

[CASE STUDY]

January 18, 2012

Moving toward Bundled Payments – Physician Leadership as a Core Competency: A Case Study of Aurora Health Care

Prepared for the Centers for Medicare and Medicaid Services



QUALITY. INDEPENDENCE. IMPACT.

B | ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

MITRE

Foreword

The Centers for Medicare & Medicaid Services (CMS) requested that The MITRE Corporation (MITRE) create three case studies in order to support organizations that want to provide services using bundled payment (BP). CMS selected three sites, each one illustrative of a set of capabilities necessary for an organization to deliver cost-effective care in a setting where it bears financial risk for that care. The Engelberg Center for Health Care Reform at the Brookings Institution (Brookings) worked with MITRE to generate the case studies, conducting interviews with organizational leaders and affiliate experts from the case study sites, as well as performing a comprehensive environmental scan of peer-reviewed journal articles, white papers, and publicly available evaluation reports from past BP pilots to inform the studies.

This case study focuses on Aurora Health Care and describes how the health system developed physician leadership. This leadership was necessary for the organization to engage in strategic initiatives around care delivery transformation, which would subsequently allow it to position itself to thrive in a value-driven marketplace.

Brookings and MITRE gratefully acknowledge the valuable contributions of the following experts from Aurora Health Care and its affiliates in the preparation of this study:

- Jackie Gisch, RN, Director of Care Management, Aurora Health Care
- Brent Phillips, Chief Operating Officer, Aurora Medical Group
- Patrick Falvey, Ph.D, Senior Vice President & Chief Integration Officer, Aurora Health Care
- Michael Marshall, M.D., M.M.M., Vice President Medical Operations, Aurora Health Care
- Myrle Croasdale, Public Affairs Manager, Aurora Health Care

Contents

Foreword	2
1. Introduction	4
2. Background	4
3. Physician Engagement and Leadership	4
3.1. Using Data to Create a “Burning Platform”	5
3.2. Building and Resourcing Formal Leadership Capacity.....	6
3.3. Supporting Physician Leaders and Practitioners with Information and Tools	7
3.4. Communicating Consistently and Bi-directionally	8
3.5. Aligning Incentives—Compensation Model Innovation.....	8
4. Conclusion	9
5. Acronyms	10

Figures

Figure 1. Sample State of the Union Presentation Material.....	5
Figure 2. Sample Individual Physician Report.....	8

1. Introduction

Aurora Health Care (AHC) is an integrated, not-for-profit health care system serving communities throughout eastern Wisconsin and northern Illinois. AHC operates 15 hospitals, more than 200 clinics, and 82 retail pharmacies. It employs more than 30,000 caregivers, including 1,400 physicians and 600 advanced practice providers. In 2010, AHC treated 1.2 million individuals, saw more than 3.6 million ambulatory care visits, and processed more than 92,000 inpatient discharges.¹ Although many providers are employed by AHC, the organization also contracts with a number of primary care and specialty providers and for services supplied by specialized children's hospitals.

To date, AHC does not operate under bundled payment (BP) contracts. However, AHC has prepared for what it believes will be a shift away from traditional fee-for-service reimbursement toward models that create incentives for more coordinated and higher-value care, under which payment will be more tightly linked to performance, quality, and efficiency. AHC and its leadership have invested significant time and capital to prepare the organization for changes to payment, including shared savings and BPs. A central component of AHC's effort to succeed under new payment models has been the development—and the execution—of a comprehensive strategy to engage AHC physicians in the redesign of care. Under these new payments models, physicians are considered critical to successfully delivering coordinated, evidence-based care that eliminates waste and inefficiencies while improving quality and reducing costs. AHC views physician leaders as essential to capitalizing on the opportunities available through care redesign.

This case study considers how AHC has engaged physicians and developed physician leaders to support care delivery innovation and the organizational competencies that were essential to accomplishing that objective.

