement Instrument & a Wisconsin Case Study**

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# **Thumbnail of our agenda today**

- Overview of The Alliance
- The Alliance's work to date in pay-for-performance
- Boston University's development of a survey instrument to access provider attitudes
- Boston University's national experience with the survey
- The Alliance's use of the instrument
- The Alliance's lessons learned from the survey & what it plans to do with those lessons

# The Alliance profile

- An employer-owned and directed, not-for-profit cooperative
- Incorporated in the spring of 1990 by seven founding employers
- Currently represents 158 large to mid-size employers providing health benefits to 83,000
- 43 hospitals, 4,300+ physicians and ancillary providers
- Catalyst for system reform by driving increased awareness & access to affordable, high quality health care through public reporting, consumerism & purchasing

*“Helping employers manage the total cost of ensuring the health and well-being of their workforces”*

# **Overview of our work in value based purchasing: Public reporting**

- **Outpatient Public Reporting**
  - Beginning in 1997
    - Focused on consumer satisfaction survey results
- **Inpatient Public Reporting**
  - Beginning in 2001
    - Reporting quality (outcome measures)
    - Research on our public report published by Judith Hibbard, PhD, evidenced that such reporting improved quality  
*[HealthAffairs '03, '05]*
  - Beginning in 2006
    - Reporting quality (outcomes & process) & “cost” (severity adjusted repriced amounts via 3M™APR DRGs)

# **Overview of our work in value based purchasing: Quality based purchasing**

- **Inpatient Pilot**
  - Beginning in 2004
    - Measures: Mortality, complications, Leapfrog CPOE & ICU
    - Incentive: Incremental increase to FFS payments based on:
      - Quality (target & improvement)
      - Severity adjusted cost
  
- **Outpatient Pilot**
  - beginning in 2005
    - Measures: Diabetes process & outcome measures
    - Incentive: Incremental increase to FFS payments based on:
      - Quality improvement

## Why evaluate our P4P work?

- The direction from our employer members is to use incentives in a pilot to both:
  - Simply pay higher performing organizations more
  - Provide a financial incentive to improve performance
- Thus, need a plan to evaluate whether the incentive is resulting in improvement
  - If yes, great. If not, identify where & how to revise it before rolling it out further

## **How to evaluate our P4P work?**

### **The hypothesis & 2 tests of the hypothesis**

- The hypothesis:
  - Financial incentives will result in an improvement in the quality of care in the areas subject to the incentive at a faster pace than when a financial incentive is not used

# **1<sup>st</sup> test of hypothesis: Measure performance pre & post invention**

- Gauge if improvement is greater for entities exposed to the incentive compared to others in our network

