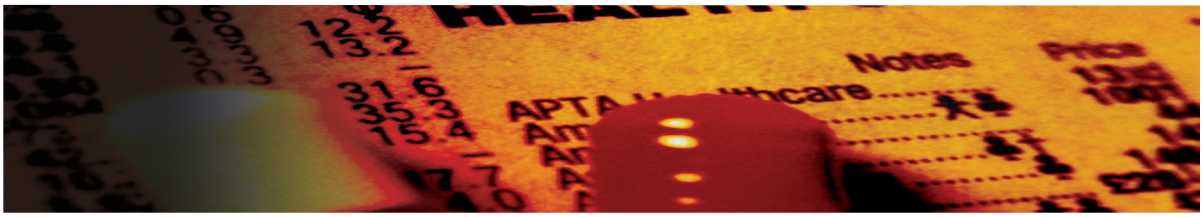
Vo.9 Issue 2



JUNE 2014

IN THIS ISSUE

The article "Effects of individual physician-level and practice-level financial incentives on hypertension care: a cluster randomized trial" by Laura Petersen, et al., appeared in the Sept. 11, 2013, issue of *the Journal of the American Medical Association*. Petersen is the director of the Center for Innovations in Quality, Effectiveness and Safety and associate chief of staff for research at the Michael E. DeBakey Veterans Affairs Medical Center. She is also a professor in the Department of Medicine and chief of the Section of Health Services Research at Baylor College of Medicine.

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RICE UNIVERSITY'S BAKER INSTITUTE

HEALTH POLICY research

Rice University's Baker Institute-Baylor College of Medicine
Joint Program in Health Policy Research

Can pay for performance improve physician practice?

Yes, according to a recently completed trial at 12 hospital-based primary care clinics in the Veterans Affairs (VA) Administration. The U.S. government has introduced pay for performance to all hospitals paid by Medicare, as part of the Affordable Care Act, and the New York City Health and Hospitals Corporation has announced a performance pay plan for physicians. These and other value-based purchasing systems are intended to align incentives to promote high-quality health care. However, evaluations of the effectiveness of pay-for-performance programs have shown contradictory results.

Laura A. Petersen, M.D., M.P.H., and colleagues conducted a randomized controlled trial to test the effect of explicit financial incentives to individual physicians and practice teams for the delivery of guideline-recommended care for hypertension. The examination at a dozen VA outpatient clinics showed that financial incentives to individual physicians — but not to practice teams or combined incentives — resulted in greater blood pressure control or appropriate response to uncontrolled blood pressure.

The trial enrolled 83 physicians and 42 nonphysician personnel (e.g., nurses and pharmacists). The interventions were physician-level (individual) incentives, practice-level incentives, both or none. Intervention participants received up to five payments every four months; all participants could access feedback reports. The primary measured outcomes were the number of patients achieving guideline-recommended blood pressure thresholds or receiving an appropriate response to uncontrolled blood pressure, the number of patients prescribed guideline-recommended medications, and the number who developed hypotension (abnormally low blood pressure).

The average total payment for physicians over the course of the study was $4,270 in the combined physician and practice-level group; $2,672 in the individual physician-level group; and $1,648 in the practice-level group. Physicians randomized to the individual incentive group were more likely than controls to improve their treatment of hypertension as measured by achievement of blood pressure control or appropriate response to uncontrolled blood pressure. The difference in change in proportion of patients achieving blood pressure control or receiving an appropriate response between the individual incentive and no incentive group was 8.36 percent. This means that a physician in the individual incentive group caring for 1,000 patients with hypertension would have about 84 additional patients achieving the outcome after one year. Although the use of guideline-recommended medication increased over the course of the study in the intervention groups, there was no change compared with controls. The effect of the intervention was not sustained after the incentive was withdrawn.

Far more intervention than control group participants viewed their feedback reports on the website (67 percent vs. 25 percent), suggesting that participants were aware of the relationship between performance and rewards. Although concerns about overtreatment have been cited in criticisms of pay-for-performance programs, there was no increase in the incidence of hypotension in the panels of physicians randomized to the incentive groups.

Taken together, the findings suggest that individual incentives can be part of an overall program for improving quality, even in a setting such as the VA, where baseline quality is high, and there is a culture of measurement, reporting and accountability.

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JAMA. 2013 Sep 11: 310(10): 1042-1050.

Ann Intern Med. 2006 Aug 15: 145(4):265-272.

HEALTH POLICY research presents a summary of findings on current health policy issues. It is provided by Vivian Ho, Ph.D., James A. Baker III Institute Chair in Health Economics at Rice University's Baker Institute, in collaboration with Laura Petersen, M.D., M.P.H., chief of the Section of Health Services Research in the Department of Medicine at Baylor College of Medicine.

This publication aims to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of Baylor College of Medicine.

The Baker Institute and Baylor College of Medicine's Section of Health Services Research work with scholars from across Rice University and Baylor College of Medicine to address issues of health care — access, financing, organization, delivery and outcomes. Special emphasis is given to issues of health care quality and cost.

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