Where's the Value for Physicians in VBHC? Four Strategies for ACOs and Other APMs

written by Theresa Hush | June 7, 2018

When we talk about "value" in Value-Based Health Care (VBHC), we're referring to the high-quality/lower-cost services that buyers want from health care providers. Who are the buyers? Health plans, Medicare and other governmental purchasers, plus employers (for the most part, the term is notably *not* interpreted to include patients). What do buyers want? "Truth in purchasing" for the best health care they can get.

Indeed, the very term "Value-Based Health Care" implies that buyers are on a righteous quest for good care from irresponsible providers. Provider organizations, in turn, have sometimes adopted a similar attitude toward physicians. The generation of physician scores, workload requirements and incentives (which are not really bonuses but reductions in pay) for quality measure results are all stick and no carrot for physicians.

And herein lies the problem: physicians aren't getting enough in return for their participation. No one is asking what's the benefit of VBHC for physicians. And that may be why VBHC is meeting such resistance, with CMS expressing frustration with organizations for not moving

fast enough to accept financial risk, and physicians threatening to leave if risk is imposed on them.

It's no real surprise that ACOs are loath to adopt downside financial risk. Health care organizations are vested in Fee-for-Service for revenue stability and growth. Providers' progress toward VBHC is incremental. The uncertainty of lowering costs, especially with no limits on patient choice of provider, is huge.

Physicians Are Bearing the Brunt of Change to VBHC

Leadership and finance directors aren't the only ones avoiding risk; physicians have an even bigger impact on the pace of reform. And the pace of VBHC acceptance is slow. According to one study, the rate of acceptance from 2016 to 2017 moved just three points, from 26 percent to only 29 percent among responders—mostly physicians. That's undoubtedly because physicians are the ones shouldering much of the change and collateral damage:

> Physician burnout;
> Coping with lack of tools and resources to operationalize VBHC models involving coordinated care, population health and case management;
> Loss of clinical as well as administrative autonomy and independence as practices have been purchased or merged;
> Technology overload from EMR adoption and documentation requirements;
> Changes in compensation tied to VBHC that they don't feel they can control;
> Pressures on time and productivity.

Consolidation in Health Care Has Affected Health Care Culture

What was once a clinical enterprise has been replaced by the administrative health care complex throughout the U.S., wherever hospitals have merged into systems and purchased physician practices. Layers of bureaucracy create and analyze analytics, implement EMRs and data repositories, and oversee physician and other clinical operations. Physicians who want to be more involved often don't know how to start.

Even physicians who wished to remain independent have merged practices, responding to the need for scale to support technology and other VBHC requirements. Although these groups may not have their practice autonomy burdened by hospital operations, they still need to address the actual cost of hospital care under VBHC. Ultimately they will have to connect with hospital or health system enterprises to be relevant players in a VBHC provider network.

ACO and APM Costs are Determined at Physician-Patient Level

In defense of organizations, all understand that medical decisions—made by the physican, patient, or both—are driving costs. A physician's decision to recommend a scientific inquiry of symptoms using certain diagnostic tests or images, or to engage in more extensive diagnostic investigations, is rooted in preferences as well as training, access to technology and specialists, and the culture of the physician environment.

The organization, however, also enhances access to and value of diagnostic inquiry by rewarding physicians for ancillary referrals, implicitly through analytics of highly valued physicians or explicitly through compensation incentives. As a result, the physician gets mixed messages about how to practice and what the organization values.

Physician-determined interventions drive revenue for the practice owners and earn tangible benefits for physicians, especially under Fee-for-Service (FFS). The problem for providers: there is no equivalent reward system for VBHC. Why? Because health care organizations, still deriving most revenues from FFS, are ambivalent. While physicians may have some incentives tied to VBHC, particularly regarding quality scores and productivity, organizations don't really reward providers for bringing in *less* money. VBHC-optimized medical decisions are not accommodated in the reward structure.

Likewise, time is the resource that determines how much will happen between the physician and patient at a visit. The amount of time available controls how much information the physician will obtain from the patient before interrupting, and how willing the physician is to educate, explain and work with patient preferences.

Physicians who work under productivity standards that run counter to VBHC need to engage patients through processes like goal setting and shared decision-making, or to discuss options for overcoming barriers to treatment. Surveys of both physicians and patients make abundantly clear that lack of time has damaged the physician-patient experience.

The Dilemma Of VBHC: Simultaneously Acting As Payers and Clinical Enterprises

Given physician frustration with the current medical environment, gratuitous efforts to correct time pressures and lack of clinical autonomy, or generalized advice like "involve physicians in the organization," are not enough to shift the tide of burnout and resistance.

