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IssueBRIEF

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Supporting Better Physician Decisions at the Point of Care: **What Payers and Purchasers Can Do**

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INTRODUCTION

For decades, researchers have noted considerable variation among physicians treating otherwise similar patients, with frequent failures to deliver evidence-based care (Schwartz et al. 2014; McGlynn et al. 2003). Studies have highlighted an array of factors that contribute to these deviations from evidence-based practice (Reschovsky et al. 2015; Contreary and Rich forthcoming). In this brief, we use four illustrative clinical cases to explore barriers to and facilitators of physicians recommending evidence-based treatments at the point of care. Because payers determine the financial incentives intended to shape the environment in which physicians make these decisions, we focus on how payment reforms might address these incentives to promote more evidence-based recommendations, and thus higher-value care.

Drawing from prior research, interviews with physicians, and discussions with stakeholders, we note opportunities for health insurers and other purchasers to promote a practice environment that supports following evidence-based recommendations (Mathematica Policy Research 2016). Our analysis suggests that the feasibility and likely effectiveness of these strategies can vary considerably across practice settings, communities, and clinical problems. We conclude that the most promising strategies are those in which local payers and community organizations provide resources or preferential payments so physicians and practices can adapt attributes of their point-of-care setting to facilitate more evidence-based care.

INFLUENCES ON PHYSICIANS' DECISIONS AT THE POINT OF CARE

To ground our investigation in real-world practice, we framed our investigation of factors contributing to or hindering evidence-based practice around four common cases, representing the different types of decisions physicians make on a daily basis. We chose topics from the *Choosing Wisely*® initiative—a program sponsored by the ABIM Foundation. Each topic involves a decision for which there is currently significant variation in practice, but for which the relevant specialty society has endorsed a specific choice as a best practice based on strong available evidence. Our first example concerns

the choice of which diagnostic test (if any) to order for a child presenting with suspected appendicitis. Computed tomography (CT) has better diagnostic accuracy than ultrasound, but exposes the patient to a large dose of ionizing radiation. Due to increased cancer risk from radiation exposure, evidence-based guidelines recommend against CT scans for children until ultrasound has been considered (American College of Surgeons 2013). Our second example involves the use of cardiac imaging technology as a regular part of long-term monitoring in patients with known coronary heart disease (CHD) who are not experiencing new cardiac symptoms. Routine imaging involves both excess radiation exposure and the risk of unnecessary downstream care, and is hence recommended against (American College of Cardiology 2012). Our third example involves weighing medical versus surgical therapy for patients with intermittent leg pain from peripheral arterial disease (PAD). Surgical interventions are not recommended until risk factor modification and pharmacologic treatment have been attempted (Society for Vascular Surgery 2015). The final example concerns a decision made after an initial treatment has already been selected and symptoms are controlled: continued medication treatment in patients with gastroesophageal reflux disease (GERD). In order to prevent harmful side effects, the recommendation is that physicians adjust their patients' dosage of long-term acid suppression therapy to the lowest dose that does not prompt a recurrence of symptoms (American Gastroenterological Association 2012).

For each of these encounters, the physician must make one or several decisions depending on the nature of the patient's problem, and where the physician and patient are in the decision-making process. As illustrated in Figure 1, this process includes identifying the patient's primary concern(s), deciding whether and which diagnostic test(s) to order, interpreting any test information to make a diagnosis, and finally recommending a treatment to address the patient's health concern(s). Various aspects of the complex environment in which care is delivered can influence each of these decisions. We consider the following: the *physician's own characteristics*, including training, knowledge, and clinical experience, as well as attitudes toward risk and interpretation of professional responsibility; the *practice site*, or the physical location where the physician provides care, including both the social context and the medical infrastructure available to physicians; the *practice organization*, meaning the organization employing the physician; *networks and affiliations* with hospitals or other physician practices; and the general *market environment*, including the number and types of physicians, practice organizations, and payers in the market, as well as medico-legal characteristics.

For example, in the appendicitis case, physicians' personal characteristics can influence the recommended action. Several general surgeons noted that, given their years of experience, in cases of suspected appendicitis they would feel comfortable either ordering an ultrasound or proceeding to the operating room "right away," but reported some younger colleagues are more likely to order a CT scan before proceeding. Specific patient factors can also be a consideration; in the CHD case, several cardiologists noted some patients have specific expectations that can influence the recommendations regarding an imaging study. Some patients, for instance, see the annual stress test as a "milestone," according to one cardiologist. The specific practice location where the patient is seen can also have a substantial influence on what the physician recommends to a patient. For example, in the appendicitis case, various surgeons voiced concerns that when skilled ultrasound technicians are not available in house, doctors "default to a CT scan." In the GERD example, the role of other team members at the practice could also be quite important; one gastroenterologist noted that in his practice, refills for medication intended to control GERD would primarily be handled by a nurse.

