

MEDICINE AND SOCIETY

How to Keep Diffusion of Responsibility From Undermining Value-Based Care

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Abstract

Diffusion of responsibility describes how individuals can underperform in circumstances of shared accountability. While not well studied in health care settings, this phenomenon is an unintended consequence of the health care sector's complexity and fragmentation. This article considers 3 ways in which monetary and nonmonetary incentives can mitigate negative consequences of diffusion of responsibility. First, incentives should be finite and focused. Second, health care organizations can incentivize both individual and team performance. Third, organizations can use peer comparison feedback to amplify effective incentivizing strategies.

Diffusion of Responsibility

Diffusion of responsibility describes how individuals can underperform in circumstances of **shared accountability**. While not well studied in health care settings, the phenomenon has been described in a number of other fields.^{1,2,3} It increasingly represents a concern in health care, as care delivery complexity increases and the nation continues to shift toward value-based programs that hold clinicians and organizations financially accountable for the quality and costs of care.

Consider care fragmentation—which occurs when patients receive care from multiple clinicians without a main one who guides or coordinates care⁴—as a prominent manifestation of diffusion of responsibility. When patients receive care from multiple clinicians in multiple organizations, diffusion of responsibility can result if each clinician assumes that others have taken on the role of coordination for a patient's care.⁵ Unfortunately, a growing body of data demonstrates that higher levels of care fragmentation are associated with adverse outcomes, including increased emergency room, hospitalization, and total health care spending.^{6,7}

As a field of study that seeks to explain why individuals consistently make suboptimal decisions, behavioral economics provides a set of principles⁸ that can be applied to help mitigate negative performance and outcome consequences of diffusion of responsibility. In particular, health care leaders can use principles and concepts from behavioral

economics to design and implement financial and nonfinancial incentives to establish accountability, set achievable performance goals, and effectively provide performance feedback for individuals and groups—3 key strategies that can counteract diffusion of responsibility across individuals, teams, and organizations in the era of value-based care. Here, we apply behavioral economics principles to strategies related to incentive design and performance feedback.

Individual Incentive Design

Leaders can minimize diffusion of responsibility by giving individual clinicians clear direction about their roles and accountability.⁹ As evidenced by contemporary value-based programs¹⁰ and payment codes that encourage delivery of transitional care,¹¹ individual incentives can be promising strategies for achieving this accountability. This is particularly true when incentives are designed and implemented using the behavioral economics principles of *choice overload* and *goal gradients*.

Choice overload. As a behavioral principle, choice overload describes the demotivation that can occur in situations defined by an abundance of choices.^{8,12} For instance, dozens of menu options may leave a restaurant patron paralyzed to make a decision, whereas she can make a quicker, more decisive choice between 3 options. As an example within health care, clinicians may be discouraged by quality incentive programs that require choices among a large set of potential performance metrics as opposed to a small set of potential performance metrics. The effect of choice overload, which is compounded by the fact that clinicians participate in multiple quality incentive programs for multiple payers, underlies efforts by policymakers to create “core measure sets,”¹³ which seek to improve clinician performance by reducing the burden of choosing among large numbers of metrics.

It is important to counteract choice overload—specifically, the negative impact on clinician motivation of large numbers of both tasks and clinical team members—by designing incentives that streamline the number of tasks and team interactions. Doing so can create positive, synergistic results that encourage rather than discourage accountability by harnessing the motivation created by incentives while averting demotivation due to choice overload.

Goal gradients. Individual incentives can also counteract diffusion of responsibility by incorporating goal gradients, a behavioral economics principle that describes the use of graded thresholds as opposed to a single benchmark to set performance goals.⁸ One of the limitations of single benchmarks is that while they can motivate individuals near the threshold (ie, those with high likelihood of meeting it), they can be very demotivating for those either above (ie, those for whom the threshold does not apply) or considerably below (ie, those with little hope of meeting the threshold).

Motivation can be increased by setting goals that apply to all individuals regardless of current performance. For example, Blue Cross Blue Shield of Massachusetts’ Alternative Quality Contract—a value-based payment model that was associated with decreased costs and improved care quality over 2 years¹⁴—incorporated the principle of goal gradients by establishing, for each participating group, 5 sequential performance “gates” for each quality measure, thereby creating achievable graded targets for all groups, regardless of starting performance level.¹⁵ The presence of multiple gates increased the probability that groups across a broad spectrum of starting performance levels would achieve bonuses, with each successive gate offering an increasingly higher

financial incentive. Similarly, individual incentives that incorporate goal gradients could help reduce diffusion of responsibility by motivating individuals.

