Non-Financial Provider Incentives: Looking Beyond Provider Payment Reform

The U.S. healthcare system has long required a transformation—from rewarding volume to encouraging the delivery of high-value care. Our current system is plagued with inefficiencies. Unit prices are high, quality is uneven and lack of transparency complicates matters at every turn. Additionally, approximately one third of healthcare spending is wasted on services that could be eliminated without negatively impacting the quality of care that patients receive.1

Healthcare consumers, payers, providers and policymakers consistently call for better value, but we have not yet found a “silver bullet” when it comes to consistently delivering high-value care. As frontline providers, physicians play a critical role in these efforts, making them the primary target of strategies to address poor quality and high costs.

For decades, efforts to modify provider behavior have emphasized new methods of reimbursement—with mixed success.2 Rather, a growing body of evidence suggests that a combination of financial and non-financial incentives is key to improving healthcare value.3,4

This brief describes various types of non-financial provider incentives and evaluates their ability to deliver better value by increasing the use of high-value services, decreasing the use of low-value services and lowering excess prices.

What are Non-Financial Provider Incentives?

Broadly, non-financial incentives can be categorized into three groups: mission-based incentives, reputational incentives and eliminating informational barriers to the delivery of high-value care.5

Mission-Based Incentives

Although many physicians are generously compensated for their services, the intrinsic reward of helping patients in need is often the driving force that motivates them. Mission-based incentives aim to influence physician behavior by tapping into providers’ “internal motivation to be a good doctor.”6

Appeals to physicians’ better natures have long existed, yet they have not prevented our healthcare system from evolving into one that is inefficient and promotes low-value care. This may be due, in part, to systemic stressors (such as poor work-life balance, workforce shortages and a lack of resources) that can diminish providers’ intrinsic motivation over time. Furthermore, research shows that intrinsic motivation can be overridden by other incentives, such as financial gain and loss.7 Despite these challenges, evidence suggests that mission-based incentives can be
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successfully employed at the organizational level to engage clinicians in the pursuit of better value. The following sections explore two ways in which organizational leaders can inspire this change.

Tapping into Providers’ Professional Ethos

It is common for physicians to take a ceremonial oath upon graduation in which they pledge to uphold a number of medical ethical standards. As a result, they often feel a tremendous moral responsibility to act in ways that are consistent with that oath. By using language that resonates with clinicians’ guiding principles, organizational leaders can impress the importance of (and better incentivize physicians to participate in) value improvement activities.

For example, while administrators often measure “value” in terms of an organization’s ability to improve quality while reducing or maintaining costs, it is important for them to recognize that physicians may define value quite differently. Rather, a physician might view value as a willingness to do everything possible to improve patient outcomes despite the cost. At the system level, this mentality may (and frequently does) result in the overuse of services that increase spending yet provide minimal additional patient benefit. Rather than focusing on reducing avoidable costs to the organization, leaders can incentivize change by reframing the issue to emphasize the various types of patient harm that can result from overuse. This framing more closely aligns with physicians’ priorities and invokes their professional obligation to “do no harm.”

Establishing Shared Purpose

Organizations may also attempt to inspire behavioral change by creating a sense of shared purpose. This strategy seeks to align organizational values with “core principles of the medical profession” to unite leadership and clinicians in the pursuit of common goals.

In a healthcare setting, aligning physician goals with organizational aims can be difficult due to the fact that some physicians are not employees of the organizations in which they provide care. As a result, these physicians may be less susceptible to the traditional punishments and rewards that motivate most employees. Furthermore, physician engagement may be lower due to their strong sense of professional autonomy. Many providers’ loyalty primarily lies with the patients they serve rather than the organizations in which they work.

As discussed above, creating a common language is essential for organizational leaders to effectively engage clinicians in value improvement initiatives. Once this language has been established, leaders should create a statement of shared purpose to guide providers’ efforts moving forward. Effective statements articulate a focus on prioritizing patients’ needs; acknowledge that current conditions are unacceptable and must change; and express that collective action is required to achieve shared goals.

