Six Transformation Goals for the Change-Focused CMO
Your mandate: Speed up the pace of change.

Today’s CMOs have a new normal. Their responsibilities span not only traditional hospital spheres such as medical staff leadership and conventional “quality improvement,” but also new terrains like population management, care coordination, and clinical IT. They are setting a new care standard, even in the grey areas of medicine where no clear guidelines exist today.

Most CMOs understand the challenges ahead and are making real progress. The problem is that many are not making progress fast enough. Powerful external forces, such as downward margin pressures and accelerating growth of performance-based narrow networks, are at work.

They add up to a market in which some hospital organizations—even ones solidly on an improvement track—will be left behind.

To meet the aggressive and unforgiving timeline for change, hospitals will need medical staffs that act as partners in change agency. And this type of resilient, improvement-oriented medical staff will not build itself.

CMOs must purposely create the cultural and operational platform to enfranchise all physicians as transformation leaders, elevating their personal performance and creating systems that raise performance among their peers and broader teams.
We’ve identified **six goals** to guide you in rapid transformation.

Working for and with CMOs, we have distilled our 2014–2015 research into six concrete goals. Each is supported by additional Physician Executive Council resources that are part of your membership. We can also support you directly in your efforts. And if you’re looking for strategic advice, more detail, or just a sounding board, we look forward to hearing from you.

1. Understand what future health care purchasers will be looking for

2. Prioritize the care variation opportunities with greatest quality and cost-avoidance ROI

3. Modernize individual physician leadership roles

4. Upgrade and expand clinical leadership structures

5. Open channels to communicate with 100% of your medical staff

6. Build will for clinical transformation among your C-suite and board

For more information, email Amanda Berra at berra@advisory.com
Imagine a mash-up of payer-driven performance risk and consumer-oriented retailization. That’s your future marketplace.

Sweeping change in insurance coverage and the way consumers use health care services add up to a whole new marketplace for hospital services. To survive and thrive there, organizations must simultaneously win share of volumes by getting selected at the point of care by an increasingly cost-exposed, price-sensitive patient and secure enrolled lives by making themselves attractive to those assembling narrow networks and those selecting plans.

Degree of Hospital Exclusion Across Public Exchange Plans
20 Urban Markets, December 2013

Network assemblers prioritize affordability, geography, scope of service, and quality. While others in the C-suite work on scope of service and geography, CMOs have a critical role to play in positioning the organization to make the cut on both affordability and quality. The clinical transformation work they lead is essential to both.

- **Reducing unwarranted cost variability** in acute care services is fundamental to delivering (sustainable) lower unit prices in a fee-for-service world—and can help lay the groundwork for controlling total cost trends through lower overall utilization across the continuum.
• **Improving patient outcomes** is the right answer no matter how broadly you define “quality.” Differentiate your organization from competitors on quality and cost by reducing complication rates, lowering ICU and overall LOS, and ensuring patients’ needs are being met.

The harsh reality is that there are very few indispensable hospitals or health systems out there, and all provider organizations are scrambling to gain an edge. **The most important thing the CMO can contribute is to successfully partner with the medical staff to lead clinical standardization and increase the rate of practice of evidence-based medicine.** The pace cannot be slow and incremental over time—it has to be rapid and pervasive enough to build the kind of organization that can meet the demands of the market—now and in the future.

To meet this mandate, you will need to:

- **Initiate conversations about resource stewardship with the medical staff**
  Both hospitals and physicians will be selected, at least in part, based on cost and price. Physicians unwilling to engage on cost challenges risk losing access to both wholesale and retail volumes.

- **Expand your discussions of quality to include access and service**
  Traditional clinical quality metrics matter mainly to network assemblers and will remain paramount. But the definition of quality must expand as retail purchasers presume quality and base decisions on cost, reputation, and availability.

- **Develop an understanding of consumer preferences**
  With competition from retail providers, hospital organizations must develop more sophisticated approaches to product design and development, based on a granular understanding of consumer preferences. Physician executives must incorporate this perspective into discussions of care protocols and patient experience.

- **Design a physician leadership infrastructure that reinforces your strategy**
  You must shape physician leadership roles with the end in mind; the physician enterprise should lead the rest of the organization in repurposing existing assets for new strategic imperatives.
GOAL 2: Prioritize the care variation opportunities with greatest quality and cost-avoidance ROI

Analyzing cost variability isn’t just about finding savings; it’s a way to detect systematic clinical quality shortfalls.

