# Market Driven HealthCare

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CHAPTER 5

## *What you need to know before searching for a position*

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**The Governance Institute** provides trusted, independent information, resources, tools, and solutions to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

**The Governance Institute,** a service of NRC Health, is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, online learning, conferences, and advisory services.

# In This Chapter

As any good anthropologist will tell you, understanding the people, landscape, language, and culture you'll encounter on this adventure is a prerequisite for success.

You'll want to know the location of dangers and pitfalls. The peaks and valleys. The smooth, safe path and the treacherous, rough rock. In this stage, you'll learn how hospitals and medical groups are changing, about the roles and responsibilities of those you'll be working with, and the pressures and economics that drive hiring decisions.

You'll learn how to enter the changing world of healthcare and map your path to success.

So let's dig in.

P.S. By the way, they've had some rough luck recently, with a major earthquake impacting the landscape of healthcare. Be alert. It's a jungle out there.

## OUTLINE

1. The Changing Landscape of Healthcare
2. Healthcare Market Trends
3. The Big One: Healthcare Reform
4. Hospital Organizational Structure
5. Evaluating and Selecting the Right Practice Type
6. Must-Have Physician Competencies
7. Action Checklist

## GOALS

- Read an organizational chart to understand the reporting structure of the practice, including the functional relationships between, among, and within the specific components and learn how you fit into the big picture.
- Analyze market conditions as drivers, shapers and influencers and assess their impact on each of the physician, patient and administration audiences.
- Understand how physician compensation is impacted by market and patient care trends as well as hospital/practice structure.
- Identify weaknesses as areas for improvement to address in your short-term career planning strategies.
- Assess various practice settings to determine your practice preference and enhance your potential for success.
- Assess the pros and cons of each type of practice setting based on their perspective and interest level.

**LET'S GET STARTED**

## READ:

# The Changing Landscape of Healthcare

Throughout medical school and residency, you may have been exposed to or even experienced for yourself the political turmoil and silo mentality that has been beleaguering many physicians in the hospital setting for a long time.

With the onslaught of rapid-fire change occurring within the healthcare industry, let's gain a basic understanding of hospital structures that exist today and briefly discuss the new structures of tomorrow.

## Recent Past: Silos

For decades, healthcare organizations operated essentially as independent units within a larger whole. Until very recently, hospitals and physicians functioned in separate worlds. Hospitals provided practice privileges for physicians seeking to provide patient care in the hospital setting. Those physicians made up the "independent medical staff," and largely functioned as a group of individuals. The medical executive committee (MEC) typically was (and still is) the interface between hospital administration and the medical staff.

This independence was encouraged over the years, with the traditional payment structure in which physicians and hospitals were reimbursed separately for services, based on a fee-for-service payment schedule. This encouraged doctors and hospitals to provide more services in order to get paid more — more volume, not value. It did not provide incentives for hospitals and doctors to coordinate care.

## Today: Moving Away from Silos into Clinically Integrated Networks

The healthcare system overall is still very fragmented, with thousands of independent providers — many in the same market area — duplicating services. However, this duplication of services is reducing rapidly as private and government payers (Medicare, Medicaid) are increasing pressure on providers to reduce waste, duplication, and total cost of care.

The main driver of this shift is payers moving toward value-based reimbursement models and a focus on "population health" (e.g., targeted/standardized

care models for populations of patients with chronic conditions such as diabetes or heart failure. This model relies on better care coordination and preventive care for patients most at-risk for developing a chronic condition, "This is known as the "triple goal" or triple aim"; to reduce cost, improve the health l, and improve of the patient, and improve the health of the population as a whole.

In order for providers to be successful in these models, hospitals and physicians must work together more closely than ever before to improve quality and reduce costs. This has resulted in an increase in direct physician employment by hospitals and health systems, integrating medical staffs across hospitals in a system, as well as building clinically integrated networks and accountable care organizations (ACOs) with physicians at the helm. In 2018, em-ployed physicians made up 47.4% of the total physician workforce while 45.9% of physicians remained self-employed.

