

Why Compensation Tied to Group Quality Metrics Makes Sense

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ABSTRACT

Incorporation of group quality metrics into an adult primary care compensation track facilitates team-based care and accountability for shared groups of patients. This article describes the reasoning behind group quality metrics and shares lessons learned and improvements in health outcomes as a result. Take-away points are as follows: 1) group quality metrics in a compensation plan help foster team-based care toward quality goals and shared accountability for the health outcomes of attributed patients; 2) definition of the work team is important and should include members who share responsibility for the same groups of patients; 3) information technology infrastructure and dashboards for performance and feedback are critical to the success of a quality incentive program; 4) inclusion of key stakeholders early in the process of designing team-based incentives is important for acceptance; and 5) ongoing education is needed to ensure continued focus on quality goals.

INTRODUCTION

Most health care clinicians choose their careers to improve the health and well-being of patients, but financial compensation can affect career choice, and financial incentives can drive behavior.^{1,2} As health care systems are increasingly paid for improving quality and patient experience (fee-for-value) instead of volume (fee-for-service), these new goals should be represented in how providers are paid.

As our organization sought to redesign its clinician compensation plan, we underwent an analysis of how to incorporate quality metrics. Our previous compensation plan included a base salary with opportunity for incentive above a work relative value unit (wRVU) threshold. Those who were eligible for this incentive had 5% withheld for an individual quality incentive, which was returned if a composite goal was achieved. Each specialty had its own set of quality metrics: Some were operational, such as handwashing; others were health outcomes surrogate measures, such as blood pressure or diabetes control. The incentive was small, usually a few hundred dollars, and complicated to calculate, on the basis of a composite score of 10 or more metrics.

Ours is a large academic health care system with ambulatory clinics in a variety of communities. Before the clinician compensation redesign, we built a dashboard in our electronic health record to track quality metrics and wRVU data at the clinician practice, and department levels. In our most underserved areas, we struggle with high no-show rates and lower volumes compared with other clinics, such that clinicians who choose to work in underserved areas are less likely to receive wRVU-based incentives.

GUIDING PRINCIPLES

Before redesigning our compensation plan, we surveyed our clinicians to understand what they liked about our current compensation plan and what should change. The results showed that our

primary care clinicians wanted to be rewarded for wRVU-based productivity and for high-quality care independent of wRVUs. We incorporated the survey results into our compensation philosophy and followed these guiding principles:

- Fair, equitable, and objective
- Data-driven using external benchmarks
- Transparent/clearly understood by all parties
- Flexible to changes in market conditions and reimbursement methods
- Optimizes clinician productivity, quality of care, patient experience, and provider citizenship
- Includes at-risk components that are based on the clinician's performance relative to predetermined metrics
- Administered in a consistent and timely manner.

We considered how to design a system that rewards quality, population health, panel management, and value-based care; is affordable for the organization; and rewards wRVU-based productivity. One option would be to retain a wRVU-based productivity compensation plan and layer on “bonus” payments from value-based contracts. Such payments vary from year to year, making it difficult to attribute contribution to the many individuals on the health care team who help support the success of population health and value-based care as well as difficult to administer and sustain from year to year.

For adult primary care, to meet our compensation philosophy and guiding principles, we established a compensation track for adult primary care. As per our guiding principles, we wanted our compensation plan to be fair and equitable in its distribution. What does “fair” mean when speaking about quality and health outcomes? What metrics should we use, and what targets are considered fair? Fortunately, in primary care, we have nationally benchmarked quality metrics, such as those employed in Medicare accountable care organizations (ACOs), to compare our performance. The metrics chosen can change from year to year depending on the focus of the organization and the needs of our patient population.

GROUP QUALITY METRICS

For year 1 of our project, we chose 2 metrics we wanted to improve on in the upcoming year: 1) hemoglobin A_{1c} (HbA_{1c}) above

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9% or up to date for patients with diabetes and 2) colorectal cancer screening. We had national benchmarks of performance, data on our own performance, and clear ideas on how to improve on these 2 metrics. However, these ideas and solutions were dependent on multiple members of the health care team, including clinicians of other specialties, across practice locations, from physicians to nurses to administrative support teams. We questioned whether it is “fair” to hold an individual clinician’s incentive payment beholden to the performance of the entire team. Is an individual clinician a “bad” clinician deserving less pay, because his/her quality scores are lower than his/her peers? What if the reason a clinician has poor quality scores is because s/he chooses to work with a challenging, noncompliant population? What if the clinician is new and has not yet transferred his/her paper records to the new electronic system in which the data are collected? There are so many variables that affect individual quality scores such that using individual performance on quality metrics becomes impossible to control for. In a system in which our mission is to care for all members of our community irrespective of patient behavior and complexity, using an individual quality incentive could result in clinicians funneling complex and challenging patients to others. To reward clinicians for high-quality care for all patient groups regardless of complexity or compliance, we decided to use group quality metrics, rather than individual quality metrics.

