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PHYSICIAN LEADERSHIP IN CRISIS AND RECOVERY

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

In this article ...

Although creating and maintaining healthy organizational cultures in times of adversity is challenging, it is critical in order that people can develop the persistence and resilience necessary to provide the best care possible. Physician leaders are the driving force behind attaining that goal.

DURING THE PAST SEVERAL MONTHS, ALL generations of the world’s citizens have witnessed, or experienced, what will be recognized in history as a truly monumental period of global adaptation.

We all have stories about life in the yet-to-be-determined new world order. Many of us are losing patients; some of us will become infected ourselves. Many of our peers have demonstrated profound leadership by leaning into the front lines of care; unfortunately, some have succumbed to the virus in the process.

Let’s take a moment to pause and remember the innumerable healthcare providers from all disciplines who place their lives at risk every day in order to help those in need during these times of overwhelming demand.

If you are one of those healthcare providers, we thank you for your contributions, and we thank your colleagues for theirs. May all those whom we have lost be remembered for their bravery. We extend our sincere appreciation to everyone for their sacrifice!

TIMES OF ADVERSITY

“The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen.” — Elizabeth Kubler-Ross, author of On Grief and Grieving

As physician leaders, we routinely face adversity, but we also see examples of leadership amid adversity. The core nature of who we are as physicians, how we were trained, and how we practice our skills helps provide us with the resilience to weather adversity.

RESILIENCE AND PERSISTENCE

“Resilient people do not let adversity define them. They find resilience by moving towards a goal beyond themselves, transcending pain and grief by perceiving bad times as a temporary state of affairs. ... It’s possible to strengthen your inner self and your belief in yourself, to define yourself as capable and competent. It’s possible to fortify your psyche. It’s possible to develop a sense of mastery.” — Hara Estroff Marano, in her May 2003 Psychology Today article, “The Art of Resilience”

As is apparent by the ramifications of COVID-19, our healthcare industry must continue to evolve at an ever-increasing pace despite ongoing adversity. It is imperative that we, as physician leaders, continue to develop the
resilience necessary to manage that adversity and achieve necessary results at all levels.

During World War II, recognizing the challenge of England’s ongoing fight with Germany, Winston Churchill tried to lift the spirits of the British people through a metaphor for persistence: “The nose of the bulldog is slanted backwards so he can continue to breathe without letting go.”

Churchill is also recognized for “We shall not fail or falter; we shall not weaken or tire. Neither the sudden shock of battle, nor the long-drawn trials of vigilance and exertion will wear us down. Give us the tools, and we will finish the job.”

The fact that we persevered through years upon years of education to enter a career that requires persistence and resilience is a testament to our commitment. As physician leaders, however, we must continue to develop the complex skills of resilience and persistence — not only for us as individuals, but also for our patients and the organizations in which we work.

All physicians are viewed as leaders at some level, and often the presumption is that we have the innate ability to manage adversity effectively. That is not always the case, however, and it underscores my point about the need for each of us to consider how better to evaluate our current degree of resilience and how to expand it. Our persistence in improving resilience will lead not only to a better end result for our patients, but also to benefits for us, our families, and our communities.

THE CULTURE OF HEALTHCARE

“The culture in healthcare is intricate and complex. And we know that all healthcare is ultimately local. The recent responses to COVID-19 has underscored the commitment and loyalty of our healthcare culture to providing the best of healthcare delivery to all patients in spite of the most challenging of circumstances — circumstances that often placed physicians, nurses, and other allied health providers at risk without adequate resources.”

— Anonymous Physician Leader

The COVID-19 pandemic is providing all of us with opportunities to learn and grow from the stories we hear about overcoming adversity — stories from patients, families, and other providers.

The pride we can all feel in the way our diverse healthcare workforces have come together is overwhelming, and it has become a foundational element within our healthcare culture. We have been challenged, and we have risen to the occasion in the most professional of self-sacrificing ways — at times with the ultimate sacrifice.

Physician leadership has helped drive this cultural shift.

Our society clearly benefits from the focus and skills of physicians who serve as leaders. Reflect for a moment on how strongly society has relied on physician leadership in the past several months as we navigated this public health crisis of coronavirus. Physicians were at the top echelon of influence regarding our country’s initial response, and we have continued to be at the top-tier of all health systems as each system responds. Physician leadership is critical for effective healthcare!

This is a prime opportunity for physician leaders to help initiate the changes necessary to improve our healthcare systems in the ways we so desperately desire. We must all work toward creating larger-scale change by demonstrating resilience and persistence when it comes to improving the next generation of outcomes for patient care, as well as the next generation outcomes for higher quality, safer more efficient systems of care.

A refreshed culture of optimism for healthcare is possible in the coming weeks and months … even as COVID-19 persists.

It is my personal commitment to physician leadership that motivates me to improve my own persistence and resilience. I do this by seeking a variety of athletic challenges, which to me represent adversity. I encourage you to find your own symbolic challenges and use persistence to develop your resilience. The culture you help create around yourself will ultimately benefit the culture around others as well.

LEADING CHANGE

Leading and creating change is our association’s overall intent. AAPL focuses on maximizing the potential of physician-led, interprofessional leadership to help create personal and organizational transformation that benefits patient outcomes, improves workforce wellness, and refines the delivery of healthcare internationally.

We must all continue to seek deeper levels of professional development and to recognize ways we can each generate positive cultural influence at all levels. As physician leaders, let us become more engaged, stay engaged, and help others to become engaged. Creating a broader level of positive change in healthcare — and society — is within our reach.

Our patients will appreciate the outcome.

INSPIRING CHANGE. TOGETHER.

NOTE: Portions of this column are adapted from the March/April 2016 PLJ CEO column.
Free Leadership Resources in the Midst of Crisis

The current outbreak of COVID-19 (coronavirus) continues to create worldwide concern. Here you will find helpful information, resources and guidance specific to this evolving situation. We will provide regular updates as the situation evolves. [www.physicianleaders.org/resources/leadership-in-the-midst-of-crisis](http://www.physicianleaders.org/resources/leadership-in-the-midst-of-crisis)

Thank you for your work in your communities and for all you are doing to address this pandemic.

**Wellness**

**RELATED RESOURCES**

**ARTICLES**
- Physician Wellness & Resilience
- Traumatized by Practice: PTSD in Physicians
- Effective Ways to Handle Medical Practice Workplace Stress

**WEBINAR SERIES**
- How Workplace Wellness Can Change an Organization's Culture
- Implementing Wellness Techniques to Achieve Work-Life Balance
- Personal Well-Being & Spirituality
- Focusing on Your Health in the New Year
- Balancing Family Dynamics & Personal Wellness for Physicians

**CONTENT REPOSITORY**
- Wellness

**Disaster Planning & Recovery**

**RELATED RESOURCES**

**PODCASTS**
- The Use of Technology and Telemedicine in the Battle Against COVID-19 and Coronavirus
- Building a Culture of Trust
- Leading Virtual Teams
- Remote Patient Monitoring Systems: What You Need to Know
- Tactical Tips for Telehealth
- Stop Workplace Drama

**EBOOK**
- The Medical Practice Disaster Planning Workbook

**ARTICLE**
- Keeping Your Practice Healthy in the Aftermath of a Disaster

**Change Management**

**RELATED RESOURCES**

**COMPLIMENTARY PRODUCT COLLECTION**
- Leadership Strategy Series

**ARTICLES**
- The Drive Toward Effective Change
- The Five Fundamental Tasks of a Transformational Leader

**Stress Reduction & Management**

**RELATED RESOURCES**

**CONTENT REPOSITORY**
- Practicing Mindfulness
- Stress Management

**COURSE**
- Practical Tools for Physician Self-Care

**ARTICLE**
- Survey: EHRs the biggest contributor to Physician Burnout

**Additional Resources**

- American College of Healthcare Executives: COVID-19 Resource Center
- American Medical Group Association: COVID-19 Resources
  [https://www.amga.org/performance-improvement/covid-19-resources](https://www.amga.org/performance-improvement/covid-19-resources)
- American Society of Health-System Pharmacists: Coronavirus Disease 2019 (COVID-19)
  [https://www.ashp.org/Pharmacy-Practice-Resource-Centers/Coronavirus](https://www.ashp.org/Pharmacy-Practice-Resource-Centers/Coronavirus)
- College of Healthcare Information Management Executives: COVID-19 Response Center
  [https://mydigitalhealth.com/community/COVID-19-Response-Center/67b392b0e7f797f3a5054be5](https://mydigitalhealth.com/community/COVID-19-Response-Center/67b392b0e7f797f3a5054be5)
  [https://www.hfm.org/topics/coronavirus.html](https://www.hfm.org/topics/coronavirus.html)
- Medical Group Management Association: COVID-19 Resource Center
- National Association for Healthcare Quality: COVID-19 Resource Center
- AMA: COVID-19 National Emergency - 6 Top Insights from 2 AMA Presidents
- American College of Surgeons - Bulletin: COVID-19 Surgery Information and Resources
  [https://www.facs.org/about-aco/covid-19](https://www.facs.org/about-aco/covid-19)
- Emerald Publishing: Free content related to Coronavirus and the management of epidemics
  [https://www.emeraldgrouppublishing.com/journals/coronavirus.htm](https://www.emeraldgrouppublishing.com/journals/coronavirus.htm)
- Health Affairs: Collection of COVID-19 content from Health Affairs journal articles and additional resources providing timely commentary, expert analysis, and policy proposals.
- Society of Critical Care Medicine (SCCM): Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19)
- ACCME Resource List
  [https://www.accme.org/coronavirus-resources](https://www.accme.org/coronavirus-resources)
- COVID-19: President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak
- Harvard Business Review Coronavirus Articles
  [https://hbr.org/in-depth/coronavirus](https://hbr.org/in-depth/coronavirus)
- Kaiser Health News on COVID-19
  [https://khn.org/coverage-coronavirus/](https://khn.org/coverage-coronavirus/)
- CMS Partnership Toolkit
- SCCM ICU Availability
THE INTERPLAY OF STRUCTURES AND PROCESSES

Healthcare is a complex interplay of structures and processes organized in a manner that optimizes resources and outcomes. Physicians leaders must understand how to work within this structure and to ensure they are meeting the needs of their patients and teams. In this issue of the PLJ, you will find three articles that address major components of this interplay of structure, process, outcome, and resource.

First, we have included a discussion article examining the Ethics in Patient Referrals Act enacted in 1988, also known as the Stark Law. This legislation is designed to prohibit physicians or their immediate family members who have a financial relationship with a healthcare entity from making Medicare referrals to those entities for the provision of designated health services.

Despite several “exceptions” that permit legitimate ownership interests, compensation arrangements, and forms of remuneration, the law is a major hurdle in the path to achieving value-based healthcare reforms. This article is a must read for all physician leaders and was initially released online at physicianleaders.org/news/proposed-stark-regulations-small-step-forward.

In addition, there is a discussion article describing the mental health of physicians and the many challenges they face to living healthy in a career that has complexity and inefficiency, and results in emotional drain. While considerable attention and effort are being applied to preventing provider burnout, the author suggests there may be root causes embedded in health system design that also need to be addressed to ensure physicians live healthier and avoid mental health challenges like burnout, addiction, and even suicide.

Also, you will find a research article that examines innovative models of care delivery in primary care. Despite the presence of team-based models, the integration and expansion of telehealth and virtual visits, which are intended to improve access, decrease costs, and improve quality, their effects on patient satisfaction are unknown. This research study helps us continue to have a data-driven approach to our patients as new care delivery models and approaches take hold to make our work as physicians more efficient.

As you read through this collection of articles, which we have carefully selected for this issue, I encourage you to consider their relevance to the work you are doing with your teams every day — not just for the purposes of informing your own leadership strategies, but also in terms of the ways you can help to inform your colleagues, staff, and others.

As the official journal of the American Association for Physician Leadership, PLJ 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, particularly as physician leaders, 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 assure that you and your team are well cared-for in our demanding careers.
For 2021, Centers for Medicare and Medicaid Services (CMS) is proposing significant adjustments to the Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes and the corresponding Work Relative Value Unit (wRVU) values. SullivanCotter can help your health care organization better understand these anticipated changes and assess the potential impact on physician compensation and productivity.

Discover more on this topic at: www.sullivancotter.com/cptcodes
“THERE’S NOTHING MORE IMPORTANT than speaking to the people on the front lines,” says Clifford Medina, who has spent the past several years identifying areas for improvement across Mount Sinai Medical Center’s primary care ambulatory sites.

His leadership approach is neither authoritarian nor dictatorial, but collaborative and empowering. “I regularly visit our primary care ambulatory sites to discuss patient care with our physicians, clinical staff, and administrators. Together, we identify operational shortcomings and develop solutions that make sense,” he says. Subsequent meetings with colleagues help gauge the effectiveness of changes implemented. It’s a “front-line”/follow-up approach he applies in all problem-solving matters:

In customizing MSMC’s EPIC electronic health record system, how did you identify the needs and how were those needs met?

Customization required regular collaboration with multiple stakeholders, including primary care physicians who needed an accurate, efficient EHR system that streamlined the ordering and documentation process, and the organization, which needed to capture data elements for assessment of clinical performance metrics and appropriate billing and coding procedures. Customization was followed by discussions with end-users and iterative enhancements.

Given your strong IT background, what exactly did you do to optimize these practices?

Preparing for the Merit-Based Incentive Payment System (MIPS) was a significant undertaking. I wanted to ensure that our EHR accurately reflected the incredible patient care we were providing. Optimizing practices required that we enhance clinical and administrative workflows or develop new ones. Thoughtful integration of our workflows with our EHR enabled us to assess how well we were performing across a variety of metrics.

In your efforts to increase physician productivity, what challenges did you face and how were they overcome?

As more physicians enter into employment agreements with healthcare organizations, the greatest challenge is adjusting the mindset that physicians are now accountable for their contributions to the team. While performance incentives go a long way toward aligning physicians, my approach includes building group identity and comradery. Personal productivity fosters group productivity which, in the long run, secures growth and stability.

As someone who mentors physicians, can you explain the need for and goals of physician mentorship?

I believe physicians need mentors throughout their careers to help navigate a rapidly changing healthcare landscape. Mentors provide objective, thought-provoking, supportive, and reassuring viewpoints. I develop relationships with physicians in my division and make myself available to them as a mentor. Regular meetings allow me to determine how I can best support them.

What was the inspiration for the workflow program you established for depression screening in patients?

Because depression often goes undetected by primary care physicians, we decided to enhance clinical care by screening all our patients for depression and providing appropriate treatment. I led a committee to develop an evidence-based workflow that could be easily adopted by our staff. Once the screening tool was integrated into EPIC, the workflow was disseminated and is now utilized annually for wellness visits.

To suggest an AAPL member for this ongoing series, email us at journal@physicianleaders.org.
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In locating the right clinical job, I have questions about the use of professional recruiters. Any basic advice you could share?

There are decidedly different avenues for a clinician to find the right job. Included on that road are the professional recruiters, who generally are either retained or contingency fee-based.

For the most part, retained recruitment firms are more the norm for a healthcare system or hospital that might have many open searches throughout the year and need a company, or multiple companies, searching full time on their behalf to fill their open physician slots.

Private practices, however, might have a finite need — one or two slots to fill that are very specific and don’t require an ongoing retained relationship with a recruiter. In these instances, the practice might use a contingency fee-based recruiter. Contingency agreements usually are for the duration of a search but can be part of an ongoing relationship where the agreement is signed and in effect every time a practice has a physician need to fill.

These two forms of agreement are what they seem: In a retained search, a firm is paid to find a candidate. In a contingency agreement, the recruiter is not paid until after the candidate is delivered, meaning payment is contingent upon the deal coming to fruition.

It’s not unheard of in a contingency agreement for a recruiter to place a candidate and receive a majority, if not all, of its fee after the placement. Some caveats built into the contingency agreement may allow for the organization to recoup some of its money if a candidate does not stay on the job for six months or a year.

Recruiters are a good option in your search. Since it’s their business, many recruiters have their ears to the ground and a feel for what jobs are out there. They’ll do a great deal of the legwork for you. There also are recruiters who work in subspecialties, so if you are in a specialty with limited spots available, these recruiters might offer an even more acute awareness of opportunities throughout the country.

A recruiter can help cut down on the paperwork and reduce the length of the search process. And it’s a good business for them when they make a hit. In some specialties, a recruiter could garner $18,000–$30,000 to land one physician for a practice.

Lastly, most recruiters work for the searching physician group, which means the hiring practice will pay the finder’s fee. If a recruiter asks for a fee from you, run, don’t walk to the nearest door. Though I’ve never seen this scenario, you can rest assured that these folks are not looking out for you. It’s the same scenario in publishing: if an agent wants up-front money from you, they’re in it for themselves, not you. You may want to contact your associates to determine what recruiting firms they’ve used in the past.


In this feature, our experts answer your questions about careers, aspirations, and challenges. Submit yours to journal@physicianleaders.org. (We’ll keep your identity confidential.)
Start with a Strong, Solid Foundation

Fundamentals of Physician Leadership

Your leadership journey starts with the popular Fundamentals series. Nobody can build their physician leadership skills without a strong foundation to build upon. The Fundamentals of Physician Leadership series is the go-to collection for future leaders to start transforming healthcare, and themselves. Go in-depth into the skills they didn’t teach in medical school from leveraging your unique communication style to making large-scale business decisions.

www.physicianleaders.org/fundamentals
THE UNSPOKEN STRUGGLE OF BURNOUT

THE CHALLENGE: Burnout is more than just stress on the job; it’s a feeling of not being able to recover from feelings of exhaustion, frustration, or failure. Take advantage of the tools that are available to help you overcome feelings associated with burnout. You are not alone — but recovery starts with you.

KEY TAKEAWAYS

- **Recognize your symptoms.** Burnout shows up differently for different people. Common symptoms are exhaustion, cynicism, and inefficacy on the job. Keep an eye out for these symptoms and acknowledge them when they occur.

- **Change your mindset.** Burnout can destroy your motivation and attack everything you once loved about your job. Embracing aspects of a “growth mindset” can help improve your overall sense of well-being.

- **Ask for help.** Confiding in others and asking for help can help break the burnout loop. Look for trusted individuals who will listen without judgment.

- **Recognize that everyone is different.** Uncovering your personal needs can help you fight against burnout. Recognize your needs and brainstorm ways to shift your mindset toward positivity.

- **Reflect to guide your realization.** Journaling can help you create a healing experience on your own. When feeling overwhelmed, take 10–15 minutes to reflect and write down your feelings.

- **Take time off.** Your patients’ health is at risk when you are burned out. Take a personal day or two when you feel yourself struggling — you may be surprised at the difference it makes.

THE BOTTOM LINE: Burnout symptoms not only impact the health and well-being of physicians, they pose potential risk to patients if unaddressed. An abundance of proven tools, strategies, and practices can help you in your recovery efforts.

Adapted from *Practical Tools for Physician Self-Care*, part of the American Association for Physician Leadership’s comprehensive online curriculum. More information about our educational offerings can be found at [physicianleaders.org/education](http://physicianleaders.org/education).
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Siaoming Wong
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Deeper Dive

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

TRENDING

CAREERS
CEO EXIT STRATEGIES: CEOs who are reluctant to relinquish their position, who avoid, procrastinate, or sabotage succession planning efforts by the board — or who withdraw from the process altogether — not only harm the organizations they lead but often and selfishly tee up their successors for failure. This story explains how the best CEOs are already planning their exits. physicianleaders.org/news/succession-planning-ceos

HUMAN RESOURCES
DEVELOPING GOOD HIRES: Conscientious and often exhaustive efforts to identify and hire the best job candidates are an important step toward organizational success, but don’t stop there! Equip new hires to become productive, high-performing, long-term assets by acclimating, training, and supporting them to maximize their potential. “If you don’t support and groom them, they’re going to quit. And turnover is very expensive,” says SoundPractice podcast host Mike Sacopolus, who is joined by co-host Cheryl Toth to explain how onboarding “does not have to be an expensive or time-consuming endeavor.” physicianleaders.org/news/turning-goodhires-into-greatemployees

LEADERSHIP
OPIOID RESTRAINT: Whereas opioids are prescribed as a front-line pain modality for patients after surgery and medical procedures in the United States, they are dispensed only as a last resort in Germany. This explains, at least in part, why drug overdoses killed 10 times more Americans than Germans in 2016, and why the percent of Americans suffering opioid addiction is three times that of Germany. What can we learn from the Germans? This story explains. physicianleaders.org/news/how-germany-verted-an-opioid-crisis

HOT TOPIC

AVOID HIRING NARCISSISTS: DO YOUR HOMEWORK, KNOW THE SIGNS

All it takes is one narcissist to poison an entire workplace culture, cripple morale, harm patient relations and outcomes, and cost a practice far more than just its reputation. Healthcare leaders must recognize narcissistic traits during the interview process and explore a person’s previous work history to avoid regrettable, destructive, and costly hires.

Word of warning: The deck is stacked against physician leaders who are unprepared to identify and deal with the entitled and dismissive behavior of narcissists. And yet it is ultimately their responsibility to do precisely that.

The best strategy? Don’t hire a narcissist in the first place. This article offers excellent advice on how.
physicianleaders.org/news/avoid-hiring-narcissist

Read these and other articles at physicianleaders.org/news
Establish Yourself Online

New Course: Building Your Online Presence

We’re living in a digital age, but has your online professional presence caught up? More people than ever are relying on online reviews and social media to find their next physician, so you want to make the best impression possible. In our latest online course, we’ll help you identify your target audience, develop your own distinct ‘brand voice,’ and where you should be establishing your presence from social media and blogging to personal websites. Discover the actionable strategies that will make you shine online with this brand-new online course.

PHYSICIANLEADERS.ORG/ONLINE-PRESENCE
Advocacy Work: Antidote to Burnout

Advocacy work is one way physician leaders are amplifying their passion for helping others — and reaping personal benefits as well.

MORE THAN HALF OF EMERGENCY medicine physicians suffer burnout, but Stephen Anderson, MD, FACEP, who practices at MultiCare Auburn Medical Center in suburban Seattle, isn’t one of them.

During his hospital shifts, he saves lives one at a time. During his off hours, he meets with school superintendents, mayors, governors, members of Congress, and anyone else in a position to change public policies to improve health and safety for the populations they serve.