To increase buy-in, leaders should present objective data linking a proposed initiative to improved efficiency and health outcomes, and provide anecdotes highlighting individual patient experiences. This approach taps into providers’ rationality and desire to put patients’ needs first, inspiring them to make changes that may initially be uncomfortable. Physician champions can also be tremendously helpful in this process, especially if the champion is a well-respected peer. Characteristics that organizations should look for when recruiting physician champions include: excitement and passion for the proposed improvement initiative; strong interpersonal,

### Types of Non-Financial Provider Incentives

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leadership and communication skills; and responsiveness to opposition and feedback.\textsuperscript{15}

Ultimately, the ability of organizational leadership to establish a shared purpose can make or break the success of an initiative. Engaging physicians in the pursuit of a common goal increases the likelihood that they will take ownership of the project—helping develop, evaluate and improve the initiative. Oppositely, improvement activities that are not built on shared purpose may be perceived as “manipulative, disrespectful to physicians’ professional identity and as statements of power.”\textsuperscript{16}

Despite its significance within an organization, development of a shared purpose alone is unlikely to sufficiently incentivize the steadfast delivery of high-value care. Rather, the strategy should be viewed as a complement to other, more direct incentives, such as peer comparisons or public reporting.

**Reputational Incentives**

Like many highly skilled professionals, physicians take pride in their expertise and appreciate positive feedback. Reputational incentives leverage physicians’ desire for respect and recognition by distributing performance data both within and outside the organization.

**Internal Peer Comparisons**

Arguably, the majority of physicians desire the respect and admiration of their colleagues and generally strive to perform at or above the level of their peers. By making a physician’s performance data internally transparent, healthcare organizations and insurers aim to change the behavior of “outliers” to more closely align with standards of care.

Peer comparisons come in many forms, including mailed letters, emails and automated dashboards. A strong body of literature supports the notion that peer comparison is an effective strategy to incentivize behavioral change, although the effectiveness varies significantly depending on the manner in which the “peer pressure” is applied. A 2016 study published in *JAMA* found that emails comparing clinicians’ prescribing habits to those of “top performers” significantly decreased inappropriate antibiotic prescribing rates, from 20 to 4 percent.\textsuperscript{17} In contrast, researchers from MIT and Columbia University recently found that mailed letters comparing “outlier prescribers” to top performers in the Medicare Part D program had a negligible effect on physician prescribing habits.\textsuperscript{18,19}

Furthermore, research conducted at the organizational level reveals that aggressive comparisons (in which there is a greater perceived risk of reputational harm) are more effective than passive strategies at incentivizing change.\textsuperscript{20} Passive strategies shy away from “shaming” clinicians by making their data internally available, but omitting personal identifiers or declining to rank order the data.\textsuperscript{21} These methods hold poor performers less personably accountable than more aggressive approaches, such as unmasking data so that physicians with poor performance can be easily identified (see box above).

Additionally, evidence suggests that peer comparisons using utilization data may be more effective when provided with normative benchmarks (i.e., information on the appropriate amount of care to provide).\textsuperscript{22} In fact, failure to provide normative benchmarks may have the opposite of the intended effect. For example, ambiguity over what constitutes desirable behavior could cause low-utilizing physicians to increase their use of unnecessary services in an effort to conform to the practices of their high-utilizing peers.\textsuperscript{24}

**Public Reporting**

Public reporting similarly holds providers accountable for quality and costs by making performance indicators available to external audiences, such as consumers, employers, insurers and other providers. The underlying strategy is to incentivize physicians to deliver better value
randomized controlled trials have been conducted on the
subject. Moreover, conclusions from studies comparing
provider performance before and after public reporting
are weakened by delays between the times performance
indicators are announced and when reporting begins.
This lag time allows providers to jumpstart improvement
activities before baseline performance is actually
measured, biasing results. Finally, public reporting
initiatives are often implemented in combination
with other improvement activities (like financial
incentive programs), making it difficult for researchers
to determine the effectiveness of the standalone
intervention. 

