Do You Speak My Language? When Patient Care Meets Cost-Effectiveness

JOSÉ A. PAGÁN, PHD; AND BRENDAN SALONER, PHD

"Accountable care organizations," "bundled payments," and "health homes"—new healthcare delivery, financing, and reimbursement models associated with the Affordable Care Act (ACA) have widened the reach of a vocabulary in healthcare systems focused on incentives, cost reductions, and quality improvement efforts. The reorganization of clinical care, and how to pay for it, is at the core of these new models. While commentators have debated whether these new models and incentives are appropriately designed to achieve the desired savings,[1] considerably less attention has been focused on whether these changes are congruent with the training and perspective of clinicians. Yet, whether these provisions ultimately succeed will depend not only on their technical merits, but also on whether reformers successfully embed these new ideas within the language of medicine—a language focused on the experiences of individual patients and their relationship with providers.

Economists and business leaders who champion reforms often concentrate on expected system-level outcomes such as the rate of return (ie, the amount of money saved by an initiative relative to the upfront expenditure). Nonetheless, the promise of these outcomes is rarely sufficient on its own to gain acceptance from clinicians. For example, the integration of community health workers and patient navigators in clinical teams within patient-centered medical homes has been shown to generate cost savings through reduced hospital readmissions, but their use is certainly not widespread in primary care settings.[2] This is perhaps not surprising, as new models disrupt established clinical practice and carry considerable uncertainty. Amid these changes, physicians and other frontline providers are likely to raise important concerns about how these innovations will translate into tangible health benefits for their patients.

Unfortunately, these concerns often go unheard. Health system leaders, managers, and financial analysts are accustomed to thinking in terms of whether or not there is a business case or a costs savings opportunity for a given initiative, and as a result, their support for new models and reforms is often framed using this language. Advocating for reforms using this approach is unlikely to persuade many clinicians to change their practice, though this is not necessarily because of an inherent status-quo bias or a lack of desire to improve—clinicians are highly motivated to change the delivery of medicine. However, improving patient outcomes (eg, decreasing mortality, increasing mobility, and reducing pain) are more central to the training and focus of physicians than are system-level objectives, such as reducing waste or "bending the cost curve."

Relatedly, many physicians do not see an argument for changing their own clinical practice to save the system money if it threatens what they perceive as best practice medicine. A 2012 survey of 3897 physicians found that almost 4 out of 5 respondents (78%) agreed with the statement that doctors "should be solely devoted to individ-

ual patients' best interests, even if that is expensive," while only 36% believed that they had a major responsibility for reducing healthcare costs.[3]

Our discussion above implies that greater attention must be paid to how specific delivery system reforms are "pitched" to potential adopters, and how the ground-level experiences of physicians are communicated back to system reformers, thereby allowing for a continual dialogue about quality improvement. Recognizing that people see the world through the lens of their own training and professional experience is a first step, but this is not as easy or obvious as it sounds since it is very difficult to fully visualize what drives others in healthcare leadership roles.

Successful communication means finding ways to address the concerns and values of all stakeholders. Research on organizational change strongly suggests that reforms are more likely to take hold when problems are framed in terms that are familiar to stakeholders, and with potential solutions that are consistent with the core values of the organization.[4] When innovations take root in healthcare systems, it is often because of the presence of an organizational champion—an individual who is able to convey the key objectives of reform in terms that are likely to motivate and inspire others to action.[5] One of the key roles of a reformer is "sensegiving"—creating a workable interpretation of a change that helps others to understand how it relates to their own values and vision.[6] For example, a psychiatrist may be more willing to participate in a bundled payment program with a group of primary care providers if the intervention aims to improve functioning of schizophrenic patients in the community, whereas a healthcare administrator may be most convinced by cost savings from reduced hospitalizations. In order to span the understanding of both system leaders and clinicians, there is a need for system "translators"—individuals who speak the language of cost containment and organizational efficiency but also appreciate the training and values of clinical medicine.

A recent patient-centered medical home demonstration program from the Veterans Health Administration provides a good illustration of the importance of orienting change around a vision that is shared and understood by both administrators and clinicians.[7] The initiative involved implementing new prevention and chronic disease management techniques and required intensive consultation and focus on new data outcomes within interdisciplinary primary care teams. What distinguished successful teams (ie, those able to meet early implementation targets) was their ability to not only define and share their responsibilities, but to also converge around shared beliefs about how change would enable them to improve the delivery of patient-centered and timely care in clinical roles that they already recognized as important. From this perspective, clinicians could see an emphasis on measurement and data as being supportive of excellent patient care, rather than being punitive or undermining.

