Does Money Really Talk? A Resident-Driven Pay-for-Performance Pilot

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In this issue of the *Journal of Graduate Medical Education*, an article entitled "Successful resident engagement in quality improvement: the Detroit Medical Center story" by Hussain et al[1] presents an interesting foray into the world of pay-for-performance. The authors focused on a resident-driven pay-for-performance initiative that targeted venous thromboembolism (VTE) prevention and stroke care in a large urban academic medical center. In addition to being predominantly resident-driven, the intervention is unique, in that it successfully obtained full institutional support of an educational endeavor. It thus serves as an excellent example of what can be achieved when educational and institutional goals are aligned. The article also highlights the importance of adopting adjunctive software that augments established electronic health record systems to improve the quality of care delivered to a target population. In the pilot described by the authors, a decision support tool was utilized that tailored evidence-based recommendations for VTE prevention and stroke care to the patients being evaluated.

The study offers a first look into whether resident behavior can be modified by the use of financial incentives. We know from earlier research that physicians' performance can be changed, for better or for worse, based on financial incentives.[2] The most illustrative example of financially motivated behavioral changes comes from a 2004 United Kingdom (UK) experiment. Family medicine physicians were incentivized to adhere to 136 clinically based core measures, known collectively as the Quality and Outcomes Framework. As we now know, the results were astounding, in that the payouts reached 83.4% of available incentive payments within the first year of the program and increased to 97.8% by 2007.[3] Hussain et al[1] have shown that resident behavior can similarly be altered by financial motivations.

As educators, it is encouraging to know that an educational program can achieve results of this magnitude across multiple disciplines and at the same time be completely self-policed and self-maintained. Not only does this exemplify the importance of institutional buy-in, but it also demonstrates the success that can be achieved through engagement of front-line staff rather than through blanket edicts. To date, most residency programs have predominately payed lip service to the quality movement, asking trainees to understand the relevance of quality metrics and pay-for-performance by using hypothetical scenarios rather than real life situations.

While this program demonstrated resounding success in achieving the designated performance measures, a number of concerns spring to light related to the integrity of the pay-for-performance concept. The performance metrics used in the authors' study were process measures, chosen for their ease of measurement and the ease with which they can define success. The reader is left with the age-old question of whether achieving these measures had an impact on clinically relevant outcomes, and if so, were the outcomes such that the financial input necessary to achieve them was reasonable. We know that to implement such a broad and far-reaching resident-run program using additional electronic health record decision support, a $250,000 startup cost was required. It would be interesting to know whether the hospital realized equivalent cost savings as a result of this initiative.

Similar to questions raised by the UK experiment, with the intervention described by Hussain et al[1] there are issues to be considered on a local level. The achievement gap discussed in this article was extremely narrow, with compliance rates for VTE performance measures increasing from 88.5% at baseline, to 94.2% at 6 months, and an astounding 100% at 12 months. Similarly, the performance measures for stroke care improved from a baseline of 88%, to 96.6% in 6 months, to 100% compliance at 12 months. While impressive, one could argue that with the preimplementation baseline being so high, such improvements have little practical meaning in terms of both cost savings and patient outcome benefits. Readers also should be wary any time a performance indicator achieves and maintains long-term sustainability at 100% compliance. While we revel in these outcomes, "to err is human," even with decision support programs. The 100% success rates compel us to ask: Were there patients who were inappropriately excluded from the denominator

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because they were deemed ineligible? This is called "gaming," and it was clearly present in the UK experiment.[4] Conversely, were there patients who received unnecessary treatment for VTE and stroke care simply to assure that there were zero misses? A commonly occurring example of this is the practice of providing fluid management counseling to every patient discharged from the hospital, whether they carry a diagnosis of heart failure or not. We have checked the box, but have we made a difference?

The article by Hussain et al[1] is certainly thought provoking. It shows that residents can be motivated by pay-for-performance incentives, and that they are capable of policing themselves when it comes to such plans. Unfortunately, such a program is susceptible to all of the pitfalls that previous pay-for-performance schemata have fallen prey. From Atul Gawande we know that checklists are useful for improving processes.[5] But do they improve outcomes that are clinically relevant to patients? Given continual changes in medical knowledge and practices, how are checklists kept accurate and current to inform trainee learning? Importantly, can the emphasis placed on checklists, performance measures, and public reporting be counterbalanced by a goal to preserve shared decision making with our patients? Do we spin our recommendations to patients when we know there is a dollar sign behind success when success is defined as a narrowly outlined performance measure? While we would all like to answer in the negative, previous experience with pharmaceutical influence on providers has shown that we are highly susceptible to commercial influences: what we believe to be true and what we know to be true can be on opposite ends of the spectrum.[6]

In summary, Hussain et al[1] should be applauded for their success in integrating the contentiously related concepts of pay-for-performance and quality improvement into the educational schematic of their training programs. If the purpose of this endeavor was to expose trainees to the real world experience of incentivized medicine and to provide contextual relevance to quality improvement as its own discipline, then they have achieved success. However, if the purpose was to determine if clinically relevant patient outcomes could be achieved through a resident-run pay-for-performance program using decision support tools, the verdict is still out. Where the pendulum lands between access to care that is both equitable and evidence-based and care that is patient-centered has yet to be determined. While performance measures and pay-for-performance programs can and should be part of the solution, they are by no means a panacea.

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