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Commentary: **Sense and Sensibility: The Role of Specialists in Health Care Reform**

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Abstract

How to redesign the incentives structure in the United States to reward effective coordinated care rather than production volume is a staggering public health policy challenge. In the mind of the public, there is a fine distinction between health care rationing and rational health care. Specialists have a vital but underappreciated role in reining in health care costs, but specific incentives to elicit behavior change with positive social outcomes remain ambiguous. It is imperative, therefore, that redesigning the incentives structure is thoughtfully

considered, modeled, and tested prior to implementation, lest an inferior-quality model is inadvertently adopted and costs are only marginally contained. Quality metrics need to be universal and reflect real patient outcomes instead of the degree of investment by the institution in the reporting tools. Still, specialists should take immediate action to implement safe and efficient procedures and to assess their long-term impact on patients' quality of life. Scientific evaluations should guide both the assessment of the appropriateness and

the safe delivery of care. Investment in high-quality data architecture and the science of health delivery implementation is an imperative if health care reform is to achieve its goals. Coordination and collaboration between specialists and primary care physicians is essential to this enterprise. Specialists can champion these efforts as they pertain to their areas of expertise by considering their care episodes in the context of the entire patient, working closely with generalists, and returning to the mindset of the specialist as a family doctor.

The 2010 Patient Protection and Affordable Care Act seeks to address quality, cost, and population health on a national level. Accountable care organizations (ACOs), a voluntary demonstration project in Medicare, are one of several new payment reform initiatives included in the legislation. Although ACOs have been conceived out of the need to control health care costs, they are not intrinsically designed to discourage the use of resources but, rather, to promote a more coordinated approach to treating illness and maintaining wellness. Effective coordination of primary and specialty care within a delivery system, like that

advocated by the ACO model, will be a vital driver of success if shared savings across an institution's care continuum are to be realized. Given the divergent stakeholders and a skeptical public, successfully redesigning incentives to reward effective coordinated care instead of production volume is a staggering public health policy challenge. To the American public, there is a fine distinction between health care rationing and rational health care.

To date, the public health policy debate primarily has focused on the coordination and management of chronic conditions so as to reduce the need for their treatment in acute care settings. Relatively little attention has been aimed at addressing the enormity of resources used once the acute or technical care threshold is crossed. Remarkably, this setting, high in complexity and dominated by specialists, is equally mired by a lack of care coordination and connectivity despite the presence of all the care components often housed under a single roof. How can specialists serve as effective and forward-thinking change agents and thereby assist their health organizations' partners in developing value-based resource use strategies? With much of a typical health organization's profit margin generated by surgical and procedural productivity, highly compensated technical specialists

may be tempted to resist change and remain complacent. Global models offer important examples illustrating that the status quo is unsustainable regardless of the strength of the economy or political party in power. No health care system in the world can provide its population with unlimited access to resources in perpetuity. Unfortunately, for busy specialists in most acute care settings, the burning platform is either invisible or overlooked because these discussions have not yet been prioritized. For the thoughtful specialist with a long-term view of acute care medicine, today represents a remarkable opportunity to provide leadership and vision for greater care coordination across all settings.

Unless the incentives structure is redefined, reducing procedural volume may seem counterproductive to specialists' interests. This shift will involve substantial change, more than just in mindset, for almost all specialties to move toward getting paid for keeping people healthy. In this challenge lies an opportunity for specialists to successfully transition from our current, volume-based health care economy to a more value-based model that addresses and cares better for populations. Specialists, such as invasive cardiologists, surgeons, anesthesiologists, and radiologists, may work with their organizations under a variety of models, but consistent across

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these relationships is the mandate to streamline an efficient procedural enterprise through clinical integration that increasingly emphasizes interdependence, clinical pathway design and execution, cost awareness, and quality monitoring.