The organization that employs the physician can also strongly influence how decisions are made.

> *Hospital administrators will occasionally "Come around and talk about how we need to do more procedures."*
>
> —Vascular Surgeon

For example, in the GERD case, one gastroenterologist noted that managing proton pump inhibitor (PPI) titration would be both "easier" and more "feasible" if his delivery system facilitated patient communication by email. The

physicians and their practices can have a variety of affiliations that can also influence decisions at the point of care. For example, in considering management of a patient with PAD, one vascular surgeon noted that hospital administrators will occasionally "Come around and talk about how we need to do more procedures."

The market for health care services can affect the care delivered to patients, and which patients are seen by different physicians. As one vascular surgeon noted of his local market, when "… the referring physician doesn't get the result he wants from a vascular surgeon, …" he can "… send [the patient] to an interventional cardiologist [for more aggressive treatment.]"

Physicians' decision making at the point of care

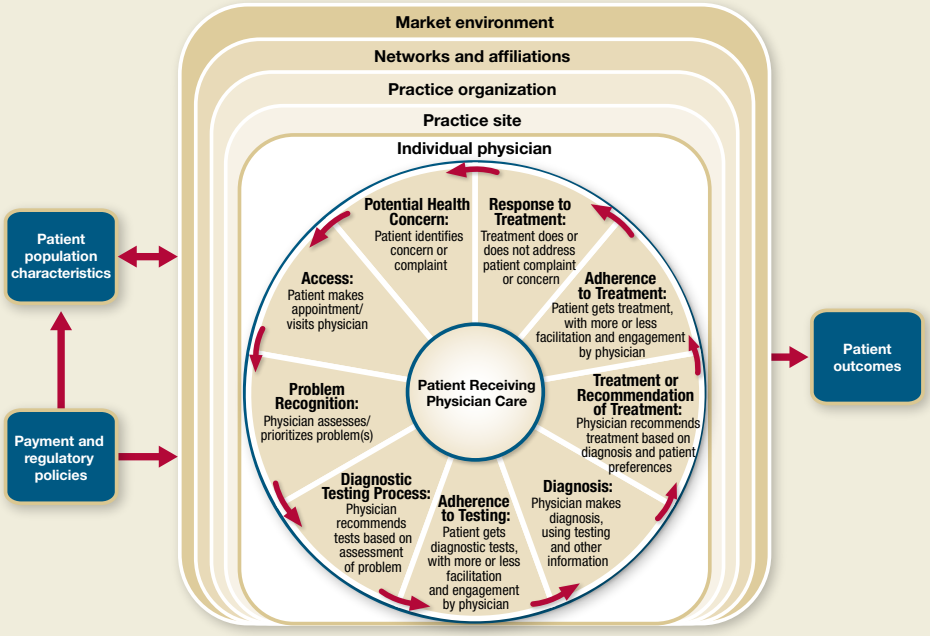

Figure 1.

HOW PAYERS CAN SUPPORT PHYSICIANS' DECISIONS AT THE POINT OF CARE

In our four example cases, we found various opportunities in which payment policies by health insurance or other purchasers of care might promote or impede more evidence-based care. Although purchaser payments typically are directed at the practice organization, these incentives are often translated by the organization down to the individual clinician either in how he or she is paid, or through internal management mechanisms. We will organize this discussion in terms of the basic tools available to insurers or other purchasers of care in a local health care market. These include how they pay for services and the types of providers with which they enter contracts. We will also consider some emerging approaches that local payer and purchaser coalitions and other community-based initiatives are using to facilitate practice transformation.

In recent years, there have been numerous calls for reform of physician payment to promote higher value care (Robinson 2001). Various discussions with physicians and other stakeholders reflected this concern. As one stakeholder said, "We need to blow up the payment structures we have, pay [for things] differently." However, as recently noted by the Center for Healthcare Quality and Payment Reform, "The fact that a payment system is different from the traditional fee-for-service [model] … does not automatically mean that it is better" (Miller 2015). We will consider the major options here in the context of promoting more evidence-based care in our four clinical cases.

Fee-for-service. Fee-for-service (FFS) is a model in which each service is paid for separately. Because volume (for example, number of visits and procedures) determines payment, FFS can reward overprovision of services. For example, one vascular surgeon we interviewed perceived that having a billing code for a new procedure sometimes contributes to overuse. Conversely, absence of FFS payments for some highly effective services could lead to less evidence-based care. Stakeholders noted that, "Medicare … doesn't cover supervised exercise," despite strong evidence of its effectiveness; consequently, vascular surgeons might underuse supervised exercise. In the GERD case, one gastroenterologist noted that being compensated for phone calls would "help [his personal] satisfaction level" in managing such issues.

