

VIEWPOINT

Professionalism, Performance, and the Future of Physician Incentives

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High costs, variable quality, and substantial waste in the US health care system have led governments, payers, and health care organizations to pursue physician accountability and quality improvement efforts aimed at producing higher-value care.¹

These efforts, such as Medicare's Value-Based Payment Modifier and many commercial performance-based payment programs, often use pay-for-performance (P4P) and other financial incentives. Overall, these programs have not been shown to consistently improve patient outcomes or reduce costs, and, in some cases, have distracted attention from other important areas of health care, such as improving patient experience and minimizing low-value care, and possibly exacerbated health disparities by penalizing physicians and health care organizations who care for more socially or medically complex patients.² Several factors have contributed to the failure of these performance improvement programs, but among them is an often unstated assumption that care is below expected performance levels because physicians are not sufficiently motivated or do not know how to improve care. This has spurred programs that are often inconsistent with physician professionalism and fail to harness what motivates most physicians: autonomy, mastery, and purpose.

Many physicians view programs in which they are paid for reaching narrow performance targets as manipulative, burdensome, and discordant with their professional identity.³ As the late health economist Uwe Reinhardt said, "The idea that everyone's professionalism and everyone's good will has to be bought with tips is bizarre."⁴ Of course, even before P4P incentives, professionalism alone was not enough to improve quality of care, and many patients have received and continue to receive too much, too little, or low-quality care because of a fragmented medical system, variable penetration of care-improvement processes, and fee-for-service incentives that encourage volume over value. But, the current iteration of P4P incentives has also not achieved a great deal and may be hindering progress.

Current performance improvement programs have several fundamental flaws. These programs have emphasized narrow financial incentives over broad nonfinancial rewards and relied on distant, centralized accountability instead of local culture and organizational responsibility. Future iterations of performance improvement programs should aim to capitalize on physician professionalism by emphasizing nonfinancial rewards, resources for quality improvement, team-based assessment, continuous learning, locally-determined targets, and organizational culture (Table).

First, most current programs use financial incentives to change physician and organizational behavior. However, evidence suggests that financial incentives may crowd out intrinsic motivation, particularly for the pro-

social behaviors and cognitively complex tasks that dominate physicians' work. Many aspects of what makes work satisfying for physicians, such as managing illness and restoring patients' health, solving diagnostic dilemmas, collaborating with colleagues, and teaching students, cannot be reduced to individual metrics. A more effective evaluation strategy is one that emphasizes professional recognition through awards or promotions and global assessments by supervisors and peers. The Cleveland Clinic, for example, uses detailed annual performance reviews during which physicians not only receive feedback, but can also raise concerns and discuss how the organization can improve. These rigorous reviews have been described as central to Cleveland Clinic's culture and its ability to consistently function as a high-performing health system.⁵

Second, current programs tend to focus on physician compensation, whereby the underlying assumption is that physicians need to be motivated to work harder. But, many health improvements result from better care processes and system-level investments. Future programs should focus on rigorously and regularly identifying the needs of patients and frontline physicians and providing resources for care improvement. For example, better long-term hemoglobin A_{1c} control for patients who are homeless or have mental health disorders is unlikely to be reflected in bonus payments to physicians. However, this outcome may result from more robust care management services and integration of behavioral health services. One promising effort, the Medicare Comprehensive Primary Care Plus Initiative, has helped participating practices transform care delivery by providing funds to support chronic disease management. Other areas of improvement often identified by clinicians include data analytics support, quality reporting infrastructure, and improvements in the electronic health record.⁶

Third, most current programs offer individual incentives, which may encourage competition and self-interest over collaboration and learning. Because medical care is increasingly delivered in teams, future programs should emphasize team-based rewards instead. For instance, until recently, endocrinologists at Geisinger Health System were rewarded for improved glucose levels in all patients with diabetes in their clinics, not just in patients they personally treated. This team-based reward system cultivates the shared purpose and collective engagement necessary for organizations to be effective, and, at Geisinger, resulted in marked improvements in hemoglobin A_{1c} levels in patients with diabetes.⁷ Some high-performing health systems, including Geisinger, have since moved away from narrow financial incentives altogether and rely on developed institutional culture to drive performance.

