Are Your Specialists and ACO Ready for the Referral Revolution? Part 1

written by Thomas Dent, M.D. | July 29, 2015

The practice of physician-determined referrals to specialists is deeply embedded in the culture of medicine. But it no longer works under Value-Based Health Care. A revolution in referrals is underway, one that will dramatically change physician alignment and engagement in ACOs and other Pay for Performance models.

Outcome measures can distinguish the performance of one specialist versus another—and this performance data is available to both health systems and physicians. We all know that pure comparative performance data has a lot of flaws. But Medicare is publishing provider-specific performance for PQRS and group performance for ACOs, and calculating comparative scores under the Value-Based Payment Modifier.

As health systems and value-based networks develop a new set of criteria for referrals by their physicians based on these outcomes, new referral patterns will rock both historical referral patterns and governance. ACOs and their physicians, in particular, need to understand the implications and be prepared for significant challenges ahead, both political and economic.

The Old Way Versus the New Way of Making Referrals

As a primary care physician, I recognized the need to find excellent specialists for my patients, and that my patients trusted me to refer them only to the best—relying on my judgment. When choosing a specialist, I considered those who had prior good results or for whom I'd received positive feedback from my patients or colleagues. I did not refer based on evidence of excellent performance on the part of the specialist, because such data were not available.

But that’s no longer the case. Not only is performance data becoming essential to specialist referrals under Value-Based Health Care, but also the majority of primary care physicians are now in employed groups. Under the new at-risk programs, they may not have a choice when referring patients to specialists. Even if they see the Medicare numbers they will be told what to do.

The Dilemma: Reach Future Goals Only At The Cost Of Near-Term Revenues

Let’s look at the following likely scenario:

There are three physician groups in a hospital-based ACO. Groups A and B are private practice specialty practices in the same specialty, while Group C is employed by the institution and is multi-specialty. All three groups belong to the same ACO sponsored by the institution. An outcome measurement process is begun, which shows that Group A has much better outcomes than Group B.

What happens to the referral process? There are two basic possibilities:

- The primary care physician in employed Group C is told to use the employed Group C specialist for the sake of the employed practice, regardless of the outcomes, OR
- The primary care physician in employed Group C is told to use private Group A because that will better affect the shared savings potential of the ACO.

You can imagine the ensuing conflicts. The political and economic consequences of either option is a problem for both the specialists and the employing delivery system, and may also create resistance in the ranks of the primary care physicians. Particularly as primary care physicians are being held accountable for results of specialty services, they will be unwilling to ignore the results of data.

The specialists in the employed group might well feel they sacrificed their independence when they sold the practice to the delivery system for an assured business from the other physicians in the employed practice. They might even refuse to participate beyond the minimum in the ACO’s performance measurement or population health initiatives. The independent practice physicians will also be furious if their good results did not produce referrals, and they may sabotage efforts among other private practices in the ACO.

How To Move Toward Understanding and Alignment

With so much at stake, it’s imperative to work through these political and economic issues to create engagement by physicians in a unified vision for the ACO. Here are some foundational

principles for that process:

- Review the data for deeper explanations. Outcome results are potentially tricky and unfair, as the patient population has a great impact on the results. The populations of employed and independent specialists in the above scenario might be very different, and it could be incorrect to label the employed group as performing worse than others.
- Involve physicians in the collection and measurement of outcome data. Many organizations forget that physicians should actually be involved in the process of reviewing and measuring data, thinking it an administrative issue. On the contrary, only if physicians contribute to the validation of data, or are asked to contribute to the data, will it be accepted.
- Foster collaboration between primary and specialty physicians in outcomes improvement. This must be done in a constructive problem solving process. Most worrisome in the above example is the refusal of the employed specialists to participate any further, thus removing the opportunity for improvement. The absolute outcome results, while important, are likely to be less important than active engagement by primary and specialty physicians in determining the causes of unexpected good or poor results. This collaboration will only become more important in outcome improvement processes that CMS will be expecting in the future.

Next: What are the best tactics that ACOs can use to implement fundamentals of the outcomes improvement process?

ICLOPS CEO Theresa Hush contributed to this post.

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