Similarly, typical FFS payment structures do not reward care coordination or active management of chronic conditions by a primary care clinician (Ginsburg 2013; Berenson and Docteur 2013). Various stakeholders noted that the GERD case might have been best managed in the primary care setting. As one stakeholder said, "The GERD patient [should] never get to a gastroenterologist.… It's not a good use of gastroenterologists' time to be titrating PPI doses; they're way too expensive for that." This comment reflects both the misalignment of payment toward procedures over discussions with patients, as well as the lack of accountability and role confusion that such payments create among some clinicians.

> *"Coming up with payment systems by using a micro level of condition is never going to make a system more evidence-based."*
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> —Stakeholder

Although interviewees and stakeholders noted the potential value of recalibrating current FFS payment mechanisms to encourage evidence-based services over those of little value to the patient, many cautioned that iterative micromanagement of FFS to encourage evidence-based care can be counterproductive. One stakeholder noted that, "Coming up with payment systems by using a micro level of condition is never going to make a system more evidence-based." A group of stakeholders agreed that "there needs to be some systemic solution here."

> *"Emergency room docs want to free up the emergency room, and these time pressures sometimes falsely interfere with practicing evidence-based medicine."*
>
> —Stakeholder

FFS with pay for performance. A variation of traditional FFS has been to add a pay-for-performance (P4P) adjustment to FFS payments based on an individual physician's scores on measures of quality and/or cost (American Medical Association n.d.). One current example is the value-based modifier being implemented across a wide range of physicians paid through the Medicare Fee Schedule. Various commentators have noted the limitations of P4P as a solution to promoting improvements in medical practice (Berenson and Kaye 2013), in part because many clinical cases do not lend themselves to quality measurement. Interestingly, some surgeons and stakeholders perceive that performance metrics for emergency room physicians might even promote non-evidence-based care for children with suspected appendicitis. "Emergency room docs want to free up the emergency room," one stakeholder summarized, "And these time pressures sometimes falsely interfere with practicing evidence-based medicine." For these providers, performance measures related to rapid emergency room evaluation might promote CT (which is easily offered around the clock) over abdominal ultrasound. Indeed, some stakeholders noted that P4P for physicians might not be effective for addressing this problem because the relevant decision might be made by protocol before either the surgeon or the emergency room physician was involved. "A lot of the issues were hospital incentives, not physician incentives."

Restrictions on payments. Another way payers and purchasers can influence clinical decision making involves placing restrictions on payments such that a service is reimbursed only when certain conditions are met. For example, a visit to a cardiologist might not be reimbursed unless the beneficiary is referred by a primary care physician (gatekeeping). Payers can also require a specialist to obtain prior authorization from the health plan in order to be reimbursed for a test or procedure.

> *"From a consumer perspective, prior authorization is horribly branded.... You think they're trying to find some reason not to pay."*
>
> —Stakeholder

Restrictions on payments have had mixed success in the past (Mays et al. 2003) and proved cost-ineffective for many services. A stakeholder discussing the cardiology case noted, "The issue is whether the patient is defined as asymptomatic. If you want to do the test, just define the patient as symptomatic." Likewise, some payers and consumers view these as unattractive solutions to the challenge of promoting more evidence-based recommendations: "From a consumer perspective," one stakeholder explained, "Prior authorization is horribly branded.… You think they're trying to find some reason not to pay." Perhaps for these reasons, none of the physicians interviewed about our case examples reported facing gatekeeping or prior authorization restrictions that would influence their recommendations.

Bundled payment. An alternative, less disaggregated, payment approach involves bundling all services related to a medical care episode (episode- or condition-based payment).[1] For example, in the case of a child presenting at the emergency room with appendicitis, instead of paying separately for an emergency room evaluation, an abdominal CT, an appendectomy, and an inpatient stay, a payer would pay a lump sum to a physician practice for all care related to the episode of appendicitis. However, such a bundled payment does not necessarily promote more evidence-based care. In the appendicitis case, for example, the definition of an episode could be important, with potentially opposing forces on costs: choosing CT might mean the surgeon performs fewer appendectomies, but this expensive test will mean higher testing costs per episode. Although some stakeholders noted the potential value of bundled payments oriented around specific conditions (such as appendicitis), others voiced concern with the operational feasibility of bundled payments, and counseled more attention to addressing the problems in FFS and capitation.

