NSA

2020 Virtual Fall Meeting

Tuesday, November 17, 2020

Virtual Event

REGISTER HERE

6:30 p.m. - 8:00 p.m.

6:30 p.m. Welcome & Introduction

6:35 p.m. Keynote Speaker: Ron Harter, MD, FASA

7:30 p.m. NSA Business Meeting

8:00 p.m. Adjourn

About the Presenter

Dr. Ron Harter is the Jay J. Jacoby, MD, PhD Professor and Chair of the Department of Anesthesiology at The Ohio State University College of Medicine and a practicing anesthesiologist at the university's Wexner Medical Center. Over the course of his career, Dr. Harter has prioritized education and has held either a clinical instructorship or professorship since 1993. He has been recognized for excellence in education by the Department of Anesthesiology and the OSU College of Medicine. He holds a fellowship with the American Society of Anesthesiologists and has sat on several ASA committees on topics ranging from bylaws to governmental affairs to governance effectiveness and efficiencies. Dr. Harter also currently serves as the Speaker of the House of Delegates for the ASA. He has also been an active member of the Ohio Society of Anesthesiologists since 1996, including acting as president in the early 2000s. Dr. Harter lives in Columbus with his wife Katharine and their five children.

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Business Meeting Agenda

I Financial Report & Administrative Updates

II ASAPAC Update

III Membership Update

IV Governmental Affairs Update

V Adjourn

NSA is now online!

If you haven't already done so, visit our new website at nebanes.org. We're working hard to serve all our valued members across the state of Nebraska. In an effort to keep you informed, we invite you to connect with us on social media. Ask questions, stay up to date, and build your network by joining our new private Facebook group.

Harvard Business Review

REPRINT H042V3
PUBLISHED ON HBR.ORG
DECEMBER 15, 2017

ARTICLE

LEADERSHIP DEVELOPMENT

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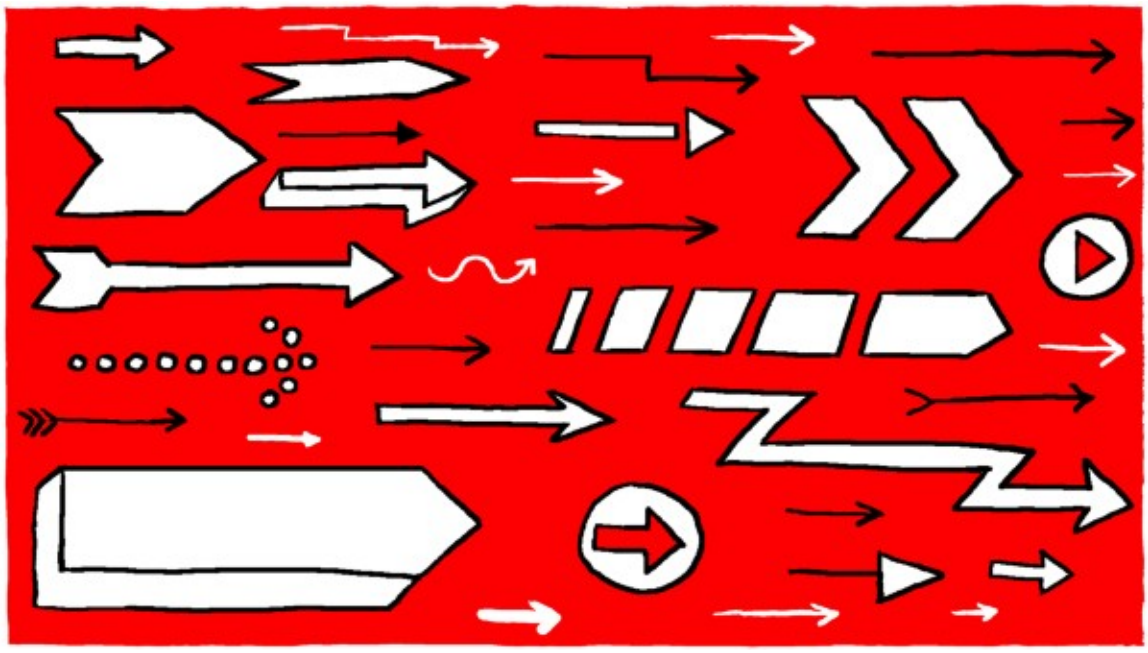

