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As a physician leader, you are managing change day-to-day, engaging other physicians and building your teams to effect change and treat your patients. We have online courses to assist you in making this happen.

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POLARITY, PARTISANSHIP, AND ONGOING PROGRESS

By Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon)
President and CEO, American Association for Physician Leadership

In this article ...

Managing partisanship with the intricacy of polarizing influences is a complex undertaking. Leadership can provide the necessary resourcefulness to help create an optimal balance for any organization to move forward constructively and successfully — especially in the complex industry of healthcare.

REMEMBER THE FIRST TIME YOU PLAYED

with magnets as a child? You probably were completely mesmerized. Why did they come together in such a tight bond and then repel one another when flipped? Fascinating. Just totally fascinating!

And then some adult tried to explain to you the rationale and science behind magnetism. Do you remember their initial explanation? Nope, me neither — I was too busy playing with them to listen. In fact, I still stop to play with magnets whenever I am in a toy store or happen to see them on someone’s countertop in passing.

As all of us moved through our education, regardless of the field, the concept of polarity became more evident. Science, philosophy, religion, the arts, romance, athletics — they all have components of polarity if you think about it. Good and evil, light and dark, male and female, reason and instinct, yin and yang, consciousness and unconsciousness — pairs of opposites are prevalent everywhere.

Those of us in medicine recognize how the homeostasis of our physiology depends on polarity. The host of electrolytes and their membrane exchange systems are critical and essential... simple anion-cation polarity mechanisms that help keep the majority of our milieu intérieur stable and balanced.

So, in a general way, it is polarity that binds everything together at times. But polarity also can create strong oppositional forces at other times.

When defined as a noun, a partisan is an adherent or supporter of a person, group, party, or cause. Partisanship is the characteristic of a person who shows an especially biased, emotional allegiance and sometimes blind adherence to a particular person, group, party, or cause.

Partisanship, therefore, can effectively represent polarity in opposite directions. When a group of like-minded partisans get together in a community to share, strong interpersonal bonds are created that provide unity of purpose and ideals. However, when a partisan group collides with other groups that hold a different sense of purpose and alternative ideals, partisanship might lead to catastrophic outcomes.

Is this not what we continue to recognize in healthcare (let alone our federal systems): polarity and partisanship often at odds?

A CHANGING LANDSCAPE

There is no doubt the landscape of healthcare is changing continually. The influences that are creating change come from all directions so, predictably, certain components of partisanship and polarity arise. Intriguingly, there is always a bevy of promises for a better future in some corners and zealots claiming an impending apocalypse in other corners. Fascinating. Just totally fascinating!

Fortunately, smarter heads are prevailing in many other corners as well. Progress is being made at both the
individual and the organizational levels. There always will be bell-shaped curves and references to standard deviations from the norm, but the incidence and frequency of successful efforts toward improving healthcare continue to escalate and the entire bell curve of healthcare is gradually moving forward in better directions. This is good news!

But it is also a messy business at times, and this is when leadership must provide the necessary resourcefulness to help generate an improved balance of approach. As a leader, simply asking the question “Why can there not be approaches and benefits to a neutral or more central position?” will often reap the rewards and benefits of polarity and partisanship.

Leading is often more about deep listening — listening to others with a temporary suspension of one’s personal judgment and with a willingness to receive new information. And so, listening closely to the voices of polarity while also recognizing the driving forces behind partisanship circles often provides deeper levels of insightful information on how to achieve an improved balance of attitudes and approaches in finding new ways forward.

The astute leader can then use this information and improved sense of balance among individuals of an organization to develop a new network of partisans. This new network can subsequently facilitate further change and create ongoing breakthroughs for an organization — even create a process of ongoing change management that becomes infectious on several levels.

Restating it for emphasis: Successfully concentrated, it is polarity that binds everything together at times. Not successfully concentrated, partisanship may foster strong oppositional forces that create and even nurture unproductive outcomes.

CREATING BALANCE

Joseph Campbell, author of The Hero With a Thousand Faces, in commenting on a hero’s journey and how emergence across barriers is necessary for ongoing growth to occur (simplistically described as deep-level birth/rebirth experiences), stated: “The hero of yesterday becomes the tyrant of tomorrow unless he crucifies himself today.”

The implication is (and perhaps grossly overstated by this writer) that individuals, and indirectly organizations as a whole, must be cognizant of past behaviors. By doing so, they must remain open-minded toward recognizing and pursuing new approaches that are not necessarily based on premises of prior success…and that difficulties encountered in the process of change often provide deeper insights for achievements in the future. Failing to do so creates the potential for incomplete success over the longer term — an unsuccessful organizational hero journey, if you will.

Polarity is pervasive in our natural worlds. Partisanship is a natural tendency of human behavior. By recognizing the inevitability of both, leaders potentially can better manage the complexity of this duality to create an optimal balance for any organization to move forward constructively and successfully. Other industries harness these influences, why not ours?

In fact, I believe it essential for physician leaders to embrace the responsibility of helping foster an improved balance between polarity and partisanship in this most complex of recognized industries. At some level, all physicians are considered leaders in our society. And there clearly remains opportunity for physicians to grasp the opportunities always available for creating an improved equilibrium in healthcare — our milieu extérieur.

As AAPL continues to maximize the potential of interprofessional physician leadership to create significant personal and organizational transformation, I encourage each of us to also continue seeking deeper levels of professional development — and to appreciate better how we can each generate positive influence at all levels. As physician leaders, let us get more engaged, stay engaged, and help others become engaged. Creating a broader level of positive change in healthcare — and society — is within our reach. Our patients and their families will appreciate the eventual outcome.

INSPIRING CHANGE. TOGETHER.
Compassion, Respect, Equality and Justice for All

**Statement from the American Association for Physician Leadership**

The year 2020 began with unique challenges from a global pandemic and widespread economic strain. Our healthcare workforce has responded magnificently well despite these trials. Now, part-way through the year, we also face the opportunity of responding to, and learning from, events framed by ongoing social inequities in the United States of America.

In addition to the recent civil unrest emanating from the tragic death of George Floyd, we must better comprehend and address the statistic that African Americans, who constitute 13 percent of our population, have suffered more than half of COVID-19 cases and nearly 60 percent of its deaths nationwide; and Latinos, who constitute 18 percent of the population, account for nearly 30 percent of new COVID-19 cases.

Clearly, we require deeper levels of appreciation and subsequent action before we can truly understand all of the social determinants for health care in America.

As physicians, we are bound by a timeless oath emanating from the 5th century BCE – the Hippocratic Oath* – to serve the health and well-being of all patients; and to maintain the utmost respect for human life. Further, we pledge to not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between our duty and our patients. This oath embraces and strengthens our sacred profession, and physician leaders must strive to continually emulate all of its facets.

And while the American Association for Physician Leadership is proud of its constellation of efforts with diversity and inclusion in recent years, as physician leaders we must still do more in this regard for our world. Physician leadership increasingly drives improvements in healthcare, uniquely enhanced by the caring and compassion at the core of our profession. Our profession acknowledges and embraces diversity, inclusion, and justice for all human beings; and has done so through the ages.

AAPL remains committed to helping our global society and our AAPL constituency with the collective effort of continually advancing equality and justice for all human beings. We shall continue AAPL’s commitment to honor this effort as our society draws further lessons from these events of 2020.

“Injustice anywhere is a threat to justice everywhere.”

Martin Luther King – Alabama 1963
The Physician’s Pledge*

**AS A MEMBER OF THE MEDICAL PROFESSION:**
I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
I WILL RESPECT the autonomy and dignity of my patient;
I WILL MAINTAIN the utmost respect for human life;
I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I WILL RESPECT the secrets that are confided in me, even after the patient has died;
I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
I WILL FOSTER the honour and noble traditions of the medical profession;
I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;
I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;
I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;
I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
I MAKE THESE PROMISES solemnly, freely, and upon my honour.

*Updated modification to the Hippocratic Oath; endorsed by the World Medical Association in 2017.*

Signed,

Peter B. Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon)
President & Chief Executive Officer

Executive Committee, AAPL Board of Directors
LEADING BY PROVIDING COMFORT IN UNSETTLING TIMES

By Anthony Slonim, MD, DrPH, CPE, FAAPL
Editor-in-Chief, American Association for Physician Leadership

SINCE THE LAST ISSUE OF THE PLJ, OUR lives and our work have been transformed. The importance of a physician leader’s role has grown significantly since the COVID-19 pandemic took hold around the world. While the fundamental competencies of our work continue to play out in examples like quality, information technology, medical staff relationship building, and value-based care, there is added pressure, both clinically and financially, for our patients, health systems, communities, and colleagues that creates new work to be accomplished.

People are anxious and afraid of what COVID-19 means for them, their family, and their survival in both a literal and a figurative sense. As physician leaders, we can provide comfort that helps people thoughtfully and methodically move through this crisis.

The comfort we provide can be seen in the expertise we offer about virus transmissibility. The comfort can be seen in recommendations we make regarding when to re-start elective surgeries. The comfort comes from a place of providing confidence that tomorrow will be better than today. And, the comfort comes from holding the hand of a dying patient and telling him it’s going to be OK — especially if his family is not be able to be there.

The ways and methods that we choose to comfort are so fundamental to our work as physician leaders that it has become the newest competency that needs to be added to our repertoire. We look forward to hearing more about the ways you and your colleagues are demonstrating this comfort in submissions to the PLJ. Please feel free to share a field report about your work and how you are driving improved outcomes for our patients even in the context of COVID-19.

In this issue, we have included a field report examining a medium-sized hospital’s transformation of its Medical Staff Quality Committee. This article thoroughly describes the former and current states of the committee’s quality review process and the resulting improvements in transparency, mutual understanding, and a culture of safety and justice.

Another field report describes the Ambulatory Surgery Strategy for Value-Based Care and the need to incorporate ambulatory surgery into a complex system of care that delivers improved outcomes while controlling costs.

Finally, you will find a research article that examines the importance of preparing future physician leaders in management, strategy, policy, and operations of healthcare delivery.

As the official journal of the American Association for Physician Leaders, the Physician Leadership Journal provides a platform for you to share your research with members throughout the world. Now is the time to use this platform to help inspire change in healthcare and to improve the way we deliver care to the patients, families, and communities we serve.

Send me your thoughts at editor@physicianleaders.org. We would enjoy hearing stories about relevance of mentorship and the methods you use to ensure you and your team are well cared for in our demanding careers.
Make meaningful connections.

Whether you’re looking for solutions to your toughest on-the-job challenges, the contact that can help you advance your career, or a lifelong connection to like-minded colleagues, you’ll find it at AAPL. Learn more about membership today.

PHYSICIANLEADERS.ORG/NETWORKING
A YEAR AFTER JOINING WOODLAND

Memorial as CMO in 2017, Sarada Mylavarapu began noticing increased numbers of readmissions and ED visits. After discussions with hospital social workers and care coordinators, she realized these increases were attributed largely to homeless patients. In fact, between 2017 and 2019, the homeless population of Yolo County, California, spiked 43 percent — indicative of a state with the nation’s largest homeless population.

This revelation led Mylavarapu to visit the director of population health management at Adventist Health in Ukiah, California, where she was introduced to their widely respected street medicine program. The experience was a game-changer for Mylavarapu, as she explains:

How would you describe your first visit with the homeless in Ukiah?

We had a police escort into the back alleys where I watched a registered nurse and social worker take H&P on a tablet, provide medical care from a backpack, and refer patients to urgent care or connect them to a PCP based on need.

What was the turning point in your decision to initiate a similar program at Woodland?

One of the homeless individuals I met was a retired registered nurse who couldn’t afford a home because her savings had been depleted after her husband’s death. It made me realize that she is not alone, that anyone could be in that situation due to either loss of job, loss of a partner, or major illness. At that point my focus was no longer on reducing readmissions and ED visits for my institution but on improving healthcare access for these people.

What steps did you take to begin a similar program in your own community?

I spent time understanding the operational, clinical, and resource requirements of the project in Ukiah, then interviewed several stakeholders in the program there, studied local and national demographics for the homeless, and helped secure a combined $1 million in funding from Sutter Health, Yolo County’s Health and Human Services, and Dignity Health through our leadership at Woodland Memorial.

How is the program helping homeless patients there so far?

The project is still in its early phases, but by using the mobile medical unit — a medical van with walking teams — the street medicine committee intends to provide vaccinations, preventive care, management of chronic diseases, dental care, behavioral healthcare, and substance-use treatments for an unserved, underserved, and unsheltered population. When fully launched, I am confident it will save many lives.

What is the cost benefit of a program like this?

It’s difficult to put a number on savings related to disease prevention, but the value is apparent. In this program, secondary and tertiary preventive measures decrease the advancement of chronic diseases like hypertension and diabetes mellitus. Providing proper food decreases hypoglycemia and providing shoes decreases the likelihood of foot ulcers and injuries — all of which decrease ED visits and hospital admissions and readmissions.

To suggest an AAPL member for this ongoing series, email us at journal@physicianleaders.org.
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I’m planning for a career transition and need a roadmap of both practical and deeper questions to consider as I re-engineer my next move.

At this stage, you need to answer several important questions before the transition can move forward. Some of the questions are practical and relate to basic resources; others are more elusive and probe the very depths of your own self-understanding. These questions include:

1. What financial resources are available to assist me in the transition? Will these resources support a 3–6 month leave without pay?
2. If my financial resources aren’t adequate for an extended time without pay, do I need to work full time or can I reduce my clinical work to part time during the transition?
3. What professional resources am I willing and able to use (e.g., career coach, therapist, mentor, accountant, financial planner, insurance agent)?
4. What non-professional sources of support can I use (e.g., spouse, family members, mentors, friends)?
5. What is really important to me; what are my values and what is my purpose? What is my calling?
6. What am I passionate about?
7. What aspects of work bring me joy and satisfaction; what aspects do I dislike and want to give up?
8. What are my marketable skills?
9. How will I continue to find personal meaning, a sense of contribution, and personal connection to others once I leave the practice of medicine?
10. What legacy do I wish to leave?

Success in this transition stage requires that you clearly identify your personal values, purpose, sense of calling, and unique skills and abilities that have value in the marketplace. Answering these questions can help you do that. By using and integrating this knowledge of yourself, you can craft a new vision for your career or for retirement — one filled with passion and commitment and integrated with your deeper values.

Adapted from The Three Stages of a Physician’s Career: Navigating from Training to Beyond Retirement by Neil H. Baum, MD; Joel M. Blau, CFP; Peter S. Moskowitz, MD; and Ronald J. Paprocki, CFP. http://physicianleaders.org/three-stages-physicians-career

In this feature, our experts answer your questions about careers, aspirations, and challenges. Submit yours to journal@physicianleaders.org. (We will keep your identity confidential.)
How Physicians Can Leverage Their Clinical Skills to Transition to Another Career

Sylvie Stacy, MD, MPH

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THE CHALLENGE: You’ve spent years perfecting your clinical skills through research, reading, and practice. Now that you’re ready to take the leap into the next level in your career, you aren’t finding the opportunities you had hoped would be there. You watch as others advance and wonder what you are doing wrong. You might be lacking some of the nonclinical “soft” skills required for career success in healthcare — the interpersonal skills that often manifest through life experiences rather than formal education. How can you improve these skills, which are anything but “soft”?

KEY TAKEAWAYS
Many soft skills can be learned and honed with a little extra effort.

- Communication. Good communication skills are often cited as lacking in prospective job candidates. Improving your communication skills is always a good investment.

- Empathy. Those who are empathetic often are viewed as caring individuals who try to understand others. Research has shown this skill to be partially innate and partially learned.

- Problem Solving. The ability to devise practical strategies to move past challenges is critical to improvement in healthcare.

- Multitasking. While the brain can actively think of only one task at a time, it can quickly jump from one task to another. Those who do this well often are more productive.

- Interpersonal Skills. Those with strong interpersonal skills focus on collaborative approaches to problem solving.

THE BOTTOM LINE: Although you may have developed some sought-after soft skills through life experiences, you may be lacking in others. Self-awareness and practice often are key to helping you grow and improve.

Adapted from Transferable Career Skills for Physician Leaders, part of the American Association for Physician Leadership’s comprehensive online curriculum. Learn more about our educational offerings at physicianleaders.org/education.
Accelerate your career.

In the ever-changing world of health care, it can be complicated to understand how to best navigate the path to professional growth. Our career services team is ready to help you with career coaching, leadership skills assessments, and wellness support.

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Wellness is the ability to thrive in the face of adversity and enjoy a heightened sense of joy and peace regardless of one’s circumstances.

- DIAN GINSBERG, AAPL WELLNESS DIRECTOR

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Deeper Dive
Here’s some of what’s new for you, exclusively at our website.

TRENDING

LEADERSHIP

TIPS FOR MANAGING ORGANIZATIONAL CHANGE: When it comes to achieving organizational change, the difference between success and failure can be as simple as your approach. Change that is mandated from the top down is often met with resistance or even sabotage. On the other hand, the power of empowerment usually results in buy-in and successful transformation. This article offers four proven tips for managing successful organizational change.
www.physicianleaders.org/news/4-tips-for-managing-organizational-change

LEADERSHIP

4 PHASES OF CARE MODEL TRANSFORMATION: In this excerpt from their best-selling book Value-Based Healthcare and Payment Models: Including Frontline Strategies for 20 Clinical Subspecialties, Grace E. Terrell, MD, MMM, CPE, FACP, FACPE, and Julian D. “Bo” Bobbitt Jr., JD, say that improving cost and quality in the healthcare delivery system depends on designing care models that improve outcomes for patients — that core transformation must occur at the clinical level, not just at the reimbursement level.

HOT TOPIC

STRATEGIC APPROACH FOR RECRUITING AND RETAINING PHYSICIANS

A 2019 survey revealed that more than 20 percent of all physicians were planning to make a career change within 12 months; another publication suggests that up to 70 percent of all specialists plan to change jobs within their first two years of practice. The reasons? Compensation, of course, but also because of demands on their time (and resulting burnout), desire for change of scenery (metropolitan, suburban, rural), indecision about what they want in their careers or in life, and lack of career advancement opportunities or mentorship and guidance. This article explains how to build a multi-pronged recruiting strategy that will help attract and retain physician candidates for years to come.

Read these articles and others at physicianleaders.org/news.
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Hiring based on gender and diversity does not mean settling for less-qualified candidates. It means hiring those who are most qualified AND increasing your organization’s competitive edge through cognitive diversity. Is that even possible? Yes — if you make it a priority.

WHAT WOULD YOU DO?

Consider that your organization has a diversity and inclusion program, that leadership is committed to more diversity hires, and that you’re choosing between two candidates for a single job opening. Both are quality candidates, but the first clearly is more experienced and better-suited for the job. The other is a less-qualified minority applicant. Which would you hire? Which should you hire?

It’s a common dilemma in just about every industry today, but shared angst does not make this seemingly win-lose situation any less difficult — not when you are wondering if you should lower your hiring standards in order to meet company diversity objectives.

Michellene Davis, executive vice president and chief corporate affairs officer for RWJBarnabas Health in West Orange, New Jersey, was asked a similar question at a previous job:

Does diversity and inclusion mean having to lower your hiring standards?

“Why in the world would you ever have to do that?” she replied. “Do you think the standards were lowered to hire me?”

No, the standards were not lowered, but Davis’ status as an African-American woman had been a primary determinant in her appointment as CEO of the New Jersey Lottery in 2005. Only later did she learn that minorities had been targeted for the position and, as a board member told her, she “certainly [was] at the top of that group.”

Michellene Davis
Believing that the diversity and inclusion of its broadly multicultural board and staff inspires innovation and creativity and helps develop better solutions for its team, members, and clients, AAPL fully embraces and advocates the initiative.

The AAPL began a process of contemporizing the association, with focused attention to increase the diversity of the AAPL staff, its board of directors, and its overall constituency of members and organizations. The AAPL believes with dedicated effort comes great value.

DEFINING DIVERSITY

Often lumped together, diversity and inclusion are in fact two different concepts. For example, an organization might be remarkably diverse yet not at all inclusive.

Diversity and inclusion are most effective when working in tandem. Why? Because the true value of D&I comes not solely from diversity of staff but from leaders soliciting and tapping into the varied backgrounds, life experiences, and rich diversity of thought, ideas, and opinions staff members bring to an organization, representing its varied community of stakeholders. Scott E. Page, a scholar at the University of Michigan and author of The Diversity Bonus: How Great Teams Pay Off in the Knowledge Economy, calls this “cognitive diversity” — an expansion of thought — which is the fertile outgrowth of inclusion.

“Diversity is important, but I want to caution you: If we think that diversity is gender and race, and that by putting people of different races and genders together in an organization we have checked the diversity box and can move on, we’re totally wrong,” Lester insists, “because the task in diversity is broader than identity alone. The idea of diversity is integrating diverse identities and ways of thinking, creating the ‘cognitive repertoire’ of scholar Scott Page. And this cognitive repertoire brings much greater capacity and power than if you did not have diversity of thought.”

Diversity and inclusion are complementary and essential, Lester continues, “because inclusion creates a culture where all of those diverse people can interact in a constructive and productive way, where everybody is an equal part of the team, where their contributions are recognized and respected and they can freely share them with each other.”

That’s where the real work comes in, where leaders must exercise intentionality, consistency, perseverance, culture-building, and team-building; where understanding the lifetime of implicit bias various diversity groups faced — whether gender, race, ethnicity, sexual orientation, or religion — can optimize an organization’s ability to resolve complex issues.

The reciprocal benefit, Lester adds, is that “the equity principle provides additional support for mitigating these biases with behavioral design.” Behavioral design, as Iris Bohnet defines in her book What Works: Gender Equality by Design, is creating processes and methods that mitigate implicit bias.

“Diversity and inclusion have a practical, business side when dealing with complex situations, which are predominate...
in healthcare,” Lester says. “It also has an equity side, which means we have to do what is right and fair.”

That requires leadership to acknowledge and rectify past practices of inequity, including, for example, when an organization “does not have in leadership those who represent the greater microcosm of society,” Davis says, adding that such initiatives can’t be achieved with words alone. It doesn’t make a difference, for example, if a CEO says, “This is what we’re doing. This is who we are,” and then walks out without offering instruction or goals, leaving those in charge to their own devices.

“We’re wonderfully human with all of our own implicit biases,” Davis offers, “but unless you show me how, I do not know, and when the pressure is applied of trying to do more with less — as so many of us are merging and becoming these uber large organizations — our muscles atrophy. So, I return to what I’ve always done naturally. It’s better if I understand and can grasp goals you give me, then aid me with an assessment or tools that the organization adopts to lead me through the thought process.”