Capitation. The most highly aggregated payment approach involves capitation, or purchasing care on a monthly or annual basis for an insured population. This alternative incentivizes providers and provider organizations to find more cost-effective ways of treating patients, while avoiding the administrative costs associated with trying to micromanage clinical behavior through the FFS system. Looser forms of capitation have been applied in accountable care organizations (ACOs), in which payers and providers share financial risk for the costs of care. Population-based payments, such as capitation or shared risk, offer a well-recognized reward for more parsimonious care (for example, for the cardiology or vascular surgery cases).

> *"From a payer perspective, the risk of pure capitation is underuse."*
>
> —Stakeholder

Capitation can also encourage greater involvement of primary care physicians in some of these cases. However, stakeholders noted that building an integrated network of providers who are skilled at delivering high quality care can be a long and complex process. Without careful risk-adjustment, incentives under capitation can lead to stinted care. As one stakeholder noted, "From a payer perspective, the risk of pure capitation is underuse." Others noted the issue of patients' trust as important to point-of-care decision making; some studies have suggested capitation payment might be associated with lower patient trust (Kao et al. 1998).

HOW PAYERS CAN FACILITATE PRACTICE TRANSFORMATION

As previously noted, conditions at the practice site or within the practice organization can present barriers to evidence-based recommendations by physicians. Payers and purchasers could attempt to minimize these barriers by contracting only with organizations that have demonstrated the ability to provide more evidence-based care. For example, our interviews suggested that inconsistent availability of timely and reliable ultrasound imaging is one reason CT scans are often the first choice for children with suspected appendicitis. Payers could require that appropriate options for imaging services be available as a prerequisite to

[1] Episode-based payment is a bundled payment that covers all services delivered by all providers during the episode related to the procedure or treatment, including services provided by physicians, hospitals, and other providers. Under condition-based payment, a physician practice can bill and be paid for treating or managing the care of patients with a specific health condition (or combination of conditions), rather than having payments tied to the delivery of specific services or treatments. The bundle could be defined to include services delivered on a single day or over a longer period of time, such as a month (Miller and Marks n.d.).

contracting with providers for emergency care of children with conditions such as appendicitis, which could improve quality, but would likely also increase costs.

Other innovations are underway that might be considered for more elective cases. For example, one stakeholder noted that, "We should have tech-enabled second-opinion strategies—like the tech-enabled peer-review machines and electronic consults used by Mayo and Cleveland Clinic." Some stakeholders also pointed to potential benefits from requiring physicians and practices to disclose their financial incentives and conflicts of interests. Others were less certain regarding the likely effectiveness of this solution, perhaps reflecting the mixed research findings related to such disclosures (Institute of Medicine 2009).

Stakeholders also noted that strict requirements for contracting practices would likely be more effective in some markets than they would in others. When one stakeholder wondered, "Why aren't we talking about the Minnesota model?" another responded: "You have 50 years of culture … that has permeated [Minnesota]. [That model] doesn't work in Georgia or Brooklyn." Another stakeholder noted, "There are a variety of approaches suggested by local conditions… state, regulatory, culture of practice organizations … [look] at market conditions as they vary around the country.… A one-size-fits-all policy situation is not very helpful."

There is a great deal of experimentation occurring in the realm of payers rewarding (instead of requiring) new practice configurations. One approach can be to encourage changes in provider practices through enhanced payments to providers who adopt features such as meaningful use of electronic health records (EHRs).

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>
> —Stakeholder

In another example, stakeholders noted that private payers are establishing "centers of excellence" for certain services (Robinson and MacPherson 2012).[2] Some of these reward changes in practice configurations by altering the incentives faced by consumers, rewarding high quality and low-cost providers with increased volume, rather than with enhancements in FFS payments. We discuss incentives for consumers further in our companion brief (Collins et al. 2016). Some stakeholders suggested that implementing such centers of excellence could "get around the variation in care that the [cases] show."

Support for medical homes is another example in which payers are encouraging physician organizations to introduce new practice features to improve how physicians (and patients) make decisions at the point of care. Such approaches might be used to promote more comprehensive, evidence-based care for the example cases studied here. Enhanced payments through patient-centered medical home models such as the Comprehensive Primary Care initiative (Center for Medicare & Medicaid Innovation 2015) might also reward further involvement of primary care clinicians in such cases, reducing the need to involve specialists in managing less complicated cases. Enhanced payments could also be directed to specialty practices to introduce new features such as EHR-based clinical decision tools, practice registries, and/or other internal quality improvement programs to support more evidence-based use of services.

