

STAAR Issue Brief: Reducing Barriers to Care Across the Continuum - Engaging Physicians

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Overview: Reducing Avoidable Rehospitalizations

Rehospitalizations are frequent, costly, burdensome for patients and families, and fortunately, actionable for improvement. Many rehospitalizations within 30 days of discharge are considered potentially avoidable if communication was more effective and care better coordinated. Opportunities abound to improve transitions out of the hospital and into the next setting of care, and efforts to improve care transitions and reduce rehospitalizations are proliferating in the US in response to signals from local, state and federal payers and policymakers.

New, Innovative Roles Must Have Physician Support

Many efforts to reduce rehospitalizations focus on improving **communication between settings and care management over time**. Notably, much of this work is done by **nursing professionals**, through payer-supported care coordinators, grant-supported discharge advocates or patient coaches, and/or hospital-resourced nursing or case management staff.

These are **important and innovative roles** to deploy. However, without a substantive effort to **engage physicians** as partners and allies in the challenge of seamlessly **integrating clinical information and treatment plans across settings, among specialists, and over time**, nursing professionals charged with these new roles may find resistance among a critically important constituency: the treating physicians.

Engaging Physicians: Insights from STAAR Focus Groups

The physicians engaged in the 67 cross-continuum teams in the STAAR Initiative recognize cross-setting communication and care coordination must be improved, and if improved, would reduce avoidable rehospitalizations. **Physicians generally feel that they are responsible** for the processes involved in rehospitalization reduction – and **agreed that they could do better**.

The insights reported in this brief are from STAAR physicians who are voluntarily willing to improve care across settings, and have committed to doing so. Despite the presence of expert technical assistance and collaborative peer support, the challenges in this cross-setting, longitudinally focused improvement initiative are apparent. Multiple specific constraints to doing better were identified, including:

- **Social complexity** of patients (poverty, lack of social support, marginalized communities);
- **Overburdened or non-existent care management** for socially or medically complex patients;
- Lack of readily available **health information across settings**;
- Difficulty in **identifying** the outpatient primary care physician when there are several MDs;
- Difficulty in securing **timely access to primary care** (for new appointments or early follow-up);
- **Lack of compensation for coordination** activities, including RN directed coordination;
- Significant, non-billable, **opportunity costs of successfully averting a rehospitalization**;

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- **Ambulatory system is not prepared for intensive (timely and/or daily) management** of patients with non-critical but symptomatic presentations; to facilitate an evaluation or monitor a patient the hospital is perceived as a safer or more feasible setting;
- **Scarcity of physician time** and resources to lead effectively;
- **Pressures to discharge** hospitalized patients irrespective of outpatient readiness to “receive”
- **Low volumes** of rehospitalizations at the **individual physician level** make it difficult to engage physician concern;
- **Breakdowns in the handoff of discharge information** were felt to be the most critical determinant of eventual rehospitalization, with physicians across practice settings suggesting it was the necessary element in reduction;
- **“Medical specialty silos”** may stymie the interdisciplinary collaboration necessary to invoke true coordination. One respondent noted, “we don’t see this because **[we] just don’t know each other – we don’t ever get together** with other subspecialties to improve patient flow;”
- **Poor buy-in for existing interventions** secondary to skepticism over the results, particularly given poor measurement of efficacy and a dearth of randomized data to support any findings – making it difficult to determine if an individual physician’s efforts are directly affecting rehospitalization rates;
- **Substantial variation of institution-level efforts** at rehospitalization reduction.

Findings from the Field: The Role of Financial Incentives

Financial incentives are an integral part of many change initiatives; certainly when financial incentives are misaligned, as in the case of reducing rehospitalizations, practice is less likely to change. The question of whether financial incentives to reduce rehospitalization are an appropriate motivator proved challenging to for providers to answer.

- Certain physicians – nearly half of the total respondents – saw **significant power in the use of financial incentives to motivate physicians and delivery organizations** to engage in reduction efforts. These physicians saw a need to realign the financial pressures currently in competition with the goal of reduction, noting that **bundled payments in particular** could lead to more **collaborative efforts** across practice environments and subspecialties.
- The other half of respondents, however, felt a **balance** needed to be struck between **financial and non-financial incentives** for physician engagement efforts to succeed. These physicians questioned whether the impact of financial incentive reform would be felt at the level of an individual rehospitalization, suggesting that paying for the time needed to coordinate care was more important than paying for an outcome measure such as reduced rehospitalizations.

Although aligned financial interests are important, physician opinion in the focus groups emphasized the necessity of **physician champions** to lead reduction efforts if the initiative is to garner buy-in among physicians broadly – and for **allocation of appropriate resources and support mechanisms** to ensure that initial buy-in translates to actual engagement in rehospitalization reduction.

