Physicians and New Care Models

By JOHN MORRISSEY

For doctors who have lived independent lives seeing patients, admitting them to hospitals for procedures and pushing to do more of both, it may seem, at times, that life is being turned upside down. The volume-to-value shift in health care is ushering once-independent physicians into large organizations. It is putting the brakes on procedure growth. And, gradually, it is making doctors responsible for keeping a sizable panel of patients healthy, seen or unseen.

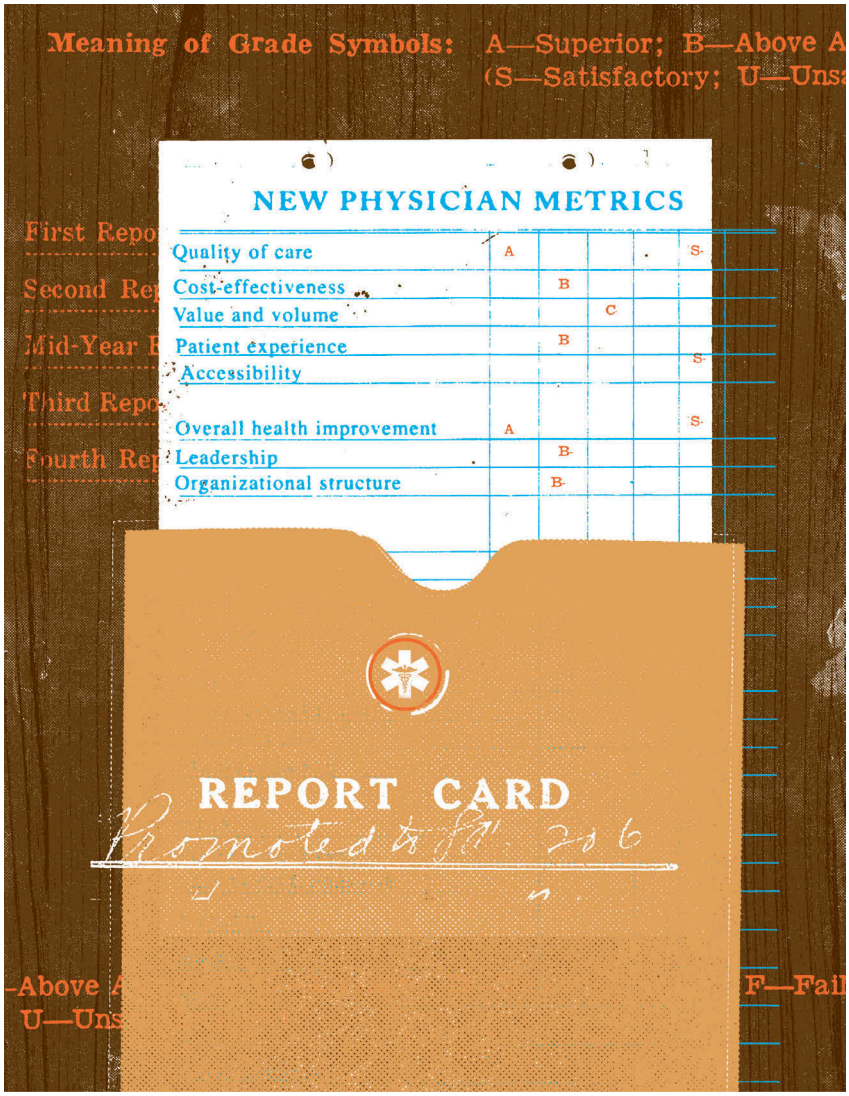
New business and clinical equations — not all solved yet — have specialists and family physicians suddenly focused on meeting quality metrics, not just revenue targets. They are having to change their practice mentality to conserve costs and mind well the patients they have, rather than expand to the broadest geographic and service-line reach possible to increase patient volume.

Physicians practicing within Catholic Health Initiatives (CHI), headquartered in Englewood, Colo., have heard the news that the system's "destination metric" is to become an organization in which 65 percent of revenue is *not* from acute care services, said Clifford Deveny, MD, senior vice president of physician services and clinical integration. That, he says, has "huge implications" for, say, a large specialty group "that maybe signed a long-term deal with a CHI facility that was premised on income preservation, service preservation and that nothing would change."