2. Background

AHC has evolved into a fully integrated health care system over the last 20 years, during which it has acquired and integrated primary care and specialty practices, clinics, and retail pharmacies driven by the belief that “integrated care is a better way to provide health care.”² More recently, AHC has developed innovative care delivery programs, both in response to and anticipation of rapid and potentially profound shifts in the marketplace and in the regulatory environment. One AHC executive said,³

“The pace of change in health care has reached an unprecedented level, putting pressure on health care providers, like us, to accelerate our efforts to innovate.” — AHC Executive

AHC's early efforts to introduce innovations in health care design and delivery progressed slowly on a path that one executive described as “relentless incrementalism.”⁴ Recognizing the need to engage physicians more effectively to accelerate the change process, AHC focused on efforts to involve physicians in both the planning and implementation of innovative strategies for care delivery. AHC achieved greater physician engagement using a broad set of tactics as described in the next section.

3. Physician Engagement and Leadership

AHC recognized the importance of involving physicians in efforts to fundamentally reconfigure processes for care—both at a leadership and at an operational level. This change required coordinated efforts on a number of fronts. AHC has focused on five areas to advance its physician engagement and leadership agenda:

- Using data to create a “burning platform”—a reason for change
- Building and resourcing formal leadership capacity
- Supporting physician leaders and advanced practice providers with information and tools

¹ Aurora Health Care. “About Us.” Retrieved October 2011 from <http://www.aurorahealthcare.org/aboutus/news-media-center/our-organization.aspx>.

² Eliot J. Huxley, MD. “Aurora Health Care Study.” Retrieved October 2011 from www.greatboards.org.

³ Aurora Medical Group Presentation. “XYZ Clinic All Provider Meeting.” Accessed November 2011.

⁴ Aurora Health Care, personal communication, October, 2011.

- Communicating consistently and bi-directionally
- Aligning incentives—compensation model innovation

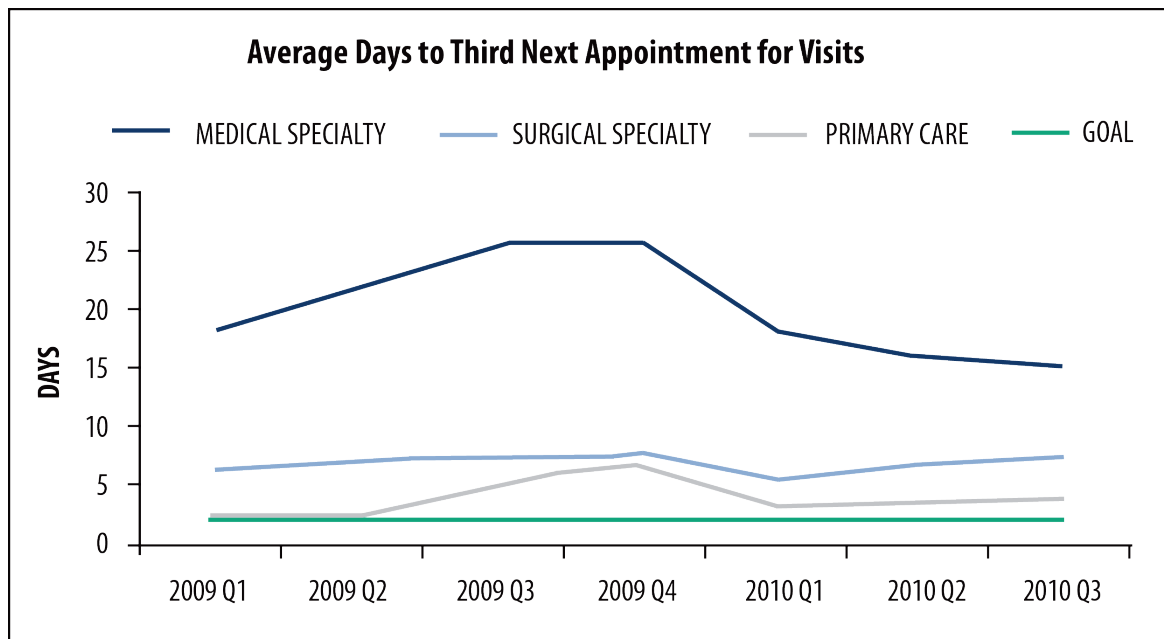
3.1. Using Data to Create a “Burning Platform”

Although the necessary competencies for engaging physicians and physician leadership go far beyond health information technology (HIT), AHC decided to invest in HIT, data, and information resources as a first step in its efforts to engage physicians in the change process. To date, AHC has made, and continues to make, significant investments in its HIT, data, and information resources.