The adult primary care compensation track we developed uses group quality metrics and includes a base salary with a small “bonus” for quality, essentially base salary at risk. Additionally, we included a wRVU-based incentive with quality incentive carve-out, enabling both those who are productive with wRVUs and those without such productivity to achieve a quality incentive. Ideally, who gets to participate in this group quality incentive program should be members of a work team. People on a work team should have a clearly defined goal requiring them to work interdependently, boundaries that differentiate between team and nonteam members, authority and autonomy to manage work processes, and stable membership over a reasonable time.^{3,4} Following this framework, we chose to define the group as all adult primary care clinicians (Internal Medicine, Family Medicine, Medicine-Pediatrics, Geriatrics), as well as our express care clinicians because they often see walk-in and same-day overflow patients from the primary care practices. We believed that such a grouping would facilitate shared responsibility for our panels of ACO and non-ACO patients within our practices and across our health care system.

We implemented our group quality incentive plan in March 2018. We brought together a group of respected primary care clinicians to select the quality goals for 2018, and this group helped to educate their peers and champion this new incentive plan. For 2018, the group chose to focus on 2 quality metrics, to match with our system ACO goals: HbA_{1c} greater than 9% or up to date and colorectal cancer screening. We also included a patient experience/clinician communication composite metric, which was measured on an individual level. Various amounts of improvement in each realm were associated with points, and the amount of incentive payment was based on the number of points achieved. To be eligible for the quality or nonproduction

incentive, there were certain “citizenship” triggers that must be met. These included completing mandatory conflict of interest forms and closing patient encounters within 5 business days.

Several system-level initiatives were initiated to improve on the quality metrics included in the clinician compensation plan. For the metric of HbA_{1c} greater than 9% or up to date, we educated our providers about the importance of the metric and how to get help for their patients, and we implemented a workflow for nursing staff and express care providers to order the HbA_{1c} test and route results to the primary care providers to act on. For colorectal cancer screening, our Population Health Institute used its care coordinators to order fecal immunochemical test (FIT) screening for all eligible patients with automatic follow-up of abnormal results. The role of the team remained critical because nursing staff needed to recognize that a FIT had been ordered in the system, actively release the order for the FIT screen, and provide the FIT kit to the patient at the time of a laboratory or nurse visit.

To build and maintain momentum around our group quality metrics, our quality directors sent monthly e-newsletters highlighting excellent performance and sharing best practices.

OUTCOMES AND LESSONS LEARNED

These efforts made a difference in outcomes. In April 2018, a total of 7553 (34.6%) of 21,846 patients with diabetes in our system had either a HbA_{1c} above 9% or no HbA_{1c} measure in the past year. After almost 1 year, as of March 2019, we have improved that rate to 33%. For colorectal cancer screening, our rate of colorectal cancer screening was 54% in 2017 and as of March 2019, has risen to 60%—close to the ACO national benchmark of 62% for commercial health maintenance organizations (67% for a Medicare health maintenance organization).

Our organization is, to our knowledge, one of the first academic health care systems in the US to implement team-based incentives and feedback systems to drive improvements in health outcomes. Our experience mirrors that of others who have gone through the process of developing such team-based incentives.⁵

We have learned the following lessons in the process:

1. Information technology infrastructure and the ability to measure data and provide feedback is critical to the success of a quality incentive program. The development of a near real-time clinician dashboard in our electronic health record was vital.
2. Cultural barriers can be broken down with a culture of inclusion. We engaged key clinical leaders and respected clinicians early in the process, incorporating their feedback into the design and analysis of the quality incentive plan. Doing so helped pave a smoother acceptance among the larger clinician community.
3. Ongoing education is needed to ensure that all members of the team continue to focus their attention on quality goals.

Incorporating group quality metrics into our clinician compensation plan has helped us improve on quality efforts at a system level and as a team. Although compensation is a small piece of what motivates clinicians, the incorporation of group quality metrics into our compensation plan has raised awareness of which quality metrics the organization wants to focus on for the

upcoming year. It has also forced us to break down the barriers of responsibility for quality outcomes and to think as a larger team and system about how to address quality. Although we have made positive progress in our first year of implementation, we need to do a better job building team cohesion and creating ways to reward the entire team for team-based work. Overall, our experience with group quality metrics as part of the adult primary care compensation track has been positive and has moved our organization in the right direction: Toward better patient outcomes. ❖

Disclosure Statement

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