It is important to note that the effectiveness of this
strategy may be severely limited depending on the
environment in which it is applied. For example, public
reporting is largely ineffective when applied to non-
shoppable services (such as emergency care) for which
consumers do not have the time nor the resources
necessary to make an informed decision. Additionally,
observations that few consumers use this information to
shop for services (even when it is available) may diminish
public reporting’s impact on providers’ behavior.

Furthermore, public reporting has been associated
with a number of unintended consequences. Perhaps
most notably, critics argue that publically reporting
quality metrics like mortality rates unfairly penalizes
providers that take on sicker patients and/or perform
high-risk interventions. This is because most consumers
interpret higher mortality rates as a sign of low quality,
not realizing that the measure may not adequately
represent a provider’s ability to provide high-quality care
if the provider treats a high volume of patients with low
chances of survival. Additionally, mortality rates may be
artificially inflated for providers that perform procedures
on a small number of patients, versus those with high
caseloads. Thus, fear of reputational harm may cause
some providers to take on fewer high-risk patients. It is important to note, however,
that the same price transparency may also incentivize
some low-cost providers to increase their prices to meet
the established rate.

Quality Reporting: Case studies suggest that, under the
right circumstances, public reporting of quality metrics
can also provide a meaningful impetus for change. In the
early 2000s, an employer-purchasing cooperative based
in Madison, Wisconsin released a report containing
performance results for local hospitals using information
from a statewide database. Studies showed that, compared
to Wisconsin hospitals not subject to public reporting,
Madison-area hospitals participated in more quality
improvement initiatives and “improved more over time.”

At University of Utah Health Care, posting patient
experience data and comments online led to a significant
increase in patients’ satisfaction with their physician.
Before the initiative, only 1 percent of the health system’s
physicians ranked in the top 1 percent for patient
satisfaction nationally. After the intervention, the
proportion of physicians ranking in the first percentile
increased to over 25 percent.

Despite anecdotal evidence of effectiveness,
determining the impact of public reporting on quality is
difficult for a number of reasons. For one, as of 2015, no
randomized controlled trials have been conducted on the
subject. Moreover, conclusions from studies comparing
provider performance before and after public reporting
are weakened by delays between the times performance
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Eliminating Informational Barriers to the Use of High-Value Care

Even with reputational and mission-based incentives, clinicians cannot alter their practice patterns to deliver better value without a basic understanding of evidence-based guidelines, quality and costs. The Institute of Medicine (IOM) estimates that approximately 50 percent of U.S. healthcare services are delivered without clear evidence of effectiveness. Stated plainly, nearly half of all clinical decisions are based on judgement, with costs and patient outcomes varying widely as a result. Increasing funding for comparative-effectiveness and cost-effectiveness research will be critical to addressing the evidence gap identified by the IOM.

When evidence-based standards of care do exist, efforts to make the information widely available will help providers improve quality and avoid unnecessary spending. These include making evidence-based clinical guidelines and cost information readily accessible at the point of care.

It is important to note that increasing provider awareness of costs and best practices is unlikely to motivate behavioral change when implemented in isolation. However, in combination with other financial and non-financial incentives, these indirect incentives can successfully promote the “high-quality, cost-conscious use of…resources.”

Clinical Decision Support

Embedding clinical decision support (CDS) into electronic medical records systems (EMRs) is a common way to facilitate the use of best practices at the point of care. Ideally, CDS aids physician decision-making by providing patient-specific, timely information in the form of alerts, reminders and condition-specific order sets, among other supports.

CDS has been shown to improve adherence to evidence-based guidelines, particularly with preventive care and prescription drugs. Specifically, studies have found that CDS increased use of preventive care, improved accuracy of provider medication selection and decreased the likelihood that a patient would have an adverse reaction to a drug. Successful adoption of preventive care and drug prescribing CDS has been attributed to the fact that these systems require minimal data input during the physician-patient interaction. This allows for useful recommendations to be generated instantaneously at the point of care, causing minimal disruption to the physician's workflow.