So now, physician and hospital-based care (inpatient and outpatient) is being delivered in an awkward, hybrid environment, mostly still within fee-for-service but with an increasing percentage of managed care contracts in value-based models or "fee-for-value" at the same time. This has sometimes resulted in patients being treated differently based on which payment contract they fall under, with healthcare leaders scratching their heads as how to reconcile the difference. They also have to figure out how to move more efficiently towards value-based care without taking a hit financially while waiting for payers to catch up.

"I feel very strongly that hospital administrators should work harder to improve their communication and relationships with ALL doctors. The disconnect greatly contributes to physician burnout."

"Physicians have historically done more with less in terms of clinical support staff and physical space. These two items are likely to lead to increased burnout if not addressed soon."

"I am encouraged by the initiative demonstrated by my administration to make moves that will ensure our organization's share in the local and regional market. More concrete initiatives are needed in terms of outreach organization, telemedicine, and improving the outpatient clinical space."

"I feel that great improvements have been made recently towards wellness for staff and providers and an emphasis in self-care has helped. As we improve our implementation of team-based care, I think physician satisfaction will increase and burnout will decrease as all team members work to the highest level of their training/degree."

# FIELD NOTES

Success means so many things to so many different people. Really define what success means to you and choose your career path based on that. If money speaks to you the most, then it becomes a numbers game. If helping patients is your top focus, then focus an opportunity in a medical underserved area. The bottom line is if your heart is happy, you have found your own success.

*– Tara Gaugh, Physician Relations & Recruitment Specialist*
*Southern Illinois HealthCare*

## Tomorrow: Systems

The need to work together has begun to cause the physical makeup of the hospital and medical staff to go through many changes and transitions. New physicians will find themselves in organizations in the midst of forming a new direction, with existing physicians seeking to protect their autonomy, and administrations seeking to engage physicians in care coordination.

In 2016, The Joint Commission updated its 2009 leadership standards in its (Comprehensive Accred-itation Manual for Hospitals) that refocused the leadership structure of healthcare organizations from silos to a collaborative system:

*"For many years prior to 1994, the standards included chapters on 'Management,' 'Governance,' 'Medical Staff,' and 'Nursing Services.' Each department in the organization had its 'own' chapter of standards, as if the good performance of each unit would assure the success of the organization. The Joint Commission sought the advice of some of the nation's leading healthcare management experts and clinical leaders from both practice and academia to redesign this unit-by-unit approach. They were unanimous in their advice: stop thinking of the healthcare organization as a conglomerate of units and think of it as a 'system.' A system is a combination of processes, people, and other resources that, working together, achieve an end."*[3]

As a result of this shift in thinking about the structure of leadership for healthcare organizations, The Joint Commission created a recommended leadership structure that not only included the governing body of the organization (Board of Directors or Board of Trustees) and an administrative staff (C-Suite), but also a team of physician leaders (licensed independent practitioners) who could speak uniquely to the clinical aspects of care that drive quality of patient care and safety. According to

the white paper, "In a hospital, this third leadership group is comprised of the leaders of the organized medical staff. Only if these three leadership groups work together, collaboratively, to exercise the organization's leadership function, can the organization reliably achieve its goals."

With the need for collaboration among the three leadership groups of a healthcare organization, the function and makeup of the medical staff is changing. Some health systems have combined/integrated their medical staffs to enable more standardization in clinical care protocols, reduce clinical variation (which usually affects quality and cost negatively) as well as to allow certain specialties to expand their care across the system to improve access to care and reduce cost and duplication. We believe this will only continue and increase.

For now, hospitals continue to be required to have a medical staff (of some form or another) to meet Joint Commission standards. The question will be how to comply with these regulations while making the transition to clinical integration and accountable care, or how the regulations will be updated to adjust to new care models.