“The surest way to make your own well-being better is to help others, and advocacy gives you the chance to do that on a huge scale,” Anderson says. “You can go out there and change the world.”

He is one of many physician leaders who find that advocacy work is an antidote to clinician burnout — a finding reported in an August 2018 article in The New England Journal of Medicine. The work can be time-consuming and frustrating; it can take time away from patient care and other responsibilities; and it may require using vacation days and a physician’s own financial resources, but enthusiasts say the rewards of advocacy efforts outweigh all that and, indeed, outweigh the frustrations of medical practice.

Donn Dexter, MD, FAAN, a neurologist and sleep medicine specialist with the Mayo Clinic Health System, finds that educating members of Congress about the need for research funding is empowering. He worked with colleagues at the American Academy of Neurology (AAN) and other physician organizations to push for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative, a National Institutes of Health-led partnership that is researching brain disorders such as Alzheimer’s and Parkinson’s diseases, depression, and traumatic brain injury. The initiative has invested more than $950 million to fund more than 500 projects since 2014.

His patients may never know of his efforts, Dexter says, but he knows the value of the work. “I like to think that hundreds of millions of dollars of research translates into saved lives down the road for my patients with complex neurological disease,” he says.

A past president of his local medical society and a board member for the state society, Dexter has advocated for patients and physicians at all levels of government. He has helped start a state government relations team for Mayo Clinic Health System, met with state legislators at the Wisconsin Medical Society’s annual Doctors Day events, and organized a forum in which local physicians, healthcare leaders, and politicians met with the Congress members who represented their district.

He also regularly participates in annual Neurology on the Hill events sponsored by the AAN. Last year, 214 neurologists from 48 states convened in Washington, D.C., to educate lawmakers about the dangers of step therapy in certain situations, the need for more NIH funding, and other matters.

“Being around that group of people [who] have this incredible passion and knowledge about advocacy, it couldn’t help but rub off on you,” he says. “You just come back energized. Being involved ... is a powerful way to transform your understanding of your role in society. It’s a powerful antidote to burnout — I truly believe that.”
HOW TO BE HEARD

One well-known driver of physician burnout is loss of autonomy. The government, insurance companies, and health system administrators tell physicians what to do and how to do it and, in many cases, compliance is not optional.

“When you take away physicians’ choices in taking care of their patients after they spent all these years training, they can get very frustrated,” says Ross F. Goldberg, MD, FACS, president-elect of the Arizona Medical Association. “Advocacy is a way for me to get involved and say, ‘Look, you can’t make this decision on your own; I have to be a part of it.’”

Goldberg, a general surgeon, is vice-chair of surgery at Valleywise Health in Phoenix. He chairs the American College of Surgeons’ Health Policy Advisory Council and serves on the ACS Board of Governors and its Legislative Committee. He also chairs the Advocacy and Health Policy Committee of the Society of American Gastrointestinal and Endoscopic Surgeons and serves on its board of governors.

Consequently, he was well-positioned in 2017 to help craft state legislation addressing the opioid epidemic. The state Medicaid program sought his input about exceptions to the strict limits on opioid prescriptions that had been proposed. He helped write the surgeon-prescription guidelines included in the Arizona Opioid Epidemic Act that went into effect last year.

“I was not the only one — obviously our lobbyists and other physicians were working on it — but some of the exceptions in that law were written by me or taken from other places and introduced through me,” he says. “It feels great to have had that kind of effect in the state of Arizona on such an important issue.”

Through his advocacy work at the state and federal levels, Goldberg has sharpened the leadership skills needed to be an effective advocate within his own health system.

“It’s a very cool feeling to be able to reach out to the CEO and chief medical officer of your institution and say, ‘I need to have a conversation,’” he says. “They’re willing to listen, and willing to act upon my input if it’s reasonable. That does help prevent burnout because I know I can enact change.”

Melissa S. Dillmon, MD, a hematologist/oncologist at the Harbin Clinic in Rome, Georgia, chairs the Association for Clinical Oncology’s Governmental Relations Committee. She typically devotes one day a week to advocacy work. Like Goldberg and most other physician advocates, she is not reimbursed for her time away from the office.

“It’s time away from my family and definitely there is a monetary cost, but it keeps me passionate about what I do,” she says. “Being involved positively in change, although it may be slow, makes me hopeful that I will be able to maintain at least some of what I went into medicine for, which is the interaction between me and a patient and the ability to make a difference in their lives.”

Increased funding for National Cancer Institute-sponsored research is Dillmon’s most satisfying success at the federal level. Closer to home, she pushed for state legislation in Georgia that forbids pharmacy benefit managers from mandating the use of mail-order pharmacies, which are associated with the wrong drugs or wrong doses and delayed delivery, all of which potentially hurt patient care.

“A lot of my patients are fearful of what the future holds and whether or not they will be able to receive the treatment that they need and that they deserve,” she says. “So when I tell them about why I’m going to D.C. or why I’m going to Atlanta and what I’m advocating for, it makes them feel hopeful.”

MAKING A DIFFERENCE

The emergence of the patient-centered medical home has transformed care delivery — for patients and clinicians — in the past 15 years. Rheumatologist Robert McLean, MD, FACP, president of the American College of Physicians, helped give it birth.

As chair of the Health and Public Policy Committee for ACP’s Connecticut chapter in the mid-2000s, McLean was having dinner with U.S. Rep. Nancy Johnson, R-Connecticut, an influential health legislator at that time, as part of his routine relationship-building activities. The ACP had recently developed a policy paper describing the potential merits of the medical home model, and McLean handed Johnson a copy. “It wasn’t really a topic of the evening, but I said, ‘You might be interested in reading this in your free time,’” he remembers.

A few weeks later, the congresswoman called a hearing on the topic of the advanced medical home, as it was then called, and invited the ACP to testify before the subcommittee. That led to early funding to pilot the concept, which in turn led to broad federal support — and support from private insurers — for the medical home care model.

“When you have instances where your presence or activity really made a difference, you feel ‘I need more of this because I feel so good about it,’” says McLean, medical director of clinical quality for Northeast Medical Group, an affiliate of Yale New Haven Health.

Such big wins are rare; advocacy work is usually tedious and slow. Early in his career, McLean learned the value of having good relationships with policymakers and being present when they are learning, discussing, and considering issues that will affect physicians and their patients. That became clear to him when nurse practitioners lobbied to be allowed to practice independently in Connecticut and, for the first time, he met with legislators to share the ACP’s perspective.

“I quickly realized that, if the physician voice was not there at certain times, other healthcare voices that may not have had the physician interest — or, quite frankly, the patient interest — in mind would have more influence,” he says. “You need to be there, and I came to realize that being in the process is very empowering.”

That provides balance from the frustrations of medical practice today. “While I have the same dysfunctions of the system when I’m seeing patients, these other activities are empowering because they make me feel like I can — and in fact, I do — make a difference,” he says.
HELP OTHERS, HELP YOURSELF

During his residency, Anderson was trained to create a hard boundary between his work with patients and his life outside the hospital.

“We’re taught early in our medical training in emergency medicine that, to not burn out, you have to leave the day behind as best you can when you walk out the doors,” he says. “And then we are told that whatever is going on in our personal lives, we have to leave it at the door when we come to work.”

Anderson, immediate past chair of the American College of Emergency Physicians, ignored that advice, and that has worked to his benefit and to the benefit of others. Throughout his career, the crises that bring patients to the emergency department have become his advocacy initiatives.

Frustrated that schools in Washington state were no longer teaching cardiopulmonary resuscitation, he took action. “We went out and had a fundraiser and put defibrillators on the wall of every school,” Anderson says. “And then, we got the CPR curriculum back in schools — a one-hour class that’s taught in every junior high and high school in Washington state, so that, by the time they graduate, people have been trained in CPR twice.”

Frustrated by America’s ongoing mental health care crisis, Anderson worked with the mayor of his hometown to develop a one-hour course for students — Real Emergency Aid Depends on You (READY) — designed to eliminate the stigma associated with mental health problems and teach basic skills to use during a mental health crisis.

Frustrated by the increasing number of drug overdoses coming into the emergency department, he started working nearly a decade ago to find solutions to the opioid crisis. One strategy is equipping every police vehicle in his local community with naloxone, the opioid antagonist used to counter the effects of overdose.

When Anderson’s daughter Kayce overdosed on heroin a few years later, a police officer used a naloxone kit to save her life.

“The first time your daughter ever gets resuscitated with naloxone you start to realize that this is a drug that really... needs to be every place where people might need it,” he says. “Now naloxone through political actions that I have been a very big advocate for, is available over-the-counter in Washington state so that anybody [who] might need it to save a life can have access to it.”

When a travel delay prevented his daughter from starting a rehabilitation program on the day planned, Anderson found himself driving her to a dealer’s house to get through the night. Medication-assisted treatment — using buprenorphine and other medicines to support withdrawal — was not available at the emergency department. “After Kayce got on the plane the next morning and started in her rehab, I got very active,” he says. “If people want help, they should be able to turn to the emergency department.”

Anderson’s daughter died in early 2019; last fall, he was using his days off work to help get a statewide medication-assisted treatment program in Alaska. “And I was in Denver last week trying to make a difference, and in Utah before that, trying to make a difference,” he said in a telephone interview. “If you’re passionate enough and you’ve got a story that people will bond to, you get people’s ears, and you give people a chance to make the world a safer and a better place.”

Lola Butcher is a freelance healthcare journalist based in Missouri.

REFERENCE

WHEREVER THEY WORK, PHYSICIANS BELONG
there. They belong in hospitals, outpatient practices, and clinics. They belong in pharmaceutical company headquarters, consulting firm client sites, labs, lecture halls, government buildings, health insurer offices, and the crammed spaces of health tech startups.

Though the vast majority of their training takes place in clinical settings (with good reason), the potential environs to which physicians can take their careers are not limited to these. Physicians are needed outside of healthcare delivery settings to develop and implement services and products that ultimately affect disease treatment and prevention.

Sometimes the physician’s relevance to patients in these alternative venues is clear and proximate; at other times, the connection is loose, distant, or gradual. Regardless, a physician who is tasked with forming a line of business or overhauling a process can help clinicians deliver improved patient care through better knowledge or equipment. A physician also might develop a health policy that guides how clinical care is administered or contribute in another way to better healthcare.

Any organization whose products affect human health can benefit from the insight, experience, and knowledge of a medical doctor.

VALUE OF PHYSICIANS IN NONCLINICAL ENVIRONMENTS

Just as the primary medical team caring for a hospitalized patient might consult a specialist to assist in health management, physicians working in education, insurance, business support, biotechnology, and other industries indirectly function as consultants to the providers and systems treating patients.

An attending physician considers input from others on the care team, yet final management decisions are determined by the attending. Similarly, physicians working as medical directors or in comparable roles in other sectors are routinely viewed as authoritative, but input from other professionals and disciplines is often considered.

A hospital’s clinical teams rely on processes, leadership guidance, and strategy to deliver patient care. In the same way, physicians outside healthcare delivery settings are regularly engaged in strategic planning and provide clinical direction for the company.

There is a growing need for physicians in organizations that don’t deliver patient care; industries that touch the healthcare system are increasing at rates that rival or exceed clinical services sectors. The expected compound annual growth rate (CAGR) — only one of many possible measures of growth, but useful for this comparison — of the hospital services market over the next several years is roughly 8 percent.1 Compare this with the healthcare IT market growing at a 16 percent CAGR,2 the biotechnology growing at a 10 percent CAGR,3 and the professional services market growing at a 9 percent CAGR.4 Physicians must be involved to ensure that this growth is accompanied by changes and innovations that are in the best interest of patients and the profession.

While clinicians frequently are the end-users of health IT solutions such as electronic health records, these services have become progressively multifaceted, now encompassing...
other aspects of healthcare operations such as revenue cycle management. Health IT solutions are regularly marketed to corporations other than clinicians; therefore, physician input upstream in health IT product development is key to rendering tools that are useful to both clinicians and patients.

Health technologies also are increasingly directed toward consumers, allowing individuals to take charge of their own health. These technologies must be safe and evidence-based; their design must ensure there is no delay or risky avoidance in seeking medical care.

As a result of advancing technologies, as well as evolving regulation and complexities of care delivery, health systems often depend on outsourced services to meet some of their needs, including analytical infrastructure, cost management, quality management, and clinical information services. Demand by hospital systems is increasing for high-level business consulting to help them stay viable. The fundamental goals of healthcare are blurred if physicians are removed from these services.

There is a similar need with regard to pharmaceutical products. High drug prices create a barrier to patient treatment despite evidence of effectiveness. New classes of drugs and approaches such as precision medicine require changes in the way that drugs are tested and marketed. Physician involvement is imperative for success.

The need for physicians isn’t limited to private, for-profit organizations. The role of public health in our communities is broadening.

State and local public health spending increased by nearly 33 percent between 1990 and 2018. My own county’s department of health, for example, is acutely focused on addressing gun violence and neighborhood blight from a health perspective. This creates an opportunity for physicians to essentially practice medicine on a population level through work with their state and local governments.

Nonprofit organizations — many of which have missions related to healthcare, combating disease, and patient advocacy — have enjoyed an upward trend in charitable giving in recent years. Who better than those with extensive clinical training and medical knowledge to guide how those funds are used?

These are a few illustrations demonstrating the value of physicians in nonclinical environments.

**CHANGE IN MINDSET**

Making an impact outside of healthcare delivery requires full-time physician participation.

A change in mindset is necessary to fully leverage physicians in these roles. It’s not enough to expect physicians to be involved in these settings and situations “on the side” by acting as consultants, advisors, or board members, and certainly not solely as volunteers, committee members, champions, or task force participants. Though such roles are essential, they serve a different purpose from full-time appointments dedicated to nonclinical responsibilities.

It is not uncommon for a physician to act as an educator, medical writer, policymaker, strategist, expert consultant, clinical reviewer, and more in a single nonclinical position. Success in a job of this type requires a solid understanding of the company, the field, the science, the relevant regulation, and the competitive landscape. This multifaceted involvement, when combined with the depth of medical knowledge gained from medical training and clinical experience, is an immense asset to a company’s workforce; moreover, its impact on the company’s product or service is substantial.

Some physicians say they wouldn’t work for “industry” out of principle; however, industries such as the biopharmaceutical industry are here to stay, and they have enormous impact on how we treat patients. This has been recognized by some countries that distinguish pharmaceutical medicine as a medical specialty, including the UK, Ireland, and Switzerland.8

I’m not advocating for this in the United States; rather, it suggests the gravity of physician involvement in bringing medicines to patients. Furthermore, while the use of doctor’s skill sets in other sectors may not warrant discrete specialties, it is weighty enough that it should recognized as a commendable way to spend a medical career.

For our profession and our patients to maximally benefit from physician contributions outside of healthcare delivery settings, we cannot consider nonclinical jobs negatively. They do not represent “quitting medicine” or “selling out.” They shouldn’t be thought of as a last resort option for the burned out or discouraged physician.

Considering a nonclinical position can be viewed as equal to deciding between private practice and hospital employment, inpatient and outpatient responsibilities, or urban and rural practice location.

**CONCLUSION**

The span of physician territory goes beyond hospital and clinic walls. This is not only acceptable, but also necessary to ensure the highest quality patient care and best health outcomes for our communities.

There are several ways that physicians can help to normalize nonclinical career paths and increase awareness of the roles that medical doctors play in nontraditional work environments. First, be inclusive of physician colleagues in all positions. Second, to the extent possible, engage with physicians working with your organization as vendors, consultants, or as part of a collaborative effort. Finally, educate medical students and trainees about the expansive career options available and the diverse ways they can use their knowledge and skills.

Sylvie Stacy, MD, MPH, is a board-certified preventive medicine physician in Bessemer, Alabama, and founder of Look for Zebras. She is the author of *50 Nonclinical Careers for Physicians: Fulfilling, Meaningful, and Lucrative Alternatives to Direct Patient Care* published by the American Association for Physician Leadership. sylvie.stacy@gmail.com
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HEALTH LAW AND POLICY

DISCUSSION ARTICLE

PROPOSED STARK REGULATIONS: SMALL STEP IN THE RIGHT DIRECTION

By Bhagwan Satiani, MD, MBA, DFSVS, FACHE, FACS; Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA; and Jessica L. Bailey-Wheaton, Esq.

ABSTRACT: The Ethics in Patient Referrals Act, known as the Stark Law, was designed to prohibit physicians (or their immediate family members) who have a financial relationship with a healthcare entity from making Medicare referrals to those entities for the provision of designated health services. Despite several “exceptions,” the law is a major hurdle to achieving value-based healthcare reforms. The Centers for Medicare & Medicaid Services (CMS) recently issued a highly anticipated proposed rule that seeks to establish new exceptions and definitions, and provide additional flexibility to support the current shift in the U.S. healthcare delivery and payment system from volume-based to value-based reimbursement. This article summarizes the proposed exceptions and discusses their proposed changes to the definitions of the “Big Three” Stark Law exception requirements — fair market value, commercial reasonableness, and the volume or value standard — and potential implications for physicians.

CONCERN ABOUT PHYSICIANS’ DECISIONS placing financial rewards above patient interests led Congress in 1988 to pass the Ethics in Patient Referrals Act, also known as Stark I, named after the sponsor of the bill, U.S. Rep. Pete Stark of California.1

The Stark Law governs those physicians (or their immediate family members) who have a financial relationship (i.e., an ownership investment interest, or a compensation arrangement) with an entity, and prohibits them from making Medicare referrals to those entities for the provision of designated health services (DHS).2

The law includes a large number of exceptions related to ownership interests, compensation arrangements, and forms of remuneration.3 These exceptions were necessary to prevent legitimate transactions from being open to prosecution under the Stark Law.

Similar to Stark, the federal Anti-Kickback Statute (AKBS) was established to prevent intentional abuse of the healthcare system to realize financial gain. Physicians can take advantage of “safe harbors” and exempt certain arrangements from its prohibitions. This differs from the Stark Law in that, under AKBS, a financial relationship outside a safe harbor is not necessarily illegal, whereas under the Stark Law, a relationship must fit into one of the many regulatory exceptions to avoid prosecution.1

During the past three decades, physicians have practiced in fear of violating (even unintentionally) these fraud and abuse laws, as the federal government prosecutes physicians for unintentional violations, including documentation errors, for their financial relationships with other physicians who make referrals for DHS. Furthermore, whistleblowers or qui tam plaintiffs can sue physicians for alleged Stark Law violations under the False Claims Act, thereby resulting in treble damages and other penalties.

In a recent survey of 162 healthcare chief executive officers and executives, 36.2 percent pointed to fraud and abuse laws that don’t support new models of care as standing in the way of improving healthcare.4
PROPOSED MODERNIZATION OF STARK

On October 9, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to modernize and clarify the Stark Law. The proposed rule changes were published in conjunction with the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS), which published proposed rule changes to the AKBS.4

Historically, the application of the Stark Law (and the AKBS) has, at times, been at odds with the goals of healthcare reform. Specifically, the discord between the objectives of fraud and abuse laws, and the objectives of value-based reimbursement models reflected the disjointed approach to healthcare reform by the numerous federal agencies tasked with regulating the healthcare industry.

For example, HHS and CMS have pushed value-based healthcare initiatives, which require provider alignment and collaboration, while the OIG and the Department of Justice (DOJ) have intensely scrutinized these arrangements as they relate to the Stark Law and AKBS, and their potential liability under the False Claims Act. Ultimately, this disjointed approach resulted in a scenario wherein the left hand didn’t know what the right hand was doing.5

Under the proposed rule, CMS seeks to establish new exceptions and new definitions, as well as provide additional flexibility to support this necessary evolution of the U.S. healthcare delivery and payment system. This article will summarize the new Stark Law exceptions proposed by CMS and discuss their proposed changes to the definitions of the “Big Three” Stark Law exception requirements: fair market value, commercial reasonableness, and the volume or value standard. The potential implications of these rule changes on physicians, including how the proposed rule may reduce current regulatory burdens on providers and influence hospital/physician arrangements going forward, are also addressed.

PRIME REASONS FOR CHANGE

The majority of the proposed changes to the Stark Law acknowledge the shift of healthcare reimbursement from volume-based to value-based payment models and seek to accelerate it.6 Hence, the prime reasons behind the change are adopting value-based care, promoting coordinated patient care, and fostering improved quality, better health outcomes, and improved efficiency and clarity in how the Stark Law relates to new forms of reimbursement and bonus sharing, telemedicine, and accountable care organizations.

Under the proposed rule provisions, CMS aims to adopt new Stark Law exceptions and revise or reconsider certain existing Stark Law definitions and exceptions. The stated intent of these changes is to: (1) alleviate the undue impact of the Stark Law on parties that participate in alternative payment models; (2) facilitate care coordination; and (3) balance genuine program integrity concerns against the burden of the Stark Law’s billing and claims submission prohibitions. The initiatives are aimed at reducing regulatory barriers and accelerating the transformation of the healthcare system into one that better pays for value and promotes care coordination.4,6,7

PROPOSED CHANGES

The changes are part of the larger effort by HHS (of which CMS is part) to modernize and clarify fraud and abuse laws as part of the Regulatory Sprint to Coordinated Care initiative and CMS’s Patients over Paperwork initiative.4,7 The aim of the Regulatory Sprint program is to remove potential regulatory barriers to care coordination and value-based care under certain federal healthcare laws, including the AKBS and Stark Law.

CMS proposed a few new and revised exceptions to the Stark Law, which are summarized in Table 1. Additionally, the proposed rule seeks to clarify several of the definitions regarding the “Big Three” requirements included in most Stark Law exceptions for compensation agreements: fair market value, commercial reasonableness, and the volume or value of referrals standard.

Fair Market Value (FMV). The proposed revision of the FMV definition seeks to clarify previous definitions and guidance on FMV and separate the term and definition from other intertwined terms: general market value and the volume or value standard.