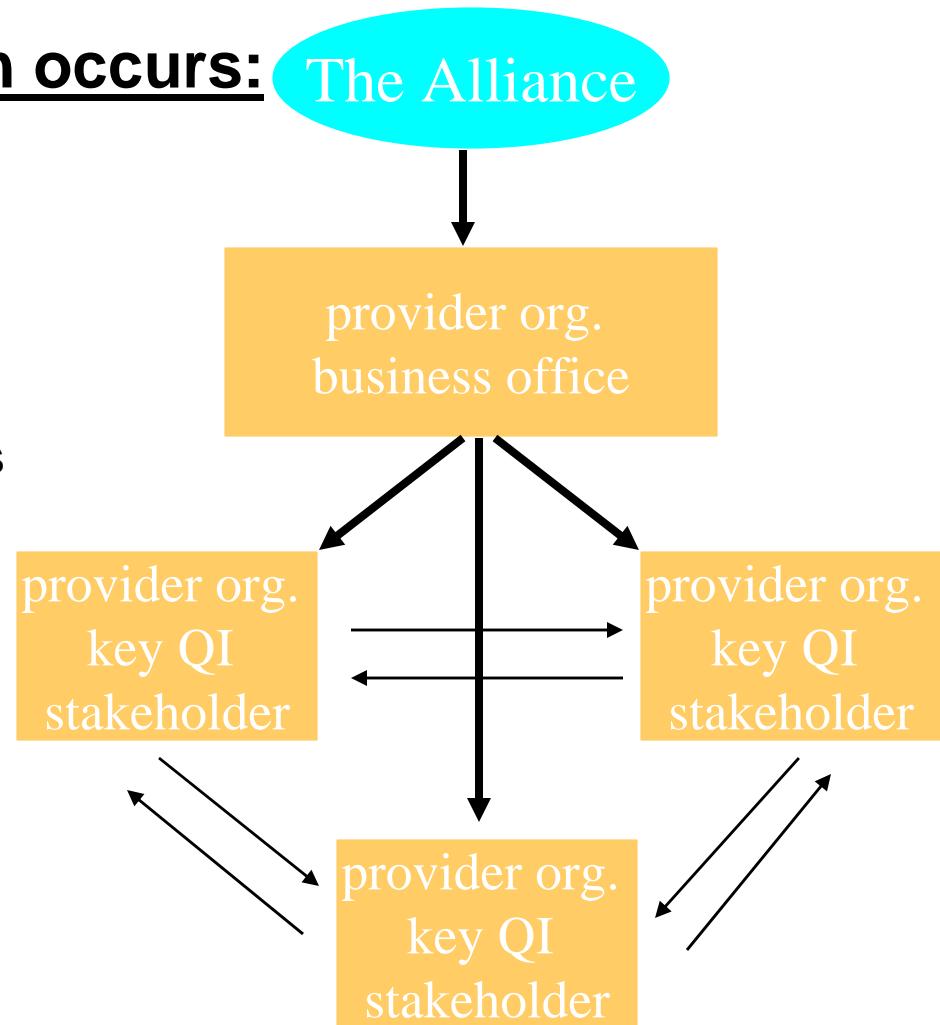
Several challenges with this test of the hypothesis:

- Several years of trending the data needs to occur
  - Plus, add the lag time in receiving & analyzing the data
- Piloting with a small set of organizations in the pilot phase makes it difficult to draw conclusions
- Even if it appears P4P pilot organizations are making improvement at a greater clip than others, it's difficult to attribute the change to the incentive
- All said, years will likely pass with inconclusive findings
  - However, during this time you need to figure out how to improve upon your P4P pilot or expand it "as is"

## 2<sup>nd</sup> test of hypothesis: Gauging the causal chain

**The following causal chain occurs:**

- Provider entity business office is motivated to make improvements in the areas incented
- The incentives & areas incented are communicated to key QI stakeholders in the organization
- Key QI stakeholders are interested & motivated to make improvements in the areas incented
- Action is taken to improve care in the areas incented



# **Enter the survey instrument developed by Boston University**

- Having just sketched out a plan to evaluate our pilots, we asked ourselves:
  - *How will we get at this causal chain?*
- Then the lightning rod moment:
  - In an AHRQ hosted webinar Boston University presented on a new survey tool . . .

# **Pay-for-Performance Program Evaluation**

**Bert White, DMin, MBA  
Boston University  
Health Policy and Management Department  
School of Public Health**

**Presentation for IHA Pay for Performance Summit**

**February 16, 2007**

**Financial support from Agency for Healthcare Research and Quality;  
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# Rewarding Results National Evaluation Team

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3 VA Center for Organization, Leadership, and Management Research

Meterko M, Young GJ, White B, et al. Provider attitudes toward pay-for-performance programs: development and validation of a measurement instrument. Health Serv Res 2006;41(5):1959-78.