When it comes to reducing care variation, CMOs have too little time and too many “opportunities.” Clinical leaders and staff are stretched thin across a huge spectrum of initiatives, looking at everything from care paths for broad patient populations to rationalizing use of specific resources (like blood, implantable devices, or imaging).

Cost variability, linked to cost-avoidance ROI, can be your compass for prioritization. Not because capturing the financial upside of standardization is the sole, comprehensive, or even most important consideration when it comes to assessing opportunities, but because cost variability is a powerful way to analyze quality and cost together.

Variation in cost per case (or its defensible proxy, charges) is closely linked to variation in quality:

• **Excessive cost variability** among clinically similar patients signals randomness in the delivery of medicine. Either no comprehensive standard exists—or clinicians are not adhering to the standard.

• **Cost per case variability is linked** to variability in patient outcomes, especially high complication rates. Complication rates, ICU use, and excessive length of stay are all typical drivers of cost variability and all suggest problems in quality of care.

• **Because it is a roll-up metric** that spans clinical areas (each of which has different metrics for measuring clinical quality), cost variability is extremely helpful in hot-spotting unnecessary care variation across a wide range of disparate services and patient populations.
Introducing the Care Variation Shortlist: Methodology in Brief

To identify the greatest opportunities for care standardization in acute care today, Physician Executive Council researchers partnered with the data scientists of Advisory Board Research and Development to analyze Crimson Continuum of Care data.

The Crimson data gave us a nationwide all-payer sample of more than 600 hospitals, representing approximately 25% of all inpatient admissions. To flag unwarranted variation, we force-ranked DRGs with the greatest physician-level variation, first measuring and then aggregating differences among “like” cases within the same facility to avoid noise (like differences in chargemaster or geographic practice patterns).

Force-ranking DRGs by greatest overall variability created an initial “top opportunity” list, which we then cut further by considering feasibility. Of all the hugely variable areas of medicine, where could a typical acute care-focused CMO in a hospital or health system today most likely find avenues for immediate improvement?

The resulting list represents today’s greatest care standardization targets in acute care—the largest, most actionable opportunities for clinical leaders to improve quality and capture cost-avoidance ROI at the same time, right now.

Turn Page for the Full List
The Care Variation Shortlist

Your most important, actionable opportunities to curb care variation:

1. **Heart Failure**
   The ever-changing guidelines for HF incompletely guide care for a clinically complex population. Engaging physicians to develop consensus and providing better information to clinicians at the point of care will make a huge difference here.

2. **Sepsis**
   Existing guidelines pose many operational challenges to providers working to deliver the right care in time. Yet some organizations have found ways to formalize identification, accelerate treatment, and hardwire accountability.

3. **Hip and Knee Replacement**
   Completely aside from opportunities in standardizing device costs, excess LOS and ICU use are driven by issues in clinical quality. Emerging models like the Perioperative Surgical Home aim to address these challenges.

4. **Labor and Delivery**
   Intensifying focus on quality and safety in both vaginal and caesarean delivery will not only improve outcomes and reduce direct costs—they can also drastically reduce malpractice liability.

---

**Conditions That Missed the Cut: Very Variable, Just Not as Actionable**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>Total volume not as great as other conditions on the list—except in high tobacco-use states.</td>
</tr>
<tr>
<td>Percutaneous vascular procedures:</td>
<td>Total hospital volume not as great as other conditions.</td>
</tr>
<tr>
<td>Psychiatric DRGs:</td>
<td>Improvement lever relates to outpatient infrastructure; difficult for inpatient-based CMOs to inflect in most delivery systems today.</td>
</tr>
</tbody>
</table>
Featured Resources

**TOOLKIT**
Heart Failure Toolkit: Resources for Reducing Variation in the Acute Care Setting
[advisory.com/pec/heartfailuretoolkit](advisory.com/pec/heartfailuretoolkit)

**STUDY**
Ten Imperatives to Reduce Sepsis Mortality: A Playbook for Elevating Sepsis Care
[advisory.com/pec/elevatesepsiscare](advisory.com/pec/elevatesepsiscare)

**ON-DEMAND WEBINAR**
Using the Perioperative Surgical Home to Improve Joint Replacement
[advisory.com/pec/webcon/surgicalhome](advisory.com/pec/webcon/surgicalhome)

Research on Raising Quality in Labor and Delivery Forthcoming in 2015

**BLOG**
Sign up for the PEC blog “Prescription for Change” to stay apprised of new resources.
[advisory.com/pec/blog](advisory.com/pec/blog)
Beyond Prioritization: How Can You Build a Change-Hardy Clinical Workforce?