**READ:**

## Medical Market Trends

There are many emerging trends impacting the business side of medicine. Whether you allow these market conditions to impact your relationships with your employer, patients, and/or your family will be determined by how you react. Will you be a victim to the market conditions or rise above by any market condition to fulfill your life and career goals?

## How Market Conditions Impact Patients, Administration, and Physicians

### Shortage of Physicians

- 43% of docs are age 55 or older [5]
- Not enough docs to replace those retiring
- 36% of physicians overall are females, with a majority who choose to work part-time[6]

| Physician Impact | Organization Impact | Patient Impact |
|---|---|---|
| ○ More stress<br>○ Burnout<br>○ No moment to themselves<br>○ Stretched to the limit<br>○ Working in a crisis mode<br>○ No work/life balance<br>○ Carry over to home life | ○ Access to care will be an acute issue as more uninsured and underinsured patients are able to obtain health insurance and begin seeking care.<br><br>○ Recruitment efforts and integration models/incentives for physicians need to be a top priority to attract needed physicians to the community. | ○ Patients may experience longer wait times to see the doctor.<br><br>○ Less access to a physician as more mid-level practitioners step in to fill certain care delivery roles |

## Affordable Care Act (ACA), Medicaid Expansion, and Economic Factors

- More patients have insurance now that the ACA has been fully implemented, but many states have not expanded Medicaid; many of those that have are imposing work requirements, so the number of uninsured, while stable, may go up rather than down.
- For people who do have insurance, high-deductible plans are becoming more popular because premiums are more affordable. However, this often results in patients delaying necessary care because they don't want to or can't pay deductibles and/or copays. Thus, when they do present for care, they are often sicker, require more (and more expensive) care, and hospitals have a harder time collecting reimbursement for care provided.
- More private insurance companies are paying closer to Medicare rates, so less cost-shifting is possible, pressuring hospitals to be able to "break even" at Medicare rates in order to stay open.
- Hospital closures and bankruptcies are adding to the mix as many struggle to maintain operating margins.
- Physicians are struggling to maintain revenue and working more in order to do so; more are seeking employment to gain more job security and better work/life balance.

**Table: Impact of ACA, Medicaid Expansion, and Economic Factors**

| Physician Impact | Organization Impact | Patient Impact |
|---|---|---|
| ○ Increasing pressure and burnout.<br>○ Physicians moving into employee role versus owner role.<br>○ Less connection with patients from spending less time with them. | ○ Increasing pressure to cut costs as much as possible.<br>○ Instability in longevity.<br>○ Losing top-line revenue.<br>○ Decreasing staff retention.<br>○ Patient satisfaction could be lower. | ○ Increasing out-of-pocket costs despite industry and ACA attempts to reduce them.<br>○ Often avoid seeking care to avoid any out-of-pocket costs.<br>○ Potential increased emotional stress due to avoiding/delaying care.<br>○ Impaired effectiveness/productivity at work while sick. |

**Use this for citation on impaired effectiveness/productivity at work while sick:**
**http://md.careers/Managedhealthcare**

# Reflection + Activity

**What impact might these trends have on your decision to practice medicine?**

**What's your understanding of these trends? What have you heard or been exposed to?**

## READ:

### The Big One: Effects of the Affordable Care Act (ACA) To Date

There are three major shifts occurring related to healthcare reform: substantial increase in covered populations, shifting Medicare and Medicaid fin-ancial risk to providers, and reduction in Medicare payment rates.

### Substantial increase in covered population

In 2013-2014, about 16 million Americans were added to the Medicaid programs while Medicaid reimbursements were raised to Medicare levels for general internists, family physicians and pediatricians.