## **National focus on bridging the quality chasm from IOM**

- Patients receive evidence-based care only 55% (McGlynn, NEJM 2003)
- Unwarranted variation is a ubiquitous feature of U.S. health care (Wennberg Health Aff 2004)
- P4P key component for transformation of healthcare payment system (Rewarding Provider Performance -- Aligning Incentives in Medicare IOM 2006)

# Rewarding Results responds to IOM's Crossing the Quality Chasm

- Rewarding Results Demonstration Projects
  - Robert Wood Johnson Foundation
  - California HealthCare Foundation
  - Commonwealth Fund
- National Evaluation Team (NET) Boston University
  - Agency for Healthcare Research and Quality
  - Robert Wood Johnson Foundation

# REWARDING RESULTS

DEMONSTRATION SITES	UNIT OF ACCOUNTABILITY	PRIMARY GEOGRAPHIC REGION
Blue Cross Blue Shield of Michigan	Hospitals	MI
Blue Cross of California	Individual physicians	San Francisco Bay area
Bridges to Excellence	Individual physicians & Group practices	Cincinnati, OH Louisville, KY Boston, MA Albany, NY
Excellus/Rochester Individual Practice Association (RIPA)	Individual physicians	Rochester, NY
Pay for Performance – Integrated Healthcare Association	Group practices	CA
Local Initiative Rewarding Results – Center for Health Care Strategies	Individual physicians & Group practices	CA
Massachusetts Health Quality Partners	Group practices	MA

# **Provider attitudes toward P4P: Qualitative interviews with contracting entities**

- Telephone interviews with group practice executives (63 practices)

<b>Setting</b>	<b># Group practice executives</b>
<b>Massachusetts</b>	<b>26</b>
<b>California</b>	<b>37</b>
<b>TOTAL</b>	<b>63</b>

# **Instrument developed to assess provider attitudes on incentives for quality**

- Extensive literature review and expert comments
- Conceptual framework
- Questionnaire developed and field tested
  - Pilot tested
  - 2,497 primary care physicians
  - Derivation and validation random samples
  - Exploratory factor analysis
  - Multitrait analysis
- Seven attitudes demonstrated substantial convergent and discriminant validity

# Provider attitudes toward P4P: Survey

- Over 4,000 randomly selected physicians across 3 settings
- Response rates:

Setting	# Physicians	# Respondents	Response Rate
Massachusetts	1,750	554	32%
Rochester, NY	573	246	43%
California	1,819	689	38%
<b>TOTAL</b>	<b>4,142</b>	<b>1,489</b>	<b>36% overall</b>

# **Seven provider attitudes identified to measure key features of P4P programs using a valid and reliable 23-item survey**

- Awareness and understanding
- Financial salience
- Clinical relevance
- Control
- Cooperation
- No unintended consequences
- Impact

# Measuring key features and implications for P4P design and implementation

- Awareness and understanding of quality targets, criteria and distribution rules
- Salience incentive compared to costs in time and effort required
- Clinical relevance as evidence-based for actual patients