Despite these potential benefits, our interviews and stakeholder discussions also confirm findings from various pilot initiatives that many physicians and practices are already quite busy endeavoring to meet their basic responsibilities. Thus, caution must be taken when payers and other stakeholders introduce new requirements for physicians and practices to earn enhanced payments or greater patient volumes. The potential consequences include administrative requirements that distract from clinical care, and perceptions of further micromanagement of medical practice.

HOW PAYERS CAN FACILITATE PROFESSIONAL COMMUNITY INITIATIVES

An alternative to requiring (or paying) practice organizations to undertake certain initiatives themselves is for community stakeholders (for example, payers, purchasers, and community coalitions) to support local medical communities in those initiatives.

[2] Use of centers of excellence involves shepherding patients to hospitals that provide high quality care (especially in a particular type of service or treatment), and are willing to provide services at a discount in exchange for the higher volume of patients.

> *"Washington [State has a] collaborative of...medical group[s] in the state... all sharing what they're doing in Choosing Wisely."*
>
> —Stakeholder

For example, local organizations can sponsor collaboratives and learning systems, such as those the Center for Medicare and Medicaid Innovation currently runs to assist Medicare ACOs (Centers for Medicare & Medicaid Services 2015). Several promising initiatives are now underway, organized around *Choosing Wisely* examples. As one stakeholder noted, "Washington [State has a] collaborative of…medical group[s] in the state… all sharing what they're doing in *Choosing Wisely*." In these efforts, a shared infrastructure is developed to help local providers exchange data on rates of service use and best practices on how to promote more evidence-based care in the local environment.

By investing in such learning systems, the local payers, governments, and community organizations can promote the introduction of practice setting, physician organization, and hospital features that promote more evidence-based care, but, perhaps more importantly, they can appeal to physicians' sense of professionalism. Launching such initiatives can be challenging, requiring organizers to aggregate data across payers and health plans to invest in programs that could benefit patients covered by competitors. One stakeholder observed that, "The challenge is that these local communities have multiple payers who are competing with each other. They don't want to collaborate in paying for this." Another noted that, "Payers are continually tweaking their contracting with providers, trying to find the secret sauce to make this work for them. Too often it becomes proprietary.… We should not be competing on [learning collaboratives among payers and providers] because this is about safety." Some promising examples are currently underway by publicly convened, multipayer initiatives. One stakeholder said, "We found multipayer initiatives at the state level can be very effective. It involves the state Medicaid agency, other state agencies, and large organization players."

CONCLUSION

In the current complex health care environment, practicing physicians can face a variety of barriers to recommending the most evidence-based solutions. There are opportunities for payers to promote a practice environment that supports physicians offering more evidence-based recommendations to patients, but the feasibility and likely effectiveness of these strategies can vary considerably across practice settings, communities, and clinical problems.

In some clinical examples, such as our CHD and PAD cases, various adjustments in how physicians are paid for services (FFS revisions, P4P, bundled payment, and capitation) might be effective. However, the specific payment policy interventions would require careful design to be feasible and beneficial across different clinical settings and patient circumstances. For others, including urgent diagnostic problems such as appendicitis or therapeutic monitoring as in the GERD example, payment changes targeting physicians might prove an impractical solution. Although important opportunities remain to refine both FFS and capitation payment to support more evidence-based care, the applicability of these efforts to the broad range of clinical decisions will likely be limited. Given the myriad decisions physicians and patients consider each day, it is unrealistic that specific payment adjustments can be the chief tool used across diverse communities and practice settings to promote more evidence-based care.

In addition to changes in payment for physicians' services, payers can also create requirements regarding which providers are eligible to receive payments. Drawing on our four clinical examples, these approaches might be effective in promoting more evidence-based decisions in some local markets, but would likely prove difficult to implement in others. For instance, efforts to ensure 24-hour access to ultrasound services might be impractical in the emergency rooms of smaller or rural hospitals. Thus, these interventions would have to be carefully designed for relevance to specific communities and practice configurations to succeed in helping physicians and patients choose more wisely.

More widely feasible, and thus more promising, strategies to promote evidence-based care are approaches in which local payers and community organizations offer preferential payments or other resources to support beneficial practice features. For each of these four clinical case examples, strategies are available to reduce barriers to physicians presenting more evidence-based recommendations. For instance, initiatives to support more primary care involvement hold promise in scenarios such as our CHD, PAD, and appendicitis cases. Another promising example is local collaboration across providers in reviewing data on rates of evidence-based care, and on best practices for improving use of appropriate services. The challenge for these clinical settings is having sufficient resources or incentives to introduce these changes in the midst of competing demands for the time and attention of busy health professionals and practice leaders.

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