In this article...
Hospital and health system chief medical officers face multiple new challenges with the shift from volume to value in health care delivery.

CHIEF MEDICAL OFFICERS (CMOs) OPERATE IN a changing health care environment where they must balance regulatory mandates with organizational demands to gain the most value from each health care dollar while guiding diverse medical staffs to deliver the highest quality care to patients.

To gain insight into the common concerns among CMOs, Hayes Inc. gathered a group of health system leaders from around the country to participate in a CMO roundtable. Raymond Fabius, MD, CPE, FACPE, cofounder and president of HealthNext, served as facilitator for the meeting.

Seeking diversified points of view, Hayes Inc. invited CMOs with varying specialty backgrounds from health systems large and small (Table 1). These experts came from all regions of the United States (Figure 1). CMO participants represented 184 hospitals, nearly 35,000 beds and more than 1 million inpatient and outpatient visits annually.

THE TRANSFORMATION FROM VOLUME TO VALUE — It was no surprise that every CMO reported being challenged as health care moves from a volume-based payment model to one that incorporates measures of value. With traditional payment systems, providers had strong financial incentives to deliver more services to more patients but could be penalized financially if fewer services were provided, even if improved health outcomes were the result.

Stakeholders today recognize that better outcomes are not necessarily the result of more services and more spending. The transformation is underway to give providers greater responsibility to deliver more effective and efficient care, and to reward them for keeping patients healthy and controlling costs by providing preventive services and reducing duplicative and unnecessary procedures.

CMOs noted that the quest to achieve such a transformation is a difficult and painstaking process. Existing systems are stretched to the breaking point, and providers are being asked to do more with less, often resulting in declines in personnel and revenue.

Organizations are being pushed to develop new integrated delivery networks and innovative ways in which to grow in scale, as well as geographic coverage to improve operational efficiencies and reduce overhead costs.

CMOs agreed that transformation demands systems that are scalable, automated and cost efficient. In addition, achieving true clinical transformation is synonymous with achieving the Triple Aim of health care reform — simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of payers and communities.

POPULATION HEALTH AS A FOUNDATION — There was general agreement that population health strategies were foundational to clinical transformation and that equal effort
needs to be exerted to keep healthy people well and provide treatment for the ill. This approach will require the development of new revenue streams and skill sets, and likely require more community-based activities to surround health consumers within environments more conducive to wellness. Additionally, there will need to be a strong focus on risk reduction within attributed populations and chronic care management for those already managing their diseases and conditions.

**PILLARS OF CLINICAL TRANSFORMATION** — Transformation to value-based care has the potential to improve the quality of care provided to patients and reduce out-of-control health care costs. Participating CMOs discussed several important pillars and associated issues health care systems need to address when moving from volume to value (Figure 2).

The top 3 pillars of most concern to the CMOs who participated in the roundtable were:

- Care coordination
- Clinician and patient engagement
- Systematic process improvement

CMOs viewed care coordination, clinical engagement and systematic process improvement as interrelated issues that impact their organizations’ ability to achieve the Triple Aim of health care reform.
CARE COORDINATION AND PROVIDER ALIGNMENT — Care coordination involves multiple providers working in concert for the benefit of the patient to deliver quality, satisfaction and cost through teamwork. CMOs agreed that patients want access, speed and convenience when they have health care needs; they are not necessarily seeking to establish a long-term relationship with a health care provider. Nevertheless, developing trusted relationships with providers is a vital aspect of patient engagement that improves patient health.

CMOs are looking for ways to balance patients’ desire for episodic care with the need to improve care coordination. There was agreement that alignment among providers so that transitions between levels of care become more seamless would enable health systems to use resources more effectively.

CMOs viewed the primary care practitioner and the concept of the medical home as critical for care coordination and clinical integration. However, they noted that certification of practices alone is not sufficient. Many level III patient-centered medical homes were not performing optimally in their systems.

In addition, CMOs supported the use of evidence and evidence-based tools upon which to formally base their clinical processes when developing the plan of care and care coordination to ensure that their health delivery systems are working effectively and efficiently.

CLINICIAN AND PATIENT ENGAGEMENT — Engagement of clinicians and patients was defined by roundtable CMOs as a vital component in the clinical-transformation process. Achieving the Triple Aim requires clinicians who are engaged in ongoing health-improvement efforts and who reinforce positive health behaviors in their patients.

CMOs reported problems with physician engagement, especially in systems with large geographic spread. Some of the CMOs remarked on the lack of physician engagement and inherent problems that arise when trying to manage medical staffs in which a majority of the clinicians are private practitioners who are not employed by the health system.

This difficulty in gaining buy-in from nonemployee clinicians was seen as a significant impediment to health systems’ efforts to transform practice, especially when actively moving from a volume to value model of care delivery. The transition process is difficult and trying for the health system and physicians, with financial losses and provider dissatisfaction as central issues.

Limited patient engagement is another concern among hospital leaders. CMOs noted that a large segment of the population they serve is not engaged. Research shows, however, that patient engagement fosters health.

CMOs have had limited success in finding ways to address the population’s need for very timely, rapid access, while forming clinician-patient relationships that can foster needed behavior change, compliance with evidence-based care practices and wellness. Clinician leaders and administrators are looking for mechanisms through which they can gather metrics and outcome data so that over time they gain a better sense of what works and what doesn’t with regard to patient engagement.