Still, many doctors have no interest in this new pool of Medicaid patients. Throughout the country, some doctors are trying to lower their percentage of both Medicaid and Medicare patients or even eliminate them entirely. Some doctors will also avoid the new Medicaid patients because they feel that dealing with government insurance programs is a snarled tangle of frustrating paperwork. Some physicians in more affluent areas are going into "boutique" practices that don't accept insurance at all and are made up exclusively of self-pay patients who either pay per service or pay a monthly fee to have a doctor at their beck and call. This, however, is still a very small minority of physicians; we don't see it as something that would grow to more than 10% of physician practices across the U.S. This is, however, another example of how physicians are reacting to the current environment.

Most physicians don't have these choices. A lot of physicians operate on very short margins and are unable to cut their overhead. They get paid relatively little per patient visit and need to have volume. Yes, there are premier practices that won't accept insurers offering less than Medicare rates, but they are the exception rather than the rule.

## Shifting Medicare and Medicaid Financial Risk to Providers

The exploding interest in accountable care organizations (ACOs) sparked by the health reform legislation represents a sea of change in the way hospitals and physicians currently function. An ACO is a clinically integrated healthcare group (various models, including hospitals with an employed physician group, or a physician group that has contracted in some way with a hospital or health system) that assumes responsibility for the quality of patient care as well as the cost decisions behind that care.

ACOs receive one "bundled" payment for an entire episode of care (from the initial doctor visits to the procedure in the hospital, to the follow-up visits, etc.). The ACO is then responsible for dividing that single payment across the various providers involved in the episode of care. The majority of ACOs participate in Medicare programs, and the bundled payments vary depending on patient outcome (i.e., positive outcomes and lower costs will receive higher payment; thus the ACO is accepting risk). However, this model is expanding beyond Medicare to private payers, and research is showing that moving faster to two-sided risk (in which the ACO receives both increased payments for reaching/exceeding quality and cost targets and also must pay penalties for not meeting targets) will make a larger impact. In the long term, most experts assume that this will be the primary direction most payers will move towards, not just Medicare.

This has opened up new challenges and opportunities for physicians in practice and those in new leadership roles. Physician career paths will reflect calls to move into a new mix of clinical practice and leadership roles for such diverse positions as:

- Traditional medical staff leadership
- Health system clinical care councils
- Care management committees
- Clinical service line management in hospital systems
- Health plan care management
- Medical directorships for many functions within integrated healthcare systems

## Understanding Market Conditions & Healthcare Reform

Like caring for a critically ill patient, market conditions and the healthcare industry will continue to change at an often unpredictable and rapid pace. It's important to keep the following in mind when assessing these fields:

- Rapid change will continue to be constant. Stay as informed as possible.
- Conduct your own research.
- Surround yourself with positive people. Remember to look for the "silver lining" in every challenge.
- Don't fall prey to negativity you may hear and experience from other doctors.

## Reduction in Medicare Payment Rates Continues

In general, hospitals continue to receive lower reimbursements across all payers. Immediate challenges are maximizing efficiency and eliminating waste in care delivery systems to maintain operating revenue and credit rating. They must position themselves to accept bundled payments and risk-based payments.

With regard to insurance, changes in managed care, rising medical costs, and government regulations will no doubt impact insurance costs as well. In the short term, Medicare patients may find fewer doctors willing to accept them. In the longer term, payments will likely level out, and physicians will need as many patients as they can get, so fewer will be turned down based on insurance/payment levels.

In 2015, Congress repealed the Sustainable Growth Rate (SGR), which determined physician reimbursement. The SGR was designed to counter the tendency toward spending growth driven by the fee-for-service model that rewards volume and intensity. It automatically reduced Medicare physician fees if physician spending exceeded a target based on overall economic growth. But it was a flawed formula that served as an impediment to payment reform. The volume-based cuts to fees under the SGR have been replaced with modest annual updates instead, usually about 0.5%. The 2019 reimbursement levels will remain in place through 2025, but high-performing providers and those in alternative payment models such as ACOs will have the opportunity for additional payments.4

## Oh - One More Thing...

The ACA has not yet shown much movement in reducing the overall costs of care and the enormous investment our society makes in healthcare as a percentage of GDP (primarily because the majority of the payment system is still within fee-for-service, and care delivery transformation takes time). Thus, there is an increasing effort to move healthcare payment reform toward a single-payer system, or some interpretation of "Medicare for All." This is obviously very politically contentious. Some politicians are still trying to repeal the ACA, while others are trying to find ways of strengthening it. The future healthcare payment landscape is currently a very grey area!

