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Into Practice

Into practice: How Advocate Health System uses behavioral economics to motivate physicians in its incentive program

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Implementation lessons

- Pay-for-performance incentives can drive physician behavior change when using specific design principles, highlighting success where other P4P programs have failed.
- Incentives targeted at groups allow use of value-based metrics that would otherwise be unfair to individual physicians.
- Non-financial incentives, such as public recognition and real-time data feedback, and financial incentives can be used to reinforce one another and address shortcomings of each incentive type.

1. Background

Stimulated by the Affordable Care Act and recent announcements by the Department of Health and Human Services, U.S. health care is moving from volume to value-based payment systems on an increasingly larger scale.[1,2] To be successful in value-based payment models, provider organizations must be able to engage physicians in this change. This is a change that extends beyond maximizing achievement on quality metrics used in traditional fee-for-service based pay-for-performance (P4P) programs (condition-based processes and outcomes such as foot exams and hemoglobin A1c for diabetic patients), but also involves consideration of 'value metrics' (e.g. emergency department and hospital utilization) that are only reliably measured and incented at the health system level. This dichotomy of incentive types poses a central challenge for health systems – physician engagement in coordinated care is essential to avoiding ER visits and preventable hospital admissions, but the locus of control is hardly exclusively within their purview. Within value-based payment models, it has yet to be determined if a health system can successfully use physician incentives to improve the provision of value-based care.

Advocate Health was one of the very first clinically integrated networks with an initial focus on harmonizing quality metrics across payers and motivating performance through a physician P4P program. More recently, Advocate began taking on financial risk.[3] Since 2004, Advocate leadership evolved the physician incentive program to balance core values of meaningful quality metrics, system-ness, coordination and accountability through experimentation and trial-and-error. These were deliberate pragmatic attempts to solve a central business problem; the evolution culminated in a program that employs several behavioral economic principles. While the implementation of these principles has been customized to Advocate, they illustrate how other health systems that face similar challenges may uses incentives to align physicians with organizational goals.

Notably, Advocate is distinctive in its sustained success in risk-based models and as a national leader in quality. The system is consistently ranked by Truven as a top five health system in the country.[4] In 2014 and 2015, five Advocate hospitals were identified by Truven as Top 100 hospitals in the nation.[5]

Because P4P programs have not reliably been effective,[6] this case study explores Advocate's program and the key features that its leadership believes are responsible, in large part, for its success.

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We examine Advocate's program in the context of its behavioral economic design principles that support physician engagement and performance.

2. Organizational context

Advocate Health Care is a fully integrated system in the Chicago and central Illinois area. The system comprises Advocate Health Care, which owns eleven hospitals and one medical group that includes employed physicians providing ambulatory services at over 250 sites. It also includes a home care division. Advocate Physician Partners (APP) is a joint venture between Advocate and approximately 5300 physicians. These include physicians belonging to twelve Provider-Hospital Organizations (PHOs) centered around each Advocate hospital and one clinical affiliate hospital. Within APP, 1400 physicians are employed (i.e. salaried) and 3900 physicians are affiliated, which means they are credentialed by and retain contracts with Advocate, but are paid largely directly by insurers (i.e. mostly fee-for-service). APP is the primary contracting entity with insurers and provides care management services to the entire pool of physicians. Within the employed medical groups, approximately half are primary care physicians and half are specialists. Within the affiliated physician group, approximately one quarter are primary care physicians and the remainder are specialists. The average practice group size within the aligned group is 2.5 physicians. The 5300 APP physicians are a subset of the 6300 physicians on the Advocate hospital medical staffs.

APP uses a shared governance model in which over 200 physicians are in leadership roles within local PHO committees and boards, and the APP board and its committees. All decisions to make changes to the physician incentive program, called the Clinical Integration (CI) program, are determined through majority vote by the Advocate executives and physician leaders on the APP board. All 5300 physicians in APP participate in the CI program.

APP's history of investments in infrastructure for quality and cost management provided a foundation of experience and tools to approach alternative payment models. The leadership believed the advent of shared savings represented an attainable opportunity that aligned with its mission. In fact, engaging early was thought to confer a competitive advantage. However, the design of initial programs was focused almost exclusively on traditional P4P metrics consistent with those used by commercial payers. Furthermore, APP was rapidly expanding its geographic footprint within greater Chicago with corresponding growth in its affiliated physician base. As APP's revenue became predominantly risk-based, including commercial ACO programs, Medicare Shared Savings Program and, most recently, Medicaid Managed Care, the stage was set for its central challenge – designing a physician incentive program to succeed in the new value-based payment models.

3. Problem

3.1. Problem 1—achieving physician buy-in

Advocate was challenged with developing an effective physician engagement strategy that would not only continue to produce consistent and exceptional performance on quality outcomes, but would also result in high performance in value metrics. This strategy also included the daunting task of cost containment amongst a large and growing number of affiliated physicians. Advocate decided its Clinical Integration incentive program was the best vehicle for aligning and engaging physicians, but needed to adapt it to achieve new 'value-based' metrics. Advocate did not have a ready example to follow. Further, Advocate patients only comprised a subset of affiliated physicians' panels. Advocate needed to get ahead of any growing physician skepticism. Thus, Advocate was challenged to keep physicians engaged in the CI program while expanding the breadth of coordination needed to achieve value-based metrics, which seemed significantly more complex. How could Advocate incorporate value-based metrics into its program and still retain strong physician buy-in? How could it translate those metrics to the individual physicians in a way that caught their attention and resulted in participation rather than disillusionment?

3.2. Problem 2 – incorporating value metrics into the physician incentive program

The second problem Advocate faced was how to maximize the impact of each incentive dollar invested. Past national P4P programs did not provide best practices to adopt, as frequently the incentives were paid to physicians who were already doing well, and the size of incentives were relatively small compared to FFS income. Advocate, on the other hand, wanted to use each incentive dollar to get incrementally better patient care; it wanted to motivate real behavior change. From a metric perspective, Advocate hoped to influence performance in both traditional quality metrics and relatively newer value metrics. Most process metrics can be assessed on an individual physician level and can be approached with a relatively straightforward incentive design. However, most value metrics are only meaningful at a group level, although individual behaviors still very much impact collective performance. To address this problem, Advocate needed to do two things: (1) figure out a way to incent both individual and team performance and (2) set physicians up for success (i.e. provide sufficient resources) in achieving performance goals for both traditional quality and newer value-based metrics.

Both problems were amplified in the context of an ever-growing network with new affiliated physicians and PHOs joining APP – many without prior exposure to a high functioning P4P program or a culture that fosters high quality performance.

4. Solution

4.1. The Clinical Integration Program

Advocate approached the challenges outlined above in its CI physician incentive program. APP leadership, including many physicians, was integrally involved in the design and governance of the Clinical Integration Program. To create trust and equity, the same program, with the same metrics, methodology, and thresholds, was deployed across all employed and aligned physicians. Even primary care and specialty physicians had many common metrics to create common ground and encourage cross-collaboration.

In the CI Program, individual physician incentive amount is determined by the "CI Score" (see Fig. 1), which calculates individual metric performance, care coordination and group (PHO) performance. There are a total of 150 measures (a portion of which apply only to primary care and others which apply only to certain specialties). The individual measures are separated into domains that include: chronic disease care (54 measures), patient experience (12 measures), care coordination and patient safety (29 measures), efficiency (16 measures), health and wellness (37 measures), and infrastructure and education (9 measures). Measures are specialty specific with primary care having approximately 30 measures and other specialties fewer. For specialties with few measures, Advocate elicits specialists' input in incentive

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