



The NEW ENGLAND JOURNAL of MEDICINE

Audio Interview: Pay for Performance — Recommendations of the Institute of Medicine, with Dr. Elliott S. Fisher and Dr. Karen Davis. N Engl J Med 2006;355(13):e14.

Transcript

Rachel Gotbaum: I'm Rachel Gotbaum. On September 21st, a committee convened by the Institute of Medicine issued a report on the pay-for-performance approach to compensating health care providers. I'm talking with two members of the committee: Karen Davis, president of the Commonwealth Fund in New York, and Dr. Elliott Fisher, a professor of medicine and community family medicine at Dartmouth Medical School.

Dr. Fisher, can you begin by explaining the general concept of what is pay for performance?

Elliott Fisher: In a nutshell, pay for performance is about giving financial incentives to providers to improve the quality of care they give their patients. There are a number of examples of pay-for-performance measures. In the hospital setting, hospitals can be rewarded for making sure that patients receive appropriate discharge medications. In the outpatient setting, physicians can be rewarded for appropriate testing for diabetic patients, for example, or for bringing their diabetics' blood sugar levels under control.

RG: What were the major sticking points for the committee to determine what to recommend here? Ms. Davis, can you address that?

Karen Davis: Well, I think one major issue is what types of behavior do you want to reward. Obviously, we want high clinical quality, but we also want care that's responsive to patients, that rewards physicians that communicate well with patients, that coordinate care well, so we want patient-centered care. But we also want efficient care. The work that Dr. Fisher and others have done demonstrates that there's wide variation in the total cost of care for treating a patient with a hip replacement or for colon cancer, and there doesn't seem to be any relationship between cost and quality. So we also want to reward efficiency and look at the total standardized cost of caring for patients—and reward those providers that do a good job of making economical use of resources.

RG: Isn't the idea of efficiency a real challenge here in this pay-for-performance ideal?

KD: It certainly is one of the most difficult issues. The Institute of Medicine committee defined efficiency as getting the highest quality care for any amount of money you spend on health care. So that's making sure that we get value for the care that we give to our patients and that we're not wasting money. Some of the studies that the Commonwealth Fund has supported, for example, find that patients are reporting the test is repeated when it's already been done but

nobody can find it or it's not convenient. So efficient care—eliminating waste, eliminating duplication—is something we need to be sensitive to, and there's just no incentive in the current system to look for overutilization or for duplication or waste.

EF: I think there's great concern among physicians that the focus on efficiency will be, in fact, the only focus. That payers are currently only concerned about the price of services and are trying to squeeze the cost. The Institute of Medicine's committee—our committee—was very clear on the importance of a pay-for-performance system that rewards high clinical quality, patient-centered care, and efficiency. All three of those domains in order to make sure that we are not simply skimping on care and rewarding low-cost care.

RG: How do you define efficiency and high quality? How does that happen?

EF: I think if you have good measures of quality that are reliable and that physicians and patients believe in, and you can demonstrate that there are ways of providing that care at half the cost, all of us—physicians and patients—would agree that providing equal outcomes at lower cost is a good deal, and that's really what the committee means by efficiency. Achieving high quality with less waste of resource, less repetition, less unnecessary time in the hospital, fewer unnecessary readmissions to the hospital—that's really what the committee meant by efficiency.

RG: What does the IOM recommend to ensure that this would happen?

KD: The IOM recommends giving pay-for-performance bonuses to physicians, hospitals, and health care providers depending upon their performance in all of these domains of clinical care, patient-centered care, and efficiency. So, for example, you might set aside 2% of Medicare's total spending on physician services and put that into a bonus pool. And if you've got high performance on care of your diabetics, you would get additional payments for that. If you do a good job of communicating with your patients, you would get bonuses for that. And if you're prudent in the use of resources. So, taking into account the patients' outcomes, their health risks, the difficulty of caring for those patients, what's the total amount that Medicare is paying for the care of that patient, say over the course of a year, if a patient has diabetes?

RG: Will the new system ensure that payments reflect the different patient mix that many specialists see?

EF: We called for great care in the implementation to make sure that it did not create incentives to avoid sick patients, to avoid complex patients, and that will require adequate risk adjustment and careful measurement.

KD: One of the implications of that is that the Institute of Medicine committee felt strongly it was important to learn as one goes along, to start modestly with modest incentives and with a starter set of quality measures where we've got good measures and good data, and then learn how well it works when we start with that, and then extend it to more measures and perhaps more significant bonuses over time.

RG: So can you give us the key points of what are the IOM recommendations?

KD: There are basically six recommendations. The first is that the Institute of Medicine supports pay for performance and feels that Medicare needs to move in this direction. Second, it addresses the issue of where you get the money, and that is specifically trying to be budget-conscious. We know we're in an environment where there's not a lot of new money, so it is looking and trying to be budget-conscious and looking at, for example, setting aside out of the base Medicare payments some modest amounts to form this bonus pool. Third, it recommends that it take into account the different dimensions of performance, including clinical quality, patient-centered care, and efficiency. Fourth, it recognizes that we need to start with bonuses for physicians, bonuses for hospitals, but really where we want to go is a single pay-for-performance pool that rewards coordinating care as you move from the hospital to home to physicians' offices, you want to foster shared accountability among physicians and physicians and hospitals. Fifth, we think that it's important that we have a good database and that providers receive rewards just for reporting data, at least initially. Many of them are going to have to adopt information systems that make it easy to generate this information. And sixth, we feel that it's important to invest in research and really evaluate how this is working as it plays out over time.

RG: So who is going to pay for the new technology that is needed to collect and monitor this data?

EF: The report is quite clear in recognizing that this may require increased investment in order to ensure data collection systems in physician offices that make participation in pay for performance practical. There's great concern among physicians that the current cuts in physician payments may make it impossible for them to take on additional burdens within their office practices. And the report calls upon the secretary and Congress to consider increased investments, specifically in the area of physician office practice to help with data collection.

RG: Is there much evidence from places where pay for performance has already been used and that it actually works?

KD: The Commonwealth Fund helped support a study to evaluate some pay-for-performance incentive systems in California and found out that when medical groups were given bonuses—for example, for preventive care—they did a better job. Take, for example, pap smears. A higher proportion of women got pap smears when the medical groups got bonuses in California than, for example, the medical groups in Oregon and Washington, where they didn't get those bonuses. So there is some evidence, but I think the committee's basic conclusion is that at this point there's a lot to learn, and while we see the promise of it, we need to really go slow and learn as we go to make sure that we're rewarding the right kinds of outcomes, that there are enough incentives out there to really change behavior, and that we don't have any unintended consequences.

RG: Karen Davis is President of the Commonwealth Fund, and Dr. Elliott Fisher is a professor of Medicine at Dartmouth Medical School.