The Emerging Chief Clinical Officer Role

Elevating physician leadership to drive system-wide clinical transformation

Look inside for:
• Five hallmarks of the chief clinical officer role
• Four detailed case studies of executive leadership restructuring
• Spotlight on the key responsibilities—and impact—of the new chief clinical officer role
Five hallmarks of the emerging role of the CCO, with illustrative examples of successful models

Advice on how to develop the CCO role from Dr. Dennis Weaver, EVP and CMO of Advisory Board’s Consulting division

In-depth profiles of four organizations undergoing significant executive leadership restructuring, with a focus on the addition of a CCO role
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Executive Summary

Finding their executive leadership structures insufficient to respond to market pressures and drive change system-wide, many organizations have begun to overhaul executive roles and responsibilities. These changes aim to address a fractured leadership structure that hinders clinical transformation. Traditionally, physician and operational leaders have not partnered effectively to make decisions, hurting both financial and clinical outcomes. Silos also exist between physician leaders, who tend to be scattered across their health system. Despite working on similar issues, they oversee discrete parts of the enterprise and often operate in isolation.

Physician Leaders Not Always Unified Across the Health System

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**Strategic Initiatives Requiring Cross-Silo Coordination**

- Physician network and contracting strategy
- Reducing readmissions and post-acute care costs
- Clinical variation reduction, including cross-continuum pathways
- Streamlining care management efforts across settings

Introducing the Chief Clinical Officer Role

Organizations that have strengthened connections between operational and physician leaders, and unified clinical leadership, have done so in part by creating a chief physician executive role, commonly called the chief clinical officer (CCO). While other organizations use titles such as the system chief medical officer or chief physician executive, the semantics are less important—what is critical is the expansive authority of this role.

Perhaps the best way to define the new CCO role is in relation to a more common physician executive role—the chief medical officer (CMO). The CCO generally has oversight for the traditional CMO realm, but the CCO’s role is more expansive. He or she has cross-continuum oversight of clinical care delivery, accountability for the entire physician enterprise, and is fully integrated into the system executive team to ensure decisions are strategically sound from the clinical perspective.
Core Responsibilities of the Traditional CMO and Chief Clinical Officer

Tradition CMO
• Medical staff affairs
• Inpatient quality, safety, case management, infection, etc.

Chief Clinical Officer
• Clinical variation reduction across the continuum
• Accountability for full physician enterprise
• Significant budgetary authority
• Member of system executive team

This paper provides insights from four organizations that have each taken a different approach to changing their executive leadership structures, but have all developed a CCO role.

Read on to learn:
• Five hallmarks of the emerging role of the CCO, with illustrative examples of successful models
• Advice on how to develop the CCO role from Dr. Dennis Weaver, Executive Vice President and CMO of Advisory Board’s consulting division
• In-depth profiles of four organizations undergoing significant executive leadership restructurings, with a focus on the addition of a CCO role

While the profiled organizations have had success in developing the CCO role, this type of leadership position may not be appropriate for every organization, or perhaps not the right addition at this time. Leadership restructurings require significant change, time, and investment.

To discuss this critical decision with an expert, please contact Megan Zweig at the Physician Executive Council at zweignm@advisory.com
# About Our Profiled Institutions

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<td><strong>Banner Health</strong> • Headquartered in Phoenix, Arizona • Facilities in Arizona, Alaska, California, Colorado, Nevada, Nebraska, and Wyoming</td>
<td>• 29 hospitals, including three academic medical centers • 2,000 employed physicians and advanced practice professionals, and 8,000 affiliated</td>
<td>• Five executives run four teams: the Strategic Growth Team, the Clinical Product Team, the Integrated Delivery Team, and the System Operations Team • EVP and system CMO leads the Clinical Product Team, with oversight for cross-continuum care delivery and the physician network</td>
<td>• ACO ranked first in cost savings, third in savings per beneficiary, and fifth in quality in 2015 • Grown from $2B to $7.5B in annual revenue in 15 years • Produces 10-15 new or updated clinical standards every quarter to be deployed system wide</td>
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<td><strong>CONE Health</strong> • Headquartered in Greensboro, North Carolina • Facilities across the Piedmont Triad region of North Carolina</td>
<td>• Six hospitals • Medical staff of 1,300 physicians</td>
<td>• Eight executives support two teams: Continuum of Care, and Strategy and Support • Introduced a CCO role which co-leads the Continuum of Care team with the COO • CCO has oversight for cross-continuum care delivery and the physician network, including the medical group and ACO</td>
<td>• Top hospital in the nation in acute myocardial infarction (AMI) readmissions • Lowered probability of 30-day readmissions in high-risk population from 15% to 13% • Positioned to advance their transition to population health through ACO integration</td>
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<td><strong>Mercy Health</strong> • Headquartered in Cincinnati, Ohio • Facilities in Ohio and Kentucky</td>
<td>• 23 hospitals • More than 34,000 total employees</td>
<td>• Eight executives comprise the Lead the Ministry team, which sets system strategy; a broader leadership team comprises the Operate the Ministry team, which executes strategy • Introduced a CCO role which co-leads the Operate the Ministry team with the COO, including direct oversight of Regional CEOs who manage the hospitals and medical group within their respective region</td>
<td>• Greater integration among medical group, hospital, and ACO leaders • Nimble decision making due to convening of small, influential stakeholder groups • Integration of clinical and operational teams at all levels</td>
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<td><strong>Texas Health Resources</strong> • Headquartered in Dallas-Fort Worth, Texas • Facilities in 16 counties across north central Texas</td>
<td>• 29 hospitals • More than 5,500 physicians with active staff privileges and over 550 employed physicians</td>
<td>• Introduced clinical-operational leadership partners at all levels • CCO and COO function as a system-level dyad • Each of three zones led by a clinical leader and operational leader who report to the CCO-COO dyad • Each facility led by a triad consisting of the hospital president, CNO, and CMO, who report to a zone dyad</td>
<td>• Positioned to advance their Fresh AIR strategy of Accountability, Innovation, and Reliability • Integration of clinical and operational teams at all levels • Strategy to align expectations and incentives across all physician contracts</td>
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Hallmarks of the Emerging Chief Clinical Officer Role

All of the case studies featured in this publication include an overview of the organization’s broader leadership restructuring. While that extends well beyond clinical roles, every restructuring includes the creation—or enhancement—of a system chief clinical officer role. Though the profiled organizations vary in size, geography, and other critical characteristics, each reflects a set of common hallmarks that ensure the appropriate authority and desired impact of the CCO role.

1. The CCO has a seat at the table with other senior executives, ensuring clinical considerations inform all strategic decisions.

The CCO is an essential stakeholder taking part in all organizational strategic decisions.

2. The CCO holds significant authority across the clinical and physician enterprise—and often beyond.

Though explicit oversight of the CCO will vary across organizations, most have comprehensive—including financial—responsibility for all clinical and physician network endeavors across the continuum.

3. The CCO is paired with an operational executive counterpart.

Most CCOs are paired in a CCO-COO dyad. These dyads do not exist in name only; clear role definitions, joint accountabilities and incentives, and often shared direct reports create a strong partnership.

4. The CCO bridges entrenched functional and site silos to advance system-wide initiatives.

CCOs—with operational counterparts—organize forums and accountability mechanisms to galvanize partnership across cross-functional stakeholders and settings, often overcoming historic disconnects and miscommunication.

5. The CCO uses all potential levers—from contracting to transparency—to align physician practice with system goals.

With oversight for the physician enterprise, the CCO is in a unique position to drive alignment between physicians across the system regardless of their employment status, facility, or contract standing.
1. The CCO has a seat at the table with other senior executives, ensuring clinical considerations inform all strategic decisions.