Diagnostic CDS—which assists in the determination of patients’ diagnoses—has had comparatively less of an impact on provider decision-making, largely stemming from the increased complexity of electronically generating a diagnosis compared to a simple alert or reminder. Unlike preventive care and prescription drug CDS, diagnostic CDS requires substantial amounts of patient information to generate a meaningful result. Information that is not electronically available (for example, through an EMR) must be manually entered into the system, increasing physicians’ workload and slowing the pace of a patient encounter. The added burden may cause some physicians to abandon the system and revert to their traditional mode of practice, defeating the purpose of electronic decision support. Integrating CDS into an EMR can be an efficient way to ensure that the necessary electronic patient information is readily available at the point of care, increasing busy physicians’ ability to incorporate the technology into their daily workflows.

Other reasons for the comparatively low adoption of diagnostic CDS include decreased accuracy of diagnoses caused by incomplete data entry; delay between the time recommendations are generated and when a physician needs them; and low-specificity of advice. Addressing these problems is vital to successfully incentivizing providers to use CDS in the pursuit of higher-value care.

Computerized Physician Order Entry

Computerized physician order entry (CPOE) systems can also be integrated into EMRs to allow physicians to order medications, tests, procedures and consultations electronically. Systematic reviews have shown that, when implemented successfully, CPOE improves quality by decreasing prescribing errors among clinicians.

The Meaningful Use program encouraged providers to adopt CPOE by offering financial incentives to those who used CPOE between 30 and 80 percent of the time for eligible patients. As a result, the majority of hospitals
and outpatient providers use some type of CPOE today. As with CDS, CPOE systems vary and some are more user-friendly than others.

Poorly designed systems can add to physicians’ workloads, leading to the use of workarounds or abandonment of the system altogether. Thus, designing CPOE systems to be simple to use and integrate smoothly into clinical workflows is vital to encouraging uptake among physicians.55,56

CPOE systems can contribute to efforts to improve healthcare value by providing pricing information to encourage providers to make value-driven decisions at the point of care. For example, when ordering a prescription or service, most providers must manually enter the name of the medication or test they wish to order, the prices of which are likely unknown. Designing CPOE interfaces to display the price of a medication or test next to the providers’ selection would help them compare the costs of various treatment alternatives, possibly leading to the selection of a cheaper but equally effective course of action. Studies have shown, however, that increasing the availability of pricing information alone may not be sufficient to change providers’ ordering habits.57,58 Rather, some researchers posit that it is the manner in which the information is presented that determines the level of impact (see box above).
Combining Financial and Non-Financial Incentives

Ultimately, the greatest behavioral change will likely result from an informed combination of financial and non-financial incentives. Blue Cross Blue Shield of Massachusetts has had some success with its Alternative Quality Contract (AQC), which combines these incentives in attempt to improve quality and limit spending growth.

The AQC holds participating provider groups financially accountable for quality and costs by paying them through global budgets, rather than the traditional fee-for-service. Global budgets provide a one-time, fixed payment for the continuum of care over a specified period of time, exposing providers to both upside and downside risk. Additionally, the program offers bonuses for positive performance on quality, outcomes and patient experience metrics. These awards are distributed at the organizational level, preserving autonomy by allowing provider groups to determine how rewards will be allocated amongst individual clinicians. Importantly, bonuses are based on absolute (as opposed to relative) performance, allowing all organizations demonstrating superior performance to be recognized.

Non-financial incentives are delivered through the AQC Support Program, which provides a number of resources designed to help participating organizations succeed. For example, Practice Pattern Variation Analyses aim to reduce informational barriers by highlighting differences in physicians’ treatment of similar clinical conditions. These reports help provider groups recognize opportunities to employ best practices, supporting the use of high-value care. Other data and analytics reports offer a comprehensive overview of patients’ medical care to help participants identify areas for improvement and to measure progress. The reports also include peer comparisons to further inspire high performance.