Prioritization can help, especially in making the greatest bang-for-buck progress in the immediate term, but ultimately clinical transformation must still encompass all the many initiatives that today are creating so much noise in quality improvement.

Clinicians Facing Burnout

“Requiring health care providers to improve on all mandated measures at once, in an atmosphere of reduced reimbursements and frequent staff shortages, is a goal that risks burnout, discouragement, and apathy—all signs of initiative fatigue.”

Brooks JV, et al.,
The Dangers of Quality Improvement Overload, Health Affairs Blog
Knowing that clinical transformation is a marathon, not a sprint, CMOs must focus on building a change-hardy clinical workforce. Of all the many lessons learned in building an agile, resilient medical staff, three stand out from our conversations with CMOs this year.

**Obstacle:**

Low-value, duplicative, or vague physician leader roles across the organization don’t set up those leaders to act as a high-performing team capable of delivering on modern hospital organization goals.

Organizations must engage all physicians, not just those in formal leadership roles, to pitch in on the complex, controversial work of setting, harmonizing, and continuously refining clinical standards.

Hospital executives may be reaching highly engaged “go-to” physicians, vocal outliers, and those in leadership roles, but they aren’t getting high-priority messages out to the “silent majority” of physicians, who, paradoxically, feel uninformed and not heard, continuing a cycle of unengagement.

**Solution:**

Redesign your physician leadership roles

Upgrade and expand your clinical leadership structure

Build a functional platform to communicate with 100% of your medical staff

Now, let’s take a closer look at these building blocks, each a critical prerequisite to creating a change-capable medical staff.
It doesn’t matter how much time or money you spend to develop physician leaders if you don’t have the structure to support them.

We all agree that physician leadership is critical to achieving organizational short- and long-term goals. Virtually all hospital organizations are investing heavily to build that bench, deploying internal and external training and educational resources to create a robust pipeline of well-prepared physician leaders. Our 2014 Physician Leadership Survey revealed that, on average, hospitals spend $100K annually on physician leadership training, with some investing as much as $500K each year.

Yet today’s reality is that many physician leaders struggle to achieve goals or make a meaningful difference. And CMOs nationwide frequently share frustrations with the performance of the physician leadership team as a whole.

Many CMOs Questioning the Value of Physician Leadership Investment

“We are spending $2.2M annually on medical director stipends. And for what? It is not clear what any of them are actually doing.”

“Everyone is off doing basically whatever they want to do.”

“Honestly, I’d like to fire everyone.”

“Some of my department chiefs are highly resistant to instilling proven quality improvement practices in their units.”

“We do have some really talented and engaged leaders. Sometimes I’m not sure I have them in the right place to make a difference.”

A large part of the problem stems from the legacy physician leader roles that have layered onto one another over time, forming an unwieldy, ill-defined, and duplicative leadership structure—a structure that no executive would come up with as the best way to achieve today’s aims. Even the best-prepared, most motivated and talented individual will struggle in a dysfunctional system.
The good news? Executives and boards across the country are beginning to ask the same questions: How could we achieve change? And what would a comprehensive, streamlined, and effective physician management structure look like?

Health systems redesigning their physician leadership structures are solving for many problems at once, but they all boil down to five common goals:

1. Raise the standard of care
2. Build and lead service lines
3. Promote systemness across acute care facilities
4. Manage the care continuum
5. Integrate facilities, medical group, and CI network
Roles Taking One of Two Paths: Leading Change or Governing

We need physician leaders for two very different types of work: governance and leading change toward the delivery system of the future. And different-in-kind work may require two different types of physician leader roles. To succeed, they’ll each need different kinds of individuals and explicit role definition.

- **Primarily Leading Change**
  - Preparing for population management and risk contracting
  - Building cross-continuum service lines
  - Reducing care variation
  - Spearheading initiatives to implement new care models

- **Primarily Governing**
  - Quality assurance of staff and processes
  - Recruitment and retention of high-quality staff
  - Leading research and teaching
  - Representing physician interests and concerns

When this split occurs, CMOs, cross-continuum service line leaders, and in some cases, medical directors, tend to be the ones asked to lead change, while VPMAs, department leaders, and the Medical Executive Committee are asked to govern the existing system.

Organizations Professionalizing Physician Leader Roles

All physician leaders wear two hats, balancing clinical and leadership responsibilities, often feeling that this dual focus is critical for staying clinically up to date and maintaining credibility among peers. But perhaps because of that dual-identity, organizations have long hesitated to give physician leaders the same leadership supports—and accountabilities—given to other types of leaders.

