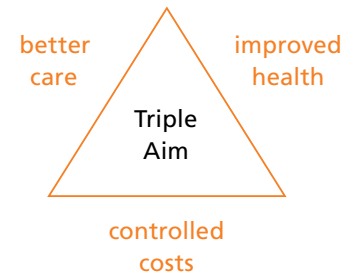


The Contemporary Physician Leader

By Miles Snowden, MD



The “Triple Aim”—a term coined by the Institute of Healthcare Improvement to embody the goals of better care, controlled costs and improved health—has become a rallying cry in the health care industry.¹ As the health care market in the United States focuses on changing incentives to accomplish the Triple Aim, a new generation of leaders is needed who can clinically and financially transform provider organizations. Chief medical officers (CMOs) and other physician leaders in hospitals, group practices and integrated delivery systems have unique qualifications that can allow them to take ownership of these important changes. However, their success in this new era will require that they evolve away from the roles they have traditionally played.



This paper will share the perspectives of five physician leaders who represent the contemporary physician leader. In doing so, it will discuss the skill set, experience and qualities physician executives need to lead their organizations’ conversion from volume to value.

Physician executive roles continue to evolve

The role of the physician executive has evolved over the years. The traditional physician leader in a hospital setting is a medical director. Medical directors were sometimes employed by facilities but often were independent, affiliated doctors. These providers served as liaisons between hospitals and the credentialed medical staff. They worked closely with hospital administrators but rarely had a seat at the executive table.

As hospitals and other provider groups expanded in the 1990s to become integrated systems, physician relations became more complex. Many larger organizations hired hospital-based physicians, often giving them the title of vice president of medical affairs. These employed physicians would focus on quality, compliance and medical staff affairs. Their medical staff duties typically included ensuring effective credentialing, medical education and staff relationships. In their compliance-related work, they were responsible for securing the necessary accreditation, certification and licensure the hospital needed and addressing public health concerns. As a visible champion of quality and performance, their job was to improve clinical lines-of-service performance, such as enhancing orthopedic profitability through standardization of device procurement or securing clinical excellence recognition for the organization.

Because of this scope of work, VPs of medical affairs needed to be recognized by their peers as high-quality physicians. The clinician needed to be perceived as fair-minded, able to represent the views of all stakeholders and adept at consensus building, effective communication and negotiation. Over time, many physician executives were elevated to the “C-suite” and given the title of CMO. As such, they were expected to have an aptitude for business and to provide a clinical perspective to the provider organization’s business decisions. But the qualifications for the job largely remained the same.

However, the traditional skill set may not be enough for the contemporary CMO. The surge in popularity of population-based performance measurement and reimbursement arrangements is putting providers in the uncomfortable position of having to accept more patient health risk. That puts a premium on leaders who not only have business acumen but who also have clinical expertise—the definition of the physician executive. Providers are looking for such leaders who can have an impact on the organization's ability to drive efficiency and utilization management, align both employed and independent physicians to organizational initiatives, adopt and implement enabling technologies, and innovate programs and processes for high-risk patient populations.

A contemporary leader focuses on reducing hospitalizations

One such physician leader is Nancy Boerner, MD, chief medical officer of Monarch HealthCare, an independent practice association (IPA) in Orange County, California. Monarch contracts with 2,300 providers to provide them access to nearly 200,000 health plan members. The health plans rely on Monarch's expertise in coordinating care and ensuring patients get the right care by the right provider in the right setting at the right time.

Dr. Boerner, a physician executive with Monarch for five years and its chief medical officer since 2010, had been in private practice for 17 years. She became the vice president of medical affairs for a hospital that was a part of a nonprofit hospital system. Her experience with that hospital was typical: working with affiliated physicians in an effort to get them to refer their patients to the hospital, encouraging them to comply with Joint Commission standards. In contrast, her roles at Monarch always centered on driving high clinical quality at a lower cost.

In 2009, Monarch was one of the four providers chosen to be part of the Brookings-Dartmouth accountable care organization (ACO) pilot project, in which they partnered with a commercial health plan and agreed to accept the clinical and financial risks associated with their members' health.² In 2012, Monarch was chosen to be among the 32 Medicare Pioneer ACOs.