## Overall Impact on Physicians

What do doctors stand to gain or lose in all of this? As people in a caring profession, many doctors are either truly or theoretically happy that about 20 million more Americans have health insurance. Yet physicians have every right to be concerned about their own livelihoods and medical practices. For some doctors, the healthcare bill will create benefits

and opportunities. Others see no benefits, particularly specialists. And funding the reform — despite what politicians say — could portend an ominous future for physicians. It truly leaves physicians learning how to wield a double-edged sword.

Although all physicians are likely to face the same pressures from the reform era as their colleagues, this guidebook provides you an opportunity to understand the landscape and take control of your mind and seek the solutions that align with your values. In the future of healthcare, physicians should be prepared to face any of the following challenges in the business of medicine:

- More public calls for improvements in clinical quality and better patient safety.
- More 24/7 public reporting on the internet of quality and cost-performance metrics.
- More regulatory oversight from state and federal governments that potentially impact clinical decision making.
- Squeeze in take-home pay as practice expenses rise and revenues are constrained.
- More multi-specialty groups will be formed by and with hospitals in an effort to prepare for accountable care.
- Exploding demands to rely on electronic medical records (EMRs) and actuarial data across care settings to better manage chronic disease.
- ACO's demand for clinical integration will continue to move more physicians into leadership roles.
- Regulators and governing boards will demand more formal accountability and development of physician leaders as a means to successful physician alignment.
- Increasing need for more primary care physicians to serve as patient population managers.

The nation may therefore face the challenging irony of offering more coverage for more people, but having fewer physicians ready, willing and able to respond to the new needs and demands for care under the new reforms.

The opportunity today for physicians is in integrating with provider networks, hospitals, health systems, ACOs, and other physician groups in order to better leverage with payers and engage in population health and value-based payment models. This may provide opportunities for care coordination and models in which nurse practitioners or other members of an interdisciplinary care team see the low-acuity/non-complex patients and free up more time for physicians to see the higher-acuity and more complex patients, without negatively affecting volume and therefore reimbursement. The faster we can get away from fee-for-service and into fee-for-value, the better for all involved. This is the future of care delivery.

# Recommended Tool

## How Market Conditions Impact Patients, Administration, and Physicians

Use this tool to understand how medical market conditions may present challenges for physicians, patients, and administration.