Historically, the Stark Law has defined FMV generally (with additional modifications of the definition as applies to equipment leases and office space leases), and intertwined the term with the volume or value standard and the term general market value.9 CMS proposes to provide three separate FMV definitions: (1) generally; (2) for the rental of equipment; and, (3) for the rental of office space.7 However, the agency emphasizes that “the proposed structure of the definition merely reorganizes for clarity, but does not significantly differ from the [previous] statutory language...”7

CMS clarified that the volume or value standard is “separate and distinct” from fair market value requirements.7 Thus, CMS no longer believes it necessary to include the volume or value language as it appears in connection to the FMV definition.7

Further, CMS provided guidance on the difference between the terms fair market value and general market value and recognized plausible scenarios wherein a physician may be paid higher than the industry mean, and require a deviation from industry normative benchmark data to account for the specific facts and circumstances related to a given transaction.

CMS provided a hypothetical wherein a hospital seeks to employ an orthopedic surgeon. Industry salary surveys indicate an appropriate annual salary of $450,000 in that locale, but the physician is one of the top orthopedic surgeons in the United States and is in high demand by professional athletes.7 Consequently, CMS posits that the hospital would be justified in compensating the physician significantly more than the general market value, i.e., $450,000 per year, based on the physician’s skill set.
<table>
<thead>
<tr>
<th>Exception</th>
<th>Proposal</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-Based Arrangements</td>
<td>Provides several new definitions, including for value-based activity (VBA), value-based enterprise (VBE), value-based purpose, VBE participant, and target patient population. The exceptions would apply only to compensation arrangements, but would apply to all patients, not just Medicare beneficiaries.</td>
<td>To present lower (and fewer) regulatory hurdles for providers seeking to pursue legitimate VBAs that are intended to coordinate care, improve the quality of care, and lower costs for patients. The rule keeps in place some traditional protections against overutilization and associated harms.</td>
</tr>
<tr>
<td>Limited Remuneration to a Physician</td>
<td>Allows for limited remuneration to a physician for items or services provided by the physician on an “infrequent or short-term basis,” in an aggregate amount not exceeding $3,500 per calendar year (as adjusted by inflation) if: (1) The compensation is not determined in any manner that considers the volume or value of referrals or other business generated by the physician; (2) The compensation does not exceed the fair market value of the items or services; (3) The arrangement is commercially reasonable; and, (4) Arrangements for the rental or use of office space or equipment do not violate the prohibitions on per-click and percentage-based compensation formulas; remuneration does not need to be set in advance, and the arrangement does not need to be set forth in writing in order to comply with this exception.</td>
<td>To provide some flexibility to providers undertaking non-abusive business practices, in recognition that the safeguards contained in such a limited arrangement would pose little to no risk of program or payment abuse.</td>
</tr>
<tr>
<td>Cybersecurity Technology and Related Services</td>
<td>Addresses donations of cybersecurity technology and related services that are “necessary to implement, maintain, or reestablish security.” For the exception to apply, a number of conditions must be met, including: (1) that the volume or value of referrals not be considered; and, (2) the receipt of such technology may not be a condition of doing business with the donor.</td>
<td>To address the growing threat of cyberattacks on data systems and health records; allowing for the donation of cybersecurity hardware, but only if that hardware was determined to be “reasonably necessary” based on the donor’s risk assessments of its organization, as well as of the potential recipient.</td>
</tr>
<tr>
<td>Group Practice Requirements</td>
<td>Clarifies the following standards and definitions for the Group Practices exception to lower the barriers to qualifying as a “group practice”: (1) Volume or Value of Referrals Standard; (2) Profit shares and productivity bonuses (loosening the Volume or Value of Referrals Standard restriction); and, (3) Overall profits.</td>
<td>To explicate various requirements within the Group Practice exception to decrease barriers for providers seeking to comply with the rules for qualifying as a group practice.</td>
</tr>
<tr>
<td>Period of Disallowance</td>
<td>Removes the rules related to the period of disallowance, defined as “the period of time during which a physician may not make referrals for DHS to an entity and the entity may not bill Medicare for the referred DHS when a financial relationship between the parties failed to satisfy the requirements of any applicable exception.”</td>
<td>To strike rules that CMS now believes to be “overly prescriptive and impractical,” as it believes that such analysis should be conducted on a case-by-case basis to account for the facts and circumstances related to the relationship at issue.</td>
</tr>
<tr>
<td>Financial Relationship</td>
<td>Revises the definition of a financial relationship to: (1) Exclude titular ownership or investment interests (wherein financial benefits from interest(s) are not received) (2) Exclude any interests arising through participation in an Employee Stock Ownership Program (ESOP).</td>
<td>To provide greater flexibility and certainty for those operating in states with corporate practice of medicine prohibitions.</td>
</tr>
<tr>
<td>Compensation and Ownership or Investment Interests</td>
<td>Revises the writing and signature requirements of compensation arrangements such that they may be satisfied if: (1) The arrangement fully complies with another exception except for the writing/signature factor; and (2) The writing/signature is obtained within 90 days of the date of noncompliance.</td>
<td>To recognize that some financial arrangements are fully compliant with the Stark Law, even if they are not set forth in writing and/or signed, and that there are circumstances that require the parties to begin performance prior to the agreed-upon provisions being reduced to writing.</td>
</tr>
</tbody>
</table>
**Commercial Reasonableness.** CMS proposed two alternative definitions for the commercial reasonableness standard as follows:

1. “The particular arrangement furthers a legitimate business purpose of the parties and is on similar terms and conditions as like arrangements”; or,
2. “[T]he arrangement makes commercial sense and is entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty.”

Significantly, CMS unequivocally noted that an arrangement may be commercially reasonable “even if it does not result in profit for one or more of the parties”? This is a particularly important development for employed physicians whose specialty may result in a financial loss for the hospital.

For example, psychiatric and burn units are hospital service lines that often operate at a loss; further, hospitals have licensure and regulatory obligations, such as the Emergency Medical Treatment and Labor Act, that require them to contract with certain physician specialists, regardless whether the volume of services performed by the specialist will be sufficient to render the physician profitable. This “profitability” caveat may make hospital employment of (or alignment with) certain physician specialists less regulated and benefit patients with service lines and illnesses that are unprofitable for hospitals.

**Volume or Value of Referrals Standard.** CMS proposed four bright-line objective rules for determining whether a compensation arrangement considers the volume or value of referrals or other business generated between the parties, so as to clarify the requirement.?

Many Stark Law exceptions require that the compensation arrangement at issue “not [be] determined in a manner that takes into account the volume or value of referrals by the physician..[or be] determined in a manner that takes into account other business generated between the parties.”? In response to commentator concerns, CMS proposed mathematical calculations that will provide objective tests for determining whether a given compensation methodology violates this standard.?

<table>
<thead>
<tr>
<th>“De-Coupling” From the AKBS</th>
<th>Removes from Stark Law exceptions the requirement that the arrangement not violate the AKBS.</th>
<th>To remove a superfluous requirement, as CMS is “unaware of any instances of noncompliance with the [Stark Law that] that turned solely on an underlying violation of the [AKBS].”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price Transparency</td>
<td>Solicits comments on:</td>
<td>To accelerate CMS’s move toward its larger priority goals, i.e., price transparency aimed at lowering the growth rate of healthcare costs and enhancing patient choice.</td>
</tr>
<tr>
<td></td>
<td>(1) The availability of pricing information and out-of-pocket costs to patients;</td>
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<td></td>
<td>(2) Whether to require cost-of-care information at the point of a referral for a healthcare item or service provided to patients;</td>
<td></td>
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<tr>
<td></td>
<td>(3) The burden of requiring the provision of such information; and,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Whether such requirements should be applied to value-based exceptions.</td>
<td></td>
</tr>
</tbody>
</table>

**IMPLICATIONS FOR AKBS**

Physicians and health systems also want CMS to decouple the Stark Law from the AKBS by eliminating regulatory exceptions to Stark that link and forbid any financial arrangements from violating the AKBS.

Physician groups argue that the two laws should not be tied together as they are different with respect to who can be prosecuted, safe harbors/exceptions, intent standards, penalties, and enforcement mechanisms. HHS has proposed changes to the AKBS and the Beneficiary Inducement Civil Monetary Penalties Law (the Beneficiary Inducement Statute) through the OIG. HHS collaborated with the OIG by issuing a request for information to determine how Stark Laws could be modified to fit with the value-based era but still protect existing federal health programs and patients.

**EFFORTS TO PROMOTE PRICE TRANSPARENCY**

CMS did not make any specific proposals related to price transparency, but instead used the proposed rule to solicit comments as to the pursuit of the Trump Administration’s price transparency objectives and whether to require cost-of-care information at the point of a referral for a healthcare item or service provided to patients.

The idea of requiring cost-of-care information is part of CMS’s larger priority goal of price transparency aimed at lowering the rate of growth in healthcare costs and giving patients a better understanding of healthcare costs before embarking on a referral.

**IMPLICATIONS FOR EMPLOYMENT MODELS**

Proposed changes in the Stark exceptions are predicated upon the idea that these changes will somehow speed up the growth of value-based programs. Some argue that unless clinical processes are accelerated, realistic savings targets issued, and more efficient care models rolled out, these changes may not be enough to ease regulatory burdens on physicians.

In an era of increasing employment of physicians by health systems, although they can be more flexible if within an
accountable care organization where they can share quality data, true alignment may not be possible with existing Stark and AKBS laws.

First, the new exceptions related to value-based arrangements likely would reduce burdens for physicians and other providers to align to provide care coordination and other value-based measures without fear of violating the “volume or value of referrals” prohibition. Note that any value-based arrangements must satisfy crucial and specifically defined elements within the new exceptions, including value-based activity, value-based arrangement, and value-based enterprise (see Table 1). These exceptions may pave the way for private advanced payment models that were previously considered risky arrangements by payors, hospitals, and physician medical groups.

Second, a proposed exception seeks to provide flexibility to business practices and arrangements CMS finds to be “non-abusive.” The Stark Law currently allows “non-monetary compensation” of $416 per year if it is not solicited by a physician and does not take into account the value or volume of referrals by the physician. Additionally, the law permits $35 per instance to medical staff for non-cash items or services, such as trinkets given out on Doctors Day.

A new exception will allow limited remuneration from the employing institution to a physician, “even in the absence of documentation regarding the arrangement and where the amount or a formula for calculating the remuneration is not set in advance of the provision of items or services.” This would be allowed if certain conditions are met and only if the remuneration does not exceed $3,500 per year. Some examples to which this exception may apply, according to CMS, include:

1. A hospital and physician agree to an arrangement wherein the physician will provide call coverage services, but the arrangement was not documented (the first $3,500 would be covered under this exception, but any subsequent services/payments would need to fit under another Stark exception);
2. A hospital and physician have a call coverage arrangement that fits within another Stark exception, but the hospital subsequently engages the physician to provide sporadic supervision services, which was not documented (so long as the amount paid for the supervision services is less than $3,500 for the year); and,
3. A hospital and physician have a call coverage arrangement that fits within another Stark exception, but the hospital subsequently engages the physician to both provide sporadic supervision services and perform occasional EKG interpretations, neither of which arrangement was documented (so long as the amount paid for both the supervision services and the EKG interpretations is less than $3,500 for the year).

Third, specific to group physician practices, CMS proposes changes to multiple standards and definitions to lower barriers for physicians seeking to qualify as a “group practice” as set forth in Table 1.

Of note, CMS proposes changing the rules regarding profit shares and productivity bonuses so that going forward, a group practice could directly distribute profits emanating from a physician’s participation in a value-based enterprise (including profits from the physician’s referrals) to that physician, and that distribution would be deemed to not directly take into account the volume or value of the physician’s referrals.

**VALUATION IMPACT ON PHYSICIAN PRACTICES**

Perhaps the most revealing takeaway from the proposed rule for physicians stems from CMS’s acknowledgment that not all physicians or compensation arrangements are the same, and that compensation arrangements may have qualitative benefits that outweigh quantitative costs, i.e., profitability. The significance of this recognition is critical—it means that hospitals may be more willing to purchase physician practices, even if the purchase results in a “book financial loss” for the hospital.

CMS’s proposals recognize that an arrangement may have inherently subjective, qualitative elements. For example, there are plausible scenarios that may require a valuation professional to deviate from industry normative benchmark data to account for the specific facts and circumstances related to a given transaction. This further demonstrates the need for valuation professionals in the healthcare industry who use an evidence-driven methodology that includes both qualitative and quantitative assessments of the specific facts and circumstances related to the transaction; document their consideration of these facts and circumstances; and, articulate their ultimate applicability to the transaction in support of their opinion.

**DOWNSIDES TO THE PROPOSED CHANGES**

In 2018, three large settlements with DOJ were reached for physician remuneration in exchange for patient referrals ($260 million), free or discounted physician office space in exchange for patient referrals ($84.5 million), and excessive physician compensation above fair market value in exchange for referrals ($24 million). Proposed relaxation of Stark rules have led to concern that changes in these healthcare relationships may lead to more fraud, patient harm, and anticompetitive behavior by large health systems and hospitals.

**FINALIZATION**

The rules were published in the Federal Register on October 17, 2019, and all comments on the proposed rule were due 75 days from the date of publication, i.e., by December 31, 2019. Upon the end of the comment period, CMS has no official timeline by which it must publish the Final Rule.

**CONCLUSIONS**

CMS’s proposed rule changes clearly aim to remedy the current Catch-22 situation that physicians and providers face, making it easier for them to provide value-based care without
running afoul of the Stark Law. CMS has made significant strides in attempting to reduce the burden of compliance while also maintaining strong safeguards against fraud and abuse. Medical groups are concerned about the proposed changes because they believe the fundamental issue of unfairness to physicians has not been addressed and that any changes will simply add more layers to existing law. Ultimately, if major structural modifications are needed, Congress will need to step in and deliver further alterations to existing law.15

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REFERENCES
10. Exceptions to the referral prohibition related to compensation arrangements. 42 C.F.R. § 411.357(k).
ABSTRACT: Compared with the general population, physicians suffer higher rates of burnout, depression, suicide, PTSD, and substance use disorders. They tend to ignore their own mental health needs despite being aware of their symptoms. Working in the current health system further contributes to physicians’ malaise. Remedies include treating not only physicians, but also the health system that envelops them. Toward that end, incorporating prevention into medical practice and reconnecting practice to principles embodied in population health may help; however, a complete cure will require a fundamental reordering of the healthcare system, including the coordinated efforts of medical educators, health insurers, government agencies, policy makers, and professional organizations.

PHYSICIANS ARE IN A STATE OF CRISIS — A mental health crisis. Although doctors have an alarming rate of depression, suicide, burnout, substance use, and PTSD — a rate higher than the general public! — they are loath to seek treatment.

The collective denial of medical professionals evokes the phrase “Crisis? What Crisis?” because it depicts a false sense of security amid a calamity (see the cover of Supertramp’s 1975 album of the same title). Let’s take a closer look at the crisis and some possible solutions.

SUICIDE

The equivalent of one physician per day commits suicide in the United States, the highest suicide rate of any profession and more than twice that of the general population. The dynamics underlying suicide are many and varied — a perfect storm of biopsychosocial factors.

New research, however, suggests that information on a few key risk factors may help predict future suicide attempts with a high degree of accuracy, including a self-reported history of suicide, severity of suicidal thoughts and behaviors, and positive screens for mental disorders. A small percentage of physicians, however, will die unexpectedly by suicide and for unknown reasons.

BURNOUT AND DEPRESSION

Approximately half of physicians nationwide are experiencing substantial burnout symptoms such as emotional exhaustion, depersonalization (i.e., negativism or cynicism), and reduced professional efficacy, causing doctors to leave medicine or think about leaving practice.

Burnout is a complex and multidimensional problem, but the major culprits are high work demands coupled with too many administrative tasks, long working hours, and frustration over electronic health records.

Burned out physicians underperform on clinical and administrative responsibilities, threatening to undermine the provision of care. They also are a financial strain on their organizations; the organizational cost of physician burnout can range from $500,000 to more than $1 million per doctor in terms of recruitment, sign-on bonuses, lost billings, and onboarding costs for replacement physicians.

Burnout has been declared a public health crisis, and the syndrome was recently added to the 11th revision of the
International Classification of Diseases as an occupational phenomenon rather than as a medical condition. Unlike major depressive disorder (MDD), burnout is situation specific to and driven by chronic workplace stress that has not been successfully managed.

Yet many symptoms of burnout overlap with those of MDD (see Table 1). Mistaking depression for burnout could have dire consequences because erroneously labeling a physician’s distress as burnout may prevent or delay appropriate treatment of depression.

**SUBSTANCE USE**

Alcohol has become a tonic for work stress. A survey of 7,288 U.S. physicians from all specialties found that 12.9 percent of male physicians and 21.4 percent of female physicians met diagnostic criteria for alcohol abuse or dependence. Alcohol abuse or dependence was associated with burnout, depression, suicidal ideation, decreased quality of life, decreased career satisfaction, and medical errors.

The identification of problematic drinking and illicit drug use in physicians has been subject to considerable clinical and regulatory attention by state licensing boards, giving rise to physician health programs, which provide a comprehensive system of referral, evaluation, treatment, and long-term monitoring, resulting in five-year abstinence and return-to-work rates nearing 80 percent. However, many physicians believe they have been unjustly diagnosed with a substance use disorder and their licenses have been suspended or revoked without due process. Several have shared their accounts on the Internet.

**PTSD**

The cumulative stress of practice, or simply witnessing traumatic incidents — called vicarious trauma — may result in post-traumatic stress disorder (PTSD), especially in emergency physicians. Regardless of specialty, all physicians over time are emotionally vulnerable to the ongoing details of patients’ disturbing experiences, suffering, disease, death, emergencies, and unreasonable demands. A significant change to the DSM-5 diagnostic criteria for PTSD included the addition of “repeated or extreme exposure to aversive details of the traumatic event(s),” which applies to workers who encounter the consequences of traumatic events as part of their professional responsibilities.

This new criterion supports the notion that physicians’ exposure to trauma is a job-related risk and suggests that if left unaddressed, vicarious trauma may progress to PTSD.

**ROAD TO RECOVERY**

The road to recovery for ailing physicians begins with proper diagnosis and treatment, including maintaining a high index of suspicion for the occurrence of burnout, depression, substance use, and PTSD in predisposed physicians. Individual or peer-group therapy is helpful, along with medication when indicated. Fostering resilience and incorporating the concepts of vicarious trauma and burnout in residency training programs may aid in its prevention.

Physicians, however, must first realize and accept that they need help. It is not uncommon for physicians to recognize symptoms of mental health disorders in themselves, but

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**TABLE 1: FEATURES OF BURNOUT VS. A MAJOR DEPRESSIVE EPISODE**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Burnout</th>
<th>Major depressive episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core features</td>
<td>Extreme emotional and physical exhaustion, depersonalization, and decreased sense of accomplishment</td>
<td>Persistently depressed mood and/or loss of interest/pleasure in daily activities</td>
</tr>
<tr>
<td></td>
<td>Job performance may be impaired</td>
<td>Fatigue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Functional impairment</td>
</tr>
<tr>
<td>Common features</td>
<td>Extreme exhaustion</td>
<td>Extreme exhaustion</td>
</tr>
<tr>
<td></td>
<td>Feeling unhappy</td>
<td>Feeling unhappy</td>
</tr>
<tr>
<td></td>
<td>Reduced performance</td>
<td>Reduced performance</td>
</tr>
<tr>
<td>Context</td>
<td>Job-related and situational</td>
<td>General (context-free)</td>
</tr>
<tr>
<td>Affect</td>
<td>Variable; may feature positive emotions and use of humor</td>
<td>Sad, blunted, restricted</td>
</tr>
<tr>
<td>Thought content</td>
<td>Preoccupation with work</td>
<td>Feelings of hopelessness*</td>
</tr>
<tr>
<td></td>
<td>Self-esteem generally preserved</td>
<td>Suicidality*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mood-congruent delusions*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-esteem generally low*</td>
</tr>
<tr>
<td>Course</td>
<td>Correlates with workload</td>
<td>Persistent and not tied to specific thoughts or preoccupations</td>
</tr>
<tr>
<td></td>
<td>May resolve with changes in job environment, workplace, or other occupational factors</td>
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</table>

*Symptoms are specific to depression

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they often are reluctant to seek professional treatment, in part because doctors who are overworked, exhausted, and discontent have normalized their unhappiness and pretend it’s not as serious as it seems.

**TREATMENT BARRIERS**

More physicians suffering burnout, depression, substance use disorders, and PTSD could be helped if barriers to seeking treatment were removed — especially the stigma attached to mental health treatment. The repercussions of disclosing mental illness could irrevocably affect a physician’s career; yet questions related to mental health treatment are asked on licensing and credentialing applications. Such questions frighten physicians who have sought treatment in the past or are contemplating it in the future.

Physicians are placed in a Catch-22; even though they’re encouraged to seek treatment for mental disorders, regulators may doom their careers if they do enter treatment. Regulators who have concerns that psychiatric treatment might jeopardize physicians’ ability to practice medicine create a perverse situation for opioid-addicted physicians, who are often denied the crucial recovery option of medication-assisted therapy. Public disclosure of a physician’s psychiatric treatment may lead to shame and guilt, exacerbating substance abuse and symptoms of PTSD and depression.

A 2019 survey of more than 15,000 U.S. physicians in more than 29 specialties found that some doctors admit they have received psychiatric treatment but have kept it a secret by driving a considerable distance from their hometown for treatment, not using insurance, and even using a fictitious name. Although healthcare organizations and academic medical centers are becoming more proactive about helping doctors who feel burned out and stressed, independent physicians often are left to their own devices to get help.

Clearly, state officials and legislative bodies should make it easier for physicians to use employee assistance programs, peer support programs, and other mental health services without fear of recrimination. Licensing application questions about a physician’s mental health should be limited and focused on current rather than past impairment. Reframing discussions about “mental illness” as “mental health” may permit suffering physicians to seek psychiatric treatment without being judged.

Leonard Su, MD, a consultant for mental health issues in the workplace, wrote, “Ideally, we would approach all doctors broadly with a focus on mental health, burnout or not. Imagine gathering a small group of doctors in a room. You tell them to talk about mental illness. Nobody speaks. Those with mental illness will certainly clam up, while those without mental illness have nothing to say. Instead, if you tell the group to talk about mental health, it at least provides a forum to discuss things that have otherwise been considered taboo: feelings, emotions, yes, mental health.”

