How to Involve Physicians Effectively in ACO Population Health

written by Theresa Hush | November 15, 2018

In a recent post, we addressed the many types of population health initiatives and some guidelines for creating the most benefit. Now let's take a closer look at one of those guidelines: integrating population health into regular or routine care of patients—specifically, with greater involvement and communication by the patients' physicians.

ACOs and their participating physicians have an opportunity to break with the historical obstacles between the physician's employer organization and the physician, especially in hospital-directed ACOs. Even in physician-led ACOs, working seamlessly with physicians to achieve better health for ACO patients is key to achieving both quality and cost goals. Either way, the movement toward financial risk will compel ACOs to use efficient mechanisms like population health to ensure changes across the patient base, rather than duplicate efforts one patient at a time. Population health will also be the key program for driving changes in outcomes in populations with difficult, socially-determined health issues.

So, how should population health be implemented to achieve goals for patients? Even though population health is the standard bearer of Value-Based Health Care, it remains an obscure concept for most physicians, largely because population health technology and initiatives have sidelined physicians and their interactions with patients. Physicians aren't even universally sure about what population health means, nor what role they are supposed to play.

Physicians Must Understand Goals to Be Population Health Partners

Physicians may be only vaguely aware of their ACO's patient outreach and similar population health initiatives that target particular clinical needs, especially gaps in care. If the patient shows up at an appointment to receive missing services, there is an expectation that physicians will identify and deliver those services. For many physicians, however, this encounter marks the first time that they become aware of systematic efforts to follow patients, as well as unmet patient needs.

Other population health projects may be directed at cost reductions in emergency room use, post-acute care services and readmissions. The physician may not be involved at all in such initiatives, a lost opportunity for discussion at the next patient encounter.

Regardless of specific initiatives, it would appear obvious that physicians cannot be partners in achieving population health goals if they aren't aware of those goals or don't understand them.

ACOs and health systems may well intend to help physicians by unburdening practices from running population health initiatives, but leaving physicians out of the loop has risks. These include a deteriorating bond between physician and patient that erodes communication and agreements about shared goals, making it actually more difficult to achieve better outcomes. Also, by favoring administrative ease over cultivating the physician's relationship with the patient, organizations can actually exacerbate physician burnout when their providers feel like mere cogs in the wheel.

Recognizing that population health initiatives require more time and logistics than physicians can provide on their own does not negate physician involvement; it means, rather, that these initiatives should be better integrated into physicians' delivery of care and the technology they use in the process .

Physicians Can Play Three Key Roles in ACO Population Health

Physicians have valid and essential roles to play in the development and execution of population health initiatives, which fall into three main categories:

1. Routine population health initiatives to address high risk patients, immunizations and other care needs.

Physician involvement should be structured to take advantage of their clinical knowledge and build upon their bond with patients. This could include:

- Participation in the development of population health goals and prioritization of strategies;
- Guidance regarding clinical and non-clinical criteria for selection of patients for initiatives, and creating the exception process for patients who should be excused;
- Delivery of medical services and clinical communication with patients as part of population health initiatives.

2. Population health initiatives that represent public health priorities.

The nature of population health and its targeted initiatives needs to evolve beyond personal health into public health. Curiously, this has been absent from most discussions. By virtue of their clinical knowledge and direct provision of care, physicians are the best ones to guide this shift. Clinicians could develop and run population health initiatives to address public health priorities within physician control:

- Antibiotic conservation, including systematic tracking of and changes in physician prescribing patterns for routine infections as well as standing orders for antibiotic use;
- Opioid prescriptions and monitoring.

3. Population health initiatives that help physicians change specific health conditions and behavior of their patients.

With training in motivational interviewing, physicians could supplement their clinical skills to help patients improve their health status:

- Obesity;
- Smoking;
- Addictive behaviors and behavioral health.

No doubt many will point to trends in antibiotic overuse and the opioid epidemic as evidence that physicians cannot be effective guardians of public health-oriented initiatives; nor has there been historical success with encouraging patient lifestyle changes. However, in neither category have *structured, clinician-involved* and *data-facilitated* initiatives been the norm, nor have physicians generally had the tools to improve. Complex clinical population health projects must be carefully designed with physician involvement and be supported with analytics, specific training, administrative support and technology integrated with the physician clinical systems.

Supporting Physicians in Population Health Is Essential to the Partnership

Involvement is important, but so, too, is restraint when it comes to physician responsibilities for population health. With a looming physician shortage and a majority of physicians reporting burnout, ACOs must strike a fine balance between demanding too little or too much.

Here are the most common questions about physicians involvement in population health initiatives:

How much should a physician need to document?

The answer should be very little. There are easy and passive ways of gathering clinical information from systems, plus other methods of allowing patients to self-report outcomes, preferences and additional data. Where it is necessary to provide patient information for physician consideration, support staff (such as patient coordinators) should gather and input data into the record, programmed for easy viewing by physicians. There is no reason why a physician, apart from normal clinical documentation, should have to do much more than

validate the provision of counseling or information to patients.

Who should produce patient informational materials?

All population health projects should have centrally produced patient informational materials. Patient preferences should be gathered in a streamlined pre-visit process when possible or made easy to collect and document during the visit.

How much data should physicians see?

Physicians should have the ability to see a variety of two to four comparative analytics that show key population health metrics, such as outcomes and trends over time. The data should not only compare their results against those of their peers but also provide optional drill-downs into patients' individual data . Some physicians want to validate the information by viewing patients and should have that ability.

Should physicians be responsible for selecting or eliminating patients?

There is no reason why this should be required, if ACOs can monitor the characteristics of patients in both categories. It provides a false sense of involvement in the project, and unless physicians encounter issues with patient lists, they should not be involved in busywork once the criteria for patient inclusion are set.

Physicians Should Be Rewarded for Population Health Involvement, Not Sanctioned for Failure

Many ACOs or clinically integrated networks attempt, too soon, to sanction physicians for "failure" of population health initiatives, just as they do for quality measures. This only serves to distance the physician from partnership and the initiatives. Organizations must foster an environment of learning, exploration and support. Population health represents an entirely new role for physicians as they transition from providing patient-at-a-time service to taking on responsibility for patients as a whole. A soft start is essential to allow physicians to learn, experiment and train themselves to operate in a new environment.

There is no easy path to establishing worthwhile population health initiatives, either with physicians or with patients. Neither responds well to management of their choices or to additional work. To succeed in this endeavor, ACOs should appeal to physicians' mission to do well, respect their integrity as clinicians, and support them with the time and resources to

make population health work.

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