The migration to basing performance and compensation targets on evidence of quality also is creating a measure of anxiety, said Ziad Haydar, MD, senior vice president and chief medical officer of Ascension Health, headquartered in St. Louis. "We live in a world where value is becoming increasingly important, cost-effectiveness is becoming increasingly important, where accountability for quality is increasingly important, while physicians don't necessarily trust that the systems used to measure quality are complete."

And it's not as simple as trading revenue run-up for demonstrable value, said Brent Asplin, MD, chief clinical officer of Catholic Health Partners, based in Cincinnati. "It's not value or volume, it's value *and* volume," he said. "Fee-for-service reimbursement is not going to completely disappear in the foreseeable future. So physicians and care teams have to simultaneously manage both the financial pressures of remaining viable . . . while becoming accountable for measures of quality, [patient] experience and total cost for populations. We have to optimize both sides of that equation to be successful. It creates a lot of tension."

New business and clinical equations have specialists and family physicians suddenly focused on meeting quality metrics, not just revenue targets.



It's up to health administrators to acknowledge, alleviate and ultimately resolve these tensions by educating physicians about the business models into which they are being incorporated.

Executives responsible for physician relations are beseeching docs to adjust their sights from the upheaval around them to a promising horizon. Their message: Instead of the physician's life being turned upside down, it's finally turning right-side up.

"The incentives are finally coming into place to do what we always knew was possible, which is to deliver better outcomes, improve the health of the populations we're serving and make health care more affordable," said Asplin. "We knew this has been possible for some time, yet the system really was not structured or incented to deliver value for populations."

Taken further, he said, the aspect that physicians are recognizing "is that the care model can't be transformed without physician leadership." The organizations that can engage physicians in leading the change "are going to be the most successful in demonstrating their value to the communities they serve," Asplin asserted. That said, "I wouldn't suggest for a moment that the transition will be easy."

DOCTORS DIRECTED, DIRECTING

Consider the contrast between the demands and rewards of the old system and the imminent new one on practicing physicians:

- Responsibility not just for patients in front of them but afterward, when failure to comply with treatment comes back to ding a doctor's performance and pay
- Off-loading patient exams, routine decisions and follow-up to other practitioners, activities that formerly were the purview of and steady income source for physicians
- Heightened demand to execute care guidelines, which are then reported as quality metrics
- Compensation programs that penalize physicians for costly interventions that for many years were sources of high income

It's up to health system administrators — in many cases, the employers of physicians — to acknowledge, alleviate and ultimately resolve these tensions by educating physicians about the business models into which they

are being incorporated. From there, executives must develop proactive measures to keep physicians satisfied in the practice of medicine while encouraging teamwork among health professionals and fulfilling evolving government guidelines.

A first step is to make clear the pivotal role of physicians in the new model, which some might not realize and need to prepare for. Physician leaders in practices, for example, have been mainly individual problem-solvers and advocates for their group in negotiating with hospitals, said Deveny. "In many cases, these people have never had to work with a partner. There's a new dynamic of having to either lead a team or be a consensus builder or a partner with somebody."

Executives must develop proactive measures to keep physicians satisfied in the practice of medicine while encouraging teamwork among health professionals and fulfilling evolving government guidelines.

Physicians typically don't go to school, at least initially, to become leaders of health care organizations, said Brenda Bowers, PhD, senior vice president and system chief nursing officer for Wheaton Franciscan Healthcare, based in Glendale, Wis. "But as we continue to move out of this fee-for-service world into population health management, we also know that in physician-led organizations — even organizations that see physicians as key partners whether they would consider themselves physician-led or not — the physicians need to be developed in areas that they have not been exposed to during their typical medical training," said Bowers, whose executive oversight for aspects of system work includes organization and leadership development functions.