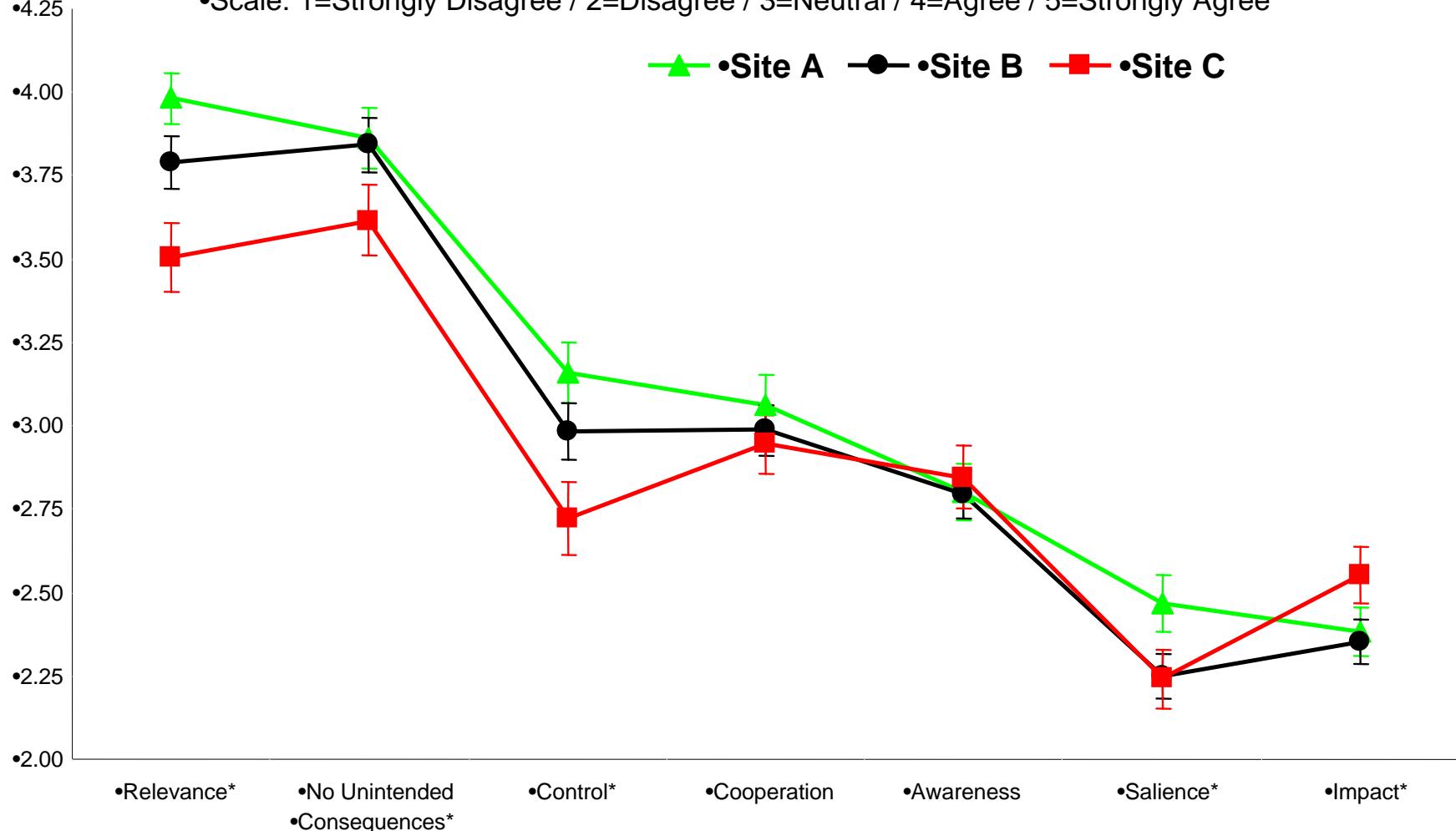
# Measuring key features and implications for P4P design and implementation

- Control over activities and resources required to achieve target from patient
- Cooperation of other program-required tests or services from professionals
- No unintended consequences that detract from otherwise important aspects of care

•Survey Results:  
•Physician Attitudes (n=1116) Toward A Specific Incentive Program

•Mean Score with 95% Confidence Interval

•Scale: 1=Strongly Disagree / 2=Disagree / 3=Neutral / 4=Agree / 5=Strongly Agree



# **Early lessons from the Rewarding Results demonstration projects**

- Clinical relevance about unintended consequences are not major barriers for P4P programs
- Examples
  - Evidence-based HEDIS and JCAHO measures
  - However, concern about number, rotation, and scope of measures
    - Too many
    - Inconsistent measurement requirements

# **Early lessons from the Rewarding Results demonstration projects**

- Awareness and understanding are low
- Examples
  - Bonus checks discarded
  - Physicians unaware of quality measures with no incentive benefit

# **Early lessons from Rewarding Results demonstration projects**

- Salience is low
- Examples
  - Costs incurred to attain incentive
  - Benefits from changes in provider behavior flow to other stakeholders in the healthcare system
  - Generally accepted ROI methodology needed
    - Full cost accounting
    - Multi-stakeholder share of cost and benefits