Patient education is an important element of clinical engagement. CMOs recognized that efforts are needed to educate consumers about the need for evidence-based care. These physicians discussed the need to link consumers’ out-of-pocket costs to the proven or unproven value of an intervention.

CMOs speculated that when consumers have some “skin in the game,” so to speak, they may be less likely to request services they don’t need or to engage in unhealthy behaviors.

SYSTEMATIC PROCESS IMPROVEMENT AND CHANGE MANAGEMENT — Systematic process improvement involves not only transitioning from “medicine as usual” to an evidence-based, patient-focused model, but also embracing and managing change. CMOs agreed that patient care decisions are clinical, and clinicians should lead the decision-making process that includes the development of clinical protocols. Without physician leadership and guidance, systematic process improvement is doomed to fail.

The implementation of standardized, patient-focused care-delivery models is possible only through the application of proven, evidence-based best practices. CMOs concurred that evidence-based processes embedded in standardized care protocols and practices eliminate unnecessary treatment and can lead to improved clinical and financial outcomes.

Unfortunately, CMOs admitted that moving toward evidence-based approaches is not an easy task, and organization-
wide agreement is difficult to achieve. There was overwhelming consensus among the group that even when evidence is readily available, institutions will use evidence only when they perceive a need for change and are ready to take action.

This attitude meshes with the change-enablement equation for success developed by Dixon Thayer and Craig Brum- mell (Figure 3). As the figure shows, lasting change can occur only when institutions have these six components in place simultaneously:

1. Need for change
2. Clear, shared vision
3. Management commitment and behavior, that is, action after commitment is made
4. People involvement
5. Supporting structure and process
6. Performance measures

BUILDING EVIDENCE INTO PRACTICE — Despite the widespread recognition that achieving the Triple Aim requires the use of evidence, CMOs remarked that building evidence into practice is not easy. They recognize the value and necessity of bringing to their clinician leaders and stakeholders evidence-based and unbiased information that is free from vendor influence and will support clinical decisions at the population and patient-specific levels, enabling clinicians to make decisions that result in cost-effective health care.

LIMITED PATIENT ENGAGEMENT IS ANOTHER CONCERN AMONG HOSPITAL LEADERS.

In particular, CMOs want information about comparative effectiveness, especially as it relates to clinical programs, devices, pharmacy and therapeutics. Being able to supply evidence-based and data-driven information and recommendations with an unbiased perspective to committees that are trying to reduce cost and clinical variation was perceived to be of great value by participating CMOs because it would enable their systems to make better decisions.

CMOs expressed concerns that the bias inherent in some evidence presented a barrier to its use. They recognized that study design and execution, as well as the funding source, are factors that influence the quality of the evidence derived from clinical studies.

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**TABLE 3**

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Discerning between “good” and “bad” evidence can be a daunting task. CMOs acknowledged that guidance from experts who know how to analyze the quality and strength of the evidence would complement their health systems’ efforts to build evidence into practice. Whereas some CMOs favored on-site evidence experts who would be embedded in their facilities, others noted that evidence experts — whether on-site or off — would have a positive impact only on those organizations that were ready to take action.

CMOs stressed that to make clinical decisions that improve outcomes, not only do clinicians need evidence-based information that will guide action and answer questions, they need to receive it in certain ways. It must be delivered:

- To the right stakeholder (clinicians and patients)
- In the right format, based on intended use (as in the form of alerts, order sets, clinical guidelines, in-depth assessments, recommendations)
- Through the right channel (Internet, mobile devices, clinical information systems/electronic medical records)
- And at the right point in the workflow to influence key decisions and actions

The challenge will be reaching organizations when they are ready for change and getting the evidence into the hands of those stakeholders who will become champions for clinical transformation. CMOs remarked that supply chain is probably not the best place to start due to the typical lack of physician involvement, a focus on purchasing and standardization versus utilization, and the difficulty in removing vendors from the equation. A better approach is to create a physician leadership model to drive evidence-based practice, quality and change. Engaged physician leaders will be the key.

**NEXT STEPS —** It was clear from the roundtable discussion that hospital and health system leaders are looking for focused solutions to similar challenges with regard to leading physicians, leading organizations and determining how to keep the patient in the center of the care-delivery model. It was extremely rewarding to hear how these leaders have embraced the challenges, recognized the need to evolve and applied creativity within their organizations to transform health care delivery in this country.

We have an opportunity now to make real improvements in the outcomes and satisfaction of the patients we serve, in the overall health of the population, and to do so in a way that makes wise use of the limited health care dollars available.

Ultimately, the ability to transform health care delivery depends on the support and engagement of all of the stakeholders in the health care system — consumers, payers, providers, purchasers, government officials and others. Nevertheless, with engaged physician leaders such as those who participated in the roundtable, we feel confident that we will be successful in reaching our goal of achieving the Triple Aim of health care reform.

Their collective recommendation to physician leaders involved in clinical transformation is to focus on population health strategies, care coordination, engagement of providers and patients, and systematic process improvement. All of these efforts should be based on the best clinical evidence available.

**REFERENCES**

