Rewarding Results Pay-for-Performance Initiative
Ten Lessons Learned

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1. **Financial incentives do motivate change.** But they need to be large enough to make a difference. Bridges to Excellence for example suggests that at a minimum the incentive be set at $5,000 per physician to affect quality improvement; others suggest that they need to be structured to account for at least 10 percent of a physician’s annual income. The seven Rewarding Results sites are offering incentives at a variety of levels.

2. **Non-financial incentives also can make a difference.** Just providing support for additional staffing to make a physician’s job easier or supporting infrastructure to supplement technology can motivate physicians to hit quality targets.

3. **Engaging physicians is a critical activity.** All seven projects have worked hard to engage physicians, with varying degrees of success. If physicians are not brought into the process early as collaborators to ensure that goals are clinically meaningful, they will not adopt and sustain the change.

4. **There is no clear picture yet of return on investment.** Estimating the return on investment of P4P is essential but few projects nationally are conducting rigorous research on this topic. There are still questions about who should benefit from cost savings and over what time span the return on investment should be calculated.

5. **Public reporting is a strong catalyst for providers to improve care.** However, providers need adequate tools and data to keep improving. To maximize improvement, providers also need to be rewarded for installing and using health information technology and building infrastructure to track and compare performance.

6. **Providers need feedback on their performance.** Frequent, clear and actionable feedback to providers is essential. Many of the Rewarding Results projects issue public report cards to help physicians compare their performance to others and make their performance more transparent to consumers. Physicians need to understand what aspect of their performance will be evaluated; how performance will be measured; and how performance and incentives are related. They also need to be given tools and guidance on how they can improve.
7. **Providers need to be better educated about P4P.** Physicians are deluged with clinical and reimbursement information. For any payer, even those with a large share of the market, it can be challenging to attract provider attention. But they need to find effective communication tools to raise awareness about P4P; if they don’t, physicians will ignore quality improvement demands or as in one case, inadvertently throw bonus checks in the trash because they aren’t aware of the program.

8. **Data integrity is important.** Most health care providers are deluged with quality measures from a variety of payers. They are more likely to participate and embrace P4P if they view measures as valid and scientifically based. Quality targets also need to be clinically relevant.

9. **Experience with managed care matters.** Markets where managed care has more of a foothold seem to have an easier time with P4P because physicians and the general public are more comfortable with issues related to quality improvement such as transparency, accountability, and performance comparisons.

10. **P4P is not a magic bullet.** It is one of a number of activities underway by the public and private sectors to improve quality and change incentives in the way health care is delivered and financed. If it’s implemented well and aligned with other incentives including performance feedback, public reporting, and support for systems improvement, it appears to be an extremely useful tool.