As a critical member of the senior executive team, the CCO participates in all major organizational decisions and reports directly to the CEO. The CCO role signifies a leap from the legacy physician leader role, which too often served only to lend credence to the notion that the organization valued physicians and their input. As one physician leader put it, “There were times when you felt like you could be a cardboard cutout of a doctor. The system just rolls you out when they need it in front of everyone.”

Most organizations have evolved beyond this legacy model, but even valued physician executives often function primarily as a conduit to physicians—communicating changes, soliciting input, and managing physician performance. This model assumes the physician executive is responsible for engaging physicians in the organization’s strategy, rather than enfranchising physicians to shape that strategy. Embracing this shift in physician participation was a critical and evident component all of the profiled organizations’ restructurings. At these organizations, no strategy is determined without physicians at the table. And this is represented at the highest levels by the CCO role. Of course, a physician executive is an important signal value to physicians. But the contribution of the CCO is even more important for its strategic value, to be an equal partner to other executives in strategic and operational decisions.

For instance, at Banner Health, EVP and System CMO Dr. John Hensing leads one of four senior leadership teams, the Clinical Product Team, reporting to the CEO. As part of that senior executive team, Dr. Hensing reviews all important system proposals, such as capital investments and mergers and acquisitions, alongside the other three teams. It’s an inclusive, iterative decision-making process that allows each executive to identify and flag any issues before moving forward. For example, a recent acquisition proposal promised strong financial returns, but the Clinical Product Team uncovered litigation exposure and clinical performance risks related to issues with credentialing and EMR connectivity. The teams still decided to move forward with the acquisition, but this careful assessment allows Banner to proactively correct these clinical disconnects.

Banner Health’s Inclusive Decision-Making Process for System Proposals

1) Though Dr. Hensing does not have the CCO title, his role is equivalent to that of a CCO as described by this publication.

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2. The CCO holds significant authority across the clinical and physician enterprise—and often beyond.

At each of the profiled organizations, the CCO oversees clinical care delivery across the system. This includes traditional CMO responsibilities such as inpatient quality and safety, risk management, and medical staff affairs. However, the CCO role generally includes expanded oversight—including financial and operational oversight over two primary areas:

- The physician enterprise beyond the inpatient structure, including the employed medical group, clinically integrated network, and Accountable Care Organization (ACO), if applicable
- Cross-continuum quality, including the reduction of unnecessary care variation across all sites of care

This expanded purview is critical for the CCO as he or she seeks to drive transformation beyond the inpatient setting. In addition to these common functions, each CCO at the profiled organizations also had unique added responsibilities, some of which are highlighted below.

Representative Oversight of the CCO

![Diagram of CCO Oversight](image)

At **Cone Health**, EVP and CCO Dr. Mary Jo Cagle manages the system CMO, as is typical for a CCO. Dr. Cagle also manages the ACO and physician network, including the employed physician group. Dr. Cagle works with each of these teams to develop and meet their budgets each year. Unique to the CCO position at Cone, Dr. Cagle also has full responsibility for Cone’s insurance product and several risk contracts in the ACO.

At **Mercy Health**, CCO and President of Mercy Health Physicians Dr. Anton Decker’s purview spans far beyond the typical CCO role. Dr. Decker shares direct accountability alongside his COO dyad partner for ensuring system strategy translates into action. The dyad manages seven regional CEOs. Each regional CEO oversees the acute care facilities in the region, and serves as the regional medical group president. The regional CEOs present annual budget proposals to the CCO-COO dyad, who field questions, make revisions to budgets, and then sign off as a single unit. With this purview, the CCO and COO ensure all regional CEOs are working across the continuum—and with each other—to realize system goals.

The expanded purview of the CCO role also encourages the development of innovative and expansive roles for other physician leaders within the system. For instance, **Banner Health** calls on division CMOs to lead system-wide initiatives, such as promoting clinical stewardship, in addition to their CMO responsibilities.
3. The CCO is paired with an operational executive counterpart.

Dyad partnerships are becoming increasingly common, particularly at the service line and department level. The model pairs a physician leader with an administrative counterpart, reflecting the need for joint operational-clinical decision making.

At most of the profiled organizations, a dyad partnership exists at the executive level between the CCO and COO. This model allows the dyad to take on expanded responsibilities that are too large for any single role or function, such as transforming toward accountable care and engaging all care providers in redesigning care system-wide.

Effective dyad partnerships are carefully crafted to drive maximum impact through joint decision-making and accountability. As such, these organizations have undertaken a thorough role-definition process to optimize the CCO role in relation to the COO.

Three Features of Effective Executive CCO-COO Dyads

- **Shared Oversight**
  Ensures joint responsibility for cross-continuum quality and clinical operations

- **Joint Decision Making**
  Eliminates traditional clinical and operational silos

- **Identical Goals and Incentives**
  Establishes shared priorities and accountability

At **Texas Health Resources** (THR), the CCO-COO dyad reports to the CEO, and is jointly responsible for clinical transformation of the system. This shared accountability is spelled out explicitly in their job descriptions under a section titled, “Partnership Responsibilities.”

Additionally, clinical-operational partnership at THR extends beyond the system executive level. Each zone (i.e. region) is led by a zone dyad (consisting of a clinical and operational leader) that reports to the system CCO-COO dyad. Those zone dyad leaders oversee facility-level leadership triads consisting of a hospital president, chief nursing officer, and CMO. This structure elevates clinicians across the organization to leadership positions in which they share accountability for system transformation alongside operational counterparts.

To ensure each member of a dyad (or triad) has a clear scope of their individual role and accountability, THR employs the OVIS model to determine who Owns, Vetoes, Influences, and Supports each activity. A task team consisting of key representatives from the facility triads and zone dyads led the OVIS discussion to define explicit functional responsibilities and accountabilities for each role. As a result, every role has a consistent function.
4. The CCO bridges entrenched functional and site silos to advance system-wide initiatives.

All of the profiled leadership restructures seek to better integrate leaders and efforts across sites in pursuit of system goals. The CCO, often with his or her operational partner, is tasked with operationalizing this integration. At most organizations, this means (1) creating forums for leaders across settings and functions to meet and make decisions, and (2) holding those leaders jointly accountable for goals.

For example, the CCO and COO at Mercy Health are responsible for operationalizing system strategy. To do so, they oversee the “Operate the Ministry (OTM)” team, which includes the president of the ACO (Mercy Health Select), seven regional CEOs who oversee acute facilities and the medical group in their respective region, the chief strategy officer, and other key system operations and finance leaders.

The OTM team meets on a monthly basis to assign next steps for strategic priorities. Because this structure brings together all relevant stakeholders, it ensures no one second guesses a decision due to lack of participation. It also accelerates decision-making, as decisions can now occur in a single meeting instead of trying to secure support from hospital, medical group, and ACO leaders separately.

Similar to Mercy Health, the CCO-COO dyad at Cone Health partners with leaders across the continuum to advance system goals. The dyad assigns accountability to a pair of leaders for each “True North Goal” (annual system goal). Each pair includes one direct report from the CCO and one direct report from the COO. The CCO and COO meet with these leaders the first Friday of every month to assess progress, identify systemic barriers, and develop action plans.

This shared accountability across clinical and operational leaders has yielded significant results. For instance, a primary care physician leader and hospital nursing executive were assigned to Cone’s 2015 access goal: reduce the wait time for the third next available appointment. Together, the team uncovered opportunities to address lower acuity patients unnecessarily using the ED and grow e-visits. As a result of their ability to work with leaders across sites, the wait time dropped from 30 days to nine.

In addition to working towards annual goals, the system CMO and other clinical leaders at Banner Health have built a permanent, multidisciplinary governance structure to realize one ongoing system goal: advancing a single care standard across the enterprise.

