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POLICY BRIEF

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Implementation of Pay-For-Performance in Rural Hospitals: Lessons from the Hospital Quality Incentive Demonstration Project

Overview

Pay-for-performance (P4P) strategies establish different payment levels for health care providers based on their performance on a set of measures of quality and/or efficiency. In 2003, the Centers for Medicare and Medicaid Services (CMS), in collaboration with Premier, Inc., a nationwide alliance of not-for-profit healthcare systems and hospitals, launched the Hospital Quality Incentive Demonstration (HQID) project. Experiences from the demonstration project, which involves over 260 Premier hospitals, will help shape the nationwide value-based purchasing program authorized under the 2006 Deficit Reduction Act and scheduled to be launched in fiscal year 2009.

Rural health care providers have voiced concerns over the possible impact of P4P initiatives on rural providers and communities. Concerns have focused on the extent to which unintended consequences of P4P may result from differences between larger rural and urban hospitals and their smaller, more remote, counterparts. That is, differences in the availability of information system infrastructure, medical and clinical staff resources, and capital as well as the narrower scope of services and lower patient volumes of smaller, more isolated hospitals may require a different set of strategies to achieve the goals of a national P4P initiative. However, information to help determine whether there may be a differential impact on rural hospitals is lacking.

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To identify the institutional, organizational, and environmental factors that could influence the future performance of small rural hospitals in P4P programs, a telephone survey of hospital quality managers, Premier and CMS staff was conducted in fall 2005. In the survey, specific attention was given to the issues surrounding the ability of hospital staff to comply with the HQID criteria for three common clinical conditions: 1) acute myocardial infarction (AMI); 2) congestive heart failure (CHF); and 3) community acquired pneumonia (PN).

The results of this study suggest that the ability of small rural hospitals to successfully participate in P4P programs similar to the HQID will depend on their familiarity with performance improvement strategies, access to human resource strategies for data collection and analysis (in lieu of electronic infrastructure), and the commitment of senior staff and board members.

Key Findings

The quality managers contacted as part of the survey typically described their initial P4P experience as an on-going challenge to collect accurate and consistent quality measurement data, analyze those data, and use the findings to improve performance. Even though all small rural hospitals participating in the HQID had worked with Premier's data software, only two of them possessed electronic medical record capacity. For the most part, data collection, analysis, and performance improvement interventions were accomplished by individuals using a paper-driven information system.

Although many quality managers and other hospital staff encountered difficulties in the initial stages of program participation, they exhibited considerable ingenuity and innovation in developing and implementing processes and protocols to help medical and clinical personnel meet the needs of their patients and at the same time fulfill the data requirements of the HQID. Hospitals implemented new and revised admission and discharge protocols and forms, as well as standing orders to cover situations when direct physician oversight could not always be assured. Data collection and analytic tools were developed to assist physicians and nurses with their program-related responsibilities (e.g., pre-printed order sheets, colorful stickers to highlight critical data entry points in patient charts).

Supportive and motivated executive staff and board trustees were shown to be very important to creating the type of corporate culture needed to maintain staff enthusiasm and program focus.

Financial and Non-Financial Incentives

- Hospitals with fewer than 100 beds, which comprise the majority of rural hospitals, typically have low patient volumes and fragile financial margins. The volume-driven bonus structure of programs like the HQID place them at a distinct disadvantage. Even under exemplary conditions, it will be difficult for smaller rural hospitals to generate sufficient financial bonus payments to balance program-related investments for performance improvement (e.g., personnel and information infrastructure).

- Physicians and nurses are motivated by non-financial incentives such as feedback on the quality of care they are providing to patients. In addition to clinical feedback, many hospitals acknowledged high performance staff through peer recognition programs for individuals and departments that excelled. The close-knit staffing of small rural hospitals and community networks in many rural communities may give added emphasis to more personal approaches to motivate performance excellence.

Feedback Regarding Performance

- Frequent, clear, and accurate feedback is critical for physician and nurse performance improvement. The lack of information infrastructure and greater demand on available staff in many rural hospitals will be a challenge to providing feedback during initial participation in P4P programs.

- Freestanding rural hospitals are likely to have greater difficulty in garnering the knowledge, human resources, and electronic infrastructure necessary to providing feedback to improve performance than facilities that are part of healthcare systems or that are linked with larger facilities.

Hospital Staffing and Involvement in P4P

- Physician and nurse involvement is critical for successful participation in P4P programs. Rural hospitals facing physician and nurse shortages may encounter greater challenges enlisting clinical staff as P4P champions.

- Rural hospitals faced with limited clinical staff resources can especially benefit from the adoption of defined skill sets for quality management staff. This can facilitate the hiring and internal acceptance of non-clinical staff to meet the data extraction, documentation, and analytical responsibilities that would otherwise have to be completed by nursing staff.

- Limited availability of pharmacists, phlebotomists, and laboratory staff will challenge most rural hospitals to meet critical timing and sequencing requirements for blood cultures, initial antibiotics, and immunization assessments making adoption of alternative strategies important for success (e.g., standing orders and structured protocols). This can be particularly critical in emergency departments where coordination is difficult due to fluctuations in staff availability, patient volume, and critical needs. Standing orders allow physician extenders to manage care needs that otherwise would require contacting on-call physicians. Cross-training nursing and ancillary staff can provide coverage for skills that otherwise might only be available on-call.

Access to Capital

- Limited access to capital will be a challenge for most small rural hospitals in the adoption of the information technologies and infrastructure that support performance improvement efforts.

Key Issues for Future P4P Initiatives

- Future P4P programs need to be clinically relevant for small rural hospitals in terms of scope of conditions and patient characteristics.
- Financial incentives based on competitive/balanced-budget designs make it difficult for low performers to achieve program goals.
- Future national P4P programs should include design features that accommodate the varying degrees of information system sophistication available in rural hospitals. These features also should guide and encourage local markets with limited IT systems to build capacity through participation.
- The development of national P4P initiatives should be coordinated with the work of a National Quality Coordination Board that has rural expertise. This approach can facilitate standardization of the many data collection and reporting requirements of hospitals and providers while considering the administrative burden on small hospitals with limited staffing resources.
- Incentives should be provided to hospital and healthcare systems, networks, and alliances to foster greater sharing of resources and expertise that result in the development of a coordinated health information infrastructure capacity for small rural hospitals.

About the Study

The hospitals in the study have 100 or fewer staffed beds and are located in a non-metropolitan (rural) county as defined by Office of Management and Budget criteria. Survey respondents included thirteen quality managers representing all fifteen small rural hospitals participating in the HQID, along with four quality managers from small rural hospitals that decided not to participate in the HQID, and seven senior project staff from Premier, Inc., and CMS. The survey interviews were conducted by Walt Gregg.

The information in this policy brief is based on Upper Midwest Rural Health Research Center Working Paper #2 by Walter Gregg, MA, MPH, Ira Moscovice, PhD, both from the University of Minnesota, and Denise Remus, PhD, RN, Premier, Inc.

The Working Paper is available at http://www.uppermidwestrhrc.org/

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