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Findings from the Field: Beyond Direct Financial Incentives

Conventional wisdom holds that financial incentives are sufficient to stimulate a desired change in performance. However, the challenges providers face in improving care coordination over time and across settings are only in part influenced by the fee-for-service payment system. More vexing, are the **systemic constraints and social complexity** that make supporting individuals safely in the community based setting difficult. A consensus emerged that **systemic interventions would help facilitate physician engagement and leadership**:

- **Resource allocation** – such as supplying ancillary providers, case managers and dedicated patient discharge managers to “do the leg work” was a recurring theme, with physicians responsible for ensuring contact is made with the outpatient provider. One respondent mentioned the “right hardware and software” needs to be in place to facilitate physician engagement;
- **Community-based supports for socially and medically complex patients** – was a recurring desire among physicians, most of whom want to see patients intensively and successfully cared for in the community setting;
- **Coordination with community based non-clinical support services**, as the medical and community-based non-clinical support services each have resources but are not coordinating to respond to the range of patient needs in a timely manner;
- Respondents consistently touched on **publicity** as a mechanism of increasing physician engagement. They specifically mentioned having **public leaders** within the institution –whether physicians or otherwise – **describe the institutional value** of rehospitalization reduction;
- Several respondents pointed to the need for a **visible commitment by organizational leadership** to orient physicians and other providers to make reduction a priority. As one hospitalist commented, “it’s important to create a culture where rehospitalization **reduction is valued and prized**, similar to publishing or teaching;”
- The need for **updated, visibly transparent data for populations**, not just by individual payer, was thematic during our discussions with physicians;
- Physicians sought to **capitalize on the intrinsic competitive nature** of their colleagues, suggesting that reporting on rehospitalization rates might motivate physicians to demonstrate that they could be an **excellent performer** in the area of care transitions.
- Beyond competition, use **data to hold providers accountable for improved performance**.
- Other tools cited as potentially effective included **IT infrastructure, performance incentives** and emphasis of the role of **physician excellence**.

Findings from the Field: Influence Professional Standards and Norms

The role of professional norms – whether institution-specific or at a broader, societal level – remains unexplored in the effort to reduce avoidable hospitalizations. Physicians generally share three core professional values: (1) **physician autonomy**, (2) **pursuit of excellence** and (3) the **practice of evidence based medicine**. Respondents demonstrated a general consensus that professional norms could play a significant role in **physician engagement strategies** around rehospitalization reduction.

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- **Medical education**, particularly at the graduate medical education (GME) level of residencies and fellowships, should establish **new professional norms** of practice. Resident education should emphasize the importance of the physician's role in manage a successful transition of care across settings, and the importance of the execution of a **clinically meaningful and timely discharge summary**. Notably, the fact that the discharge summary at academic medical centers is typically delegated to the **intern level** was discussed as either problematic or requiring additional specific instruction and supervision.
- **Establishing principles of excellent care at the time of transition** was felt by most respondents to be filled best by **professional societies** (such as the American Medical Association and subspecialty societies) and programs in graduate and continuing medical education. Accrediting bodies such as the Joint Commission were felt to be more appropriate for directing recommendations regarding hospital operations.

Recommendations to Providers and Hospital Administrators:

- **Capitalize on the pursuit of excellence:** provide **performance data** to providers. Create a culture of expectations via the use of evaluations and metrics, both on outcomes and process, to give physicians the transparent information necessary to motivate them to succeed.
- **Engage physicians via established gatherings.** Use established mechanisms for presenting the case for and ways to improve care coordination at times of transition, such as Grand Rounds, noon conferences, morning reports and other medical education venues.
- **Adopt practice or hospital policies** necessary to ensure that physician leadership in the discharge process becomes a norm, such as: **Discharge "holds"** that prevent a patient from leaving the hospital prior to completion of the discharge summary and communication with the outpatient "receiving" physician; **discharge checklists** that must be completed and reviewed with the interdisciplinary medical team, prior to departure; and **monthly performance data** on patients discharged over the previous 30-, 60- and 90-day intervals.
- **Avoid "improvement fatigue" by relating the goal of reduced rehospitalization to patient experiences.** Engaging physicians in a process they find compelling to the care of their patients is essential. Implement cross-continuum rehospitalization case reviews that meet regularly and draw participants from a mix of medical subspecialties and practice settings. Connecting practice-based changes with the experience of recently treated patients is a powerful engagement strategy.
- **Foster physician champions and leaders** by liberating time to participate in quality improvement efforts, whether through lessened clinical load in a Full Time Equivalent (FTE) calculation (for salaried physicians at academic medical centers) or contracted work with the delivery organization (for non-salaried inpatient and outpatient physicians). Payment structures such as these reduce the opportunity cost for physicians interested in taking a leadership role in reduction efforts – and provide a valuable public signal to other physicians of the high importance that the organization places on improvement.

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Recommendations to Policymakers:

- Understand the core values of the medical profession –***the pursuit of excellence and the practice of evidence-based medicine*** – and employ policy strategies to shape professional norms around excellence in coordinated care over time and across settings.
- ***Sustain the current high-profile attention to avoidable rehospitalizations***, as policy signals from state and federal policymakers and other national stakeholder groups has appreciably raised awareness around and understanding of the basic messages around avoidable rehospitalization reduction.
- Develop payment policies or incentive strategies to ***promote cross-setting collaboration***.
- Develop payment policies to ***compensate physician time to improve care coordination*** and reduce rehospitalizations, and policies to ***compensate non-physician time to improve care coordination*** and reduce rehospitalizations.
- Explore a variety of ways to ***share savings with both inpatient and outpatient providers*** who work to avert rehospitalizations.
- Develop coverage or payment policies that ***allow providers to invest resources in socially or medically complex patients*** to avoid repeated rehospitalizations.
- ***Develop all-payer claims databases*** to capture the longitudinal patient care trajectory across all providers and settings.
- ***Improve current measurement systems*** for patient experience of care across settings, care coordination, and rehospitalizations.
- Develop health information technology policies to allow for ***timely access to electronic medical data across organizations and settings***.
- Develop policy or procedures for ***state or federally funded community-based non-clinical support services to be available to coordinate with clinical care providers***, especially at times of transitions or following hospitalizations.