This “Care Management” structure convenes 22 system-level Clinical Consensus Groups (CCGs) to define clinical standards. Teams are led by a physician-nurse dyad, with representation from clinical informatics, pharmacy, therapy, and other care team members. The multidisciplinary CCGs work across sites to develop cross-continuum care pathways where appropriate.

Once CCGs define a suggested care standard, the Care Management Council—overseen by the system CMO and with participation from all facility CMOs and CNOs—approves the standard before it is simultaneously deployed at all Banner care sites.
5. The CCO uses all potential levers—from contracting to transparency—to align physician practice with system goals.

Given their broad physician oversight across facilities, specialties, and contracts, the CCO is in a unique position to spearhead broad change across the physician enterprise. CCOs can leverage contracts to drive behavior change by aligning incentives and expectations with system goals. Additionally, the CCO can use non-financial levers to spur behavior change, such as sharing physician performance data, supporting physician leadership, and communicating a clear rationale for change.

Common Physician Alignment Levers

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<td><strong>Communication and Change Support</strong></td>
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<tr>
<td>• Contracts include consistent performance expectations</td>
<td>• Physician leaders support and communicate system priorities</td>
</tr>
<tr>
<td>• Incentives align with system priorities</td>
<td>• Performance data shared regularly with physicians</td>
</tr>
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<td>• Consistent performance measurement across the enterprise</td>
<td>• Training and workflow supports soften impact of changes</td>
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At Texas Health Resources, the CCO has focused on aligning the entire physician enterprise with health system priorities. To do this, Dr. Varga formed the Physician Enterprise Alignment Team (PEAT) to oversee all physician contracts across regions, specialties, entities, and employment status. When physician contracts come up for renewal or development, PEAT ensures contractual expectations align with THR’s greatest priorities. For instance, THR now includes minimum training requirements on high reliability in all contracts. This alignment mechanism illustrates the value of the CCO role in directing the physician enterprise towards a common aim, ensuring THR is capturing the full value of its physician investment.

Mercy Health implemented an organization-wide performance scorecard that provides specific feedback by region and group (hospital, medical group, and ACO) on system goals. The monthly scorecard is available on a user-friendly web interface that provides a streamlined, single-page overview of each region and/or group’s performance. The scorecard also includes patient and provider stories to capture the human impact of the work, and highlights progress to celebrate groups that have excelled in certain areas. Critically, these scorecards allow physicians to understand and assume ownership of their performance in the context of system-level priorities, which motivates improvement and upends traditional ownership assumptions. For example, as Mercy Health sought to engage physicians in cost efficiency initiatives, leaders used the performance scorecard to provide transparency into their group and region’s financial and operational performance.
Q&A with Dennis Weaver, MD, MBA

Dennis Weaver, MD, MBA, leads consulting engagements to help health systems revamp their executive leadership structures – including the creation and implementation of Chief Clinical Officer roles. We sat down to discuss what he’s learned:

What is the driving force behind the emergence of new-in-kind physician executive roles like the Chief Clinical Officer?

As systems work to transform care delivery outcomes, many find traditional leadership structures don’t cut it. In the past, clinical change too often meant administrators connecting ad hoc with physicians in the lounge. Now, organizations are tasked with building a system of care that necessitates collaboration across complex clinical, operational, and financial sectors. These problems are intricately intertwined across the full continuum of care, so the solutions and stakeholders must be integrated as well.

Executive structures at most health care organizations don’t yet reflect this new reality—physician leaders are tasked only with clinical quality or with discrete areas of operational oversight, and they don’t yet have the ability to fully impact all clinical operations.

Is the key giving physician leaders more financial and operational authority?

Having operational and P&L responsibility at the executive level, in addition to traditional oversight of clinical care, is a key differentiator in the CCO-type role. But this is a necessary, not sufficient, condition. It’s also critical that their authority spans the full continuum. You have to think about clinical care in the context of multiple domains including population health, consumerism as well as reducing unwarranted care variation.

This means oversight and input into clinical operations in addition to physician network strategy for employed and aligned physicians.

How are organizations identifying, or recruiting, these chief physician executives?

This is a big challenge. Ideally, you’d want to recruit from within to preserve institutional knowledge, but few organizations have physician leaders with the operational and executive skills to match the clinical experience necessary to succeed. CCOs are tasked with ensuring the system realizes return from its investments to provide high-value care. If a CMO hasn’t done that on a smaller scale, it’s difficult to apply at a system level. Similarly, experience in more than one domain – like ambulatory and acute – is an ideal prerequisite.

They also need the right temperament—one that is able to persuade, in addition to command. Traditionally, physicians call the shots in clinical practice. It’s not that way in the c-suite. It takes someone who can adapt to and thrive in a team based, collaborative decision making environment. Ultimately, the person who wants the CCO role may use it as a stepping stone on his or her path to a CEO position.

How do you best position this new role to succeed?

Finding the right person is important, but success also hinges on whether or not they’ll get support from their colleagues. The hardest part, really, is restructuring existing executive roles in a way that both maintains buy-in and gives them the authority and support they need. The entire leadership team must be on board from the start.

Setting this person up for success comes down to two things. 1) Organizational commitment to physician leadership within the executive team. And 2) The CCO must collaboratively participate in decision making at the senior most level. If not, an organization is only creating a title and not an executive position – an action that will become apparent to key system stakeholders and ultimately won’t generate the clinical, operational, and financial results desired.

For more information, contact:
weaverD@advisory.com or advisory.com/consulting
Full Case Profiles

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Supplementary Resources
For additional detail and accompanying implementation resources such as CCO job descriptions, full organizational charts, and other case study artifacts visit advisory.com/pec/CCO
Banner Health

Case in Brief

About: Headquartered in Phoenix, Arizona, Banner Health is a 29-hospital system with facilities in Arizona, Alaska, California, Colorado, Nevada, Nebraska, and Wyoming. The system includes three academic medical centers. A single operating board oversees the entire system, which has a heavily centralized leadership and operating structure.

Banner was created in 1999 from a merger between Lutheran Health Systems and Samaritan Health System. In 2015, Banner merged with the University of Arizona Health Network in Tucson, Arizona. Banner Medical Group and Banner-University Medical Group employ approximately 2,000 physicians and advanced practice professionals, and the system is affiliated with over 8,000 private practice physicians. Banner Health Network, formed for assuming financial risk for its members, is comprised of its own Banner Medical Group, Arizona Integrated Physicians (an independent provider risk sharing group), and Banner Physician Hospital Organization.

Executive leadership structure: In spring of 2015, following the merger with the University of Arizona Health Network, Banner reorganized its executive leadership team to advance rapid decision making and integration across the continuum. System executive leadership now run four system-wide teams: the Strategic Growth Team, the Clinical Product Team, the Integrated Delivery Team, and the System Operations Team.

Physician executive leadership: Banner’s senior-most physician executive, Dr. John Hensing, is the Executive Vice President and system Chief Medical Officer. Dr. Hensing leads the Clinical Product Team, and his representation on the senior executive team ensures the clinical perspective is considered during all major strategic decisions. Dr. Hensing has oversight for the traditional CMO domain—inpatient and cross-continuum quality, safety, and risk—in addition to care variation reduction efforts and the clinical performance and leadership of Banner Health Network and Banner Medical Group.

Impact: Banner is a top performing Pioneer ACO with one of the largest memberships at 52,000 members. In the 2015 performance year, the ACO ranked first in cost savings, third in in savings per beneficiary, and fifth in quality—with tremendous year over year improvements. Banner has grown from $2B to $7.5B in annual revenue over the past 15 years. Additionally, Banner is a national leader in reducing care variation, typically producing 10-15 new or updated clinical standards every quarter, which are deployed system-wide.