The contrast between her role at a traditional provider organization and her role at Monarch provides a window into what the contemporary CMO's position looks like.

"It's a different approach for an IPA, where the whole goal is to keep members from needing to be admitted to the hospital," Boerner said. "We keep them out of the hospital by keeping them healthier or by referring them to a more appropriate setting, such as palliative care or hospice. It's the other end of the spectrum from my previous role at a hospital, where my mindset was always, 'If your patient needs to be admitted or needs an MRI, send them here.'"

A contemporary leader ...

- 1 Focuses on reducing hospital readmissions
- 2 Possesses a strategic vision
- 3 Embodies the "Triple Aim"
- 4 Engages and empowers physicians
- 5 Pulls from a wide body of knowledge

A contemporary leader possesses a strategic vision

Mark Werner, MD, also began his physician executive career as a vice president of medical affairs for a community hospital, and his rise through the ranks covers a lot of the territory a physician executive could travel. Four years after accepting that position, he was chosen to be the chief medical officer for an integrated delivery system. For a time, he was concurrently the executive vice president over the system's multi-specialty group. He eventually became the chief clinical integration officer for a Minnesota-based health system, and most recently, became the chief clinical and innovation officer for a health plan in Minnesota.

Dr. Werner's experience is that chief executives need CMOs who can strategically navigate waters ahead.

"I think most health system CEOs are beginning to look for CMOs with strong strategic thinking capabilities," Dr. Werner said. "What are the community-based strategies? How are we going to engage the physician community? Where are we going to look at mergers and acquisitions? Where are we going to look for partnerships with technology companies? All of these questions have huge strategic implications."

A contemporary leader embodies the "Triple Aim"

John Walker, MD, is in the heady position of being the first CMO of one of the leading accountable care organizations in the United States. After practicing gastroenterology for 17 years, seven at High Point, N.C.'s Cornerstone Health Care, he became the organization's inaugural CMO in 2010.

Dr. Walker's hiring coincided with Cornerstone's push towards accountable care, and in the past three years, the multi-specialty practice has undergone a major makeover. He led Cornerstone's effort to become a recognized patient-centered medical home (PCMH) and under his direction has significantly improved the practice's patient satisfaction scores. Most significant, he directed the redesign of the organization's primary care models. Cornerstone is now one of the first physician practices in the country where 100 percent of payer contracts include a quality-based incentive.

Cornerstone's expectations of him are very different from a traditional CMO.

"I see myself as the steward of the 'Triple Aim' at Cornerstone," Dr. Walker said. "I'm responsible for all the things in the company that help us lower the cost of care, improve the quality of care and make our patient experience better."

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*—John Walker, MD
Cornerstone Health Care*

A contemporary leader engages and empowers physicians

As chief physician executive for Community Health Network in Indianapolis, Tim Hobbs, MD is the “chief change agent” among physicians that practice under the system’s umbrella. Dr. Hobbs was a family practitioner in private practice for 20 years when he was tapped to become the medical director at a Community Health-owned primary care practice. He eventually became the CEO of the 220-physician practice, in addition to being the top physician leader at Community.

“I’ve seen the physician leader’s role evolve from trying to improve care and make sure that we keep all the physicians in line to trying to engage and empower physicians to become business partners, with the goal of improving care and quality,” Dr. Hobbs said.

In this era of new care models, physician leaders need to become change agents by being bilingual, speaking the language not only of the clinician but also of the administrator.

“If the only language we speak together is finance, we end up stuck,” he said. “It’s really about how to engage and get [clinicians and administrators] speaking together, influencing both cultures to work in tandem to produce a result.”

A contemporary leader pulls from a wide body of knowledge

Jeff Burnich, MD is accustomed to blazing new trails in health care leadership. In 1998, he caught the vision of what process improvement could do in health care and became one of the first physicians to earn a black belt in Six Sigma. Then, in 2000 and 2001, he led Trinity Health’s Six Sigma incorporation, an effort that was the first of its kind in the health care industry. Now, as a senior vice president at Sutter Health and the chief executive of the Sutter Medical Network, he helped lead the clinical integration effort that will lead the way for the network to go to market as a contracting entity and to accept patient risk.