But again, as organizations strive to mirror the demographics of their communities, they accomplish little by hiring minorities simply to achieve diversity goals.

“Having [diversity] goals is not a bad thing,” Davis says, “but how you come up with your goals is important as well. You don’t want to have official, role-specific mandates because then you do two things: You insult the candidate that you’re hoping to secure, and you set them up for a difficult situation. I don’t think it’s always helpful when we’re flooded with candidates who may be diverse but, quite frankly, may not have the qualifying experience. So, you’re setting them up for failure, but checking off your list of diversity candidates for a search?”

That’s never the goal.

**HOW TO FIND D&I CANDIDATES**

How many times have you attended a meeting and observed that everyone there looked pretty much the same?

Davis calls that a missed opportunity “because if you begin talking about how patients are cared for, how your service is delivered, how a new product is brought on board, about succession planning or a new hiring, but you do not have gender, racial, or ethnic diversity, then you are truly harming your organization’s ability to achieve all that it can possibly do to serve all that it possibly can.”

If it’s a missed opportunity, it’s also a wake-up call to leaders to look beyond their comfort zone, beyond their network of friends and colleagues if they’re truly serious about pursuing top-shelf diversity candidates.

Davis says finding such candidates is never an issue for her, but acknowledges that’s not the case for many who approach her with their frustrations. Her advice: Find another search firm or alter your search methods.

“I’m not trying to be funny, but why do I know so many and you seem to know none at all?” she asks them. “A lot of that deals with how we have historically placed people on boards and put them in pipelines because we socialize with them. It’s who we know. You’re at the club and you say to the person who was in your foursome after an enjoyable 18 holes, ‘I’d love to be sitting across the table from you. Why don’t you come to be on my board?’”

The problem is that networks tend to be analogous, resulting in a great deal of sameness. Her advice:

- Go online and take the Harvard Implicit Association Test (https://implicit.harvard.edu/implicit/education.html) to become aware of your own bias.
- Ensure your hiring process is as objective as possible; unquestioned subjectivity often proliferates bias.
- Understand the difference between searching for and securing diverse candidates by ensuring that the job is attractive to the candidate.

“One of the things I’ve heard,” Davis says, “is, ‘Wow, we tried to secure them, but they’re asking for so much money’.” To which she answers: “And they’re going to get that from someone else.”

It’s important to first find the most highly qualified candidates early in the recruiting process. Then, all qualifications being equal, whom do you choose?

“In a situation where I’m intentionally adding to the gender diversity of my organization,” Lester says, “I’m going to choose the woman. [The candidates] are equal, but I’m going to choose the woman because of the identity diversity that she’ll bring to the table. You haven’t made a choice to not choose someone who’s more qualified. You’re choosing among equally qualified people.”

**CREATE A PIPELINE FOR THE FUTURE**

As a member of the search team, Davis observed that one organization for which she was conducting a search was “extremely monolithic” and she wondered why. When she asked fellow search committee members about their track record of producing diverse candidates, they indicated that they had never produced diversity candidates for that particular organization. Davis recalls: “When I asked them why, they said because that client never expressed that it was an issue of concern or desire of the organization, nor was it their aim for the ideal candidate.”

Another missed opportunity, she laments.

It’s the same kind of missed opportunity that Barry H. Ostrowsky, president and CEO of RWJBarnabas Health, mentioned to Davis years ago, citing a clear lack of administrative diversity in the healthcare industry as a whole.

Not only did Ostrowsky understand the issue, he mandated diversity components for all hiring and retention efforts, required systemwide diversity assessments for senior-level management, and empowered Davis to create internal programs for recruiting, coaching, mentoring, and sponsoring diversity candidates and staff.

The results include a program that provides paid internships for college and graduate students and recent graduates from a variety of socioeconomic backgrounds (many of whom become full-time hires), and a formal women’s leadership
program. Together, these in-house programs are grooming candidates and providing a sustained corporate pipeline of gender and diversity leadership.

“It’s not that hard,” Davis says. There’s more value to these kinds of programs than just the depth of diversity leadership they provide; they also show a commitment and investment in diversity employees that goes a long way toward enhancing workplace culture and improving employee retention.

“The fact that we are losing millennials to Google, Apple, and Amazon isn’t just about the names Google, Apple, and Amazon,” Davis argues. “It’s about your most marketable, non-mainstream members leaving when they realize ‘I’m in an organization that’s not invested in me.’ Folks are looking for a particular experience, an experience that is made better by having a diversity of thoughts and individuals who have a different type of lens through which they view the world. I call it the kaleidoscope.”

Says Lester: “If we’re talking about the culture that enables a team with diverse cognitive repertoires to work together and share ideas, to be constructive together, to be accepting of each other’s differences, and to focus all of that in a common goal, that’s a real cultural aspect. Mentoring and internal leadership programs can foster that kind of culture.”

Failure to implement such programs “creates this hamster wheel of incredibly high turnover,” Davis cautions. Hiring high-quality diversity candidates is the first objective, but retaining your “most marketable talent” is equally important.

“The young [diversity] geniuses you hired, they’re still in entry-level positions and about to hit mid-level management, but if they see everyone else around them getting mentored, coached, and sponsored and they do not receive these same career benefits — this same level of investment — then your organization is sending them a direct and succinct message, one that conveys that they are not welcome there, that they are not welcome to grow and matriculate into senior ranks,” Davis says, “whether that is the intent of your message or not.”

Davis sounded her own message with the creation of the Young Professionals Advisory Council, which assists employees in their early- to mid-career ascension, fosters a sense of community, encourages their involvement in framing corporate culture, and makes clear the company’s commitment to invest in them.

The cost of such investments is minimal compared to what Pearson describes as “the huge value in career guidance and personal development.”

“It really helps to have mentoring that helps you navigate a new culture or shows you the resources that are available,” she says. “Even just the social factor is a huge bonus to people. For women in particular, role models can be harder to find because they’re under-represented in many leadership roles. A lot of people who move into leadership have had good mentors who encouraged them along the way. I think the best mentors are maybe not similar to you; they challenge you and have different perspectives to help push the way you think about things or open you to new ideas and opportunities. That’s the value of a mentor.”

**A BONUS FOR LEADERS**

“When I look at the way I lead or build teams now, I’m really looking for that ‘diversity bonus,’“ Pearson says. “I’m looking for people’s different strengths to come together, knowing that not everybody can be the best at everything and not everybody has the same background and perspective, and that finding ways that we can complement each other can really move us forward.”

“Like any big initiative, it needs to be driven by leadership,” she says. “They definitely have to buy into it. You have to have your senior-most executives believing that this is important and able to speak to it.”

Speaking to it and being intentional: Making diversity hires, welcoming them to the table, encouraging them to be part of the conversation, and enabling their ascension into leadership roles.

Without that leadership support, the windfall of a “diversity bonus” is lost.

“They lose out on evidence that shows that diverse work groups work harder, that they come together in a different way than a homogeneous group,” Pearson says. “Obviously that bonus is an advantage to any organization that wants to be productive and move forward as far as possible. Without that, they limit their capability. In looking at how complex problems are in healthcare now, if you don’t have that diversity to address the complexity, you’ll struggle — and it’s not going to get any easier.”

**RELATED RESOURCES**

- *The End of Diversity as We Know It: Why Diversity Efforts Fail and How Leveraging Difference Can Succeed* by Martin N. Davidson, Berrett-Koehler Publishers, 2011
- *The Person You Mean to Be: How Good People Fight Bias* by Dolly Chugh, Harper Collins Publishers, 2018
- *Invisible Visits* by Tina Sacks, Oxford University Press, 2019
As with any initiative on the scale of diversity and inclusion, success is defined by leadership: the foresight to recognize a need for change and the fortitude to make that change happen.

Of course, it helps if you know what you’re doing because “there’s a huge cost if you do it wrong,” warns Michellene Davis, executive vice president and chief corporate affairs officer for RWJBarnabas Health in West Orange, New Jersey.

 “[Diversity and inclusion] really needs to be fostered and brought about within an organization through a design methodology,” she advises, “which means that we look at it, we tweak it, we look at it again, we roll it out, we tweak it. It’s got to be talked about. There’s a lot of socialization that goes into it. There needs to be a communications strategy around it. And there needs to be a lot of one-on-one discussions with asset leaders across the organization because everyone needs to own a little bit of it.”

The process for implementing an effective D&I program may vary from one organization to the next, but there are steps that can streamline the process and experience for all involved. Weighing in with their own reasoned ideas are three D&I experts: Davis; Mark Lester, MD, MBA, CPE, FAANS, FACS, FAAPL, chairman of the AAPL board of directors; and Anne Pearson, MD, CPE, senior vice president and CEO at Physicians Memorial Hermann in Houston, Texas.

**Do an organizational assessment:** Identify current gaps in identity and cognitive diversity, from the boardroom to the basement. Ask what you want to achieve and why. What is your organization and what are its priorities? If you achieve diversity and inclusion, what will that look like and what will it mean to your strategy and purpose?

**Borrow ideas:** Investigate what other organizations across the country are doing — both inside and outside of healthcare. “It’s uber important that you not begin this work by making it up as you go along,” Davis says.
Dare to compare: Compare your organization to the population you serve, then compare that to similarly situated organizations in comparably sized states. “How do they deal with an increasingly diverse population?” Davis asks. “What have they done in order to attach to them in a way that welcomes them into this space? What are some of the challenges?”

Build trust: “Your No. 1 resource is a leader or team who can get folks to trust them, who leads by example, who is collaborative and coalition-building,” Davis says. “They have to have the CEO’s inherent authority, shared authority … someone who understands that everyone comes from different spaces and places.”

Empower: “Make certain you’ve got as many people (on board) as possible,” Davis advises, “and then give them the opportunity to be leaders — to be ambassadors — to help you achieve the best-case scenario for the organization in this space.”

Recognize implicit bias: “We don’t want to admit that we feel certain ways that are built into us from our background and experiences and how that influences us,” Pearson says, “but acknowledging bias and moving forward can be powerful. To get past that you need to put a lot of structure, processes, and leadership development into shaping an environment that mitigates bias.”

Mitigate bias: A few ideas include:

1. Hide names at the tops of resumes to eliminate any unintentional first impressions that might result from “name bias.”
2. After panel interviews, have panelists render decisions and offer feedback independent of each other.
3. Provide standard questions with objective scoring for each candidate so that everyone gets fair consideration. “If you ask questions based on what you need or want for a role, you don’t end up talking about the fact that you both like golf,” Pearson says, “because that’s how interviews can veer off track.” And how decisions can be swayed.

Ensure area representation: Create an advisory board of individuals who can speak for organizations that represent the demographics and backgrounds of the region. “That means going to the leader of the Hispanic Chamber of Commerce or Hispanic Bar Association as well as a local civil rights organization,” Davis suggests. Just getting the minister of the local black church is not enough, she adds. Attract individuals who have a history of experience in your region, who will make you aware of current or developing issues and concerns, and who ultimately will serve as your ambassadors.

Use internal consultants: Some organizations create a specialty position just for D&I. “If you do that, be careful you’re not focused solely on demographics and identity,” Lester cautions. “Demographics and identity should be a pathway to cognitive diversity, and your goal is to achieve the cognitive diversity that benefits your organization.”

Lead by example: “There’s something to ‘seeing is believing,’” says Pearson. “Seeing someone (woman, minority) who has moved into a decision-making role can inspire others to believe that they can also contribute. That’s ideal.”

Garner leadership support: “What you really need is organizational leadership support to say this is important — to do this because it’s the right thing to do. Otherwise, it will be a struggle unless people really believe in it and are willing to self-diagnose the issues,” Pearson says.

Be intentional: Statistically speaking, the representation of women and minorities in leadership positions is proportionately less than it should be. Increasing that representation requires intentionality. “It has to be supported by leadership that is willing to allow people who think differently and challenge status quo to be at the table,” Pearson says.

Be committed: Know the market demand for diversity hires and prepare yourself accordingly if you wish to secure them. “What you can’t do is go to my friend, the MD from Harvard, and offer her less than what she knows you’re paying,” says Davis. “Highly sought-after diversity candidates know what the market demand for them is (via publicly accessible 990 forms and market research). Have a made-up mind about commitment and then follow through.”

Again, for a program on the scale of diversity and inclusion, “change requires time and a great deal of training,” Davis says, “but it really takes us back to what we learned in kindergarten: Treat one another as you wish to be treated.”

COVID-19: PEER-TO-PEER, REAL-TIME LEARNING

By Anthony D. Slonim, MD, DrPH, FAAPL, and Kirtan P. Patel, MBA

In this article ...

Nine physician leaders share their perspectives on the challenges and lessons of COVID-19.

THE COVID-19 PANDEMIC HAS CHANGED THE world, likely for an exceptionally long time. In the healthcare sphere, physician leaders are needed more than ever. Yet, with all the competencies we strive to acquire during our leadership journeys, some lessons become evident only in the context of substantial and widespread change. These lessons fulfill the goals of the Physician Leadership Journal (PLJ) because they provide a platform of lifelong learning and help us to gain knowledge from other physician leaders in the trenches dealing with real-life problems.

In mid-April 2020, in the midst of the pandemic, we reached out by email to members of the PLJ’s Editorial Board, which is comprised of Certified Physician Executives and Fellows of the American Association of Physician Leadership, and asked them to respond to two questions:

1. How has COVID-19 challenged you as a physician leader?

2. What leadership pearl have you learned from your COVID-19 experience that you would like to share with other physician leaders?

Their responses have been lightly edited for clarity and length and are provided as a mechanism for real-time peer-learning to the readers of the Physician Leadership Journal.

HOW HAS COVID-19 CHALLENGED YOU AS A PHYSICIAN LEADER?

Chad Brands, MD, CPE
Division vice president for Texas, Hospital Corporation of America, based in Tennessee

The pandemic has reflected a very rapidly changing health crisis with information that is fluid and dynamic. We must continue to adapt with our colleagues by providing new solutions, models, and thinking on a moment-by-moment basis in real time to a set of very new, challenging, and recurring problems and issues, while collectively advocating for a long-term fix to the supply chain for equipment, medicines, and vaccines.

Gregory Cooper, MD, PhD, CPE
Regional president (East Region), Baptist Health Medical Group, based in Kentucky

The biggest challenge has been the initial need to rapidly assimilate a great deal of information about the disease, including the potential public health impact and most appropriate responses to mitigate this impact. It is impossible to provide direction without a clear understanding of the threat.

Amin Hakim, MD, CPE, FIDSA, FACPE
Vice president of clinical operations for United Healthcare, based in New York

As a physician on the COVID-19 Task Force of a national healthcare organization and as an infectious disease specialist, it was hard to stay on top of the flood of science and to sort through what is relevant, hype, or misleading. This has been and continues to be essential to guide the business continuity plan (BCP), actuarial modeling, closing or opening of locations, employee health, and developing communications for patients, providers, employees, and others.
Perhaps obvious, but the operational aspects of ramping up and sustaining critical care services have been paramount. We went from staffing 16 MICU beds with two day-time and one night-time team (attending physician, fellow, and two residents) to covering up to 96 ICU beds on five floors in three separate buildings, including the former ambulatory surgery center, with six teams. We are asking physicians to work 13-hour shifts seven days in a row, and having to rapidly train hospitalists, anesthesiologists, and neurologists to provide critical care to satisfy the surge in demand. Meeting the 30-minute threshold for critical care billing becomes impractical with expanded caseloads, but care still has to be delivered, even at a loss.

The stress of the situation has become an X-ray machine to identify hidden flaws and obvious deficiencies in the healthcare system, from the unintended subsidy of hospitals to insurance companies (via the imbalance between the cost of physician effort versus billable care events) to supply-chain inadequacies at the national level.

**Ponon Dileep Kumar, MD, FACP, CPE**
*President of East Michigan Hospitalists, based in St. Clair County in Eastern Michigan*

We had a proactive approach from the very beginning of the epidemic. Once it was clear that there was a possibility of community spread, we cancelled all face-to-face meetings and activated social distancing. All the CME meetings at the county level were also cancelled until further notice. I was afraid of making a decision that might be unnecessary, but stories coming out of Italy and later New York and nearby Detroit validated our decisions.

**J. Matthew Neal, MD, MBA, CPE, FACP, FACE, FAAPL**
*Assistant dean for faculty affairs and professional development at Indiana University School of Medicine in Indianapolis, Indiana*

As Charles Dickens said, “It was the best of times; it was the worst of times.” I have seen the “best” in 95 percent of my physician colleagues who have rallied to the occasion to help in any way possible. Yet, I have seen the “worst” in the 5 percent who are self-centered and only care about themselves and how this affects them. Unfortunately, such is human nature. The positives far outweigh the negatives, however.

**Scott Ransom, DO, MBA, MPH, CPE**
*Partner, Health Industries Advisory, PricewaterhouseCoopers LLP | Strategy&, in Dallas, Texas*

Balancing and effectively communicating the very real business, public health, clinical, and psychological issues associated with the COVID-19 crisis has required strong and insightful physician leadership. In addition to professional responsibilities, supporting family and friends and managing personal stress during this time has presented unique challenges.

**Juan Sanchez, MD, MPA, CPE, FACS, FACHE**
*Chairman of the Department of Surgery at Ascension’s St. Agnes Hospital and an associate professor of surgery at Johns Hopkins University School of Medicine, both in Maryland*

The COVID-19 pandemic challenged my ability to communicate effectively and make clear the dimensions of the threat to my colleagues. It was only after the media coverage provided a backdrop that I was able to have enough traction to make the changes that needed to be made. The crisis also allowed me to realize that this response needed to be a collective effort despite my inclination to control the entire response to the crisis.

**Anthony Slonim, MD, DrPH, FAAPL**
*President and CEO, Renown Health, and professor of internal medicine and pediatrics, University of Nevada, Reno, School of Medicine both in Reno, Nevada*

COVID-19 challenged me as a physician leader by helping me to be more comfortable with “letting go.” In the context of command center operations, both internally and externally, you have to rely on other team members and the process to get you through. Although I visit the command center often, the team and I have to realize that I am there in a support role and not to direct decision making even though I am the CEO.

As they often say in command function, leave your hat at the door. Externally, in the context of the pandemic, the public health infrastructure has jurisdiction. In both of these scenarios, while you can let go, you also have an important responsibility to lead, influence, and persuade when the team looks as though they are too far down in the details, but even though you have to perform this work from the background, believe in its importance.

**WHAT LEADERSHIP PEARL HAVE YOU LEARNED FROM YOUR COVID-19 EXPERIENCE THAT YOU WOULD LIKE TO SHARE WITH OTHER PHYSICIAN LEADERS?**

**Chad Brands, MD, CPE**
Communication from executive leaders is very important in times of calm and vitally important in times of crisis. The communication should quickly describe the context of the challenges, concisely summarize the data pertinent to the problems, clearly identify the new priorities, and then calmly provide a clarion call to action so that individuals and groups can continue to engage collaboratively with their best efforts to achieve best outcomes.

**Gregory Cooper, MD, PhD, CPE**
The greatest lesson learned was to trust my fellow physicians. The key is to assemble the right people with the right expertise, create a framework to support their efforts, trust their...
ability to do the work and create good processes, and then facilitate their efforts. It is more important for leaders to create and support a team than to do all the work themselves.

**Amin Hakim, MD, CPE, FIDSA, FACPE**

Effective communication across different areas of the organization is essential to successful collaboration and to an effective BCP, even in the face of unforeseen challenges arising in the midst of the pandemic. It is also important in addressing questions about confusing information and contradictory news, and in coordinating internal and external communications.

**Tom Higgins, MD, MBA, CPE, FACP, MCCM, FAAPL**

Celebrate the small wins! My hospital plays the “Theme from Rocky” over the PA system every time a COVID-19 patient is discharged, and those intermittent reminders of success help balance the inevitable fatigue and disappointments.

More personally, be sure to repeatedly thank everyone on your team: the nurses, patient care techs, and housekeepers braving COVID-19 exposure; the case managers keeping patient flow moving; the cafeteria staff delivering much-needed food to teams who are too busy to take lunch; administrative staff handing out masks; and security keeping everyone safe and where they belong. This is a team effort, and everyone is a hero.

**Ponon Dileep Kumar, MD, FACP, CPE**

These puzzling times will challenge you as a leader. One thing I have learned is to lead from the front. Rather than confining yourself into the comforts of the conference rooms, working with frontline workers will resonate well with them. I have seen and heard resentment among various individuals and groups when this was not happening.

**J. Matthew Neal, MD, MBA, CPE, FACP, FACE, FAAPL**

Being able to use and deploy the existing provider workforce to achieve the maximum benefits and efficiency. Not every provider is skilled at caring for critically ill COVID-19 patients, but all can contribute something — be it virtual patient visits to cover other providers, answering messages, or performing other important tasks.

**Scott Ransom, DO, MBA, MPH, CPE**

Optimally managing the current COVID crisis requires fact-based and calm leadership built on a foundation of trust and credibility that balances the unique business, public health, clinical, and other human challenges. The physician leader must be a great role model, over-communicate, balance conflicting views, and inspire confidence to effectively lead a diverse set of constituents including his or her own family during this unique and challenging time.

**Juan Sanchez, MD, MPA, CPE, FACS, FACHE**

In the early phase, when the warning signs and magnitude of the potential harm were fuzzy, I learned that acting urgently and correcting course along the way was a more effective strategy than getting the surge plan right at the outset. I truly learned that perfection is the enemy of good and that time-to-action was key when confronting an ambiguous threat.

**Anthony Slonim, MD, DrPH, FAAPL**

As a physician and public health professional, I have always known how important these two lenses are to caring for our patients, our community, and our nation. What became clear to me during COVID-19 was the tension between the medical model and the public health model.

In the medical model, physicians have a duty to advocate for their patients and the families that they care for. In the public health model, particularly in times of state and federal emergencies, the needs of the community and population take precedence over the needs of the individual, particularly in times of scarcity. Physician input is still critically important in these situations, but the entire reason that the public health infrastructure exists and has jurisdiction in times of crisis is that you do not want the burden of allocation decisions to be made by individuals at the bedside because it will lead to high levels of variability.

I am certain that this tension is instructive for how we go about educating physician leaders around population health in the aftermath of COVID-19.

Anthony D. Slonim, MD, DrPH, FAAPL, is president and chief executive officer of Renown Health and editor-in-chief, Physician Leadership Journal.

