OUR MISSION

Our mission is to help lead the future of health in our communities by providing exceptional learning and relationship building opportunities for community hospital and system executives.

Calendar of Events

COMMUNITY HOSPITAL 100 CONFERENCE

October 23-25, Pinehurst NC

REGIONAL ROUNDTABLE

November 16–17, 2011
Ritz-Carlton Philadelphia

For more information and to register, please contact:
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Community Hospital 100 Executive Summary

The second Community Hospital 100 Regional Roundtable in 2011 convened on May 25 in Boston, MA. A northeast hospital and its affiliated medical group shared their progress on instituting a medical home in preparation for accountable care and population health initiatives. The following summary of the presentation and ensuing discussion was drafted by Luke Peterson, National Director of the Strategy Practice at Kurt Salmon.

Medical Homes: From Medical Widgets to Population Health

Healthcare in the United States is undergoing a dramatic change. With mounting costs and generally worse outcomes than other developed nations, there is consensus that the healthcare industry must start intervening earlier in the disease process at the stage where prevention and management provide higher value.

This consensus, paired with the increase in the public consciousness of healthcare's value, healthcare reform legislation, and accelerating unit-reimbursement declines for providers, have served to shift most hospitals' strategies from growth of volumes to incorporating more emphasis on effectiveness of care.

Shifting the strategic emphasis has many implications for how hospitals are structured, partnered, operated and financed. One result is interest in medical homes as a model for reducing costs and improving care. The medical home concept is not new, having been around since at least 1967 when it was introduced by the American Academy of Pediatrics[1]. The renewed interest; however, starts with the promise of "improving quality of care by organizing care around the patients."[2] This promise hits at the heart of the goals of healthcare reform and the drive toward effectiveness of care: spend fewer resources and create a better result.

While not yet definitive proof, the results can be convincing. According to the most recent study authored by the Patient-Centered Primary Care Collaborative, there is strong evidence that investments in primary care, particularly related to the medical home concept, can reduce overall healthcare expenditures, generally with the reduction of hospital admissions.[3] In total, more than 100 demonstration projects have already tested the effectiveness of the patient-centered medical home concept with a variety of approaches and populations. Today, thirty-one states are planning or implementing medical home pilots within Medicaid or the Children's Health Insurance Program (CHIP), and at least 12 states have developed medical home initiatives that involve multiple payors[4]. However, apart from various pilot programs available in many states[5], the financing mechanism for implementing medical homes is not well defined.

The medical home, also known as the patient-centered medical home (PCMH), is a model that provides accessible, continuous, coordinated and comprehensive patient-centered care and is managed centrally by a primary care provider, with the active involvement of non-physician staff.

As such, the success of medical home models, coupled with the financial implications for hospitals appears to present a moral dilemma related to implementing any model that jeopardizes the financial health of their organizations.

To understand these implications and discuss potential solutions, Community Hospital 100[6], a leading organizer of community healthcare leaders in the United States, brought together a group of regarded hospital leaders and industry partners to discuss medical homes and the challenges of moving from growth to effectiveness.

From Growth to Effectiveness

Healthcare executives around the country are challenged by the healthcare reform rhetoric and desire to overhaul the healthcare system in the United States. Fundamental to this shift is how healthcare is reimbursed. Currently, reimbursement for providers favors growing volumes of sick patients needing treatment. In response, hospitals have developed large fixed infrastructures and processes dedicated to treating the acute needs of the sickest patients. As the focus changes from treating the sick patient to preventing progression of disease and managing the health of an entire population, hospitals' infrastructure and processes become less of an asset.

As such, healthcare executives find the industry in a state of contradiction. Current reimbursement favors volumes (though at a decreasing rate) while rhetoric and future projections favor more effective models of care.

Cheshire Medical Center/Dartmouth-Hitchcock Keene in Keene, NH is at the forefront of the change. With a clear vision to advance the health of its community, CMC/DHK has challenged itself to create a better model of care for its community. Using the medical home model with its team of care-givers who holistically address the needs of patients, CMC/DHK has created a more effective healthcare model.

Use of this model has resulted in improved patient satisfaction and health, and reduced use of acute healthcare resources, particularly at the hospital setting.[7]

While the expansion of additional personnel and caregivers has been mostly funded through pilot programs and grants, CMC/DHK has found the losses from the reduced utilizations of hospital services a challenge under the current reimbursement system. Under the current reimbursement system, providing a better care model for its community has cost the organization financially. However, in the words of one executive, "you can only curse the darkness for so long before someone needs to do something."