An evaluation conducted four years into the program revealed that the AQC’s unique combination of financial and non-financial incentives reduced costs, improved quality and slowed spending growth among participating organizations. Moreover, evidence suggests that provider

Spotlight on Financial Incentives

Health system transformation activities at the state and federal levels have primarily relied on financial incentives to alter provider behavior, including pay-for-performance, capitation and bundled payments. Generally, these incentives aim to advance policy goals (e.g., improve quality or reduce wasteful spending) by aligning them with providers’ self-interest. The underlying rationale is that paying physicians based on their ability to meet specific quality or efficiency measures will incentivize them to do it more frequently.

Research suggests that, while financial incentives are important and do lead to some improvements in care delivery, they alone are not moving the market toward achieving higher value care. Studies show that financial incentives work best for narrow, routine tasks, but become less effective as the task’s complexity increases. In fact, tangible rewards may actually decrease motivation to complete a desired task in situations that are highly complex or require creativity. The goal of improving healthcare value is inherently complex, made more so by a lack of agreement on what high-value care is and how to measure it. It also requires significant creativity on the part of providers to “hunt for waste, resolve safety issues and sustain improvement.”

Another barrier to success has been an inability to align payers to reward performance based on a core set of quality metrics. Because many providers receive payments from multiple sources, incentive programs tying physicians’ reimbursement to different measures can send conflicting messages, making it difficult for providers to meaningfully invest in improvement activities. Thus it behooves us to look beyond the use of financial incentives alone in our efforts to transform healthcare delivery.
groups generally support the program, with many altering traditional modes of practice to improve performance. Examples of changes include adopting new staffing models to facilitate team-based care; hiring professionals to address behavioral and social needs; embracing new forms of health information technology; and developing and/or strengthening relationships with other provider groups. Participants also reported seeking partnerships with like-minded organizations and, in some cases, distanced themselves from partners that are less focused on improving quality and controlling costs.65

Conclusion

Although many strategies to improve healthcare value rely on financial incentives, it has become increasingly clear that financial incentives alone will not achieve our goal of getting to better healthcare value. Like all humans, physicians are complex, and their behaviors are motivated by factors beyond financial self-interest. Therefore, diversifying incentive programs to incorporate non-financial incentives can be incredibly effective in encouraging the provision of high-value care.

Conversations about achieving healthcare value are compromised by a lack of consensus over what healthcare value is and how to measure it. As noted above, best practices do not exist for every condition, challenging even the most well-intentioned providers to consistently deliver the highest quality care. Additionally, cost-effectiveness studies do not exist for every treatment, forcing physicians to make personal judgements about which therapies offer the greater value. Increasing the availability of these studies and providing forums for physicians to regularly discuss new evidence and research are important prerequisites to delivering higher value care.66

Ultimately, the greatest behavioral change will likely result from an informed combination of financial and non-financial incentives. Furthermore, the appropriate suite of incentives will vary depending on the care setting in which it is applied.67 For example, physicians’ reactions to incentives differ according to the types of organizations and cultures in which they work, how they are paid, their areas of professional focus and individual personality traits. Understanding and accounting for these differences is difficult, but essential for successfully incentivizing change.

Notes

6. Ibid.
13. Lee and Cosgrove (June 2014).
14. Ibid.
19. The findings from this evaluation contradict numerous studies demonstrating a positive impact of “similar informative letters," leading researchers to recommend further investigation to determine whether alternative types of letters may be more effective.
22. Lee and Cosgrove (June 2014).
24. Ibid.
33. Lee and Cosgrove (June 2014).
34. Roland and Dudley (December 2015).
36. Liao, Fleisher and Navathe (Sept. 20, 2016).
38. Roland and Dudley (December 2015).
46. Jaspers, et al. (May 1, 2011).
47. Ibid.
48. Ibid.


54. Percent of the time providers were required to use CPOE increased with each stage of the program: from 30 percent of the time for eligible patients in Stage 1 to 80 percent of the time for eligible patients by Stage 3.


60. de Brantes and Eccleston (Aug. 7, 2013).

61. Ibid.


63. Khullar and Safran (March 2017).


66. Bishop et al. (March 2017).


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