VCU Health: Optionalism, Exceptionalism, and the Public Trust

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Bundled Payment for Care Improvement: Examples in Practice

The Center for Medicare and Medicaid Innovation (CMMI) created the Bundled Payment for Care Improvement (BPCI) initiative as part of an effort to encourage hospitals, physicians, post-acute facilities, and other providers to work together to improve health outcomes while lowering costs. As of January 2016, the AAMC was supporting the efforts of more than 30 hospitals to implement BPCI through the AAMC Facilitator-Convener Group.

The Examples in Practice Series highlights the challenges faced and strategies used by leaders at five health systems while participating in BPCI. These examples offer potential lessons for other academic medical centers pursuing delivery reform under alternative payment models and for the insurance administrators and policy makers designing alternative payment models.

For more information on bundled payments, go to aamc.org/bundling.

This Q&A is with Stephen Kates and Gregory Golladay. Kates is a geriatric orthopaedic surgeon, the chairman of orthopaedic surgery at VCU Health, and formerly the Hansjörg Wyss Professor of Orthopaedic Surgery and the associate director for the Center for Musculoskeletal Research at the University of Rochester, New York. He is editor of Geriatric Orthopaedic Surgery and Rehabilitation *and is past president of the International Geriatric Fracture Society. Golladay is the Adult Reconstruction Fellowship director and associate professor of orthopaedic surgery at VCU Health. He is the surgeon champion for the VCU Health Bundled Care Program. In an informative Q&A conducted in December 2015, Kates and Golladay discuss the opportunity and risks of engaging physicians in alternative payment programs.*

Dr. Kates, you've been engaged in bundled payment for joint replacements for more than a year now. You're an expert in the area of hip fractures in the elderly, a major issue in this bundle. What were some of your primary lessons learned?

Overall, bundled payment models give us a clear opportunity, direction, and incentive to provide better care for our patients. We experienced the emergence of several risks that are likely to impact many academic medical centers. One risk is the lack of continuity of medical leadership in these programs. It is essential that the alternative payment models [APMs] are managed by an integrated team, not a single physician or leader. The risk is great when an inspirational leader leaves an organization. The program can stagnate in a leadership void, as the institutional history and project gains tend to leave with that person. Multidisciplinary teams must be convened to provide structure for the program and share accountability for outcomes.

Another risk is the failure to commit to serious and deep physician engagement. Prerequisites to robust engagement include a history of trust and transparency between providers and the hospital, provider-specific data sharing, clearly defined incentives for good citizenship, and gainsharing [that is, sharing savings with clinicians who actively engage and improve their performance].

Describe some specific barriers to full physician engagement in your experience.

The biggest challenge to physician engagement is getting buy-in from every individual provider. Historically, many doctors, especially surgeons, have been independent practitioners who have made the majority of their decisions without significant oversight or regulation. In general, it seems that physicians who have demonstrated prior resistance to change tend to pose challenges when presented with health system design changes. While most physicians acknowledge that new payment models are here to stay, recognize the opportunity to improve care and value, and are willing to create and follow standard plans of care, as you might expect, there are exceptions! There's a necessary paradigm shift from the way many doctors were trained and have always delivered care in an individualized way to adopting standardized protocols and practices.

In addition, some doctors are providing care in new settings and under new arrangements. These physicians are not accustomed to restricted implant selection or the requirement to follow a standard care protocol. In many cases, this means surgeons must adopt clinical pathways that are quite different from what they've been accustomed to throughout their training and years of practice. They are used to a care model that they believe worked well for them and their patients, making decisions based primarily on the clinical outcomes of their last 5 to 10 cases. Unfortunately, such decisions are not always based on the best scientific evidence and rarely reference peer-comparison data.

We've observed that while many physicians involved in new payment models may agree to use a care coordinator, use a

standard clinical pathway for preoperative and postoperative order sets, and are willing to direct patients to lower-cost and higher-quality settings after discharge, friction can develop over relatively minor decisions. While adopting standard practices requires little behavior or practice change on the part of the physician, certain decisions—like choosing a prophylactic anticoagulation agent—can incite significant emotional responses. Completing a preoperative checklist in the EMR documenting appropriate indications and addressing the patient's comorbidities and optimization for surgery can be seen as additional, burdensome work.

