Healthcare ∎ (∎∎∎∎) ∎∎∎–∎∎∎

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/hjdsi

The Leading Edge

Physician leadership in changing times

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ARTICLE INFO

Keywords:
Physicians
Organization and delivery of care
Accountability
Leadership

ABSTRACT

Today, hospitals and physicians are reorganizing themselves in novel ways to take advantage of payment incentives that reward shared accountability for the total health care experience. These delivery system changes will take place with our without physician leadership. To optimize change on behalf of patients, physicians must play a conscious role in shaping future health care delivery organizations. As physician leaders of three of the nation's largest integrated health care delivery systems – Kaiser Permanente, Virginia Mason Medical Center, and the Mayo Clinic Health System – we call on physicians to view leadership and the development of leaders as key aspects of their role as patient advocates.

1. Introduction

In health care, as in life, change is the only constant. Today, the tides of change are pushing the health care system toward ever greater shared accountability among physicians, hospitals, and payers. Whether that change will ultimately benefit patients – or simply become an exercise in rearranging the deck chairs on the Titanic – will depend, in large part, on the skill of those who are leading the movement. As physician leaders of three of the nation's largest integrated health care delivery systems – Kaiser Permanente, Virginia Mason Medical Center, and the Mayo Clinic Health System, respectively – we believe physicians must be central to this effort, in solid partnership with skilled administrators.

Among all providers, physicians have a disproportionate impact on the health care system and therefore have a disproportionate responsibility and opportunity to lead change. Patients experience their own health and the health care system in many ways: physically, socially, psychologically, and financially. As the first and primary point of contact with the health care system for most people, physicians must therefore act as caregivers, teachers, trusted information sources, and fiduciaries for their patients. They cannot and should not opt in and out of accountability toward their patients in any of these roles. In post-reform health care delivery systems, physicians are ideally positioned, and in fact compelled, to take responsibility for helping shape the health care system – *not just their own practice* – to better serve patients' physical, social, psychological, and financial needs. Many physicians in small, private practice are already experienced as civic and small-business leaders in their communities. However, the skills needed to run a small business and manage its resources are very different from those needed to lead delivery system change. This expanded paradigm of physician leadership cannot be accomplished working in isolation from the integrated systems of care, nor with indifference to the resources necessary to achieve good outcomes for entire populations.

We have a uniquely bright view of physicians' ability and willingness to take on this expanded leadership role. We also believe physician *can* be led as trusted and respected members of a team that is greater than the sum of its parts. We call on physicians as a profession to view leadership – and the development of leaders – as key aspects of their role as advocate for their patients. In doing so, we draw on our 68 years of collective experience leading physicians into stable, respectful relationships with other delivery system stakeholders to support some of the most successful, patient-centered care systems in the nation.

2. Why now, and why physicians?

Since the Institute of Medicine released its *Crossing the Quality Chasm* report in 2000, there has been growing recognition that high quality, high value health care cannot be achieved through the uncoordinated actions of individual physicians and other health care providers serving the interests of individual patients, one at a time.[1] Instead, all the stakeholders in the health care system must work together toward a broader vision of excellent care for individuals, better population health, and lower costs.[2] In 2002, recognizing the need to make explicit this shift in thinking for medical professionals, the American College of Physicians Foundation and the European Federation of Internal Medicine

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2213-0764/$ - see front matter © 2014 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.hjdsi.2014.01.001

created a new "Physician Charter," calling on physicians to protect not only individual patients' welfare, but also the principle of social justice – or the fair distribution of limited health care resources.[3]

Historically, physicians have been trained to work and make decisions autonomously, and have been rewarded for individual achievement. Their value as physicians – as well as their sense of self – was built upon their ability to be the best in their area of specialty. Despite this training, physicians' desire to look beyond individual patients to the welfare and wellbeing of populations – an activity that requires teamwork among providers – is not new. The "medical home" model of population health is an example of recent efforts to improve team-based care that pre-dates the passage of the Patient Protection and Affordable Care Act (ACA). In a typical medical home, physicians work with other health care professionals to engage with a patient population proactively to anticipate medical care needs, coordinate care, and support self-care and shared decision-making. However, it is only in the last 10 years or so that health care stakeholders – in particular purchasers, policymakers, and patients – have begun to hold providers explicitly accountable for reaching these goals. This trend has been accelerated by the passage of the ACA, with its call for accountable care organizations.