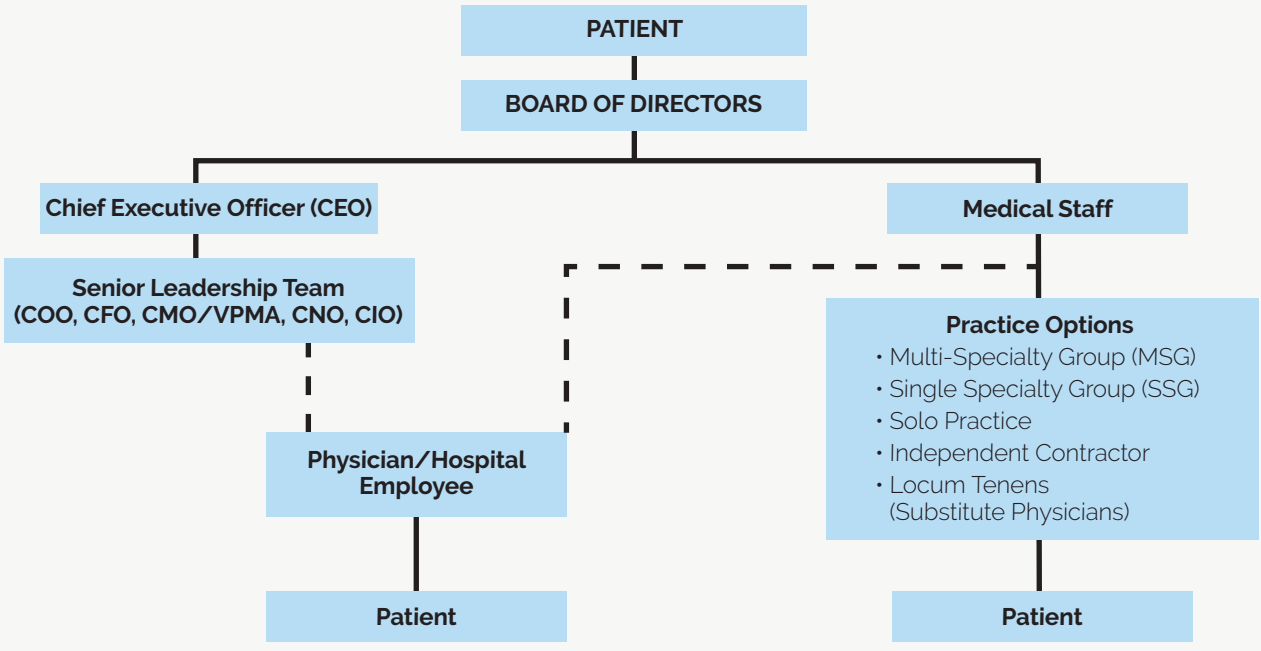
**http://md.careers/E-33**

## READ:

### Hospital Organization Structure

The following chart provides an overview of the connection points between patients, hospitals, and physicians in regard to hospital organization structure and practice options. By understanding each of the roles of senior leadership teams, the board of directors, community, and how each practice setting is connected to the hospital will give you an understanding how an or-ganization operates as well as providing you insight on what type of setting is the

**HOSPITAL ORGANIZATIONAL CHART**



## Role definitions:

**Board of Directors:** The board of directors is responsible for strategic and generative thinking about the organization and its mission, including vision and goals. It also encompasses oversight of the organization's functions; first and foremost its quality of patient care and, at a close second, its financial sustainability. The governing body has a *fiduciary obligation* to provide safe and high-quality care to the patients who seek health services from the organization. If the hospital is a 501(c)3 not-for-profit — as most hospitals are — the governing body also has a responsibility to improve the health of the community, often called "community health need" and "community benefit."

**Chief Executive Officer (CEO):** Responsible for quality of care and fiscal responsibility, including:

- Providing information and support systems
- Providing recruitment and retention services
- Providing physical and financial assets
- Identifying a nurse leader at the executive level who participates in decision making
- Representing the hospital in the community
- Speaking for the hospital in matters of regulatory, legislative and accreditation issues

**Chief Operating Officer (COO):** Responsible for the day-to-day operations (staffing, resourcing, service, plant and clinical equipment) of the hospital.

**Chief Finance Officer (CFO):** Responsible for the registration and billing of patients, negotiations with third-party payers, and management of all issues related to the balance sheet of the hospital (debt structuring, investment management, accounts payable, etc.).

**Chief Medical Officer (CMO)/Vice President Medical Affairs (VPMA):** Responsible for the effective organization of the medical staff structure, including the medical executive committee; together with the CNO, assures the quality of care provided and patient safety.

**Chief Quality Officer (CQO):** Responsible for leading the quality improvement staff and working with the board-level quality committee to ensure that the organization has allocated necessary resources towards data infrastructure and change management expertise in order to successfully improve quality of care on a continual basis, and that the metrics being tracked show a realistic picture of the organization's quality record.

*(Note: In forward-thinking hospitals and health systems, the CFO, CMO/VPMA, and CQO work very closely together.)*

**Chief Nursing Officer (CNO):** Responsible for the effective organization of the professional nursing structure; together with the CMO/VPMA, assures the quality of care provided and patient safety.