Dr. Burnich argues that the new physician leader can benefit from an outsider’s perspective.

“Sometimes you get land-locked in health care as an executive and you only see, you know, your world through either doctor/business eyes or even doctor/doctor eyes,” Dr. Burnich said. “Sometimes you forget there’s a whole other part of the world out there that can teach you a lot about how to think about delivering care without going broke.”

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Navigating the line between volume and value

In our volume-based reimbursement world, a provider organization's focus on quality is driven by a need to fill operating rooms, emergency rooms and inpatient beds. The higher quality you can demonstrate, the more demand for services you can create. But as the industry transitions more toward value-based reimbursement, the focus on quality becomes less about profitability and more about efficiency. (Efficiency, in the new model, will drive profitability.) CMOs and other physician leaders will likely focus on meeting the population quality measures needed to earn pay-for-performance revenue and on achieving the population medical cost targets necessary to participate in payer gain-sharing arrangements.

In many cases, the contemporary CMO will be focusing for the first time on readmissions, length of stay, transitions in care, emergency department utilization, chronic disease management in the ambulatory setting and other activities that may reduce utilization.

As they focus more on utilization management activities, CMOs will need to rely on their traditional talent of relationship building and their reputation for fair mindedness. Dr. Mark Werner directed an effort within an integrated delivery system that tested those abilities. He instituted a care protocol system-wide designed to reduce unnecessary back surgeries. The effort was successful: so successful, in fact, that the top-producing back surgeon's volume dropped by 70 percent, and one of the system's hospitals lost millions of dollars.

Dr. Werner spent a lot of time in the surgeon's office listening to the surgeon's concerns and frustrations, explaining the evidence-based nature of the care protocol and reminding the surgeon that he declined to participate in the protocol's development. He convinced the surgeon that the drop in volume would be temporary and that volume would gradually increase under the evidence-based guidelines. He also worked with the hospital administrator and the system's CFO to adjust the hospital's performance targets as they integrated evidence-based standards.

"In a volume-based world, CMOs were asked to create the kind of economic alignments between the physicians and the hospital that would cause all to prosper. That meant driving volume," Dr. Werner said. "In the volume-to-value transition, we need entirely new economic arrangements between hospitals and physicians. And creating those types of arrangements is really hard."

Applying clinical and business insights to technology decisions

While consensus and relationship building will continue to be a valued skill set, physician executives need to augment their legacy skills with new competencies in system performance that will prove essential in the new health care environment.

For instance, expertise in the adoption of technology for provider connectivity and population analytics will be critical. CMOs will need to promote the utilization of such technology for accomplishing the organization's financial and clinical quality goals.

According to Monarch's Dr. Boerner, physician leaders need three aptitudes related to technology. First, be open to innovative, practical technology that helps their organization do critical functions better and faster than they've previously done them. Second, focus on using data for measuring technology usage and effectiveness. And third, err on the side of technology that makes a positive financial impact.

“One of my keys is to work really closely with our CIO,” Boerner said, “because we need to have measures in place to help us understand why we’re doing what we’re doing and how effective it is.”

New care management solutions are beginning to facilitate provider connectivity and population analytics. For instance, Optum’s Care Suite identifies patients in need of care intervention and can stratify those patients within separate patient populations. Other technologies have potential to take care management directly to patients, such as telepresence and robotic technology.

“If you can, you want to push as much care to a lower-cost environment as possible without hindering clinical outcomes and then use other means to reach people,” said Sutter Health’s Dr. Burnich, pointing to technologies that facilitate e-visits. For example, Sutter’s patient health record portal has grown to more than 800,000 active patients, and Sutter physicians field an average of three to four messages per day through the portal.

Engaging physicians in a rapidly changing environment

CMOs will also require a deep knowledge of the application of effective population health management solutions. Once a solution is acquired, their ability to align other physicians with the care management solution will be key. CMOs who engage their affiliated physicians early and often, identify physician champions, support transparency and peer discussions, and involve physicians in monitoring results will help population health management and other new programs take hold within their organizations.