Hospitals and physicians – collectively the two largest providers of health care – are reorganizing themselves in novel ways to best take advantage of new public and private payment incentives that reward shared accountability for the total health care experience. We are just at the beginning of this "accountability" movement.[4] Now is a critical time for the medical profession to leave behind, once and for all, the cottage industry model and to develop a paradigm that allows for collective action and accountability while simultaneously nurturing professionalism and supporting the trust between physicians and patients.

The current anxiety and distress about the future of health care suggests a leadership vacuum in the physician community, and nature abhors a vacuum. Eventually, one of the primary stakeholders will step forward to take the lead in organizing physicians for the new paradigm. If physicians do not decisively accept that leadership role soon, they will have missed an opportunity to serve their patients. Indeed, there is already evidence that insurers, recognizing the central role of physicians, are increasingly acquiring physician practices.[5] Many insurers are linking payment to process and outcomes measures or paying for entire episodes of care. Another common insurer strategy is to create smaller physician panels and work exclusively with physicians that agree to collaborate on reporting, quality, safety, and cost control.

Hospitals are also buying physician groups. As noted by one prominent research group, "Hospitals view physician employment as a way to prepare for payment reforms that shift from fee for service to methods that make providers more accountable for the cost and quality of patient care."[6] More than half of U.S. physician practices are now owned by hospitals, with the employment trend increasing for both primary and specialty physicians.[7] The trend is most visible among new physicians; in 2009, almost half (49 percent) of physicians hired out of residency or fellowship were placed within hospital-owned practices.[8]

Many physicians bemoan this trend toward hospital employment because it runs counter to their notions of professionalism. At the same time, many hospital leaders – even as they are purchasing physician practices – complain about a lack of physician engagement and leadership in their organization. Recognizing that the traditional medical staff is not an adequate partner in system transformation, many hospitals are asking how they can find or create physician leaders. Now is the time for physicians to show hospitals they are committed and engaged partners in leading health system change. There are numerous high-profile examples of physician groups that adopted this orientation decades ago; we represent just three of them.

We believe that the most successful models of accountable care will embrace true partnership between physicians and professional administrators in an integrated group practice of medicine.[9] In the most advanced practices of this type, physician leaders work as trusted partners with administrative colleagues to align the practice with the business model and serve patients' interests jointly. Both parties share the same goals and objectives. One of the primary reasons for the many "physician-hospital organization" failures in the 1990s was that there was not sufficient organization or leadership on the physician side. For the relationship to be collaborative, physicians must have the ability to speak with one voice, which requires both leadership and "followership."

While there are many ingredients to successful integrated group practice, aligned and skilled physician leadership is a foundation for the rest. Leaders must have a clear eyed focus on system challenges, a realistic view of national health care reality, and a coherent, proactive, and rigorous implementation plan. We will discuss these topics in detail in subsequent articles in this series.

3. What is a physician leader?

When we speak to the leaders of the nation's most respected multispecialty group practices, one theme stands out: leadership is not the same as management. Many physician leaders are also good managers – and those less skilled in management know the importance of working closely with experienced administrative leaders. The key factor that makes a manager into a leader is the ability to create a vision of the future and inspire physicians to change through engagement stemming from a clear understanding of *why* things must change.

How, then, does an organization teach a physician to create a vision and inspire change? More pointedly, can an organization develop these attributes and through training, or must they must be innate? We believe the answer is both. Training works. Many of the most highly-integrated multispecialty group practices in the country have formal leadership training programs. At the same time, training will be most effective for individuals who already exhibit many of the desired attributes and behaviors. It is a leader's responsibility, and a key part of his or her management strategy, to identify and nurture the skills of these high-potential individuals.

4. Policy levers

The health care system is increasingly focused on improving value and increasing accountability for better outcomes at a lower cost. Academic medical center priorities, payment models, and rigorous measurement all have the potential to encourage physician leadership in support of this future.

All physicians, regardless of their current practice setting, were "born" in an academic medical center. In that setting, acclaim depends upon individual achievement in a specialty. That is changing and must continue to change if we hope to create health care leaders who value collaboration and shared accountability across specialties and between physicians, hospitals, and other caregivers. Faculty tenure and advancement in the academic community must depend on the physician's ability to function as part of, or to lead, an interdisciplinary team. Public funding for undergraduate and graduate medical education can be a strong lever to encourage this type of change. Curriculum development, faculty support, and course time devoted to practice re-engineering

Please cite this article as: Cochran J, et al. Physician leadership in changing times. *Healthcare* (2014), http://dx.doi.org/10.1016/j.hjdsi.2014.01.001

will accelerate implementation of new models of care that require physician engagement in shared decision-making and delegation of work to teams of providers.

