Author's response to reviews

Title: Design choices made by target users for a pay-for-performance program in primary care: an action research approach

Authors:

Kirsten Kirschner (k.kirschner@iq.umcn.nl)
Jozé Braspennning (j.braspenning@iq.umcn.nl)
J.E. Annelies Jacobs (j.jacobs@iq.umcn.nl)
Richard Grol (r.grol@iq.umcn.nl)

Version: 3 Date: 12 March 2012

Author's response to reviews: see over
12 March, 2012

Dear Sir,

Thank you for giving us the opportunity to submit this revised version of our paper with the title “Design choices made by target users for a pay-for-performance program in primary care: an action research approach”. We would like to thank the reviewers for their comments which helped to improve the quality of the paper furthermore.

We made two documents:
- A file that includes additions and changes made in accordance with suggestions by the reviewers;
- A letter in which we describe in detail how we dealt with the comments.

An appendix with all the indicators of the P4P program is also added. A possibility would be to make this appendix only available on our website.

We hope that our adjustments and comments are satisfactory and are looking forward to your reply.

Yours sincerely on behalf of the other authors,

K. Kirschner
Scientific Institute for Quality of Healthcare
Internal code 114
PO Box, 9101
6500 HB Nijmegen, The Netherlands
+ 31 24 3616338 (phone)
+ 31 24 3540166 (fax)
Referee comments and response

Reviewer 1
The reviewer states that the paper is much clearer now with the adjustments made. Though in his opinion there are some minor essential revisions needed. We will reply point-to-point below. The reviewer makes several suggestions to discuss possible limitations of design choices made. We, therefore, added a paragraph to the discussion section to discuss the strengths and limitations of the design choices of the developed P4P program. The paragraph of implications became a bit redundant and has been cancelled.

1. The reviewer indicates that it is not clear which approach we will follow regarding to the non-incentivized aspects of care issue and possible approaches to tackling it. This paper describes the choices that were made for the P4P program on the short term. For the long term no decisions have been made nor discussed, yet. In the extra section on strengths and limitations of the design choices we discuss the possible decline in non-incentivized aspects on page 12 (line 1-4) and the improvement of outcome indicators that are indirectly incentivized on page 12 (line 5-8).

2. The second point of the reviewer is about the remuneration.
   a) The reviewer asks us what the seven levels of care are. These levels are not set beforehand; they depend on the performance of all participating practices. To calculate the seven levels the quality scores of all practices are divided in seven equal groups. The levels have no absolute but relative ‘thresholds’. A more explicit explanation can be found in the results section ‘appraisal’ on page 8 (line 27-29 and 32-34).
   b) The reviewer mentioned that someone could argue that the 25th percentile is pretty low and we are rewarding practices for good quality of care that are achieving worse than the average practice. Our P4P program is developed to stimulate practices with a high performance as well as practices with a low performance. In the discussion on page 11 we added that the series of tiered thresholds have attainable goals for each practice (line 6-8).
   c) We removed box 1. Table 2 shows the bonus per patient for the seven levels of quality and for the quality improvement in clinical care, practice management and patient experience in year 1 and the following years. The exact ‘thresholds’ of the seven levels are not known because they depend on the performance of the participating practices. The maximum bonus in year 1 and in the following years for a practice with 1000 patients is added to the results ‘reimbursement’ section on page 9, line 31-33.
   d) The reviewer questions the remuneration levels for improvement and suggests that this might be an invitation to practice gaming. As mentioned above the levels depend on practice performance of all participating practices. When all practices show this calculating behavior, there is no change in the next year because the levels are relative. In theory this can decrease practice performance. We will discuss this issue in the strengths and limitations of the design choices. Furthermore a practice that is in level 6 for quality, will not necessarily be at level 6 of improvement. It is more likely that this practice is in level 2 or 3 for the improvement. Quality level and improvement level are calculated separately and are both based on the performance/improvement of all participating practices.

3. The reviewer accepts the explanation on how we suggest to deal with baseline performance that improves before introducing the program, but misses this explanation in the limitations section. We added this to the limitations section of the design choices on page 12 (line 9-13).
4. The reviewer suggests the issues under point 4 to be addressed in the limitation section.
   a) We added the issue about sustainability to the limitations section of the design choices on page 12 and 13 (line 27-33 and 1-2).
   b) A concern of the reviewer is the inclusion of process indicators and exclusion of outcome indicators (better proxies of health) in the P4P program. We added this concern to the limitations section of the design choices on page 12 (line 5-8).
Reviewer 2 states that we have adequately addressed the reviewers’ comments and concerns.