Primary Care Physicians' Ethical Dilemma: Meet Goals for Patients or Practice Owners?

written by Thomas Dent, M.D. | April 27, 2017



Primary care physicians are on a collision course with health care consumers—their patients. While trying to deliver best clinical care, they must navigate a competitive business environment that encourages higher spending.

The business of health care has undergone rapid consolidation in physician practice ownership. Spurred by the need to compete for patients, use EMR technology and manage within the heavily regulated health care industry, physicians have moved from smaller to larger group practices. Primary care physicians have made this transition faster than specialists by selling their practices, and are now more likely to be employed by a hospital.

But this arrangement is not always in the consumer's best interests, because it leads to higher costs and greater use of specialists. Primary care physicians are required to fulfill

hospital directives, even if they don't always share the same goals.

Physicians' New Business Environment Increases Pressure for Productivity and Referrals

Hospitals are working to maintain revenues in a market that is moving back to financial risk through ACOs and health plans. They have solidified their position by recruiting physicians (especially primary care) and building a physician network through a combination of ownership and joint ventures. Their ability to provide EMRs and other technology as well as administrative support to practices has been highly attractive to physicians looking for a way to escape administrative burdens.

In the past, hospital-physician relationships were tightly controlled by Stark anti-kickback laws that prohibited hospitals from providing financial benefit to their referring physicians. But that all changed when hospitals started paying those doctors' salaries.

In fact, the Stark Law says an employment agreement with a physician *can require* the physician to make referrals to the hospital employer unless: (1) the patient expresses a preference for a different provider; (2) the patient's insurer determines the provider; (3) the referral is not in the best interest of the patient's medical care in the physician's judgment; or (4) the required referral is beyond the scope of the employment (i.e. the physician is employed part-time by the hospital and is still required to refer all of the physician's private patients unrelated to the part-time employment by the hospital).

Primary care physicians thus may have referral obligations that their patients know nothing about. This is complicated by the fact that when physicians are employed by a larger organization, the business functions are out of sight. While this arrangement holds financial benefits for the organization, how does this affect patients' financial interests and outcomes? There is more at stake than strictly inside referrals; the primary care physician's judgment is constrained as to who will best achieve better results for the patient.

Patients Want Lower Cost, More Control

Health care consumers are experiencing more financial risk with higher deductibles, copayments and premiums. As patients, they want knowledgeable assistance in making health care decisions that carry big cost consequences, and they want this help from their doctors.

However, that discussion may not be occurring. In a study where 63 percent of patients reported a desire to speak with their physician about out-of-pocket costs, and 79 percent of physicians believed that patients, in general, want to discuss these costs, only 35 percent of physicians and 15 percent of patients reported ever having discussed these costs.

Made aware of these issues, primary care physicians will and do respond to their patients' financial distress, but this response is reactive and not part of an organized effort.

The question—and challenge—is this: How can primary care physicians act in the best interests of their patients when they are separated from the decision-making apparatus of the large organizations to which they belong, as well as the

critical financial information they need to share?

How to Create a Patient-Responsive, Financially Viable Organization

The financial pressures on patients will ultimately impel them to act like consumers, choosing providers based on cost and quality profiles. As we all know, however, those “scores” are, at best, weak indicators and, often, erroneous. Nonetheless, hospitals and physicians must respond to patients’ needs to address large, unaffordable costs and achieve better results for patients, and primary care physicians—like it or not—must be aware of the mounting cost burden on patients.

Assisting patients in treatment decision-making is a role well suited to primary care physicians. However, the entire health care organization that employs the physician must adopt principles and practices that will promote the delivery of efficient quality care. If the organization maintains goals and reward systems internally based on volume, it will put pressure on primary care physicians to reflexively order more referrals, diagnostic testing and other hospital-based services—without first reviewing the patient’s financial situation and value of the services.

How do organizations make the shift?

> Establish a process to measure quality, outcomes and costs for the most common conditions and procedures (episodes). Aggregate data to perform these measurement, which will best involve a Qualified Clinical Data Registry, since providers may be able to qualify the activity as a performance improvement activity under MACRA MIPS.

Measure specialists in the referral network to include input and feedback from the primary care physicians who have referred to these specialists: Do the primary care physicians receive reports or notification if they are on the same systems? Are they included in the process of defining outcomes for the patient and in the final, shared decision process?

Measure primary care referral practices. Primary care physicians should also be subject to assessment by their consultants. Was the need for the specialist referral (and the expectations) adequately communicated to the consultant? This is what it means to “close the loop” in the referral /consultation process.

Create episode-based cost transparency for patients. Primary care physicians should have access to the calculated costs of episodic care and be responsible for delivering that information to patients as part of shared decision-making.

Establish and train physicians in a shared decision-making process. Physicians are not trained to coach patients in dealing with harm and benefit of treatments, discussing cost issues and affordability. This needs to become a priority in physician education as well as part of an organization’s culture.

Provide resources to physicians to access latest research data on benefit and harm. Current research reveals a woeful lack of ability for physicians to read research, which could lead to flawed understanding of the numbers and an inability to help the patient. Having access to basic data, such as the kind of research, the numbers of patients, the absolute improvement in outcomes (if any), is essential to teaching the patient how to assess a treatment’s value. Organizations should consider how they can develop tools that will assist

physicians in this context.

Measure the outcomes in referred episodes of care. Outcomes measurement must be impartial. When proceduralists measure the outcomes of their own procedures, the results probably won't be trusted even by peers, particularly if money and rankings are involved. Referring clinicians should be able to assess and capture results related to their referrals. The organization should analyze variations, including unexpectedly good or poor outcomes.

Performance improvement and results sharing should be part of the process. Implementing interventions to improve the outcomes and tracking the results should follow. Sharing the results of interventions should be considered a quality measure. These interventions should include cost as well as quality/outcomes in the interventions.

Hospitals will need to assess honestly the value of specialist services independent of employment status. It will often be more effective for the primary care physician to refer the patient outside the system than to capture the patient inside the system. As financial risk for providers is implemented, clarifying financial and outcome performance, this goal will be more achievable.

The role of the primary care physician will evolve along with the financial incentives of both health care organizations and their patients. We should expect to see a return of the primary care physician to the center of the patient-care team relationship.

In that new environment, primary care physicians must become facile in discussing cost options during treatments and helping

patients navigate the system. Primary care physicians may need to work with entities retained by patients to address financially challenging situations. Awareness of these negotiations and their results by the primary care practice can also benefit other patients.

Patients in the future will be able scrutinize and compare costs and the results for referrals, diagnostic services, and medications, with close support from the primary care physician. These clinicians will quantify the results from their referrals and share them with patients and like-minded primary care physicians. Access to cost information such as Medicare's SQRUR can serve as a beginning, with all-payer data being the goal. Patient ownership of medical records will be essential for managing the information flow.

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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