Session 17AB
Physician Leadership in Evolving Health Systems: Out With the Old, In With the New

Presented by:
Todd Sagin, MD, JD
Physician Leadership in Evolving Health Systems:

Out with the Old, In with the New

Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

- Todd Sagin, MD, JD
Learning Objectives

- Explore why the historical medical staff model provides an inadequate leadership framework to meet hospital needs
- Discuss how to organize numerous new physician leadership roles into a coherent and efficient structure
Agenda

• A brief history of physician leadership and the ‘organized medical staff’ and its current status, strengths and weaknesses
• How new leadership roles for physicians in hospitals and health systems have emerged to address the inadequacies of the organized medical staff
• Options for physician leadership redesign
• Case studies in physician leadership redesign

Physician Leadership:
‘In Absentia’ in the 20th Century

Historical sources of physician ‘leadership’:
• Organized medicine
• Leaders of the ‘organized medical staff’

Physician leaders generally were not focused on quality of care, patient safety, health system improvements, access, patient centered initiatives, cost, efficiency, value, …
Tasks for a new cadre of Physician Leaders

- Clinical care redesign
  - Delivery of more efficient/cost effective/high value care
  - Delivery of more ‘patient centered care’
  - Improved quality and patient safety
- Leadership in the development of ‘population health’ management
- Team leadership in an era of increasing integration and enhanced care coordination
- Creation of vision and values for new clinical structures (PHOs, ACOs, employed group practices, comprehensive service lines, hybrid insurance models, patient centered medical homes, perioperative surgical homes, etc.)

Good News! Physician Leadership is Playing a Growing Role in Healthcare Management

Traditional Physician Leaders:
Medical staff officers, department and committee chairs
Physician leaders in academic affairs

Expanding Roles for Physician Leaders:
Physician executives (CEOs, CMOs, VPMAs, CQO, CIO, Chief Integration Office, Chief Transformation Officer, etc.)
More physicians serving on hospital governing boards
Physician leaders of ACOs and CINs
Medical directors of service lines, centers of excellence
Physician leaders of employed and contracted group practices
Physician leaders in PCMHs, perioperative surgical homes, PACE programs, etc.
Not such good news: Physicians Poorly Prepared for New Roles

- Leadership development programs have been largely inadequate
- Formal degree programs equally inadequate
- Lack of strong coaching and mentoring initiatives
- Most physicians step into a particular leadership role with little applicable experience and no orientation/onboarding or ongoing support

Changes on the Way & On the Horizon

- Internal leadership development efforts maturing in some institutions
Some quick perspectives on leadership development:

- Leadership can be taught
- Most critical skills are emotional intelligence and ability to lead teams and drive change
- Little evidence to support current typical efforts (e.g. local programs, purchased ‘academies’ and other commercial services)
- Reasonable evidence for formalized coaching and mentoring
- Dyad management has mixed track record but good potential

Changes on the Way & On the Horizon

- Internal leadership development efforts maturing in some institutions
- Organized medical staffs changing
The ‘Organized’ Hospital Medical Staff

Designed long ago for a different era in medical care delivery where:

– Most physicians were in private practice
– Doctors needed hospitals and an unspoken ‘contract’ existed between the two – a ‘quid pro quo’
– Regulatory demands were minimal
– Quality and patient safety were assumed
– Interdisciplinary care was not the norm/integrated care was uncommon

The ‘Organized Medical Staff’ has been an ossified entity for more than fifty years, but is slowly evolving to fit into a changed health care world.

What does medical staff change and evolution look like?

More professionalization of roles

• More continuity
• Qualifications for positions (including availability to do the job adequately)
• Training and skill development

Streamlining run-away bureaucracy

• Fewer committees; Fewer categories
• Downsizing or eliminating departments/divisions/sections
• Returning to the hospital responsibilities not essentially medical staff duties
• Downsizing policies, eliminating rules and regs
**Stronger Focus on Fundamental Medical Staff Responsibilities for which its Leaders are Accountable**

Oversight of the quality of care rendered by practitioners holding clinical privileges at the hospital or health system

- Credentialing and Privileging
- Peer Review and Corrective Action
- Collaboration with hospital on quality and patient safety initiatives
- Promotion of communication between the professional medical community and hospital management and governing bodies
It's not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change.