The challenges of translating the benefits of new ideas in healthcare delivery are likely to intensify not only due to the continued adoption of core provisions of the ACA (eg, medical homes, bundled payments), but also due to the growth of a data-driven culture, already revealed by a growing interest in unlocking the potential of "big data." Reform efforts that are only focused on data-driven solutions could easily flounder, as physicians grow frustrated with "deliverables," "milestones," and "targets" that often seem out of touch with patient care, while managers and leaders accuse physicians of being sluggish in embracing cost-saving innovations. Professionals that can communicate with ease using the language of reform, costs, quality, and patient health outcomes may facilitate these interactions by providing a vocabulary for change that embraces and cross-cuts the goals of both system reformers and physicians, thus orienting the conversation toward high-value care for all patients.

To our knowledge, there is no established model for health systems translators, but we believe that such a person would need to be fully immersed in the culture and practice of medicine and have a health systems perspective; clinicians with healthcare management training provide one potential group of prospective translators. Ideally, these individuals would receive this training through partnerships with academic or professional organizations while working within the health systems that are undergoing improvement. Translators would help to develop communication strategies within their health system while relaying concerns and questions from physicians and other providers to health system leaders.

It must be acknowledged that there are many structural and systemic problems that translators cannot solve. New systems can create real tensions because of added burden and changing models of compensation, and addressing these tensions requires that incentives and responsibilities are aligned with value and rhetoric. Reforms can also exacerbate management and leadership conflict in organizations; clear lines of communication must therefore be met with clear lines of accountability that appropriately match the responsibilities of individuals within organizations. Translators can play a useful role in these organizational challenges by helping clinicians to understand how new responsibilities and expectations align with the values of patient care and quality improvement.

Making translators fully-fledged partners in the reform process will likely make reform not only more credible, but also more effective. Clinicians are the gatekeepers to systemwide change, and without their support, efforts to transform the established system will not succeed. Ensuring effective communication among clinicians, managers, and leaders is essential to overcoming the current barriers to widespread innovation adoption.

Author Affiliations: Center for Health Innovation, The New York Academy of Medicine (JP), New York, NY; Department of Population Health Science and Policy, Icahn School of Medicine at Mount Sinai (JP), New York, NY, and Leonard Davis Institute of Health Economics, University of Pennsylvania (JP), Philadelphia, PA; Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health (BS), Baltimore, MD.

Source of Funding: Dr Saloner gratefully acknowledges funding support from the Robert Wood Johnson Foundation Health and Society Scholar's Program.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (JP, BS); drafting of the manuscript (JP, BS); critical revision of the manuscript for important intellectual content (JP, BS).

Address correspondence to: José A. Pagán, PhD, Center for Health Innovation, The New York Academy of Medicine, 1216 Fifth Ave, New York, NY 10029. E-mail: jpagan@nyam.org.

REFERENCES

1. Burns LR, Pauly MV. Accountable care organizations may have difficulty avoiding the failures of integrated delivery networks of the 1990s. *Health Aff (Millwood).* 2012;31(11):2407-2416.

2. Nielsen M, Langner B, Zema C, Hacker T, Grundy P. Benefits of implementing the primary care patient-centered medical home: a review of cost & quality results, 2012. Patient-Centered Primary Care Collaborative website. http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf. Accessed August 5, 2014.

3. Tilburt, JC, Wynia, MK, Sheeler RD, et al. Views of US physicians about controlling health care costs. *JAMA.* 2013;310(4):380-388.

4. Fernandez S, Rainey HG. Managing successful organizational change in the public sector. *Public Administration Review.* 2006;66(2):168-176. doi:10.1111/j.1540-6210.2006.00570.x.

5. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: systematic review and recommendations. *Milbank Q.* 2004;82(4):581-629.

6. Gioia DA, Chittipeddi K. Sensemaking and sensegiving in strategic change initiation. *Strat Mgmt J.* 1991;12(6):433-448. doi:10.1002/smj.4250120604.

7. Solimeo SL, Hein M, Paez M, Ono S, Lampman M, Stewart GL. Medical homes require more than an EMR and aligned incentives. *Am J Manag Care.* 2013;19(2):132-140.