Physician wellness, now regarded as an important quality indicator, cannot be achieved unless doctors are allowed to speak openly, retain respect, and avoid humiliation.

**A SICK HEALTHCARE SYSTEM**

Perhaps it’s not physicians who need help as much as does a sick healthcare system. It’s been said that the United States has a great “sick care” system but not a great healthcare system. Once a leader in healthcare, the United States now ranks 35th in the world. Leonard Reeves, MD, a member of the American Association of Family Physicians Board of Directors, observed, “We have a disjointed, siloed, fragmented system that chops a patient into individual parts and maximizes profit.” Reeves lamented, “Where did the ownership of the patient go? Where did the care of the patient go?”

Multiply the angst expressed by Reeves about a million times (the approximate number of physicians practicing in the United States) and it becomes obvious why physicians’ mental health suffers. Here are just a few symptoms of a sick healthcare system:

- The loss of “touch” in medicine — literally, the abandonment of the physical examination.
- Over-reliance on technology — labs, imaging, electronic records, etc.
- Generic vocabulary — client instead of patient, encounter rather than visit, physicians relabeled as providers.
- Extraordinary emphasis on data — HEDIS® measures, utilization statistics, clinical “dashboards,” billing and diagnostic codes, etc.
- Third-party/prior authorization micromanagement of services.
- The gross intrusion (and influence) of corporations in medical practice.

**REMEDIES**

A variety of remedies have been suggested for the sick healthcare system, from preventive care to patient-centered care to greater use of artificial intelligence (AI), and while there are pros and cons to all of these and other potential cures, prevention wins out — AI adds to the over-reliance on technology and patient-centered care may have the unintended consequence of putting the onus on patients to direct their treatment, possibly excluding their physician.

Preventive care, on the other hand, calls for a fundamental reordering of priorities that will result in shared values between physicians and the healthcare system. These values are central to patient care and remind physicians why they wanted to become doctors in the first place.

In the seminal article “From ‘Sick Care’ to Health Care: Re-engineering Prevention into the U.S. Health System,” authors Farshad Fani Marvasti, MD, and Randall L. Stafford, MD, wrote: “Our very culture devalues disease prevention. Changing the system requires recognition of cultural, technological, and economic obstacles and identification of specific means for overcoming them through alterations in medical education, medical research, health policy, and reimbursement.”
The authors offered many recommendations to heal the sick healthcare system, including:

- Introducing prevention strategies early in the medical school curriculum.
- Emphasizing motivational interviewing aimed at modifying unhealthy lifestyles.
- Addressing psychological, social, and economic determinants of disease.
- Learning about homeostasis and health in addition to traditional disease and diagnosis.

Recommendations geared toward payers and providers included:

- Enabling primary care physicians (PCPs) to become health coaches.
- Placing greater value on the role of the PCP, especially as a coordinator of patient care.
- Strengthening the presence and delivery of primary care medicine in communities.
- Reimbursing expanded health maintenance and prevention services.
- Finding innovative ways to deliver care, such as medical homes.
- Encouraging and rewarding multidisciplinary treatment teams.
- Establishing reimbursement parity for cognitive and procedural-based treatment providers.

A BROKEN COVENANT

Additional recommendations aimed at curing the sick healthcare system have focused on issues of trust and ethics.20, 21 The noted physician commentator Danielle Ofri, MD, observed that the medical establishment has broken its “covenant” with doctors. She remarked, “Most doctors are not burned out in the traditional sense of the word: most love taking care of patients.... The source of agony is the profession — or rather the corporatization of the profession — that has so impinged upon doctors’ ability to practice medicine. Doctors placed their trust in the medical profession, but that trust has been roundly trounced.”20

To regain the trust of physicians, Ofri suggested that C-suite executives witness how care is actually delivered, for example by attending clinics with doctors or making rounds on inpatient units. They also should regularly help staff the front desk and the call centers. Only by leaving the C-suite and immersing themselves first-hand in the delivery of care — both the clinical and administrative aspects — can non-medical executives experience and understand how the system thwarts the efforts of physicians bent on doing their best for patients.

Ofri concluded: “If the profession wants to earn the trust of its members, it might be time to shift the primacy of patient care out of mission statements and into actual facts on the clinical tarmac.”20

The implication is that solutions to burnout and curing the sick healthcare system must be grounded in ethics, enabling physicians to act in accordance with their professional values. Doctors must be permitted to advocate for issues that directly impact their patients, and organizational ethics must be aligned with medicine’s professional values, rather than vice versa. Profits must be prioritized toward giving physicians adequate time with patients and ensuring that the clinical ranks are fully staffed and not over-worked.

A “MORAL” APPROACH

A “moral” approach to practicing medicine is, in fact, consistent with the goals of the Stanford University wellness program, considered a national model for combating burnout.22 The program seeks to increase professional fulfillment by improving physicians’ work experience and building an efficient, high-quality system that promotes teamwork and work-life balance.

To make physicians’ professional fulfillment a priority, Stanford’s program has ensured that comprehensive culture changes in the organization and practice environment have occurred, beginning with leaders’ commitment to wellness. A top priority is to identify and address basic inefficiencies in the system, such as the daily obstacles and annoyances that turn a clinic day into a frustrating marathon.

A call-to-action23 by physicians from Stanford and several other institutions referenced cost analyses estimating that for every dollar spent on wellness there is a $3 to $6 return on investment, presumably linked to reduced medical errors, increased productivity, decreased staff turnover, and improved quality of care and patient satisfaction.

Table 2 lists strategies for attaining professional well-being developed by the Mayo Clinic,24 the American Medical Association,25 and the National Academy of Medicine.26 All organizations emphasize the role of physician leaders in promoting wellness and creating less stressful workplaces for clinicians.

CONCLUSION

In the late 1970s, the British Labour Party collapsed under Prime Minister James Callaghan. His battle with trade unions sparked widespread strikes that crippled public services during the infamous 1978–1979 “Winter of Discontent.”

Upon returning to the United Kingdom from an economic summit in Guadeloupe in early 1979, Callaghan was caught off-guard by a reporter who asked, “What is your general approach [to rectifying the economy], in view of the mounting chaos in the country at the moment?” The prime minister, apparently unaware of the very serious state of affairs that had sneaked up on him, responded, “I don’t think other people in the world would share the view [that] there is mounting chaos.”22

The headline that subsequently appeared in the British tabloid The Sun was: “Crisis? What Crisis?”

One can only hope that history does not repeat itself with respect to healthcare in the United States.
treating unwell physicians is an immediate priority. So, too, is recognizing and treating the sick healthcare system that engulfs physicians. Failure to act on the “mounting chaos” is the real crisis in American medicine.

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REFERENCES


ABSTRACT: Outpatient practices are evolving into non-traditional models of care in an effort to maximize efficiency and patient volume. This has led to team-based models and the integration of telehealth and virtual visits. As patients now receive medical care from multiple sources and providers, the authors surveyed 796 patients’ preferences when receiving their care. Results indicate that most patients over age 65 prefer provider consistency and in-person medical care. Convenience is a preference for patients with higher household incomes.

AN AGING POPULATION AND THE INCREASING complexity of integrated chronic disease management have increased the need for primary care providers.1 To meet this increased need, traditional models of care are being challenged.

Integrated delivery systems have responded with the evolution to team-based care and the emergence of novel practice models such as increased use of nurse practitioners (NPs) and physician assistants (PAs) as well as increased use of technology in the form of virtual visits.1-3 These new models are intended to improve access, decrease costs, and improve quality, but their effect on patient satisfaction is unknown.

TEAM-BASED AND CONTINUITY OF CARE

Team-based care, defined as care provided by more than one provider in a collaborative fashion, was introduced to healthcare with the goal of decreasing provider burnout, improving quality, and decreasing costs.4 Team-based care has been shown to improve hypertensive, hyperlipidemia, and coronary artery disease outcomes in clinical studies.5,6 However, the realized benefits have been otherwise inconsistent. The care model also has been shown to increase costs and can have a negative financial impact in fee-for-service environments.6

Continuity of care can be adversely affected when patients are managed by multiple providers, which can negatively affect clinical outcomes. Studies have shown continuity of care can decrease mortality and overuse of procedures and reduce hospitalization in longitudinal primary care settings.7,8 Relatively, comprehensive care models, in which physicians care for their patients in both outpatient and inpatient environments, have been shown to decrease hospitalizations and improve patient experience.9 General provider consistency also has been associated with improved patient satisfaction and medical compliance.10,11

A systematic review addressing patient satisfaction with team-based care versus standard treatment showed inconsistent data with either a positive relationship between team-based care and patient satisfaction or no relationship.12 Given current healthcare system practice trends toward team-based care models in the context of inconsistent evidence, we sought to investigate patient preferences regarding team-based care.

METHODS

We distributed a 13-question survey to all patients in the Division of Community Internal Medicine outpatient clinic of Mayo Clinic Arizona over a six-week period from January 29, 2018, to March 9, 2018. The Mayo Clinic Institutional Review Board (IRB) determined that the study was IRB-exempt as an anonymous survey. Thus, consent for participation was not obtained.

Mayo Clinic Arizona is located in metropolitan Phoenix-Scottsdale and provides longitudinal primary care.

The Division of Community Internal Medicine comprises about 25 providers, six of whom are PAs or NPs. The providers are all primarily outpatient providers, using a Mayo
Clinic hospitalist division for inpatient care. The providers are divided into three teams of 7–8 providers. When patients are unable to see their assigned provider, they usually are seen by a provider on the same team to promote familiarity and continuity. Additionally, the physicians staff an acute care clinic with residents in a rotating fashion. NPs and PAs support the physician practice panels, but they also have slightly smaller patient panels of their own.

It should be noted that Mayo Clinic tends to attract relatively medically complex patients, and some patients have an additional primary care provider elsewhere. Internal medicine residents also see patients in CIM, but they were excluded from this study.

In all, 1,731 eligible patients received surveys; 796 surveys were completed. The survey was anonymous with no patient identifiers. There were no exclusion criteria, and the survey was English language only. The optional surveys were handed to patients at the beginning of their appointments; anonymous collection boxes were placed at the nursing station located outside the exam rooms.

Four discrete choice experiment scenarios were used to assess patients’ preferences: 1) when visiting the clinic for yearly physicals and/or routine medical follow up; 2) when sick (for example, with the flu) or have a new health concern; 3) virtual visits vs. face-to-face; and 4) when communicating with nurses and medical assistants. Virtual visits were intended to include Internet-based encounters, such as the use of messaging and video.

For each scenario, the patient was to select among five choices to express preference and importance. The level of importance could be expressed as “much more important,” “somewhat more important,” and “no preference.”

The survey included questions regarding demographics such as age, gender, education level, income, age of children at home, time as a patient at the Mayo Clinic, primary provider (physician vs. NP or PA), and primary provider preference (medical doctor or doctor of osteopathic medicine vs. NP or PA).

Descriptive statistics were used to summarize outpatient practice model survey responses. A chi-square test was used for categorical variables and Fisher’s exact test was used when appropriate. Differences between age groups were determined by Pearson chi-square.

P-values <0.05 were considered significant. Statistical analysis was performed using SAS version 9.4 (SAS Institute Inc.). The Cochran Armitage test was used to assess the association between age and responses for annual visits and virtual visits.

RESULTS

Males and females were well-represented among survey respondents, most of whom were older than 65, with no significant differences of preferences between them. Most of the survey respondents reported an annual household income of more than $100,000, and nearly all reported at least some college education. Most of the patients had been at Mayo Clinic for more than five years, and the overwhelming majority were assigned to a MD or DO for primary care as opposed to a nurse practitioner or physician assistant. See Table 1 for a detailed breakdown of patient demographics.

Age and annual household income were significant factors in patients’ preferences. Regarding annual exams,

<table>
<thead>
<tr>
<th>TABLE 1: SURVEY RESPONDENT DEMOGRAPHIC DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Total 796</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;35</td>
<td>31 (4)</td>
</tr>
<tr>
<td>35–50</td>
<td>77 (10)</td>
</tr>
<tr>
<td>51–64</td>
<td>222 (28)</td>
</tr>
<tr>
<td>&gt;65</td>
<td>466 (58)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years at Mayo Clinic</th>
<th>Total 792</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>104 (13)</td>
</tr>
<tr>
<td>1–5</td>
<td>163 (21)</td>
</tr>
<tr>
<td>&gt;5</td>
<td>525 (66)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Primary Care Provider</th>
<th>Total 741</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD or DO</td>
<td>680 (92)</td>
</tr>
<tr>
<td>NP or PA</td>
<td>61 (8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Preference</th>
<th>Total 665</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD or DO</td>
<td>641 (96)</td>
</tr>
<tr>
<td>NP or PA</td>
<td>24 (4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Household Income</th>
<th>Total 563</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$50,000</td>
<td>54 (10)</td>
</tr>
<tr>
<td>$50,000–$99,000</td>
<td>123 (22)</td>
</tr>
<tr>
<td>$100,000–$250,000</td>
<td>229 (40)</td>
</tr>
<tr>
<td>&gt;$250,000</td>
<td>157 (28)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child Under 18 at Home</th>
<th>Total 742</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>681 (92)</td>
</tr>
<tr>
<td>Yes</td>
<td>61 (8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest Education Level</th>
<th>Total 722</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>57 (8)</td>
</tr>
<tr>
<td>Some College or Associate’s Degree</td>
<td>176 (24)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>235 (33)</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>146 (20)</td>
</tr>
<tr>
<td>Professional Degree</td>
<td>59 (8)</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>49 (7)</td>
</tr>
</tbody>
</table>
84.5 percent of patients younger than 65 preferred seeing their regular provider while 90.6 percent of those older than 65 felt the same (p<0.05) (see Figure 1).

When further dissecting and comparing age groups — younger than 35, 35–50, 51–64, and 65 and older — there were significant differences among the groups, with those preferring to see the provider increasing with age (53.3 percent, 57.5 percent, 69.5 percent, 76.5 percent respectively; p<0.05).

As for acute visits, 41.7 percent of those aged 65 and older preferred their regular provider while 41.5 percent of those younger than 65 preferred an appointment when they wanted it (p = 0.7949).

Regarding virtual visits, 71.7 percent aged 65 years and older preferred face-to-face visits, while 53.4 percent younger than 65 preferred the same (p < 0.05) (see Figure 2). The Cochran Armitage test for trend revealed an increased patient preference for virtual visits (Z = 5.108, p = <0.0001) as the probability of being younger than 65 increased. Similarly, for annual visits, preference for provider consistency increases as the probability of those 65 and older increases (Z = 3.06, p = 0.001).

When communicating with nurses and medical assistants, of total patients answering age demographics, 32.5 percent preferred the same person while 48.4 percent preferred a quick response (p < 0.05).

Variations among annual household incomes were perhaps more stark: 55.4 percent of those with annual household incomes greater than $100,000 were interested in getting prompt nursing replies rather than speaking with the same person, while 37.5 percent of those with annual earnings less than $100,000 preferred the same (p < 0.05). Of those with annual household incomes greater than $250,000, 28.6 percent would prefer a prompt virtual visit as opposed to face-to-face visits (p <0.05), while 12.8 percent of those earning less than $100,000 annually said they would choose the same (p = 0.0026) (see Figure 3).

**FIGURE 1: SEEING REGULAR PROVIDER VS. TIMELY APPOINTMENT (P < 0.05)**

This graph shows those who prefer seeing their regular provider as opposed to seeing any provider in a timely manner for both annual visits and acute visits.

84.5 percent of patients younger than 65 preferred seeing their regular provider while 90.6 percent of those older than 65 felt the same (p<0.05) (see Figure 1).

When further dissecting and comparing age groups — younger than 35, 35–50, 51–64, and 65 and older — there were significant differences among the groups, with those preferring to see the provider increasing with age (53.3 percent, 57.5 percent, 69.5 percent, 76.5 percent respectively; p<0.05).

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**DISCUSSION**

This study shows that patients fundamentally still value the doctor-patient relationship, particularly for yearly physical examinations. This is consistent with findings in a previous study by Pereira and Pearson.\(^\text{10}\) However, this is discordant...
from review findings by Wen and Schulan, which cited studies suggesting that patients had higher satisfaction with team-based care.12

There are statistically significant differences between age groups above and below age 65, but more than 80 percent of patients surveyed preferred seeing their regular provider for yearly exams. In contrast, the doctor-patient relationship appeared to be less important for acute visits, as there was no significant difference between choice of consistent provider versus a timely appointment with any provider.

As with other studies, convenience seems to be more important for some patients when accessing the medical system, including telehealth, for acute problems.13,14 Virtual visits, while potentially a popular and cost-effective model that also improves access, were not uniformly preferred by patients in our study. Those 65 or older were the least likely to choose this option, but there was relative popularity among those patients aged 35–50. Potential reasons for the differences between the age groups could be understanding of or comfort with technology, preference of visit type because of constraints of time, or different values between generations and age groups.

Virtual visits also were more popular among those with household incomes greater than $250,000 and those with higher education levels. This could be secondary to time constraints on those with higher wage positions, comfort with or knowledge of technology between higher and lower educated groups, or possible value differences between higher and lower income and education groups.

This study has some limitations. This is a single-center study conducted on a relatively homogenous patient population. The survey was given only in English, lending to possible misunderstanding by those who do not understand English or for whom English is not a primary language. However, the difference in survey results offered in other languages would presumably be small. English-only surveys were chosen because of the low number of non-English speaking patients in the clinic.

Ethnicity was not queried in the demographic information and may lend to differences in answers among ethnic groups; therefore, generalizability of this study to institutions with higher racial and ethnic patient heterogeneity may be inappropriate. Additionally, there were some unanswered demographic questions. Finally, some discrete choice experiment responses were discarded because the answers were not interpretable (i.e., the respondent checked two or more responses).

Nevertheless, this information can provide a direction for both large integrated delivery systems and small medical practices looking to optimize patient experience. Overall, provider consistency, in the right setting, was highly preferred by those studied. Aiming to increase this experience for patients would seem to lead to higher satisfaction for institutions that perform a significant number of annual exams.

Increased team-based care, expressed by patients as getting any provider in a timely manner, would be supported for institutions and practices with higher acute-based visits. A balanced approach of offering both provider consistency and timely appointments with any provider would be a benefit for institutions with the means and appropriate patient appointment type.

If a system or clinic has a large number of patients in the 35–50 age group, higher education, or household income greater than $250,000, offering virtual visits could benefit patients. This study could be duplicated at institutions where demographics differ from those in this study to better relate to local preferences.
CONCLUSION

In conclusion, our study negatively supports the use of team-based care, favors the use of consistent providers in annual exams, but supports the use of team-based care for acute issues. With the right patient demographics, virtual visits could be offered and preferred by some patients.

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REFERENCES


SURVEY

The outpatient primary care practice at Mayo Clinic is interested in your opinions about access to medical providers. We are always working to meet our patients’ needs and enhance our patients’ experience. Thank you for your participation in this anonymous survey.

1. What is your age?
   a. Under 35
   b. 35–50
   c. 51–64
   d. 65 or older

2. What is your gender?
   a. Female
   b. Male
   c. Prefer to self-describe
   d. Prefer not to answer

3. For how many years have you been seen in Mayo Clinic Primary Care (Family Medicine or Internal Medicine)?
   a. Less than 1 year
   b. 1–5 years
   c. More than 5 years

4. Which best describes your main primary care provider? This is the provider assigned to manage or oversee all of your care at Mayo Clinic Primary Care.
   a. Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO)
   b. Nurse Practitioner or Physician Assistant
   c. I don’t know

5. Which type of healthcare provider do you prefer to manage or oversee your primary care?
   a. Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO)
   b. Nurse Practitioner or Physician Assistant
   c. No preference

6. When making appointments, sometimes patients need to choose between getting an appointment at a time that is convenient for them and seeing their preferred primary care provider. Which best describes your preference in the following two scenarios? Please choose one box for each scenario.

<table>
<thead>
<tr>
<th>Seeing my preferred provider is much more important than getting an appointment when I want it</th>
<th>Seeing my preferred provider is somewhat more important than getting an appointment when I want it</th>
<th>I have no preference either way</th>
<th>Getting an appointment when I want it is somewhat more important than seeing my preferred provider</th>
<th>Getting an appointment when I want it is much more important than seeing my preferred provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>When visiting the clinic for yearly physicals and/or routine medical follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you are sick (for example, with the flu), or have a new health concern</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. Virtual visits are computer- or phone-based patient interactions with a primary care provider. Mayo Clinic may have them available in the future. Which best describes your preference regarding virtual visits with any primary care provider versus face-to-face visit with any primary care provider for urgent healthcare concerns? Choose one box.

<table>
<thead>
<tr>
<th>Seeing any provider in person is much more important than getting a virtual visit when I want it</th>
<th>Seeing any provider in person is somewhat more important than getting a virtual visit when I want it</th>
<th>I have no preference either way</th>
<th>Getting a virtual visit with any provider when I want it is somewhat more important than seeing any provider in person</th>
<th>Getting a virtual visit with any provider when I want it is much more important than seeing any provider in person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

8. Patients can often have their needs met (medication refills, paperwork, and appointment requests, etc.) through a phone call to their main primary care provider’s nurses or medical assistants. Which best describes your preference regarding communication with nurses and medical assistants? Choose one box.

<table>
<thead>
<tr>
<th>Communicating with the same nurse or medical assistant is much more important than receiving a quick response</th>
<th>Communicating with the same nurse or medical assistant is somewhat more important than receiving a quick response</th>
<th>I have no preference either way</th>
<th>Receiving a quick response is somewhat more important than communicating with the same nurse or medical assistant</th>
<th>Receiving a quick response is much more important than communicating with the same nurse or medical assistant</th>
</tr>
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<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

9. What is your annual household income?
   a. Less than $50,000
   b. $50,000–$99,999
   c. $100,000–$250,000
   d. More than $250,000
   e. Prefer not to answer

10. What is your current marital status?
   a. Single, never married
   b. Married or domestic partnership
   c. Divorced
   d. Separated
   e. Prefer not to answer

11. Do you have children under the age of 18 at home?
   a. Yes
   b. No

12. What is your highest level of completed education?
   a. High school
   b. Some college or associate's degree
   c. Bachelor's degree
   d. Master's degree
   e. Professional degree (example MD, JD)
   f. Doctorate degree
   g. Prefer not to answer
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INFLUENCE
CLIMBING THE LADDER TO CEO PART II: LEADERSHIP AND BUSINESS ACUMEN

This is the second 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 “CLIMBING THE LADDER TO CEO: PART I”**
(March/April 2020 Physician Leadership Journal) we explored the hiring of a hospital CEO through the eyes of prominent healthcare search consultants. Central to the discussion was that hiring boards are very risk-averse.