Organizations need to reconfigure their organizations to maximize clinical value, not administrative. In moving toward VBHC risk-based models, however, the health care system response has been akin to emulating health plans, versus achieving clinical excellence and cost-effectiveness. The structure of the provider organizations is administrative, with a heavy focus on technology and revenues to fuel growth. Both physicians and patients are becoming "assets" in a market play for more territory, rather than the central focus.

That's perhaps one reason why so much energy is focused on low-hanging fruit for achieving ACO savings, such as curtailing readmissions and reviewing post-acute care. While those are important activities for immediate savings, the longer-term savings will only come from better medical decisions and lifestyle choices by patients, strengthened by a physician-patient partnership to achieve those goals.

In sum, we need to rethink how physicians should practice in health systems, both in ACOs and other VBHC models. We also must address the patient in the central physician-patient decision-making team, but that's another blog post.

Four Key Tactics To Help Physicians Get Value from ACOs and other VBHC Activities

1. Invest in physician leadership skills.

Leadership results when one party recognizes the big picture—here, both the health care organizational mission and market imperative, and the patient needs—and others look to that leader for direction. A leader is given power by another party voluntarily, when the needs of the one giving up that power are satisfied.

There are really two options for physician roles in the organization: they can be either leaders or cogs in the wheel. To move from one to the other requires education, trust and willingness to collaborate.

Cultivating physicians as leaders helps them to embrace a different role in VBHC. The investment in physicians should not be for selected physicians—the skills must be cultivated for all.

What does it mean to create a leadership investment? A few examples of how this should work:

> Educate physicians on the challenges and successes of the organization, the market environment and the benchmarks imposed by that environment.

Let physicians determine how they will provide input into the organization and its goals. Provide an ongoing channel for communication at all levels. It will not be a same-size-fits-all approach but determined by individual skills and time.
Help physicians realize the trends of health care consumerism and embrace changes in how patients see their responsibility for care. One of the most difficult tasks will be the emerging role of physician as clinical educator and guide, versus sole decision-maker. Again, this role is crafted by leadership.
Ensure that physicians feel supported in keeping up with clinical expertise and knowledge.
Put physicians in charge of initiatives, rather than on committees, and facilitate their roles with support.

2. Create physician interaction with data and analytics.

Physicians should not see only *fait accompli* analytics. They should have the tools to interact with and respond to the data, query it and attest to its validity. This includes frequent sharing of data across the organization that is well beyond "need to know" data relevant to the physician's own patients or decisions.

Again, this sharing is best worked within peer groups and projects that will improve performance in quality:

Facilitate physician response to 'scores' of quality as well as individual patient outcomes.
Encourage physicians to get involved with experimentation and testing of interventions in performance improvement technology, enabling comments related to project structure as well as individual results.
Create response teams around organizational goals, financial targets and appropriate performance improvement budgets.

3. Select physicians to serve as leaders or stewards of all performance improvements, both cost-focused as well as those for improving quality and outcomes.

Engagement in the actual details of performance improvement gives physicians a better understanding of the detailed decisions that will affect the results and invests the physician in success. Physicians need to be involved at all levels of the organization, from practice groups to specialty departments, and across the organization.

Skills for attaining performance improvement are gained over a long period and require time to implement. Education is key to helping physicians work through project decisions and results. Obviously, the physician must be supported administratively to ensure both that clinical services do not suffer and that their expertise is focused on decisions rather than minutia.

4. Support physician activity in VBHC and redesign incentive structure for physician leadership.

Engaging physicians to support ACOs and VBHC requires a complete review of compensation, incentives and measures applied to physicians to participate in the clinical enterprise. This must include the following steps:

- Carefully connect all reward structures to expectations under the future financial risk of VBHC, especially those that highlight differences in groups of physicians:
    - Rewards for specialists versus primaries, such as those built on attribution of inpatient or outpatient services to attending physicians;
    - Physician referral tracking and rewards;
    - Incentives for higher workloads that may inadvertently discriminate against women.
- Ensure that physicians have compensation (part of value) dedicated to VBHC activities and participation, including leadership cultivation. This will also require time for physicians to gather patient preferences and discuss options with patients in value-based decisions.
- Provide dedicated VBHC staff who can work under physician direction, as opposed to centralized physician staff.
- Create a centralized library of materials for physicians to share with patients—clinical education, treatment options for various conditions and procedures, research data supporting those options, and cost information. Physicians should not have to produce these or construct these within practices.

Physicians can and will see value in Value-Based Health Care when the deck is no longer stacked against them. It will be up to individual physicians to embrace leadership functions; organizations cannot “demand” that physicians participate. As physicians are rewarded more clearly for being part of an innovative environment, the culture will shift. And everyone will gain value from growing leadership and pride among physicians working together to meet the goals of ACOs and VBHC.

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