Steps Toward Population Health

The medical home model described by CMC/DHK and other leaders of the Community Hospital 100 group is a clear shift from the old "treat the sick" to the new "prevent the progression of the disease" paradigm. Moving in this direction is not without challenges; however, especially financial. As such, the Community Hospital 100 think tank discussion centered around five key steps to move towards these new models.

1. **Timing is everything.**
   The current reimbursement structure is simply not in place to provide financial incentives for hospitals to organize physicians in moving towards a medical home model. While grants and pilots may offset personnel costs, the loss of admissions can represent a significant financial burden for the hospital. Nevertheless, there is increasing evidence that elimination of a large number of hospital admissions will be the result of many future care models. Whether they lead or follow, hospital executives must learn to survive in an environment with inpatient utilization rates much lower than they are today. Moreover, as results pour in, these new models appear to be required by many of the hospitals' missions related to the health of their communities.

One executive summed it up best, "It looks like we are being taken over a cliff, but sometimes you have to do the right thing anyway."

Implementing the medical home model increasingly appears to be a question of timing rather than interest. Those likely to adopt the models most quickly include sole providers with a relatively captive market and providers in markets where the payors have capitated large portions of the market.

2. **Start with primary care, but engage specialists.**
   The medical home model is fundamentally about primary care. Developing a team of care givers around strong primary care is an essential first step. Nevertheless, care must be taken with the specialist relationship. Specialist engagement is a key concern for many hospitals.[8] A CEO summed up the concern by pointing out the medical home model will reduce referrals to specialists along with hospital admissions. This threat to specialist volumes may create challenges in the relationship between hospital and specialty physician. However, a drop in specialist volume may be offset by the quality of referrals. In any case, it is clear that if hospitals lead the development of medical homes, they must also take a leadership role in maintaining strong relationships with specialists during the transition period.

3. **Alignment and integration are required.**
   Organizations must have greater alignment of the major elements of the delivery model to influence how the distribution of the elements is changed. Without full integration, it is difficult to change incentives. "We are talking about the big 'I' integration not the little 'i' integration," says one executive.

   Increasingly, the preferred alignment and integration is becoming physician employment. Regardless of strategy, if the hospital is not fully aligned and integrated with its physicians, it will be difficult to manage the implementation of a medical home or other model where reductions in hospital volumes is the likely outcome.

4. **Change the culture.**
   The medical home model, as other new models, depends on a tightly functioning team across historically separate elements of the continuum of care. While incentives must change, so must the culture in order to break down the silos that have developed between specialties and elements of the continuum of care.

   The goal is to create a single team with multiple perspectives. Beginning early is key as changing culture takes time.

5. **Involve the community and provide the leadership.**
   In the end, population health is about the community. Hospitals that can leverage interests and stakeholders throughout the broader community not only gain a better understanding of what effective care and healthcare value means to the community, but often gain advocates and new champions for the hospital's mission and vision.

In the future healthcare environment, the hospital is not the central hub it once was. As such, leadership must be shared across multiple stakeholders. This generally starts with the physicians, but also includes the community and other members of the continuum of care.

Throughout this stakeholder involvement process, the hospital leadership must lead the charge of defining "what is health?"

Where to Begin

As with any endeavor, it all starts with the determination to begin. Everyone agrees that change is needed and is coming. Hospital leaders therefore must decide to what degree they lead that change or follow it. There is a case for both strategies. For those that want to lead the change five points are offered on how to begin:

1. **Understand the financial impact that must be mitigated under the current reimbursement structure.**
   a. Identify grants and pilot studies available to pay for increased primary care staffing. A list of state-level grants can be found here: http://www.nationalpartnership.org/site/DocServer/HC_Summary_StateMedicalHomePrograms_081028. pdf?docID=4262. Other major resources include the National Committee for Quality Assurance (www.ncqa.org), the Patient-Centered Primary Care Collaborative (www.pcpcc.net) and the Centers for Medicare and Medicaid Services' advanced primary care initiative site (www.cms.gov).
   b. Create plans to manage costs out of the hospital infrastructure as volume declines with the implementation of a better care model. Determining what decisions must be made in a market with reduced hospital volumes is important before beginning down this process as inpatient and ER volumes are likely to be reduced by 20% or more.

2. **Identify the most fully aligned physicians and those that you can work with to implement a medical home model.**
   a. Alignment with all physicians is important, but more so when instituting a significant change in the structure of care.
   b. Medical home models are not for all physicians; physicians implementing medical home models must agree with the major principles of operating as a team under the medical home model.

3. **Determine the scope and scale of the project**.
   Is this a demonstration to test the waters or a whole-hearted jump into the medical home model?