**Chief Information Officer (CIO):** Responsible for building and maintaining efficient, cost-effective, and secure clinical and business information technology networks to support the day-to-day and strategic needs of the hospital.

**Medical Staff:** Oversees the quality of care, treatment and services provided by those individuals with clinical privileges; self-governing but accountable to the governing body, who approves the medical staff structure and clinical privilege criteria, which conforms to medical staff guiding principles. There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirement.

# FIELD NOTES

I remember what my first medical director said to me: "If you do what's right for the patient, you can never be wrong." Fight for your time to be at the bedside with patients; the patients will be grateful for your time, and you will increase your longevity and resiliency.

– Anonymous

## READ:

## Evaluating and Selecting the Right Practice Type

Just as there are a variety of types of vaccines given at well-child checks, there are a number of different styles of medical groups in which you can provide patient care. When deciding which of the following kinds of groups seem to appeal to you, remember to reference back to chapter 7 and define what lifestyle and values are driving your choices in career paths. Let's take a look at some of the variety that is the spice of practice life:

**Multi-Specialty Group (MSG):** A physician-owned group with more than three physicians with a minimum of two different specialties.

- **Pros:** Trial period before commitment; less risk up front; minimal administrative and management duties; focus on clinical vs. business
- **Cons:** Less autonomy; multiple partners may have different philosophies and priorities; higher stress to drive revenue and perform; chance of not being voted in as a partner; dealing with staffing, administrative and business issues; less stable, more volatility with income

**Single-Specialty Group (SSG):** Two or more physicians within the same discipline. Generally, physicians are employed for one to three years, with a track to partnership.

- **Pros:** Trial period before commitment; less risk up front; minimal administrative and management duties; focus on clinical vs. business
- **Cons:** Chance of not being voted in as a partner; dealing with staffing, administrative and business issues; less stable, more volatility with income

**Solo Practice:** Private practitioner who is solely responsible for decisions. Physicians can be supported by the hospital through an income-guarantee arrangement, or they can set up their own practice if they are self-funded or if they choose to leverage through a bank.

- **Pros:** Complete autonomy, high reward
- **Cons:** High risk; little back-up; high overhead; less stable, more volatility with income

**Independent Contractor:** Similar to solo practitioners except that the physician contracts with a hospital or group to provide a service for a specific amount of money per year.

- **Pros:** Flexible hours; work when needed or desired; opportunity to write off business expenses
- **Cons:** Inconsistent hours and schedule; less security

**Locum Tenens (Substitute Physicians):** This arrangement allows physicians to choose their own hours and the number of days they would like to work. The locum tenens organization plans out their work schedule and sends them on assignments.

- **Pros:** Opportunity to travel; great schedule time; able to experience many different types of practices
- **Cons:** Long-term travel can be wearing; many have to travel to undesirable communities; uncertain schedule; unstable income

# Reflection + Activity

**Given current market trends and pros and cons of each practice setting, which one(s) appeal to you right now?**

## READ:

# Must-Have Physician Leadership Competencies

The swirling array of pressures for change and calls for medical care that is more accountable, more transparent, of higher value and better quality cannot happen without physicians. But perhaps the physicians of tomorrow will be different than the ones of the past. Physicians entering practice are likely to experience these factors in their practice reality:

- More likely employed in multi-specialty groups within integrated healthcare delivery systems
- Work as a member of an interdisciplinary care team involving physician assistants, nurse practitioners, care coordinators, social workers, and others
- Have a new balance between the calling of a medical career and the calling of family and eclectic lifestyle pursuits
- Influence the health and healthcare of thousands of people a year through practice, but also through leadership roles in many physician leadership positions
- Need to master social networking tools and EHRs to manage more engaged and assertive patient populations

Most new graduates will have received little preparation in medical school or residency for these new challenges and opportunities. Lifelong learning will not only apply to keeping pace with an explosion of clinical knowledge for the practice of medicine, but also a dizzying selection of new technologies and consumer expectations to deliver health gain as well as healthcare, and to provide better value for the money with a superior patient care experience.