Kirtan P. Patel, MBA, is value analysis manager for Renown Health and associate editor, Physician Leadership Journal.
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Nevada
ABSTRACT: The medical staff leadership of Carroll Hospital, a medium-sized community hospital in central Maryland, sought a better method of conducting provider quality reviews to decrease a two-year-long backlog, simplify the process, increase accountability, and improve patient safety. This led to the complete transformation of the Medical Staff Quality Committee (MSQC), which is responsible for provider quality reviews. The medical staff used iterative design: a workflow in which the process is tested and evaluated repeatedly at different stages of design to eliminate flaws to improve the design over time. The result was an increase in the quality of care, a decrease in opportunities for improvement, and positive reviews by providers, board members, and administrators.

THE SOLE HOSPITAL IN CARROLL COUNTY, Maryland, Carroll Hospital is part of LifeBridge Health. Founded in 1960, this not-for-profit facility has 169 inpatient beds, a 50,000 visits/year Emergency Department, 1,000 newborn deliveries/year, and about 550 credentialed medical staff members (450 physicians and 100 advance practice providers) in 38 medical specialties aligned in nine departments.1

The hospital’s medical staff leadership sought a better method of conducting peer reviews, which led to the transformation of the Medical Staff Quality Committee (MSQC), which is responsible for provider quality reviews. The MSQC changes occurred in three discrete but interconnected stages: (1) reformation of the medical staff clinical quality review process, (2) communication of the aggregated data and trends to the medical staff at large, and (3) establishment of standardized departmental Ongoing Provider Performance Evaluations (OPPEs), which The Joint Commission mandated in 2007 that accredited hospitals provide to ensure quality practitioner performance.2

These efforts yielded a greater collaboration and deepened the trust between the medical staff and governing body. Each step led to greater transparency, mutual understanding, and a culture of safety and justice.

THE PROBLEM AND OPERATIONAL SIGNIFICANCE
By 2015, our hospital’s MSQC, which had served us well for many years, was unable to keep up with the volume of case reviews requested. It also had not taken advantage of opportunities to link its protocols and procedures with ongoing practice reviews, best practices, and the provider core competencies. The last were defined by the Accreditation Council for Graduate Medical Education (ACGME)3 in 1999 and subsequently adopted by the American Board of Medical Specialties (ABMS) and included into their Maintenance of Certification (MOC) programs.4 They include practice-based learning and improvement, patient care, systems-based practice, medical knowledge, communication skills, and professionalism. The Joint Commission emphasized these measures in its 2007 Medical Staff Standards.5

Peer review had become uncoupled from periodic performance evaluation and operated in isolation from other hospital quality-improvement efforts. The quality and credentialing arms of the organized medical staff operated in
Recognizing the opportunity, medical staff leadership undertook a sweeping reform and issued a mandate to reduce the backlog, increase representation/participation of medical staff members, harmonize reviews with OPPEs and other quality processes, promote equity, better disseminate information, and increase involvement of the governing body.

These opportunities appear in the Strengths, Weaknesses, Threats, and Opportunities (SWOT) analysis that emerged during Medical Executive Committee (MEC) deliberations (see Figure 1).

**THE PREVIOUS OPERATIONAL PROCESS**

Until 2015, the Carroll Hospital medical staff held a quality committee meeting once a month to review cases referred for suspicion of deviation from standard of care by a privileged member of the medical staff. At that time there were no defined inclusion criteria for a case to be referred or forwarded to the committee. A screening body first reviewed and processed the complaint, but it did not include a licensed and privileged provider. Ratings did not have objective criteria for scoring. The members of the review committee did not reflect the diversity of the medical staff.

Because the committee met only once a month and could get mired down in prolonged discussion about one case, the queue for cases to be reviewed by the committee swelled to two-year backlog. When finally presented to the medical executive committee for their review, many cases concluded in a recommendation that was moot because the provider in question had left the institution, a system process change had already been adopted, or other events and actions had eclipsed the recommendations of the committee.

To confuse matters, a member of hospital administration, the chief medical officer, acted as spokesman for the medical staff and presented the finding to the MEC and the board. It was clear that the medical staff did not fully own the process nor were they invested in the outcomes. When questioned, almost no member of the medical staff knew how cases were referred to the committee or how the conclusions were presented afterward. Likewise, providers could not identify which actions could be taken to advise, mentor, or surveil their colleagues who were found to have deviated from the standard of care.

There was a great deal of apprehension and misunderstanding of the role of the quality review process. Providers viewed the process as punitive rather than as a tool to improve quality of care. In short, providers found the medical staff quality process opaque at best and a potential threat to their privileges or careers at worst.

**THE IMPLEMENTED INTERVENTION**

While the burgeoning backlog was the immediate concern, it became apparent that solving one problem granted the opportunity to address the others. This led to a rapid series
of interventions that wound up recharacterizing the entire process and the composition of the committee. Each stage was discussed and vetted by the MEC and governing body before being adopted. Thus, changes were made iteratively.

**Timeliness**

Previously, cases went through a lengthy process before final adjudication: submission, initial screening, assignment, committee discussion, and presentation to the medical executive committee and board of directors. The backlog could exceed two years. Meanwhile, memories faded, opportunities for rapid improvements were lost, and the medical staff did not see an effective connection between quality surveillance and action. After a review of the workflows, we determined that some steps were extraneous, and providers had too much time to respond to inquiries.

Timeliness is critical for quality. The sooner an error, system obstacle, or improper process can be identified, the sooner it can be addressed and fewer patients will be placed at risk. Providers who can be counseled soon after an event have the episode fresh in mind and can incorporate counseling or other recommended remedies long before the event fades from memory.

We considered many options, but the most compelling choice was to double the size of the committee and divide it into two panels. That would allow for a meeting every two weeks and would increase by 100 percent the capacity of the MSQC process. Combined with better screening and new members who were committed to focused reviews, this increased capacity slashed the backlog from 140 cases to zero in less than a year.

**Representation/Participation**

Creating a second panel required a doubling of the number of medical staff members participating in the committee. This allowed us to broaden the representation of the medical staff so that MSQC more accurately reflected the demographics of the medical staff as a whole: specialty, affiliation (employed, contracted, independent), age, gender, and years on staff. This allowed for a wider perspective and for more voices to contribute.

The larger departments (medicine, surgery, emergency) have at least one member on each panel. The smaller departments (pathology, pediatrics) have at least one member on one panel. Reviewers from the same department as the provider being reviewed present the events and salient details of a case to be deliberated. They collect statements from the provider being reviewed as well as any other hospital staff involved in the case. The reviewer offers a recommendation regarding whether care was appropriate and, if not, where opportunities for improvement exist.

While members of the panel rely on the opinion of a peer specialist for matters of clinical expertise or procedural skill, all can render judgment about professionalism, responsiveness, documentation, decision making, and behavior. This also confers credibility on the committee as it more closely mirrored the medical staff membership at large.

By longstanding tradition, MSQC reviews and summaries were not presented to MEC and the governing body by a member of the medical staff, but by an administrator: the chief medical officer, who had no vote at MEC at the time and may have had an alternate opinion or recommendation from the version he presented as an agent of the medical staff. This uncoupled the roles and responsibilities of the medical staff.

The medical staff needed to take ownership over quality among its members. A provider is more receptive to the opinions and recommendations that arise from a body of peers rather than from an administrator. Likewise, the medical staff would take its role more seriously and coach, mentor, and guide medical staff members if representatives had a clearer understanding of the entirety of the process and were responsible for presenting the findings to the MEC and board.

We created the position of a quality officer. The quality officer, a physician who is an active member of the medical staff, presents the findings to the MEC and answers any questions. The administration no longer acts as the spokesperson or advocate for the medical staff in its own executive meeting. The quality officer also sits on the screening committee and has a role in selecting cases for further review. As a licensed provider and privileged member of the medical staff, this perspective is given great weight.

**Harmonization with OPPEs and Other Quality Processes**

Previously, cases made their way to the quality committee by rule of thumb or subjective criteria. To make the process uniform, able to withstand critique, and amenable for analysis, we needed to develop specific criteria for inclusion, and we elected to have those criteria reflect the core competencies of The Joint Commission/Accreditation Council for Graduate Medical Education.

Not only does the committee review clinical acumen and procedural skill, but also communication, professionalism, and teamwork. We also devised a new rubric for ratings to move from the loose and subjective designations of “minor and major opportunity for improvement” to outcomes such as effects on patient condition and interventions (see Figure 2).

The new process imposed a tighter timeline and more efficient operations:

1. The clinical departments, through their chiefs, collaborate with the hospital department of quality and chief medical officer to jointly decide on review triggers. These may be rates-, rules-, or review-based and are predicated on the six core competencies defined by the Accreditation Council for Graduate Medical Education and subsequently adopted by the American Board of Medical Specialties as a set of standards for maintaining a high level of quality care: Practice-Based Learning and Improvement, Patient Care and Procedural Skills, Systems-Based Practice, Medical Knowledge, Interpersonal and Communication Skills, and Professionalism. Figures 3 and 4 provide examples of review triggers from the departments of psychiatry and medicine.
2. The hospital quality department monitors provider and hospital quality data, as well as complaints from patients, payors, and staff, to identify cases for review.

3. Quality analysts from the hospital department of quality summarize cases, list findings of fact, and obtain statements from staff involved in the case.

4. One MSQC panel member, always in the same specialty as the provider being reviewed, is selected by the clinical quality officer to manage the presentation, proposing conclusions and recommendations for questions to ask the practitioner. If a case involves multiple specialties — for example, if the concerns about care spanned a patient’s journey from the emergency department to surgery to the critical care unit — then reviewers from each specialty coordinate their presentation of the case. Multiple providers may be reviewed and rated on a single case.

5. The case is reviewed by all MSQC panel members in advance.

6. At the MSQC meeting, the case is NOT rehashed; it is settled or further input is sought.

7. The MSQC determines ratings and recommendations.

8. The findings communicated and improvement plans are created.

9. If care involves nursing or if there is a system issue that is beyond the control of the provider, the case is referred to Nursing Practice Review and/or to the safety and quality departments for root cause analyses or failure mode and effects analysis.

Our goal is for each case discussion to take 5–10 minutes. Our target turnaround time, from initial trigger to disposition, is less than 60 days.
This not only makes the chiefs accountable to their peers, but also familiarizes them with their own data and allows other members of the medical staff to learn more about a department not their own. The outside perspectives prove valuable as comments and insights are offered from individuals with no inherent bias or interest.

These reports are forwarded to the MEC and Medical Committee for review. Chiefs take pride in presenting their data and are eager to show improving trends for safety and quality.
The panel will still deliberate and make its findings and recommendations known to the MEC. An appeals committee was created such that if a provider disagrees with a rating, a second body can review the case. In all matters, the Medical Executive Committee renders a judgment and then passes the matter on to the Quality Committee of the board of directors for a final decision.

**FIGURE 4: REVIEW TRIGGERS FOR DEPARTMENT OF MEDICINE**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator Description</th>
<th>Core Competency</th>
<th>Type of Indicator</th>
<th>Data Source</th>
<th>Physician Attribution</th>
<th>Exemplary Target</th>
<th>Acceptable Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>Need to define</td>
<td>System-based Practice</td>
<td>Review</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent Presence</td>
<td>Consent form presence</td>
<td>Interpersonal and Communication Skills</td>
<td>Rule</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent Quality</td>
<td>Consents are signed and dated by the physician and reflect the actual procedure performed</td>
<td>Interpersonal and Communication Skills</td>
<td>Rate</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Founded Patient Relations Complaints</td>
<td>Patient complaints about physicians</td>
<td>Professionalism</td>
<td>Rule</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Events</td>
<td>Inappropriate behaviors as reported by peers or associates</td>
<td>Professionalism</td>
<td>Rule</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Documentation Not Completed Within Required Timeframe</td>
<td>Includes: H&amp;Ps, patient consents, and delayed/absent discharge summaries</td>
<td>Interpersonal and Communication Skills</td>
<td>Rule</td>
<td>Quality Access Database, HIM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Completed in a timely and accurate manner on admission and discharge of each patient</td>
<td>Interpersonal and Communication Skills</td>
<td>Rule</td>
<td>Quality Access Database</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call-Backs Within 30 Minutes</td>
<td>Responds to pages of messages within 30 minutes of receipt</td>
<td>Professionalism</td>
<td>Rule</td>
<td>Quality Access Database</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Reviews</td>
<td>Includes all cases rated as &quot;Major Opportunity for Improvement&quot;</td>
<td>Patient Care</td>
<td>Rule</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at Department Meetings</td>
<td>Attends 50% of department meetings</td>
<td>Practice-based Learning</td>
<td>Rate</td>
<td>MS Office</td>
<td>&gt;50%</td>
<td>50%</td>
<td>&lt;50%</td>
</tr>
<tr>
<td>Stroke Continuing Medical Education Compliance</td>
<td>Meets the stroke physician education requirements</td>
<td>Practice-based Learning</td>
<td>Rule</td>
<td>MS Office</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VTE Core Measure Compliance</td>
<td>Core measure specifications</td>
<td>Medical/Clinical Knowledge</td>
<td>Rate</td>
<td>MIDAS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

as well as the granularity and accuracy of the data. This was identified as a best practice on our last TJC survey.

**Equity**

In the rare cases when there is a concern for conflict of interest or a high likelihood for litigation, cases may be sent for an external review as well, but the panel will still deliberate and make its findings and recommendations known to the MEC. An appeals committee was created such that if a provider disagrees with a rating, a second body can review the case. In all matters, the Medical Executive Committee renders a judgment and then passes the matter on to the Quality Committee of the board of directors for a final decision.
body, medical staff, and administration collaborate to provide safe, quality care.

There were several reasons to combine the separate meetings into one:

1. About 90 percent of the same material had been presented at each meeting.
2. Only one set of minutes is required.
3. More board members can attend the MEC meeting and hear firsthand the discussions; they no longer need to rely solely on minutes and reminiscences of others.
4. Better bonding of and understanding among board members and MEC members is facilitated.
5. Reduces time to credential and privilege providers and take action on rules, bylaws changes, policies, and quality reports.
6. About 90–120 minutes of meeting time is cut from the schedules of executives, physician leaders, and board members, thus also saving money in otherwise lost revenue-generating hours.

The final step, not directly related to the MSQC process, was for the full board to grant final privileging action to the Quality Committee. In routine, noncontroversial cases — about 98 percent of the time — the final approval could be granted right after the combined meeting. This sped up the process by about five weeks, increasing our revenue by setting up providers for insurer credentialing much sooner.

### Dissemination of Information

Because the panels are composed of 25 members of the medical staff (about 10 percent of the active medical staff) and represent every department, the successes are well known and medical staff members are confident that the proceedings are fair, deliberate, and objective. Composited and anonymized data are presented to the interdisciplinary quality committee (see Figure 5). This has the salutary effect of informing hospital staff that providers are held accountable and their practices are reviewed. This has not led to an increase in cases reported for review.

### Governance Changes

For the next step, which took a few years to complete, we combined the meetings of the Medical Executive Committee and the Quality Committee of the board (governing body). These meetings had been on separate days, about a week apart. Only a few members of the board were present at MEC meetings. Once the meetings were combined, all the members attended. As a condition of participation, the Centers for Medicaid and Medicare Services require that the medical staff is accountable to the governing body for the quality of care provided to patients. The MEC is required to administer continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges. While the governing body is ultimately responsible for the quality and safety of care at the hospital, the governing body, medical staff, and administration collaborate to provide safe, quality care.

The final step, not directly related to the MSQC process, was for the full board to grant final privileging action to the Quality Committee. In routine, noncontroversial cases — about 98 percent of the time — the final approval could be granted right after the combined meeting. This sped up the process by about five weeks, increasing our revenue by setting up providers for insurer credentialing much sooner.

### FIGURE 5: COMPOSITED ONE-YEAR RESULTS OF THE MSQC BY DEPARTMENT

**Rating Outcome by Department**

- Multiple departments can be involved in the same case.
- Anesthesia = 1 – No Opportunity for Improvement.
- Behavioral Health = 1 – No Opportunity for Improvement.
- Diagnostic Radiology = 4 – Minor Opportunity for Improvement: 1 – Clinical Judgment; 2 – Diagnosis; 1 – Technique/Skills.
- Emergency Medicine = 2 – Major Opportunity for Improvement: 2 – Clinical Judgment 8 – Minor Opportunity for Improvement: 3 – Clinical Judgment; 2 – Diagnosis; 1 – Communication; 1 – Follow-up; 1 – Treatment Planning. 15 – No Opportunity for Improvement.
- Medicine = 3 – Major Opportunity for Improvement; 3 – Clinical Judgment. 20 – Minor Opportunity for Improvement; 8 – Clinical Judgment; 11 – Communication; 1 – Diagnosis. 64 – No Opportunity for Improvement.
- OB/GYN = 1 – Major Opportunity for Improvement; 1 – Clinical Judgment. 4 – Minor Opportunity for Improvement: 3 – Clinical Judgment; 1 – Communication. 9 – No Opportunity for Improvement.
- Pediatrics = 0 – Opportunity for Improvement.
- Surgery = 1 – Major Opportunity for Improvement; 1 – Clinical Judgment. 4 – Minor Opportunity for Improvement. 2 – Technique/Skills; 2 – Communication. 15 – No Opportunity for Improvement.
A CONCISE DESCRIPTION OF RESULTS

After we had undertaken the reforms to our process, we saw a quick resolution of the backlog, increased medical staff participation, greater representation from multiple demographics, and a better understanding of the process and its goals from the governing body and the medical staff leadership.

Since our screening process was led by a physician, the process became more efficient at triaging out cases that had no opportunity for improvement; only cases that required deliberation made their way to the panels.

In 2014, 147 cases were sent for review (contributing to the backlog) and the committee decided that 80 percent had no identified opportunity for improvement. In 2015, 90 cases made their way out of screening for full deliberation (see Figures 6 and 7). Of those, 50 percent had opportunities for improvement identified.

Because there were two panels, each case was afforded more time for discussion and backlogs were prevented. The panels spent their time and energy on cases that merited the consideration of the medical staff and warranted specific recommendations to improve safety and quality.

During the next few years, the medical staff and hospital staff became educated on which cases were appropriate to send for review. Consequently, more true positives and fewer true negatives made their way into the queue. Interestingly, approximately the same number of cases made their way from the screening committee to the review panels (~90/year) (see Figure 8). This allowed the panel to spend more time devising opportunities for improvement.

As the committee and panels matured, they identified more opportunities for system actions and referred cases to other hospital or departmental quality committees. These referrals were in addition to, not in lieu of, MSQC action (see Figure 9).

A CONCISE DESCRIPTION OF OPERATIONAL IMPLICATIONS

The most salient features of the new process are the increased engagement of the medical staff and the unprecedented collaboration and mutual understanding between the medical staff executives and the governing body. Whereas only a fraction of the medical staff had any concept of the quality process before 2015, a significant segment of the hospital providers, especially those who are the most active, have an increased understanding. They are also more trusting of the process and are more likely to participate.

The entire quality committee of the governing body now attends the combined meeting. While only three board members may vote, all are free to pose questions, make comments, or ask for more information. There is no delay in transmission or diminution in the volume of information transmitted.

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**FIGURE 6: NUMBER OF CASES REVIEWED BEFORE AND AFTER REFORM OF THE MEDICAL STAFF QUALITY COMMITTEE**

<table>
<thead>
<tr>
<th>Total Cases MSQC Reviewed</th>
<th># of Cases Rated No Opportunity for Improvement</th>
<th># of Cases Rated Minor Opportunity for Improvement</th>
<th># of Cases Rated Major Opportunity for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 147</td>
<td>118</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>2015 90</td>
<td>45</td>
<td>23</td>
<td>22</td>
</tr>
</tbody>
</table>

**FIGURE 7: COMPARISON OF RATINGS BEFORE AND AFTER REFORM OF THE MEDICAL STAFF QUALITY COMMITTEE**

Comparison Case Ratings

- # of Cases Rated Major Opportunity for Improvement: 2015 - 10, 2014 - 22
- # of Cases Rated No Opportunity for Improvement: 2015 - 45, 2014 - 45
- Total Cases MSQC Reviewed: 2015 - 90, 2014 - 118

- Total Cases MSQC Reviewed: 2015 - 147, 2014 - 147
has further reduced the backlog, generated mutual trust and understanding, and inspired collegial thinking among medical executives and board members.

Since the department triggers and standards are rational and evidence based, the process is swift and transparent, and the entire management and governing team is unified, recommendations to improve quality, whether counseling and monitoring of providers or re-engineering other hospital processes have been strong and actionable. This has raised the bar for provider performance and has led to fewer providers on staff who conduct themselves outside of the expected standard.

The medical staff quality process dovetails with our credentialing and privileging activities. The software and metrics that surveil and guide the former generate data and reports for the latter, which is especially helpful during periodic recredentialing.

The MEC and board have expressed satisfaction and confidence in the process. It is swift, transparent, and has multiple checks and balances. It is fair for the providers reviewed and has multiple avenues for collaboration with other hospital committees (quality, nursing practice review, safety) so that best practices may be shared, or other reviews may be triggered as warranted.

**A CONCISE DESCRIPTION FOR NEXT STEPS**

As more providers participate in the process and as they continue to gain confidence in the fairness and intentions of the efforts, they have suggested additional improvements. For example, providers wish to be notified immediately if one of their cases is being reviewed. If the initial screening panel
determines that no deviation has occurred, the providers will receive letters that explain that finding and encourage them to continue their quality care.

We will begin to review cases identified as having excellent or exemplary care so that we may learn from them as models of practice. We will continue to review trends. All these data points are now pulled into a software program for OPPE/FPPE developed at our hospital. This aids the department chiefs to respond to complaints, counsel providers, give the periodic feedback required by The Joint Commission.

We have engaged a biostatistician to review our outcomes and suggest how many cases need to be reviewed to yield the fewest false negatives and positives. At his suggestion we have randomly taken cases that scored “no opportunity” at the screening panel and sent them blindly to one of the review panels to test the accuracy of our screeners.

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REFERENCES
ABSTRACT: Although hospital-owned ambulatory surgery centers (ASCs) continue to drive ambulatory strategy, hospital leaders must incorporate ambulatory surgery into a complex system of care that delivers improved outcomes while controlling costs. These outcome, cost, and quality improvement goals are delineated by new value-based payment models that use a variety of payment mechanisms that have significant implications for ASC operations and clinical care design. Providing high-quality care that is also financially sustainable has always been a challenge for ASCs, but the continued evolution of payment models is rapidly pushing ASCs beyond traditional strategies.

To succeed under value-based care, most hospitals need to transform their ambulatory surgery strategy. Physician leaders can support this strategic shift by helping their colleagues understand the underlying trends, design the clinical care model, create an exceptional experience for surgery patients, and develop a balanced approach to facility planning.