Ensure your physicians have the skills and goal-oriented accountability your organization would provide to any other high-potential (non-physician) leader, especially:

- **Role scoping**: Clearly defined mandates, sized for that leader’s bandwidth, along with matching authority, to focus their leader work on the areas where they can have the greatest impact.
• **Project management:** Necessary training, resources, management toolkits, and upper-level management support provided to leaders for execution on unit-level and organization-wide initiatives.

• **Performance management:** Clear direction and substantial accountability against concrete goals linked to organization-wide priorities.

• **Coherent leadership structure:** Reporting lines and organizational structure road maps to help individuals, divisions, and entities relate productively to one another.

**Systems Using Physician Leadership Redesign to Build Systemness**

Once you have optimized individual roles and properly supported individual performers, it’s time to look at the higher-level problem: overall organizational design. Despite their attempts at integration, most health systems (and even stand-alone hospitals) still struggle with “systemness,” because of fragmentation that affects everything from contract negotiations to cost containment—and, especially, your patients.

In response, forward-looking organizations are envisioning the leadership structures they need to deliver on future goals and adapting in that direction. They are using a redesign of the leadership structure as a way to change the DNA of the clinical delivery system as a whole.

The pace of change in physician leadership structures varies, with some opting for incremental changes and others quickly overhauling and creating new structures.

**Featured Resource**

Our publication and discussion guide, *Building the Physician Leadership Team of the Future*

• Outlines several major trends reshaping how physician leaders are deployed in health systems today

• Facilitates conversations among physician leaders, executives, and the board on the evolving role of the physician leader
Evolve and expand clinical leadership to build a culture of evidence-based practice.

Expanding and better supporting the work of organization-wide clinical leadership groups in setting, refining, and rolling out evidence-based guidance can make a tremendous difference in achieving real change. Such groups need greater authority, resourcing, and cross-organization representation in order to be able to rapidly deploy robust new clinical standards and achieve broad adoption across diverse services and settings.

A group that can lead adoption of today’s best-established evidence-based guidelines can also take on the necessary next goal: Acting as a platform for clinical leaders to define and implement a higher “right-care” standard, meaning a standard that includes the principles of high-quality practice, reasonable consistency across providers, and resource stewardship. In many cases, that means creating a unified approach even where no fully vetted guideline yet exists.

It’s an ambitious reach, but one that some hospital organizations have made. Their experience and results help us understand the power of strong clinical leadership bodies to transform culture and bring providers together around the vision and challenging daily work of delivering high-quality, safe care to every patient every time.

**Desired Evolution of Physician Practice**

<table>
<thead>
<tr>
<th>Self-Directed Medicine</th>
<th>Evidence-Based Practice</th>
<th>Right Care</th>
<th>Shared Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians practice according to own training and knowledge, yielding dramatic variations in care</td>
<td>Physicians practice according to the most up-to-date clinical evidence, yielding greater standardization where evidence exists</td>
<td>Physicians practice EBP², and even where the evidence is unclear, physicians identify and weed out unwarranted variation and excess costs of care</td>
<td>Physicians incorporate costs of care into shared decision-making conversations with patients</td>
</tr>
</tbody>
</table>

Cost-conscious physicians practice at this end of the spectrum
Banner’s Commitment to Reducing Variation Yields Returns

Banner Health, a 25-hospital nonprofit health system headquartered in Arizona, has built a clinical governance structure to support its philosophy of reliable, right-care delivery.

In the early 2000s, the system—which has approximately 1,000 employed and 8,000 affiliated physicians—committed to system-wide clinical standardization as a means to improve quality and reduce unnecessary care utilization. To support this endeavor, Banner built “Care Management,” an infrastructure with strong clinical leadership committed to developing and implementing system-wide standards of care.

The approach has contributed to improved quality outcomes and financial growth (from $2B to $5B in annual revenue) over the past 15 years.

Banner’s System-wide Clinical Leadership Engine

**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 25 facilities** “go live” with new care standards on the same day, with the help of system implementation experts.

What can we learn from Banner? Three critical components ensure this structure delivers a culture of evidence-based practice:

**Authority**: Physician leaders in the clinical consensus groups have the power to set the care standard for the system.

**Inclusivity**: All facilities are represented, and good ideas are sourced from anywhere and everywhere across the system. Interdisciplinary experts and diverse specialists are always consulted along the way.

**Resources**: Banner supports its clinicians with process engineers and project managers to guarantee an efficient process and usable guidelines—and to ensure the group’s clinicians are investing their scarce time in making only top-of-license contributions.
You’ve accepted that you can’t reach every physician—but you shouldn’t.