Group Incentive Design

Leaders can also implement **group incentives** to motivate shared accountability and team performance. Given their broad focus, group incentives might seem like a counterintuitive strategy for mitigating the diffusion of responsibility. However, their potential benefits arise from the widespread presence of social pressure, which describes how individuals are driven to change their behavior based on how they are, or desire to be, perceived by others. Group incentives designed to leverage social pressure thus can focus rather than diffuse responsibility for patient care.

This phenomenon of social pressure has been observed in multiple settings. For instance, many restaurants opt to pool tips among the waitstaff, thereby motivating servers not only to perform well individually but also to pull their weight to contribute to the benefit of the group. As another example, a law firm may choose to allocate a substantial percentage of partner compensation based on overall firm performance.

Group incentives have also been successfully implemented in the setting of value-based health care. For instance, a hospital system that implemented a value-based bundled payment program successfully engaged its physician groups by designing **financial incentives** that were based on group performance.¹⁶ In particular, individual physicians were only eligible for financial bonuses if the entire group achieved a certain performance level—an approach that organically generated self-policing behavior, such that physicians actively held each other accountable and encouraged each other to meet performance goals. This design helped the hospital system achieve savings, maintain care quality, and become a top performer in the program.

Importantly, social pressure can be combined with behavioral economics principles to further increase the salience of group incentives. For instance, in the example above, the hospital system further motivated its physicians to engage in the bundled payment program by combining social pressure with the above-mentioned principle of goal gradients in designing its group incentives. Not only did social pressure motivate individuals (ie, to be perceived positively by their peers for contributing to group performance), but goal gradients increased the personal salience of these efforts by financially rewarding individual performance.

Peer Comparison Feedback

Peer comparison feedback—feedback on individuals' performance relative to that of their peers—is another promising strategy for combating diffusion of responsibility. The power of such feedback lies in its application of the behavioral economics principle of *relative social ranking* and can be further strengthened by incorporating the behavioral economics principle of *immediacy*.

Relative social ranking describes the motivational power of seeing information about one's performance relative to that of others.⁸ In an example outside of health care, utility companies promoted energy-conserving behavior by sending customers regular peer comparison feedback reports that included data about their energy usage compared to that of their neighbors. By harnessing relative social ranking via peer comparison feedback, the intervention led to a reported \$1.1 billion in savings.¹⁷

Similar dynamics have been demonstrated in health care. For instance, primary care physicians reduced inappropriate antibiotic prescribing in response to receiving peer comparison feedback about prescribing behaviors.¹⁸ Peer comparison feedback can include more than just information; it can also incorporate a normative appeal (ie, a judgment about the desirability of a given behavior) as further motivation to improve.¹⁹ Using the example of antibiotic prescribing, health systems could pair peer comparison feedback with normative statements about the inappropriateness of regularly prescribing antibiotics for uncomplicated upper respiratory infections to reduce guideline-discordant antibiotic prescribing.

Importantly, peer comparison feedback need not occur at the individual level to be effective in changing behavior and addressing diffusion of responsibility. For example, a health plan in California used clinic-level rather than individual clinician-level peer comparison feedback to rank clinics based on opioid prescribing behavior. This intervention was a key part of a program that was associated with reductions in opioid prescriptions.²⁰

The behavioral economics principle of immediacy describes the association between timeliness of feedback and motivation. In the context of performance feedback, the timelier the feedback, the greater the motivation to change behavior.⁸ For example, anecdote²¹ and experience suggest that technology such as wearable activity trackers can create and sustain individuals' motivation to increase physical activity by providing immediate feedback about performance and goals.

Immediacy also has a potential role in guiding clinician behavior. For instance, health systems have used immediacy to refine physician incentive programs by moving from quarterly to real-time data feedback as part of a strategy that ultimately improved overall physician quality performance scores.²² Similarly, by shortening the feedback loop when providing peer comparisons, leaders can leverage the benefits of immediacy to further reduce diffusion of responsibility.

Conclusion

As the US health system continues to shift from fee-for-service toward value-based payment arrangements, the need for accountability for the quality and costs of care is likely to spotlight the problem of diffusion of responsibility in patient care. The use of behavioral economics principles in designing monetary and nonmonetary incentives can be effective strategies for addressing this issue and motivating clinicians and teams in the era of value-based care.

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Citation

AMA J Ethics. 2020;22(9):E802-807.

DOI

10.1001/amajethics.2020.802.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.