Ready for Risk? How to Foster Physician Alignment with Your Health System's APMs

written by Theresa Hush | March 23, 2016

We've seen unprecedented consolidation among hospitals, hospital systems and physician groups in recent years, sparked by the drive for greater market share. As systems organize competitively to participate in risk models such as ACOs and bundled payments, however, the dramatic surge in hospital employment of physicians hasn't helped ACO success.

In fact, most Medicare ACOs have not met cost targets needed to generate revenue. All too often, hospitals or health systems and their physicians clash over goals, expectations, outcomes and basic communication regarding Alternate Payment Models (APMs).

As a Registry helping large systems take steps toward clinical integration, ACOs and performance improvement, we spend a lot of time conversing with providers. Talking to physicians who were once in successful private practice can be sobering. They want to do better under the new models, but they feel alienated. Alienation foments distrust, exacerbated by analytics and reports that call them out for "bad" behavior or poor results. In the early stages of risk model evolution, we often encounter a lot of Us (physicians) versus Them (hospitals) attitudes.

Destructive as these dynamics can be, don't think that patients are immune to the conflict. Perhaps it's because my family doctors know I'm in the industry, but I get "the talk" at every visit about how bad everything is, now that the hospital is in charge. Not a great way to encourage me to restrict my health care to that organization.

Moving forward with successful implementation of APMs means nothing less than fixing this

cultural schism between the hospital or hospital system and its newly employed physicians (and, depending on the organization, all physicians). Here's a blueprint to shift the conversation toward mutual support and success:

Physician Engagement is *Not* the Same as Alignment

Sometimes we get things backwards. The concept of Physician Engagement is a good example. Let's be honest: The real objective of most health systems is for physicians to pay attention to their results and get in line with the targets. That means asking physicians to "engage" in the data we are giving them or in the processes we expect of them.

Most health systems don't want the messiness of real physician Involvement, which seems like an impossibly long process of getting everyone on board and agreeing to the same goals. This is mostly true. Real physician involvement does take a long time and involves a lot of disruption and emotion. But serious dialogue is also necessary to create a partnership that will work.

What Do Physicians Fear About ACOs?

Physicians and affiliated providers have legitimate concerns about ACOs and other forms of risk. These can include:

> Additional administrative work, such as more documentation about quality processes, more review of reports;
> Lower compensation or reimbursement, coupled with serious doubts that the "savings" will ever be realized;
> Comparisons with peers in a way that causes embarrassment;
> Lack of control over outcomes;
> Undermining of clinical expertise, losing the ability to manage patients based on knowledge and experience;
> Becoming a cog in the wheel rather than a member of a vibrant professional team, and its corollary, being subjugated to yet another model dreamed up by non-clinicians who want to redesign care.

For physicians to overcome these obstacles to trusting the health system's purpose and goals, their concerns must be addressed by a good partnership. The worst way to gain their buy-in is for providers to be corralled by nature of their employment or put on the defensive so they become protective of their practice positions. A contentious, punitive stance by management will not produce the collaborative drive for better results that is essential for success under risk models.

Do Hospitals and Health Systems Send the Wrong Signals to Physicians?

What drives practitioners is often very different from the needs of hospitals and hospital-based systems. Physical facilities, equipment, information systems, operating systems and staff demand constant re-investment and ongoing funding. Of course hospitals must focus on inpatient and outpatient revenues—that's what fuels their survival.

Until the incentives change under a risk scenario, the majority of hospitals will pay more attention to occupancy and staffing ratios, operating costs, patient satisfaction with their inpatient experiences, and revenue trends than they will to any effort that will cause fewer admissions or revenues in the short term. And, hospital leadership will also care more about high physician admitters and referring networks.

Despite the huge acquisition of medical groups, some hospitals are still more focused on the hospital side of the business and just want the physician groups to "do their jobs." Accustomed to dealing with nurses and other less independent staff, they may overreach in imposing new rules of play on employed physicians, fostering reluctance, at least, and direct opposition, at worst.

