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## Helping Doctors Choose Wisely: Three Innovative Principles For Health Care Organizations

Posted By [Jon Tilburt](#) On April 30, 2015 @ 9:00 am In [Costs and Spending,Health Professionals,Hospitals,Payment Policy,Public Health](#) | [3 Comments](#)

Achieving higher value, cost-conscious care that eliminates waste and optimizes quality is a crucial priority. Recent professional and policy initiatives aiming to spur individual physicians to achieve that priority include the American Board of Internal Medicine's [Choosing Wisely Campaign](#) <sup>[1]</sup>, the [High Value Cost-Conscious Care Initiative](#) <sup>[2]</sup> from the American College of Physicians, and new content in the [American Medical Association Code of Medical Ethics](#) <sup>[3]</sup>.

Although professional organizations can be influential, physicians work in organizations, and evidence suggests health care organizations [influence individual physician behavior](#) <sup>[4]</sup>. Systems such as large multispecialty medical groups can [support](#) <sup>[5]</sup> individual behavior and provide processes that make errors less likely and improve quality. Accountable Care Organizations (ACOs) are an example of a change in the organization of care that aims to decrease waste by aligning business incentives with efficiency and quality, rather than volume. Within and beyond ACOs, how can health care organizations create supportive systems so that individual physicians can deliver high-value, cost-conscious, and patient-centered care?

We've been asking primary care and specialty physicians about their practices and responsibilities regarding health care costs in surveys and focus groups for the last several years. Ten focus groups with 62 primary care and specialty physicians in the northern Midwest who worked mostly in not-for-profit health care organizations helped us understand [what doctors want and need](#) <sup>[6]</sup> from their organizations to eliminate waste in their practices. Three overarching themes related to creating supportive systems came out of those discussions:

1. Nudge choices, but preserve and promote clinical judgment;
2. Promote relationships and communication; and,
3. Encourage low-tech, high-touch care.

Forward thinking, truly innovative health care organizations that help doctors choose wisely will be serious about helping physicians meet their professional obligations, do the right thing for patients, and maintain their own long-term competitiveness.

### Nudge Choices, But Preserve And Promote Clinical Judgment

An institutional environment that gives complete latitude to individual physicians can lead to unwarranted practice variation and waste. Conversely, an organizational culture that overly restricts or puts obstacles in the way of individualized care can create an "us-versus-them" climate, pitting doctors and patients against "bean counters." However, an organization that preserves and promotes clinical judgment can still nudge physician behavior in ways that are cost-conscious *and* patient-centered.

For example, ordering system defaults can and should help nudge choices toward evidence-based, cost-effective options, such as reminding doctors about flu shots or colon cancer screening guidelines. Similar systems could strategically influence prescribing by presenting cost-effective options first in a list (to benefit from so-called "order effects"). Such defaults make it easier for providers to choose proven, cheaper medications without eliminating access to other options or presenting obstacles (e.g., preauthorization) that may "consume" as many resources as they save — in the form of time and effort for requests, appeals, responses, etc.

We should note, however, that ordering system defaults can sometimes result in costly overuse. For example, a primary care physician ordering an orthopedics consult should not be *required* to

order an X-ray she considers unnecessary. Similarly, physicians need flexibility to override automated ordering based on “best practices” (e.g., lipid panels, cancer screening) when such interventions will not benefit a particular patient.

Other organizational norms have the potential to contribute to efficient, patient-centered care. At one of our institutions, physicians “priority page” their colleagues to facilitate informal communication of clinical judgment across specialties. The organization expects that physicians will respond to these pages unless they are with a patient.

This sort of “curbside consult” can often improve care with less expense *and* less delay than a formal referral and visit. (Obviously, physicians providing such informal consults must be properly compensated and protected from unwarranted liability.) We suspect that the time saved, the human connection between physicians, the timeliness of answers to questions, and the value to patients of an opinion from an expert can enhance patient-centered care, humanize work life for physicians, and reduce the expense of formal consultation.

## Promote Relationships And Communication

Organizations can encourage appropriate resource use by promoting continuity, relationships, and conversations. Physicians tell stories of how they make tradeoffs between the time it takes to talk to patients who request a specific service (e.g., drug, referral, test) that isn’t indicated, and the cost of the unnecessary service. Physicians also talk about their desire to provide ready access for patients with urgent needs, especially those with complex medical conditions, in order to spare them a visit to the emergency department.

Emergency physicians are unfamiliar with the patient, work in a culture of acute, life-threatening illness, and rely on expensive imaging to rule out bad diagnoses. A headache in a patient known well, from whom the physician elicits a history of sleep disturbance or a new job, is far less likely to “need” an MRI than that same patient presenting unknown to an emergency department. If a primary care physician can honestly tell a patient, “call if anything changes,” and that call is answered and responded to quickly, a costly emergency visit might be avoided.

