



THE POWER OF A LITTLE INCENTIVE A SHORT STORY

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This short story tells the tale of a little incentive that was so powerful, it leaped into tall hospital buildings, jumped through silos and inspired health care team members across many disciplines to communicate, collaborate, and work to improve the quality of patient care.

There was a hospitalist program whose physicians had some of their income at risk for the quality of care they provided to their patients. These incentives were established on a yearly basis and—like all appropriate incentives should be—were relevant, measurable, under the direct control of the action of the physicians, and of course, legal.

Through attendance at quality meetings and direct conversation with the hospital's Chief Quality Officer, the director of this hospitalist program learned the relevance and importance of core measures. They knew these measures of the quality of hospital patient care were reported to the general public and would soon affect hospital reimbursement.

The director worked with the Director of Clinical Affairs of the hospital-owned medical group, and with friends in Quality and Decision Support, to establish quality incentives based on core measures of performance. It was tricky business. For some core measures, the number of patients that the medical group treated was too small for the results to be significant. Other core measures were not under the direct control of the physicians. By working together, this team was able to identify an appropriate set of core measure quality incentive targets for the physician group.

One of the core measure quality incentives involved patients who came to the emergency department with pneumonia, and received antibiotics within 6 hours of arrival. Rapid treatment is very important in order for these patients to improve. Nationwide, the average hospital accomplished this task in 94% of affected patients, and the best hospitals accomplished it in 99%. The particular hospital in our story had previously set a target range of between 90% and 100%. The hospitalist group had historically succeeded on

this core measure 91-97% of the time. Based on this information, the target for the hospitalist group was set at 97%.

When this was shared with the group, the physicians noted this high target and remarked that one "miss" could cause them to lose their full incentive. The program director reminded the group that their ultimate goal was to treat 100% of their patients the right way 100% of the time. The group accepted and took ownership of this incentive. They discussed and brought to the attention of the director that they use a standard set of orders for hospital pneumonia based on evidence and best practices. This order set recommends the use of an antibiotic combination of Ceftriaxone and Azithromycin, unless the patient has an allergy to penicillin, in which case Levofloxacin is recommended. The group pointed out to the director that in their experience, the emergency department (ED) physicians appeared to order Levofloxacin for all pneumonia patients. The group wondered if the ED physicians should be following the same treatment guidelines. They also wondered if the recommended antibiotics were always kept in stock in the ED for timely administration to patients. Some were fairly certain that Azithromycin was not kept in stock in the ED.

The director of the program met with the director of the emergency physicians. He acknowledged the antibiotic recommendations for pneumonia, reflected on the current prescribing patterns of his physicians, and agreed to educate his physicians regarding the pneumonia order set and recommended antibiotics. He also identified that Azithromycin was not stocked in the ED, unlike the other two antibiotics. This could delay the patient receiving the recommended antibiotic combination, possibly beyond the 6 hour time window.

Both directors met with the clinical pharmacist assigned to the emergency department. He did a quick analysis and saw that Azithromycin was ordered frequently enough to merit keeping it in stock in the ED. He agreed to make changes so that Azithromycin would

always be kept in stock in the emergency department, along with the other two antibiotics. Subsequently, because the pharmacy was now aware of the importance of timely provision of Azithromycin, and because the ED physicians were committed to following the protocol for its use, the pharmacy arranged to provide Azithromycin to the pharmacy so quickly that it didn't even have to be stocked in the ED.

The end of this story is that through the power of this little incentive, patients in the emergency department who have pneumonia will receive recommended antibiotics in a timely fashion. This positive change occurred through person-to-person communication and collaboration, and did not require a committee or a task force.

Indeed, the power of a little incentive.

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