Five Keys for Hospitals and Health Systems to Develop Physician Alignment

As a Registry trying to help health systems implement new structures to accommodate risk-based reimbursement, we gain a broader perspective from the outside than I saw from working inside these systems. Consultation to many health systems also helps us to identify patterns that emerge over and across many organizations. Based on those observations, here are five keys for systems that are ready to embrace risk models, including ACOs:

1. Create the right environment for provider involvement.

    Establish an effective physician organization, including a practice structure with real physician governance. Cultivate leadership and help your physicians become informed and be recognized and respected as experts in risk.
    Understand the physician enterprise and the correct legal and financial structure—including implications of basics, such as Tax Identification Number (TIN) and how this matters to all ACO and other physician incentive programs like MIPS. These may seem like inconsequential administrative issues, but changes in TIN assignments during the year can have a big impact on your incentive programs.
    Gather details about physicians in a common place, like TIN-NPI (provider number) groupings, residents, specialties and EMR/practice management system information for all acquired groups. It is impossible to participate in PQRS reporting without knowing how physicians are organized and what volume you have. Providers should see and validate

this data.
Understand your referral sources and your providers' referral preferences. Know how providers fit into the whole network of care before you take action to disrupt current arrangements.
Create a sense of community in the large group, driven by a positive approach to change, rather than one driven by compliance and negativity.

2. Build performance and outcomes initiatives on aligned incentives.

Establish practitioner-focused performance measurement and improvement:

Create common goals for outcomes;
Focus on performance measures that will inspire and engage providers, rather than impose processes they think of as trivial or administrative;
Consider a Qualified Clinical Data Registry (QCDR) for your PQRS reporting method—it can transform a PQRS effort into an all-patient, cohesive performance measurement strategy that will engage physicians.

Gain a detailed understanding of physician-based Value-Based Health Care programs and what works to bring both revenue and recognition to physicians.
Look before you leap. Take your performance pulse before you undergo an ACO transformation and work toward the design of networks and incentives that will bring you shared savings and better gains against competitors. One of the key ways to do this is to evaluate your Quality Resource and Use Reports (QRURs).

3. Reach beyond a "check the box" initiative for ACOs, other Alternative Payment Models (APMs) and MIPS.

Make performance a leadership, not administrative, initiative by requesting provider participation in goal setting, review of data and forming performance improvement projects, based on their interest or expertise.
Physicians—and patients—sniff out false initiatives, so avoid ACO "cost savings" based exclusively on approaches such as one-time patient outreach, without addressing real interventions to improve outcomes and cost.
Independently capture information from patients that evaluates outcomes, functionality and patient choices. Share those results with providers.
Focus performance on positive, not just negative results. What is working and what could be better? Start there with providers to elicit curiosity rather than judgment. Seeking out the bad apple is not the right approach to physicians and will ultimately block progress.

4. Facilitate physician-patient bonds and shared decision making.

> Structure intensive case management by supporting practices, not replacing them. Physicians are very sensitive to outside communication with their patients.
> Help physicians communicate and collaborate with patients by inquiring about and incorporating patient goals. Since patient cooperation is another part of the results equation, think about how to assist physicians in embracing the "new" culture of patients who will not accept an authoritarian approach to their health, but seek understanding and participation in clinical treatment plans.

5. Don't be an isolationist.

While many systems are developing analytical systems and internal resources to resolve problems, it is also smart to seek outside expertise and knowledge. This is especially important because all health plans and governmental payers are now comparing results between providers. Don't stay in the dark:

> Take advantage of Specialized Registry reporting under Meaningful Use Modified Stage 2, to give you access to benchmarking and comparisons with others.
> Use a Clinical Data Registry to help you deploy performance improvement initiatives that test the effectiveness of your interventions as well as compare you with other health systems.

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