Three Fixes for ACOs' Physician Engagement Strategies

written by Theresa Hush | September 10, 2020

ACOs know that reducing costs is the key goal for Value-Based reimbursement. But strategies on how—or even whether—to engage physicians in that goal have not always been successful, to the detriment of all involved.

Part of the problem is that provider revenues still stem from Fee-for-Service payments. Physicians are still rewarded based on meeting volume of patients and revenues. Even if participating in an ACO, your physicians get very clear messages about meeting volume and revenue targets. Hospital and health system-based practices survive by ensuring that volume is maintained—especially in these times.

As health plan capitation and new Value-based risk payment models emerge, however, you should reassess your strategy for involving physicians. If your history involves using administrative tactics like coordination of care and population health as your main cost control strategies, you are curtailing opportunities to address the central cost drivers: decisions made by physicians (diagnostic or treatment choices) and patients (health and treatment choices).

Don’t avoid that terrain if you plan for success under Risk.

Frustration about physician involvement has worn out some provider organizations, including ACOs. Years of reliance on a few physicians willing to attend steering groups or attend sessions takes its toll. Physicians, for their part, complain of burnout and excessive documentation and hours. They see administrative meetings as irrelevant and data as untrustworthy. And, they want to spend their time with patients and doing what they were educated and trained to do. One result: ACOs adopt a “we’ll do it without them” approach, which will limit success.

Let’s examine physician engagement and how three overlooked strategies promise greater success for your ACOs and participating physicians.

1. Create the Clinical Language for Costs

It is rare that physicians ever see cost data that is rich enough for them to believe, let alone understand, why higher costs occur with some of their patients. The point of providing data to physicians is to provide actionable information that can segue into a process to reduce clinical costs. The data they get, and how it is organized, is the essential element that must be changed to make engagement possible.

The current usage of “physician engagement” implies that clinicians are off in a different world and must be herded into an organizational lockstep march. While not always intended as hierarchical processes, these efforts often connote compliance and the need to meet expectations.

Your review of many ACO physician engagement strategies will no doubt reveal that they often focus on communication, not involvement. They tout the need to disseminate information through different channels, and reach out broadly to carry the organization’s message. It may be good advice, but passive messaging is not a foundation for physicians to be involved in costs.

The key to physicians’ investment is creating a connection between costs and clinical practice. When the adoption of Risk drives cost discussion to be more serious, many COs resort to a common strategy of releasing comparative physician scores. The idea behind scores is that physicians will pay more attention to where they fall on the curve and gravitate to the mean. Scores include comparisons of annual per-patient costs by primary care physicians, as well as comparisons of attributed emergency room or inpatient admissions. Most of this data isn’t actionable: it lacks the detail necessary for clinical evaluation of the events. As a result, scoring comes off as a shaming mechanism, if there is no recourse or intervention process for

physicians to actually improve. Measurement, alternatively, can be positive if it is presented for feedback as part of a process that involves improvement.

Measurement must be structured so that physicians can make sense of cost data. Physicians can benefit by seeing individual episodes that are constructed as a comparison of inputs to care and total costs, plotted along a cost curve or displayed with outcomes. Those data illuminate variation in the costs across patient cases, as well as the distinct ingredients—imaging, tests, procedures, and therapies—that contributed to higher costs in each case.

For primary care physicians, even annual per-patient costs can be displayed as patient episodes and show the conditions/factors in individual patients that led to higher annual costs. And it may be even more valuable to review episodes according to populations with single or multiple conditions.

Unless physicians can see the costs related to their own clinical decisions or those of specialists made during the diagnostic or treatment phases, how can they be involved in improving cost performance? Stripped of important clinical information, data is not enough to examine whether costs are excessive or not.

2. Help Physicians Review Common Variables that Influence Costs

Highest cost patient cases have something in common: they often result from major medical issues or trauma, but there is little opportunity to define future savings. In the middle and lower part of the cost curve of patient cases, however, lie your opportunities.

An ACO-facilitated initiative could generate a physician review process based on small samples of patient cases, with the purpose of investigating both clinical services and costs. This kind of review, with the right data, will be revealing and important to physicians, especially if they have never seen their own patient data in sufficient detail. Again, the key to comparing costs between patient cases is to construct clinical episodes that standardize what services will be included in each episode and over what time frame.

Even examination of low cost cases has enormous value. The episodes may explain the circumstances of the patient or the process that contributed to lower cost, yet good patient outcomes. A shared process over many physicians could provide avenues for broader adoption through review of diagnostics, drug therapies, devices, and the physician-patient communication.

Patients with average to above-average annual costs can reveal common variables to address through discussion and review. The only "magic" is the construction of patient episodes and cases to reveal the important clinical information.

3. Introduce Cost Transparency to Support Physician-Patient Decisions

The real truth about costs is that physicians, patients, and the clinical environment are collectively responsible for making the medical decisions that drive costs. Incentives matter, as well as physician practice style and clinical expertise. But so do patient preferences that are influenced both by their belief systems and what they have been told by medical professionals.

All the parties have been operating without the necessary information to guide medical decisions based on cost and outcomes. The reason? Providers do not consolidate data into patient events and episodes, so that the ramifications of decisions—down to specific drug therapies, diagnostics, and treatment plans within care plans—can be discussed with patients. How many times are diagnostics with little value to ultimate treatments requested, but patients end up paying unnecessary costs? How often are patients given side-by-side comparisons of therapies with both expected clinical outcomes and their relative costs, so that they can make real decisions?

ACOs are in a unique position to help physicians engage in better patient care by using patient episodes for cost transparency in physician-patient decision-making. With episode costs that reflect various options for treatment or other services, physicians are empowered and invested in care that will be both affordable and important to the patient's health.

Physician engagement means investing physicians in a process that will lead to better care as well as better performance. Create the foundation for trust and analysis among your physicians. You will need technology to organize the clinical and claims data and then customize applications to fit your improvement processes, so that you can facilitate the conversation.

Physicians were trained to be scientific problem-solvers, not cogs in the wheel. Reach your potential by tapping into their overlooked talent to find the balance between best practice and costs.

Founded 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.

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