Fourth, many current programs emphasize management-driven design and evaluation, with relatively

Table. The Current vs Future State of Performance Improvement Efforts

Current State	Future State	Example
Financial rewards and penalties	Nonfinancial rewards, such as awards, recognition, and reviews	Detailed annual performance reviews at the Cleveland Clinic
Focus on physician compensation	Resources for quality improvement and care process investment	Medicare Comprehensive Primary Care Plus Initiative
Individual incentives	Team-based rewards	Department-based rewards in the endocrinology department at the Geisinger Health System
Management-driven design and evaluation	Continuous learning and locally determined targets	The "give a darn" method for identifying quality improvement measures at Providence St Joseph Health Practice Pattern Variation Analyses at Blue Cross Blue Shield of Massachusetts
Remote, faceless, centralized accountability	Local culture and organizational responsibility	The Leadership Saves Lives collaborative

little input from frontline physicians about the appropriateness of performance targets. Future programs should foster an environment of continuous learning by giving physicians timely feedback and soliciting locally determined targets to give them a greater say in the measures they feel accurately reflect high-quality care. For example, Providence St Joseph Health uses the "give a darn" method for selecting quality metrics, in which clinicians are asked to identify the quality measures they would feel most proud to be above average at, as well as the measures they think their patients care most about. If a measure is included in both groups, it is viewed as a worthwhile outcome. Blue Cross Blue Shield of Massachusetts (BCBS-MA) provides physician practices with periodic reports, known as Practice Pattern Variation Analyses, that describe how physicians within groups vary in their approach to similar patients. Why do some physicians prescribe angiotensin II receptor blockers twice as often as angiotensin-converting enzyme inhibitors while other physicians do the opposite? BCBS-MA does not mandate, or even recommend, changes to treatment, but rather provides information for group leaders to engage clinicians internally in a conversation about variation. This approach has been shown to reduce practice variation and overuse of certain medications and procedures.⁸

Fifth, current programs tend to be remote, impersonal, and centralized. Because these programs are disconnected from the needs of patients and physicians within organizations, they often result in erroneous metrics, gaming of the system, and unidirectional assessments that emphasize meeting thresholds over open dialogue. Future efforts should focus on strengthening organizational culture, which may be the most important determinant of how patients ultimately fare and how physicians use their time, energy, and attention. Organizations in which physicians are encouraged to identify problems, engage in care improvement processes, and discuss challenges with leadership are likely to have more robust and lasting quality improvements than those relying on narrow financial incentives.⁹ The Leadership Saves Lives collaborative, a 10-hospital initiative aimed at improving care through positive culture change, found that hospitals that successfully shifted organizational culture reduced 30-day mortality for patients with acute myocardial infarction.¹⁰

The transition from the current performance improvement environment to a future state more consistent with human motivation and medical professionalism is supported by theory and preliminary evidence. However, each of these models can and should be tested in rigorous experiments. For example, large integrated delivery systems could randomize their clinics to financial vs nonfinancial rewards; team-based vs individual assessments; or local vs centralized selection of performance targets. The Centers for Medicare & Medicaid Services and large commercial payers aiming to reduce readmissions for high-need, high-cost patients could randomize practices to receive bonus payments for individual physicians or broad funding for care management investments. Researchers could use qualitative and quantitative methods to understand how positive culture is created and maintained within provider organizations, and what effect culture change has on patient outcomes compared with traditional P4P programs. Randomizing cohorts of delivery systems to different models and evaluating the effects on physician performance and patient outcomes would create the evidence needed for policy change.

No single strategy for encouraging performance improvement is likely to be effective across organizations because of heterogeneity in their individual cultures and the attitudes of physicians in various specialties. But, a future state more aligned with human behavior, patient needs, and physician professionalism is possible. Getting there will require evidence-based research, leadership, and a commitment to act.

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