EDITORIAL

Financial Incentives in Primary Care Practice
The Struggle to Achieve Population Health Goals

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It is estimated that 66% of total health care spending in the United States is directed toward care for about 27% of individuals with multiple chronic conditions.[1] Many policy experts suggest that improving the quality of chronic disease management is a key strategy in controlling costs. Thus, insurers and payers are creating and evaluating incentives to improve the quality of care, including reducing the underuse, overuse, and misuse of clinical services.[2] Pay for performance (P4P) is one of the most common strategies under evaluation, and the types of P4P incentives may vary based on whether it is implemented in a capitated or fee-for-service environment or on the size of the practice.[3]

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In this issue of *JAMA*, 2 randomized trials report the comparative effectiveness of financial incentives in primary care settings. These studies advance the current understanding of the role of financial incentives in quality improvement in diverse practice settings but also raise questions about the continued focus on the role of financial incentives targeted at physicians as a mechanism to reduce health care costs.

Bardach and colleagues[4] assessed the effect of P4P incentives in 84 small practices with a common electronic health record system (EHR) on reducing long-term cardiovascular risk (antithrombotic prescription, blood pressure control, cholesterol control, and smoking cessation). Similarly, Petersen and colleagues[5] assessed the effect of individual physician-level and practice-level financial incentives or the combination of both, compared with no incentives, on hypertension care across 12 Veterans Affairs (VA) primary care clinics.

The 2 studies compared different types of financial incentives in different payer settings and had different baseline levels of control for their hypertensive populations and therefore should be viewed separately. The only commonality was use of an EHR in the primary care setting. The trial by Bardach et al assessed the implementation of a practice-level incentive in small practices after 9 to 10 months of EHR implementation, with a mix of payer reimbursement (33% commercial, 25% Medicare, 36% Medicaid, 5% uninsured) and with a baseline adjusted rate of blood pressure control (without comorbidities) of 32% in the control group and 45% in the incentive group. At the end of the study, intervention practices had greater absolute adjusted improvement in rates of appropriate antithrombotic prescription (12.0% vs 6.0%), blood pressure control (9.7% vs 4.2%), and smoking cessation interventions (12.4% vs 7.7%). The trial by Petersen et al assessed individual-level, practice-level, or a combined incentive compared with a control group in a VA population with a baseline level of blood pressure control ranging from 75% to 85% across the 4 groups. The adjusted estimated absolute change over the study of the patients meeting the combined blood pressure measure (achieving guideline-recommended thresholds or receiving an appropriate response to uncontrolled blood pressure) was 8.84% for the individual incentives group, 3.70% for the practice-level incentives group, 5.54% for the combined group, and 0.47% for the control group.

The results of these 2 studies and those of others indicate the effects of P4P will vary based on the types of financial incentives implemented, payer mix, and baseline level of quality care. Larger effects of P4P are likely seen in practices that are newly adopting an EHR and do not have an existing quality improvement structure, with a ceiling effect for those practices with longstanding EHR and quality improvement implementations. Moreover, the sustainability of P4P incentives is unknown. The trial by Bardach et al[4] was not conducted long enough to look at sustainability issues. The trial by Petersen et al[5] showed that removal of the financial incentives resulted in a return to the baseline for each intervention group.

Even though the findings of these 2 studies are encouraging in advancing understanding of the P4P strategy, the reports also raise questions about the solitary focus on clinician performance in achieving these population health goals. Both studies suggest that even with elegant incentives applied at the practice level, gaps in clinical performance still remain. These results suggest that although there is some room for improvement of individual performance, these gaps represent systematic shortcomings rather than an issue with performance at the individual clinician level. In a population health model, a variety of strategies is used to achieve success. Some of these strategies would be clinician focused, some technology focused, some community focused, and some patient focused. The appropriate allocation of resources to each of these strategies would be based on economic analysis—how to gain the greatest increase in population health from optimizing interactions across all of these efforts. This type of framework transforms the question from the effectiveness of primary care practice to the effectiveness of primary care service embedded in a community.[6]

What might this approach look like? First, clear clinical goals need to be established for the patient population. For instance, assume that the delivery system had a goal of 90%

achievement of services recommended by the US Preventive Services Task Force or similar levels of guideline ascertainment on a population level. Senior leaders would examine population health metrics rather than utilization metrics as they focus their efforts for their team. A clinical operations core unit would include analysts assigned to assess gaps in performance and coordinate resources and strategies. Technology would be focused on achieving population health goals in partnership with patients—using portals, electronic reminders for patients and clinicians, and smart phone-based strategies. In addition, population health management teams would track individual patients struggling with their goals and focus attention on their special needs. The proposed financial incentives would be targeted at leadership to hold them accountable for the performance of this system in conjunction with the individual clinicians caring for patients. Public reporting would include clinical performance on these goals instead of the highest rating received of the many discordant hospital rankings currently available. Of course, systems do not require ownership of all of the elements of this process: just an ability to identify responsibility and share data to achieve these results.

Both studies raise the question of the unique contribution of primary care physicians in this population health model. Is the highest possible application of their skills and abilities implementing specific performance goals on a routine basis, or is it some other set of services that only primary care physicians can provide (eg, care coordination, counseling, personal health planning)? What are the economic and opportunity costs of directing the primary care workforce in this focused but limited direction?

The trials by Bardach et al[4] and Petersen et al[5] provide a great opportunity to ask the question of how to best use the limited but expensive primary care physician workforce in the most effective manner in the evolving health care delivery system. But this question also suggests that a clear understanding of system-level goals and responsibilities is needed to enable the transformation of clinical care.

ARTICLE INFORMATION

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