UNDERSTAND THE UNDERLYING TRENDS

In the three decades before 2011, the share of surgical procedures performed on an outpatient basis increased from 19 percent to more than 60 percent.¹ The pace of this transition has accelerated for many procedures. For example, the percentage of hysterectomies performed in an outpatient setting recently increased from 36 percent to 64 percent in just four years.²

Several clinical factors are driving this trend, including advances in technology, surgical technique, pain management, and post-surgical rehabilitation. Financially, all payers see ASCs as an important tool for bringing down the cost of care. For instance, the Centers for Medicare & Medicaid Services (CMS) saves 34 percent on unicompartimental knee arthroplasty performed in an ASC as opposed to a hospital.³

Looking forward, ambulatory surgery appears to be poised for a new burst of growth. According to one forecast, hospital inpatient surgery volumes will decline 3 percent between

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³Appendicitis surgery.
The table below provides an overview of value-based payment models, their financial impact, and implications for ASCs.

**TABLE 1: VALUE-BASED PAYMENT MODELS: FINANCIAL IMPACT AND IMPLICATIONS FOR ASCS**

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>Financial Impact</th>
<th>Implications for ASCs</th>
</tr>
</thead>
</table>
| Bundled payments    | Single payment (reflecting a discount) covers entire 90-day admission-to-recovery episode | > To operate sustainably, ASCs must optimize patient outcomes and control costs  
> Requires tight coordination of pre-, intra-, and postoperative care and recovery  
> Cost control also relies on efficient OR schedule  |
| Performance incentives | Payment bonus for high quality, safety and cost efficiency (typically up to 2%) | > ASCs must optimize performance on a range of quality and safety measures  
> Organizations may also be evaluated against benchmarked spending levels  |
| Outcome penalties   | Payment reduction for poor performance on quality metrics (especially “never events”) | > ASCs must prevent and minimize SSIs, sepsis, and other perioperative problems  
> Key tools include protocol and process standardization  |
| Admission penalties | Payment reduction (typically up to 3%) for excessive unplanned hospital admission rates | > ASCs must optimize processes to prevent unplanned hospital admissions  
> Key is highly coordinated care (such as the Perioperative Surgical Home model) |

2018 and 2028. During the same period, procedure volumes will increase 19 percent in hospital outpatient settings and 30 percent in ASCs.4

While these trends make outpatient strategy a priority for hospital systems, the rise of bundled payments and other value-based models is complicating the transition. Value-based payment models have a significant financial impact on surgical services organizations and they have extensive implications for how ASCs must manage clinic operations and clinical care in the coming years (see Table 1).

By 2022, approximately half of reimbursement for surgical care will be tied to healthcare value. The current strategic challenge is to take advantage of growing demand for ambulatory surgery while creating a delivery model that optimizes surgical outcomes, patient satisfaction, and cost efficiency.

**REDESIGN THE CARE MODEL AROUND SURGICAL VALUE**

In the emerging ambulatory environment, a general focus on clinical quality is no longer enough. Cost and outcome pressures built into value-based payment demand that ASCs adopt a delivery model that optimizes every aspect of clinical care and operations. Physician leaders can support care model redesign by helping their colleagues focus on three key opportunities:

**1. Care coordination and standardization.** Poor coordination of care is a factor in poor patient outcomes; it also can drive unnecessary spending. To redesign an ambulatory surgery strategy for value-based care, healthcare leaders must create organizational structures that harmonize providers, patient data, operational processes, clinical protocols, and patient pathways across the entire spectrum of surgical care, from pre-operative prep through intraoperative care and long-term recovery.

Until recently, ambulatory surgery centers have focused on getting patients safely through their procedure while the patient was at the facility. ASCs must now take responsibility, with the surgeon, for supporting the patient post-discharge and ensuring their procedure was successful in terms of resolving the underlying reason for surgery — for example, reduction in knee pain for a knee replacement procedure or reduction in sinus infections for an endoscopic sinus surgery.

One effective approach is the perioperative surgical home (PSH), a surgical care model analogous to the “patient-centered medical home.” Under the “traditional” surgery model, patients receive services from an array of loosely organized providers and units (surgeon, scheduling, pre-admission testing, anesthesia, OR nursing, PACU, floor, rehabilitation, etc.). Poor coordination of these providers can result in suboptimal care, resource inefficiency, and a disjointed care experience for patients.

In contrast, the PSH model focuses on optimizing surgical care through full interdisciplinary coordination, pathway standardization, and team-based decision making.5 A recent review of more than 150 studies showed that PSH initiatives consistently lead to improvement in surgical quality and patient outcomes.6

The surgical home approach can be very effective in the ASC setting. For example, a Los Angeles-area hospital recently reported on efforts to apply the PSH model to ambulatory laparoscopic cholecystectomy. The highly choreographed protocol involves dozens of elements, including multimodal analgesia, procedure batching, instrument standardization, streamlined hand-offs, careful follow-up procedures, and ongoing quality tracking.

Adoption of this model reduced unplanned hospital admissions from 8.5 percent to 1.7 percent and also significantly
reduced total time in the hospital. The model also included several protocols that helped reduce post-operative nausea and vomiting (PONV). PONV has a major impact on patient satisfaction, which is an important component of value-based care reimbursement.

The PSH model is especially important for outpatient surgery reimbursed under a bundled-payment program. Since the model encompasses pre-, intra-, and post-operative care, it can help align ASC operations with bundles that cover the entire 90-day episode of care.

2. Predictive analytics. One of the biggest challenges to succeeding under value-based care is operational efficiency. High case-cancellation rates (>1 percent), low on-time start rates (<90 percent), long turnovers (>25 minutes), and low overall utilization (<60 percent) push costs up and erode margins.

Historically, lean staffing and streamlined processes at the typical ASC have helped create more efficient environments. As ASCs face more capped payments, leaders in outpatient surgery must wring additional waste out of scheduling structures and processes.

Leading ASCs are using predictive analytics to gain a highly granular picture of patient volumes per day and per hour. They use this analysis to design schedules that ensure room availability closely matches demand. Appropriate room capacity helps prevent the bottlenecks that can slow down patient throughput. It also helps optimize labor costs by minimizing staffing during times of low demand.

3. Performance measurement. ASCs in general have a good record on quality. Traditionally, however, most outpatient quality programs have focused on acute and near-term measures such as wrong-site surgery, patient falls and burns, and hospital transfers.

To achieve high performance under value-based payment, ASCs need to expand their performance metrics to encompass the entire episode of care. For example, physician leaders can play a key role by helping ASCs develop systems for tracking long-term outcomes.

One good model is measure ASC-11: improvement in patient’s visual function within 90 days following cataract surgery. Data submission for this measure is still voluntary under the Ambulatory Surgical Center Quality Reporting (ASCQR) program, but this metric underscores the fact that CMS intends to focus increasingly on long-term outcomes.

Similar measures could be put in place for other procedures. For example, to monitor its hip arthroplasty program, an ASC might begin tracking not just early mobilization rates but physical mobility 3 and 6 months after surgery. The focus should be not just whether the procedure was “successful” when the patient left the facility, but whether the surgery succeeded in resolving the patient’s original health problem.

CREATE AN EXCELLENT PATIENT EXPERIENCE

The patient’s experience of care is an important component of the Value-Based Purchasing (VBP) program and other government and private payer initiatives. As organizations redesign their ASC strategy, physicians can play a key role by supporting a focus on improving the patient experience before surgery, during the ASC stay, and over the recovery period.

There are three priorities:

1. Expand services to provide complete disease support. Traditionally, successful ASCs have focused on a single specialty or a narrow range of procedures, such as ophthalmology or arthroscopic knee surgery. While this approach offers important efficiencies, ASCs today must widen their focus by offering patients complete support in managing their disease. The model is no longer the focused factory, but the full-service surgical health center.

For example, an orthopedics center might expand from its core arthroscopy services to include a full range of minimally invasive and open orthopedic surgeries, including joint replacement. It might also add advanced imaging services, in-house pain management specialists, physical and occupational therapy, and other related services. Under this model, the ASC encompasses both surgical care and the full range of services to support patient health goals.

Comprehensive facilities can also offer non-surgical treatment modalities such as high-intensity focused ultrasound (HIFU), a non-invasive treatment for several kinds of malignant and benign tumors. For patients with prostate cancer, for instance, HIFU can be an important alternative to an open invasive procedure. For ASCs, the strategic opportunity will be to build market share by providing a comprehensive array of complementary services. Physician leaders can play a critical role by helping their organizations evaluate these treatments and understand how they can support ASC strategy.

2. Make patient engagement a priority. Under value-based care, patient engagement must be a key component of delivery model design. More engaged patients are more likely to have a positive patient experience and comply with caregiver directives, which helps prevent poor outcomes.

Successful ASCs secure patient engagement by emphasizing communication. ASC leaders should develop systems for delivering pre-procedure education and communicating expectations, conveying discharge instructions, and following up at 24, 48, and 72 hours post-discharge.

Many leading surgery organizations are exploring opportunities to use smartphone apps to improve surgery outcomes. Uses include delivering pre-operative medication instructions, post-operative symptom tracking and alerts, and the ability to submit wound site photos for specialist review.

3. Create a culture obsessed with patient satisfaction. In 2016, CMS began implementing the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery (OAS CAHPS) Survey. Although voluntary participation has been extended, data from the survey are now publicly available and mandatory participation cannot be far off. In response, leading ASCs are developing an organized approach to patient satisfaction.

An effective patient satisfaction strategy includes consistent monitoring of OAS CAHPS results, use of physician dashboards to track individual performance, structured follow-up on low outliers, and systems for rewarding high performance
and performance improvement. Note that provider organizations are permitted to add up to 15 additional questions to the OAS CAHPS. This enables leaders to create a highly customized instrument for measuring patient satisfaction and creating targeted improvements.

**TAKE A STRATEGIC APPROACH TO FACILITY PLANNING**

Should a health system structure a new surgery center as a hospital outpatient department (HOPD) or a true off-campus ASC? This has always been a complex decision involving state regulation and local market dynamics. In the current environment, however, OR leaders must help their executive colleagues understand several additional issues:

**First, what is the sentiment within the physician community?** Where surgeons are eager to take more control over care delivery, there is often a strong opportunity to build an off-campus ASC as a joint venture. Conversely, in communities where many physicians have opted for hospital employment, an on-campus HOPD may be more convenient for staff surgeons.

**Second, where is the best opportunity to create an excellent patient experience?** In many cases, the best option is to start with a clean slate: Build an off-campus ASC that offers state-of-the-art facilities and a consumer-like experience. However, achieving this goal on campus is possible. The key is to make sure the HOPD is entirely separate from the main OR, with a dedicated facility, leadership, and staff.

**Third, what payment opportunities are available?** Currently, reimbursement is higher for procedures performed at an on-campus HOPD than at an off-campus ASC, but the differential is certain to shrink in the coming years. At the same time, the lower cost structure of an off-campus ASC could help a hospital secure preferred provider status with private payers and contract directly with self-insured employers. It could also help the organization offer lower out-of-pocket costs to patients, which is especially important as patient-pay balances grow.

**CASE STUDY: BENEFITS OF VALUE-BASED ASC STRATEGY**

An urban hospital in the Midwest demonstrates that a comprehensive approach to outpatient surgery is critical to achieving the goals of value-based care.

**Situation.** The hospital is located in a disadvantaged neighborhood within a large metropolitan area. To balance the effects of an unfavorable payer mix, hospital leaders sought to increase penetration in an adjacent geography offering better reimbursement opportunities. The hospital’s existing market share in the target region was only 5 percent.

**Challenges.** The hospital’s initial strategy was to construct a physician office building in the target market; however, oversaturation in the area led to financial losses with no improvement in market penetration. Returning to the drawing board, hospital leaders shifted their focus to outpatient surgery, yet realized that a traditional freestanding surgery center was unlikely to succeed in the relatively affluent geography. Any new ASC would need to offer comprehensive surgical health services.

**Strategy.** Hospital leaders began by identifying a core group of entrepreneurial surgeons willing to partner on a new off-campus ASC. Thanks to the market’s growing population, securing a Certificate of Need (CON) was comparatively straightforward. The ASC was structured as a joint venture, with the hospital as the general partner and the surgeon group as minority investors. In addition to surgical suites, the new facility included diagnostic imaging (CT and MRI), a radiation oncology clinic, an emergency room, and office space for both primary care physicians and specialists.

Under the governance of a physician-led Surgical Services Executive Committee (SSEC), the ASC emphasized clinical optimization through evidence-based medicine and operational efficiency. Surgeon scorecards were used to create accountability around key value-based metrics, and anesthesiologist and nursing compensation was carefully aligned with quality and efficiency goals.

**Outcomes.** The opportunity to build clinical and operational workflows from scratch enabled the ASC to deliver high-quality care and a positive patient experience while also providing exceptional service to surgeons. Surgical volumes grew rapidly through the first 24 months of operation, allowing the facility to quickly achieve profitability without cannibalizing procedure volume from the main hospital OR.

Within a few years, the ASC was consistently delivering annual ROI of 25 percent. Eventually, an academic medical center in the region chose to affiliate with the hospital, citing the hospital’s comprehensive outpatient surgery network as a key rationale for the partnership.

**FOCUS ON CORE ELEMENTS**

This case study illustrates several key lessons for hospitals that aim to update their ambulatory surgery strategy for the value-based environment.

1. Any initiatives to standardize and coordinate surgical care must be championed and executed by physician leaders. In the case study above, a surgeon-dominated SSEC led all efforts to create evidence-based care protocols and orchestrate care processes. Physician leadership is essential to creating true healthcare value in terms of better outcomes and lower costs and to meeting the demands of value-based payment models.

2. A strong performance measurement strategy is essential to progress. At the ASC in this case study, provider dashboards helped focus all physicians on specific clinical and cost targets and overall value-based goals.

3. A patient-centered approach to surgical care is an important key to success. In the case discussed above, ASC leaders developed a full-spectrum surgical care strategy designed to secure patient engagement, optimize patient outcomes, and maximize patient satisfaction.

4. The key to an effective facility strategy is finding the right balance among market dynamics, reimbursement, surgeon aspirations and politics. For the healthcare organization discussed above, an off-campus joint venture ASC was the right solution, but the best arrangement will vary for every hospital, surgical staff and community.

Physician leaders can play a key role in ASC strategy redesign by helping their colleagues understand and implement the core elements of a modern approach: clinical optimization,
careful facility planning, an emphasis on patient satisfaction, and integration of outpatient surgery into a comprehensive system of care. An ASC strategy built on these elements is positioned to thrive under a payment system that rewards quality of care, cost control and excellent patient outcomes.

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HEALTHCARE ORGANIZATION
THE PHYSICIAN LEADERSHIP INSTITUTE BRIDGES THE GAP IN PHYSICIAN LEADER DEVELOPMENT

ABSTRACT: To evaluate the efficacy of the Physician Leadership Institute (PLI) curriculum, specifically as it relates to the internal advancement and career development of Henry Ford Health System (HFHS) physicians/scientists, a survey was emailed to all PLI graduates actively employed by HFHS. The questionnaire items were designed to identify the PLI’s influence on staff physicians’ personal and professional growth. Results indicated that the PLI develops capable physician leaders who understand the unique culture, challenges, and opportunities at the institution. Successes of the curriculum are evidenced by subjectively reported satisfaction, high physician retention, and numerous in-house promotions among PLI graduates. The PLI may serve as a model for other institutions interested in developing homegrown leadership talent, minimizing the need for outside leadership training programs, recruiting agencies, and consulting firms.

NEARLY 50 PERCENT OF SENIOR LEADERS AT healthcare organizations nationwide are approaching retirement age within the next 10 years.1 This impending vacancy in leadership, together with a rapidly changing landscape of healthcare delivery and academia, has accelerated the need for succession planning with appropriately prepared physician leaders.2

With the larger part of medical education, residency training, and early career promotion practices centered on scientific achievement and clinical and educational excellence, it is not surprising that the majority of current physician leaders ascended into executive positions based on the same criteria.3 However, this career selection process renders accomplished physicians initially ill-equipped to handle the administrative and leadership responsibilities required of the office.

To function effectively in the profoundly complex healthcare enterprise, future leadership must not only understand the intricacies of clinical medicine and academic scholarship, but also be educated in management, strategy, policy, and operations of healthcare delivery. Furthermore, the evolution from a paternalistic healthcare model to a collaborative team-based, patient-centered approach calls for rising physician leaders to develop superior communication skills and emotional intelligence.4

In response to the foreseeable void in physician leaders and the dearth of formal leadership training, in 2010, the Physician Leadership Institute (PLI) was founded at Henry Ford to identify early to mid-career physicians with inherent leadership strengths and to cultivate their development into adept physician leaders capable of navigating the unique culture, challenges, and opportunities within Henry Ford Health System (HFHS) and the Henry Ford Medical Group (HFMG). The primary aims of the PLI are to:

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1. Establish basic leadership competencies — including technical knowledge, industry knowledge, problem-solving skills, communication, commitment to lifelong learning, and emotional intelligence — and provide training tools to cultivate physician leaders.

2. Strengthen and evolve a unique culture that engenders diversity and inclusion and broad connectivity across the enterprise and aligns with institutional mission and goals.

3. Facilitate opportunities for career advancement to keep competent physician leaders within the organization.

The mission of HFHS and HFMG is to provide clinical care, medical education, and research. As such, the term physician leaders used here also refers to the research scientists who participated in the PLI.

The current study aimed to evaluate the outcomes of the PLI curriculum with special focus on physicians’ internal advancement and career development.

**METHODS**

**PLI Curriculum**
Selected participants include 12–20 staff physicians and post-doctoral PhD faculty who are nominated annually by departmental chairs for their innate aptitude and desire to lead. The final selection is made by the executive committee of the PLI, consisting of four to six physician and administrative leaders. Selection is made to ensure the diversity of the class in terms of specialty physicians/primary care physicians, gender, ethnicity, and practice site (Henry Ford Hospital/satellite/affiliated hospital). Because research is an integral part of the mission of HFHS, each class includes a scientist. As the PLI is designed to prepare the next generation of leaders within HFHS, general (but not absolute) guidelines include those who had been with HFHS for at least five years and are early- to mid-career and hence typically younger than 45.

The PLI curriculum includes eight monthly education sessions and requires the completion of a capstone project. Each of the education sessions lasts a full day and features reflection exercises, small-group activities, large-group discussions, and interactive didactics led by senior leaders across many disciplines, including finance, business strategy, patient safety, healthcare management and leadership, health system operations, and talent management. Figure 1 details an overview of the PLI curriculum. Teams were also paired with advisors to facilitate the design and completion of the capstone projects. As appropriate, selected invited non-HFHS faculty were also included.

**Influencer Model**
PLI participants are encouraged to identify and leverage their individualized leadership strengths and taught to practice the influencer model as a means to change behaviors to achieve measurable results. The influencer model focuses on clarifying measurable results, identifying vital behaviors, and analyzing six sources of influence.

**FIGURE 1: PLI CURRICULUM OVERVIEW**

**Session 1**
- Opening Remarks & HFHS Leadership
- Core Leadership Competencies
- Emotional Intelligence Development Plan
- Leveraging Your Leadership Strengths
- Influencing as a Leader
- Reflection & Journaling
- Introduction to Business Planning
- Capstone Project “Idea” Submission Form

**Session 2**
- Making Positive Connections & Expressing Gratitude
- Culture of Leadership Development
- Leading with Emotional Intelligence
- Project Managing as a Leader
- Business Planning

**Session 3**
- Business Planning
- Leadership Activity
- Crucial Conversations
- Reflection & Journaling

**Session 4**
- Quality & Safety at HFHS
- Risk Management & Sentinel Events
- Care Coordination & Readmissions
- Patient & Family Engagement
- Ambulatory Quality, Population Health, & the Henry Ford Accountable Care Organization
- HFHS Analytics

**Session 5**
- Leadership Activity
- Capstone Projects
- Business Planning
- Crucial Conversations

**Session 6**
- Compassion: For Self & Others
- Business Planning
- Crucial Conversations
- Healthcare Equity
- Talent Management
- Reflection & Journaling

**Session 7**
- Leadership Activity
- Storytelling to Influence as a Leader
- Business Planning
- Appreciative Inquiry
- Reflection & Journaling

**Session 8**
- Psychological Flexibility
- Capstone Project Presentations
- Physician Peer Partner Mentoring Program
The first step of the influencer model asks participants to create a measurable result that quantitatively describes the desired outcome in time-bound manner. Second, participants are challenged to identify crucial moments and vital behaviors that will lead directly to results. Vital behaviors are actions that explain exactly what to do and how to do it. For example, a crucial moment may be “I want to sleep an additional 30 minutes in the morning.” The vital behavior would then entail “write one paragraph each weekday morning” which would ultimately lead to the result: “complete the manuscript by the end of the month.”

Subsequently, participants are called upon to analyze six sources of influence that impact the vital behavior and, therefore, the measurable result. The first source of influence analyzes personal motivation and asks what might be painful, frightening, boring, or uncomfortable about the vital behavior; the second source of influence evaluates personal ability and what gaps in knowledge, understanding, physicality, or social skills may interfere with the vital behavior.

The third and fourth sources of influence call for analysis of social motivation and social ability. This involves assessing whether peers are encouraging the vital behavior and if they are providing the help, information, and resources required.

The fifth and sixth sources of influence look at structural motivation and ability to determine whether pay, promotions, performance reviews, or costs are encouraging the vital behavior and if there are adequate tools, facilities, proximity to others, and policies to facilitate the vital behavior. Through adoption and application of the influencer model, PLI participants are capable of changing their attitudes and behaviors to produce measurable and sustainable results.

Emotional Intelligence
Throughout the PLI curriculum, particular emphasis is placed on emotional intelligence, the core leadership competency. Originally coined by Salovey and Mayer in 1990, emotional intelligence describes the capacity for recognizing one’s own feelings and those of others, and for the effective regulation of emotion in oneself and in relationships.5

Participants are challenged to enhance their emotional intelligence through the development and application of its four key elements: self-awareness, social awareness, self-management, and relationship management. In becoming self-aware, participants learn to anticipate how they are perceived, which in turn fosters their social awareness as they are better able to recognize, respect, and relate to the emotional cues of others. Subsequently, participants are taught to channel this personal and social awareness into becoming superior self-managers who exercise control, adaptability, and optimism, as well as strong relationship managers, capable of inspiring and influencing others to enhance the execution of their vision.

