Incentives Can Drive Change in Residents' Patient Care

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The article by Turner and colleagues, "Improving Resident and Fellow Engagement in Patient Safety Through a Graduate Medical Education Incentive Program," in this issue of the *Journal of Graduate Medical Education*, describes a significant improvement in resident reporting of patient safety events, which was sustained over a 3-year period at 1 academic institution.[1] This report provides strong support to the concept of using incentives to change behavior in residency training, which is consistent with other studies that also reported positive results.[2–5]

It has been clear since the Institute of Medicine report, "To Err Is Human,"[6] that our previous dependence on error reporting, from departmental morbidity and mortality (M&M) conferences, based on a culture of blame, is not sufficient. These conferences focused primarily on individual provider errors and less on the system factors that led to errors. M&M conferences can be made more system focused,[7] but without feedback from the institution, departments will focus on changes that can be made by departmental physicians and health care providers rather than reporting system-based errors to the institution. In this context, residents need assurance that systems reporting will effect change in the system. If feedback and change is not clearly happening, "work-around" fixes will continue to be created.

To promote an institutional culture of safety, the Accreditation Council for Graduate Medical Education (ACGME) developed the Clinical Learning Environment Review (CLER) program. These site visits to teaching hospitals are intended to increase the focus of graduate medical education (GME) and senior institutional leaders on the need to encourage all physicians and other health care professionals to increase safety event reporting at the system level. The recent CLER 2018 report shows that many learning environments have demonstrated an increase in resident and fellow reporting of patient safety events between the first and second site visits.[8]

While some authors debate the effectiveness of monetary incentives,[9] in GME there have been successful examples of driving change through financial incentives. Even prior to the CLER process, many health care organizations and hospitals had developed pay for performance incentive programs aimed at engaging employees in reporting errors to meet new quality and safety standards. Using incentives can be a driver for aligning residents, program directors, and GME and hospital leaders so that important changes reach the entire system of care. Vidyarthi et al[3] reported that, prior to their GME financial incentive program, the University of California, San Francisco (UCSF), had implemented an incentive award program for all nonphysician staff. The program was designed to engage and align employees with the medical center's mission. This also is the goal of the ACGME CLER program and quality improvement requirements. For these incentives to be effective there must be alignment of goals. By using hospital data and quality and safety goals, GME and hospital leaders can be more effective. Most critical is the engagement of residents who are on the frontline of errors. In this frontline role, residents can identify when system-level features are not working well.

Of the existing reports on incentive programs, the work of Vidyarthi et al is most impressive.[3] That study used incentives to improve institution-wide quality at UCSF through goals applied to all programs. When this showed that many residents were frustrated as their program/specialty had no individual effect on many institutional goals, the researchers found that after a move to program-specific goals, residents became more engaged.

In addition to financial incentives, other interventions were used to engage residents at UCSF and in the current study at Duke University. In the Duke study, an extensive experiential method for teaching residents was added to the incentive program to improve reporting.[1] The authors also described a new online patient safety reporting system and an educational module explaining the importance of patient safety reporting and its value to the institution. Enormous efforts to provide feedback to residents included putting links to the reporting system on the resident management website and creating peer scorecards that compared resident reports among programs. To enable follow-up and effect change,

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issues were forwarded to clinical service units and institutional, program, and departmental leaders.

It is not reasonable to expect incentives alone to drive change or engagement of residents or other health care providers. It is the positive achievements of these larger multifaceted programs that makes the difference: improving patient outcomes, improving resident effectiveness and efficiency of care, and decreasing errors within the system through the use of hospital data and alignment of hospital and resident training goals. Having a common goal of improving patient care allows GME and C-suite leadership to recognize and prioritize system factors based on actual patient outcome data rather than based on "who" asks. When residents see that patient care improves from safety event reporting, the work of the entire health care team will become more effective and satisfying.

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