Executive Leadership Structure

Becoming a “Clinical Quality Company” Requires Physician Leadership

Shifting to an Operating Company

“We communicated to everyone that we were acting like a holding company, but that we were going to function as an operating company... The significance of that mind-shift is tremendous. An operating company plans strategy and execution; a holding company accumulates assets and lets each guide its own fate.”

Peter Fine
CEO, Banner Health

Following the merger of Lutheran Health System and Samaritan Health System in 1999, Banner’s CEO, Peter Fine, committed to transform Banner from a hospital holding company to a clinical quality company as a means to differentiate the system from competitors. To help guide this transformation in care delivery, Mr. Fine made, for the time, a largely unprecedented investment in physician leadership.

Mr. Fine appointed Dr. Hensing to lead this effort, and care reliability became the core tenet of clinical improvement at Banner. To support this, Banner grew its physician leadership ranks from three full-time physician leaders in 1999 to 28 full-time physician leaders focused on leading excellence in clinical outcomes across the organization.
Much of Banner’s success is attributed to this sustained investment in physician leadership.

**A Senior Executive Team with an Embedded Clinical Perspective**

Since the University of Arizona Health Network merger, Banner’s executive leadership,—previously one senior management team, now consists of four teams led by five executive vice presidents (EVPs) reporting to the CEO. The three key operating teams include the Clinical Product Design Team, the Strategic Growth Team, and the Integrated Delivery Team. Those three teams are supported by a fourth, coordinating team—the System Operations Team.

The Strategic Growth Team is led by the EVP of strategic growth and is currently focused on charting the transition from volume to value and determining which products to bring to market. This is the only team on which the CEO has a seat. The EVP and system CMO oversees the Clinical Product Team, with a focus on ensuring Banner is delivering consistent care across the enterprise. The Integrated Delivery Team, co-led by the EVP of Banner academic delivery and the EVP of community delivery, focuses on operationalizing a consumer-centric experience across the entire continuum. Finally, the System Operations Team supports the aforementioned teams via traditional corporate functions such as human resources, legal, and finance.

**Four Executive Teams Lead Banner**

1. **Strategic Growth Team**
   - Led by EVP of Strategic Growth
   - Oversight of volume-to-value, payment reform strategy

2. **Clinical Product Team**
   - Led by EVP and system CMO
   - Oversight of clinical product, care management infrastructure

3. **Integrated Delivery Team**
   - Co-led by EVP of Banner Academic Delivery and EVP of Community Delivery
   - Oversight of consistent consumer experience

4. **System Operations Team**
   - Finance, HR, Legal

**Streamlined Executive Decision-Making, with a Clinical Voice**

One of the benefits of this new structure is inclusive decision making. The Strategic Growth, Clinical Product, and Integrated Delivery teams are consulted on major strategic decisions, such as large capital investments or mergers and acquisitions. The goal is for all key leaders to quickly assess decisions across three domains: Is it strategically rational? Is it clinically relevant? And, is it operationally feasible?

First, the Strategic Growth team determines if the proposal aligns with the strategic direction of the organization, refining proposal elements if necessary. If approved, the Clinical Product Team assesses the proposal based on clinical merits and potential obstacles. Finally, the Integrated Delivery team evaluates whether the proposal makes sense from a system integration perspective. If every group approves the proposal, it continues to the System Operations Team for implementation.
This new structure and decision-making process is particularly important from the clinical perspective. Historically, many major decisions were made based off of a financial pro forma without a nuanced assessment of the clinical implications or risk exposure. Now, the Clinical Product Team assesses major proposals to identify and correct issues which require further refinement. For instance, a recent acquisition proposal promised strong financial returns, but the Clinical Product Team uncovered litigation exposure and clinical performance risks due to issues with credentialing and EMR connectivity. The teams still decided to move forward with the acquisition, but this careful assessment allowed Banner to proactively rectify these clinical disconnects.

While still fairly new, senior leadership agree that this decision-making process has proven effective. They are working to continuously refine the process, with the goal of analyzing and making major decisions within a predictable timeline.

Expansive Role of the System Chief Medical Officer

The system CMO has a more expansive role than a traditional CMO. He oversees the clinical leaders addressing all aspects of cross-continuum clinical performance (quality, safety, consistency, and risk), and the departments of Care Management (Banner’s vehicle for reducing care variation), Clinical Innovation, Informatics, and Research.

Purview of the System Chief Medical Officer

Banner heavily relies on physician leadership to advance system strategy. This theme carries into the authority granted to senior physician roles beyond the system CMO. For instance, there are three division CMOs, all of whom hold a dual role. Each division...
CMO manages CMOs of a facility, medical group, or other part of the organization. The other portion of each division CMO’s role includes oversight for a system-wide function:

- The first division CMO is also VP of clinical stewardship. This role entails overseeing the Clinical Evaluation Team (CET), which reviews all new devices and other technology to determine what the system should adopt. After conferring with the appropriate clinical experts, the CET makes a final recommendation to the Clinical Product Team.

- The second division CMO is also the VP of clinical integration, which includes oversight for the CMOs in post-acute care, hospice, pharmacy, and the medical group.

- The third division CMO is also the VP of health management and oversees the clinical performance of Banner Health Network, which has 400,000 members (approximately half of which are at risk).

The system CMO’s broad oversight, along with the expansive authority granted to other senior physicians, allows for rapid changes to be developed and deployed across the entire delivery system, engaging both employed and private practice professionals. This is particularly true in regards to Banner’s work to reduce care variation.

A System Engine for Clinical Reliability

Perhaps the most significant—and lasting—impact of physician leadership at Banner has been to build a permanent, robust infrastructure for advancing clinical reliability, called the Department of Care Management. The goal of Care Management is to define and implement evidence- and consensus-based standards across the entire system in the pursuit of higher-quality, efficient care.

Twenty-two system-level Clinical Consensus Groups (CCGs)—each with a particular clinical focus—develop all clinical standards. The Care Management Council (CMC), led by Dr. Hensing, oversees the CCGs and approves all clinical standards. Using this consistent approach, Banner produces an average of 10 to 15 new or updated clinical standards every quarter and deploys them simultaneously across the system.

Banner’s Care Management Infrastructure

Care Management Council
- consists of clinical executives and retains oversight of all care standard creation and deployment

Clinical Consensus Groups
- include multidisciplinary participants who develop system-wide care standards within a given clinical area

All 29 facilities “go live” with new care standards typically on the same day, with the help of system implementation experts

For more resources on this topic, visit advisory.com/pec/BannerClinicalStandardization
CCGs Evolve to Meet System Needs

Though the CCGs initially focused on reducing inpatient variation, Banner has expanded its purview to deliver reliable care across the continuum. For instance, they recently introduced Primary Care, Post-Acute Care, and Palliative Care CCGs.

Additionally, rather than just seeking CCG input on clinical standards, Banner is evolving the role of the CCGs. The CCGs now are consulted on resource stewardship decisions such as whether to adopt new drugs or devices. Plans are underway to evolve to version “CCG 2.0,” which includes CCGs in a broader set of strategic and operational decisions.

In essence, the CCGs are being positioned as the clinical “brain trust” of the organization that executives can call on whenever they need the physician point of view. It is a testament to Banner’s emphasis on physician leadership that it can create a governance mechanism like the CCGs that engages physicians in clinical and strategic decision-making, with real authority to enact change in the system.

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**Expanding the CCG Role**

“We are evolving the CCGs to the point where they are advisory beyond just clinical practice. They have a strategic role to help the system make rational clinical decisions. It’s an advisory role, not an authoritative role. But they do much more than clinical standardization.”

