Original Contributions

Pay-for-performance incentive program in a large dental group practice

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ABSTRACT

Background. Dentists increasingly are employed in large group practices that use financial incentive systems to influence provider performance. The authors describe the design and initial implementation of a pay-for-performance (P4P) incentive program for a large capitated Oregon group dental practice that cares primarily for patients receiving Medicaid. The authors do not assess the effectiveness of the incentive system on provider and staff member performance.

Methods. The data come from use of care files and integrated electronic health records, provider and staff member surveys, and interviews and community surveys from 6 counties. Quarterly individual- and team-level incentives focused on 3 performance metrics.

Results. The program was challenged by many complex administrative issues. The key issues included designing a P4P system for different types of providers and administrative staff members who were employed centrally and in different communities, setting realistic performance metrics, building information systems that provided timely information about performance, and educating and gaining the support of a diverse workforce. Adjustments are being made in the incentive scheme to meet these challenges.

Conclusions. This is the first report of a P4P compensation system for dental care providers and supporting staff members. The complex administrative challenges will require several years to address.

Practical Implications. Large, capitated dental practice organizations will employ more dental care providers and administrative staff members to care for patients who receive Medicaid and patients who are privately insured. It is critical to design and implement a P4P system that the workforce supports.

Key Words. Compensation; financial incentives; dental care delivery; quality improvement; managed dental care.

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Increasingly, especially among newer graduates, dentists are employed in large dental group practices with 500 or more employees.[1-3] These large practices and Federally Qualified Health Centers are expected to provide an increasing part of the safety net for patients with low incomes.[4]

Practices serving the Medicaid population receive fee-for-service reimbursement per encounter or per member (capitation payments) directly from payers or from intermediary organizations. Often, dentists in large groups receive salaries or salaries plus incentives. Dentists employed in private solo or small group practices usually receive fee-for-service pay with a productivity incentive. Both payment models have strengths and weaknesses.

In fee-for-service payment systems, financial incentives encourage productivity but also overtreatment. In salaried payment systems, financial incentives may reduce overtreatment but also may lead to lower productivity and undertreatment. In both payment models, prevailing incentives and metrics tend to encourage treatment of patients without regard to disease risk, which potentially encourages overtreatment and the use of scarce resources for those with lesser need.

For medical and hospital care, the Affordable Care Act mandated public disclosure of established quality metrics and pay-for-performance (P4P) measures used to achieve these metrics[5] (for

example, asthma medication use, breast cancer screening). Even before they were mandated, such changes in reporting and compensation were examined intensively.

Results of a comprehensive review of medical care provider performance systems indicated only modest short-term improvement in ambulatory care quality metrics (for example, blood glucose levels for people with diabetes) over a 2- to 3-year period.[6] Payment incentives were most effective when there was alignment between performance and incentive structures, organizational goals, and a strong administrative and clinical infrastructure. Public reporting significantly improved program effectiveness.[7]

Results in the medical literature[8,9] suggest that the following structure of financial incentives contributes to program effectiveness:

- blending positive incentives (rewards) with negative incentives (penalties), directed to clear and specific performance targets;
- combining individual-level incentives with group and team incentives;
- including input on incentive design by the health care providers subject to the prospective rewards and penalties;
- timing incentive payoffs as closely as administratively possible to the provider performance period;
- rightsizing the incentives (not too large and not too small), thereby avoiding crowding out intrinsic provider motivation and covering providers' costs of responding to the incentives.[10]

In addition, setting achievable performance targets is critical.[11] Such targets ensure that individual providers and groups subject to incentives view the targets as attainable; otherwise, efforts to improve fail to produce gains sufficient to cover the considerable costs of adjusting behavior and administrative systems.

In this article, we describe the design and implementation of a P4P program in a large Oregon dental care organization (Advantage Dental Services [Advantage]). In this article, we do not provide any data on the effectiveness of the program because it is still at an early stage of development.

The primary purposes of this article were to place this initiative in the context of P4P and delivery innovation in health care, outline the phases of its design and implementation, and identify implementation challenges and lessons learned based on early implementation and to articulate preliminary implications for dental practice. The project is part of the Robert Wood Johnson Foundation Solving Disparities Through Payment and Delivery System Reform program.[12]

Advantage is a large Oregon dental organization, with 40 staff-model group practices (66 dentists) and contracts with approximately 200 affiliated smaller, largely rural primary care practices. The objective of the Advantage performance improvement initiative is to reduce barriers to access to care and disparities in oral health. In 2016, the Advantage traditional practice-based delivery system was augmented with the development of a school-based system. The new delivery system is part of an Advantage-initiated quality improvement project (Population-centered Risk- and Evidence-based Dental Interprofessional Care Team [PREDICT]) designed to evaluate how changing the delivery system, instituting quality metrics, and incentivizing employees will reduce disparities in access and oral health for Medicaid members.

ABBREVIATION KEY

Advantage: Advantage Dental Services.
ASTTD: Association of State and Territorial Dental Directors.
NA: Not applicable.
P4P: Pay for performance.
PREDICT: Population-centered Risk- and Evidence-based Dental Interprofessional Care Team.

METHODS

In 6 test counties, community dental teams composed of Expanded Practice Permit dental hygienists working in schools and other community settings provided screening, risk assessment, primary and secondary preventive care, caries stabilization, and referral to a dental practice where appropriate. Care was governed by a set of algorithms that specify conditions for restorative or urgent care that cannot be provided in the community setting. Regional managers were responsible for agreements with community organizations that allow hygienists to deliver service in community settings (for example, schools, Head Start programs). Centrally located case managers served as navigators to facilitate the referral of patients to dental practices for services that could not be provided in community settings. In 8 other control counties, the delivery system and incentive structure remained largely unchanged.

The company used a global budgeting approach, in which all capitation funds were pooled and allocated according to prospective budgets by function. A portion of the funds allocated for clinic care were set aside for incentives. Dentists and other employees were incentivized financially for performance of prespecified quality care metrics. As base compensation, staff model group practice