Specialists based in acute care or ambulatory settings need to appreciate how hospitals, primary care providers, and payers perceive them. These constituencies are all under financial pressure and view unjustifiable variations in care delivery and use as the ripe targets for savings. Hospitals will get penalized for readmissions, and payers will offer financial incentives to primary care physicians to control the use of care. One substantial lever of control for the primary care physician is specialist referral. Consequently, specialists should consider their position and choose either to defend the status quo or to proactively participate in, and even lead, these conversations and leverage their expertise to make this cost savings journey even more fruitful for the overall system. The alignment of cognitive and procedural specialist input in charting rational and measurable care pathways should be central in the cost discussions happening within medical communities today.¹ It would be a missed opportunity for specialists to allow these conversations to occur without their thoughtful and vested counsel.

To assist the specialist, the federal government has issued guidance documents and pledged to manage legislation (e.g., Stark, antitrust, antikickback) that has inadvertently obstructed innovative models for improving delivery and reducing costs. Such guidance opens the door for transparent financial discussions that can lay the groundwork for incentives, which drive provider efficiency and alignment with quality goals. Specialists, by definition, are relied on to determine the appropriateness of complex therapies and procedures. However, in the future, specialists have the opportunity to leverage this expertise by providing a discriminating oversight role in the deployment and adherence of evidence-based pathways to produce health care value. For these complex therapies, the specialist can fill the role of standardization expert within the community—someone who is relied on

by the hospital, trusted by the primary care physician, and rewarded by the payer for ensuring the execution of appropriate, high-quality, team-based care with predictable outcomes.

Yet, how do we accomplish this change? In economic theory, changing the payoffs in a system is the most efficient way of changing behavior and exacting a paradigm shift. But, economists also agree that creating incentives to elicit behaviors is delicate work and that unforeseen externalities frequently arise and lead to unanticipated and sometimes undesirable consequences. As part of the Shared Savings Program described in the Proposed Rule of March 31, 2011, the Centers for Medicare and Medicaid Services provides conceptual guidance, but few precise details, on how incentive savings will be calculated or shared in an ACO model. Historical benchmarks for expenditures per beneficiary are highly variable and, more significantly, not risk adjusted. The methodology of attributing beneficiaries to specific ACOs is ambiguous. Also, quality measures are poorly defined and may ultimately be unrelated to quality care. Providers who are already efficient may be disadvantaged in this new system as the marginal value of additional savings may not be worth the effort. Without clearly predefined rights and rules that are demonstrated to be effective in reducing overall health care costs while maintaining stakeholder revenue, why would rational providers act in potential opposition to their best financial interest? This classic prisoners' dilemma must be addressed before a durable model can be embraced.

An illustration of this challenge resides with a progressive group of oncologists who developed a patient-centered oncology home for their patients.² Relying heavily on care coordination software that streamlined visits and specialist communication, coordinated complex multimodal treatment plans, tracked medication, and promoted patient engagement and on-demand access to care, the providers demonstrated a reduction in the frequency of hospital admissions, emergency room visits, and chemotherapy infusions.² End-of-life discussions with patients with noncurative (Stage IV) diseases and access to palliative care improved quality

of life for patients and their families. During a 12-month period, the coordination implemented by this novel provider group saved approximately \$6.5 million in health care costs across the continuum of care but also resulted in a coincident decline in practice revenue. Such successes need to be studied and emulated, but until the rewards for such innovative thinking and sweat equity are clear, such successes may not be broadly implemented.

Even in the face of these uncertainties, plenty of opportunities for unambiguous savings exist today. Unlike primary care visits, specialist visits often lead to invasive and costly episodes of care frequently involving devices, prosthetics, or imaging modalities. Errors that occur in these settings are of high consequence to both the patient physically and the delivery system economically. Given the broad economic footprint of specialty care, specialists have a key responsibility to thoughtfully monitor resource consumption equally as much as (and perhaps more so than) generalists. Opportunities for decreasing operational costs include the adoption of mathematical models for efficient procedural site management as well as the creation of cultures of reliability and safety in critical care units and operating room suites. The redesign of clinical processes with the aid of technology holds promise for reducing the incidence of critical errors, including ventilator-associated pneumonia, central line and surgical site infections, blood component utilization, and wrong site surgery, which are all huge drivers of acute care costs.