AHC’s initial efforts to generate physician participation in clinical process transformation were met with suspicion and resistance. Physicians did not believe there were problems with the quality of care. AHC’s leadership recognized that it could best overcome this resistance with data. Thus, AHC established the IT capabilities to provide reports to physicians that documented significant variations both in the process and, in some cases, the outcomes of care at AHC.⁵

At the center of this data-driven engagement strategy was a “State of the Union” tour, conducted in every market, through which AHC senior medical group leadership shared national and state health reform updates and key clinical and cost data for the health system. Figure 1 shows an example of the data shared during the tour. In these open meetings, AHC leadership first presented evidence and then sought guidance from physicians to address key shortcomings and discuss near and long-term system-wide strategic initiatives. The open meetings provided AHC an opportunity to begin recruiting AHC physician leaders to work alongside executive leadership to resolve problems revealed by the data and develop tactics to ensure future success.

Figure 1. Sample State of the Union Presentation Material



⁵ Subsection 3.3 presents a description of the IT infrastructure required.

State of the Union meetings focused on three AHC priorities: Patient Experience/Access, Clinical and Operational Excellence, and Financial Performance.

State of the Union meetings focused on three AHC priorities: Patient Experience/Access, Clinical and Operational Excellence, and Financial Performance. AHC identified goals through rigorous data analysis in areas where opportunities for performance improvement were real, substantial, and deemed critical for the organization to sustain itself in a marketplace that was developing a stronger focus on quality and value. Presentations highlighted challenges facing the AHC system with respect to financial, patient satisfaction, quality, and access outcomes.

State of the Union presentations and subsequent data-driven conversations established that there was variation in care at AHC, which represented an opportunity to the organization. Some physicians undoubtedly saw this as a problem for others to solve. However, a small group of physicians emerged organically to embrace the challenge, demonstrating that they wanted and needed to be involved. This first group of informal leaders formed the nucleus of what was to become an essential part of AHC's strategy for change.

3.2. Building and Resourcing Formal Leadership Capacity

AHC first began to recruit and develop a group of physician leaders during State of the Union tours. As AHC leadership began to present information and data and seek physician feedback and guidance, a set of natural leaders who were highly engaged and eager to help play a role in AHC's organizational change efforts emerged. AHC initially charged these physician leaders with working with their peers to identify and then address variations in care. AHC management also requested their help to advance key projects in one of AHC's three strategic priority areas: Patient Experience, Clinical and Operational Excellence, and Financial Performance. Over time, AHC developed a new formal structure for physician leaders—AHC "physician champions."

AHC physician champions are practicing physicians who are given time (approximately 10–20% of their regular hours, with some variation given individual project demands) to assist AHC in identifying and disseminating best practices, and in assisting their colleagues to solve problems in their own practices. Physician champions also chair local clinic management committees that offer a structural link that helps management to reach physicians "on the ground." More importantly, these practicing physicians have a direct avenue to voice ideas and concerns to AHC leadership (see subsection 3.4 on communication). These committees, and the physician champions who lead them, serve as important listening posts and take concerns and innovative ideas back to AHC system leaders. The committee structure allows for innovation and evidence-based practices to flow to system leadership and then elsewhere within the AHC system. Through these physician leaders, AHC has created a culture in which physicians feel a strong sense of ownership for care delivery and that they have the opportunity to guide its revision. Initially, physician champions were volunteers and self-selected. As the role became more important and better defined, formal job descriptions evolved, and began to identify and develop physician leaders. AHC looks for three characteristics in potential physician champions:

- Clinical expertise, which is essential to establishing credibility with their peers;
- Operational effectiveness—the ability to work effectively in a business/operations environment—a skill that may need to be developed; and
- Proven, effective communication skills—in particular, the ability to communicate effectively with peers and other clinical and non-clinical colleagues in the AHC system.