Appreciative Inquiry
The concept of appreciative inquiry is taught and accentuated as an approach for generating positive transformation. The concepts of positive core and the 4-D cycle are presented as tools to aid in the development of an appreciative inquiry, which evokes positive imagery that leads to positive action.6

To establish a positive core, participants are asked to reflect on strengths, peak experiences, best practices, past successes, and key learnings. This positive core serves as the framework for construction of a 4-D cycle that circulates through 1) Discovery: appreciating the best of what is working well; 2) Dream: envisioning what might be; 3) Design: discussing what should be; and 4) Destiny: innovating what will be.

Integration of the positive core within a 4-D cycle facilitates participants’ ability to appreciate, envision, and co-construct positive change within themselves, their departments, and the greater HFHS community.

At the inaugural session, participants are divided into three teams with which they execute the capstone project. Together, team members work to develop and submit three project proposals that aim to improve the HFHS system, are capable of implementation within 12 months, and impart some measurable, meaningful, or sustainable deliverables.

PLI facilitators, in discussion with senior leadership, then review and select one of the three proposed projects from each team. Over the next eight months, teams work to develop a business plan, which consists of a report that defines the project’s intent, identifies necessary resources, organizes the development, outlines measurements of success, and projects the return (financial or other). At the final session, each team presents its business plan to the HFHS budget oversight committee, at which point they may establish funding to execute their capstone project.

In its final stage, the projects are presented on day of graduation to senior leadership (including CEO, COO, hospital director, CMO, department chairs), and faculty as a final presentation with open feedback.

Participants and Sampling
Staff physicians were considered eligible for the current study if they: (1) graduated from the PLI; (2) were active employees at HFHS; and (3) entered the SurveyMonkey website through a provided link and answered the questionnaire. The questionnaire was sent via email through the link produced at the SurveyMonkey website (https://www.surveymonkey.com/r/RNSFWV7).

Questionnaire — Physician Leadership Institute Graduate Survey
The English version of the questionnaire, “Physician Leadership Institute Graduate Survey,” was emailed to all PLI graduates actively employed by HFHS. The questionnaire items were designed to identify the PLI’s influence on staff physicians’ personal and professional growth. Sub-groups of items objectively evaluated career advancement (e.g., year of graduation, current position, promotions since graduation, election to the Board of Governors), while others assessed attitudes and beliefs about individuals’ leadership journey, impact of the PLI, and interest in future opportunities. Additional comments were accepted as the last item on the questionnaire. Detailed information regarding the questionnaire or the full version can be obtained from the authors upon request.

Data Analysis
Descriptive statistics were provided to report the respondents’ year of graduation from the PLI, current position at HFHS,
Twenty-eight (38.89 percent) physicians/scientists reported having received a promotion and 11 (15.28 percent) endorsed serving on the HFMG Board of Governors, an elected body of physicians/scientists, since graduation. Table 1 stratifies the number of promotions received and election to the Board of Governors by year of graduation from the PLI.

Seventy-one (98.61 percent) respondents provided free text responses to the question “Since graduating, how would you describe your leadership journey?” Sixty-three (88.73 percent) responses were categorized as “positive,” describing their journey as continuous, evolving, or progressive, while 8 (11.27 percent) responses were categorized as “negative,” chronicling their journey as stagnant, unchanged, or regressive.

Sixty-nine (95.83 percent) respondents provided free text responses to the question “What impacted you most about your PLI experience?” The majority of responses reported developing connections and networking (44.92 percent), cultivating emotional intelligence (20.29 percent), strengthening communication skills (17.39 percent), and receiving coaching from senior leadership (17.39 percent) as impactful. In addition, several responses reported gaining institutional and operational knowledge (15.94 percent), learning finance concepts and executing the capstone project (11.59 percent), developing team-building skills (13.04 percent), and identifying and maximizing strengths (8.70 percent) have impacted their development. Detailed information regarding the most impactful portion of the PLI curriculum is provided in Figure 3.

Sixty-two (86.11 percent) respondents answered the multiple-choice question “Are you interested in any of the following with other PLI graduates?” The majority (66.13 percent) were interested in networking opportunities, social events, and educational opportunities. Of the remaining respondents, 17.74 percent were exclusively interested in educational opportunities.

**RESULTS**

From the years 2011 to 2018, a total of 123 staff physicians graduated from the PLI, and of these, 110 (89.43 percent) are still active employees at HFHS. The survey was emailed to the retained PLI graduates in April 2019 and the response rate from the collected data was 65.45 percent (72/110 individuals). Respondents represented all eight graduating classes, with the majority having graduated in more recent years. Figure 2 details the percentage of respondents stratified by PLI graduating class.

**FIGURE 2: PERCENTAGE OF RESPONDENTS BY YEAR OF GRADUATION**

![Figure 2: Percentage of Respondents by Year of Graduation](image-url)
opportunities, 12.90 percent were exclusively interested in networking opportunities, and 3.23 percent were exclusively interested in social events.

**DISCUSSION**

The PLI has successfully trained competent physician leaders who embody the culture of HFHS and HFMG and are well-acquainted with the organization’s infrastructure and senior management. An emphasis on core leadership competencies, a formal didactic and interactive curriculum, and the PLI capstone project have contributed to the growth of both personal and team-oriented skills.

Based on “practice management,” the prototypical physician leader development model, pioneered and implemented at the Cleveland Clinic in 1990, the PLI ensures core leadership competencies — technical knowledge, industry knowledge, problem-solving skills, communication, commitment to lifelong learning, and emotional intelligence — are taught, exercised, and reinforced throughout the curriculum with diverse methodologies.8

Additionally, formal didactics in finance, strategic planning, and operations are interspersed with reflection time and small-group discussions to encourage physician self-awareness and mindfulness. During this time, physicians are encouraged to reflect on how to leverage their strengths, express compassion, offer gratitude, and exhibit psychological flexibility in the context of a team. Principles of the influencer model and appreciative inquiry are incorporated and emphasized throughout the curriculum to promote a

### TABLE 1: CAREER ADVANCEMENT DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Graduation Year</th>
<th>Promotion Received N (percent)</th>
<th>Election to Board of Governors N (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>3 (10.71)</td>
<td>2 (18.18)</td>
</tr>
<tr>
<td>2012</td>
<td>2 (7.14)</td>
<td>2 (18.18)</td>
</tr>
<tr>
<td>2013</td>
<td>3 (10.71)</td>
<td>2 (18.18)</td>
</tr>
<tr>
<td>2014</td>
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<tr>
<td>2016</td>
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<td>2 (18.18)</td>
</tr>
<tr>
<td>2017</td>
<td>4 (14.29)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>2018</td>
<td>3 (10.71)</td>
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</tr>
<tr>
<td>Unknown</td>
<td>4 (14.29)</td>
<td>0 (0.00)</td>
</tr>
</tbody>
</table>

### FIGURE 3: MOST IMPACTFUL COMPONENTS OF PLI CURRICULUM

[Bar chart showing the most impactful components of PLI curriculum according to graduates (%).]
growth mindset and foster the development of aspirational, yet achievable, goals.

Finally, the PLI capstone project provides a practical on-the-job opportunity for physicians to apply their newfound financial, analytical, managerial, and marketing skills in the creation of a business plan. The process of working as a team to navigate through various administrative channels and secure resources builds camaraderie among participants from different departments as well as regional and statewide HFHS locales, and allows physicians to better understand the project-approval process at a hospital level.

Even in cases where a project does not receive the requisite funding, the completion of a capstone project has been shown to ingrain newly learned competencies and improve each physician-leader’s probability of future success. Examples of successful PLI capstone projects include the development of a virtual wound care program, an initiative to reduce transfers/referrals to non-HFHS providers and hospitals, implementation of best practice standardization of IV fluids, and creation of a comprehensive venous disease program.

The majority of PLI graduates characterized the trajectory of their leadership journey as positive, citing the development of meaningful connections, continuous networking, insightful communications, senior leadership coaching, strength optimization, skillful team-building, enhanced emotional intelligence, and broad institutional, operational, and financial knowledge as most impactful in their careers.

Furthermore, there is a high retention rate among PLI graduates (89.43 percent from 2011–2018) with 38.89 percent having received a promotion since graduation. In recognizing talented physicians with innate leadership abilities and equipping them with the unique tools required for administrative success within the infrastructure of our institution, the PLI produces a pool of candidates for senior leadership succession spanning many departments. By hiring from within these candidates, the PLI has addressed the challenge of finding and recruiting leaders who embody the experience, skillset, and outlook to best succeed at HFHS.

Despite the strengths of the PLI reported in this study, there are limitations that should be acknowledged. First, the PLI selection process represents an inherent bias in that participants are nominated and chosen because of their evinced leadership abilities; therefore, it is possible the graduates’ career success is attributed to the initial selection process, rather than completion of the PLI. Second, there is a response bias associated with the employed survey methodology, as those who are satisfied with the PLI education were more likely to reply. Finally, this study presents mostly descriptive statistics, which are of limited predictive value.

CONCLUSION

The successes of the PLI may serve as a model for other institutions interested in cultivating and retaining physician leaders.

The development of similar initiatives that emphasize leadership competencies, core institutional values, business planning, operational practices, and completion of a capstone project may aid other hospital systems in creating a self-sustaining pool of candidates for senior leadership who are capable of both innovation and implementation. Ultimately, this self-sustaining pool may help to minimize the need for outside leadership training programs, recruiting agencies, and consulting firms.

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In this article ...

As the COVID-19 pandemic shapes our new normal, telehealth and locum tenens work are redefining healthcare — how it’s delivered and what that means for Americans.

FROM LYFT AND UBER TO POSTMATES AND Instacart, more than 57 million Americans have been employed through the gig economy which, according to a recent Intuit survey, had been expected to comprise 43 percent of the workforce this year.

The gig economy trend has extended to healthcare as well. Consumers across the country have more accessible healthcare thanks to apps and startups that connect them to a physician via a telemedicine video appointment or to schedule care online. So, how have doctors and other medical professionals been impacted by the gig economy?

Currently, COVID-19 is the top concern of providers. Telemedicine’s potential for virtual care will be essential in treating those with the virus and protecting the healthcare professionals leading the charge. Expanded access to care through digital tools also addresses other problems, including lack of rural healthcare, physician shortages, and burnout.

GROWING INTEREST IN TELEMEDICINE, PART-TIME WORK

The popularity of telemedicine has steadily increased over the years. A report¹ issued last year revealed that from 2015 to 2018, the number of physicians who self-reported telemedicine as a skill doubled; the number continues to increase by approximately 20 percent per year. This implies that the number of doctors leveraging telemedicine is growing quickly. This finding is also consistent with significant growth in the number of telemedicine patient visits, which increased annually by 261 percent between 2015 and 2017, according to a recent study² published in JAMA.

With the global pandemic of COVID-19, telehealth has seen a huge surge in the past few months. As of March 2020, 18 states had enacted emergency regulations to increase the use of telehealth against the epidemic; some states now allow doctors and patients to collaborate by phone.³

A Doximity study showed that in addition to telehealth, a growing number of physicians are interested in locum tenens work. Locum tenens is a long-standing fixture of the medical world and can be defined as a physician who temporarily fulfills the duties of another doctor. For example, locum tenens may fill in for a physician who is on family or maternity leave, or the locum tenens may be temporarily employed by a hospital or practice that is under-staffed. These temporary positions can be part-time or full-time.

Looking at these trends along gender lines, it is interesting to note that women were 10 percent more interested in telemedicine jobs than were men, but in evaluating physician interest in locum tenens opportunities by gender, women were significantly less engaged than their male counterparts.

When examining physician interest by age, the study found nearly equal engagement in telemedicine job postings across various age groups, proving that older physicians are equally interested in adopting digital health technologies.

TREATING COVID-19 AND OTHER INFECTIOUS DISEASES

The COVID-19 pandemic is putting healthcare workers under tremendous stress; much is unknown about treatment and
long-term effects, and it’s not always clear when patients need to be seen by a physician.

Virtual care has the potential to ease concerns among patients by broadening access to care and providing consumers with important health information no matter where they live. Physicians can see their patients via video, discuss symptoms, and ultimately decide if COVID-19 testing is required. This reduces the stress of healthy individuals who are concerned that they might have the virus, and it helps prevent contagion from those who have contracted it by limiting unnecessary travel or visits to clinics, hospitals, and other care settings.

Because a two-week quarantine is recommended for those who have been infected with COVID-19, telemedicine tools give physicians the opportunity to check on patients to ensure they are recovering without additional health concerns or complications. This also protects physicians by allowing them to advise and treat concerned or infected patients from a safe distance.

Dealing with new and deadly viruses could be the new normal. Telemedicine tools can help the world better prepare for these epidemics by connecting doctors to patients virtually and protecting both from higher risk of infection.

**BENEFITS FOR PHYSICIANS**

Telemedicine can provide physicians more flexible hours and scheduling than traditional care settings might. Eliminating lengthy commutes or allowing doctors to work around personal obligations such as child or family care may help alleviate the burnout that physicians feel in more traditional care settings and improve overall attitudes about the profession.

Physicians also benefit from being able to expand their patient base, reach new patient groups, and view patient cases in distant venues that they may not have otherwise encountered. Part-time work in both telemedicine and locum tenens can help offset medical school debt as an additional source of income.

According to the Association of American Medical Colleges, 75 percent of medical school students in the class of 2018 graduated with an average loan debt of $196,520, which included debt from medical school, undergraduate studies, and other higher education expenses. With a $197,000 student loan balance, a young doctor on average would owe $2,212 a month on the standard, 10-year federal repayment plan, (assuming a 6.25 percent average interest rate).

Included in the costs associated with running a practice is malpractice insurance, the cost of which varies from state to state. In California, a surgeon can expect to pay between $22,000 and $34,000 per year. With telemedicine work, malpractice insurance typically is covered by the telemedicine staffing organization.

**PATIENTS BENEFIT TOO**

Telemedicine offers many benefits for patients as well — the most notable being affordability and increased access to care. Patients’ out-of-pocket costs are often less than for traditional care. A 2017 Health Affairs Study found that on average, a telehealth visit costs about $79, compared with about $146 for an office visit. This difference can be life-changing for patients who are struggling to pay for certain health services and could reduce what the nation spends on healthcare annually.

While the benefits for patients were outside the scope of our report, other studies have shown that patients benefit from more flexible access to physicians via telemedicine, especially for routine medical questions and checkups, mental health care, and post-natal care. Telemedicine also expands access to care in rural areas, where doctor shortages have been most acutely felt.

In rural areas, telemedicine helps patients access both primary care and specialists that are otherwise unavailable. Nearly one in five Americans lives in a rural area and depends on local hospitals that may not have all specialties represented on their clinical staffs. During the past 10 years, 120 of those hospitals have closed, leaving millions of patients across the country with limited access to care, particularly specialty care.

With the increased use of telemedicine tools, patients get “on-demand” access to care, which means that parents with a question about their infant can conveniently connect with their physician, as can a full-time professional who must fit mental health care around a busy work schedule. Locum tenens work can also encourage physicians from urban areas to work temporarily in rural towns to help mitigate the losses experienced when a hospital closes.

Mental health is also an area where telemedicine improves the delivery of care. One in five adults in the United States lives with a mental illness, but the stigma associated with mental illness often prevents them from seeking treatment. Because of the stigma attached to mental health issues, some patients are daunted by the thought of visiting a doctor’s office. With telemedicine, patients can conveniently connect with their doctor or therapist at any time or place, even on vacation, all from a private venue. This can lessen the pressure or anxiety a person feels about seeking help.

With telemedicine, patients can choose mental health professionals across the country with the assurance that they will not have to switch doctors if they move to a different area.

Telemedicine platforms are increasingly being offered and covered under major health insurance plans as well as via apps, which makes them affordable for patients. Payers are also signaling their support for telemedicine, praising the many positive changes in federal and state policies in 2018. These factors have contributed to the 1.7x rise in telemedicine health benefits among large employers (27 percent in 2015 to 74 percent in 2018).

**TRANSFORMING THE HEALTHCARE LANDSCAPE**

Clearly, physicians are embracing the gig economy and turning to telemedicine as an alternative to traditional clinical settings. Outstanding among the many benefits of telehealth are flexibility, safety, and convenience. The trend toward increased adoption of telemedicine — which is certain to continue unabated — will transform the healthcare landscape; physician shortages, access to care, and affordability will be eased.

As physicians across a broad range of specialties, age groups, and geographic regions are drawn to telemedicine
and temporary positions, more patients will gain access to quality care. Whether it be a potential case of COVID-19, a video chat with a mental healthcare provider, or a follow-up visit with a provider for a patient who lives 100 miles from the closest hospital, doctors and patients across the country will benefit from the rise of telemedicine.

Peter Alperin, MD, trained as an internal medicine physician at UCSF and currently is vice president at Doximity, where he leads the development of products geared toward clinicians. He has also had roles in product development with Archimedes and ePocrates and served as director of informatics with Brown and Toland Medical Group. He remains in active medical practice in San Francisco. palperin@doximity.com

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Communication is the centerpiece of good healthcare and the use of technology (remote evaluation and monitoring, basic video conferencing, telemedicine) is being used to triage patients during the COVID-19 pandemic. Dr. Alperin discusses how physicians and payers are embracing telehealth, using technology for clinical care, and the emerging models for reimbursement for these services. Physicians are also honing their clinical skills, working remotely in a safe manner, and looking for jobs and opportunities that leverage telemedicine and other technologies.

Join us as Dr. Alperin shares his thoughts on technology and telemedicine benefits for patients and physicians, particularly when practicing amid an infectious disease pandemic like COVID-19.
FINANCIAL MANAGEMENT

THE FUTURE OF PRIVATE EQUITY IN HEALTHCARE

By Lola Butcher

In this article ...

Private-equity firms’ interest in hospitals and physician practices is growing. Whether that bodes well for the future of healthcare is a point of debate.

PRIVATE-EQUITY INVESTMENTS IN HOSPITALS and physician practices, which have been building for several years, will continue to grow for the foreseeable future — on this point, there is consensus. But whether private equity’s influence on physicians, their patients, and the healthcare sector overall will ultimately prove to be good or bad is up for debate.

Private-equity firms, investing capital from pension funds, university endowments, high-wealth individuals, and other sources, are intensely interested in healthcare providers, according to research conducted by the Medical Group Management Association (MGMA). Globally, more than 10 percent of the $560 billion in private-equity investments in 2018 occurred in the healthcare sector — and more than half of that was invested in the provider sector.

“That’s double from the level of investment in 2017,” according to Halee Fischer-Wright, MD, MMM, FAAP, FACMPE, president and CEO of MGMA. “We are seeing more deals and we’re also seeing bigger deals at the global level,” she says.

In the United States, private-equity investment reached $29.6 billion in 2018, with $23.2 billion invested in the provider sector. That includes medical practices and hospitals, but also a much broader range of providers, such as home health care companies, Fischer-Wright says.

PwC’s Health Research Institute named private-equity investment as one of its top healthcare trends in 2019. This year, PwC forecasts private equity will continue its healthcare focus for four reasons:

1. With a U.S. stock market correction widely forecast, healthcare is considered one of the safer sectors in which to be invested. “Healthcare is not necessarily 100 percent recession-proof, but it is at least a bit recession-resistant,” says Ben Isgur, who leads PwC’s Health Research Institute.

2. Consumers are looking for better access to healthcare, which requires investment and willingness to change. “There is some consumer power behind this,” Isgur says. “They are wanting more connection points and more convenience.”

3. The private-equity industry, having unprecedented success in the past five years, has a lot of money to invest, and the healthcare sector, representing more than 18 percent of the U.S. gross domestic product, is a logical target.

4. Because the healthcare industry is fragmented, it offers opportunities to create value by consolidating multiple entities and addressing inefficiencies to lower costs and increase profits, says James Prutow, principal in PwC Private Equity Value Creation.

Certain specialties, such as dermatology, ophthalmology, anesthesiology, and gastroenterology, have been attractive to private-equity firms in recent years, but PwC trend watchers see that list expanding. Prutow and Isgur predict all specialties, including family practice and pediatrics, will be private-equity targets going forward.
Isgur points to behavioral health, where the need for services outstrips the supply, as a logical opportunity for private-equity investment. “Any type of investment in technology or operations that could make existing behavioral health networks more efficient and able to see more people will be an area of real growth going forward,” he says.

HOW DEALS WORK

Lawrence P. Casalino, MD, PhD, chief of the Division of Health Policy and Economics at Weill Cornell Medicine in New York, led a group of researchers who interviewed consultants, attorneys, investment bankers, and leaders of private-equity firms, physician practices, and health insurance companies to document how private-equity investments of physician practices work. Their findings, published early last year in the Annals of Internal Medicine, include:

- Private-equity firms typically acquire 60 percent to 80 percent ownership stake in practices. They want physicians to remain as investors so they are incentivized to grow the practice.
- Deals generally are anchored on the acquisition of a large, well-managed practice that has a good reputation in the market. The investors typically pay eight to 12 times EBITDA (earnings before interest, taxes, depreciation, and amortization) for the platform practice, but much less — typically two to four times EBITDA — for the smaller practices that are merged into it.
- Investors expect an average annual return on their investment of at least 20 percent. Private-equity firms try to reach this goal by assembling independent practices in the hope that they can share fixed costs, find synergies among the practices, increase efficiency, increase leverage when negotiating prices with insurers, and sell the assembled practices within three to five years for much more than the private-equity firm’s initial investment.
- Practice owners may receive as much as $1 million or more per physician but, after the acquisition, they receive market rate salaries and little or no revenue from ancillary services.

Private-equity investors typically hold investments for about five years, says PwC’s Prutow, although he sees some variability when it comes to physician practice investments.

“It wouldn’t surprise me at all if we saw more situations where the hold periods are approaching 10-plus years,” he says.

There are three exit options:

1. The practice is sold to a larger company, perhaps one connected with an insurer.
2. The practice is sold to another private-equity fund that may own another practice in the market and sees opportunities for further consolidation.
3. The investors cash out through a stock offering, although initial public offerings (IPOs) are less common for physician practices than some other healthcare investments.

PHYSICIAN PERSPECTIVE

Private-equity investments can be a lifeline for physician practices that need an infusion of capital and leadership or administrative support during a challenging time, says Byron C. Scott, MD, MBA, CPE, FACEP, FAAPL, deputy chief health officer with Simpler Consulting, IBM Watson Health.

Fischer-Wright of MGMA agrees. “This can provide the resources to compete in a business environment they were never trained to go into, so it has the potential to do greater good,” she says. “But the burden is on the physician to know that the entity that you’re doing business with has the values that are aligned with your values.”

She cautions physician leaders to consider that their autonomy and independence — two attributes that private-practice physicians have traditionally valued highly — will change when an outside investor buys controlling interest in the practice.