Nicholas Blechman for hbr

Rising pressure to achieve better medical outcomes with increasingly limited financial resources has created an acute need for more physician leaders. Several studies (including this one) have shown

that doctors want to be led by other doctors; they trust physician leaders to make the right decisions about redesigning health care delivery and balancing quality and cost. Fair or not, they believe it's harder for leaders without clinical expertise to see how cutting costs impacts quality of care.

Yet most doctors in the U.S. aren't taught management skills in medical school. And they receive little on-the-job training to develop skills such as how to allocate short- and long-term resources, how to provide developmental feedback, or how to effectively handle conflict – leadership skills needed to run a vibrant business.

A popular way of bringing physicians up to speed is to elevate them into management roles and team them with business executives. But this approach, called the "dyad model," is not an optimal long-term solution, for reasons we'll describe. Rather, we suggest a different approach: carving out a career path for younger physicians with leadership potential and creating a well-designed development pipeline so doctors emerge able to effectively lead large organizations of medical providers.

The Dyad Model and Its Limitations

What often happens with the dyad model is senior physicians are paired with business executives, either as co-leaders or with one reporting to the other, to run an organizational unit, region, or business segment (e.g., acute care hospitals, rehab clinics, physician practices, and urgent care centers). Some health care businesses use duplicate dyad management structures—one to oversee the clinical enterprise and another to oversee the business and operations that support the clinical enterprise. It's important to note that, in all cases, these organizations still need a chief medical officer (CMO) who focuses solely on clinical operations, and who oversees quality, compliance, and other key aspects of care. The CMO should not be part of the dyad model.

The dyad model can help break down silos, improve the way clinical and operations leaders work together, and coordinate care. And this has produced good results at a number of organizations, including the Mayo Clinic (two leaders shared the top job until 2015), Cigna Medical Group, and Carle Foundation Hospital.

However, dyads can create inefficiencies and duplication of resources (not to mention higher-than-necessary salaries) and delay decision-making. The model can also create confusion about roles and spawn outright conflict; we've seen power struggles between leaders with different priorities, who often issue conflicting messages to the areas they lead.

Finally, this model doesn't go far enough to prepare doctors to be organizational leaders. It doesn't require physicians to learn deeply about the business and gain critical financial, operational, and management skills – limiting their ability to grow into stronger leaders or advance further in the organization.

In an environment of intense cost pressures, we believe it's more economically sustainable in the long run for a health care organization to have a single, highly effective physician leader running the business and holding both clinical and administrative responsibilities, rather than bifurcating the role. There are two reasons: One is you don't need to pay two leaders to do the job that one highly capable leader could do. The second is, it can reduce physician turnover (and thus the cost of recruiting) and boost morale. While having such a big job may sound like a heavy burden – being responsible for clinical stewardship, key strategic and operational decisions, and financial management – when physician leaders' development is effective, their roles are clear, and they know how to focus their attention, they can handle the job without burning out.

But to do this, organizations need a cadre of physician leaders who are interested in taking on management roles and have the necessary business skills to lead effectively.

Building a Physician Leadership Pipeline

Based on work with dozens of health care organizations, we have adapted the leadership development model of Ram Charan et al to outline a leadership path for physicians.

This pipeline moves physicians through five levels of leadership – each allowing them to take on greater responsibility and gain the experience and skills necessary for succeeding at the next level. Over time, they develop the capacity to lead beyond the clinical enterprise and a more holistic view of the organization's needs.

Each level involves a specific focus and set of skills:

Individual Practitioner: This level comprises practicing physicians who are part of a practice, group, or solo private practice and are focused primarily on patient care. Technical proficiency is valued most in this individual contributor role.