Because these skills are often not fully developed, AHC provides formal educational support and the opportunity to participate in projects targeting specific system initiatives to physicians who appear to have leadership potential. Participation in these projects helps physicians assess their interest in an operational role and builds—and permits the evaluation of—critical "operational effectiveness" skills.

AHC expects physician champions, in partnership with administration, to lead, or develop and lead, system-focused projects. These projects give physicians the opportunity to work alongside leaders in other AHC business units and develop business cases and project plans. The physician champions can participate in team project tasks, including team recruitment and development, project execution, outcome measurement, and ultimately project

communication. AHC views each task as a key element in the toolkit that each physician champion must master in preparing for leadership roles in their local markets and the system itself.

AHC has also involved physicians in two other elements of their leadership structure. A 130-member Physician Leadership Council, comprising physician leaders, administrative leaders, and medical directors, acts as a direct advisory body to AHC's senior executives. In addition, three AHC physicians serve on AHC's Board of Directors. The opportunity for physicians to bring their voices to these high-level management and governance bodies has been important to creating a sense of real empowerment among physician leaders at AHC.

Currently, **eight physician champions** are working alongside the administration to implement an EHR across AHC's 170 clinics and eight hospitals. These physicians spend **25-50 percent** of their time helping to train care teams at individual sites as part of the roll out.

3.3. Supporting Physician Leaders and Practitioners with Information and Tools

Enabling physicians to lead the redesign of care processes requires that they be supported in their efforts to analyze, develop, and evaluate the impact of their efforts on quality and efficiency. In parallel with its efforts to build physician leadership capacity, AHC has invested both in the information resources and in the tools and techniques that help physicians design strategies to deliver care more effectively and more efficiently.

Together, these capabilities—**robust datasets and integrated analytic staff**—have created an environment where physician leaders successfully deliver information to their peers that permits ongoing assessment of critical care processes and ongoing and rapid evaluation of the impact of an intervention on process output. Routine reports permit benchmarking at multiple levels and promote the identification and sharing of best practices.

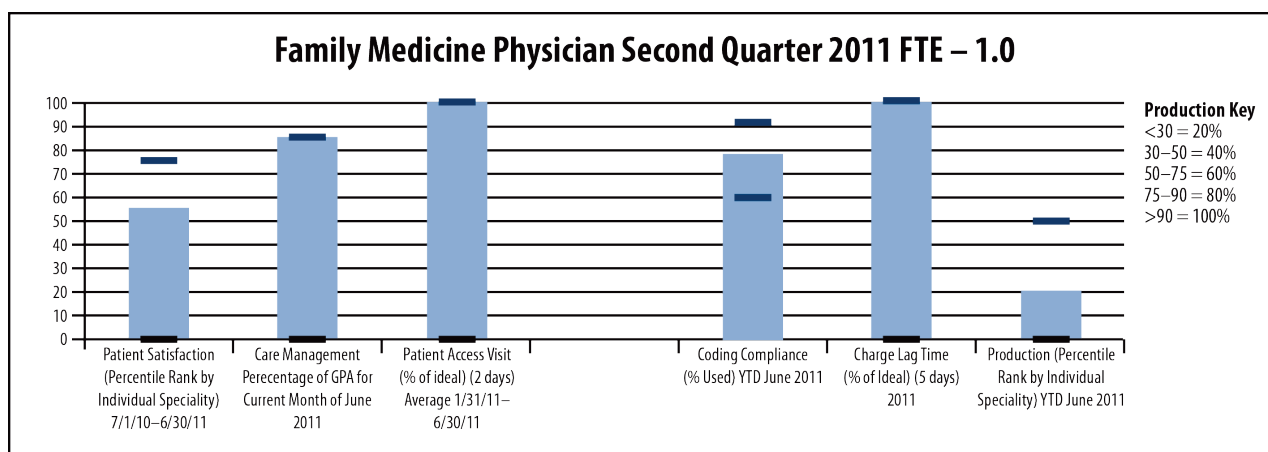
Information comes from AHC's robust electronic health record (EHR), data warehouse, and extensive IT infrastructure. AHC has aggregated virtually all of its electronic data—utilization, clinical (from electronic laboratory results and pharmacy prescription files), EHR, and data from cost accounting systems. This data is analyzed by individuals with methodological expertise who are directly linked to the care team. By co-locating analysts with clinicians who deliver care, AHC has fostered a deeper understanding in those analysts of the clinical process issues that need evaluation and improvement. Together, these capabilities—robust datasets and integrated analytic staff—have created an environment where physician leaders successfully deliver information to their peers that permits ongoing assessment of critical care processes and ongoing and rapid evaluation of the impact of an intervention on process output. Routine reports