They also should consider the long-term financial consequences for practice partners at various stages of their careers. Once it acquires control of the practice, the investment firm is likely to pay physicians the median compensation for their specialty in their market. While all partners may get a big payout when the deal closes, that payout is likely worth more to a partner who is near retirement than to a mid-career partner.

“One thing I think physicians don’t recognize is that, by and large, they’ll get a permanent decrease in salary,” Fischer-Wright says. “Say, if you have been making 40 percent above median compensation, you will be going to the median compensation. People think ‘Well, I’m going to get a million-dollar payout’ rather than ‘If I take a $150,000 hit to my salary for 20 years, what does that mean to me?’ ”

HEALTHCARE PERSPECTIVE

Some observers worry that private-equity firms, whose primary goal is to make money for their investors, are not aligned with the primary mission of healthcare, which is to help patients. That argument gained traction in 2019 when the private company that owned Hahnemann University Hospital, the main safety-net hospital in Philadelphia, filed for bankruptcy and announced the hospital was closing. Critics say the owner of the private equity-backed company that bought Hahnemann and a sister hospital in 2018 will ultimately benefit by Hahnemann’s demise because its valuable real estate will be freed up for a more profitable use.

Physician practices may also present profit-making opportunities that private-equity firms find more palatable than most healthcare providers would. Writing in the Harvard Business Review, Commonwealth Fund President David Blumenthal, MD, and two colleagues said investors’ business model is “cause for concern” in the healthcare sector. “[A]t least in some cases, the investors’ strategy appears to be to increase revenues by price-gouging patients when they are most vulnerable,” the authors wrote.

They point to the problem of “surprise” medical bills in which patients are charged for “out-of-network” services.
provided by physicians working at an in-network facility. “Private-equity firms have been buying and growing the specialties that generate a disproportionate share of surprise bills: emergency room physicians, hospitalists, anesthesiologists, and radiologists,” Blumenthal and his co-authors wrote. “Patients are often unaware that they need these particular services in advance and have little choice of physician when they use them.”

Thomas L. Higgins, MD, MBA, CPE, FACP, MCCM, FAAPL, chief medical officer at the Center for Case Management in Natick, Mass., worries that private-equity investments support the continued deterioration of America’s healthcare delivery system. “In the traditional model, the hospital made a lot of money on things like orthopedic surgery and open heart surgery and used that surplus to pay for the things that were not as well reimbursed, like behavioral health, and just simply the care of old, poor, and complex patients,” says Higgins, a member of the AAPL board of directors. “And we always felt that we had a responsibility to do the most good for the most number of people, and that included care of those who had no resources to receive that care.”

That healthcare delivery model is challenged, he says, when some stakeholders put a priority on profit over caring for patients, some of whom will never be profitable.

“What I worry about is that patients will be getting the equivalent of a coach seat on an airline designed to cram in as many patients as possible to drive corporate profit,” he says.

TIPS AND ADVICE

Fischer-Wright urges physician leaders to recognize that they have options. If one private-equity company is interested in investing in their practice, others will be as well. Physician leaders don’t need to accept terms with which they are uncomfortable.

Take the time needed to negotiate the right deal, she advises.

“I tell people it takes about 18–24 months to truly do an acquisition or investment with private equity because that time should be spent doing due-diligence,” she explains. “Be really clear about your goal. It is every bit as important for the physicians to have clarity and to be a champion for their end goal in three to five years as it is for the private-equity company.”

Scott, a member of the AAPL board of directors, spent 20 years in leadership positions at EmCare, now Envision Healthcare, a physician practice management company that went through a series of equity investments and an IPO during his tenure. He advises physician leaders negotiating with private-equity companies to think through success factors upfront.

The most important thing, he advises, is to make sure the physician practice has a strong advocate for patients.

“If you are contemplating a deal with a private-equity group, the hope is that the CEO or president of the practice will continue managing the practice,” he says. “That’s one way to make sure you have the right person in the room doing the right thing.”

Other advice:

- Honor your reputation. The name of a practice may change after an acquisition, but the brand associated with the platform practice must not. “You don’t want the transaction to impact your patients or the physicians you consult with,” Scott says. “Who you decide to sell to is important, and you have to make sure you have some say about what happens going forward.”

- Pay attention to details. The private-equity firm will have extensive experience with acquisitions, but physicians in the practice may be new to the process. Don’t make any assumptions about the contract or the working relationship after an acquisition; ask questions and make sure all parties are clear on every detail.

- Have board representation. The practice will have a new board of directors after the equity investment. “The most important thing is that the practice have the appropriate representation and leadership on the board,” Scott says. “That is a must-have to make sure the interests of the practice partners and the patients are being heard.”

- Be transparent. An acquisition affects practice partners differently from how it affects non-partner physicians and others in the practice. “Make sure you’re very transparent with everyone involved so they understand the potential benefit of doing this,” he advises.

- Lead. Help the practice’s new investors understand what is best for patients. “If you feel a decision is being made that is not completely right for patient care, stand your ground and make sure your voice is heard,” Scott says. “In the end, that is the most important thing.”

LOOKING AHEAD

The Commonwealth Fund authors wrote their commentary in the Harvard Business Review as a way to reach private-equity leaders, says co-author Lovisa Gustafsson, assistant vice president of The Commonwealth Fund. Their message: The healthcare sector can benefit from fresh thinking and new sources of capital to solve longstanding problems, but private investors should not misuse patients.

“Solve those problems and make money doing it — that’s great,” she says. “Just don’t try to price-gouge or take advantage of things in the short term.”

She points out that several states have already passed legislation to protect patients from surprise out-of-network bills, and media attention to egregious bills continues unabated.

Although an advertising campaign primarily funded by private-equity investors that own physician practices appears to have forestalled congressional action so far, growing public outcry continues to put pressure on policymakers and may lead to regulation, Gustafsson says. President Trump has said he supports such legislation.
“As this is impacting more people, Congress or regulators at the state level or the federal level are going to start asking: Is this a practice that we really think is appropriate for people when they’re sick and trying to get care?” she says.

Higgins worries that society will eventually come to see private-equity’s foray into healthcare has done more harm than good.

“I think this horse is out of the barn already, and we are not seeing the downstream consequences yet,” he says. “For the next three to five years, it’s going to be huge. It will be lucrative in the short run, but it’s not likely to perform well financially in the long-term. And then we’re going to be left with a broken system.”

Lola Butcher is a freelance healthcare journalist based in Missouri.

REFERENCES
INFLUENCE

CLIMBING THE LADDER TO CEO, PART III: FOLLOWING YOUR OWN PATH

This is the third of a five-part article series. Parts I, II, and III were originally published in The Physician Executive in 2006.

By Alan S. Kaplan MD, MMM, CPE, FACPE

In this article ...

Eight experienced physician executives share insights on how to best make the climb to the CEO post.

SHE’S A TALENTED SURGEON. HE’S A GREAT diagnostician. They should stick to what they do best; leave business matters to us.

Physician executives feel this negative bias as they venture into the business world. Larry Mathis, former Methodist Healthcare System CEO, brought it to the forefront in his book The Mathis Maxims: Lessons in Leadership, with one particular maxim: “Physician executive: an oxymoron.”

An experienced physician executive says, “Physicians are viewed as technicians not healthcare business experts.” Is this an unfounded bias creating a barrier to career advancement? A “caducean ceiling?”

Eight experienced physician executives acknowledged in recent interviews that physicians encounter a negative bias when they enter the boardroom. However, they also agreed that the bias is sometimes accurate — many physicians are not qualified for top business roles.

To be a competitive CEO candidate, you must demonstrate proficiency in addressing an organization’s top challenges. A medical degree is not a prerequisite. Consider the three top challenges identified by hospital CEOs:

1. Financial viability
2. Personnel shortages
3. Care for the uninsured

These are business matters. To be considered for a CEO position you must demonstrate that you are a proficient businessperson who happens to be a physician, not a proficient physician who happens to understand business. You will earn credentials and credibility through formal education and experience.

More specifically, experience is required in operations management, executing strategy at all organizational levels and managing the day-to-day business. This is a tough job. For non-physicians, the time required to work up through the rank-and-file to “CEO-qualified” is typically 15 years or longer.

For many physicians, this timeframe is impractical, as you have spent many years in medical school, residency, and clinical practice. Fortunately, there’s a valuable card physicians can play. Only physicians can be hired as a medical director or as the VPMA. This is an entree into a high-profile management job. Career progression from here can be difficult.
FINDING OPPORTUNITY

Here’s a look at some of the advice the eight experienced physician executives shared about moving into the CEO office.

Just as the board is risk-averse in selecting a CEO, it is likely that your current CEO is risk-averse in assigning you accountability for large-scale operations. You must show that you are capable by demonstrating consistent performance in roles of increasing magnitude.

Can you quantify your accomplishments using metrics such as margin, volume, time, or statistics? When you can deliver results, people want you. If you can only provide a qualitative summary then you are at a significant disadvantage. Simply holding a title is woefully insufficient. Every time you embark on an initiative or establish annual goals, ask yourself in advance how you will measure success.

Avoid being pigeonholed in a stereotypical physician role. Look for opportunity outside the typical physician domain. Success is evident when the CFO comes to your office to discuss a business matter rather than to seek medical advice.

However, be cognizant that you are in a competitive environment. Every time you pursue opportunity outside your traditional role you may be taking that opportunity away from another aspiring non-physician executive. You need to pursue your goals, but be considerate and respectful, as you are dependent upon your peers.

Avoid career stagnation. In a best-case scenario, you will be given opportunity to grow within your home organization. Keep abreast of new organizational initiatives, evolving conflict, market changes, and executive resignations. When opportunities arise, ask to be considered. If opportunity does not arise or you are routinely turned down, look elsewhere.

The interviews revealed that the majority of accomplished physician executives relocated for opportunity — often more than once.

One executive, now managing a $200 million budget, departed an academic facility to enter private practice in a small hospital. Here he became a part-time VPMA. Realizing lack of growth opportunity, he moved to a large inner-city health system for a full-time VPMA position. This position provided ample personal growth opportunity, which led to his current job as senior vice president of operations in a mid-size suburban community hospital — three moves.

Several search consultants say that many physicians limit their potential because they tend to be risk-adverse and unwilling to move. This is not true of non-physician executives, who expect to move for career opportunity.

CRITICAL SUCCESS FACTORS

The physician executives interviewed agreed that leadership is the number one success factor for CEOs. In operations management, being an independent performer is a death sentence. A good leader has the ability to assemble, motivate, support, and depend upon teams. You must demonstrate purpose, passion, and respect, and must develop trust by conducting yourself with fairness, integrity, and consistency. You will be judged by results, which will be delivered by your teams.

Listen and learn. You cannot possibly know everything there is about complex operations. Listen to your employees, especially the frontline workers. Get out of the office and get to know them. Allow them to be your mentors.

You will make mistakes. Take accountability, seek advice from peers, bosses, and consultants. One very accomplished executive said that six months after becoming a COO a peer told him that he was not doing his job! “I was a mediocre COO,” he admits, “thankfully I listened and worked on what I needed to do.”

Know that this is what you want to do. You will need drive and determination to succeed. Operations management is all about applying business principles, holding people accountable (including yourself), and delivering results.

You can’t worry about being popular or you will never reach your potential. You will need to weather extreme ups and downs, manage change, make deadlines, and confront tough issues. You must be able to make hard decisions despite incomplete information. You can always redirect; however, no decision equates to no results.

Develop and refine your negotiation and relationship skills. Many managers have failed due to their inability to gain the respect of peers and subordinates. Forming highly effective teams requires that you recruit and retain talent. A poor relationship with an immediate supervisor is the number one reason for turnover. A quick transition from autonomous, decision-making, self-reliant physician to team player is mandatory. Good people want to be empowered, not managed.

One physician executive learned this lesson during his MBA program. He tried to control his study group. This wasn’t working too well so he had no choice but to let go and allow himself to be dependent upon others. To his surprise it worked out well. “It changed me as a person,” he recalled.

The ability to work effectively with others goes beyond your immediate team. Success requires support from your supervisor, board, peers, medical staff, vendors, and consultants.

Most entry level physician executives have few direct reports but are still accountable for results. Consider this a great opportunity to hone your negotiation and relationship skills as you work with multidisciplinary teams. The lack of authority and direct reports is an unacceptable excuse for poor performance. Realize this and you will be much more effective in the long-term.

COMPENSATION MANAGEMENT

Managing your compensation during career transitions can be tricky. A common physician expectation is that the medical degree confers a certain level of compensation guarantee. This is certainly true of “MD/DO-required” jobs, such as medical director or VPMA/CMO. However, there comes a point at which your physician credentials are no longer relevant.

Consider a CMO transitioning to a COO role. In mid-sized hospitals, market compensation for the CMO usually exceeds...
that of the COO. Additionally, you do not need an MD degree to be a COO. Prepare for a significant pay cut unless your organization is willing to take into account your previous salary and pay a premium.

Compensation practices may appear to be counterintuitive. Assume you are a CMO in pursuit of operations experience. You are granted responsibility for laboratory services. Should you request more money for the additional responsibility?

Be careful. There are several other vice presidents who would gladly take on this operation without any expectation of increased compensation simply as a career builder, and they are frequently paid less than you!

Expect to work harder for the same pay. At some point, you may actually be performing more than one job. Most organizations follow a “market-based” philosophy. The rule of thumb is that you will be paid for the job that is more highly valued. Depending on the magnitude of your second role you may be able to negotiate an additional premium, but do not count on it. And do not even ask until you demonstrate that you can do the job — just say “thank you for the opportunity.”

One other point: larger organizations typically have higher management pay scales. Several physician executives maintained their salary level by transitioning from a CMO role in a smaller organization to an operations role in a larger organization.

The majority of physician executives interviewed for this series were primary care specialists. Management compensation is more commensurate with that of a primary care physician. Procedure-oriented specialists will most likely be required to accept lower compensation in the transition from clinical practice to management.

In the end, you must discard the notion of the “caducean ceiling.” It connotes a victim’s mentality not worthy of a leader. Instead, know what you want to do, plan your career, and earn your credentials. Follow your own path — then lead others.

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In this article ...
For Medicare for All to work for all stakeholders, physicians must play a lead role.

WE CANNOT CONTROL HEALTHCARE COSTS without greatly reducing the endemic waste that plagues our system. Moving to a single-payer, Medicare for All system would greatly reduce one part of that waste — administrative costs — but would have little effect on the waste in care delivery.

The decrease in administrative costs would occur only once, after which health spending would resume its inexorable rise. Price controls, the only other cost-reduction mechanism in the Medicare for All proposals, would harm many providers if their incomes were cut to the levels that those schemes necessitate. This is a self-defeating approach. Unless physicians can be engaged in the reform process, it is doomed to failure.

To make Medicare for All work for all stakeholders, it must give healthcare providers a strong incentive to cut the amount of waste in the system; but that isn’t as simple as just having doctors practice more efficiently in return for a share of the savings. The entire system needs to be restructured from top to bottom to provide the optimal conditions for physicians to deliver high-quality care in the most efficient manner.

Primary care doctors must be placed in charge of the system, and they must form groups large enough to take financial risk so that they can be paid for value rather than volume. By cutting waste and improving outcomes, high-performing physicians — both primary care doctors and specialists — could take better care of patients while maintaining or raising their own incomes.

Like other people, most physicians are wary of change. Under a restructured system, they’d have to make major changes in how they practice. They’d have to practice in groups different from any they’ve ever known, in many cases with physicians they don’t know. The financial incentives underlying their business would be turned upside down. Why should they do this?

To understand the reason, physicians must recognize that some kind of fundamental change is inescapable. The current fee-for-service system, like Soviet communism in 1989, cannot continue for long. The American people are crying out for change because they can no longer afford healthcare. This is the number one issue for voters. Politicians — at least on the Democratic side — are responding to this widespread popular discontent. Whatever physicians may think about Medicare for All, it’s coming, probably on the wings of a public option.

Under this approach, which is supported by Democratic Presidential Nominee Joe Biden, more and more people would join a public plan that would probably pay physicians at Medicare rates. Private insurance would continue to pay more, but it would shrink as a percentage of their business. So doctors would be faced with a painful choice: either remain as they are and see their incomes decrease, or participate in physician-led healthcare reform that allows them to recapture their lost revenue by taking financial risk. This model could save our healthcare system by cutting costs while allowing doctors to maintain or increase their incomes.

MANAGED COMPETITION
Besides risk, the other major component of this physician-led reform model is competition among providers. That may come as a surprise to those who believe that a single-payer,
tax-financed system would necessarily squelch free enterprise and result in the government making all decisions on healthcare, but this doesn’t have to be the case.

In the 1990s, the Clinton Health Plan relied largely on Alain Enthoven’s theory of “managed competition.” Under this legislation, health plans with standardized benefits would have competed for enrollees under very strict government regulation. The physician-led reform model does something similar, but with a major difference: Instead of managing the competition among health plans, it sets the conditions for competition among large primary care groups. This approach places the competition where it should be: with the providers who are best situated to reduce waste without stunting on necessary care.

Such a model would be difficult if not impossible to implement under a multi-payer system. The primary care doctors must be financially at risk for all their patients to align their incentives; under the current system, in contrast, they are constantly whipsawed between the incentives of fee-for-service and value-based arrangements of various kinds. Additionally, as long as profit-making health plans take primary insurance risk or administer the plans of self-insured employers, they will try to interfere in care management. As doctors know well, micromanagement is not good for them or their patients.

Instead, care management should be directed by primary care physicians. PCPs are best-suited to manage care because they are upstream of the major cost drivers: hospitals, specialists, ancillaries, and post-acute care providers. Through their treatment and referral decisions, PCPs influence the cost of a case and the patient’s outcome. They can appropriately manage many patients who have chronic conditions without referring to a specialist. They can coordinate care across care settings and they are well-placed to interface with community-based organizations that address patients’ unmet social needs.

Ideally, during the decade-long transition to Medicare for All, the care delivery system would be transformed along the lines described above. Primary care groups capable of taking financial risk would be incentivized to deliver high-quality care at the lowest possible cost. They’d refer to and collaborate with specialists who were committed to the same goals. Overall spending growth would slow and possibly reverse, yielding the extra money required for universal, comprehensive coverage while allowing healthcare providers to thrive as well.

This rosy scenario, however, cannot become reality without concerted action by the federal government. The corporate gigantism that has overtaken healthcare — in care delivery, health insurance, and pharmaceutical manufacturing — is too big for the free market to tame. The states are unlikely to agree on the regulations needed to rein in enormous healthcare organizations that often cross state boundaries, so any proposal to fundamentally restructure healthcare will require federal legislation.

**NATIONAL ALL-PAYER LAW**

As hospital systems become larger and employ more physicians, healthcare prices will continue to rise and independent doctors will find it harder to remain independent. Hospitals will never fully embrace value-based care as long as it threatens their primary business model, which is to fill beds and generate outpatient revenues. To create a viable, sustainable healthcare system, the market power of hospitals must be eliminated.

Federal antitrust policy is not adequate to handle this task. Even if the Federal Trade Commission had more latitude to deal with mergers among not-for-profit entities, the industry is already so consolidated that the FTC would have to break up health systems involving thousands of hospitals. Such a gargantuan effort would be practically and legally unfeasible.

**All-payer Systems**

The government could curtail health systems’ market power without breaking them up. For example, either states or the federal government could adopt “all-payer” models similar to those in Maryland and West Virginia. Under the Maryland model introduced 40 years ago, every insurer, including Medicare, Medicaid, and private health plans, pays uniform hospital rates negotiated between the state and the hospitals.

It would be difficult for other states to replicate this approach because commercial rates are now so much higher than Medicare and Medicaid rates. A more feasible approach would be to emulate West Virginia, which sets only commercial insurance payments to hospitals. In either case, however, an all-payer system would eliminate the ability of dominant health systems to extract very high rates from private payers.

Before Maryland implemented its all-payer model in 1977, the average cost of a Maryland hospital admission was 26 percent above the national average. In 2007, the average cost per case was 2 percent below the national average. In 2000, however, after the state eliminated payment adjustments based on the volume of hospital admissions, those admissions began to increase rapidly. Consequently, in 2014, Maryland started setting a global annual budget for each hospital in the state. Hospitals bill payers per admission (for inpatient care) or per service (for outpatient care) but are now expected to raise or lower their prices to remain on budget.

In the first three years after this program was fully implemented, Maryland hospital spending rose only 1.4 percent annually, well below the CMS target of 3.6 percent. Acute care admissions and gross hospital spending fell 2.7 percent and 2.3 percent, respectively, between fiscal years 2015 and 2016. Moreover, quality improved: Maryland saw a 6.1 percent reduction in readmissions and a 43.3 percent drop in hospital-acquired conditions over the three-year period.

As might be expected, providers responded to global budgets by shifting more care to the ambulatory and post-acute care sectors. Consequently, non-hospital spending in Maryland grew by 4.2 percent in 2016, greatly exceeding the national rate of 1.9 percent and offsetting the decrease in hospital spending.

**Renewed Interest in States**

It’s unlikely that most states will go in this direction; however, the federal government could adopt a national all-payer rate system. Early in the transition to Medicare for All, Congress could pass legislation requiring all private insurers and self-insured employers to pay the same rates to hospitals, with
adjustments for charity care and rural needs. Such rates would have to be negotiated by the government, which would continue to pay current Medicare rates; current state Medicaid rates would also remain in place until Medicaid was folded into Medicare during the transition period. Eventually, after private insurance disappeared, hospitals would be paid at negotiated rates across the board.

If the concept of a national all-payer system seems quixotic, no less an authority than Donald Berwick, MD, former acting administrator of the Centers for Medicare and Medicaid Services, recently proposed limiting hospital charges to 120 percent of Medicare rates across the board. “This is enough revenue to offset Medicaid underpayments and should provide appropriate pressure on hospitals to become more productive,” Berwick and Robert Kocher argued in a Health Affairs Blog post. The authors also recommended that future hospital price increases be limited to the annual increase in the consumer price index.5

DIVESTING PRACTICES

Even under all-payer rate setting for hospitals, healthcare systems that employ a large number of physicians would still have bargaining power. To eliminate their ability to raise costs by negotiating higher rates for their employed physicians, the government could simply prohibit hospitals and other non-physician-owned entities from hiring doctors or owning their practices.

There are several good reasons for doing this. Besides raising costs, hospital employment of doctors can reduce the quality of care by forcing physicians to admit patients to lower-quality facilities.6 Hospital-owned practices also have more preventable admissions than do physician-owned practices,7 and employed physicians are more likely than independent doctors to burn out because of their loss of autonomy.