This raises the question of how physician candidates can convince a board of directors that they are able to successfully lead a complex, multimillion-dollar corporation with thousands of employees.

Assuming a CEO candidate is a good organizational fit, demonstrating proficiency in two general skills will be a major determinant in getting the job offer.

The first and most important skill is leadership. It includes vision, passion, effective communication, and the ability to motivate others. Leadership can be demonstrated through past accomplishments, but also “felt” by members of the search committee during the interview process.

The second critical skill is business acumen. In its simplest form, it is the ability to produce a quality product and generate profits. This requires the ability to manage people, execute strategy, generate revenues, maximize assets, acquire capital, and successfully complete other tasks inherent to running a business.

To gain insight about how to develop these skills, I interviewed six physician hospital presidents/CEOs. Their organizations ranged from single hospitals to large healthcare systems, with $120 million to $650 million in net revenues and from 900 to 5,000 full-time employees.

**LEADERSHIP**

The CEOs interviewed were not a homogeneous group of individuals; however, common threads were evident throughout the interviews. Strikingly evident was high energy. All pursued a leadership career path with passion and purpose.

These were not clinical refugees. Without exception, these leaders wanted to have a positive influence over larger patient populations than they could influence in clinical practice. When they originally embarked on their careers, most did not want to be CEOs. They simply said they wanted to “make a difference.” This passion and sense of purpose was so infectious that at the conclusion of each interview there was little doubt in my mind as to why they were hired.

How did they develop such evident leadership skills? As one CEO put it, “I raised my hand for everything.” Career paths varied, but here are the early entry points:

- Leading committees and organizational initiatives.
- Pursuing elected leadership positions within or outside their home organizations.
- Accepting entry-level medical director positions.
- Seeking larger administrative roles in smaller organizations.
- Managing a group practice.

While there are no surprises on this list, the interviews provided insight into the qualities and traits that allowed these
individuals to grow into successively greater roles. The success factors are purpose, respect, and performance.

**PURPOSE**

Several CEOs acknowledged that they always enjoyed leading (one stated that he would rather lead the orchestra than be the lead violinist), but all were focused on something other than themselves.

This is more than just an admirable trait. It creates a dynamic that generates success and career opportunity. A person focused on self (things like money, status, and power) pursues a position. A person focused on purpose pursues a goal. Goals lead to accomplishments and accomplishments lead to opportunity.

Consider the example of two elected medical staff presidents.

The first physician agrees to his nomination and wins by popularity. He enjoys the camaraderie among his status quo preserving supporters and serves out a two-year term. During the interview for his first paid management role he states that he leads by consensus and is well liked by the medical staff.

The second physician seeks a nomination. She has a sense of purpose and sees this position as an opportunity to improve the quality of care for her community. During her interview for a management post she states that she engaged the medical staff “sometimes kicking and screaming” in organizational process improvement efforts. By the end of her term, the organization moved from the bottom quartile of 10 core measures of The Joint Commission of Accreditation of Healthcare Organizations to the top 10 percent.

Both medical staff presidents have leadership experience, but only one has an accomplishment. Is there any doubt in your mind which one is most likely to move into greater roles?

**RESPECT**

The CEOs interviewed understand the power of building relationships. They are inclusive and collaborate effectively. They have sincere respect for all team members and understand that being a physician does not trump the expertise and opinions of others.

We need to get over this “physician-ness,” one CEO said, explaining that being a physician is a credential and “there is no separate species of leader.”

“You’ll never get ahead putting others down. You must show what you can do,” another said.

Most CEOs said they have mentors. These mentors are often non-physician administrators or businesspeople whom they deeply respect and call upon for advice and guidance. Several CEOs felt strongly that this is the single greatest factor attributable to their success.

It’s a matter of respect. As a practicing physician, our patients come to us with a certain amount of trust and respect even before they know anything about our personality or ability. The CEOs have no such expectation of the people they lead. They know that trust and respect must be earned. While they are not afraid to pursue difficult goals, they understand the importance of conducting themselves with integrity and consistency.

**PERFORMANCE**

I asked the CEOs whether there was a single major accomplishment that had a significant role in propelling their careers forward. The answer was unanimous: “No.” However, one CEO said, “[but] I can think of one major failure that almost sank my career.”

Another CEO described himself as a “singles hitter,” meaning that an executive can’t depend on any single great accomplishment. Career vitality is dependent on consistent performance over time — yesterday, today, and tomorrow.

To pursue successive opportunities, it is imperative that you quantify your success using metrics such as satisfaction scores, net income, and statistics. Collect these metrics over time so that you can put together an honest, powerful resume.

Evident throughout the interviews was how these individuals were responsible for many impressive accomplishments, but not one took credit or exhibited self-promotion during the interviews. I sensed humble confidence — an admirable trait.

The CEOs were very candid about past failures. Since occasional failure is inherent to those who take risk, I wanted to understand how they survived failure. Several trends emerged.

First, the CEOs had already established a track record of success prior to their failures (i.e., they were proven entities). Blunders too early in the career path can be much more devastating and it is advisable that you initially lead what you know.

Do not attempt to leap too far beyond your current level of education and experience. Some people have done this successfully, but it is more prudent to grow your career in a logical, stepwise manner. It can be the equivalent of performing an appendectomy before your internship and residency.

Second, the CEOs took accountability for failure, protected their teams, and turned it into a positive learning experience.

**BUSINESS ACUMEN**

Demonstrating proficiency in business is a requirement for most CEO positions. There are two exceptions for physicians:

There are organizations where bylaws or traditions mandate a physician leader. These organizations tend to be large multispecialty groups with hospital ownership or tight affiliations, or academic medical centers. The structure often provides for strong non-physician administrators to be “paired” with the physician leaders. This does not mean that these physician leaders do not have strong business minds, but that operations experience may not be mandatory before hiring.

Organizations that have severely troubled medical staff relations or that view physician relationship building as a core strategy may seek a physician CEO. In either scenario, the board considers the ability to forge strong physician/hospital relations as a requirement for success and will consider a physician without strong operations experience. Often provisions are made to protect business matters, such as a strong COO or a formal mentoring process.
Although it’s subjective, let’s say that significant operations experience is arbitrarily defined as responsibility for greater than $50 million annual net revenues (not necessarily in hospitals) during a three-year period.

Only two of the CEOs had significant operations experience before obtaining their first CEO position; the others didn’t even come close. However, don’t make the mistake of assuming that demonstrating business proficiency is optional.

All the CEOs hired without operations experience were inside candidates. This is consistent with the search consultants interviewed in Part I who said the inability to demonstrate business savvy is the nemesis for physician executives seeking CEO positions outside their home organizations.

This is the missing skill that is critical to breaking through the “caducean ceiling”— the barrier so often discussed in physician executive circles. Lack of operations experience is a primary reason that only about 3 percent of the nation’s hospitals are physician-led — a percentage that has remained stable for many years.

The final installment of this series of articles will explore techniques for obtaining operations experience and shattering the caducean ceiling.

ACKNOWLEDGMENTS
Special thanks to the following CEOs who gave their time and provided insights to help shape this article:

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PHYSICIANLEADERS.ORG/EXCELLENCE
In this article …

The right technology tools can help physicians more effectively manage their time, improve the bottom line, and focus on what matters most: patients.

Physician burnout is a public health crisis that demands urgent action. A 2019 Harvard University report concludes that if left unaddressed, the worsening crisis “threatens to undermine the very provision of care, as well as erode the mental health of physicians across the country.”

Physicians today are frustrated with computer interfaces, burdened by piles of administrative tasks, haunted by quality improvement, and challenged to manage the shift from a fee-for-service to value-based reimbursement model. A 2016 study published in the Annals of Internal Medicine found that physicians spend just 27 percent of their time on direct clinical face time with patients and 49 percent of their time on EHR and desk work. That means for every hour physicians engage with their patients, they spend nearly two additional hours on EHR and administrative tasks.

With the strain on physicians and their patients caused by the growing shortage of physicians across specialties throughout the United States, time management is a vital skill for busy physicians.

Managing, sustaining, or growing a medical practice; obtaining Continuing Medical Education (CME) credits; seeing as many patients as possible; and managing administrative responsibilities can be a challenge. However, with the aid of technology, physicians can tackle many of their daily tasks, manage their time more effectively, and set out on a path to a healthy work-life balance. After all, leveraging technology to manage time is integral to any healthcare practice, as it may lead to better healthcare delivery and increased revenue.

The first step is to set goals. Many highly effective professionals, no matter their industry, use goal setting to help manage their time and keep priorities in order. Setting both short- and long-term goals can help physicians stay focused and make decisions about where and how they spend their time. Taking even minimal time to lay out and review goals on a regular basis can ultimately help physicians save time and feel more self-assured in their decision making.

Then, physicians should explore the benefits of leveraging today’s technology.

USE APPS FOR PRODUCTIVITY

Deloitte’s 2018 Global Mobile Consumer Survey found that across all age groups, Americans look at their phones more than 50 times a day. With a projection of 3.8 billion smartphone users by 2021, the app ecosystem is flourishing, and the upward trajectory is forecast to continue. Medical professionals have an abundance of options when it comes to choosing which apps will help them most; the Apple App store offers more than 2.2 million options and approximately 2 percent of all the active apps are medical-related.
Mobile apps that are hospital-approved for clinical use can be helpful. The EPIC Haiku App (https://www.epic.com/software#PatientEngagement) helps doctors locate patients in the hospital, look up lab results, and check the OR status board. The Welch Allyn i Examiner (https://apps.apple.com/us/app/welch-allyn-iexaminer-pro/id1245300824), used with its Ophthalmoscope, turns the iPhone into a mobile digital imaging device, allowing users to view and take high resolution pictures of the fundus and retinal nerve in the eye. The app then allows users to store the pictures to a patient file or email and print them.

In an era when dictation has taken a back seat to templates and typing, Nuance’s PowerMic Mobile (https://www.nuance.com/healthcare/provider-solutions/speech-recognition/powermic-mobile.html) helps make dictating more convenient. Specifically designed to enhance productivity, this app allows clinicians to use their smartphones as a dictation microphone at any workstation with Dragon Medical. It’s easy to use, and clinicians can spend more time with patients, capture notes while information is fresh in their minds, or catch up on clinical documentation from home.

When patient communication is hampered by language barriers, doctors can use MediBabble (medibabble.com), a free professional-grade medical translation tool. The tool has an extensive database of translated clinical questions and instructions that allow doctors and other medical professionals to effectively communicate with patients across multiple languages. Once downloaded, the app requires no Internet connection to function; therefore, it works well in commonly shielded environments such as hospitals, emergency departments, and radiology suites.

**IMPROVE THE PATIENT EXPERIENCE**

Millennials and Generation Z are forcing substantial change in the U.S. healthcare system. The high expectations that these generations have for healthcare isn’t shocking, as they have integrated technology into every aspect of their daily lives. After all, Gen Z is the first generation of digital natives, born and raised at a time when virtually everything can be done online.

Millennials and Gen Z both welcome technological disruption and view it as a way to make things better, faster, and more efficient. They want on-demand healthcare choices and virtual doctor visits and believe the improved use of information technology is vital for the future of the healthcare industry.

Today, physicians can send automated alerts and reminders directly to patients’ mobile devices or via email. Not only does this help prevent appointment no-shows or cancellations, it helps satiate the need of Millennials and Gen Z to use technology within the clinic.

Most scheduling software is simple to use and helps ensure that patients show up on time and don’t wait for hours to be seen, while guaranteeing smooth transitions of daily appointments according to a previously set schedule. Reducing missed appointments also helps practices improve their bottom line.

Leveraging technology to successfully enhance a patient’s experience with something as simple as an appointment reminder can have a big impact. For example, the appointment reminder from AdvancedMD (https://www.advancedmd.com/patient/appointment-reminders) lets medical practices set up to three sequential and automated reminders to schedule a patient for a recall visit. Not only does it let the user set the patient’s language (English or Spanish), it also provides the option of communicating via text message, email, or voice. By automatically sending patient reminders for upcoming appointments, medical professionals can improve continuity of care and patient engagement.

Studies have shown that phone communication with patients reduces readmissions and increases patient satisfaction, but successfully connecting with patients can be challenging. With daily schedules completely booked, there is little time to call patients during working hours.

Unfortunately, doctors are less likely to call patients outside of the office, and if they do, patients are unlikely to answer calls from unfamiliar or blocked numbers. With the help of mobile apps like the Doximity Dialer (https://www.doximity.com/clinicians/download/dialer), physicians can call patients from their personal cell phone and the patient will see the hospital’s office number as the caller ID. Doctors can make calls on the go and patients are more likely to pick up a call from a number they recognize.

**AVOID THE FAX MACHINE**

Thousands of medical students across the country had never seen, let alone operated, a fax machine until the day they entered a hospital as a medical student, according to a CNBC article. Faxing seems like an obsolete, mundane task, but healthcare has been much slower to digitize than other industries.

CMS Administrator Seema Verma has challenged the industry and developers to help make doctors’ offices fax-free by 2020. However, it’s not likely that we will see the demise of the fax machine anytime soon, given that it is HIPAA-compliant off the shelf, and digital communication is not. Even with the integration of EHRs, clinicians still need to fill out an average of 20,000 forms every year. Chances are every hospital’s fax machine will remain busy for the foreseeable future.

But for technologically advanced medical professionals who need to review a patient’s lab results while outside the office or who don’t want to wait on hold forever to do a prior authorization, there’s an app for that. eFax capability is included as part of the Doximity website and mobile app. Physicians can easily receive and send faxes from an iPhone or Android. Physicians, nurse practitioners, physician assistants, and pharmacists can use the HIPAA-secure eFax to electronically fax colleagues and sign documents using just a finger. The technology also allows users to attach images and documents for secure delivery, date and sign, and annotate documents, all on the go.

This technology helps medical professionals use their phones to fax when time is of the essence and they can’t afford to wait for a clunky hospital fax machine to send time-sensitive documents. By giving physicians a technology-enabled platform to collaborate and share findings more effectively,
physicians not only are able to provide better care, but also are better able to manage their time.

EARN CME CREDIT

A vital part of delivering the best patient care is staying current with the latest medical advancements and research. Physicians are required to document this activity by earning CME credits. Most states require a specific number of credits annually to maintain medical licenses, and many hospitals require a specific number of CME credits for their physicians to maintain privileges.

But earning CME credits can often fall to the bottom of the physician to-do list when juggling a heavy patient load, which subsequently leads to an end-of-year scramble to meet the requirement.

Physicians can attend costly out-of-state conferences or pay to watch dry clinical videos to earn credits; however, there are better options for medical professionals to earn CME credit and keep track of what they have earned.

For example, BoardVitals (boardvitals.com) offers an option to complete all CME requirements by answering board-quality cases and questions from a mobile device and reviewing supporting evidence-based rationale. Users can stay updated on the latest medical knowledge, take an online self-assessment activity to test knowledge through case-style review questions, and earn CME credits throughout the process, which is organized by specialty.

The Mayo Clinic CME app (https://apps.apple.com/us/app/mayo-clinic-cme/id8605914127) allows attendees of select Mayo Clinic meetings to browse the speaker information and presentations. Slides are also available from select sessions. An in-app feature allows users to make notes on the presentation slides from a mobile device.

Another option is RealCME (https://apps.apple.com/us/app/eopocrates-cme/id399842586), which offers frequently updated interactive educational activities in various specialty topics. All completed credits are automatically tracked within the app and users receive a personal performance report every quarter with completed CME credits. The certificates are mailed directly to the recipient.

Podcasts may be more appealing for those who prefer listening to reading. ReachMD CME (https://reachmd.com/cme) is an exclusive XM satellite radio channel that’s accessible on a mobile device. This resource allows medical professionals to listen to and take CME exams on a mobile device, while regularly being updated with new CME programs to browse by keyword.

A few other podcast-style options include: AudioDigest (audio-digest.org), which offers topical collections through a “playlist” approach, giving clinicians access to relevant and up-to-date lectures on issues related to leading medical challenges; JN Listen (https://apps.apple.com/us/app/jn-listen-audio-cme-from-jama/id1288117935), an audio CME podcast app that collects interesting, relevant podcasts based on peer-reviewed articles published in JAMA; and Pri-Med (https://www.pri-med.com/podcast), which features expert faculty discussing the most recent developments in the medical field.

THE RIGHT TOOLS

As physicians, our priority is to deliver the best quality care to patients. Technology that enhances clinical workflows, increases productivity, and improves patient experience is now more seamless than ever.

Whether it’s an app to schedule an appointment, conduct a telehealth visit, earn CME credits, or text a follow-up appointment reminder, choosing the correct tools can help physicians more effectively manage their time, help the bottom line for their practice, and have more time to focus on what matters most: patients.

Peter Alperin, MD, trained as an internal medicine physician at UCSF and is currently vice president at Doximity, where he leads the development of products geared toward clinicians. He also has 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 practice at the San Francisco Veteran’s Affairs Medical Center.

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REFERENCES


The Keys to Putting Physicians in Control

Quality Care, Affordable Care

How Physicians Can Reduce Variation and Lower Healthcare Costs

Lawrence Shapiro, MD

Regular Price: $39.95
Member Price: $34

To purchase, visit
www.physicianleaders.org/quality-care-affordable-care
PEOPLE MANAGEMENT

PSYCHOLOGISTS BRING VALUE TO SUCCESSION PLANNING

By Andy Smith

In this article …
The data and analytics psychologists provide to healthcare organizations allow for smarter decisions, fewer costly mistakes, and better outcomes.

WHEN IT COMES TO TECHNOLOGY, HEALTH-care can proudly boast that it’s usually on the cutting edge with the latest, greatest, and most innovative advancements the industry has to offer.

Yet when it comes to succession planning, healthcare often finds itself “way behind the ball,” according to Quint Studer, founder of the Studer Group, a renowned healthcare consulting organization.

“We have to have the best technology when it comes to electronic health records and clinical outcomes,” Studer says. “Yet, when it comes to assessing talent, we still do it the way we’ve done it for years.”

In other words, healthcare continues to assess talent without the kind of valuable, predictive bio-data that increases the prospects of successful outcomes in planning and promotions. So, what’s the answer?

“I’m a big believer in using organizational psychologists to help with the process,” Studer says.

One industrial and organizational psychologist Studer has relied on for more than 30 years is Chris Reilly, PhD, who’s been consulting on succession plans since 1989 and says the process for putting together a plan is “pretty standard,” though it’s also quite thorough and involved.

TAILORING THE PLAN

The first order of business for the psychologist is assessing and understanding the current structure of an organization, Reilly explains. That might mean meeting with the CEO or human resources personnel to understand the key players, hierarchy, goals and values of the company, current market conditions shaping its future, and whether it plans to grow or prefers to maintain the status quo.

“All of that impacts the actual succession plan,” Reilly says.

The role of the psychologist in all of this depends on the client. Some clients want only the data the psychologist is able to produce as an aid in developing a plan or deciding who’s promotable.

Other clients want more than data. They want the psychologist fully engaged in the development of the succession plan — identifying cultural variables, specific desired management leadership traits, and special traits required for other positions.
With regard to promoting the right person: What are their characteristics and how do those characteristics fit with the job and the organization?

“You want to look at not only what the position is now but will be required of it in the future, especially if the company is set to grow or change,” Reilly advises. “Likewise, you hope to hire people with potential beyond their current position, so you want to assess their ability to grow and take on more responsibility.”

THE BROADER VIEW

Beyond assessments, psychologists take a big-picture approach to the succession planning process by answering such questions as: What and how should it be done? Who should be included in the process?

“It’s that assessment of potential for the future when they’re hiring or assessing someone for development,” Reilly says.

The problem, he cautions, is that promotions often are based on subjective intuition, which often leads to regrettable decisions — that a person’s proven success at one level is no guarantee of success at the next.

“As much as you read about it and say, ‘Oh, I’m never going to [fail] prey to that,’ people are promoted based on what they’re doing in their current jobs,” Reilly says, and the decision maker can’t always assess objectively because “they already know the person.”

And that’s where the psychologist enters the picture, using assessments and data to evaluate a candidate’s ability to adapt and grow with the job and the organization over time.

DON’T MAKE ASSUMPTIONS

Remarkably, some organizations make plans based entirely on assumptions or without asking even the most basic question: “Do you even want this job?”

Sometimes people are identified as “a perfect fit” for a successor role but are never approached about their interest in moving into the job, or whether they’re happier staying in their current job.

“They get through the process [based on assumptions] and then the person turns them down,” Reilly says. “What a disaster.”

Disasters, however, are often as predictable as they are preventable — prevention often coming in the form of a simple commonsense approach that entails assessing candidates before promoting them. Makes sense, right? Yet that’s not what happened recently when a client rushed two promotions then asked her what her plans were. “I’m hoping to do that within three or four years.” These are the people you really want in succession planning.

Responses to questions about possible promotions generally fall into three tiers, Reilly says:

- **40 percent excited:** “Oh, my gosh, I want to be the VP and I’m hoping to do that within three or four years.” These are the people you really want in succession planning.

- **30 percent tepid:** “Yeah, I guess I could be persuaded if you really need me to move on.” These people are content in their current role, but motivating, mentoring, and investing in their development can be worthwhile.

- **30 percent decline:** “No, I’m not interested. I like what I’m doing.” Don’t even bother.

WHAT PSYCHOLOGISTS LOOK FOR

What does a psychologist look for in those being considered for promotion? The answers probably won’t surprise, but the process calls for discussions, interviews, assessments, and data collection that collectively help determine a person’s characteristics and how their traits and attributes mesh with the criteria for any given position. According to Reilly, those criteria include:

- **Insight and interpersonal skills:** An initial informal discussion can go a long way toward determining whether people have what it takes to move up — and whether they’re worth the expense of additional time, testing, or assessments. Formal interviews take a closer look at people’s ability to understand others and themselves — their strengths and weaknesses — which is then compared to objective data gathered during testing.