Community Health Network achieved impressive results aligning independent physicians to a system-wide cancer care protocol. The Community Health Network team worked closely with a highly regarded group of oncology physicians and convinced them to align with the system through a professional service agreement. Then Community Health partnered with MD Anderson Cancer Network out of Houston to become a certified MD Anderson delivery site. All physicians affiliated with Community’s oncology unit, 60 percent of whom were independent, needed to become individually certified for the oncology unit to receive the designation. All of them complied.

“These physicians, whether independent, contracted, or employed, see themselves as partners in this oncology service line,” Dr. Hobbs said. The key to making this alignment happen was a change in approach.

“Rather than treating independent physicians like customers, we treated them like partners,” Dr. Hobbs said. “We were trying to please them instead of aligning our mutual interest, and as a result, we were able to move the relationship to a new level.”

Within an employed environment, physician alignment can also be facilitated by providing leadership opportunities to physicians who have the desire and the aptitude to do so. At a practice such as Cornerstone, where the transition from fee-for-service to fee-for-value is happening at a torrid pace, physicians are in the driver’s seat, and leadership opportunities are abundant. In addition to Dr. Walker’s position as CMO, the practice has a chief clinical integration officer, a medical director over practice development and medical directors over each service line. Another layer of leadership includes medical directors with responsibility for medical and surgical sub-specialties. Finally, they have named physician champions over patient experience and provider satisfaction.

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Innovating for cost and quality improvement

Reducing readmissions within 30 days of discharge is an important consideration for most hospitals due to Medicare's Hospital Readmissions Reduction Program. CMOs are being asked to be experts in post-acute care strategies that will help reduce readmissions, as well as high-cost ED visits that can often lead to a readmission. CMOs' expertise and influence should be applied as organizations work to improve the inpatient discharge process, support post-discharge follow-up and manage care transitions.

Dr. Boerner, Monarch's chief medical officer, is overseeing an innovative program that is helping the organization not only prevent readmissions but also detect problems that could lead to an admission.

The program started out being a bricks-and-mortar clinic run by Monarch where high-risk patients would visit after they were discharged from the hospital. A care team that included a physician, a nurse practitioner, a case manager and a social worker would make sure they had the right medications, were receiving the right follow-up care, were getting the right nutrition and had a follow-up appointment scheduled with their primary care physician. But patients weren't showing up to appointments. Patients didn't want to worry about finding a new clinic, seeing a new doctor or being in a new care setting after just leaving the hospital. They just wanted to be home. So Monarch met them at their home with a nurse practitioner, pharmacist and social worker.

"Our approach became much more of a patient-centered approach," Dr. Boerner said. "It's difficult to manage and it's labor-intensive, but it has made a significant difference for our most frail patients."

The evolution of the contemporary physician leader will continue

For all physician executives in delivery systems, these market and role changes represent a compelling opportunity. This is their moment to lead, their chance to improve clinical outcomes for more people and their time to secure the sustainability of our health care system for the next generation.

"CMOs will continue to maintain focus on the Triple Aim," said Cornerstone's Dr. Walker. "They'll be putting the programs in place that our physicians need to execute on quality, cost and care improvement strategies. They'll be putting programs in place that our patients need to support their good health. And, I think the CMO of the future will really keep an eye on the global cost of care."

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¹Susan Dentzer, "The 'Triple Aim' goes global, and not a minute too soon," *Health Affairs* 32 (April 2013), no. 4, 638.

²Population Health Management in an IPA: Monarch HealthCare ACO Pilot Program, *Accountable Care Stories* (website) http://www.accountablecarestories.org/case_studies/population-health-management-in-an-ipa-monarch-healthcare-aco-pilot-program-1

About the Author

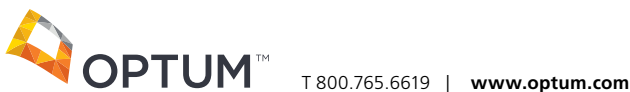
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