The reluctance of healthcare systems to embrace value-based care must also be considered. Compared to independent practitioners, employed physicians have less incentive to restrain hospital utilization, so the divestment of owned practices would liberate physicians who are now “aligned” with hospital business strategies to pursue value-based care under a different set of financial incentives.

CORPORATE PRACTICE OF MEDICINE LAWS

Many states already have “corporate practice of medicine” laws that bar corporations from employing physicians. These statutes were enacted to avoid conflicts of interest between physicians’ duty to provide the best care for their patients and their employers’ dictates — exactly the kind of conflict in which many doctors find themselves today. Most states with such laws allow hospitals to hire doctors, however, since they’re also in the business of medicine.8

The sole exception is California. That state’s corporate practice of medicine law prohibits any non-professional organization except for a public hospital, a narcotics treatment program, or a nonprofit medical research firm from directly employing physicians. Unfortunately, the California corporate practice of medicine law has not had the intended effect. Instead of hiring doctors, private hospitals and health systems simply lease their services from “foundations” that stand in for professional corporations.

The federal government could enact a stronger law that prohibits hospitals from directly or indirectly employing doctors. The statute should be written so that it also applies to insurance companies that employ doctors, such as United/ Optum and Anthem. The venture capitalists that have recently been snapping up physician practices to turn them over for a profit should be forced to divest those practices as well.9

Hospitals would not have to be compensated for returning physicians to private practice. For one thing, it’s unclear whether most hospitals would be worse off economically if their medical staffs were independent rather than employed. Considering the losses that hospitals incur on practice management, some hospitals would benefit financially from divesting their owned practices. The hospitals’ main concern would be to prevent competitors from controlling their referring doctors. If no health system were allowed to employ physicians, that wouldn’t be a problem.

Certain kinds of physicians should continue working for or exclusively contracting with hospitals because they are indispensable to inpatient or ED care. Among these are radiologists, pathologists, emergency department specialists, and critical-care physicians. Hospitals should also be allowed to employ hospitalists, who can increase the efficiency of care.

The restructuring of the system required by the physician-led reform model obviously would upset a lot of apple carts; however, it would allow doctors to take back control of healthcare and, by doing so, eliminate enough waste to make the system sustainable. Without this waste reduction, Medicare for All will simply not work. Only physicians can save our system.

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REFERENCES


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ENVIRONMENTAL INFLUENCES
LEARNING TO LIVE WITH VOLATILITY: PREPARING FOR BUSINESS CONTINUITY AND RECOVERY FOLLOWING A DISASTER

By Debra Cascardo, MA, MPA, CFP

In this article ...
While we can’t predict a disaster, we can prepare for it and, more importantly, recover from it. Here are some strategies.

TERROR ATTACKS, HURRICANES, BLIZZARDS, forest fires, burst pipes. We all think it can never happen to us, but just ask those who have seen their homes and businesses damaged or destroyed and their lives disrupted by those disasters — large or small — that they thought could never happen to them. Since large and small disasters can happen at any time, it is critical to your practice that you take prudent proactive steps to prepare a detailed disaster recovery plan that will facilitate the recovery of practice operations as soon as possible. We can’t predict a disaster but we can prepare for it and, more importantly, recover from it.

In a time of medical competitiveness, it is important for practices to be flexible and able to respond to the needs of their patients in as many ways as possible. The keys to attaining this flexibility are planning and anticipation. This holds true for all aspects of your practice, including anticipating the worst and planning on how to meet the challenges presented by any disaster. Preparing for disasters requires an investment of time and money but the benefits for you, your patients, and your practice will be significant.

Superstorm Sandy caused billions of dollars in damages throughout several states and will be requiring millions of dollars and countless labor-hours to rebuild what was. If you were fortunate to be untouched by Sandy, then count your blessing but get ready for the next disaster.

I suggest that when reading this article you also refer to the article “Preparing Your Practice for Any Emergency Scenario” published in the January/February 2012 issue of the Journal of Medical Practice Management. Integrating the information in both articles will provide the basic information you need to develop your own plan customized to your specialty and geographic area without destroying your budget.
PLANNING PROCESS

The first step in recovering from disaster is to have a business continuity and disaster response plan in place just in case disaster should strike. Disaster preparedness, however, is a process not an event. A disaster plan should incorporate the individual needs for your office, specialty, and region. Target disasters most likely to affect your practice and concentrate on those.

The objective of the business continuity and disaster response planning process is to systematically sort out the various issues and priorities so that a cost-effective plan can be developed that corresponds to the level of loss exposure your practice can reasonably expect.

The process itself can be summarized in the following steps:

1. Provide management guidelines.
2. Identify the serious risks.
3. Prioritize the operations to be maintained and how to maintain them.
4. Assign your team.
5. Take a complete inventory.
6. Know where to get help.
7. Document the plan.
8. Review the plan with your entire staff, test the plan, and train your staff.

In the initial stages of planning, it is crucial that you brainstorm with your entire staff during planning meetings. This will serve the dual role of building staff awareness as well as highlighting potential risk areas of which management may not be aware.

By focusing on establishing priorities, your practice can plan how long each operation can be suspended and designate either a manual backup mode or a longer lead time approach for each function.

Tap into task forces and plans in place through your local hospitals, medical societies, and community associations and governments. The physicians should be active in their hospital disaster program and actively contribute their specialty skills. Join with other local practices to share and pool resources.

As with all of your office policies and procedures, your disaster preparedness plan should be written with input from your staff and updated on a regular basis. Assign disaster roles and cross train every position so there are backups for each role.

Planning is the first step on the road to recovery.

STAFF TRAINING

Once you have targeted likely crises and developed plans for coping with them, all staff should be familiar with the plan and trained in the contingencies. Cross training of staff in both medical and administrative tasks is an essential element of any plan and must include drills with and without patients both during and after hours.

The goals of the initial training are to discuss the plan with staff, assign responsibilities, and walk through a drill without patients. There should be monthly meetings that eventually will become quarterly meetings with a list of things that have to be taken care of. Whether man-made or caused by natural forces like a hurricane, it is important to use recent experiences as training events.

SAFETY

The safety of your staff and patients should be paramount in the plan. If a fire, tornado, or other disaster strikes during office hours, your first concern must be the safety of those in your office, whether that means evacuating them in the case of a fire or sheltering them in the case of a tornado.

Drills without patients should be conducted on a regular basis; if possible, drills with real patients or volunteer “patients” should also be conducted periodically. As with most everything, practice makes the correct response automatic.

Key issues to focus on during practice drills include:

- Were patients evacuated promptly, safely, and without undue panic?
- Did the predetermined evacuation plan used?
- Did staff meet at the designated site outside of the office?
- Were safety guidelines met?
- Were the authorities alerted?
- Were the office doors closed?
- Were efforts made to contain or extinguish any fire?
- Were patient records isolated or protected?

COMMUNICATIONS

Communicating with your staff and patients as to the extent of the damage and the immediate contingency plans is the next major item in a disaster preparedness plan.

The plan should state who is responsible for declaring the emergency plan is in place and include at least one backup person. The employee(s) in charge of communications must be able to gather and disseminate information accurately and appropriately. Have a Twitter account, website, and email addresses to build connections with your patients, hospitals, and community, so that if a disaster strikes, you are ready. There should be an easily accessible list of staff members’ phone numbers and email addresses, so they can be immediately informed of any disaster that occurs outside of office hours and alerted as to what contingency plans are to be initiated.

For staff members, there should be an emergency hotline that is updated daily regarding the state of the disaster and whether or not and/or where they should report. For instance, if a natural disaster such as a hurricane or blizzard has struck,
Your hotline should inform the staff if your building is open or not.

Initially, an email blast, Twitter/Facebook notice, and/or automatic call to all of your patients should be sent to notify them of the disaster and the closure of your office. A hotline number to call, estimated date of reopening, and other pertinent information should be included in this message.

The patient hotline should include the contingency plan for handling emergencies and prescription renewals and information on how patients can reach you or an alternate source (another physician, the hospital, or emergency services) for medical emergencies. It should also note that someone will be in touch regarding rescheduling appointments and lab tests, reporting test results, etc., as soon as possible.

For a projected long-term recovery, your temporary address, telephone numbers, and hours should be disseminated as soon as possible.

INFORMATION TECHNOLOGY AND ELECTRONIC HEALTH RECORDS

Ensure information technology (IT) systems and records are accessible even if the building you practice in is not. To protect patient information, the HIPAA security rules require practices to have a contingency plan in case of a natural disaster, fire, vandalism, or system failure. The plan must include policies and procedures for responding to an emergency that damages health IT systems, and it must assist the practice in adhering to important aspects of the HIPAA security rule, such as the proper method for disposal of a damaged server that contains protected health information. Your electronic health records (EHRs) should be backed up twice daily. Check your IT provider’s uptime record during previous disasters before one strikes.

Your EHR system should have an order-tracking feature that lists all of the tests ordered but not yet received so you know exactly what you need to track down from outside labs or other testing facilities.

Two components of the contingency plan that address your recovery should already be part of your IT policies and procedures:

1. The data backup plan: This plan establishes procedures for the regular update and storage of PHI. It is important to discuss all of these parameters with your IT vendor and to make sure you know exactly what the procedure is.

2. The data recovery plan: This plan deals with procedures for the restoration of data.

KEEPING IT CURRENT

While most organizations have records that cover the price, make, and model number of equipment at the time of purchase, they are usually not kept current. Keep updated lists of all of the equipment and supplies in your office so it is easier to claim losses and replace items. Pictures, brand names with model and serial numbers as appropriate, date of purchase, and cost will all aid in claiming losses.

Taking inventory should also include emergency vendor contacts for all equipment.

While in an inventory mode, make copies of your diplomas and state licenses. Better yet, scan them so you also have them electronically. Also keep employee records electronically so they can be available if your office files are not. Finally, keep paper and electronic copies of all forms used in your practice.

PHYSICAL INTERRUPTIONS

Plan for physical interruptions during a disaster and devise ways to continue despite downed power lines or flooded roads. Your practice operations need adequate work space, equipment, electricity, and computer connectivity to function. Your disaster preparedness plan should have contingencies for:

- Wi-Fi or other means to access the Internet.
- Generators for electricity and heat.
- An emergency gas supply for automobiles.
- Alternate offsite practices to address emergency patient needs.
- A fireproof safe for cash and receipts.

MEDICAL RECORDS RECOVERY

In the aftermath of superstorm Sandy, many physicians were left facing the question of what to do with paper medical records that were destroyed by fire or flood. It is essential to look at what should be done in the future to try and prevent this from happening again, but more importantly, what to do now.

The American Health Information Management Association has posted guidance on what to do if medical records are destroyed. First, try to salvage any records that you can. If a damage restoration company is used, ensure that you enter into a business associates agreement with that company to ensure that any and all services are performed in accordance with the HIPAA privacy and security rules for third-party contractors.

If the paper records are totally unsalvageable and cannot be reconstructed by either electronic data recovery or through a damage restoration company, reconstruction of the records must still be attempted. This can be done by reprinting

A Disaster Can Be:

- Loss of information
- Loss of access
- Loss of personnel
documents from computer systems pharmacy records with physician orders, laboratory and radiology databases, and other data backup services. If possible, retranscribe documents from a dictation system and check with consultants or other physicians for copies of dictated progress notes or consultative reports.

If reconstruction is impossible, the healthcare provider must document the date, information lost, and event that caused the loss of patient information. In addition to documentation of loss in the individual patient record, a detailed record must be prepared that includes at a minimum a list of patient records lost, recovery efforts undertaken, and the outcome of such efforts. If any of the affected charts are requested for disclosure for any reason, the documentation of recovery efforts and loss must be sent with that disclosure. Accurate and comprehensive documentation is key to assist with billing and patient care issues. In the case of partial destruction, providers should reconstruct the records as best as they can. In either case, providers must note on the face sheet of the medical records that “This record was reconstructed because of disaster.”

**KEEP YOUR INSURANCE POLICIES UPDATED AND CURRENT**

Meet with your insurance agent every two years to review your coverage to ensure that your current policy provides adequate coverage for your growing practice. Disaster-related coverage should include business interruption, physical damage, loss of life, and liability.

**MAINTAINING CASH FLOW**

Maintaining cash flow can be an issue during a disaster depending on the extent of the disaster and how soon you are able to get back to full function. This is a good reason to consider business interruption insurance.

Ongoing expenses will drain your cash flow while patient payments dry up and office hours slow down or stop due to office damage. Repairing damage must come before ramping back up to normal patient hours. Any slowdown in your operations further hurts finances as future invoices are tied to work delivered.

The ability of an office to function during an emergency will not only ensure optimal patient care and preserve the office’s reputation but may also be financially life-saving.

**DISASTER PREPARATION ROADMAP**

Here is a list to get started with. By no means is it all-inclusive but it will provide you with basics that you can build on depending on your specialty and the area in which you practice:

- Identify and notify those employees you believe should be deemed “emergency services personnel” and who will be required to work during a storm or evacuation order. Make arrangements for providing these employees with food and shelter. Make sure to have procedures in place for the evacuation of these employees if the workplace becomes unsafe.
- Identify your “essential employees.” These are employees who are not required to be at work during a natural disaster but who are vital to the continued operations of your company.
- Establish a contingency plan to address the needs of those employees who may be temporarily living in company facilities during a disaster. Ensure that you can provide them with such necessities as gas, food, and shelter.
- Review your existing policies to determine how to distribute paychecks to employees who cannot come to work because of adverse weather conditions or a lack of power.
- Establish a communication plan. This will include identifying ways to keep the lines of communication open with your employees even if power is out in the local community. Collect primary and secondary contact sources from your employees. Consider establishing a toll-free phone line through which employees can obtain updated information regarding the company’s status during an emergency.
- Review applicable leave policies and procedures to address and allow for disaster-related leave requests, including how such leave will be treated (i.e., paid or unpaid).
- Formulate a team of decision-makers who will have authority to make crucial decisions related to other human resource matters in the midst of the disaster. This team should establish a method of communicating with each of its members during the disaster.

Finally, the underlying process is that a business continuity and disaster response plan is something you can prepare without spending a lot of money and that every provider would benefit a great deal by thinking through as much as possible beforehand. It is a process that takes time and should be a team effort. Everyone on your staff must read it and sign and have a copy to take home. Both disaster recovery and business continuity require a high level of cooperation and coordination. Putting your team together and training it in advance will make all the difference in getting back to “business as usual.”

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Approximately 7–9 percent of people will develop acute appendicitis at some point in their lifetime; in children, appendicitis is one of the most common causes of acute abdominal pain. What is taught as the “classical” presentation of acute appendicitis — periumbilical abdominal pain followed by migration to the right iliac fossa (McBurney’s point) — is actually relatively uncommon.

Appendicitis can present in myriad different ways, from mild pain and tenderness in an otherwise well-appearing person, to frank septic shock and bacteremia from translocation of gut bacteria into the bloodstream. In children, compounding the variable presentation of appendicitis is the varying ability of parents and children to provide a history of the child’s illness, and the inability of some children to cooperate with a proper abdominal examination. As such, acute appendicitis in children (and adults) can present a diagnostic challenge to even experienced clinicians.

Many risk calculators and decision rules have been developed to tackle this challenge. Most of these tools have been developed for the adult population (e.g., the Alvarado Score, the RIPASA Score, and the Appendicitis Inflammatory Response (AIR) Score), but two newer tools have focused on pediatric populations: the Pediatric Appendicitis Risk Calculator (pARC) and the Appendicitis Pediatric (APPE) Score.

In adults and older children and adolescents who have abdominal pain, the Alvarado Score is the oldest and perhaps the best-studied tool, but recent evidence suggests its performance is lacking. The Alvarado Score has been outperformed by the more recent RIPASA and AIR Scores. The RIPASA Score was initially developed for use in a Southeast Asian (and more specifically Singaporean) population, but in multiple validation studies, it has been shown to be valid elsewhere, including in Middle Eastern and Western European regions. Karami et al. (2017) performed a head-to-head comparison in a small population of 100 patients in Iran. The results of this comparison showed superior test sensitivity of the RIPASA over the Alvarado and AIR (see Table 1). The area under the receiver operating characteristic curve was the greatest for the RIPASA (0.981) than for the Alvarado (0.906) and AIR (0.867).

As with many studies comparing the various appendicitis scores, patients in the Karami et al. study were primarily adults (mean age 32 years old).

### Table 1: Comparison of Test Characteristics Found in the Karami et al. (2017) Comparison of the Alvarado, RIPASA, and AIR Scores.

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Positive Predictive Value (%)</th>
<th>Negative Predictive Value (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alvarado</td>
<td>78.41</td>
<td>100</td>
<td>100</td>
<td>38.71</td>
</tr>
<tr>
<td>RIPASA</td>
<td>93.18</td>
<td>91.67</td>
<td>98.80</td>
<td>64.70</td>
</tr>
<tr>
<td>AIR</td>
<td>78.41</td>
<td>91.67</td>
<td>98.57</td>
<td>36.67</td>
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</table>
In pediatric patients, the pARC Score outperforms the Pediatric Appendicitis Score (PAS), but the pARC Score is a relatively recently described tool, and more validation studies would be helpful in supporting its use over the PAS. The most robust study of the pARC to date is probably that by Cotton et al. (2019), who studied 2,089 pediatric patients (mean age 12 years old) in community emergency departments. They reported an AUC of 0.89 for the pARC, which surpassed the AUC of the older PAS (AUC of 0.80). The pARC had a sensitivity of 93.5 percent for lower-intermediate risk patients (score 15–24 out of a possible 100 points) and a specificity of 97.8 percent for high-intermediate risk patients (score 75–84 of 100).

The newest pediatric appendicitis scoring tool, the APPE Score, is of unclear use given the limitations in how the paper presented the study’s performance statistics. Specifically, the authors present the APPE Score’s sensitivity and specificity only for the low- and high-risk groups. The authors stated that in the intermediate-risk group, the group of interest in many studies of acute appendicitis scoring tools, the test was not sufficiently sensitive or specific to differentiate cases of appendicitis from negative cases. The APPE Score is also so new that no independent validation studies were found.

Evaluating a patient for appendicitis can be a costly and frustrating affair, usually involving serial abdominal exams, lab tests, and imaging, specifically ultrasound and CT scan in most emergency department settings. While those ill-appearing patients with appendicitis — for example those presenting with septic shock or a rigid, distended, and tender abdomen — clearly need imaging and/or consult with a surgeon, there are many who have appendicitis but appear relatively well. The ideal risk calculator for appendicitis would be sensitive enough to detect cases of appendicitis in well-appearing patients while also helping to minimize testing and imaging in those who do not have appendicitis. No risk calculator is perfect, however, and clinicians should ultimately rely on a low threshold of suspicion for acute appendicitis.

In any of these calculators, a good number of patients remain in the “gray area,” which is to say that their risk of having appendicitis lies somewhere in between “low” and “high.” While no scoring test will perfectly differentiate cases of appendicitis, some calculators consistently perform better — in particular the RIPASA score and the pARC. These calculators may be the best current tools that clinicians can apply to reassure themselves that the likelihood of appendicitis is low enough in a patient to send them home, or high enough that they will contact a surgeon early on.

For the patients in the “gray area,” more study is needed to see which of these patients — if any at all — can be ruled in or out before imaging is performed. Continually testing and refining these tools remains an important exercise; an accurate decision rule can help emergency physicians send low-risk patients home more quickly and with fewer unnecessary tests, costs, and missed cases.

Following are insights from Ronald E. Andersson, MD, PhD, a colorectal surgeon at County Hospital Ryhov in Jönköping, Sweden, about the Appendicitis Inflammatory Response (AIR) Score.7

Why did you develop the AIR Score? Was there a particular clinical experience or patient encounter that inspired you to create this tool for clinicians?

In my PhD thesis, I had analyzed the diagnostic properties of clinical variables including laboratory values. I found that the diagnostic importance of clinical variables had been underestimated. In the everyday situation, it is difficult to evaluate the importance and weight of all clinical variables. The score is therefore a way of facilitating and makes the clinical diagnosis more objective. It works as a decision support instrument.

What pearls, pitfalls, and/or tips do you have for users of the AIR Score? Do you know of cases when it has been applied, interpreted, or used inappropriately?

In diagnosing appendicitis, it is most important to identify patients with advanced appendicitis whereas mild appendicitis may resolve spontaneously. The AIR Score is therefore constructed to have high sensitivity for advanced appendicitis. However, patients with short duration of symptoms may have a low score as their immune system has not yet reacted. I therefore recommend rescoring after a few hours in such patients.

What recommendations do you have for doctors once they have applied the AIR Score? Are there any adjustments or updates you would make to the score based on new data or practice changes?

External validation shows that the AIR Score works especially well in children and in women, but may be less specific in the elderly. In the elderly, I therefore have a lower threshold for CT scans as there are also more differential diagnoses.

I will underline the importance of the proportion of neutrophils. Advanced appendicitis often has lymphopenia. That is why you can have normal or even low WBC count, but then you will always have a high proportion of neutrophils.

I also underline the importance of indirect and rebound (percussion) tenderness, which reflects the peritoneal irritation.

How do you use the AIR Score in your own clinical practice? Can you give an example of a scenario in which you use it?

We use the AIR Score as a screening instrument and decision support. A patient with a low score and unaltered general condition can be discharged with a planned reexamination next day.

For an indeterminate score, we admit the patient and do a rescoring after 4–8 hours. Often the diagnosis is more evident then. Sometimes we can do a second rescoring after prolonged observation.

How do you think this score compares with older scores like the Alvarado Score?

The AIR Score is mainly based on objective inflammatory variables and only two subjective variables reflecting peritoneal
irritation. The grading of the latter increases the reliability compared with a dichotomous answer (Yes/No). We also used a large set of patients with suspected appendicitis for the design and used a multivariable model with weights aiming at the detection of advanced appendicitis. Other scores are based on more selected patients, have more subjective variables, and the weights are based on simpler models.

**Any other research in the pipeline that you’re particularly excited about?**

By tradition, we think appendicitis needs surgical treatment, but have forgotten that many instances of appendicitis heal spontaneously. With modern diagnostic techniques, we detect more and more of these cases of mild appendicitis. This may explain the current large interest in non-operative treatment with antibiotics. I think this is a mistake. We should not use antibiotics to treat conditions that resolve with no treatment. We need to find ways of defining the prognosis in these cases and operate on those who need treatment and leave the others to resolve. That is my main goal in my current research.