*Dr. John Hensing*

EVP and System CMO, Banner Health

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**Three-Phase Evolution of Banner’s Clinical Consensus Groups**

<table>
<thead>
<tr>
<th>CCG 1.0</th>
<th>CCG 1.5 (Current)</th>
<th>CCG 2.0 (Desired State)</th>
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<tbody>
<tr>
<td>• Define evidence- and consensus-based standards with emphasis on acute care</td>
<td>• Review all order sets within relevant specialty once per year</td>
<td>• Define consumer-centric PCP delivery model and use of APPs</td>
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<td></td>
<td>• Set peer review triggers</td>
<td>• Advise on application of precision medicine</td>
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<td></td>
<td>• Set volume requirements for proceduralists</td>
<td>• Define appropriate follow-up care recommendations</td>
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<td></td>
<td>• Participate in evaluation of emerging technology</td>
<td>• Build evidence-based standards for chronic illnesses</td>
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<td>• Test and publish on research hypotheses</td>
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<td></td>
<td></td>
<td>• Advise on ACO challenges (e.g., how to reduce use of psychotropics)</td>
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Results

Though Banner’s successes over the past decade cannot singularly be attributed to their organizational leadership model, leaders have guided the organization through a decade of financial growth and quality improvement. Banner has seen impressive results for their Pioneer ACO, far outpacing counterparts when it comes to population cost savings:

- **Total cost savings**: Realized $29 million and $35.1 million in Medicare savings over the expected benchmark in the 2014 and 2015 performance years, respectively.
- **Earned shared savings**: Earned $18.7 million and $24.5 million in shared savings payments from Medicare in the 2014 and 2015 performance years, respectively.
- **Quality scores**: Achieved fifth-highest quality score for a Pioneer ACO with 95% in the 2015 performance year, including year-over-year improvement from 2012.

Additionally, Banner’s success in reducing care variation has made a tremendous impact on quality and efficiency outcomes.

Clinical Consensus Group Initiative Outcomes

- **Elective Deliveries**: Reduced early elective deliveries across the system from 21.8% in 2010 to 5.2% in 2012.
- **CT Ultrasound Use**: Created a new process to use an ultrasound to diagnose pediatric appendicitis before using a CT scan.
- **Blood Utilization**: Reduced blood utilization in total knee surgeries from nearly 17% in early 2013 to 7% in 2014.
- **Delirium and Coma in the ICU**: Achieved 90% delirium-free and coma-free days among ICU patients in 2014.

Related Resources

To access all resources related to Banner Health’s care variation reduction strategy—including interviews with key executives and sample documents—please visit: [advisory.com/pec/BannerClinicalStandardization](advisory.com/pec/BannerClinicalStandardization)
Case in Brief

**About:** Cone Health is a six-hospital health system in North Carolina with three ambulatory care centers, three outpatient surgery centers, more than 100 physician practice sites, and a medical staff of 1,300 physicians. The Triad HealthCare Network (THN) is an ACO subsidiary of Cone Health ranked fifth in the 2016 quality rankings of the Medicare Shared Savings Program (MSSP). THN has participated in MSSP since 2012. In early 2016, THN was selected to participate in the Next Generation ACO Model.

**Executive leadership structure:** Cone Health’s executive leadership structure includes eight executives comprising the “enterprise leadership team,” six of whom report to the CEO. The enterprise leadership team includes two sub-teams: Continuum of Care, and Strategy and Support. Continuum of Care is led by a dyad consisting of the COO and a newly created role in the CCO. The Strategy and Support team is led by the EVP of innovation and transformation, the EVP of people and corporate services, the EVP of strategic development, and the chief financial officer.

**Physician executive leadership:** Cone’s senior-most physician executive, Dr. Mary Jo Cagle, is EVP and Chief Clinical Officer at Cone Health. As CCO, Dr. Cagle oversees the entire clinical enterprise. All physician entities report to her, including the medical group and Cone’s ACO. Dr. Cagle also oversees quality, case management, medical education, and pharmacy.

**Impact:** Since moving to their current executive leadership structure, Cone Health has become the top-performing hospital in the nation in acute myocardial infarction (AMI) readmissions and lowered the probability of 30-day readmissions in their high risk population from 75% to 13%. Executives also feel better positioned to advance their transition to population health through improved integration with the ACO.

**Executive Leadership Structure**

**Becoming a Continuum of Care Enterprise**

In 2014, Cone Health’s new CEO announced plans for a radical departure from their current organizational structure, which had become unwieldy after the addition of several organizations and functions. Leaders functioned largely in hospital-centric silos, with the system acting more like a holding company than an operating company. The CEO believed this structure was holding them back and aimed to develop Cone into a “continuum of care enterprise,” with greater coordination between hospital leadership and leadership of their ACO, the Triad HealthCare Network.

**Creating a United Clinical Operations Team**

In partnership with a subset of leaders, the CEO created a new “enterprise leadership team” consisting of eight individuals, including the CEO. Six report to the CEO, while the CNO reports to the COO. The team meets every week for three hours with an agenda developed by the chief strategy officer and reviewed by the CEO. The goal of the meeting is to focus on long-term strategy, intentionally excluding operationally-focused issues. Topics on the agenda include capital requests, management of new entity budgets, and big-ticket requests and proposals. The team assigns ownership of each item to ensure progress on next steps.
The new leadership structure divides all executives into two sub-teams: Continuum of Care, and Strategy and Support. The Continuum of Care team is co-led by the COO and CCO. The Strategy and Support team is led by the EVP of innovation and transformation, the EVP of people and corporate services, the EVP of strategic development, and the chief financial officer.

**Cone’s Leadership Structure**

The CCO role was defined by a select group of leaders including the COO and then CMO, Dr. Mary Jo Cagle (Dr. Cagle would go on to accept the CCO position in January of 2015). They developed the role with two main goals in mind: to unify clinical oversight for the entire continuum, and to better integrate clinical and operational functions.

With the first tenet in mind, they crafted the CCO role to unite the clinical enterprise through direct oversight of the medical group, physician organization, and the ACO. This includes responsibility for several risk contracts across the ACO, physician network, and Cone’s insurance product. Dr. Cagle also manages the system CMO, who is responsible for quality, safety, case management, infection prevention, employee safety, and medical staff issues. Dr. Cagle works with each team to develop and meet budgets each year. She also ensures competency among physicians and other clinical staff, and champions physician engagement.

In contrast to other systems with the CCO role, Cone decided to keep the system CMO in place. With the system CMO largely focused on inpatient responsibilities, Dr. Cagle has sufficient bandwidth to focus on cross-continuum integration and ACO performance.

Dr. Cagle’s oversight of the ACO and medical group in particular has accelerated clinical change across the system. Previously, the ACO reported to the EVP of strategic development, as it had originated as a new strategy within that office. Meanwhile, the

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**Modeling Clinical Operations Unity**

“We feel the dyad has been very successful. Our goal is to model for our teams what it looks like when you work well together across the continuum. It’s how we’d like them to work together.”

*Dr. Mary Jo Cagle  
EVP and Chief Clinical Officer, Cone Health*
medical group president previously reported to the CEO. Now that Dr. Cagle manages both, she can ensure the medical group is helping to advance the aims of the ACO. For example, Dr. Cagle was instrumental in identifying key drivers of member costs, and has helped orchestrate practice change among the physician enterprise to realize significant improvements.

Chief Clinical Officer: Select Responsibilities

- Set System-Wide Quality Priorities
  Establish clear quality improvement priorities that cascade across the ACO, hospital setting, and physician network

- Unify Physician Leadership
  Align the physician enterprise including the employed group, ACO, and physician network

- Promote Clinical, Operational Effectiveness
  Collaborate across clinical and operational leaders to ensure effective communication, execution of common goals

- Advise on Risk, Quality, Resource Use
  Advise Cone’s ACO, medical group, and medical staff on resource use, risk management, quality assurance

Partnering Clinical and Operational Leadership

In response to the second tenet of the role—integrating clinical and operational functions—Dr. Cagle partners with the COO in a dyad relationship. They work in the same office suite and meet every week for at least an hour. Initially, they consulted each other on every major decision. Over time, they have developed sufficient alignment in their approaches to know which decisions can be made in the absence of their partner.