# **Early lessons learned by the National Evaluation Team**

- Measuring provider attitudes is important to designing, implementing and evaluating P4P initiatives
- Clinical relevance and unintended consequences not major barriers for P4P programs
- Awareness and understanding low
- Salience low
- Design and implementation challenges ahead

# The Alliance: Our reactions to the survey instrument

- 1<sup>st</sup> reaction to BU's presentation on the survey:
  - *This is a perfect fit as a key part of our evaluation!!*
- 2<sup>nd</sup> reaction:
  - *We'll need to tweak it to make it work at the medical group & hospital level*
- 3<sup>rd</sup> reaction:
  - *How can we steal this survey?!*

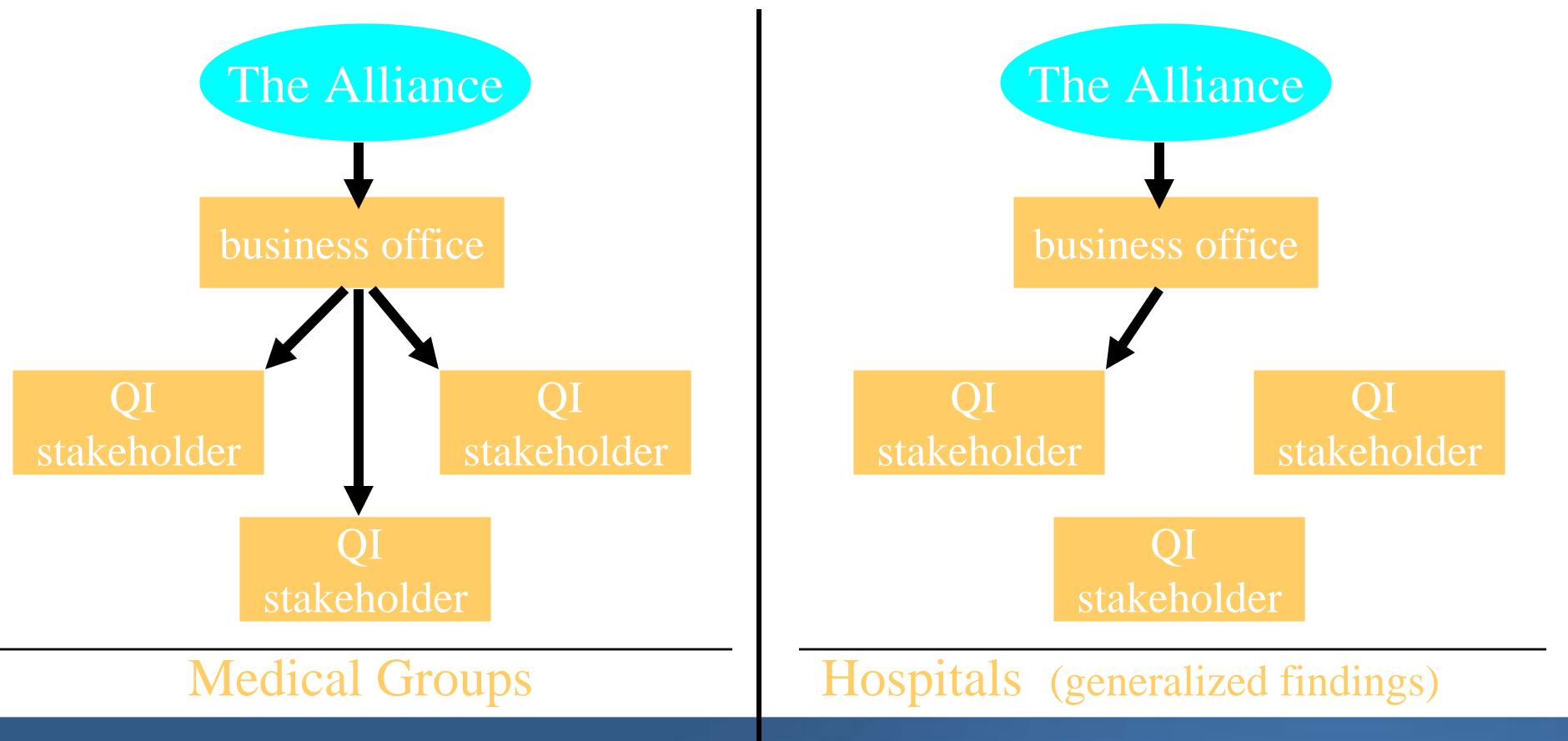
# Revising & implementing the survey

- Didn't need to steal it after all! Boston University was happy to allow us to use it.
- With the kind assistance of Boston University, adapted it for use with medical groups & hospitals
- Administered the survey via phone with an average of 4 survey respondents per hospital & medical group participating in our pilot:
  - Business office / contracting point person
  - Key administrative & clinical staff engaged in QI
- Periodic checking back with Boston University with technical questions in the implementation

## What did we learn?

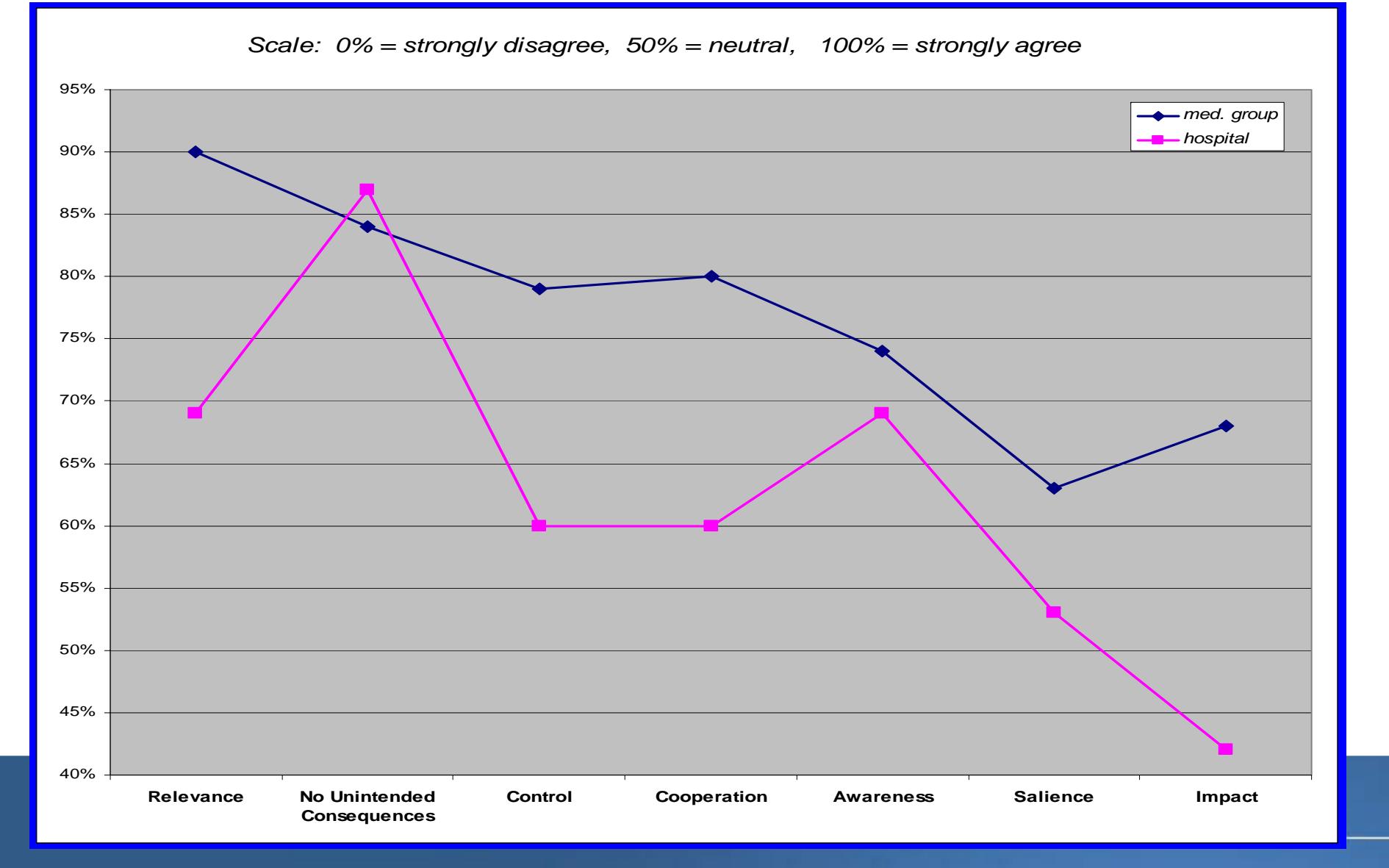
### Differences in progressing along causal chain