Relationships clearly contribute to value in health care — physicians [order more tests](#) <sup>[7]</sup> when they don’t know the patient, and having a relationship with a doctor is associated with [better outcomes](#) <sup>[8]</sup>. Ironically, lean processes that maximize “throughput” in primary care calendars can perpetuate discontinuity. If instead, organizations are committed to measuring continuity, communication quality, and access for urgent appointments, downstream savings might offset the cost of white space in primary care schedules.

## Encourage Low-Tech, High-Touch Care

Evidence suggests that low-tech, high-touch treatments like [acupuncture](#) <sup>[9]</sup>, [massage therapy](#) <sup>[10]</sup>, [physical therapy](#) <sup>[11]</sup>, and [counseling](#) <sup>[12]</sup> are effective, well-tolerated management options for a variety of [chronic syndromes](#) <sup>[13]</sup>. However, access to high-tech equipment and procedures that are well-reimbursed vastly exceeds access to low-tech, high-touch care that patients say they want and need.

If, due to profitability for an organization, physicians can obtain a routine MRI (covered by insurance) within a few days for chronic headache, but it takes three months to get acupuncture or massage therapy (that may or may not be covered by insurance), they may well choose, in order to do *something* for the patient, the easily available, expensive test. If cognitive behavioral therapy (CBT) for depression is significantly harder to access than medication, physicians get conditioned to never even offer CBT as a viable low-cost alternative.

Simple principles of supply and demand suggest that if organizations expanded access to low-tech (and sometimes safer and lower cost) care options for chronic conditions when life or limb are not threatened, doctors might avoid or delay pursuing higher cost options or testing. For example, before investing in the newest scanner, systems might first consider bolstering access to rehabilitation personnel or expanding counseling office hours, even if it is less profitable.

## Anticipating Change, Supporting The Workforce

Physicians have professional duties to advocate and care for individual patients, while acting as stewards of limited health care resources. As simple as it sounds, eliminating waste is a radical proposition in the current structures of reimbursement. If physicians see organizations allowing or even encouraging unnecessary resource use, they will justifiably chafe at expectations for them to individually practice prudently.

Instead, systems should endeavor to make the right things the easy things to do. When stakeholders ask physicians to eliminate waste by “choosing wisely,” they must also ask physicians’ organizations to create environments that make wise choices possible and easier. Principled and forward-thinking health care organizations who adopt the following three principles can demonstrate their commitment to doctors choosing wisely:

1. nudge choices, but preserve and promote clinical judgment;
2. promote relationships and communication; and
3. encourage low-tech, high-touch care.

The business case for these changes is swiftly taking shape. Signals from Washington and other payers indicate that fee-for-service payment methods will diminish, and with them the business case for “more is better.” Public and private payers are already experimenting extensively with shared savings, bundled payment, and value-based purchasing.

Health care organizations with a long view of success can innovate now and can anticipate and adopt the kind of business principles we have outlined even before those incentives are fully in place. Doing so is the right thing for patients, may help maintain long-term competitiveness, and will give doctors the help they say they need to do their job and do it well.

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URLs in this post:

[1] Choosing Wisely Campaign: <http://www.choosingwisely.org/>

[2] High Value Cost-Conscious Care Initiative:

[https://www.acponline.org/clinical\\_information/resources/hvccc.htm](https://www.acponline.org/clinical_information/resources/hvccc.htm)

[3] American Medical Association Code of Medical Ethics: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>

[4] influence individual physician behavior:

<http://www.ncbi.nlm.nih.gov/pubmed/7898409,17489907>

[5] support: <http://content.healthaffairs.org/content/29/5/991.full>

[6] what doctors want and need: <http://www.ncbi.nlm.nih.gov/pubmed/24871228>

[7] order more tests: <http://www.ncbi.nlm.nih.gov/pubmed/23917288>

[8] better outcomes: <http://www.ncbi.nlm.nih.gov/pubmed/19258560>

[9] acupuncture: <http://www.ncbi.nlm.nih.gov/pubmed/23099289>

[10] massage therapy: <http://www.ncbi.nlm.nih.gov/pubmed/18843627>

[11] physical therapy: <http://www.ncbi.nlm.nih.gov/pubmed/17986496>

[12] counseling: <http://www.ncbi.nlm.nih.gov/pubmed/15846616,10204712>

[13] chronic syndromes: <http://www.ncbi.nlm.nih.gov/pubmed/24170758,24508320>