ACOs Must Create Learning Environment for Physicians to Be Partners in Change

written by Thomas Dent, M.D. | April 12, 2018

The idea behind ACOs sounds simple enough: Build a network of primary care physicians, specialists, hospitals and other health care organizations that share risk and responsibility to provide coordinated care for each patient. Medicare or private insurers offer financial incentives to ensure that ACOs provide quality treatment while limiting unnecessary spending. Primary care physicians serve as key liaisons for each patient's care.

But ACO reality is much more complex and daunting. Shared savings have proven to be elusive. Quality benchmarks do not always accurately measure what's medically relevant. Patient attribution to specialists, rather than primary care physicians, skews costs. Nonetheless, as MIPS collapses and pressure mounts for adoption of Advanced Alternate Payment Models, ACOs are ascendant as the preferred option under CMS's Quality Payment Program.

In this intensely competitive, rapidly evolving environment, where health care organizations must learn to manage risk or perish, experience is the best teacher—with physicians as full partners in the process of managing change. The following four key strategies will help to

create an ACO culture that encourages learning from successes as well as mistakes to improve performance, meet quality targets and achieve savings:

1. Foster Learning and Innovation through Dialogue with Physicians and Other Providers

Collaborative learning in an environment that stresses education over dictum is essential for the ACO's long-term success. Several different approaches can be built into projects that review outcomes and costs. For example, in reviewing patient outcomes, clinicians who treat the same patient could share perspectives on causes of outcome variance. Clinicians learn from peers about treatment outcomes and, in turn, provide information about their own patient experiences.

This kind of peer feedback does more than simply foster learning from others' experience. If conducted within a culture that supports mutual trust and cooperative problem-solving, such exchanges can promote not only improvement efforts, but also deep collaborative relationships that help the organization move forward from the bottom up. They establish a mechanism for dialogue among physicians, practices and other clinicians, nurturing organizational nimbleness.

Data sharing is essential to this feedback loop and should be used to build teams within the organization to review patient outcomes and costs collaboratively and within performance improvement or population health projects.

None of this will happen quickly. Everyone in the ACO will be learning new processes and routines. Patience and persistence are essential, with physicians leading the development of the timeline and the process of change.

2. Pilot and Test Interventions for Cost and Quality Improvements

ACO cost and quality interventions should be a collaborative effort of all involved providers. The key here is to pilot and test changes, seeking physician as well as patient feedback, before launching interventions throughout the ACO.

The pilot-testing tactic also may be used to engage physicians in patient learning. Podcasts and, particularly, videos featuring clinicians can be an effective way to communicate with patients about common concerns. These tools can amplify the clinician's voice without requiring significant effort by physicians. A podcast and video library could be used to give patients 24/7 access to information curated by a trusted provider answering key questions.

Patients who have experienced success in self-management may also be recruited to provide messages on life-style and medication use.

3. Distribute Aggregate Cost and Quality Analytics to Physicians, Along with Individualized Data

For cost and quality data review to be both meaningful and effective, practices and individual physicians must receive data through a transparent process on a regular basis. This marks a major leap from the status quo, where most ACO physicians only receive their own data, are unaware of what else is going on throughout the ACO, and typically receive no aggregate analytics that make them feel part of a group with a shared set of goals.

Note the Hawthorne effect, whereby behaviors change just from being observed. If physicians have no access to data or ignore it, there is little likelihood for change. If, on the other hand, sharing data is framed as an opportunity to learn and grow, rather than as a performance task, there is a greater chance that clinicians will be interested in engaging in dry runs and pilot tests. Reviewing cost data across multiple years is a critical piece of this process, to identify and highlight improvement in costs—what will drive financial success for the ACO.

Remember that some critical results may need to be reported anonymously to encourage participation. Reporting on favorable or best practices, in turn, requires less need to mask feedback.

4. Develop Rewards for Physicians for Beneficial Input on Cost Initiatives and Inquiries

Encouraging and rewarding innovative thinking must be a central theme for organizations seeking to move to a risk model. ACO members that inspire others should be prized. It is exceptionally important for primary care physicians to maintain continuity of patient populations in order for the ACO to survive. But this must be accomplished through engendering loyalty, not scare or pressure tactics.

The physician reimbursement model will ultimately need to change in ACOs. The requirement for significant financial risk for the ACO must filter down to the clinicians in some fashion. The ACO must implement changes carefully to avoid unintended consequences of incentives, seeking input from stakeholders and testing effects of incentives on access to care, quality outcomes and cost.

Clinicians could be reimbursed for the additional time devoted to analysis, dialogue and cost

data review required by the ACO. They also may be rewarded, not penalized, for giving necessary time to patients, engaging in a thorough discussion of benefits and harms of clinical alternatives. As patients become more informed, they may choose not to pursue certain diagnostic or therapeutic options—and this, indeed, will assist the ACO in meeting spending targets. The time taken by clinicians to work with the patient's support system might also be compensated.

Physicians Can Become Partners Through Long-Term Collaboration

The unfortunate consequence of many performance measurement programs and quality reporting requirements is that they have led to demoralized physicians and estrangement between physicians and organizational leadership. Rewards and penalties based on short-term results such as performance measures serve to undercut the organization's goals as well as physician morale.

The future of the ACO will depend on building both patient loyalty and innovative approaches to cost and quality, through partnership with physicians. After the typical processes such as coordination of care, reduction of readmissions, and alignment of referral sources are performed, the ACO will need to dig deeper to achieve the savings targets. ACOs must invent methods to better recognize at-risk patients to avoid incidence or progression of disease and its associated costs, and develop creative methods of improving outcomes and costs associated with highest risk groups. The trust and positive attitude and involvement of physicians will be essential.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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