  “I don’t care what the rest of your skills are,” Reilly says. “If you don’t have good insight into people, chances are you’re not going far in your career.”

- **Problem-solving skills:** Also known as “critical-thinking skills,” Reilly notes that they are measured by nearly every assessment and are “weighted heavily when assessing job fit” because they are “the measure most highly correlated with performance.” He divides these skills into two categories:

  1. Verbal reasoning or intuitive problem solving; and

  2. Understanding metrics or the ability to find patterns in data and to help people understand their role.

  “If they don’t have the quantitative skills for understanding metrics, or their verbal reasoning isn’t very high, they’re not going to problem-solve well,” Reilly says.

- **Energy or activity level:** Can this person keep up with the demands of the position? What is their sense of urgency? Are they able to prioritize? Do they use the resources and tools available to them?
“You want to make sure that person can get all that done and not burn out because a lot of people, when they get promoted, the reason they end up leaving or not doing well is because it’s too much for them,” Reilly says. “So, you want to check that energy level.”

Motivation: “What’s actually driving them? What are their most basic needs?” Reilly asks. “There’s no right answer. It depends on the job and company, but you want to look at their need for structure and guidance. Are they independent enough in their current role? What is their need for stability and predictability? Are they willing to change? Do they have a high need for recognition that they won’t get in this role — or that’s inherent in the role?”

Knowing people’s motivations is just as important as knowing if those motivations will be present in the job, Reilly says, “because you want it to be a good job for them, not just the company.”

Relationship building: After defining the key players, it’s important to determine the person’s ability to establish and maintain long-term relationships with those players. This is assessed through testing and examining their work history.

“When you look at people who fail, many have most of the skills but don’t understand how to deal with a certain constituency,” Reilly says. “For example, they may try to push and tell people what to do rather than persuade and coach them, and that’s going to have ripple effects.”

Work habits: This paints a broad brush across people’s ability to organize, plan, delegate, strategize, and, again, use resources. It entails their leadership style and whether they know the difference between leading and managing people — and whether they can they do both in day-to-day operations management.

“That’s a tough one because usually they have to bend one way or the other. They might really love strategy but not like details, or they really like details but don’t like a particular academic approach,” Reilly explains. “That’s important, especially in succession planning because often you’re going from details and specifics to planning this, planning that, and taking action, too. Or, thinking more broadly: Where will we be in a year? Then setting goals and understanding how functional areas can help each other or work together.”

“You could literally look at 50 or 60 psychological and behavioral variables that would come out of an assessment,” Reilly continues, “but that can really muddy the waters. By learning about the company and job, we limit this vast database of information to the most important 10–15 characteristics that are likely to predict success.”

ASSET OR LIABILITY?

Not all jobs require the same kinds of characteristics in a person. Consequently, desired traits for a senior-level executive might be entirely different for middle-management position or other staff position.

For example, for a job that requires repetitive and relational interactions with patients or other staff, you’d probably prefer someone who is motivated by predictability, stability, and consistency.

“But if you put that same person in a role where you want them to affect change and direct people [to] do things differently for the first time, that’s a huge red flag because they’re not motivated by that and it scares them a little,” Reilly says.

ROADBLOCKS TO SUCCESS

The basis for including psychologists in succession planning — regardless of their level of engagement — is to leverage the valuable data they mine to ensure the smartest personnel decisions are made. And yet, the data in their reports — no small investment — are sometimes overridden by “strong individuals” who believe in their own intuition rather than data. In other words, it all comes down to the discipline of trusting the data.

“And discipline is really the No. 1 barrier to succession planning,” Reilly says. “That includes the discipline to collect data on everyone in the plan and then utilize the data to make informed decisions regarding the future of each individual.”

Naturally, some are more disciplined than others. Problems arise, however, when CEOs or COOs interject themselves in the process and say, “Oh, that’s great information, but I’m going to give this job to John even though Evelyn and Michelle scored higher.”

“Granted, there are times when we hire people for specific (perhaps short-term) reasons,” Reilly concedes. “But what I’m talking about is when they’re truly looking to the future in their planning. That’s when it’s critical that people follow the plan and remain disciplined.”

Other obstacles include concern about discussing succession plans with those not included in the plan, and fear that those excluded might leave and create costly turnover for the organization.

“How do you announce the succession plan without demotivating those who aren’t in the plan?” Reilly asks. It’s a fair question, but not without an answer.

Acknowledging it’s a conversation many leaders would rather avoid, he suggests offering those people incentive and hope. “You know what,” you might say, “your performance this year hasn’t been great, but here are some areas for improvement, and if you do these things then you’ll be a candidate in next year’s plan.”

The alternative is to say nothing and allow people to talk behind the scenes and draw their own uninformed conclusions. “That’s when it can get more political and negative,” Reilly cautions.

“The hard part is that the people who can’t [meet these goals] are probably going to get demotivated and may leave anyway,” Reilly resolves. “But the good part is, the people who really want to grow usually understand: ‘Here are two things I need to work on.’ And they’ll stay and work on it.”

Andy Smith is senior editor of Physician Leadership Journal.
In this article ...
Advanced care planning has both legal and humanistic dimensions and is a major focus of discussion in most physician offices.

DEATH BRINGS MANY EMOTIONS AND PROCESSES for the dying individual and his or her caregivers and significant others. Advance care planning (ACP) for death has both legal and humanistic dimensions. The legal aspects include sanctioned legal documents about medical care for people who are no longer competent to make their own decisions. Equally important is the human side — the care planning in advance for death — that allows patients to make their own decisions in advance about their medical care at the time of their death. Careful ACP supports dying individuals and their families and reduces unwanted, unnecessary, and burdensome medical interventions and needless suffering and confusion. Such planning requires significant and timely ACP conversations. Physician offices are a major site of initiating (“triggering”) and undertaking ACP conversations, which have been encouraged by CMS-identified reimbursement codes.

Advance care planning (ACP) is the process of determining in advance what a person would want for his or her medical care should the time come when the person is unable to speak for himself or herself. Although a person with decision-making capacity can change his or her care preferences at any time, people have the right to make their own medical choices in advance of such a time when they are not able to make decisions. ACP often is confused with the other major kind of advance planning for death, such as wills, trusts, and legal power of attorney documents related to financial affairs (see Table 1).

THE HIDDEN DESIRE AND NEED FOR ACP CONVERSATIONS
Two of the biggest concerns near end of life (EOL) are “being a burden” on families and the cost of care. In addition, 57% of U.S. adults said they would tell their doctors to stop treatment so they could die if they had an incurable disease and were suffering a great deal of pain, 52% said the same if they had an incurable disease and were totally dependent on another for care, and 46% if they had an incurable disease and it was hard to function in day-to-day life. A minority wanted doctors to do everything possible to save their lives. It is clear that many people need ACP to avoid otherwise automatic, unwanted interventions, particularly because it is becoming increasingly possible to keep people with terminal conditions alive longer.

In 2013, 60% of people over 65 years of age had some documented EOL wishes. Unfortunately, many such documents are completed without significant conversation — 90% said it was important to talk to loved ones about EOL care, but only 27% had done so. Similarly, 79% want to discuss EOL
TABLE 1: THE MAJOR AREAS OF ADVANCE PLANNING FOR DEATH

<table>
<thead>
<tr>
<th>Documenting: the individual’s legal documents</th>
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<tbody>
<tr>
<td>Medical decisions (legal documents)</td>
</tr>
<tr>
<td>• Healthcare power of attorney/proxy</td>
</tr>
<tr>
<td>• Living will</td>
</tr>
<tr>
<td>• Organ donation</td>
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<tr>
<td>Legacy plans (legal documents)</td>
</tr>
<tr>
<td>• Legal power of attorney</td>
</tr>
<tr>
<td>• Last will and testament</td>
</tr>
<tr>
<td>• Living trust</td>
</tr>
<tr>
<td>Personal communication of preferences</td>
</tr>
<tr>
<td>• The person’s story: verbal, written, or shared well in advance</td>
</tr>
<tr>
<td>• How the person would like others to remember him or her</td>
</tr>
<tr>
<td>• Preferences for funeral services, burial, cremation, etc.</td>
</tr>
<tr>
<td>Implementing: how healthcare responds</td>
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<tr>
<td>Do not resuscitate (or intubate) order(s)/comfort care</td>
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<tr>
<td>Physician orders for life-sustaining treatment</td>
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<tr>
<td>Medical orders for life-sustaining treatment</td>
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<tr>
<td>Patient wishes as reported by healthcare power of attorney</td>
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</tbody>
</table>

TABLE 2: POSSIBLE RESULTS OF LACK OF ADVANCE CARE PLANNING

<table>
<thead>
<tr>
<th>Unnecessary suffering on the part of the patient. Palliative/hospice care often is more comfortable than aggressive medical care.</th>
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<tbody>
<tr>
<td>Less likelihood of death at home, a frequently stated request that often is not honored at end of life.</td>
</tr>
<tr>
<td>Unnecessary anguish for the patient’s family and significant others. Large or small families can disagree on what should be done, and resentments can be ongoing.</td>
</tr>
<tr>
<td>A designated medical power of attorney may not know what the individual wanted, or be uncomfortable with the role, particularly if there has been no discussion of the medical power of attorney designation or the grantor’s desires.</td>
</tr>
<tr>
<td>Much confusion</td>
</tr>
<tr>
<td>May create higher cost</td>
</tr>
</tbody>
</table>

TABLE 3: MOLST/POLST FOR PEOPLE WITH SERIOUS MEDICAL CONDITIONS

<table>
<thead>
<tr>
<th>MOLST/POLST* are written order(s) that document a patient’s goals and preferences regarding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Resuscitation instructions when the patient has no pulse and/or is not breathing</td>
</tr>
<tr>
<td>• Instructions for intubation and mechanical ventilation when the patient has a pulse and the patient is breathing</td>
</tr>
<tr>
<td>• Treatment guidelines</td>
</tr>
<tr>
<td>• Future hospitalization and transfer</td>
</tr>
<tr>
<td>• Artificially administered fluids and nutrition</td>
</tr>
<tr>
<td>• Antibiotics</td>
</tr>
<tr>
<td>• Other instructions about treatments not listed</td>
</tr>
<tr>
<td>These orders accompany the patient from location to location, and can be followed by emergency personnel.</td>
</tr>
<tr>
<td>A minority of states have legislatively determined MOLST or POLST.</td>
</tr>
<tr>
<td>What is MOLST? <a href="http://www.hospiceofcincinnati.org/downloads/What%20is%20MOLST.pdf">www.hospiceofcincinnati.org/downloads/What%20is%20MOLST.pdf</a></td>
</tr>
<tr>
<td>About the National POLST Paradigm. <a href="http://polst.org/about-the-national-polst-paradigm/">http://polst.org/about-the-national-polst-paradigm/</a></td>
</tr>
<tr>
<td>MOLST, medical order(s) for life-sustaining treatment; POLST, physician order(s) for life-sustaining treatment.</td>
</tr>
</tbody>
</table>

THE HEALTHCARE POWER OF ATTORNEY AS A REPORTER

The assigned healthcare power of attorney (HCPOA) role can be emotional, and struggles over decisions are common. It can be helpful for the HCPOA to understand that he or she is a reporter of the person’s wishes, not the decider of death. The person has already made the decision about his or her medical care — just in advance. The prior conversations and wishes with their physician, whereas only 7% had had such a conversation. Many ACP documents also include contradictory or confusing requests.

Seventy percent of those who require EOL decisions lack decision-making capacity. Further, the patient’s decisional surrogates can experience guilt and doubt about their decisions, creating emotional difficulties and ongoing complicated grief (see Table 2).

Several systematic reviews related to ACP conversations have been published. ACP conversations are associated with care that is more consistent with patient preferences, less fear and anxiety near EOL, earlier hospice referrals for comfortable care and location, and care over and beyond within advance directives. Knowledge of the patient’s wishes also reduces negative emotional effects on his or her surrogates.

ACP often is believed to be for dying patients. But people guess wrong about when they will die or when a catastrophe may strike that requires EOL decisions. For a young, healthy person, an ACP conversation may primarily be about what they would prefer if they were in a bad accident that left them in a permanent coma or with severe brain trauma, whereas an ACP conversation with an older adult is more likely to focus on the worsening or new onset of a serious illness. In some regions or states, patients can also complete a request for Medical/Physician Orders for Life Sustaining Treatment (MOLST/POLST) (see Table 3). These are signed, specific medical orders that apply in multiple care locations, such as home, hospice, or hospital.

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documents are to help the HCPOA report or interpret what the patient would have wanted. However, without ACP conversations, “reporting” may be an inaccurate term, and then it is more of a surrogate “decision,” with a greater likelihood of discomfort and complicated grief. It is also important to remember that no written document can foresee all possible EOL circumstances, and any decisions made should be in the context of the patient’s own overall views for his or her care and take into consideration personal, cultural, and spiritual contexts.

THE GENERAL CATEGORIES OF END-OF-LIFE PREFERENCES

EOL wishes and care can be divided into three categories: palliation, function, and longevity. All of these categories include providing all care necessary to provide comfort and symptom management. In the “palliation” goal, comfort goals are primary and might include statements such as “no CPR, no 911, no hospitalization.” A “functional” goal is one where the patient hopes to balance interventions with maintaining as much function as possible, and might include statements like “treat and attempt to cure if recovery is likely, but reassess often” or “limit to less invasive and less burdensome treatments.” The functional level can include CPR or DNR preference. A “longevity” goal is one where the patient primarily wishes to prolong life by treating everything, including the use of CPR, intubation, surgery, and 911 services. This categorization of EOL care: (1) represents meaningfully different options; (2) is understandable to most people; (3) is easily measured; and (4) can be identified from a variety of different types of Advance Directives. An individual’s goals should be reassessed periodically.

WHO CAN ASSIST INDIVIDUALS AND SIGNIFICANT OTHERS WITH ACP CONVERSATIONS?

Many ACP conversations are needed, meaning that individuals other than palliative care specialists or physicians will need to do the bulk of this work. Many physicians believe non-physicians can facilitate ACP conversations, and many ACP conversations are conducted by nonclinicians. The most common facilitators probably are physicians, nurse practitioners, physician assistants, social workers, and clergy. Most of the elements of an ACP conversation do not require much clinical content, but sometimes clinicians are needed to assist with medical information, such as the patient’s prognosis. In this situation, either the clinician becomes directly involved, or the person making the ACP could ask the clinician specific questions separate from the ACP conversations.

IDENTIFYING ROUTINE TRIGGERS FOR ADVANCE CARE PLANNING CONVERSATIONS

Patients and their families, and even physicians, often avoid ACP conversations. Further, individuals without living wills in one study almost always said it was because no one had brought it up to them or that they felt it was too early to discuss the issue. In addition, many do not know about or understand the following issues:

- What types of choices may be needed near life’s end;
- That they are unlikely to be able to make their own decisions;
- That a power of attorney is not the same as an HCPOA;
- That loved ones may face specific types of difficulty when decisions need made near or after death; or
- That conversations sometimes need to be made or processed emotionally over a period of time.

Natural triggers for ACP conversations arise when someone close to an individual dies or after a funeral. Hospitalizations or new serious diagnoses (such as cancer) also often prompt ACP conversations. Other triggers can include movies, wars, new babies, or similar stimuli. However, waiting for one of these common triggers means ACP often does not take place as early as it should.

WHY PHYSICIAN OFFICES

Getting ACP conversations triggered in medical offices makes sense, because most chronically ill people with significant risk of near-term death are seen regularly by clinicians. Clinicians also have more knowledge of medical illnesses and prognoses. Furthermore, primary care physicians report that most days they see patients over the age of 65 who are very likely to die within the year. Most felt it was very important to have these ACP conversations with patients, and most also reported having at least some degree of ACP conversation with patients every week in the office. They were also in favor of Medicare coverage for ACP conversations, yet few had billed for the service.

Clinicians often struggle to initiate timely ACP discussions. Patients may interpret a mention of ACP as a suggestion that they are going to die soon. Some patients never get around to bringing their significant other/HCPOA for a joint conversation.
Yet patients do want their doctors to discuss end-of-life issues with them.27

The sidebar “Five Wishes” provides a sample discussion guide for patients called Five Wishes (a sixth wish was added later by the creators of the list).

Creating Triggers for ACP Conversations in the Office

Given the general reluctance to raise the issue, it is helpful for clinicians to have systematized triggers for ACP that are a part of office routine, such that patients understand that ACP is one element of routine healthcare. These triggers can include a routine inquiry on adult patient visit intake forms, the Medicare Annual Wellness visit, and other annual wellness visits, or when a patient becomes eligible for long-term in-home nursing care.

Some simple process rules also can identify patients most in need of ACP conversations. Individuals meeting the definition of serious illness with high mortality (i.e., “one or more conditions become serious enough that general health and functioning begin to decline with little chance of recovery, a process that continues until EOL”) have life expectancy of two years or less.28 This would include individuals with a declining functional score (e.g., the Karnofsky Score29), one or more functional impairments (by Activities of Daily Living status), multiple chronic illnesses, and age greater than 65 years. In addition, unintentional weight loss, spontaneous patient mentions of EOL, and recent hospitalizations or emergency department visits also add urgency to ACP discussions.

Information for Patients and Families

Having a packet of information and forms on hand for patients can be extremely helpful, and should include any state-specific forms or information. Short introductory pamphlets are commonly kept in waiting rooms or with other patient education material. Invitations for individuals over 65 to a group visit30 or general patient education sessions also can provide information and set the stage for more specific ACP visits and conversations.

BILLING FOR ADVANCE CARE PLANNING CONVERSATIONS WITH THE PATIENT: THE MISSED OPPORTUNITY

Two specific CPT codes for ACP services went into effect in January 2016.31 One covers the visit with the patient, and a second applies if additional time is required:

- **99497**: Work relative value unit (RVU) = 2.40. “Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.”

- **99498**: Work RVU = 2.09. “Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes.” This would be listed separately with a -25 modifier in addition to the primary code of 99497 for non-prevention visits, or with -33 modifier for the Medicare Annual Wellness Visit.

If the criteria for the initial 99497 are not reached, the clinician can consider billing with a pertinent CPT E/M code. Annual ACP conversations would be considered reasonable for most Medicare patients. There are no specific limits on the frequency of billing these codes; but pertinent changes in health status would be expected if they were completed frequently. There are no limitations for:

- Place of service (i.e., office, home, hospital, nursing home, hospice);
- Clinician specialty; or
- Specific training background of the individual in a team-based approach with clinicians (this may be limited by state law, however). In this case “incident to” provisions apply.

Documentation requirements vary by the specific Medicare Administrative Contractor, but would, at minimum, be an account of the voluntary nature of the conversation, explanations of ACP, any form completion, who was present, and the time spent face-to-face.

- 99497 and 99498 can be billed in addition to E/M services, but not on the same date of service as some specific critical care services.

- Pertinent coding diagnoses could be “administrative examination” or a serious diagnosis the patient has recently received.

- The usual Part B deductible and coinsurance applies except when ACP is furnished as an optional element of the CMS Annual Wellness Visit.31

Several of the best known and proven programs designed to encourage and support ACP are presented in the sidebar on resources.

QUALITY MEASUREMENT

The National Quality Forum briefly describes an ACP-related quality measure as “the percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.”32

CONCLUSION

ACP is a patient-centered activity that improves outcomes. It is a duty for physicians to both undertake and encourage ACP. Some ACP activities can be reimbursed. Yet physicians are not routinely taking advantage of this, in spite of many conversations they have with patients regularly, indicating many missed opportunities. Multiple available resources support efforts in medical offices.
Resources for Advance Care Planning


Sample Starter Conversations
- The Five Wishes: www.agingwithdignity.org
- Institute for Healthcare Improvement. The Conversation Project: www.theconversationproject.org

National Information Sources
- Centers for Disease Control and Prevention:
  - Give Peace of Mind: Advance Care Planning: www.cdc.gov/aging/advancecareplanning
- Agency for Healthcare Research and Quality Effective Health Care Program:
- National POLST Paradigm
  - About the National POLST Paradigm: http://polst.org/about-the-national-polist-paradigm
- American College of Physicians

CMS Billing
- American Academy of Family Physicians. Advance Care Planning: www.aafp.org/practice-management/payment/coding/acp.html. This source includes specific information on reimbursement of advance care planning by the top five insurance payers.

Quality Measurement
- Building Additional Serious Illness Measures into Medicare Programs, March 14, 2017: http://discernhealth.com/building-additional-serious-illness-measures-into-medicare-programs/

Examples of Significant Programs That Can be Implemented in an Organization or Community
- Serious Illness Conversation Guide: https://www.ariadnelabs.org/areas-of-work/serious-illness-care/resources
- Respecting Choices: http://www.gundersenhealth.org/respecting-choices

REFERENCES

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RESOURCES ALLOCATION

DETERMINING THE VALUE OF FRONT DESK STAFF IN A MEDICAL CLINIC

By Crystal Miner, MBA-HSA, FACMPE, CHC

In this article ...
Front desk staff are worth more than they are paid. They also should be held to a higher standard than in the past.

THE FRONT DESK STAFF OF A MEDICAL CLINIC typically is the lowest paid position. In recent years, expectations for these positions have increased, and their impact on the financial stability of the clinic has grown. Employees in these positions are expected to know state and federal regulations, and at the same time have excellent customer service skills, attention to detail, and the ability to take on any challenges that come up.

To evaluate the worth of a position, a clinic must review not only the expectations of the position but the amount of savings or cost the position may provide the clinic. The value of a front desk position can be determined using clinic data, including expenses, revenue, the number of visits, and the number of patients. This article suggests that front desk positions are worth more than they are paid and that they should be held to a higher standard than they have in the past.

One of the lowest paid positions in healthcare has become one of the most influential in the financial well-being of an organization. The front desk position has always been responsible for a variety of aspects of the clinic — greening patients, ensuring they arrive when and where they are expected, collecting demographic data, and collecting copays/coinsurance. All of these duties have a potential financial impact on the clinic, for better or worse. In recent years, the shift of payment responsibility from insurances to patients has increased the financial impact of the front desk position.

