Financial versus non-financial incentives for improving patient experience

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Abstract

Delivering compassionate and coordinated care is a goal for all health care providers. Humans are not always consistent, though, both individually and collectively, and this is why everyone needs incentives to be at their best and to try to always be improving.

The endlessly interesting question in patient experience is, what should those incentives look like? Should they be financial or nonfinancial? Dr. Thomas H. Lee explores what is most effective in regard to engaging and motivating physicians. While different approaches will work in different organizational cultures, financial incentives have their role in performance improvement. Compassionate coordinated care should be a social norm and be pursued by all health care organizations.

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Everyone in health care delivery wants to deliver care that is compassionate and coordinated, but we are all human. We are good humans, but human all the same – and, left to our own devices, we are not as consistent as we would like, both individually and collectively. That's why everyone needs incentives to be at their best, and to try to improve. The endlessly interesting question in patient experience is, what should those incentives look like? Should they be financial or nonfinancial?

In a 2014 article on engagement of clinicians in health care improvement, Cleveland Clinic CEO Toby Cosgrove and I described an adaptation of the four models for social action described a century ago by the German economist/sociologist, Max Weber.

- *Tradition* – e.g., a standard of behavior such as a dress code, which, if violated, threatens one with expulsion from an institution
- *Self-interest* – e.g., use of financial bonuses or penalties for achieving performance targets
- *Affection* – e.g., use of peer pressure from one-on-one performance reviews, or transparency with performance data
- *Shared purpose* – e.g., achievement of consensus that the overarching goal of a health care organization is to reduce the suffering of its patients

Our conclusion was that we need to use all four models in health care, and we need to start with the creation of a shared purpose. The vision that underlies a shared purpose (e.g., Cleveland Clinic's "Patients First") that comes from stories that

capture what makes us proud or ashamed. Trying to deliver care with the elements that make us proud – with consistency – is what performance is all about. But you have to start with a clear idea of what you are trying to achieve.

But those stories and the shared purpose they can create are not enough. Goose bumps fade away, tears dry. We need data and incentives to drive improvement, and to use the other three of Max Weber's levers. But the reason we need to start with creation of a shared purpose is this – the harsh reality is that no measure is perfect, and no data set is perfect.

Every measure can be made to look perverse if carried to an extreme (e.g., measures of patients' experience with pain can be made to look like an incentive to give narcotics to every patient). We will never get every patient to complete surveys and never be able to adjust for every variable that influences the way they respond. We should do our best to refine measures and analytic strategies, and to get as much data as possible – but we have to recognize that performance data will always have imperfections, just like the people who are being measured.

Living with those imperfections in performance data means that we need a shared purpose that compels us to pursue improvement with whatever tools we have available (as opposed to stay in one place while arguing about the problems with the information). And it also means we have to be thoughtful in how we use performance data. When do we use financial incentives? When do we use peer pressure?

Financial incentives

Financial incentives certainly catch people's attention, and many organizations are attaching 1 to 2 percent or more of clinicians' income to patient experience. Some are targeting some minimum threshold – e.g., the 75th percentile of a rollup of measures of physician performance. This approach definitely works to get improvement of patient experience on clinicians' radar screens.

The problems with financial incentives are intertwined with their strengths. People really hate to lose money. Prospect Theory, one of the core concepts in behavior economics, asserts two major themes. First, the proportion matters: If you give someone $100, they are happy. If you give them $200, they are happier, but they are not twice as happy.

The second theme of Prospect Theory is that people value losses differently from gains. Thus, if someone gives you $100, you are happy, but you might not mention it when you get home that night. But if you lose $100 (e.g., because of a speeding ticket), you are in a bad mood for the rest of the day.

So the take-home message from Prospect Theory is that you get the most return on your incentive dollar from multiple small incentives that are framed as potential losses. If clinicians are faced with loss of just 1 percent of income if they do not achieve some performance goal, they will work hard to avoid that loss – even if means not doing things that might increase their income by 2 percent.

But the dark side of financial incentives is that a normal human response is to do what one can to minimize the risk of losing money. And that means, besides working hard and learning new methods, our colleagues tend to argue about the flaws in the measures, the data and the analytic techniques. They complain about the inadequacy of adjustment for differences in populations. And they try to dumb down the thresholds for getting the incentives until the targets have little meaning.

Those dynamics are familiar to every leader who has used financial incentives to try to drive improvement in patient experience, and they should be recognized as normal human behavior.

Nonfinancial incentives

The problems with use of financial incentives for patient experience have led to increasing interest in the use of nonfinancial alternatives – i.e., Max Weber's third model, Affection. No one wants to lose the respect of his or her family, friends and colleagues. We all have delicate egos that we need to protect.

The fear of loss of affection and respect explains why many organizations have been successful in driving improvement without financial incentives, simply using intense one-on-one annual performance reviews. Others have ramped up the pressure through internal transparency – i.e., letting all of a clinician's colleagues see his or her data. There are various forms of intensity of internal transparency, and we should recognize when we are shying away from creating real pressure.
For example, some organizations do not rank order data, softening

the blow for those who might be well below average. Many share patient comments but do not organize them by physician.

The University of Utah Health Care's big leap in the winter of 2012-13 to put its patient experience data – including comments – online, on each physician's web page, was the bold conceptual leap that showed what external transparency can do. As is well known in the community of readers of this journal, University of Utah strives to survey electronically as many patients as possible, and puts 99 percent of the comments on the Internet within a few weeks of the encounter. The impact has been nothing short of astounding. Back in 2009, about 1 percent of its physicians were in the top 1 percentile. Today, more than a quarter are.

None of us has ever achieved this kind of improvement with financial incentives. When you talk to colleagues at University of Utah and other places that have followed this path, what you hear is that transparency changes the way physicians look at each patient encounter.

They recognize that it is a high-stakes interaction, for the patient and for them. The patient might write a negative comment, but the fact is that the patient is about 10 times as likely to write a positive one. All the physician has to do is try to be the kind of doctor that patients are hoping they will be.

So the focus of transparency is not on any individual metric. It is on trying to take better care of patients and feeling real pressure to do so for every single one of them. The pressure never eases up, but it is pressure to be the kind of clinicians that we want to think of ourselves as being. It's hard to say that is perverse.

Conclusions

Financial incentives have their role in performance improvement, but compassionate coordinated care should be a social norm and be pursued with the same methods as other social norms. Combinations of financial and nonfinancial incentives may be powerful – e.g., giving clinicians 1 percent financial incentives to participate in transparency initiatives. Different approaches will work in different organizational cultures. We know so much more in 2015 than we did just a few years ago about the use of incentives to improve patient experience, and we can expect to know even more a few years from now as different organizations innovate and we learn from each other.

References

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