Capturing savings without sacrificing quality will require a significant investment in the science of health care implementation—an emerging field that is focused both on the safe administration of and sensible indications for care. Without the development of an infrastructure capable of real-time and high-accuracy data collection, the scientifically rigorous evaluation of delivery models, implementation processes, or effectiveness cannot occur. Without data, the “reformed” health care delivery system for both primary and specialist care risks the adoption of unvalidated metrics and the absence of a methodology to assess the impact of interventions on the lives of patients.

Quality measures must be scientifically proven to truly reflect good patient outcomes. In short, the new, incentives-based compensation system must set aside funding for this kind of research, lest we adopt a new, but flawed, system of reforms that rewards the providers with the most advanced quality-reporting information systems rather than the ones that deliver the best patient care.

To conduct this type of research, the investment in automated information systems for benchmarking risk-adjusted outcomes and for validating meaningful performance measures is a health care reform imperative. Given the magnitude of the opportunity for improved clinical and business decision making, particularly in the acute care setting, it should be natural for specialists to champion this charge for greater information sophistication. While the integration of disparate information systems and databases with long-term outcomes registries is especially critical for surgical and procedural risk modeling (a principal domain of the acute care setting specialist), the comparative effectiveness of different interventions can best and most importantly be determined by assessing their impact on long-term physical well-being, adjusted for cost. This type of research will be attractive to payers and providers alike, and enlightened specialists should lead the effort to collect and integrate these data, many of which remain locked in noncommunicating and disparate registries and databases.

Surprisingly, scientific evidence advising patients of the risk-adjusted probability of a successful outcome for a given procedure is currently unavailable. Even evaluations of large administrative databases such as the Medicare Provider

Analysis and Review³ have, by necessity, focused on available end points like length of stay or mortality—both marginally informative metrics⁴—and few have examined specific procedures. In short, whether a patient is a good candidate for a surgical or diagnostic procedure often depends on whom one asks vital questions, such as the following: Should a patient have a procedure? Is it a good tradeoff given the recovery time and personal investment? For how many of our patients are the long-term gains greater than the short-term losses? Such questions have personal, ethical, and philosophical implications that specialists should consider as part of their professional sphere and clinical duty to patients. Effectiveness and risk-adjusted outcomes that include quality-of-life metrics are needed to enable specialist providers to help guide their patients' unique health care decisions.

Western medicine has historically placed the individual at the center of the patient–physician contract, and so, for all physicians, it should remain. Given realistic and empowering information, most patients make rational decisions about undergoing procedures. Deciding whether a patient should have a costly procedure is distinct from determining the greatest good in the public interest. The comparative effectiveness of treatments and the measurement of quality and performance standards are currently based on short-term epidemiological and self-reported administrative claims data. Until longitudinal patient outcomes are captured, it is important that these data are used to guide public policy but not prohibit individual access.

The ACO model reflects an attempt to find the middle ground between the

extremes of the fee-for-service model's unbridled capitalism and the capitation system's disincentives. The implementation and durability of any new payment model must include both a framework for measuring and disseminating successes and enough plasticity to abandon failures. Regardless of how incentives are reengineered, there is a lot at stake for the global status of American health care. Specialists are in a unique position to provide rational and coordinated experiences for patients requiring invasive procedures and should heed the clarion call to ensure that those patients undergo worthwhile procedures safely and with minimal suffering and cost. In many ways, specialists, like other providers, will need to rediscover the broader vision that all physicians once possessed when the entirety of the patient was considered in all decision making. For specialists, there has never been a better time to shift from being highly skilled technical physicians to becoming more like family doctors again.

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AUTHOR QUERIES

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