The operational-clinical dyad model has been replicated across the organization in the ACO, physician network, and information technology. While hospital presidents do not have an official dyad partner, they work with nursing executives and physician roundtables to ensure representation of the clinical voice. Additionally, the COO-CCO dyad strives to imbue this integrated clinical and operational mindset across the Continuum of Care team.

In fall of 2015, the CCO-COO dyad assembled all their direct reports—the entire Continuum of Care team—at a retreat aimed at eliminating existing clinical and operational silos. They sought to encourage all team members—whether they reported to the COO or CCO—to think of themselves as one team. To help with this, they used the terminology “Team 1” and “Team 2.” “Team 1” now refers to the entire Continuum of Care Team, and “Team 2” refers to either the COO’s or CCO’s direct reports. The goal is for everyone on the team to prioritize collaboration across clinical and operational colleagues, rather than making decisions amongst their smaller “Team 2s.”
As a unified team, the retreat participants identified critical inflection points along the patient journey to achieve system goals. Never before had clinical and operational leaders considered the full continuum together, including hospitals, outpatient surgery centers, physician offices, home health, and nursing homes. They plan to make the retreat an annual occurrence.

**True North Goals Align Leaders Across the Continuum**

Cone’s enterprise leadership team sets annual True North Goals in the domains of patient safety, patient experience, operating margin, access, and team engagement. Cone previously set eight True North Goals, but leadership determined this number led to a diffusion of focus, so they now have five.

Goals are cascaded to all settings across the system. For example, within the patient experience domain, hospitals will be evaluated on HCAHPS scores, the emergency department on Press Ganey patient experience scores, and the medical group on “rate your provider” scores from CGCAHPS. This “horizontal” translation of goals across settings ensures alignment across all leaders.

Leadership incentives have evolved to emphasize the True North Goals. Previously, leadership incentives included both system and personal objectives. Now, incentives for directors and above are based solely on system-wide True North Goals.

**Clinical-Operational Leaders Share Accountability for True North Goals**

The CCO and COO launched a new accountability model to hold specific clinical and operational leaders jointly responsible for advancing True North Goals. After the retreat in 2015, they assigned each goal to a team comprised of one direct report from both the CCO and COO, in effect creating a dyad.

This shared accountability across clinical and operational leaders has yielded great results. For instance, a primary care physician leader and hospital nursing executive were assigned to Cone’s 2015 access goal: reduce the wait time for the third next available appointment. Together, the team uncovered opportunities to address lower acuity patients unnecessarily using the ED, and grow e-visits. As a result of their ability to work with leaders across sites, the wait time dropped from 30 days to nine.
The CCO and COO meet with leaders of the Continuum of Care team the first Friday of every month to assess progress toward True North Goals, identify systemic barriers, and develop action plans. The CCO-COO dyad also rounds twice a week, at a minimum, to connect with leaders across the continuum.

Results

Cone Health has made progress in the short 17 months since they restructured senior leadership and introduced the CCO role. In particular, Cone has seen improvement in readmissions rates and readiness for population health.

- **Readmissions improvement**: Cone Health’s flagship hospital, Moses H. Cone Memorial Hospital, has the lowest AMI readmissions in the nation, according to CMS data. Cone has also lowered the probability of 30-day readmissions in their high risk population (patients who have had six or more readmissions in the past 12 months) from 75% to 13%.

- **Population health readiness**: The leadership team also believes they are well-positioned to move forward on population health through their ACO. For example they are starting to analyze total cost of care data amongst the leadership team rather than this occurring largely just within the ACO.
Mercy Health

Case in Brief

About: Mercy Health is a Catholic health system in eight regions across Ohio and Kentucky. Mercy Health employs more than 34,000 employees and operates more than 450 points of care, including 23 hospitals, eight senior living communities, five hospice programs and seven home health agencies. Its ACO, Mercy Health Select, is a successful Track 1 MSSP participant.

Executive leadership structure: Mercy Health’s executive leadership structure brings together a diverse group of executives to ensure hospital, medical, and ACO perspectives are included in system decision making and operational execution. System-wide strategy is set by the eight-person “Lead the Ministry” team, led by the CEO. The CEO then relies on a CCO-COO dyad to oversee the “Operate the Ministry” team, responsible for system-wide strategy execution.

Physician executive leadership: Mercy Health’s senior-most physician executive, Dr. Anton Decker, is Chief Clinical Officer of Mercy Health and President of Mercy Health Physicians. As CCO, Dr. Decker co-leads the Operate the Ministry (OTM) team with the COO. The OTM team includes the president of the ACO, seven regional CEOs (who also serve as regional medical group presidents), and other system leaders.

Impact: After reconfiguring their leadership structure in early 2016, Mercy Health is seeing early successes, including greater integration of clinical and operational teams, and more nimble decision making.

Executive Leadership Structure

Integration of Hospital, Medical Group, and ACO Leadership

Historically, siloed decision-making between hospital, medical group, and ACO leaders led to uncoordinated efforts to improve care. For example, the hospital might invest in care coordinators to reduce length of stay, while the ACO might deploy care coordinators to help behavioral health patients avoid readmissions. As a result, the system was investing in duplicative—and sometimes conflicting—models to improve care. This fragmented approach made it difficult to achieve the system’s patient-centered goals.

Following the retirement of its longtime leader, Mercy Health appointed a new CEO in March 2016, who sought to eradicate silos and improve alignment across teams, while preserving rapid and effective decision making.

To that end, the CEO organized senior leadership into two cross-functional, cross-site teams: the Lead the Ministry (LTM) team, and the Operate the Ministry (OTM) team. The CEO oversees the LTM team, which focuses on system strategy, governance, and organizational design. Meanwhile, the OTM team is co-led by the CCO and COO, and is responsible for executing system strategy.

Eliminating Clinical and Operational Silos

“By integrating physician and clinical leadership at all levels of our ministry, we will remove silos, increase accountability, and create alignment around shared goals. This new structure will promote collaboration, coordination and communication. [...] Most importantly, it will ensure the patient remains at the center of everything we do.”

John M. Starcher Jr.
President and CEO, Mercy Health
Expedited Decision Making

“Before the new structure it took a week of phone calls and posturing to get a decision, but now we get the right people in the room, make the decision, and move.”

Dr. Anton Decker
Chief Clinical Officer, Mercy Health
President, Mercy Health Physicians

CCO-COO Dyad Operationalizes Strategy

Dr. Anton Decker accepted the role as CCO in 2016. In addition to his role as CCO, he maintains his prior position as president of Mercy Health Physicians (Mercy Health’s employed physician group). Brian Smith accepted the role of system COO at the same time, and the two serve together in a CCO-COO dyad for the system.

As mentioned above, they run the OTM team which includes the system CMO and president of Mercy Health Select (ACO), seven regional CEOs who oversee acute facilities and the medical group in their region, the chief strategy officer, and other key system operations and finance leaders.

Rarely does a physician executive have oversight for regional CEOs, which makes Mercy Health’s model particularly unique. It’s also noteworthy that the regional CEOs oversee the acute care facilities, as well as the medical group in their region. This ensures alignment between clinical practice in the ambulatory space and inpatient setting.