When physicians do have a grasp of their significance and "understand the possibility that this could be even better for them and for their patients," said Haydar, it's the health system that may have to show it can handle the transition. Physicians may be doubtful that health systems can make it happen, he said. "There is genuine concern that hospital-centric CEOs will not understand how to lead the practices."

One response is to put physicians in a position to lead, but that's not the same as handing over power. First they have to understand their purpose in being part of the ministry, said Haydar. "I'm inviting them to have more leadership — and therefore bear the cross with us. Because it's not just about power and leadership, it's about the cross. I invite them to be leaders and stewards and define the ideal environment to serve the patient."

ILLS OF CURRENT MODEL

Health systems can begin that process by highlighting the restrictions and shortcomings of the only payment model most physicians have ever known. For as long as they have been in practice, physicians have factored in what they would like to do for their patients with what they could or couldn't charge for. "But everybody wants to make a living, and everybody adapts their craft to the business model where they are paid," said Haydar.

When volume of fee-for-service medicine is rewarded, physicians "end up not being able to spend enough time with sicker patients, have to rush the sick patients to spend time with the people who could have been taken care of on the phone," he said. "And these are the compromises that were made."

Those compromises carry over into business and personal life, prompted by umpteen variations of cost-control policy focused on reducing fee reimbursement, said David Pryor, MD, executive vice president at Ascension Health. "If you think about the experience of physicians, year after year after year, in order to make the same amount of money to take home to your family, you work harder and harder for less and less. So the way it was working wasn't really working well for a lot of docs."

"It's the small-business mantra: If your reimbursement per widget starts to go down . . . you try to increase the widgets," said Frank Mikell, MD, chief physician executive of Hospital Sisters Health System, based in Illinois and Wisconsin. Physicians try to "pack volume in" and, as a result, "when it comes to important things like care coordination and education, not to mention spending a little time with the patient on the spiritual side or the wellness side of the equation, it becomes almost impossible."

Along comes a concept promoted by the Affordable Care Act that proposes to give doctors

back their latitude to care for patients the way they should.

"Although it's a change, and change is sometimes scary, I think the end point is something that people really can get their heads around, where they're caring for groups of patients and managing their care and keeping them healthy, keeping them out of the hospital," said Daniel Post, senior vice president for clinical programs and practice development at Loyola University Health System in Maywood, Ill. Despite surface tension, "behind closed doors, everyone agrees that the fundamentals of this are sound and make a lot of sense from a business perspective, but more importantly from the patient and provider perspective."

NURTURING EXPANDED TEAMS

Organizing for value involves reconnecting physicians with their patients, a concept that is attractive but often challenging at first. CHI is putting wave after wave of primary-care physicians from its employed practices into patient-centered medical homes, a process that addresses issues of accountability and how doctors get to know everything about their patients, such as how many are diabetic or older than 65.

"Physicians typically don't know how many are in their panel," said Deveny. "They do know how many visits they had this year, but not how many people they're actually responsible for."

After a year-long education and workflow-change process, and subsequent medical-home accreditation, CHI practices that previously saw 1,200 patients now become responsible for 4,500. The only way to do that is commit to and nurture expanded care teams, including mid-level practitioners to take some of the routine tasks from physicians, and clinicians or non-medical staff to engage and monitor patients outside the office in ways that physicians never had time or the particular skills to do.

A key part of expanding the practice capacity at CHI is the hiring of advanced practice registered nurses, said Deveny. "And you know, it's being met with enthusiasm, it's not being met with resistance in most cases."

That can't be assumed everywhere. Mikell, of Hospital Sisters Health System, said his sense is that the work of nurse navigators, who are assigned to follow a contingent of patients, are not a threat to physicians because they do their navigating mainly out of the office. But some doctors, he said, feel threatened by mid-level practitioners within the office setting and are worried they will compete for patients.

"In some cases we still have doctors who are reluctant to move in that direction. But if you compare it to 10 years ago, there's been a huge move toward understanding the value of nurse practitioners," Mikell said.

"There will be naysayers and doubters early on," he said, "but if you basically show physicians they're still practicing to the top of their license, and most importantly that their compensation is not being jeopardized by the model, then doctors are more likely to come around. But it's a definite transition."