**About the Expert**

Roland E. Andersson, MD, PhD, is a colorectal surgeon at County Hospital Ryhov in Jönköping, Sweden. He is also a guest professor in the department of clinical and experimental medicine (IKE) at Linköping University in Linköping, Sweden. Dr. Andersson’s research interests are primarily related to epidemiology, immunology, and diagnosis of appendicitis, genes associated with colorectal cancer, necrotizing enterocolitis, and risk of cancer and fertility problems associated with chronic inflammatory bowel diseases.

**REFERENCES**

D&I Task Force

TASK FORCE CHALLENGES AAPL TO LEAD D&I CHARGE

IF YOU’RE NOT LEADING BY EXAMPLE, then you’re not leading.

As a leadership organization, the American Association for Physician Leadership seizes every opportunity to lead by example. Nowhere is this more evident than in the diversity and inclusion (D&I) of AAPL’s own board of directors and staff.

Of its 17 diverse and multinational board members, 30 percent are women — 10 percent higher than most corporate boards — and board members range in age from 60s to 40s.

The staff is also richly diverse and multinational. More than 50 percent are women, a ratio achieved not by targeting gender- or diversity-specific candidates, but organically by minimizing implicit bias during the screening and interview process to identify the best candidates for each position.

Still, it wasn’t enough that AAPL was already ahead of the curve in matters of diversity and inclusion. Nor was it enough that its leadership, membership, and constituency were already remarkably diverse. And it wasn’t enough that the association was already prioritizing and implementing significant D&I practices of its own.

The board of directors believed it needed to do more.

It needed to:

- Formalize the association’s position, purpose, and approach as an industry leader on the subject.
- Emphasize the role of physician leaders in creating a diverse and inclusive culture that transcends demographics and fully embraces diversity of thought — per Scott E. Page’s “cognitive diversity” — as an instrument of resolution in an increasingly complex healthcare industry.
- Recognize that professionalism demands that physician leaders consider this functional approach within an underlying matrix of equity.
- Lead the D&I conversation with its constituents, stakeholders, partners, and the healthcare community at large.

“Our board and AAPL leadership feel this area is vital in healthcare and medicine today,” AAPL Board Chair Mark Lester, MD, MBA, CPE, FAANS, FACS, FAAPL, says. “We feel an understanding of diversity and inclusion is essential for effective physician leadership.”

To increase that understanding, the AAPL board last year chartered a diverse, seven-person D&I task force co-chaired by Lester and Anne Pearson, MD, CPE, senior vice president and CEO of Physicians Memorial Hermann in Houston, Texas, and an AAPL member. It was tasked with identifying D&I issues facing today’s physician leaders and advising AAPL on how it should respond to those issues.

Relying on source books and articles by subject-matter experts, the task force met several times over a six-month
period, discussing, developing, defining, and refining its message and recommendations for the board. Lester and the others welcomed the challenge.

“Diversity is not a problem to be solved, but an opportunity to be seized,” he says, citing a quote from Martin Davidson’s book *The End of Diversity as We Know It*. “That’s a wonderful frame for an organization that wants to move in this direction.”

Given the burgeoning demographic shift among medical students, physicians, healthcare organizations, and patients, it’s no longer a matter of *if* but *how quickly* leadership must act to incorporate and reap the rewards of D&I initiatives in their institutions.

Since 2015, the proportion of women, blacks, Asians, and Hispanics enrolled in U.S. medical schools has risen steadily and significantly while the proportion of white men has declined, according to the Association of American Medical Colleges. The Pew Research Center says this trend is consistent with the current and projected U.S. population — and patients.

AAPL President and CEO Peter Angood, MD, FRCS(C), FACS, MCCM, FAAPL(Hon), notes that the association boasts members from more than 40 countries and that typically, 5 to 10 percent of CPE capstone participants are international.

“Clearly, shifts are occurring in our professional demographics, and we all need to be prepared to accommodate these ongoing changes,” Angood says. “So how, as leaders, do we proactively address these shifts?”

For its part, the task force responded with board-approved resolutions that include:

- Aligning leadership behaviors and AAPL processes to “leverage differences” for the purpose of achieving “diversity bonuses,” as explained by scholars Davidson (*The End of Diversity as We Know It*) and Page (*The Diversity Bonus*), respectively.

- Continually refining its processes to mitigate implicit bias, as advocated by scholar Iris Bohnet (*What Works: Gender Equality by Design*).

- Creating internal and industry tools and possible solution sets that enable physician leaders to lead and manage change through D&I initiatives.

- Incorporating D&I content into AAPL courses, training, career development offerings, thought leadership platforms, and live events.

- Emphasizing the role of physician leaders in creating a D&I culture within the healthcare industry.

- Advocating an approach to D&I that transcends demographics and embraces cognitive diversity for the purpose of navigating complex healthcare issues.

- Continuing to define and track strategically important diversity data to keep AAPL’s internal and external diversity strategies current.

Strategies, however, may vary from one organization to the next, Lester advises. “It depends on the organization, its mission, its members, those it serves, and how it looks to achieve a level of cognitive diversity and inclusion” that best suits its needs and its patients.

“Today, healthcare systems and hospitals are starting to look at health in a wholly different, comprehensive way — looking at it from a population perspective, looking at its social determinants, and looking at it as more than just fixing people up when disease begins to cause problems,” Lester concludes. “Care has therefore become increasingly complex and team-based. Diverse teams working inclusively can effectively unleash their full cognitive diversity in this new environment. That will allow them to transcend older ways of thinking and advance their healthcare missions.”

YOUR TURN

Share your ideas with the Physician Leadership Journal, and we might publish them for readers in an upcoming issue. Send your thoughts to journal@physicianleaders.org. Be sure to include your name, position and location.
CAREER SUPPORT

CPEs NEED MENTORS, TOO

WHEN THE AMERICAN ASSOCIATION FOR
Physician Leadership launched its complimentary
members-only mentorship program last year, there were
two general expectations among organizers:

1. CPEs would volunteer as mentors.
2. Everyone else would be mentees.

It didn’t quite work out that way as two interesting trends
quickly emerged: CPEs themselves started signing up to be
mentees and about 25 percent of the volunteer mentors
had no CPE credentials but were accomplished CMOs or
CEOs with valuable career experiences to share.

Lessons learned:

1. You don’t have to be a CPE to be a mentor.
2. CPEs need mentors, too.

Charles Fox, MD, CPE, MBA, and Steven Meister, MD,
CPE, MBA, were among the first CPEs to sign up for men-
tors through the AAPL program, and both requested
mentors with career experiences and trajectories similar
to their own.

Fox, a private-practice gastroenterologist in Atlanta
and chief of gastroenterology at Emory University Hospital
Midtown, presently has responsibilities that run the gamut
from medical to administrative; however, as is common
among many other CPEs, he plans to maintain his clinical
practice while increasing his administrative presence as a
physician leader.

Getting his CPE and MBA went a long way toward fill-
ing his knowledge gaps on the business side of medicine,
but connecting with an AAPL mentor was an opportunity
for one-on-one conversations with someone who had
walked in his shoes and could offer valuable guidance.

“Toward our mentor was a physician leader, I wanted to talk to someone who was also a clin-
ian, who did the same programs I did, and find out what
tend to do,” Meister notes.

In Kahlid Almoosa, MD, CPE, MBA, a regional CMO at
Memorial Hermann Health System in Houston, Texas, Fox
got what he was looking for: a mentor who is advising
him about organizational engagement, teamwork and
social skills, networking and the importance of continuing
education. For both, the conversations continue.

The same goes for Meister, the CMO of the Avera
Marshall Medical Center, a regional facility in Marshall,
Minnesota. With plans to become a hospital CEO or
system CMO or CEO within five years, Meister’s logical
preference for a mentor was a successful physician leader,
preferably a CEO, whose early career experiences mirror
his own. What he got in Jim Burrell, MD, he says, is “the
perfect mentor.”

“In fact, we just hit it off,” Meister says. “He started
like I did, very small, a physician owner with a group who
then sold to a bigger system, developed some leader-
ship skills there, moved on, moved up — very similar to
my path.”

By connecting with Burrell, a former tenured CEO now
serving as CMO with Hospital Corporation of America’s
Physicians Services Group, Meister is able to tap into his
mentor’s C-suite expertise to discuss goals, problems and
solutions.

“We identified the basic struggles that we’ve had with
integration physician management, because change is
hard, and physicians are particularly hesitant to change
even when it’s the right thing to do,” Meister notes.

Despite education and career experiences that are al-
ready moving Meister toward advanced leadership roles,
he says the added value of a mentor should never be
underestimated.

“I think having a mentor to guide you along the way
gives good wisdom — the good, the bad and the ugly —
and lets you know from his or her experiences what has
worked,” he says. “It’s just an invaluable, invaluable expe-
riential way to become a better and more effective leader.”

Most physician leaders began benefiting from mentors
from the time they were in med school and residency,
Meister says. These connections, “either intentionally or
unintentionally,” were made through attendings who
were liked, respected and remembered for making a
difference.

“We learn more from those that we respect and find
knowledgeable,” Meister says. “There are pearls to be
gleaned from having mentors and being able to bounce
off things that have worked, things that haven’t work —
ideas, failures, successes — all those things that you may
or may not have in your own organization, and I think it’s
really beneficial. And I think it’s worth the price of admis-
sion to the AAPL.”

The process for signing up to be a mentor or mentee
is simple: Members are encouraged to go online to the
AAPL platform, navigate to the Mentorship Program, and fill out an enrollment form on the Peer-to-Peer tile. (Have your digital CV/bio ready to upload.)

Based on enrollment-form answers, mentees’ preferences and goals are then matched to the mentors’ subject-matter expertise and experience. When a match has been made, the mentor is asked to arrange a call for an initial conversation with the mentee to gauge if they’re a good fit. If they are, conversations are scheduled at intervals convenient to both parties, usually for up to a year.

For best results, Fox suggests, “You should be open and honest about where you are in your career, where you want to go and what kind of person you’re looking for. Try to find someone to whom you feel comfortable talking, with similar values and goals as yours. And if (the first mentor) is not a good match, don’t be afraid to ask, ‘Is there anybody else available that might be a little different or better?’ and explain what the shortcomings (of the previous match) were.”

Either party may discontinue the mentoring relationship for any reason at any time. If one match doesn’t work, another will be arranged with someone else.

EDUCATION

DIFFICULT CONVERSATIONS DON’T HAVE TO BE DIFFICULT

IF YOU’RE FAMILIAR WITH WORKPLACE drama — and who isn’t? — then scenarios like these are probably nothing new to you:

- Staff who show up late or take excessive or ill-timed breaks.
- Those who are rude, sarcastic, or like to gossip.
- Arrogant physicians who won’t listen to supporting staff.
- Veteran nurses who treat new nurses like they’re stupid whenever they ask questions.

All these problems can poison the cultural environment to the detriment of colleagues and patients alike; all require the kind of performance conversations that some unpracticed leaders would rather avoid than address.

To make those otherwise difficult discussions more comfortable and productive, the American Association for Physician Leadership is offering an online course about conflict resolution.

The course will empower you with critical communication skills to help convert conflict into collaboration, correct disruptive behavior and allow everyone to reap the benefits of a more accountable culture.

Course objectives include:

- Recognizing when it’s time for a difficult conversation.
- Learning the do’s and don’ts of digital communication.
- Improving your own self-awareness to make better communication choices.
- Understanding the “Drama Triangle” and five stages of relationship conflict.

In addition, the course provides a blueprint for important conversations, explains how to focus on the vision (how to achieve a desired behavior) instead of the problem (the behavior that prompted the conversation in the first place), and the value of accountability through follow-up and follow-through.

For more information on this course, visit https://shop.physicianleaders.org/products/resolving-conflict
BY THE TIME THEY REALIZE THEIR CAREER in clinical medicine isn’t everything they thought it would be, many physicians believe they’re already too invested in their trade to turn back. Feeling burned out, disengaged, unfulfilled, or burdened by high student debt or compensation incommensurate with the demands of their jobs, they may feel irreversibly trapped and with nowhere to turn.

In her book *50 Nonclinical Careers for Physicians*, preventive medicine physician Sylvie Stacy, MD, MPH, offers physicians an escape from that bleak “trap” by identifying numerous nonclinical career options that could align with their particular skillsets and individual financial situations.

“For physicians who are just starting to consider a nonclinical job, it can be really difficult to find trustworthy, complete information about your options,” Stacy says. “Physicians often tend to be so stressed out and busy that they may not have the time or energy to seek the well-sourced information they need. This book contains an overview of nonclinical career options that is more comprehensive and accessible than any other source I’ve come across.”

Published by the American Association for Physician Leadership, the book provides an escape plan from the stressors of clinical medicine and allays much of the potential guilt associated with “selling out” their chosen profession or abandoning patients by explaining how each physician’s training and talents directly translate to patient care outside of clinical medicine.

The value of *50 Nonclinical Careers for Physicians* is in its actionable advice, including how to market yourself in job applications and interviews, and in the abundance of detail it provides — including responsibilities, range of compensation and stress levels of various nonclinical jobs — to help readers decide which alternative career is the best fit for them. While other authors encourage physicians to start their own business, Stacy focuses on full-time positions that don’t require readers to begin their own consulting business or find their own clients.

Sylvie Stacy is a Birmingham, Alabama-based preventive medicine physician, consultant and founder of Look for Zebras (www.lookforzebras.com), a blog and online community that is committed to helping physicians cultivate fulfilling and lucrative careers while appraising them of myriad career opportunities.

To learn more or purchase the book, visit www.physicianleaders.org/50-nonclinical-careers.
WHICH AFFILIATION OPTION IS BEST FOR YOU? A GUIDE FOR INFORMED CHOICES

THE NUMBER OF AVAILABLE AFFILIATION options can be nearly as daunting and confusing as the uncertainty surrounding which model is the best fit for any particular organization. Choosing the correct model is best achieved through foundational knowledge — and with an eye toward what you can expect the future of healthcare to bring.

In his book Affiliation Options for Physicians — Current and Future Strategies, Max Reiboldt, CPA, equips physicians, physician leaders, health system administrators, and private investors with an abundance of knowledge and effective strategies for making sound decisions based on the current and future environment of healthcare practice and delivery.

“The various available options for the affiliation of physicians and others can be overwhelming to potential participants, especially to those who are less familiar with the business aspects of healthcare management,” says Reiboldt, president and CEO of the Coker Group, a leading healthcare consulting firm. “Physicians, providers, administrators, private investors, public companies, and leaders across the healthcare spectrum are bombarded with possibilities for transactions. Each model has its pros and cons.”

Published by the American Association for Physician Leadership, Reiboldt’s book presents many possibilities in an organized and easy-to-digest format that explores the “what” and “how-to” applications of each option, and by providing an historical review of various physician affiliation transactions over the past 20 years, including:

- Physician to physician.
- Private group to private group.
- Private group to hospital-health systems.
- Private group to private equity/outside investors, and more.

Using history as a basis, Reiboldt and his team of experts explain how the past has shaped the current state of affiliation models and associated transactions, adding that “it is essential to understand, appreciate and consider the fundamental drivers of affiliation to prepare for the future.”

As a user-friendly resource for those weighing their affiliation options, the book also explains professional services agreements, joint equity opportunities, private equity transactions, clinical co-management alignment, clinically integrated networks and value-based reimbursement structures, legal and regulatory compliance considerations, capital procurement options, the role of IT, and the mechanics of putting together and closing the deal.

As a longtime consultant with the Coker Group, Max Reiboldt and his team have first-hand experience in the ongoing changes confronting healthcare providers, which uniquely equips them to handle strategic, tactical, financial and management issues that health systems and physicians face in today’s evolving marketplace.

To learn more or purchase the book, visit www.physicianleaders.org/affiliation-options-for-physicians.
# NEW MEMBERS

Here are the newest AAPL members, who joined or renewed March 16, 2020-May 15, 2020. To learn more about AAPL membership, visit [physicianleaders.org/membership](http://physicianleaders.org/membership).

| Abruna, Patricia | Acchiardo, Joseph, MD | Adedolapo, Tope | Agarwal, Anubhav, MD | Agrawal, Ashwin, DO, MA | Ahmed, Mohammad | Akunyili, UE | Ali, Syed | Almulhim, Saad | Apple, Douglas, MD, FHM | Arkless, Paul, MD | Arora, Tanisha, MD | Asare, Elliot, MD, MS | Baskaran, Naveen, MD | Bay, Wei-Ann | Bedsore, Russell, MD, FACP | Bhilackar, Meenakshi | Booth, Khristina, DO, MSc | Brahmbhatt, Hetal, MD | Brisebois, Amanda, MD, MSc, FRCP | Brook, Olga, MD | Brown, Douglas | Burch, Elizabeth | Burkey, Brent | Butler, Dale, MD, FACS | Campbell, Keith | Chin, Nicola, MD | Christopher, Neal, DO | Clark, Kelley, MD | Clarke, Kofi | Coffey, Michael | Cooper, Jason | Cox, E. Darrin, MD, FACS, FCCP | Curcio, Noel | d’Amaud, Lindsey | Datta, Vivekananda, MD, PhD | David, Whitney | DeMino, Mary, DO | Di Carlo, Antonio, MD, CM, FACS, FRSCS | Dickens-Carr, Kendrea, MD, FACOG | Doyle, Yves-Richard | Drake, Connor | Dunmore, Elizabeth | Dupree, Paula | Edelson, Mitchell | Edmsiton, Kirsten | Fedinec, Susan, DO, FAAFP | Fischer, Christopher | Flicker, Amanda | Fritz, Howard | Fung, Kenneth, MD, MSc, MHA, FCAHS, FRSM | Gajdowski, Richard, MD, MBA, MPH | Galgano, Richard | Gambhir, Harvir | Gandhi, Rajul, PharmD, MBA | Ganeshan, Dhakshinamoorthy | Garza, Rodolfo, MD | Gates, Kathryn, BVSc, DACVECC | Geiser, Matt | Gerth, Justin, MD | Gianos, Melissa, MD | Gifford, Sheyna | Gilman, Liz, MD | Gold, Chris, MD | Goldsmith, William, DO | Gomez, Victor | Gorthi, Janardhana, MD | Grewal, Narinder, FACOS | Hawker, Rachel | Hollard, Anne, MD | Houchn, Colton | Ilozue, Frances, MD, MPhil | Incandela, Andrew | Jackson, Brent, MD, FACS | Janowski, Kenneth | Johnson, Mark | Jones, Brittni | Kalan, Shiv, MD, FACP | Kang, Muhammad | Kazimi, Iram | Kedia, Namita | Kehrl, Thompson | Khan, Ayaz, MD, FACHE, MBA | King, Teresa, MD | Ko, Bryan | Kohl, Thomas | Kozin, Scott | Lay, Sara | Leight, William, MD | Lenk, Tara | Lheureux, Daniel, MD | Lowrance, Richard, MD | Lozano, Jacqueline, MD | Mai, Stephanie | Massarotti, Haane, MD | McAferthy, Kenyon, DO | McCloskey, Veronica, MD | McMillian, Lothar, MD | Mikhail, Michel, MD | Mohindra, Pranshu, MD, MBBS | Muhumuna, Catherine | Mylavanam, Mylashan, MBBS | Nedelka, Michele | Neff, William, MD | Negron, David | Neill, Aimee | Nelson, Maria | Nga, TeLeena | Njimoluh, Leila | Nunez, Amberly, MD | Oatu, Daniela | Orr, Jeffrey | Osunkwo, Ifeyinwa, MD, MPhil | Ottey, Colin, MD, MPH | Padanilam, Mathew | Pandit-Taskar, Neeta | Pandya, Neel, MD, MBA | Pani, Arabinda, MD | Parnes, Harold | Patibandla, Bhanu, MD | Penia, Herb, MD | Pollard, Matthew | Prasad, Amit, MD, MBA | Rahim, Shiraz, MD | Rehmatulla, AbdulAhad | Rhee, John, MD, MPH | Richert, Greg | Rowe, Lucas | Russell, Travis | Sadeddin, Mohammad, MD | Saffa, Norman | Sanni, Adesina, MD, MPH | Sarwal, Aarti, MD | Schwartz, Jessica, DO | Schwieterman, Ryan | Shah, Kosha | Shah, Umang | Shah, Vipul, MD, SFHM, FACP | Shakespeare, Walter, DO | Shashidharan, Subhadra | Siegler, MD, Joe | Singer, Karyn, MD, MPH | Singh, Priti | Sivakoti, Kirti, MD | Sivalingam, Senthil K, MD, FHS | Skvarla, Eric, DO | Song, Min Keun, MD, MPH, CMD, MDHC | Spotts, Douglas | Srinivasan, Chitra | Stephens, Brent, MD | Still, Margaret | Stubblefield, Wes, MD, MPH, FAAP | Sun Cao, Phoebe | Surry, Luke, MD, MS | Takeuchi, Tetsuya | Tanaka, Kenichi, MD, MSc | Theofanides, Marissa, MD | Tohmary, Aley Eldin, MD | Udowenko, Marina, MD/DO | Uhlenhake, Molly | Veale, Christopher | Villalobos, Miguel Angel, MD | Walker, Jeremy | Walsh, William | Walters, James | Windels, Mary | Wonodi, Ikunya | Woodworth, Amanda, MD | Wubiee, Firew | Mekonnen | Yang, Chia-Shing | Yepremian, Kelly, MD | Yoon, Eugene | Zielinski, Matthew | Zukas, Robert, DO |
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TIPS FOR SELLING A PRACTICE

When hospitals acquire practices, the ensuing transition for the incoming physicians doesn’t need to be difficult — but sometimes it is. Experienced hospitals typically have in place systems and procedures that allow for seamless transitions for their new physicians. If the hospital with which you’ve decided to affiliate lacks experience in such transactions, however, it’s up to practice leaders and their advisors to anticipate, avoid, or work through any potential post-sale problems that might arise.

Advice to consider includes:

1. Minimize post-sale issues by addressing them during the sales process.

2. Don’t be in a hurry to complete the transaction; rushing benefits neither party.

3. Opt for a flexible effective date based on identifiable milestones (such as the completion of payor credentialing applications or the installation and training of electronic health records systems) over a hard-and-fast artificial date.

4. Avoid potentially huge losses for both parties by allowing at least 60 days — or an even more realistic 90 to 120 days — for an effective date to complete the provider number and credentialing work.

5. Be proactive in answering questions and concerns from transitioning staff about salaries, benefits, job security, and the hospital’s personnel policies.

6. Ensure the hospital schedules a meeting before the effective date to answer those same questions and to explain the hospital’s employee manual.

7. Make accrual accounting easier for physicians by ensuring the hospital is prepared to share financial reports on a cash basis.

8. Ensure for the timely payment of bills and the proper accounting of funds.


http://www.physicianleaders.org/time-to-sell-guide
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