The OTM team meets monthly to learn system strategy decisions, and agree to next steps for implementation. Because this structure brings together all relevant stakeholders, it ensures no one can second-guess a decision at a later date, as all perspectives were considered in the original meeting and consensus reached. It also accelerates decision-making, as decisions can now occur in a single meeting instead of trying to secure support from hospital, medical group, and ACO leaders separately.
“From an inpatient-only perspective, the focus has been primarily on preventing readmissions. But when we break down silos and look at the total cost of care, it rewrites people’s heads and resets performance expectations.”

Brian Smith
Chief Operations Officer, Mercy Health

The CCO and COO make decisions together, allowing each leader to lend their relevant expertise. For example, regional CEOs present annual budget proposals to the CCO and COO in a single meeting, fielding questions from both. The CCO and COO offer revisions and sign off together. Once a decision is made, they communicate a consistent message so neither is viewed solely as the clinical voice or the operations voice.

Communicating System Priorities and Progress

Standardized Organizational Performance Scorecard

To further strengthen system alignment, Mercy Health implemented an organization-wide performance scorecard that organizes metrics into three pathways: amazing patient care, operational excellence, and creating the future. Each of these “Pathways to Success” translates into specific goals for each health system entity—Mercy Health Physicians, Mercy Health Select, and hospitals. This ensures leaders and physicians at each entity can explicitly see their contribution (and performance) in relation to system priorities.
Mercy Health broadly distributes the monthly scorecard to administrators and clinicians. A summary section at the front shares overall organizational performance, and subsequent sections cover performance by region. Within each region, entity-specific goals (outlined above in the table) are reported. Each region’s report also includes a brief but engaging story about a patient and clinician to reinforce the human element of these goals. As a result of this degree of personalized transparency, this scorecard is more likely to drive practice change across the system.

For example, as Mercy Health sought to engage physicians in cost efficiency initiatives, leaders realized physicians had little visibility into, or understanding of, their group’s financial and operational performance. The scorecards created transparency, and offered specific goals to work towards, particularly in the “Operational Excellence” pathway.

Results

Prior to the restructuring, Mercy Health Select was a successful ACO, generating more than $15 million in savings in 2014. In addition to greater integration between medical group, hospital, and ACO leaders, benefits of the restructuring include:

- **Nimble decision making** due to the convening of a small yet influential group of representative stakeholders.
- **Removal of silos** with full integration of the employed medical group and the ACO into the organization.
- **Integration of clinical and operational teams** at all levels across the organization, supporting rapid transformation of care delivery.

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Mercy Translates System Priorities into Entity-Specific Metrics

<table>
<thead>
<tr>
<th>Mercy Health Physicians</th>
<th>Mercy Health Select (ACO)</th>
<th>Hospital Campus</th>
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<tr>
<td><strong>Amazing Patient Care</strong></td>
<td><strong>Operational Excellence</strong></td>
<td><strong>Creating the Future</strong></td>
</tr>
<tr>
<td>- Press Ganey access to care&lt;br&gt;- Key primary care metrics (BP&lt;sup&gt;3&lt;/sup&gt; control, HBA1c&lt;sup&gt;2&lt;/sup&gt; &lt;9, Breast screen, Colorectal screen, Pneumo Vac, Nephro Screen)</td>
<td>- MTD&lt;sup&gt;3&lt;/sup&gt; mission support subsidy per provider FTE&lt;br&gt;- YTD&lt;sup&gt;4&lt;/sup&gt; total subsidy&lt;br&gt;- Key operational metrics (wRVU/Provider FTE, Visits/Provider FTE, Staff FTE/10k wRVU)</td>
<td>- EHP&lt;sup&gt;5&lt;/sup&gt; per member per month expense&lt;br&gt;• Medicare Advantage medical loss ratio&lt;br&gt;• EHP domestic utilization</td>
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<tr>
<td><strong>Operational Excellence</strong></td>
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<td><strong>Creating the Future</strong></td>
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<tr>
<td>- EHP&lt;sup&gt;5&lt;/sup&gt; per member per month expense&lt;br&gt;- Average inpatient length of stay&lt;br&gt;- ED admission length of stay&lt;br&gt;- Profit/loss per Medicare patient by condition (general surgery, heart failure, septicemia, TJR&lt;sup&gt;7&lt;/sup&gt;, Vascular surgery)</td>
<td></td>
<td>- Hospital occupancy rate&lt;br&gt;- Nursing vacancy rate</td>
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<td><strong>Creating the Future</strong></td>
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<tr>
<td>- MTD FTEs&lt;br&gt;- Q4 Headcount&lt;br&gt;- YTD net FTE provider recruitment versus target</td>
<td>- EHP visits for MHS&lt;sup&gt;6&lt;/sup&gt; PCP&lt;br&gt;- MHS PCP as % of all PCPs in market (s)</td>
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1) Blood pressure. 5) Employee Health Plan.<br>2) Hemoglobin A1C. 6) Mercy Health System.<br>3) Month to date. 7) Total joint replacement.<br>4) Year to date.
Texas Health Resources

Case in Brief

**About:** Headquartered in Dallas-Fort Worth, Texas Health Resources (THR) has 29 owned, joint-ventured, or affiliated hospitals. The system's primary service area consists of 16 counties in north central Texas. THR earned over $4 billion in revenue in 2015, and has more than 3,800 licensed beds and 23,000 employees. More than 5,500 physicians have active staff privileges at its hospitals, and Texas Health Physicians Group employs over 550 physicians and 300 nurse practitioners, physician assistants, and other advanced practice providers. THR also recently formed a clinically integrated network with UT Southwestern to provide increased access to primary care and specialty care for the people of North Texas.

**Executive leadership structure:** THR revamped its leadership structure in 2013 as it continued its transition from holding company to operating company. This included the recruitment of a new executive role, CCO, who reports up to the CEO in a system-level dyad with the COO. THR also divided the system into three zones, each covering a specific geographic area. Each zone aggregates all wholly-owned and affiliated assets and access points across the full continuum of care. Each zone is led by a dyad (consisting of a clinical and operational leader) that reports to the system CCO-COO dyad. Zone dyad leaders oversee facility-level leadership triads consisting of a hospital president, CNO, and CMO. This structure elevates physicians and other clinicians to leadership positions in which they share accountability for system transformation alongside operational counterparts.

**Physician executive leadership:** Dr. Daniel Varga is the Senior Executive Vice President and CCO for THR. In addition to overseeing THR’s system integration with the COO, he is responsible for fostering clinical leadership and engagement to redesign care across the continuum. This includes overseeing specific efforts to reduce unnecessary care variation and tightening alignment between physician contracts and system goals. Dr. Varga also oversees the newly formed Southwestern Health Resources physician network, part of the joint venture between THR and UT Southwestern.

**Impact:** The revised leadership structure better positions clinicians across the system to advance THR’s “Fresh AIR” principles of Accountability, Innovation, and Reliability—the principles they believe will transform care delivery for the communities they serve.

**Executive Leadership Structure**

*Executing on Fresh AIR: Affordability, Innovation, Reliability*

THR recognized its continued success would depend on creating added value for healthcare purchasers, consumers, and providers, as well as managing risk for the total cost of care. Thus, THR grounded its care transformation in three key consumer-centric principles called Fresh AIR: Affordability, Innovation, and Reliability. To execute on these principles in an integrated, cross-continuum manner, they decided to shed their traditional leadership structure and build a new one with greater clinician presence and collaboration across leader disciplines and levels. In 2013, the revised leadership structure took shape.

*Physicians Are Key to Affordability, Innovation, and Reliability*

“We realized the levers for us to engage in ongoing transformation and innovation, and to improve the health of our communities was more and more dependent on AIR, and there was only so much that classically trained administrators could do to pull those levers. We determined it would become increasingly critical to engage physician executives and other clinical leaders in this effort.”