Big effort at Catholic Health Partners is going into lining up the best member of the expanded team for each task required, said Asplin.

"It certainly does sometimes require physicians to give up some things that they have traditionally done for patients, because those items may be more reliably done by other members of the care team. That's certainly one of the ways that we can deliver both value and volume," he said.

"Although it's a change ... I think the end point is something that people really can get their heads around, where they're caring for groups of patients and managing their care and keeping them healthy."

— DANIEL POST

Loyola's Post said the role delineation is "like process improvement, you look at swim lanes and say, 'What's in the physicians' swim lane that they have to do, versus what can be done by the medical assistant or the nurse practitioner or others to care for the patient?'"

At Loyola, where all primary and specialty physicians and their staffs are employed, "I don't sense a lot of resistance in the organization," Post said. "One of the things we're doing to encourage people to look at this team-based approach is saying, 'We believe access is critically important; when patients call and need to be seen, we should be able to see them within 24 hours.' And that's a paradigm shift, especially in some organizations

where, because of specialty shortages, etc., it's common for patients to have to wait months to get in to some doctors."

One remedy is to start the patient with other members of the office team, he said: "Let's get them in the door, let's put eyes and ears on the patient, figure out what's going on, and let's use it as a way to facilitate access into the organization."

CANDID ABOUT CHANGE

The fact remains, however, that health systems have brought large, moneymaking specialty groups into the fold under terms that are being overtaken by events. CHI made a big commitment to cardiovascular medicine, purchasing or signing long-term agreements with large, nationally prominent groups such as Iowa Heart Institute, Nebraska Heart Institute and others in places like Little Rock, Ark., and Chattanooga, Tenn. All were promised commitments of capital, compensation and exclusivity. And it's hard for leaders who negotiated those agreements to explain to their doctors why things are changing, said Deveny.

The accountability and quality metrics are different. Bringing a heart specialist into a rural area, for example, might have spiked the number of surgeries, and that would have been a good result. Now, said Deveny, it begs the question, "Is that the best use of capital, and is that the safest thing for the patients?"

"If you show physicians they're still practicing to the top of their license, and most importantly that their compensation is not being jeopardized by the model, then doctors are more likely to come around."

— FRANK MIKELL, MD

Changing clinical and profitability standards might alter strategy in a region, leading a hospital to partner with other entities or decide to "pull out of certain things and let somebody else do it" rather than continue services that may be better provided by a competitor, he said. Adjustments to reflect the shift away from volume have led to "a lot of victimization and complaining that 'I graduated from medical school, and I bought into this business model, and I believed this was going to go on forever.' And where people have been naïve is that nothing goes on forever."

Health systems first have to stand their ground and then make the new reality transparent, Deveny said. "We use the term, 'You don't blink.'"

That happened in the past with physician relations because of concerns about losing volume to a competitor. "I don't think anyone used to even consider whether the number of knee replacements we did was appropriate or not," Deveny said. "[If] we did 200 knee replacements this year, we celebrated. But if 185 were indicated and 15 weren't, how do we deal with that?"

The new climate calls for taking a hard look at every procedure for its appropriateness, and that might not sit well with some specialists. "But it's really an industry expectation now, so the fact that they're going to run and take their toys somewhere else — there aren't many places they're going to be able to go. The world isn't the way it was," Deveny said.

Physicians can fault the measures, said Asplin, "and yes, there is controversy over both the quality measures and, frankly, even more acutely, over the patient experience measures. Yet they're both much better than they were five to 10 years ago, and they will continue to get much better . . . But they will never be perfect."

The key is how the measures are put to use, especially in applying consistent expectations on adherence to clinical guidelines across medical staffs.

"While doctors don't want to be told what to do, on the other hand they recognize that standardization often produces better results," said Ascension's Pryor. He senses "more openness" to "the concepts of quality and how you produce good quality."