- Provider organization business office communicates the P4P arrangement to key QI stakeholders



# What we learned?

## Where to focus to increase the impact



# **What we learned & what we'll do with it: Increase awareness**

## **What we learned**

- Less awareness than we had desired of the P4P arrangement in the key QI stakeholders in provider organizations

## **What we'll do**

- Identify key QI stakeholders prior to putting P4P terms in place
- Gather input from key QI stakeholder on the credibility of the measures for use in P4P

# **What we learned & what we'll do with it: Increase awareness & cooperation**

## **What we learned**

- Hospitals report receiving less cooperation among clinicians in making quality improvements in comparison to medical groups
- Medical groups report physicians tend to be unaware of financial incentives that apply to the medical group

## **What we'll do**

- Communicate with physicians about the measures & the incentives regularly when they are in place
  - Identify a means to communicate with physicians in a manner that works for each provider organization

# **What we learned & what we'll do with it: No one silver bullet**

## **What we learned**

- A mixed response as to whether provider organizations see P4P as more effective than reputational incentives.
  - In other words, no one silver bullet in quality improvement.

## **What we'll do**

- Continue our work in public reporting as well as P4P

# **What we learned & what we'll do with it: Purchasers' role in quality improvement**

## **What we learned**

- Quality measurement & comparison is seen as an important piece in QI
- Interest in more frequent measurement

## **What we'll do**

- More deeply probe what provider organizations want that we may be able to provide to aid in their QI, e.g.:
  - More frequent results?
  - Deeper analysis of findings?

# **What we learned & what we'll do with it: Help articulate the business case**

## **What we learned**

- Hospitals & medical group question whether the business case is there (savings + incentive = cost of improvement)

## **What we'll do**

- Help evidence the provider organization's business case for improvement in areas measured, such as:
  - The incentive: \$X increase if performance is Y
  - Case studies re the cost of QI
  - The internal savings, for example:
    - Hospitals lose money on HF readmissions on the aggregate
    - Hospitals lose money on many hospital acquired infections

## The Alliance's next steps in P4P

- Select measures for use in both public reporting & P4P after gauging input from provider organizations
- Implement what we've learned from the survey instrument in our “version 2” P4P model
- Regularly analyze change in performance
- Regularly administer the survey, analyze & act on the findings

## In summary: Benefits of the survey

- We see where in the causal chain the flow of information on the P4P system is not occurring, which points to where to work on
- We understand – from various key stakeholders – the perceived impact the P4P program is having on performance
- We now know what aspects of the program need to be improved, which allows us to develop a better “version 2” P4P program
- A pleasant unintended consequence: We strengthen our provider relations by simply conducting the survey
  - Common comments from hospitals & medical groups:
    - *“I’m glad you asked me my opinion!”*
    - *“It’s clear you really want to do P4P the right way.”*