Designing payment incentives to improve performance: Implications for SBI

Constance Horgan, ScD

Plenary session: Brief Interventions on Alcohol and Other Drugs: Improving Health and the Quality of Health Services Provision

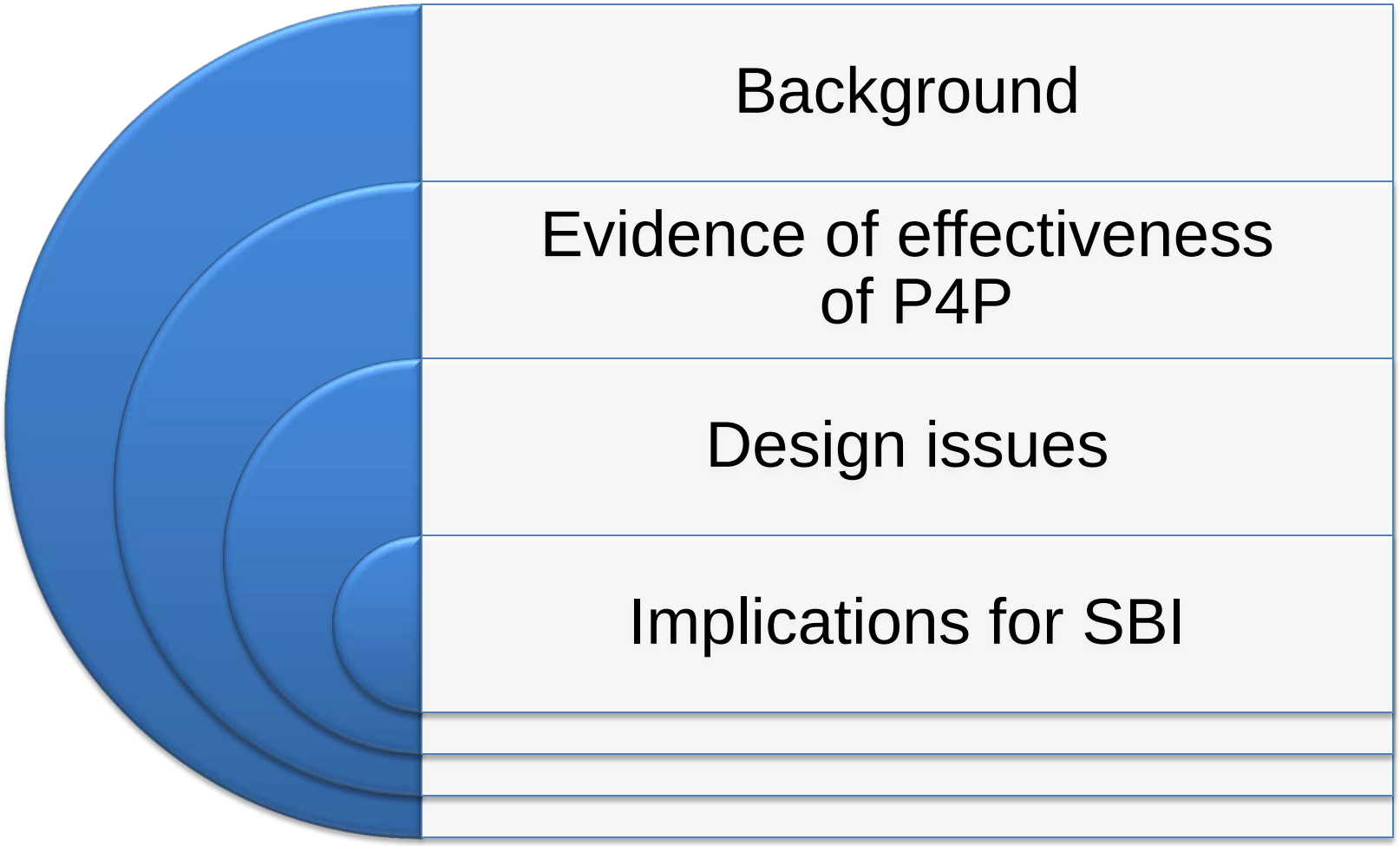
10th Annual Conference of INEBRIA

September 19, 2013

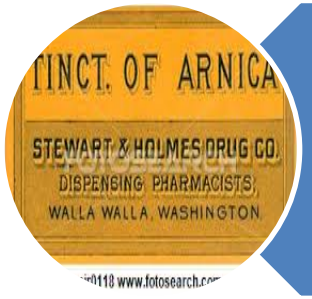
Institute for Behavioral Health
The Schneider Institutes for Health Policy

Brandeis University
The Heller School for Social Policy and Management

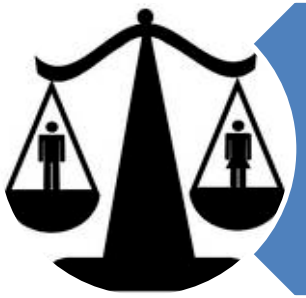
Today's Talk…


Background
Evidence of effectiveness of P4P
Design issues
Implications for SBI

Context of Pay-for-Performance (P4P)



Historically health care offers few financial rewards for performance regardless of quality or outcome (Robinson 2001)



High and low quality providers earn the same at the same volume levels, while in most other markets higher quality fetches a higher price

P4P or Results Based Financing (RBF) offer financial incentives to improve quality, care, access and efficiency

Current P4P Landscape

- P4P programs are used world-wide (e.g. Argentina, Australia, Brazil, Germany, Italy, Korea, Spain, UK, US, others)
- Sponsored by a range of purchasers (government agencies, health insurance plans, employers, healthcare providers, and others)
  - Operating in at least 19 OECD countries (OECD, 2010)
  - Across all payer types incentives are increasingly popular in health plans (Med-Vantage 2011)