4. **Set up metrics to measure success.**
   a. Understanding goals is as important as measuring success. The NCQA (www.ncqa.org) has strong criteria for what constitutes a medical home that can be a good starting place; however, each organization must define the goals it is attempting to achieve.
   b. Define how success will be defined. Is success defined in terms of cost, quality, access, utilization, service, a combination or something else entirely?

5. **Communicate measures and progress transparently with all stakeholders.**
   a. Maintaining a strong relationship with all stakeholders means communicating directly. If there are successes celebrate, if failures, work to rectify, but in both cases, communicate.
   b. Pay special attention to communications and sensitivities of the specialty physicians who may see referral volumes decline.
   c. Manage the expectation of the Board and the community.

6. **Determine the timing.**
   a. Will you advocate for changes to the reimbursement system or monitor changes already taking place.
   b. Define how the hospital as a leader in developing the model will "share" in the savings
   c. A medical home pilot is only one component to creating a more efficient system of care, once an organization starts down the road it is difficult to turn back.

Conclusion

Community hospitals can have more impact on promoting the health of their communities by realigning the fragmented resources currently being expended. Unfortunately, current financial incentives offer little encouragement to do just that. Until incentives are aligned with improved population health methods, it is likely that the medical home concept will not be encouraged by a large numbers of hospitals. The financial pressures hospitals currently face will not allow many to lead, even models that demonstrate success, when they further undermine hospital finances.

However, while hospitals can provide the management infrastructure and community connection to advance these models faster than other healthcare stakeholders, more effective models of care will continue to grow with or without community hospitals' leadership.

For those in doubt consider these facts:

1. There are at least 36 states with pilot programs in place today.[9]
2. CMS has just begun a 3-year pilot with eight states and an estimated 950-1,200 physician practices for developing medical homes for Medicare beneficiaries.[10]
3. The Department of Veterans Affairs has made the decision to shift its primary care model to a medical home model with full implementation complete by 2015.[11]
4. There are now nearly 2,200 practices recognized by the National Committee on Quality Assurance (NCQA).[12]

As a result, hospital leaders must decide when and how to lead this trend so as not to be carved out of influencing future models and instead be relegated to managing a large fixed asset of decreasing utility.

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Thank You

To our Regional Roundtable Partners, whose support and vision allows these thought-leading efforts to continue at Community Hospital 100.

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Our mission is to help lead the future of health in our communities by providing exceptional learning and relationship building opportunities for community hospital and system executives. At the center of this effort is our annual executive management conference.

The Community Hospital 100 Executive Management Conference is an elite gathering of executives from community hospitals and health systems. Many of the most dynamic players in the industry attend, offering a valuable opportunity to expand your personal network while attending focused education sessions that address today's most pressing issues.

Community Hospital 100
Executive Management Conference
October 23-25, 2011 | Pinehurst Resort, NC
www.communityhospital100.com

Footnotes:

1 History of the Medical Home Concept, Calvin Sia, MD, FAAP; Thomas F. Tonniges, MD, FAAP; Elizabeth Osterhus, MA; Sharon Taba, MEd. Pediatrics, Vol. 113, No. 5, May 2004, p. 1473.

2 National Committee for Quality Assurance's Patient-Centered Medical Home (PCMH) 2011 Standards, www.ncqa.org.

3 Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States, November 16, 2010, Kevin Grumbach,MD; Paul Grundy, MD, MPH.

4 Health Affairs; Health Policy Brief: Patient-Centered Medical Homes, September 14, 2010.

5 Side-by-Side Summary of State Medical Home Programs, March 3, 2011, Lee Partridge, National Partnership for Women and Families; www.nationalpartnership.org.

6 The COMMUNITY HOSPITAL 100 discussion was facilitated by Tim Bateman, EVP Lincoln Healthcare Events.

7 Cheshire Medical Center/Dartmouth-Hitchcock Keene, Vision 2020 presentation, May 25, 2011, and Vision 2020 Indicator Update, spring 2011.

8 Physician-Hospital Alignment, Luke Peterson, Kate Lovrien; Becker Hospital Review, February 2011; www.physicianhospitalalignment.com

9 Health Affairs; Health Policy Brief: Patient-Centered Medical Homes, September 14, 2010.

10 Center for Medicare & Medicaid Services, Details for the Multi-Payer Advanced Primary Care Practice Initiative, Q&A Fact Sheet, April 12, 2011, www.cms.gov.

11 Health Affairs; Health Policy Brief: Patient-Centered Medical Homes, September 14, 2010.

12 www.ncqa.com.