According to the Medical Group Management Association 2017 survey of Management and Staff (based on 2016 data), medical secretaries (also referred to as receptionist, front desk, Director of First Impression) are paid 7% less than other medical administrative support staff. On average, as of 2016 this position is paid $14.50 per hour in physician-owned practices.

How can clinic managers prove the value of these positions and determine the appropriate pay? To review a position’s worth to the clinic, three areas should be analyzed:

1. The expectations of the position;
2. The potential costs to the organization if the work is performed incorrectly; and
3. The potential savings for the organization if the work is performed well.

This creates a baseline value of the position. (It will not show the worth of an individual employee.)

EXPECTATIONS

Expectations of front desk staff have changed in the last few years. As insurance companies and the structure of payments move the burden to patients, the front desk must now take on pre-billing roles and duties. The days of billing the insurance company first and not attempting to collect any money from
the patient until a response from the insurance company is received are over. The challenge of collecting more money from patients at the time of service (e.g., copays, coinsurances, and deductibles) is the new workflow. The duties listed in the job description for a specific front desk staff member may vary, but the expectations from managers, providers, and patients usually are the same:

- Answer phones in a polite and welcoming way;
- Greet visitors and patients in a welcoming manner;
- Direct patients to the correct location upon arrival;
- Know the answers to all patient questions;
- Take appropriate messages with correct spelling, directed to the correct person;
- Schedule appointments for all providers in the clinic correctly (even if each provider has a different set of scheduling rules);
- Collect all patient demographic information and enter it correctly into the required system;
- Ensure all demographic information is updated and corrected for every patient, every time;
- Communicate any delays from the back office to the patients;
- Ensure appropriate messages are given to patients (from the back office or legal, such as HIPAA rules or availability of translators);
- Ensure that the front desk, lobby, and entrance to the clinic are clean and welcoming;
- Manage all patients and visitors in the lobby, dealing with any problems (e.g., patients, children, spills or messes);
- Be able to explain the clinic’s patient billing practices and answer questions about bills;
- Collect appropriate copays, coinsurance, and deductibles;
- Be familiar with insurance requirements for each patient and carrier;
- Deal correctly with all incoming paperwork: faxes, e-mails, patient portal, and
- Call insurance companies for prior authorizations or confirmation of benefit.

Some organizations may split these duties among different position titles (e.g., Receptionist, Scheduling Staff, Insurance Clerk), although usually they still fall under the “front desk” department, where employees receive lower pay than other support staff. These listed duties, however, are vital to the success of the clinic. Managers and patients expect front desk positions to be held by someone who is customer-oriented and always willing to go the extra mile. At the same time, this person must follow all of the rules that the clinic and others have set for them. The staff member must have full knowledge and understanding of HIPAA, OSHA, coding, documentation, insurance, and other rules and regulations (e.g., the requirement that translators be provided). However, the training required to reach this high level of understanding rarely is given when an employee is hired. It is expected that incoming employees already know this information or will absorb it as they work and learn the nuances of the organization.

This is in strict contrast to the other positions in the clinic. Medical support staff (e.g., medical assistants) are hired only after they have completed a certification or associates degree in the appropriate area of expertise. In addition, a number of billing positions now require the same level of education (e.g., certified coders, billers). In response, several community colleges and charter schools have created programs to meet the new need for administrative support staff training. Throughout the United States, from New Jersey (Bergen Community College) to Florida (Eastern Florida State College) and Alaska (Alaska Career College) to Texas (San Jacinto Community College), students can earn certificates or associate degrees in Medical Office Administration. The coursework includes the study of HIPAA, medical records management, and customer service, and externships in medical clinics or hospitals.

**COST AND SAVINGS**

Without the needed training and knowledge, front desk staff members can cost the organization. Poor customer service interaction or incorrect data entry can cause a financial deficit. The cost of losing a patient or delays in billing can be calculated to determine the worth (beyond wages and benefits) of a front desk position. For every one patient with a bad experience, the expectation is that they will tell at least seven others. These seven may be current patients of the organization or potential new patients that are lost. The value of a patient is calculated based on the practice’s number of visits and patients, and either the cost per visit or revenue per patient.

In contrast, a well-trained, knowledgeable front desk staff can save the clinic money. Most reviews of clinics mention the quality of the front desk staff. A positive experience keeps patients coming back and telling others. Efficiencies at the front desk can create savings elsewhere as well. A front desk staff that manages the patient schedule effectively is invaluable. When patients are scheduled for the appropriate amount of time and are checked in for their appointment correctly, more patients can be added to the schedule. It is feasible that this could allow for at least one more patient per provider per week. In addition, highly effective front desk staff can ensure that insurance claim denials for demographic errors are low.

**CALCULATIONS OF WORTH**

Using the data in the 2017 Medical Group Management Association (MGMA) Management and Staff Compensation surveys and the Cost and Revenue surveys (based on 2016 data), a general estimation of what these positions might be worth in a Family Practice and Pediatric clinic can be made (see sidebar). Reviewing visits, patient load, expenses, and revenue of a
**Worth of the Front Desk Staff in Medical Practices**

**Family Practice:**
The following figures apply to a physician-owned family practice with six physicians and six front desk staff (.98 medical receptionists per FTE provider).1

- Cost of front desk errors: $409,412.05 ($67,837.61 per front desk staff member)
  - Seven patients lost: $2,386.41 (annual revenue per patient x 7) per front desk staff
  - Delay in claims: $243,442.00 (2.5% of claims delayed due to front desk errors) for all front desk staff
  - Lost income: $146,265.20 (assuming 10% of the amount owed by patients [30% of revenue] was never collected at the time of service or thereafter) for all front desk staff
- Savings due to front desk: $235,761.84 ($33,680.26 per front desk staff member)
  - Three new patients gained: $1,193.20 (annual revenue per patient x 3) per each front desk staff member
  - Prompt payment: $171,809.40 (difference made by reduction of delayed claims by the front desk to 1.5% from 2.5%) for all front desk staff
  - Extra visits: 1 more visit per week (52) per provider (6) = $55,600.02 (lower no-shows, filling open schedules, reduction of time wasted in the back office due to incorrect scheduling of appointments) for all front desk staff

- National average hourly wage for a medical receptionist in a physician-owned clinic with six or fewer FTE physicians: $14.14 (annual salary = $29,411.20)3
  - Cost of wages and benefits per front desk staff member: $35,293.44
  - Cost per front desk staff member in errors: $67,837.61
  - Savings per front desk staff member: $33,680.26

**Pediatric Practice**
The following figures apply to a physician-owned pediatric practice with six physicians and five front desk staff (.80 medical receptionists per FTE provider)1

- Cost of front desk errors: $252,555.55 ($50,511.11 per staff member)
  - Seven patients lost: $1,426.89 (annual revenue per patient x 3) per each front desk staff member
  - Delay in claims: $78,636.15 (1.5% of claims delayed due to front desk errors) for all front desk staff
  - Lost income: $157,272.30 (10% of the amount owed by patients [30% of revenue] never collected at the time of service or thereafter) for all front desk staff
- Savings due to front desk: $61,106.72 ($10,184.45 per staff member)
  - Three new patients gained: $1,193.20 (annual revenue per patient x 3) per each front desk staff member
  - Prompt payment: $0.00 (the data show that pediatric practices are, on average, performing at the Best Performer levels; therefore, little savings can be assumed in decreasing denials)
  - Extra visits: 1 more visit per week (52) per provider (6) = $52,545.36 (lower no-shows, filling open schedules, reduction of time wasted in the back office due to the incorrect scheduling of appointments) for all front desk staff

The national average hourly wage for a medical receptionist in a physician-owned clinic with six or fewer FTE physicians is $14.14 (annual salary = $29,411.20)3

- Cost of wages and benefits per front desk staff member: $35,293.44
- Cost per front desk staff member in errors: $50,511.11
- Savings per front desk staff member: $10,184.45

**REFERENCES**


clinic gives the needed information to calculate the value of the front desk position. An organization can utilize its own data to find these values and perform a specific calculation of worth in its clinic (see Table 1).

In calculating the cost and savings that a front desk position can create for a clinic, certain supplementary information should be taken into account. Costs vary by clinic and workflow. In our examples, it is assumed that the workflow is the same and that the front desk is responsible for collecting demographic information and entering it into the billing system. As discussed earlier, the front desk staff is also responsible for the patient experience. One bad patient experience can lead to the loss of seven other patients. A good experience, leading to a great online review, has the
potential of adding one to three new patients to the practice annually.

The 2017 MGMA Practice Operations survey, based on 2016 data, found that the median percentage of claims denied on first submission ranges from 5.0% (Family Practice) to 3.0% (Pediatrics). For Better Performers (i.e., clinics performing at a high level), the median percentage of denied claims on the first submission is only 3%. The industry standard is that 90% of all denied claims are preventable. The reasons for these denials include missing or incorrect patient demographic information, services not covered, or duplicate claim submission. The first two reasons can be avoided by attentive and well-trained front desk staff. Therefore, it can be estimated that 50% of incorrect claims are the result of the front desk staff performance.

Industry studies have shown that when patients leave the clinic after their visit without having paid their portion of the charges, the chance that the clinic will collect the patient-owned amount is only 30%. Currently, clinics estimate that 30% of their revenue comes from patients directly. Thus the dramatic drop in collection probability when payment is not collected at the time of service has a large impact. It is anticipated that this percentage of income may increase to as much as 50%, as more patients have higher insurance deductibles and copays, in the next three years.

**CONCLUSION**

The data support that, for these representative practices (Family Practice and Pediatrics), the front desk staff should have a starting salary slightly higher than the 2016 national average. If the number of staff is lower, the expectation for better performance must go up, and so must the starting wages. However, each clinic is unique, and calculations should include information about specific employees. A great front desk lead, for example, can take up the slack and correct the errors of mediocre medical receptionists on the team.

These calculations do not discuss expectations for the position as a numerical value. It is assumed that the expectations must be met to ensure the savings calculated, and thus are accounted for. What is not accounted for is individual employee initiative, emotional intelligence, and work ethic. These should be considered when evaluating a specific employee and not just a position.

By reviewing visits, patient load, expenses, and revenue of a clinic, a practice can calculate the value of their own front desk. The front desk staff has as much influence on the well-being of a practice as the certified medical assistants, medical billers, and coders. Changes in the administration of medicine now require that the front desk staff be well-trained, and have a thorough knowledge of the rules and regulations and an understanding of the importance of customer service. Managers should, therefore, apply more scrutiny in hiring for these positions and set pay rates accordingly. Recognizing that the front desk staff is an important part of the organization is long overdue.

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**REFERENCES**

1. MGMA DataDive® Management and Staff Compensation 2017, based on 2016 data. MGMA, Englewood, CO.
2. MGMA DataDive® Cost and Revenue 2017, based on 2016 data. MGMA, Englewood, CO.
3. MGMA DataDive® Practice Operations 2017, based on 2016 data. MGMA, Englewood, CO.
COACH’S CORNER

DEALING WITH REBELLIOUS RESISTANCE

By Robert Hicks, PhD

In this article ...
Confronting rebellious resistance is difficult; however, attempting to deal with it by arguing with or pressuring the resisters invites failure. The key to success is to facilitate a discussion about the benefits of making a change.

UNINFORMED RESISTANCE OCCURS WHEN people are oblivious to the need to change. As I discussed in “Addressing Uninformed Resistance to Change,” in the March/April 2020 issue of PLJ, uninformed resistance is symptomatic of the precontemplation stage, as defined in Prochaska’s Transtheoretical model of change.1,2

Overcoming uninformed resistance requires that information be provided to others in a way that increases their awareness about a needed change and the advantages of making that change. Rebellious resistance, however, is another matter altogether.

Rebellious resistance differs from uninformed resistance in that the individuals generally are aware of their behavior and its potential or real negative impact on themselves or others but still refuse to acknowledge that a change is needed. Miller and Rollnick3 maintain that this happens for two reasons: (1) the person has a substantial investment in the behavior for some reason and is unwilling to give it up, or (2) the person’s personality is such that he or she is resistive to change — even if it is in his or her best interest.

In general, rebellious resisters are outspoken, tend to argue and rationalize their behavior, and deny that they have any reason to change. The objective when dealing with this type of person is to have a quiet conversation about the value a change might provide without escalating resistance. The goal of a quiet conversation about change is to facilitate a discussion about the benefits of making a change while diminishing the possibility of an escalation during that interaction. The following guidelines, which are consistent with those practices recommended for any coaching conversation, will help.

RESIST THE RIGHTING REFLEX
The righting reflex is the urge to correct another’s misconceptions or course of action so as to set things right from your point of view. It is an automatic and spontaneous habit that often prompts others to resist rather than be open to a different perspective. Specifically, in the case of rebellious resisters, instead of eliciting a recognition of the need for change, the righting reflex causes them to defend the status quo and diminishes the prospect that they will accept the need to change.

Remember: Recognition that change is needed must come from within, not from outside pressure. In other words, for change efforts to endure, they must be driven by intrinsic motivation. Telling people what they should do may provide extrinsic pressure and generally causes resistance that dampens intrinsic motivation.

USE REFLECTION
Reflection involves restating what you hear the other person saying but in your own words. Your reflection cannot include an implicit “right or wrong” judgment about what the person has said; it must be perceived as a neutral response. Using
reflection with resisters sends a signal that you are listening to others’ point of view and encourages dialog rather than argument.

It’s important not to react to arguments against change; merely reflect back the resister’s words as you heard them (e.g., “So what I hear you saying is that the way you interact with people might be a little aggressive, but it’s not something that should bother them. Is that basically correct?”). As an aside, you may also reflect back to them any spontaneous statements that indicate change may be a good thing for them. This adds motivational fuel to any potential change effort.

**EMPHASIZE PERSONAL CHOICE AND CONTROL**

Psychological reactance occurs when an attempt at social influence is perceived as threatening one’s autonomy, one’s ability to form opinions, or one’s freedom to do what one wants to do. The intensity of the reaction will be directly proportional to the importance the individual places on the choices that are eliminated or threatened. Therefore, since rebellious resistance is a product of the substantial investment people have in their current behavior, pressing them to recognize the need for change will likely result in psychological reactance.

To avoid this possibility, deflect the reactance by making statements that emphasize their personal choice and control over what happens (e.g., “Obviously, it is ultimately your choice as to what you want to do. And you may decide not to do anything at all. I guess if I were in your shoes, I might want to consider how a change might help me.”).

**SUGGEST IN THE FORM OF A QUESTION**

Making suggestions in the form of questions is a subtle way of offering your opinion about what a person might do while minimizing the possibility of triggering psychological resistance. For instance, you might say to a person who doesn’t recognize his aggressive behavior with others as a problem, “Have you thought about the fact that you may be stronger than other people and, therefore, your directness has more of an effect on them than you realize? What would be the harm in trying a different approach?”

By presenting a suggestion in this manner, you are offering an opinion that may be helpful, but you also are giving the other person room to consider what you are saying without feeling as if you are trying to tell them what to do or how to think. When used in the context of dealing with a rebellious resister, you reduce the chances that the person might become defensive.

**SUMMARY**

Confronting rebellious resistance is difficult; however, attempting to deal with it by arguing with or pressuring the other person invites failure. When you encounter rebellious resistance, avoid direct confrontation by working around the edges of the resistance until it is dissolved. In other words, have a quiet conversation about change that might induce the other person to consider that a change might be needed.

Resist your need to be right; let resisters know you are listening; emphasize that they have autonomy and, ultimately, it is their choice as to what they want to do. Finally, when you do have a suggestion, frame it as a question to be considered rather than as your opinion.

Robert Hicks, PhD, is a licensed psychologist, a clinical professor of organizational behavior, and founding director of the Executive Coaching Program at the University of Texas at Dallas. He also holds an appointment as faculty associate at UT Southwestern Medical Center and is the author of Coaching as a Leadership Style: The Art and Science of Coaching Conversations for Healthcare Professionals (2014) and The Process of Highly Effective Coaching: An Evidence-based Framework (2017).

**REFERENCES**


"Coach’s Corner" author Robert Hicks has published a book, Coaching as a Leadership Style: The Art and Science of Coaching Conversations for Healthcare Professionals. Association members can purchase the book at a 20% discount price of $39.96 by ordering online and using discount code GDC71. The discount is only valid for books ordered through this website:

http://www.routledge.com/books/details/9780415528061/
In response to the COVID-19 crisis, MDCalc is offering its COVID-19 Resource Center, including core medical calculators, as a free EHR integration for healthcare systems.

By MDCalc Editorial Team

THE LATEST THREAT TO GLOBAL HEALTH IS THE current outbreak of the Coronavirus disease (COVID-19), which is a respiratory illness that was first recognized in Wuhan, China, in December 2019. The virus, known as SARS-CoV-2, has resulted in over 1,000,000 infections and 51,000 deaths worldwide as of press time, according to the Johns Hopkins University Coronavirus Resource Center.

In response to the outbreak, several organizations, including MDCalc, have worked to gather the latest findings and information on COVID-19. MDCalc recently launched a COVID-19 Resource Center (mdcalc.com/covid-19), which includes a list of clinical decision support tools to aid decision-making about management and treatment of patients during the COVID-19 crisis.

MDCalc is also offering the COVID-19 Toolkit, an EHR integrated app with recommended calculators that connect with patient data through FHIR. These resources are offered at no cost to support the crisis response. Interested healthcare systems should reach out to team@mdcalc.com for more information on how to integrate the free MDCalc COVID-19 Toolkit.

MDCalc’s COVID-19 Resource Center includes many calculators within a variety of medical categories that are related to treating patients infected with COVID-19. Key among the various care settings include overall hospital management, ICU (respiratory), and scarce resource allocation. Instructions for using each calculator can be found by clicking on each respective link. More information on how and when to use each calculator, written by expert academic contributors, is available on the tabs on each page.

The following are descriptions of the core calculators recommended in MDCalc’s Resource Center.

CORE COVID-19 CALCS

Overall Hospital Management
- MuLBSTA Score — Only score specific for viral pneumonia; not yet externally validated.
- PSI/PORT Score — Well-studied pneumonia score for all-comers.
- Absolute Lymphocyte Count — Lymphopenia appears to suggest COVID infection.

ICU — Respiratory
- A-a O\textsubscript{2} Gradient — Worsening A-a gradient suggests worsening respiratory severity.
- Rapid Shallow Breathing Index (RSBI) — Predicts successful extubation.

ARDS and ECMO Outcomes
- Horowitz Index for Lung Function (P/F Ratio) — Quantifies degree of hypoxia; helps define ARDS severity.
- HScore — Screens for cytokine storm (including in COVID-19), when immunosuppression may be helpful (immunosuppression controversial).
- Murray Score for Acute Lung Injury — Standard score for determining when ECMO indicated.
- RESP Score — Predicts mortality on ECMO.
Scarce Resource Allocation

- SOFA Score — Broad illness severity score; included in some scarce resource protocols.
- mSOFA — Broad illness severity; requires fewer labs than the SOFA Score.
- Charlson Comorbidity Index — Widely used estimate of co-morbidity burden; estimates outcomes.
- RESP Score — Predicts mortality on ECMO.

Alongside these core calculators, MDCalc also critically reviewed other tools that are potentially helpful in care settings related to the COVID-19 crisis. Many of these tools, including the PSI/PORT, MulBSTA, and CURB-65 scores, are specific to viral pneumonia and are recommended for scarce resource situations.

OTHER COVID-19 CALCS

Scarce Resource Situations

- MulBSTA Score for Viral Pneumonia Severity — Specific for viral pneumonia and similar inputs as known COVID-19 mortality risk factors, but not externally validated.
- PSI/PORT Score: Pneumonia Severity Index for CAP — Inputs line up better with known COVID-19 risk factors; adjust risk for elderly.
- CURB-65 Score for Pneumonia Severity — May have some value in COVID-19.

Additional Calcs

- SMART-COP Score for Pneumonia Severity — Perhaps best-performing to predict ICU admissions for CAP, but unclear applicability in COVID/viral pneumonias/ARDS.

Severe Community-Acquired Pneumonia (SCAP) — Likely similar performance to SMART-COP.

Healthcare professionals on the front lines of the COVID-19 fight and non-healthcare workers looking to learn more about the complexities of this disease must understand the various factors and comorbidities that contribute to SARS-CoV-2 related mortality risks. Through a partnership with TheNNT.com, MDCalc has incorporated relevant information regarding the most up-to-date knowledge on mortality and risk factors odds ratios for COVID-19, which combine both laboratory and field measurements to provide a comprehensive overview of how these factors affect the risk to patients (https://www.mdcalc.com/covid-19/indicators-mortality-data-china-south-korea).

In addition to the comorbidity data, MDCalc has also included an expert interview with an Italian intensivist, Dr. Simone Piva, MD, discussing the Brescia-COVID Respiratory Severity Score (BCRSS). The interview explores in detail Dr. Piva’s experience managing COVID-19 patients and how the BCRSS is being used to simplify and communicate the respiratory status of patients.

For healthcare professionals enrolled in the MDCalc CME program, all activities through the COVID-19 Resource Center can be used to acquire free CME credits once the MDCalc CME service launches later this spring. Also available on the COVID-19 Resource Center are high-yield clinical resources to aid with overall management, intubation, medications, and more.

MDCalc is working to regularly update the center. Please check back and contact us at team@mdcalc.com if you have any suggestions for COVID-19 calcs or new research that should be included on their page.