*Dr. Jeffrey Canose*

*Chief Operations Officer, Texas Health Resources*
Creating Clinical-Operational Partnerships at All Levels

THR’s new leadership structure creates deliberate partnerships between clinical leaders and their operational counterparts at all levels. A clinical-operational dyad (or triad) exists at the system, zone, and facility levels:

- **System level**: A system-level CCO-COO dyad reports jointly to the CEO. The CCO and COO’s job descriptions explicitly task them with shared execution of THR’s strategic plan with respect to clinical integration and care redesign, among other joint responsibilities.

- **Zone level**: Each of the three regional zones includes a zone clinical leader and a zone operations leader who report to the system CCO and COO, respectively.

- **Facility level**: At the facility level, senior leadership consists of a hospital president, CMO, and CNO. The CMO reports to their respective zone clinical leader, while the hospital president reports to the zone operations leader. The CNO reports to a system level chief nursing executive who reports to both the system CCO and COO.

The facility triad structure places clinical leaders (both CMO and CNO) on the same level as the hospital presidents. This not only sends a strong signal of the importance of clinician leadership—it also ensures more inclusive decision-making.

This structure also ensures physician leaders report to physicians, from the facility through the system level. This ensures system leaders are aware of frontline innovations and issues. This vertical alignment also allows for more consistent communication and execution of the system’s strategy for care delivery and clinical performance.

Texas Health Resources Organizational Structure

[Diagram showing the organizational structure of Texas Health Resources]
Crafting Clear Dyad Roles

Two common pitfalls plague dyad leadership models—unclear ownership of responsibilities and a lack of clear expectations for collaboration. The result is dyad partners working in their traditional silos as usual or failing to execute on initiatives due to unclear accountability. THR guards against this by employing the OVIS model to determine who Owns, Vetoes, Influences, and Supports each activity among the dyad (and triad) roles.

A task team of key representatives from the facility triads and zone dyads led the OVIS discussion to define explicit functional responsibilities and accountabilities for each role. They drafted a proposal which was vetted through a Triad Council that included the triads from each hospital, as well as by the System Leadership Council consisting of the CCO, COO, chief nurse executive, chief information officer, chief medical information officer, and the three pairs of zone clinical leaders and zone operations leaders. As a result, every role has a consistent function in the OVIS model.

Additionally, the CCO-COO dyad is financially incented on identical key performance indicators (KPIs), cascaded to zone dyad and facility triad leadership. The CCO-COO dyad is incented 100% on shared system-wide KPIs. Zone clinical leaders and zone operations leaders are incented on these same KPIs, with 50% of rewards based on system performance and 50% based on their zone performance. Similarly, the facility triad incentive structure links 50% of the payout to zone performance, and 50% to their unique facility’s performance. As such, leaders are incented to maintain a careful balance between their immediate sphere of control and broader system goals.

Every week the CCO and COO meet with zone leaders and other senior executives to ensure they are executing across their KPIs and share best practices.

Shared CCO-COO Key Performance Indicators for 2016

- Four patient satisfactions scores from Press Ganey
- Deployment rate for high reliability training
- Readmission rate
- Mortality (observed to expected ratio)
- Hospital acquired infection rate
- Four accountable care measures from the employed physician group
- Operating margin
- Cost per adjusted discharge
Strategic Alignment of the Entire Physician Enterprise

“We believed the physician enterprise needed to be completely redesigned and coordinated under a single executive.”

Dr. Daniel Varga
Chief Clinical Officer, Texas Health Resources

PEAT Structure Develops and Aligns System Physicians

Since assuming the CCO role in 2013, Dr. Varga has focused significant effort towards aligning the entire physician enterprise—employed and affiliated doctors alike—with system goals.

The primary vehicle for doing so is the newly-formed Physician Enterprise Alignment Office (PEAO). The vision of PEAO is to, “make Texas Health Resources the network of choice for high quality physicians and ensure the physician network and hospital network are equal partners in shaping and achieving Texas Health’s overall strategy.” The Physician Enterprise Alignment Team (PEAT) is responsible for operationalizing this vision.

PEAT’s primary responsibilities include:

- Aligning performance specifications (such as Minimum Work Standards) and incentive goals for all physician contracts, including physicians employed by the Texas Health Physicians Group (THPG);
- Reviewing all physician contracts and agreements for strategic and business alignment; and
- Developing the strategic physician workforce plan and recruitment efforts to ensure physician network adequacy for managing a greater number of risk contracts.

PEAT is jointly overseen by the CCO-COO dyad, and includes the CFO, zone clinical leaders, the president of THPG, the SVP of strategic planning, and the physician enterprise executive leader.

This new structure is striking in its ability to consistently unite the entire physician enterprise in pursuit of common goals. Previously, all contracts, including employment contracts, physician service agreements, co-management agreements, medical directorships, call coverage agreements, and other hospital-based physician contracts, were reviewed locally to ensure regulatory compliance. Though this fulfilled each facility’s requirements, these contracts did not necessarily align with system goals. Now, all new contracts—and contracts up for renewal—are reviewed for strategic alignment. For example, to support THR’s AIR goal of Reliability, all contracts now include minimum training requirements on high reliability.
Physician Enterprise Alignment Team Aligns All Physician Agreements through Strategic Review Process

All physician agreements (new, replacement or renewal) reviewed by PEAT to align with system priorities

Agreements verified against system physician workforce plan to ensure network adequacy, system need

Greater performance accountability and incentive alignment across physician enterprise

Additionally, PEAT is critical for success in risk-based contracting, as it ensures physicians within the risk-bearing network are incented on goals that will help THR succeed within their payer contracts.

Results

The executive team believes THR’s ability to become an affordable, innovative, and reliable enterprise hinges on greater physician collaboration and alignment, both of which are bolstered by THR’s new leadership structure. Additionally, THR has achieved greater system integration through the following changes:

• A greater number of enfranchised physician leaders at all levels, leading to increased participation in system transformation efforts
• All physician leadership roles aligned with and incented on system goals
• Aligned physician relationships across the enterprise that reinforce THR’s strategic priorities and network needs
Advisors to Our Work

With Sincere Appreciation

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Judy Schanel  
Executive Vice President  
Chief Operating Officer

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Brian Smith  
Chief Operating Officer

**Texas Health Resources**

Barclay Berdan  
Chief Executive Officer

Dr. Jeffrey Canose  
Chief Operating Officer  
Senior Executive Vice President

Dr. Shawn Parsley  
President, Texas Health Physicians Group

Dr. Daniel Varga  
Chief Clinical Officer  
Senior Executive Vice President
Want more on **physician leadership**?

This study is a publication of the Physician Executive Council, a division of Advisory Board. As a member of the Physician Executive Council, you have access to a wide variety of resources, including webconferences, studies, toolkits, our blog, and more. Check out some of our other publications on physician leadership for clinical transformation.

<table>
<thead>
<tr>
<th>White paper: Building the Physician Leadership Team of the Future</th>
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<td>Health system executives nationwide are beginning to reimagine physician leaders’ roles to support changing organizational goals. This white paper, with a companion discussion guide, is designed to facilitate conversations among health system stakeholders to develop an approach to growing, integrating, and reimagining physician leaders’ roles in system transformation.</td>
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<th>White paper: Realizing System-Wide Clinical Standardization</th>
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<td>This white paper and accompanying discussion guide aim to help organizations create a culture and infrastructure to reduce unnecessary care variation. The white paper explores key elements of Banner Health’s clinical transformation, including their vision for reliable care, robust clinician-led infrastructure, and medical staff management.</td>
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<td>Consult this white paper for in-depth case studies and implementation tips from three organizations that have successfully standardized medical staff bylaws. Then use the accompanying discussion guide to help appropriately scope your organization’s bylaw standardization effort.</td>
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