If you ask CMOs how they get priority messages out to 100% of the medical staff, the answer is “we can’t.”

Despite lots of one-on-one meetings with leaders and vocal objectors, as well as extensive broadcasting via emails, newsletters, and more, your messages are not reaching the “silent majority” of physicians. These physicians, in turn, feel uninformed and unheard, touching off a cycle of disengagement.

There are four main pitfalls in health system–physician communication:

- **Under investment:** Despite its critical importance, organizations often lack the staff and channel infrastructure to support a scalable communication strategy.

- **Static channels:** Organizations continue using legacy communication channels despite physicians shifting their attention towards different, mobile-centric channels.

- **One-way messaging:** Physician-administration dialogue is limited to select cohorts of physicians—most physicians do not engage in meaningful dialogue.

- **Hospital-centric tone:** Messages are often not curated or scripted to reflect the physician point of view.

But of all the communication mistakes made by hospital leadership, the greatest is writing it off.

Hospital organizations can interact productively with the entire medical staff—and to execute on major strategic goals, they must.
How to Build a Stronger Communication Platform

1. Invest in a platform with functional channels to reach all physicians.

2. Put staff at the helm who are savvy about both communication and the world of physicians.

3. Create a strategy to match each message to the right channel—and curate messages in each channel so that (only) the important items get through.

4. Make sure the content of your messages appeals to physician interest and motivators. We call this tapping into the physician WIFM—the “what’s in it for me?”

5. Find innovative ways to break through the noise by packaging messages in ways that have been demonstrated to get physicians’ attention.

6. Build new channels for constant, meaningful dialogue. For example, administer frequent, highly targeted surveys on topics meaningful to physicians.
GOAL 6: Build will for clinical transformation among your C-suite and board

CMOs cannot effectively lead quality “from the middle.” Ultimately, the CEO and board hold the keys to brisker, broader progress.

Many CMOs today act as the executive team’s lead advocate for making rapid, transformative progress on clinical standardization in partnership with the medical staff.

Increasingly, we hear CMOs are developing a partner on the executive team: the CFO. CFOs are wading further into clinical terrain than ever before, working to understand the inextricable link between cost and quality.

Yet commitment to quality as a top organizational priority is still inconsistent at the CEO and board level.

▷ Quality Often Not Top Priority

*Hospital Board Chairs Ranking Quality Among Top Two Priorities*

▷ Many Boards Cannot Assess Their Organizations’ Quality

*Hospital Board Chairs Ranking Their Hospital’s Quality As “Above Average”*
Among CMOs nationwide, there is an observable “haves/have-nots” split—the difference being whether executives and the board truly prioritize quality improvement. CMO time allocation varies greatly on either side of that dividing line.

At organizations with more token support for quality among hospital or health system executive leadership, quality improvement projects tend to be grassroots-oriented, and narrowly scoped. Many are characterized as “pilots,” with different parts of the organization free to adopt or not adopt models as they see fit. The cumulative result: slow and uneven progress. CMOs who work at these organizations spend a large share of their time making the case to the CEO and board to prioritize quality and invest in needed resources.

In contrast, some CMOs work at hospital organizations where quality has been made the top priority. These organizations:

- **Create and empower** organization-wide clinical standardization groups with enough authority to make real changes.

- **Resource standardization and quality improvement** teams with all needed supports—IT, training, administrative support, clinical champions, and process engineering expertise.

- **Explicitly accept short-term financial hits** for the sake of advancing long-term quality improvement goals—for example, demonstrating willingness to let even high revenue-generating physicians “walk” if they cannot practice in ways that advance organizational efforts to set a consistent standard of care.

At organizations with a long-standing quality focus, less CMO time is spent on advocating for or standing up a platform for improving quality. More is spent on next-generation challenges, such as helping build an infrastructure for effectively managing population health.

---

**Only organizations whose CEO and board explicitly prioritize quality can make rapid and pervasive gains organization wide.** As markets evolve to reward both payer and consumer-facing value, those gains will likely make or break the organization’s chances for long-term success.
LEGAL CAVEAT
The Advisory Board Company has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and The Advisory Board Company cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, The Advisory Board Company is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member’s situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither The Advisory Board Company nor its officers, directors, trustees, employees and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by The Advisory Board Company or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by The Advisory Board Company, or (c) failure of member and its employees and agents to abide by the terms set forth herein.
Sources
All Pages: Physician Executive Council interviews and analysis.

Footnotes
1) Comparing products by the same carrier of the same tier, across 7 carriers.
2) Evidence-based practice.