There has never been a more important time for physicians to step forward into leadership roles. The healthcare system is transforming, and it is critical that physicians shape its future.

When choosing the type of practice and/or position that comprises the right fit, it's imperative that you evaluate where you are with each of these competencies and strategically interview with employers who can provide you the structure to help you grow into these roles professionally. To self-assess these competencies, set some time aside to walk through the exercises on page XX and XX.

The following characteristics describe different types of healthcare leadership characteristics in the organizations you will be evaluating:

- **Patient Centric.** Leaders in healthcare will need to focus more on the patient than ever before, even with the "system perspective." A good physician leader will understand and effectively communicate the impact on the patient for every decision being made.
- **Business Acumen.** Physicians will need a working knowledge of the world of medicine from a business perspective. Cost drivers, financial implications and ability to make decisions that have a positive impact on the organization and patient satisfaction represent key outcomes.
- **Team Focus.** Physicians are part of a team, and a good physician leader is a true collaborator and builds cohesion with aligned goals across physicians, administrators, patients, payers and other stakeholders. An important part of this

competency is being able to communicate effectively to non-physician leaders the importance of physician input in a large organization such as a hospital or health system.

- **Facilitator of Change.** Like any leader in any type of organization, a physician leader must be able to facilitate change, seek out differing points of view, encourage active discourse, and bring out the best in his or her team.
- **Systems / Strategic Thinking.** A physician leader needs a "system" perspective — understanding the roles of the physicians and other care providers inside a complex system of processes, people and care delivery. The physician should be able to develop a strategic mindset and methodology for leading complex organizational systems.

# FIELD NOTES

Many an aspiring physician runs into our beloved practice with little common sense.

The bright adventurer, accompanied by ignorance, enthusiasm and self-confidence, runs headlong into pit and peak.

Stunned and lost, the disoriented young resident will oft curse course, blame another and wonder.

A minute of preparation prevents an hour of confusion. Take heed, young doctor, seek to know the land before you tie your shoe.

*– Anonymous*

# Chapter Tool Box

The **CHAPTER TOOL BOX** consists of **RECOMMENDED TOOLS** featured throughout the chapter, along with additional resources and recommended links.

These tools will help you gain valuable insight about **MARKET TRENDS** to help ease your transition from training into your life and career.

## HOW MARKET CONDITIONS IMPACT PATIENTS, ADMINISTRATION, AND PHYSICIANS

**http://md.careers/E-33**

## MARKET TREND AND TRIALS

**http://md.careers/ST-02**

# Chapter Bibliography

Author: I would like to thank & acknowledge James Rice, Managing Director, Governance and Leadership, at Gallagher Integrated who co-authored some of the original content for this chapter.

1 See **www.ihi.org/TripleAim** for more information.

2 Commins, John, "For the First Time, Employed Docs Outnumber Self-Employed Docs," *Health Leaders Media*, May 7, 2019.

3 Schyve, Paul, M.D., Leadership in *Healthcare Organizations: A Guide to Joint Commission Leadership Standards (2nd Edition)*, The Governance Institute, 2017.

4 Guterman, Stuart, "With SGR Repeal, Now We Can Proceed with Medicare Payment Reform," *To the Point, The Commonwealth Fund,* April 15, 2015

5 **https://www.athenahealth.com/insight/healthcare-future-female**

6 **https://www.kff.org/other/state-indicator/physicians-by-gender/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**

## Congratulations on reading Market Trends!

**NEXT STEP: Track your progress with THE TRACKER** – an action plan for you to apply ***Market Trends*** lessons learned.

This step-by-step action plan consisting of reading assignments, exercises, checklists, assessments and additional resources to help you transition from training into your work /life by making good sound decisions.

To access your Market Trends TRACKER, go to **md.careers/T5**.