Why ACOs Must Build Trust with Providers and Patients to Meet Goals

written by Theresa Hush | October 4, 2018

As ACOs develop approaches to Value-Based Health Care, they are struggling with a key issue: lack of trust. How can providers commit to collective cost reductions that could have potentially negative revenue consequences for themselves individually or on their practices? If they don't believe that the other players or their ACO are operating in the best interests of all involved, how can they participate in the ACO's goals? Conversely, how can the ACO create effective leadership and collaboration if physicians are unwilling to commit to making the model succeed?

Likewise, ACOs have to work harder to earn patients' trust. Ask any ACO for their top issues and they're certain to mention the volume of out-of-ACO services. If consumers do not trust the ACO or its providers, they will not be loyal patients or necessarily follow provider-recommended treatment plans. Successful engagement requires trust.

Provider Concerns Reflect Historical Conflicts

On the provider side of the equation, lack of trust is rooted in a variety of historical and current

issues:

- ACO providers worry that downside risk may hurt some more than others—and that the reasons for those differences will not be fair.
- Physicians in hospital-owned ACOs may feel blamed for ACO cost overruns and excess expenses that are attributed to them, while their employing hospital leverages compensation incentives and other rewards to maintain volume of patient services, diagnostics, referrals and admissions—in direct conflict with the ACO's goals to reduce costs.
- Specialists and primary care physicians in many multi-specialty groups compete for revenue and recognition (through implicit as well as explicit benefits), especially in hospital-employed groups.
- When the ACO is formed by existing systems or networks, it usually inherits the politics and personalities of its parent. Regardless of whether the historical group originated from hospital-based employed physicians or a network of primary care physicians, newcomers to the network—independent primaries or specialists—will be on the "outside" and may distrust the motives and initiatives of the founding network.
- The ACO itself may not trust its providers to work toward change without a penalty structure in place; but this may cause providers to feel coerced and resentful.

A History of Trust Issues Between Providers Requires Reconciliation

Building a common vision and trusting alliances between providers requires strategies that were not needed in a Fee-for-Service world, where each provider's services and reimbursement were independent of others. By contrast, in an ACO environment, the cost of each provider is tightly connected to others by the ACO's total cost formula—and financial risk has upped the ante.

How each provider delivers medical care in the ACO, including the downstream costs attributed to that provider's treatment decisions, matters to everyone. So it's no surprise that every provider wonders whether he or she will be treated fairly in the ACO. This is a valid concern; providers have not always fared well in past instances in multi-provider groups and reimbursements.

Importantly, most ACOs are also built from prior networks, groups and relationships between providers. Past injustices and grievances swirl in the ACO mix and must be resolved in order to successfully integrate providers into a cooperative, collegial team with shared goals.

Whenever relationships are at stake, the players can only build trust by first acknowledging the validity of past problems. While providers must be willing to accept vulnerability to be part of a group risk-based reimbursement model, all parties must negotiate the terms of the relationship in advance to create a solid foundation of trust.

Consumers Also Have Legitimate Trust Concerns

For health care consumers, trust in providers has hit an all-time low. Indeed, only about a third of consumers trust American health care. Consumer trends as well as personal histories play a significant role in diminishing trust:

> Consumers are bearing a much larger portion of costs, yet providers have produced little or no transparency in pricing.
> Providers blame patients for not following treatment plans, but patients' preferences and barriers to such treatments have often not been discussed or considered.
> When asked for alternative treatments or evaluating options, providers have often given few research-based facts on treatments, benefits and harms, even in cases of efficacy. This could stem from either lack of provider awareness or belief that patients can't understand or shouldn't make medical decisions.
> Consumers don't have a mechanism that gives them comparative, valid information on providers or their quality, outcomes, cost or issues of concern (such as communication and convenience), leading them to base provider choice primarily on relationships or practicality.
> When patients seek other providers or try to evaluate other options, their current providers or institutions place expensive, time-consuming obstacles in the way of ready access to personal medical records.
> Confronted by the increasing bureaucracy of health care, the difficulty and time required to schedule and coordinate their own services, long wait times to see physicians, and the need to research their own medical concerns, consumers are effectively told that their time and money is less important than the system's.
> Employer and other coverage have forced frequent changes in providers as health plan networks changes, so consumers have learned that they cannot count on having long-term relationships with their physicians.

While ACOs are hoping to engage consumers—in part by favoring tools that make it more difficult for patients to seek out-of-ACO services—any exercise of power by the ACO may well backfire. If the proposed CMS Rule goes into effect that permits ACOs to send letters to patients explaining their ACO enrollment, many patients will interpret this information as curtailing their choices, just as once-common HMOs limited provider options—even if that is not the case.

Trust for Consumers Must Be Spurred by ACO Action

Often, a patient's closest health care relationships are with his or her own physicians. For those who place their health in their physicians' hands, a serious medical issue can leave them feeling vulnerable, physically and emotionally. That bond may cause them to hold their own physicians harmless for any infractions of trust and blame the system. Consumers who don't have such close relationships with their physicians will likely hold both their providers and the system responsible for any issues they encounter.

To create the foundation of trust for effective engagement between consumers and their providers, and with the ACO itself, ACOs must take action. The ACO plays a major role in fixing historical lapses between consumers and their health care organizations, between providers, and between providers and ACOs. In addition, they need to support their providers with tools to improve consumers' ability to make value-based medical decisions, for the benefit of all ACO stakeholders.

Ten ACO Actions: An Agenda to Re-Establish Trust

Create accountability for cost and quality that is shared between administrative and clinical leadership, so that providers are included in decision-making.
Build transparent criteria for cost and patient care performance that are shared with all physician stakeholders.
Create a non-punitive process for both primary and specialty providers to participate in review of their performance data and respond to questions.
Create standardized methods of comparing cost through episodes—mostly procedural with some limited diagnosis episodes—for which physicians have validated the inclusion and exclusion criteria.
Build and discuss distribution formulas for incentives/rewards and risk paybacks in open forums and reach consensus.
Educate providers on shared medical decision-making and help them understand their role in guiding and educating patient choices, facilitated by data.
Create central support for value-based medical decisions for key procedures, chronic illnesses, cancer care and health screenings, so that physicians and their patients have research data and appropriate criteria for reviewing key treatments, costs, benefits and risks.
Working with physicians and consumers, establish processes and instruments for transmitting validated quality of care and outcome information to help consumers choose providers.
Implement transparent pricing for episodes of care with highest volume and highest cost medical and surgical procedures, to share with consumers. Include consumers in the

development.
Review consumer touch points for the ACO and its providers to adopt streamlined scheduling and access to providers.

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.

Image: Ciara Hillyer