permit benchmarking at multiple levels and promote the identification and sharing of best practices. AHC has also invested in a simple web-based tool that gives physicians access to information that is not routinely reported.

Physicians receive two types of reports depending on their role. First, summary reports, which provide a snapshot of key performance metrics (e.g., productivity, coding, chart management, access) for all of the physicians in a group, are sent to physician administrative leaders on a monthly basis. The reports are color-coded (green/yellow/red) to give physician leaders the ability to quickly scan and identify critical issues. Reports contain detailed summary statistics and information about what each physician would need to do to improve an individual score or exceed the targeted goal. Physician leaders can use the reports to identify areas that merit individual physicians' attention and to recognize areas where there may be broader performance gaps due to an underlying system problem that should be addressed.

In addition to these summary reports, each practicing physician also receives a "balanced score card" report that summarizes his or her performance. These individual reports provide patient satisfaction scores, care management scores, patient access statistics, coding, charge lag time, and production statistics. The reports are intended to give physicians a quick visual snapshot of performance across the broad range of performances that reflect AHC's priorities. The individual reports are delivered on a quarterly basis and are designed to assist physicians to correct performance gaps in areas where they have control to implement change. Figure 2 (on the next page) depicts a sample individual physician report.

Figure 2. Sample Individual Physician Report



3.4. Communicating Consistently and Bi-directionally

In the market that AHC serves, health care reform has created an environment where the need for change is perceived to be rapid, but the direction of change remains uncertain. Given this environment, AHC leadership has emphasized communication with its physicians and other providers. AHC leadership continues to believe that real health care reform—changes in the way care is delivered—will continue to come from within its own community. Achieving such change requires frequent and aggressive listening—by everyone from senior leaders to practicing physicians and their administrative partners—to tap the energy, knowledge, and creativity available in the AHC practice community. AHC leadership uses direct “listening tours” and individual local physician leadership groups (described earlier) to keep “its finger on the pulse of the physician community.” Through these communication efforts, AHC leadership receives ideas from and advances best practices to its broad provider base.

These listening tours mirror the initial State of the Union tour and provide updates and information related to key AHC priorities. They also showcase the successes of physician champions and provide opportunities to recruit new ones.

AHC’s organizational and leadership structures embed physicians at each leadership level, from the local physician champions to their Physician Leadership Council to the Board of Directors itself.

AHC’s organizational and leadership structures embed physicians at each leadership level, from the local physician champions to their Physician Leadership Council to the Board of Directors itself, which has three physician leaders as members. This three-tiered structure ensures that AHC hears the views of physicians at each level, and that it disseminates important communications from the highest level throughout the entire physician community.