REFERENCE

1. https://coronavirus.jhu.edu/map.html

COVID-19 Resource Center Calculators (mdcalc.com/covid-19)

Core COVID-19 Calcs

Overall Hospital Management

- MulBSTA Score — https://www.mdcalc.com/mulbsta-score
- PSI/PORT Score — https://www.mdcalc.com/psi-port-score-pneumonia-severity-index-cap

ICU — Respiratory

- A-a O₂ Gradient — https://www.mdcalc.com/a-a-o2-gradient
- Rapid Shallow Breathing Index (RSBI) — https://www.mdcalc.com/rapid-shallow-breathing-index-rsbi

ARDS and ECMO Outcomes

- RESP Score — https://www.mdcalc.com/resp-respiratory-ecmo-survival-prediction-score

**Scarce Resource Allocation**
- mSOFA — https://www.mdcalc.com/modified-sequential-organ-failure-assessment-msofa-score
- Charlson Comorbidity Index — https://www.mdcalc.com/charlson-comorbidity-index-cci
- RESP Score — https://www.mdcalc.com/resp-respiratory-ecmo-survival-prediction-score

**Other COVID-19 Calcs**

**Scarce Resource Situations**
- MuLBSTA Score for Viral Pneumonia Severity — https://www.mdcalc.com/mulbsta-score


**Additional Calcs**
- SMART-COP Score for Pneumonia Severity — https://www.mdcalc.com/smart-cop-score-pneumonia-severity
COVID-19

HEALTHCARE IN CRISIS: AAPL, OTHERS RISE TO OCCASION

DURING A MARCH 6 MEETING AT A THIRD-floor conference room in downtown Tampa, more than 30 staffers huddled around a table where American Association for Physician Leadership President and CEO Peter Angood was discussing the difference between “public frenzy” and “the scientific reality” of COVID-19, and how AAPL plans to respond to the emerging global pandemic that was just beginning to filter into the United States.

His first concern is for the health of the staff and their families and he encouraged any who were not feeling well — even if just a cough — to remain at home and to work remotely, if able. Little could anyone there have imagined that just 10 days later they’d all be working remotely.

COVID-19 was moving swiftly, and the association was responding accordingly — not just with its own staff but as an industry leader at national and international levels.

“Physician leadership is an essential component within a medical crisis situation,” Angood says, “and it is clear that AAPL has a role to play.”

That role includes the following:

■ Quickly disseminating free resources in support of all healthcare leaders.
■ In consideration of the rapidly multiplying and changing responsibilities of those working toward CPE credentials, extending expiration dates for course completion with the promise of additional extensions as needed.
■ Discounting the cost of online courses by 20 percent for at least three months.
■ Introducing a new online “community” on the AAPL platform as a sounding board and measure of collaborative support among members during the pandemic and beyond.

In the face of “unprecedented challenges” for everyone in healthcare, Angood said there is “no better time to further mobilize the full strength of our individual and collective knowledge.”

To that end, a coalition of CEOs from major healthcare associations was assembled to better collate and expand the distribution of free resources for healthcare players craving information about everything from crisis management to staff and supply shortages; to do so on a continuing basis as more current resources become available; and to present a unified voice of expert-level support and balanced opinion in the face of the deadly pandemic.

The outcome of this collaboration was Leadership in the Midst of Crisis, a comprehensive collection of helpful and relevant resources about change management, disaster planning and recovery, stress reduction and management, and wellness. This free resource is accessible at www.physicianleaders.org/resources/leadership-in-the-midst-of-crisis.

In addition to AAPL, participating associations include the Medical Group Management Association (MGMA); the American Medical Group Association (AMGA); the Healthcare Financial Management Association (HFMA); the American College of Healthcare Executives (ACHE); the National Association for Healthcare Quality (NAHQ); the American Society for Health System Pharmacists (ASHP); and the College of Healthcare Information Management Executives (CHIME).

“The mission of this collaboration is to collectively and altruistically expedite crucial messaging and critical resources to industry and world leaders during these truly extraordinary times,” Angood said. “There is no better time for physician leaders to lead than now.”
CALM IN CRISIS: MEMBERS PROVIDE VOICE OF REASON

IN SCOTTSDALE, ARIZONA, NICHOLAS LORENZO, MD, MHCM, CPE, FAAPL, was being interviewed on national television about the virtues of the expanding platform of telemedicine during the COVID-19 crisis.

In Eugene, Oregon, KAREN WEINER, MD, MMM, CPE, was explaining to the hosts of a local TV station about the rapidly evolving roles of physicians in telemedicine in response to the pandemic.

In Jacksonville, Florida, MARISA SAINT MARTIN, MD, ACC, was writing about the value of resilience, meditation and “staying still” during these trying times.

And in Memphis, Missouri, RANDY TOBLER, MD, FACOG, CPE, was quoted on a national healthcare website about the financial toll that the coronavirus was having on already severely stressed rural hospitals.

This is but a sampling of members and alumni of the American Association for Physician Leadership who’ve been making news, offering advice, and sharing perspectives on a deadly virus as it cripples the nation and the world.

At a time when AAPL was already collaborating with other associations and sharing everything it could for the good of the nation’s healthcare industry and its leaders, these individuals — these leaders — were contributing what they could for the good of the public and other providers, and doing so with a voice of calm, reason, and concern in the midst of so much chaos and uncertainty.

Much of that uncertainty stems not from the virus alone but from the crash course in telemedicine being thrust upon millions of patients who were forced — and encouraged — to do so in lieu of office visits. “Can a phone call replace a face-to-face doctor exam?” they
would ask. “How can I be sure I’m getting a proper prescription just by me telling you my symptoms?”

“It’s very important in telemedicine and virtual care to treat the patients and the conditions that you’re comfortable with, that you feel you can provide the same standard of care that you could if the patient were sitting directly in front of you,” Lorenzo told Fox & Friends of his fast-growing telehealth company that provides remote medical services in all 50 states. “And we are certainly doing that at MeMD.”

Moreover, he continued, telemedicine serves as an important “first filter,” by which it can be determined if patients require testing for COVID-19. “The vast majority of the cases from the data we have thus far show that [up to] 95 percent of patients more than likely can be treated virtually and at home,” he said, an advantage not only for patients, but also to the welcome relief of staff at doctors’ offices.

Weiner, CEO of the Oregon Medical Group, understood telemedicine’s value, if not its necessity, in the face of the crisis as she immediately began “repurposing our physicians” for virtual medicine.

“We wanted to keep healthy people out of our clinics, we wanted to keep minor illnesses out of our clinics, and we wanted to talk with patients who were sick and find out if they needed to come in and see us or whether they were sick enough to go to the emergency room,” Weiner told a television audience during a live interview on ABC’s KEZI 9 in Eugene. “We wanted to start outreach to our high-risk patients … [and to] make sure we were taking care of each other in the clinics.”

Care of self and staff was precisely the topic of Saint Martin’s wellness article posted on LinkedIn.

“In times of uncertainty and stress, quieting the mind helps us cope, and then, as we become more calm and accepting, help others become calmer,” wrote Saint Martin, medical director of OneBlood, Inc. “There are many paths to mindfulness … mediation, prayer, doodling, listening to music, going for a walk and truly being in tune with nature. Staying still in our minds when everything is so fluid is difficult. However, as we practice, we are more connected to our inner selves, our demons and our peace. The more we practice, the better we get at managing anxious thoughts of a future that is still not here.”

The future is anything but bright for Scotland County Hospital in rural Missouri, Tobler said in an article by Kaiser Health News, explaining the facility might last only until May before running out of money for payroll. “In the truly safety-net areas, we’re being called to high duty,” he said. “And we’re running on fumes.”

That is a feeling certainly shared by hundreds of thousands of physicians worldwide.
GILLINGHAM APPOINTED NAVY’S
SURGEON GENERAL

A MEMBER OF THE AMERICAN ASSOCIATION for Physician Leadership since 2005, Rear Adm. Bruce L. Gillingham, MD, CPE, FAOA, RADM, MC, USN, was nominated by President Trump and confirmed by the U.S. Senate as the 39th surgeon general of the U.S. Navy. He is also the 43rd person to hold the title of chief of bureau of medicine and surgery.

“I am honored and privileged,” says Gillingham of his new title. “We are now engaged in a great power competition where our dominance is not assured (and) we must adapt and respond with urgency. The duty of every member of the Navy Medicine team is to provide a ready medical force and operational medical capabilities to save lives in the battlespace.”

Gillingham is the first orthopedic surgeon to serve as U.S. Navy Surgeon General and the first two-star surgeon general to hold the office in 50 years. In his new position, he is the Navy’s most senior commissioned officer of the Medical Corps.

In the aftermath of Japan’s Fukushima nuclear disaster in 2011, Gillingham served as the Joint Support Force-Japan Surgeon, ensuring the safety of more than 200,000 U.S. citizens, service members, and families.

He says the future of Navy Medicine will be guided by four priorities: people (military and civilian workforce), platforms (equipment and capability sets required by military), performance (measured by support of military), and power (to increase survivability) — the objective of which is “to ensure continuity of care to our beneficiaries.”

Gary Kaplan, MD, FACP, FACMPE, FACPE, chairman and CEO of Virginia Mason Health System in Seattle, Washington, was honored by Modern Healthcare as one of the top 100 most influential people in healthcare.

An AAPL lifetime member since 1985, Kaplan has been honored by Modern Healthcare several times in various categories over the years, this time ranking No. 89 on this list, which recognizes those whose leadership and action have most strongly influenced the industry.

Under Kaplan’s leadership, Virginia Mason has made great strides in reducing waste and creating a value-based healthcare experience, regardless of payment model. He also has led health and wellness initiatives that created for employees an onsite clinic focused on wellness and behavioral change.

Illustrating AAPL’s sphere of influence in physician leadership development are five former AAPL members who are also among the top 100, including Marc Harrison, MD, president and CEO of Intermountain Healthcare (No. 26); Stephen Klasko, MD, MBA, CEO of Jefferson Health (No. 42); Bechara Choucair, MD, senior vice president and chief community health officer at Kaiser Foundation Health Plan and Hospitals (No. 68); Susan Turney, MD, MS, FACP, FACPME, CEO of Marshfield Clinic Health System (No. 85); and Penny Wheeler, MD, president and CEO of Allina Health (No. 95).

The International Forum on Advancements in Healthcare honored Abdullah Al Ghamdi, MD, CTC, PGDipHI, CCFP(AM), FCFP, MHPE, MALIC, CPE, associate deputy executive director of King Abdulaziz Medical City-Riyadh, as being among the top 100 healthcare leaders. The award acknowledges international leaders for their innovations in healthcare.

In addition to his leadership role as an inter-department collaborator, Al Ghamdi, an AAPL member since 2012, facilitates the development and implementation of EHRs, health informatics, and innovative strategies focused on family medicine and primary healthcare.

Richard J. Juda, MD, CPE, MBA, is the recipient of the Albert Einstein Award of Medicine, presented by International Who’s Who for his work as CEO of Innovative Healthcare Group in Naples, Florida.

An AAPL member since 2013, Juda has played a pivotal role in cutting waste and costs while curating expert hospital business management programs that include training models that account...
Larry Kaiser, MD, FACS, has been appointed to the board of directors for FSD Pharma, a Canadian-based medical marijuana organization focused on the research and development of cannabinoid-based treatments for certain central nervous system disorders and autoimmune diseases of the skin, GI tract, and musculoskeletal system.

Before his appointment, Kaiser was already serving as chairman of FSD-P’s scientific advisory board, where he helped shape a biosciences strategy for assembling synthetic compounds that target the CB2 receptors of the endocannabinoid system in the human body. Formerly the president and CEO of Temple University Health System in Philadelphia, Kaiser is also managing director with the Alvarez and Marsal’s Healthcare Industry Group in New York, a corporate restructuring consultancy.

Timothy Groover, MD, MBA, CPE, an AAPL member since 2012, has been promoted to president of physician alignment at Baptist Health in northeast Florida. In his new role, he will lead Baptist Physician Enterprise, which is comprised of Baptist Primary Care and 15 specialty practices.

Under the leadership of Elizabeth Ransom, MD, FACS, chief physician executive at Baptist Health and a AAPL member, Groover will collaborate with physicians, practice leadership, and hospital leadership to develop and implement programs using data-driven practices to enhance clinical, operational, and service excellence.

Groover joined Baptist Health as an anesthesiologist nearly 25 years ago and most recently served as senior VP and CMO at Baptist Physician Partners.

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AS WITH ANY NEW CLASS OF BOARD MEMBERS, there always comes a welcome infusion of diverse experiences, fields of expertise, and fresh ideas — all valued components for the American Association for Physician Leadership® and its dedication to the transformation of healthcare today.

In the case of Randall Bickle, DO, JD, CPE, FAAPL; Teresa D Malcolm, MD, FACOG, MBA, CPXP, CPE; and Bruce Levy, MD, CPE, FAAPL, they bring to the AAPL board more than 80 combined years of healthcare expertise and the promise of sustaining AAPL as the world’s premier organization for the growth and support of physician leaders.

All three board additions boast CPE credentials and have contributed their leadership expertise to various AAPL course developments and other association events and initiatives.

RANDALL BICKLE: An AAPL member for 25 years, Bickle is medical director, president, and CEO of Olympia Medical Services, PLLC, in Livonia, Michigan, where he is responsible for medical and administrative oversight of 600 physicians in one of the largest accountable care organizations in the United States with 10 physician organizations, including the University of Michigan.

With a background in family practice and geriatrics, his areas of expertise include healthcare economics, next-generation payment models, innovation, entrepreneurship, and venture capital.

As CEO at OMS, his mission has been to lower costs and improve quality while developing a comprehensive care management program aimed at meeting the needs of chronically ill patients. His accomplishments include annual profitability since becoming CEO in 2003 while also decreasing the length of stay for in-patient care by 15 percent.

He has served on the AAPL fellowship committee and as a volunteer, mentor, and advocate for AAPL at its live events, where he’s encouraged active participation among newer members and, in his new capacity on the board, says he is interested in further developing “a strong presence among our young aspiring physician leaders in med school and residencies.”

TERESA MALCOLM: An AAPL member since 2012, Malcolm is founder and physician development coach of Master Physician Leaders in Scottsdale, Arizona, where she is dedicated to accelerating the learning and growth of physicians by helping them gain self-awareness, clarify and achieve development objectives, and leverage leadership skills in the transformation of healthcare.

She previously worked for 11 years as an OBGYN for Banner Medical Group in Phoenix, Arizona, where her other roles included medical director for the accountable care committee, physician executive for the Women’s Health Continuum, regional medical director for specialty care, and chief medical officer. In 2018 she branched off to begin her own business and “create a better tomorrow for physicians by helping them be aware of their own emotions and those of others, in the moment, to manage themselves and their relationships.”

With expertise in innovation, entrepreneurship, and venture capital, she has served on an AAPL task force that developed the course “From Autonomy to Teamwork.” As a board member, her interests align with association diversity and inclusion initiatives, aspiring to “make a difference for other physician leaders of color who are capable and accomplished but are not afforded the same opportunities to serve in an official capacity.”

BRUCE LEVY: An AAPL member since 2011, Levy is associate chief medical information officer for education and research at Geisinger Health in Danville, Pennsylvania, where he leads multidisciplinary teams on a variety of operational projects, analytics, and updates, and supports the informatics needs of multiple genomics projects and other research initiatives.
He is also professor of pathology and informatics at the Geisinger Commonwealth School of Medicine in Scranton, Pennsylvania.

His areas of expertise include healthcare economics, next-generation payment models, government health policy relationships, innovation, entrepreneurship, and venture capital.

Levy’s accomplishments include leading a start-up that offered forensic services to governments, using workflow analysis and data analytics to improve the level of service, and providing intelligence supporting public health/safety at significant savings. He also worked with governments to rewrite legislation and policies and started one of the first ACGME-accredited clinical informatics fellowships.

At AAPL, he has presented at meetings, been published in PLJ, served on the IT certificate task force, and created a Health Informatics Academy for the 2019 winter meeting.

As a board member, he aspires to increase AAPL’s presence as “the place where physicians can come to learn how to better balance the competing priorities of practice, medical business and personal life without adding additional complexity.”

**AAPL BOARD OF DIRECTORS**

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<th>Name</th>
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As this year’s presidential campaigns ramp up, healthcare for Americans continues to be the subject of debate, derision, and division among candidates — finding a plan that is amenable to Democrats and Republicans, patients and providers, hospitals, insurance companies, and drug manufacturers.

Headlining this discussion is Medicare for All (MFA), which some candidates are touting as a cure-all healthcare plan and which one economist describes as one “giant political issue.”


As former senior editor for *Medical Economics Magazine* and the author of two other healthcare books, Terry breaks down the candidates’ proposed healthcare plans and the role of physicians in what Terry considers to be the inevitable passage of some iteration of MFA.

Medicare for All has suddenly become “mainstream,” Terry asserts. Whatever its level of public support, however, the deep divide between Democrats and Republicans makes it unlikely that MFA will be adopted anytime soon — at least not until the disparity between escalating insurance costs and slower-growing wages reaches a breaking point for most Americans.

“When enough voters are fed up with the current system and are concerned about their own or their families’ access to healthcare, the dam will break,” Terry writes. “At that point, neither politicians nor healthcare lobbyists will be able to hold back the flood that will carry us to Medicare for All.”

It’s a flood that already comes with its share of questions and concerns.

Among the most serious flaws of MFA is a potentially significant drop in physician income, warns Terry, “and unhappy physicians spell doom for any healthcare reform plan.” It could also doom some of the brightest students from pursuing medical degrees because lower salaries would make it nearly impossible to repay student loans.

One solution, suggests Terry, is a substantial reduction in healthcare waste, an issue that physicians are well-positioned to resolve.

“They’re the only ones, in fact, who know which healthcare services can be safely eliminated without harming patient care,” Terry says. “So, to be successful, any Medicare for All proposal must include provisions to engage doctors in eliminating waste.”

In fact, he says, physicians should play an integral role in whatever plan is eventually adopted.

“Healthcare reform seems to be stuck between a rock and a hard place, but there is a rational way forward,” offers Terry. “This approach, which I call ‘physician-led healthcare reform,’ would engage doctors in building a system that was safe, effective, patient-centered, timely, efficient, and equitable, to use the Institute of Medicine’s set of foundational goals. Primary care physicians, rather than hospitals, would be in charge of the system, and they’d work closely with specialists and other healthcare professionals to produce the best patient outcomes at the lowest cost.”

It’s an idea with considerable merit if politics doesn’t get in the way.

To learn more or purchase the book, go to [www.physicianleaders.org/physician-led-healthcare-reform](http://www.physicianleaders.org/physician-led-healthcare-reform)
EDUCATION

COURSE LINKS BEHAVIOR TO STRATEGIC THINKING

IN A SHIFT FROM THE WAY WE TYPICALLY think about, understand, and implement strategic thinking, the American Association for Physician Leadership is offering a new course that addresses both the conscious and subconscious components of strategic thinking and its obstacles.

The Neuropsychology of Strategic Thinking will explain why the key to any successful shift in behavior is first understanding how positive behavioral change affects mind and body. The course also delves into executive functioning and brain development, innate temperament, and, interestingly, the function of the ego in thinking effectively.

Incorporating a holistic tenor, takeaways from this course will be immediately impactful in how you approach everyday leadership responsibilities and long-term organizational strategies. Personal and universal in its application, the course focuses on the fundamental aspects of being human, with other learning objectives that include:

- Defining effective strategic thinking.
- Explaining strategic thinking in terms of neuropsychological principles.
- Delineating the differences between personality and temperament and how this impacts the way one thinks strategically.
- Identifying the role of creativity vs. cognitive rigidity and how this impacts the implementation of strategic thinking.

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NEW MEMBERS

Here are the newest AAPL members, who joined or renewed January 16, 2020-March 15, 2020. To learn more about AAPL membership, visit physicianleaders.org/membership.

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The Certifying Commission in Medical Management honored 72 candidates with Certified Physician Executive designation after a 3½-day capstone event February 27-March 1 in Tampa, Florida.

To learn more about the CPE program, visit physicianleaders.org/CPE.

Aaronson, Nicole, MD, MBA, FAAP
Abbas, Syed, MD
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Burnett, Claude, MD
Caccamo, Michael, DO
Canady, Michael, MD, MBA, CPE, FACS, FAAPL
Capps, P. Marlene, MD, MS
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Danko, Janine, MD, MPH
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El Haraki, Amr, MD, FACOG
Entler, Paul, DO
Farmer, Alka, MD
Heroman, William “Mitch,” MD, MBA, CPE, FAAPL
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Mokraoui, Malec, MD
Molchan, Ryan, MD
Nunn, Chalmers, MD, MMM, CPE, FAAPL
Omoloja, Abiodun “Abi,” MD, MBA
Orate-Dimapilis, Christina, MD
Patel, Delip, MD
Phillip-King, Patrina, MD
Reiber, Mark, MD, FACS
Rivera, Peter, MD
Ruberto, Mario, MD, MBA
Sawyer, Sheila, MD, MMM, CPE, FACPE
Schipper, Bret, MD
Schutte-Schenck, Sara, DO, FAAP
Searles, Chris, MD, CHCQM, CPPS
Seshul, Merritt, MD, FACS, FAAOA
Shah, Hemant, MBBS, FACP, FCCP, DSM
Shaheed, Gurvinder, MD
Simmons, John, MD
Stampehl, Mark, MD
Taylor, Alan, MD
Tobler, Randall, MD
Wayt, Marta, DO, FACP, MBA
Wright, Keith, MD
Zebian, Rami, MD, FCCP

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Unstoppable Love: Dan Diamond Talks About Leading Under Crisis Conditions
The Use of Technology and Telemedicine in the Battle Against COVID-19 and Coronavirus
Our Best Hope: Value-Based Healthcare
CLINICAL CALL CENTER CHECKLIST

As financial incentives accelerate conversions to value-based payer models, more providers and healthcare organizations are turning to clinical call centers which — when properly staffed and resourced — can manage the growing onslaught of phone calls and online communication from at-risk patients while also monitoring their issues and freeing providers and front-desk staff to focus on in-office patients.

Here are some clinical call center matters and strategies:

- In a departure from many current triage strategies, require more clinically capable call center staffing, such as PAs, LPNs, or nurses, to advise and guide patients on a range of issues.

- Establish clinical standards that delegate specific issues to specific members of the call center staff.

- Provide documentation templates customized for specific situations and diseases.

- Develop clinical and operational protocols to frame and empower call center services.

- To ensure quality and timely response, monitor call centers for average response times, patient contact, and patient service advisories, including physician notification of significant events and changes of patients.

- Because of many CEHRT-product limitations, create workarounds or install compatible software that structures, tracks, and documents call center activities; monitors patient data submitted from patient homes or smartphones through third-party RPM systems; and monitors incoming messages and patient data through third-party patient portal software.

For all its benefits, be aware that a call center takes time to develop, requires a clear mandate from leadership — and the resources to fulfill that mandate.


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