The Future of Pay for Performance and Value-based Payment

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WHO REALLY KNOWS?

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SOME HINTS

- Continued Payment Innovation Creep – Maybe some Consolidation
- Continued MACRA Rollout – But Maybe at a Slower Pace

THE ELEPHANT IN THE ROOM REMAINS – 18% GDP

WHAT REALLY MOTIVATES BEHAVIOR CHANGE?

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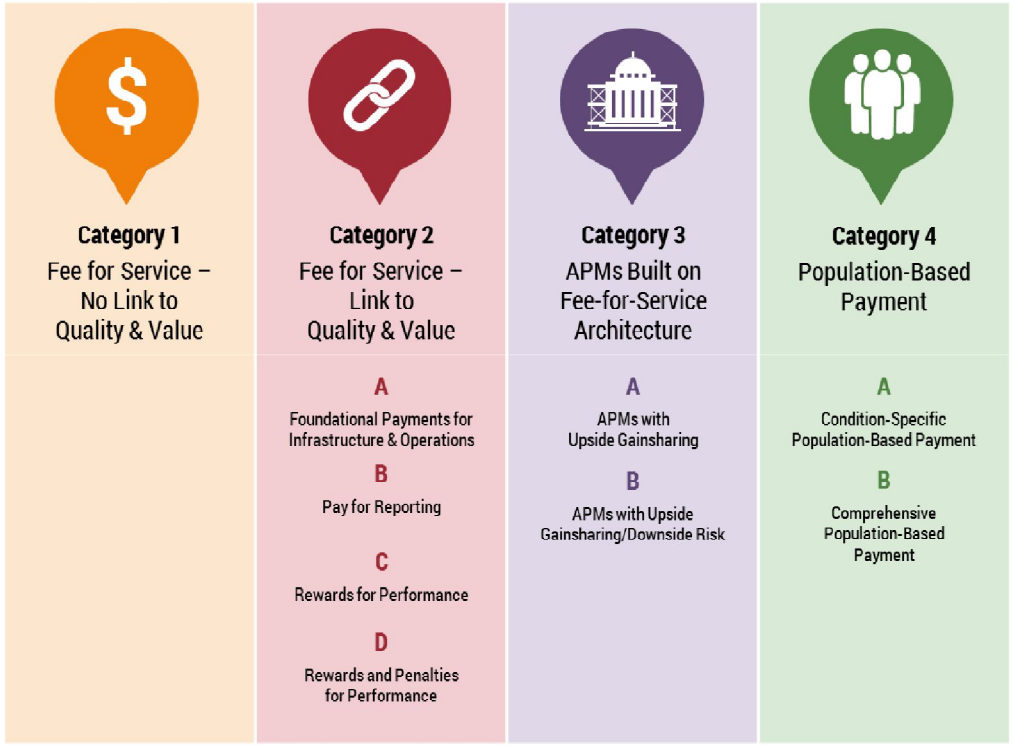
Figure 1. APM Framework (At-A-Glance)



Source: Health Care Payment Learning and Action Network - January 12, 2016

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U.S. Health Care Payments in APMs

Source: Health Care Payment Learning and Action Network - January 12, 2016

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Payment Innovation "Creep"

74 Different Models in Three Categories	
Research (4%)	Health Care Payment and Learning Action Network
Testing (59%)	Next GEN ACOs
Adoption (37%)	Integrated into Medicare – Hospital Value-Based Purchasing Program

Source: D. Muhlestein, N. Burton, and L. Winfield, "The Changing Payment Landscape of Current CMS Payment Models Foreshadows Future Plans" Health Affairs Blog – February 3, 2017.

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WHAT TO LOOK FOR?

- Expanded Population - Based Models that cut Across Silo's and Embrace the Continuum of Care - Post-Acute Care, Behavioral Health, etc.
- More Disease/Condition Specific Models – Oncology, Heart, ESRD, etc.
- Develop more Models that will Qualify to be APM Models
- Increase in Multi-Payer Initiatives at State Level – Maryland, Colorado, Vermont
- Some Potential Harmonization of Quality Measures
- Increasing Incorporation of Patient Reported Outcome Measures
- Incorporating Social Determinant Data into Risk-Adjustment so as not to Penalize those Serving more Vulnerable Populations

Source: D. Muhlestein, N. Burton, and L. Winfield, "The Changing Payment Landscape of Current CMS Payment Models Foreshadows Future Plans" Health Affairs Blog – February 3, 2017.

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A Multilevel Analysis of Patient Engagement and Patient-Reported Outcomes in Primary Care Practices of Accountable Care Organizations

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BACKGROUND: The growing movement toward more accountable care delivery and the increasing number of people with chronic illnesses underscores the need for primary care practices to engage patients in their own care.

OBJECTIVE: For adult primary care practices seeing patients with diabetes and/or cardiovascular disease, we examined the relationship between selected practice characteristics, patient engagement, and patient-reported outcomes of care.

DESIGN: Cross-sectional multilevel observational study of 16 randomly selected practices in two large accountable care organizations (ACOs).

PARTICIPANTS: Patients with diabetes and/or cardiovascular disease (CVD) who met study eligibility criteria ($n=4368$) and received care in 2014 were randomly selected to complete a patient activation and PRO survey (51% response rate; $n=2176$). Primary care team members of the 16 practices completed surveys that assessed practice culture, relational coordination, and teamwork (86% response rate; $n=411$).