AHC highlights innovative practices and regularly disseminates information to its providers via newsletters. In addition, AHC organizes a number of face-to-face meetings, including a quarterly leadership meeting when physician and administrative leaders hear directly from the chief executive officer, chief financial officer, and chief operating officer about the organization’s achievements on key metrics and best practices. AHC also holds special sessions with outside speakers to discuss the future of health care and conducts an annual leadership conference with the chief executive officer.

3.5. Aligning Incentives—Compensation Model Innovation

The final element of AHC’s approach to engaging physicians focuses on aligning physicians’ economic incentives with the organization’s objectives for higher value and more coordinated care. AHC has a history of pay-for-performance (P4P) compensation models that can be adapted as new contracts emerge. AHC is piloting new care delivery models to prepare for marketplace changes in contracts.

While AHC physicians face P4P incentives, AHC leadership acknowledges that these are still relatively modest. The current P4P system offers fixed payments to physicians as part of their compensation structure. For most physicians, this is only a small percentage of overall compensation. P4P payments are based on the following elements:

1. Patient experience (measured by patient satisfaction scores at a local level)
2. Quality (a number of specialty specific metrics at a local level)
3. Caregiver satisfaction (non-physician clinic staff satisfaction at a local level)
4. Financial targets (at the organization level)

As AHC continues to shift both its clinical processes and payment systems to reflect changes in the marketplace, P4P will become a more important part of overall compensation. AHC expects P4P to evolve away from focusing on individual physician performance metrics to metrics that emphasize results at the practice and market level.

4. Conclusion

Aurora Health Care is typical of many care delivery systems in the United States. Although it does not currently operate under BPs, AHC is anticipating and trying to prepare for a future when it will. To prepare for that future, AHC has chosen to focus on strategic, enterprise-wide efforts across a broad front. This case study summarizes two of AHC's most important efforts:

- Engaging physicians as leaders in improving the quality and cost-effectiveness of care by improving underlying care processes; and
- Aligning compensation and the business objectives of physicians with the larger organization.

AHC has focused much of its energy on—and very likely derived most of its success from—its successful engagement of physician leaders. AHC leadership identified a group of physicians who were prepared to be early agents for change. AHC used its data and IT assets to create metrics that demonstrated the need for change and developed a broad set of communication tools to convey this data effectively. Recognizing the critical role of physicians as agents for change, AHC formalized and resourced that role, establishing a network of physician champions, and developing management and leadership structures around those physician champions. Appreciating that change requires not only leadership, but information and tools to support those leaders, AHC increased its investment in the infrastructure its physician leaders required and its investment in leadership development and skill building. Finally, AHC enhanced its communication systems and processes that ensured high-caliber communications to and from physicians throughout the system.

AHC has focused much of its energy on—and very likely derived most of its success from—its **successful engagement of physician leaders**.

To a lesser extent, AHC has employed other strategies for engaging physicians. Rather than making compensation a primary focus, AHC uses compensation to reinforce the motivation that has emerged through its leadership initiatives. In this setting, it is likely that adjustments to compensation are directed more toward reducing misalignment than primarily driving organizational objectives. Most importantly, AHC is working to expose physicians to new practice models that employ different compensation models.

AHC estimates that it has achieved efficiency gains totaling over \$450 million over the past five years.⁶ The organization has also played an important role in achieving health cost improvements in the Wisconsin area. In addition, between 2003 and 2007, AHC's net commercial charges increased by just 11 percent—less than half the average for metropolitan Milwaukee.⁷

⁶ Aurora Health Care, Background for CMS Case Study, personal communication, October, 2011.

⁷ Aurora Health Care, "About Us," Retrieved October 2011 from <http://www.aurorahealthcare.org/aboutus/news-media-center/our-organization.aspx>.

5. Acronyms

AHC	Aurora Health Care
BP	Bundled Payment
CMS	Centers for Medicare & Medicaid Services
P4P	Pay for Performance
EHR	Electronic Health Record
HIT	Health Information Technology

[CASE STUDY]

January 18, 2012

© 2012 The Brookings Institution

B | ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

1775 Massachusetts Ave., NW, Washington, DC 20036
www.brookings.edu/healthreform