Full disclosure of data-quantified performance, for both clinicians and hospital management, will be the new norm at CHI, Deveny said. "Most humans want to be part of something that's always getting better, and part of that process is being comfortable with the vulnerability of having their performance out there," he said. "Our administrators, our physicians should be comfortable with that, and we have to be clear that that's the type of organization we are."

CATHOLIC MISSION IN ACTION

Returning to the Catholic legacy is a way to elevate the perspective, Deveny advised. "You've got tough conversations, you've got tough decisions to

"The story that we're living through with the Affordable Care Act in a place like Loyola is an opportunity for us to care for more souls ..."

—JOHN HARDT, PhD

be made, and at the end of the day, you can always fall back on what is the best thing for the community: Would the sisters say this is what they're about? And my sense is that really defuses a lot of tension and brings comfort to a lot of our leaders."

In a Christian context, all the shifts can be viewed positively "as an area of growth, to consider what it means to be our brothers' and our sisters' keeper," said John Hardt, PhD, Loyola's vice president of mission integration. "There's an increasing amount of accountability, there's a more sustained relationship; there are more touches on these patients' lives as we follow them through the trajectory of their lives."

For Loyola, a Jesuit-sponsored organization, "You can go back to the founding documents of the Society of Jesus and Ignatius again and again: The purpose of the Society is to care for souls," Hardt said. "And I think that the story that we're living through with the Affordable Care Act in a place like Loyola is an opportunity for us to care for more souls — it is about access, it is about our capacity to bring more people under our umbrella of care."

The centerpiece is the now-doable objective of population-based health management, said Haydar, which he asserted "is a theological mandate rather than something we just have to do because of the Affordable Care Act."

He also suggested that hospitals, more than physicians, have to embrace the goals and prove "by deeds, not by talk" that they're committed to it. "I think the vision for population health is not too complicated to explain," he said. "Physicians know it's actually better than [the focus on] hospitals."

Looking ahead, part of a Catholic system's commitment to ministry is to look for individual commitment to that guiding principle when hiring or acquiring physicians, said Bowers of Wheaton Franciscan. A special 18-month physician ministry leadership program, which culminates in August, raised that issue among a raft of projects that the 33 participants selected to reason through. The program is for practicing physicians who want to go from just interacting with patients to becoming the leadership material that will "help drive us from this fee-for-service environment into population health."

One question from that ground-level perspective, she said: "Why do we keep hiring physicians that aren't on board, physicians that don't align with the mission, vision and values, physicians that are only focused on fee-for-service and have no intention of having a mindset to transition differently?" With attention to values "that allow them to adapt and be nimble and flexible," a recommended strategy is to focus on "how to implement a physician recruitment strategy to ensure organizational and culture fit," Bowers said.

Ascension Health's Haydar, as the executive tasked to "elevate physician expertise into a position of responsibility and leadership," exercises a bit of humility.

"I can't with a straight face, as a hospital-centric system [executive], take the high ground," he said. First he has to "admit that we have been a hospital-centric system more than we should; however, we are enthusiastic supporters of the Affordable Care Act, we have lobbied for it extensively, people know that."

As an organization, Ascension Health is about quality and "compassionate, holistic care, delivered for poor and vulnerable people," added Pryor. "For most docs, they went into medicine to improve the outcomes for people; they care about the patients. So that message lines up."

In sum, evolving models appear to be aligned and consistent with Catholic mission, said Asplin. "If you look at how the most vulnerable populations have fared under a fee-for-service system, it's not a pretty picture. And in our mission to improve the health of our communities, and a particular focus on the poor and underserved, I think a value-driven health delivery model is really an opportunity to improve outcomes for the most vulnerable members of our community."

The message has to repeat on a loop as physicians adjust to delivering value and volume.

"The complexities are real," Asplin said. "The stress on physicians and other members of the care team is real. We don't have all the answers, and we'll need to continue to move forward together in trying to find those answers."

But throughout, he said, "the phrase we use with our care teams is, 'This is what we were meant to do.'"

JOHN MORRISSEY is a freelance writer specializing in health care delivery policy and performance measurement. He lives in Mount Prospect, Ill.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, May-June 2014