Promoting standardized pricing and implant-selection criteria, even though the type of implant may not be expressly mandated, creates pushback. What may seem to be relatively minor process changes commonly spark the response, "What's in it for me?" When doctors don't see a direct personal return on their time investment or don't embrace the shared goal of creating both savings and better outcomes, there's a tendency to devolve into a culture of optionalism and exceptionalism. Resistors try to exempt themselves from doing what the group had collectively agreed upon, continuing to practice in their own established ways, and promoting change with them can be difficult. That's why it's important to have everyone engaged at all points in the process and to establish shared goals and incentives early on.

Are there predictors for this kind of behavior, and what are the best strategies to prevent this outcome in alternative payment programs?

The most predictable factor is probably past resistance to change, which then leads to a lack of engagement. Usually, this is not new behavior; resistant behavior is not necessarily predicted by age, experience, academic or community role, or even individual quality metrics. Failure to attend meetings with colleagues to review goals and processes and failure to follow standard practices are diagnostic of this behavioral mode. In turn, these physicians get angry when surgeries are cancelled because, for example, their patient's hemoglobin A1C is too high for safe surgery or when an implant vendor was asked to lower the price to meet a contractual adjustment. In some cases, surgeons resist change even when there's no choice but to comply. As an example, we created a simple checklist in our EMR that reflects the key quality metrics mandated by CMMI [the Center for Medicare and Medicaid Innovation] and other national organizations. Some doctors found this to be offensive and refused to complete it.

All of these behaviors suggest an inability to adequately understand the context for change, unwillingness to adapt, and difficulty in managing the impact of the change directly. As leaders, we cannot accept failure, and we must be prepared to deal with resistance. Continuous education and transparent data sharing help align individuals with the goals of new payment models.

This is not unique behavior to clinicians in alternative payment models. What specifically has triggered these responses in APMs?

First, the shift from fee-for-service to a bundled or capitated payment is a major change in our country. It requires physicians to assume accountability for long periods of time and for conditions that are not in their direct control. Providing value rather than just volume is a novel concept for doctors. In addition, the decision about whether and how to engage in gainsharing has stimulated new conversations and has created new relationships between physicians and hospitals.

Some hospitals, given the uncertainty about generating savings in APMs, have been hesitant to enter into gainsharing strategies with physicians. Hospitals worry that a bundled program may not result in adequate savings to share, and they may not be prepared for full financial disclosures. Physicians may believe that they bear the burden of adopting all of the cost-savings measures and efficiencies, yet may risk taking a pay cut. They also worry that there are many factors outside of their own control for which they are nonetheless held accountable.

This perceived lack of transparency and lack of clear commitment to shared risks and incentives reinforce timeworn suspicions on both parts. This pattern allows trivial issues to become touch points for conflict, perpetuate distrust, and impede partnership. Collaboration is essential for survival. Both parties need to effectively articulate the shared responsibilities and challenges in the new world of payment models. Open dialogue is paramount.

What do executives and department chairs need to make this partnership work?

We all need to be able to articulate the big picture: a large percentage of health care dollars is being spent in new bundled models, and this is only likely to increase over time. The old fee-for-service model will sunset or be drastically reduced. We need to learn how to provide good care in a value-based payment environment.

During this period of great change, leaders need to listen closely to their stakeholders and be able to respond with what is in it for *each* of us, keeping our patients as our focus. Most importantly, APMs are an opportunity for us to

consciously determine what is the best care for our patients and then to monitor our outcomes and seek continuous quality improvement. We should use every opportunity to communicate to clinical departments about why this is happening and what intense market competition is and to explain that in order to remain competitive, we must learn to do this work well. Surgeons are competitive, and this message resonates. We can continue to do what we love to do, we can continue to care for our patients, and we can refine the process and system as we learn.

People have to be willing to make changes, both big and small. The small changes can seem intrusive and may impact old patterns in documentation, follow-up, and communication. But good leaders never make it about the cost of care, or about new government programs. We can use APM programs to promote the best professionalism in our peers: most doctors want to do the right thing for their patients and deliver the best possible care with the fewest complications.

Wynia et al.'s 2014 paper summarizes our opportunities well: "Professionalism is not merely an accounting of what physicians promise to patients and society. At root, it is the motivational force—the belief system—that leads clinicians to come together, in groups and often across occupational divides, to create and keep shared promises … professionalism requires that health professionals, as a group, be ready, willing, and able to come together to define, debate, declare, distribute, and enforce the shared competency standards and ethical values that must govern medical work." APMs offer us all another opportunity to earn the public trust.

Reference

Wynia MK, Papadakis MA, Sullivan WM, Hafferty FW. 2014. More than a list of values and desired behaviors: A foundational understanding of medical professionalism. Academic Medicine 2014 89(5):712–714.