# Extra pay does not improve hospital performance

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Paying hospitals extra money does not appear to significantly improve the way they treat heart attack patients or how well those patients do. But giving hospitals the information that they need to improve heart attack care does help.

A team of researchers led by the Duke Clinical Research Institute looked at whether financial incentives to hospitals for adhering to specific treatment guidelines would improve patient outcomes. They found no evidence that financial incentives were associated with improved outcomes, nor that hospitals had shifted their focus from other areas in order to concentrate on the areas being evaluated for possible increased payments.

These findings will add to the national debate over the use of “pay for performance” as a strategy for encouraging hospitals to use drugs and therapies that have been proven to save lives in large-scale clinical trials, the researchers said. The theory is that the possibility of receiving higher reimbursements will motivate hospitals to improve the quality of their care.

A study recently conducted by Premier, Inc., a group that represents hospitals participating in a large Center for Medicare & Medicaid Services (CMS) pilot project of pay for performance, found that paying hospitals extra money for following specific guidelines led to better patient care and outcomes. However, that study did not include a group of hospitals not receiving incentives as a comparison. So the Duke team

compared the CMS data with that of a registry of 105,383 patients treated for a heart attack at 500 hospitals involved in a national quality improvement effort.

“This is one of the first analyses of the impact of a pay for performance initiative on heart attack care,” said Seth Glickman, M.D., M.B.A., first author of a paper appearing June 6, 2007, in the Journal of the American Medical Association. “We found that the pay-for-performance program was not associated with a significant incremental improvement in the quality of care or outcomes for patients with heart attacks beyond that seen with voluntary quality improvements.”

“There are three important messages from this study,” said cardiologist Eric Peterson, M.D., senior member of the research team. “On one hand, the data showed that care is improving overall in the United States, which is obviously good. However, we did not find that pay for performance alone will be the sole means of improving care. In fact, it all comes down to hard work by individual caregivers and institutions.

“Here, it appears that a voluntary effort to ‘do good and improve care’ was equally as powerful as the incentive for additional payment,” Peterson said. “Finally, heart attack mortality declined significantly over time in pay-for-performance and non-pay-for-performance hospitals over time with better care processes. The bottom line is that patients win when health care providers are committed to improvement, no matter what the incentive is.”

The researchers looked at how all hospitals performed in six measurements of quality: the use of aspirin and beta blockers both at arrival to the hospital and at discharge, smoking cessation counseling, and the use of angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers for weakened left pumping chambers. These measures were selected because clinical trials have proven that

their use improves the outcomes for heart attack patients.

The monetary incentive for the CMS study was relatively small. Over a two-year period, a total of $17.55 million was paid to 123 hospitals the first year and to 115 hospitals the second year.

“Medicare’s strategy of trying to use the payment system to improve performance of hospitals is certainly laudable,” said Kevin Schulman, M.D., professor of medicine and business administration at Duke and study co-author. “However, we really need a robust research base to inform the design of the program and clearly we need to continuously monitor performance to ensure that we are achieving our clinical goals through these efforts.”

Glickman noted that “additional studies are underway to identify hospital policies and organizational characteristics that are associated with a higher standard of care in order to develop more effective incentive based strategies.”

The team plans to organize a larger effort involving the major cardiology associations.

“We’ve partnered with the cardiovascular professional societies to have an ongoing national heart attack quality improvement initiative known as ACTION,” Peterson said. “No matter what incentive will ultimately be the driving force, ACTION will give hospitals and health care providers the tools and data they need to improve.”

Source: Duke University Medical Center