- Charles Darwin

Why Combine Medical Staffs across Hospitals?

Greater “user-friendliness” for physicians
  • One application, one reappointment to track, communications from one source, fewer meetings

Efficiency
  • Consolidation of medical staff offices and staff
  • Effective use of physician leadership bench strength
  • Fewer meetings
Why Combine Medical Staffs across Hospitals?

- Fewer silos and less fragmentation of medical staff work
- Less work for health system board
- Reduced potential for liability
- Fewer accreditation reviews
- Ability to reduce unwanted variance in policies and procedures, rules and regulations, clinical practices and operational activities
- Minimize medical staff "politics"
- Opportunity to rationalize and restructure physician leadership across all aspects of the integrated delivery system

Additional Factors for Consideration

- Geographic distances between hospitals
- Multi-state distribution of hospitals
- Historic medical staff cultures
- Number of hospitals within the health system
- Length of time hospitals have been part of health system
- Historic levels of trust between medical staffs and health system leadership
Additional Factors for Consideration

- Diversity across health system hospitals & complexity of medical staffs:
  - Academic institutions
  - Large vs. small community hospitals
  - Critical access hospitals
- Tensions between employed and private staff physicians
- Controversy over on-call coverage

Complete Unification or Intermediate Steps?

- Upside/downsides to “partial” unification
- What does “partial” unification look like?
- Who should consider “partial” unification?
Changes on the Way & On the Horizon

• Efforts at ‘rationalization’ of proliferating physician leadership roles to reduce ‘silos’ and ‘fragmentation’

Case Studies: Streamlining Medical Staffs

• Health System A: 3 hospital system in California
  – From partial collaboration to unification but still complex

• Health System B: 4 hospital system in South Carolina
  – From partial collaboration to unification and simplification
Case Study: Rationalizing the Big Picture for Efficient Physician Leadership

- Hospital System C: 7 hospital system in Pennsylvania
  - System has geographic spread, mix of large and small hospitals, open & closed staffs
  - Large employed physician ‘group’ run by mgmt
  - Historically physician leadership marginal
  - Moving to unify staffs, eliminate department bureaucracy
  - Moving to create single physician leadership group over med staffs, CIN, system service lines

Physician Leadership Integration

Note: The Clinical Council serves as the physician leadership body discussions with management concerning system strategies and operations. It also represents the physician members of the governing
Case Study: Rationalizing the Big Picture for Efficient Physician Leadership

- Hospital System D: 5 hospital system in Virginia
  - System has geographic spread, mix of large and small hospitals
  - Large employed physician ‘group’ run by physicians with an early vision of a ‘physician-led’ organization
  - Unified medical staffs in concept
  - Vision and Practice are at Odds
    - Inadequate physician leadership development
    - Inadequate management ‘buy-in’
    - Physician engagement undermined
New Physician Leadership: Not Your Father’s Doctor

• Hospitals and health systems should embrace new roles for physician leaders
• Train and develop those leaders
• Clarify overlapping roles and responsibilities
• Avoid proliferation of new silos and exacerbation of fragmentation
• Get rid of what no longer yields value

Presenter Biography & Contact Info

Todd Sagin, M.D., J.D., is physician executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations. He is the national medical director of Sagin Healthcare Consulting, LLC and HG Healthcare Consultants, LLC, which provide guidance on a wide range of health care issues.

Dr. Sagin is a popular lecturer, consultant, mediator, and advisor to health care organizations. He is frequently asked to assist hospitals and physicians develop strong working relationships, as healthcare becomes a more integrated enterprise. Over the past decade he has been engaged by several hundred of the nation’s hospitals to work with their governing boards, medical staffs, and management teams to improve the quality of the care they deliver. This work ranges from leadership education to strategic planning, from strengthening medical staff affairs to creating new integration structures to bring hospitals and physicians together, including the development of physician group practice models, the merger of health system medical staffs, and redesign of health system physician leadership.

Contact Information:
Todd Sagin, M.D., J.D
Sagin Healthcare Consulting
www.SaginHealthcare.com
215-402-9176 (office) or 267-738-0877 (mobile)
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