    2006 - 10% all covered lives
    2008 - 11% all covered lives
    2010 - 55% all covered lives

- Address acute and chronic conditions
- Implemented in primary care, hospital, addiction treatment settings
- More recently adapting P4P programs into new delivery models in US, such as medical homes and accountable care organizations (ACOs)

P4P for preventive care in OECD Countries

Bonus for primary care physicians for preventive care
Australia
Czech republic
Italy
Japan
New Zealand
Poland
Portugal
Spain
Turkey
UK
US

No performance-related incentives for primary care providers for preventive care	
Austria	Korea
Belgium*	Luxembourg
Canada	Mexico
Denmark	Netherlands
Finland	Norway
France	Slovak Republic
Germany	Switzerland
Greece	
Hungary	
Iceland	
Ireland	

*Incentives for PCPs for chronic care only, not preventive care.
Source: Paris, et al. (2010) "Health Systems Institutional Characteristics: A Survey of 29 OECD Countries", OECD Health Working Papers, No. 50, OECD Publishing.

Evidence on Medical P4P – Reviews

- **Evidence of effectiveness is mixed and suggests some improvement in some contexts**
- **Van Herck (2010)**
  - Examined 128 studies from peer-reviewed empirical literature 2004-2009, **clinical effectiveness** ranged from no effect to very positive (more than 10% improvement)
  - Weak evidence suggesting P4P improves **equity** in 28 studies (none randomized)
- **Peterson et al (2006)**
  - examined 17 studies published through 2005
  - 7 of 9 studies of financial incentives at the provider level found partial or positive effects but effect sizes were small
  - 5 of 6 studies of financial incentives directed at the individual physician found partial or positive effects
  - 4 of 17 studies found evidence of gaming (e.g. excluding most severely ill)

Designing effective P4P programs

Measurement

- Choosing the measure
- Measure structure - unitary or composite
- Measurement population - targeted or universal

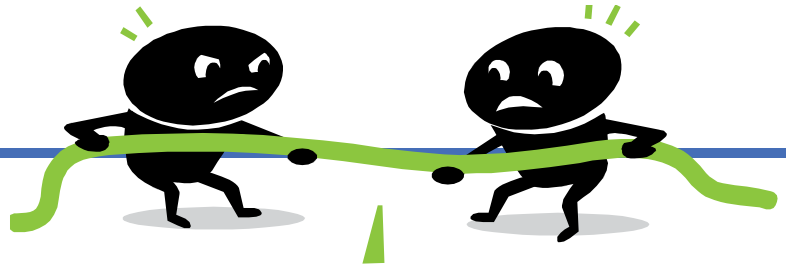
Payment

- Criteria
- Structure

Payment

Criteria for payment	Meet relative target (e.g. reward top x% of providers)
	Attainment - meet absolute target (e.g. x% of clients engaging in treatment)
	Improvement (e.g. pay providers who increase performance by x% above a minimum level)
Structure of payment	Level of payment
	Relative to cost of improvement
	Responsible unit to pay
	Market share of payer

Concerns with P4P



Improvement vs. Attainment
choice depends on your goals

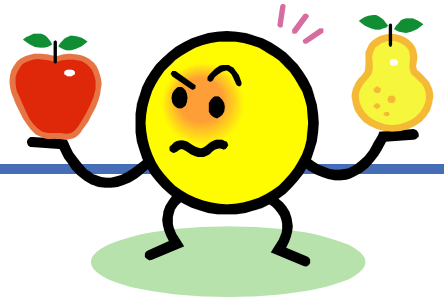
Gaming
where participants find ways to maximize measured results without accomplishing desired objective
(Rosenthal and Frank, 2006)

Multi-tasking
problem where compensation based on available measures will distort effort away from unmeasured objective
(Rosenthal and Frank, 2006)

Other unintended consequences, e.g. increased disparities
(Casalino et al, 2006)

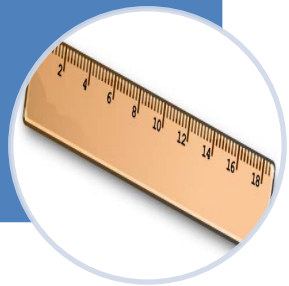
Professionalism
and engagement of providers
(Vonnegut, 2007)

Issues to Ponder for SBI



Measurement

- As more preventive care measures are developed key to include SBI
- Including SBI in composite or synthetic measures may be helpful
- Which aspect(s) of SBIRT should be incented? (Screening, brief intervention, and / or referral)



Payment

- Who should receive the incentive?
- What is the appropriate size of the payment to create motivation?
- How frequent should payouts be to reinforce preferred behavior?
- What is the effect of non-financial interventions, e.g. feedback, clinical reminders, peer comparison, public reporting, recognition programs?
- How does movement toward global payments impact P4P programs?

Summary

- **P4P initiatives growing rapidly in medical arena**
- **P4P just beginning for behavioral health screening**
- **Rigorous studies are few**
- **Evidence thus far is mixed**
  - Some null results
  - Modest improvements for some measures
  - Some unintended consequences

- **Still learning how to use P4P effectively – considerable promise and formidable challenges**

"Most of the things worth doing in the world had been declared impossible before they were done."

- *Louis Brandeis*

Acknowledgments

- **Support provided by:**
  - NIAAA R01 AA010869
  - NIDA R01 DA029316
  - NIDA P50 DA 010233
- **Brandeis colleagues:**
  - Mary Brolin
  - Candi Ramos
  - Maureen Stewart