Leadership development is a key component of health system performance, but we will not get it if we do not pay for it. The fee-for-service payment system does not provide a funding source – and therefore does not place a priority on – leadership development. In spite of this, most integrated group practices can and do prioritize leadership development. Risk-based payment models of many types allow health systems to invest in leadership development as a strategic priority. Health systems, in turn, may design payment models for their physicians that reward leadership and skill in group dynamics while continuing to recognize and reward individual competence.

As the push for accountability gains steam, public and private efforts to measure and reward accountability are also ramping up. The flurry of activity around measurement provides another opportunity to make physician leadership development a priority. Currently, the measurement sets promulgated for both private-sector and Medicare accountable care organizations do not include direct measures of organizations' capacity for physician leadership development.[10] We believe this is a missed opportunity and advocate for a simple measure as a starting place (for example, "Does the organization have or participate in a formal physician leadership training program?").

Finally, the Innovation Advisors Program of the Center for Medicare and Medicaid Innovation provides another opportunity to encourage physician leadership and to test models of training and development. Innovation advisors representing various types of health care organizations are charged with testing new models of care delivery in their own organizations and creating partnerships to find new ideas that work and share them regionally and across the United States.[11] Leadership development strategy – and its impacts – should be one component of this work.

4.1. Getting there from here: implementing change in health care

We have detailed the many reasons *why* robust physician leadership is essential to the successful transformation of care delivery. However, we recognize that there is a shortage of "how-to" guidance on physician leadership development. Therefore, this article serves as the first installment of a series that will address the specifics of building physician leadership capacity within a medical group or health system. In this series, we will call on the rich experience of physician leaders from the Council of Accountable Physician Practices, representing the nation's leading medical groups. The Council of Accountable Physician Practices is committed to the principle that physician-led, coordinated delivery systems provide high-quality health care that saves lives and enhances the health of our communities. Articles in the series will address:

- recruitment and retention of physician leaders;
- leadership training programs; and,
- the experiences of both large, well-funded and small, resource-constrained physician groups that have recently made physician leadership an organizational focus and successfully implemented new models of care for their group.

5. Conclusion

Kaiser Permanente, Virginia Mason, and the Mayo Clinic do not have all the answers to nurturing the next generation of physician leaders. However, we do have a great deal of experience, and we are committed to sharing our best practices and learnings with one another and with other health care stakeholders.

Delivery system change will take place with our without physician leadership. To optimize that change on behalf of our patients and communities, physicians must play a conscious and active role in leading and shaping the health care delivery organizations of the future.

Acknowledgments

The authors would like to acknowledge the assistance and support of Laura Tollen of Kaiser Permanente and Nancy Taylor, Laura Fegraus, and Toyomi Igus of the Council of Accountable Physician Practices.

References

1. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
2. Berwick D, Nolan T, Whittington J. The triple aim: care, health, and cost. *Health Aff.* 2008;27(3):759–769.
3. Medical Professionalism in the New Millennium: A Physician Charter. *Ann Intern Med.* 2002;136(3):243–246.
4. Audet A-M, Kenward K, Patel S, Joshi M. *Hospitals on the Path to Accountable Care: Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization.* The Commonwealth Fund; August 2012.
5. Vesely R. Marriage of convenience. *Modern Healthcare*, online, January 2012, ⟨www.modernhealthcare.com/article/20120102/MAGAZINE/301029918⟩ (subscription required).
6. O'Malley AS, Bond AM, Berenson RA. *Rising Hospital Employment of Physicians: Better Quality, Higher Costs*? Center for Studying Health System Change. Issue Brief No. 136. August 2011.
7. Kocher Robert, Sahni Nikhil. Hospitals' race to employ physicians—the logic behind a money-losing proposition. *N Engl J Med.* 2011;364(19):1790–1793.
8. Medical Group Management Association. *Physician Placement Starting Salary Survey: 2010 Report Based on 2009 Data.*
9. Kaplan G, Patterson S. The Physician/administrator team: an optimal model for leading medical practices. *American College of Medical Practice Executives Fellowship Paper*, August 2001 (abstract published in ACMPE *College View*, Fall 2002).
10. National Committee for Quality Assurance. *Crosswalk: CMS Shared Savings Rules & NCQA ACO Accreditation Standards*, December 2011, ⟨www.ncqa.org/Portals/0/ACO%20Crosswalk%20-%20CMS%20%20NCQA%20programs_5.30.12.pdf⟩.
11. See ⟨www.innovations.cms.gov/initiatives/Innovation-Advisors-Program/index.html⟩.