MAIN MEASURES: Patient-reported outcomes included depression (PHQ-4), physical functioning (PROMIS SF12a), and social functioning (PROMIS SF8a), the Patient Assessment of Chronic Illness Care instrument (PACIC-11), and the Patient Activation Measure instrument (PAM-13). Patient-level covariates included patient age, gender, education, insurance coverage, limited English language proficiency, blood pressure, HbA1c, LDL-cholesterol, and disease comorbidity burden. For each of the 16 practices, patient-centered culture and the degree of relational coordination among team members were measured using a clinician and staff survey. The implementation of shared decision-making activities in each practice was assessed using an operational leader survey.

KEY RESULTS: Having a patient-centered culture was positively associated with fewer depression symptoms (odds ratio [OR] = 1.51; confidence interval [CI] 1.04, 2.19) and better physical function scores (OR = 1.85; CI 1.25, 2.73). Patient activation was positively associated with fewer depression symptoms (OR = 2.26; CI 1.79, 2.86), better physical health (OR = 2.56; CI 2.00, 3.27), and better social health functioning (OR = 4.12; CI 3.21, 5.29). Patient activation (PAM-13) mediated the positive association between patients' experience of chronic illness care and each of the three patient-reported outcome measures—fewer depression symptoms, better physical health, and better social health. Relational coordination and shared decision-making activities reported by practices were not significantly associated with higher patient-reported outcome scores.

CONCLUSIONS: Diabetic and CVD patients who received care from ACO-affiliated practices with more developed patient-centered cultures reported lower PHQ-4 depression symptom scores and better physical functioning. Diabetic and CVD patients who were more highly activated to participate in their care reported lower PHQ-4 scores and better physical and social outcomes of care.

KEY WORDS: patient engagement; patient-reported outcomes; accountable care organizations.
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INTRODUCTION

Forty-six million Americans have diagnosed cardiovascular disease (CVD), diabetes, or both, representing a combined annual healthcare cost of $354 billion.[1–3] It is increasingly recognized that greater efforts to engage patients in their care are needed to improve outcomes for these populations.[4–9] While there is a growing body of literature on patient engagement and patient-reported outcomes of care,[10–13] little is known about what practices can do to encourage greater patient engagement and how such engagement might be associated with better patient-reported outcomes of care.[14–16]

To address this gap in knowledge, we studied 16 primary care practices belonging to two large ACOs that implemented a variety of patient engagement initiatives for patients with cardiovascular disease (CVD), diabetes, or both. We

KEY QUESTION

Will Payment Reforms/Incentives Alone Drive Change?

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THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Original Investigation

More Than Money: Motivating Physician Behavior Change in Accountable Care Organizations

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Policy Points:

- For accountable care organizations (ACOs) to be successful they need to change the behavior of their physicians. To stimulate this change, a broad range of motivators are being used, including ways to see a greater impact on patients (social purpose) and opportunities to be a more effective physician (mastery), in addition to personal financial incentives.
- From our analysis of case studies, it does not appear that the full range of motivators is being deployed by ACOs, which suggests an opportunity to develop more sophisticated and wider-ranging portfolios of motivators for greater impact.

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A Hierarchy of Physician Multilevel Domains

- **Mastery** Being good and getting better at what you do
- **Autonomy and Power** Control over your work environment and to control the work of others
- **Relatedness** Belonging to a team or organization; contributing to shared goals
- **Social Purpose** Have a positive impact on patients and co-workers
- **Hygiene Factors** Reducing stress and anxiety; Improving work-life balance; Making work easier
- **Financial** Direct or associated financial rewards for performing tasks, or achieving performance targets

Source: Adapted from M. Phipps-Taylor and S.M. Shortell. "More than Money: Motivating Physician Behavior Change in ACOs" – Milbank Quarterly – December 2016; 826-837.

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Case Studies of Four ACOs

Mastery and **Social Purpose** were the most positively mentioned across all study sites. Financial motivation was third.

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Financial Motivators Used

- Small percent tied to quality metrics and “Citizenship” behaviors
- Bonuses tied to strategic change agenda – participation in training; collaborating with care coordinators. Based on panel size
- Shared savings distribution – Based on ACO panel size

Insufficient data to distribute it – Based on individual physician performance

“The Financial Returns for the most part are coming to the health system, but then these dollars are being re-invested into activities around patient care redesign”

Non-Financial Motivator Used

"I know we need to align the dollars, but I think there is a more powerful level, that is appealing to people's intrinsic interest contributing, being a part of something knowing they are making a difference"

Mastery and Social Purpose

- Transparency of Performance Data – Individual Physician level and Clinic level

"Physicians get to see what their colleagues are doing, so that is a stimulant for behavior change over and above the dollars"

…cont'd Non-Financial Motivator Used

Helped to Focus Improvement Efforts

- Comparable Quality Metrics Important
- Recognition – Lean process management daily huddles - "Celebrations are Every Day"
- Opportunities to learn in the job – specialists teaching primary care physicians
- Fear of Failure – "We can't Fail!" - "You can see the difference you are making in a patient's life"

Key is striking a balance between Financial and Non-Financial, using a portfolio approach

THREE BARRIERS

1. Lack of physician level performance data and poor timeliness
2. Lack of harmonization of quality measures across contracts
3. Tension between efforts to switch to population health while still being paid pre-dominantly on a Fee-for-Service basis

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So, What to do on Monday?

Continue to Invest in your
"Robust Properties"
Things that will always be at least
approximately correct **regardless**
of the unpredictability and
uncertainty of the environment

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Robust Property Candidates

- Figure out what gives Healthcare Providers and Patients shared meaning
- Information technology that provides actionable feedback to providers and patients on outcomes
- Team-Building
- Patient Engagement
- Resilient continuous improvement culture

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Thank You!

For more information see:

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Your Questions?

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