MD Leader: This level involves running a medical group, hospital program, or an academic medical center (AMC) division (as a medical director of a service line or group of MDs, or a leader of a clinic or residents/fellow program in AMC) and managing other physicians or a program. These leaders learn to oversee and delegate work, and develop and coach others. Emotional intelligence is an important skill to develop at this level.

Market MD Leader: This role is responsible for a business segment or region, and oversees other MD leaders or a broader scope of clinical/MD staff (such as regional or market physician leader or chief of an AMC faculty division). This is where you often see dyad models emerge, as the role involves both clinical oversight and greater business responsibilities. The leader must learn how to manage financials, develop a longer-term view, and build knowledge of how to devise strategy. Communication and collaboration skills are paramount.

Group MD Leader: This role oversees a group of businesses, often as group president or chief medical officer for a corporation or chair of an AMC faculty department, with responsibility often expanded to include both clinical and business outcomes. Here the leader must be proficient in evaluating strategy, portfolio assessment, and factoring in the complexities of both internal and external business requirements, in addition to the skills gained in prior roles.

Enterprise MD Leader: This top leadership role, such as CEO, is responsible for an entire enterprise, including its strategic direction and overall organizational results. Leaders at this level emphasize visionary thinking, discerning key external trends, strategic positioning, and developing mission-critical priorities.

At each level, the mix of strategic, business, relational and clinical skills required to lead is quite different.

Creating a pipeline like this can help health care organizations recruit early-career physicians, develop their skills, and move them over time into key leadership positions. Consider the example of Sound Physicians. The Tacoma, Washington-based company is one of the nation's largest providers of hospitalists and post-acute care, with more than 2,500 physicians in nearly 350 healthcare systems throughout the U.S. To support rapid growth, Sound Physicians sought to accelerate the development of its physicians' leadership skills. The firm believed its dyad approach would not produce nearly the number of leaders that it needed.

Since putting a leadership pipeline in place, the firm now sees improved morale and overall engagement, lower turnover, and a greater ability to attract new business partners (by being able to place more physicians and physician leaders in the field). TeamHealth, a provider of more than 1,000 physicians and 20,000 clinicians to healthcare institutions in the U.S., has seen similar results after starting to develop physicians through these five levels.

Addressing Leadership Deficits

Without a well-designed development pipeline in place, doctors often get promoted directly into leadership roles, skipping levels and moving, for example, from an individual contributor to a market MD leader or group MD. This can lead to poor management oversight, operational decisions that fail to control costs, and morale problems. Our pipeline approach allows health care organizations to ensure that doctors have the skills they need as they advance in their careers. It also helps identify and address leadership skill deficits early. Specifically, the pipeline can prevent the three most common ones we see: an inability to manage and develop others, poor relationship management skills, and lack of strategic perspective.

Managing and Developing Others

Leading requires the ability to plan one's own work and the work of others. It also requires knowing how to delegate and mentor. This means physicians must learn to work more collaboratively — a style that isn't nurtured in a command-and-control environment. One-on-one coaching is one way to address this gap, but for large organizations it's often more economical to develop a program to help a broader group of physician leaders at once.

This is what Sound Physicians found out. When we first met Dr. Rob Bessler, the physician CEO and founder, he was looking to reduce physician turnover and increase the growth of the business. (The company had been purchased by a private equity firm that believed Sound Physicians could scale its business.) His vision was to build the next generation of physician leaders. Dr. Bessler tried a number of off-the-shelf leadership programs, but they had little impact on turnover and did not interest physicians.

Sound Physicians needed a customized physician leadership development program that focused at the bottom three levels: individual practitioners, MD leaders, and market MD leaders. The company identified the key leadership competencies (behaviors, beliefs, and knowledge) its physician leaders needed to support its values and direction. It then created a foundational leadership course that covered an array of management and leadership topics. The course brought together cohorts of physician leaders from each region. The structure allowed them to learn from one another, and the course was tailored to their organization's unique roles, culture, and challenges. Dr. Bessler particularly valued the peer-to-peer training, which brought together leaders with similar challenges.

The result? A survey one year later found those who went through training gained confidence in their ability to lead, were more engaged in their work, and improved the way they interacted with others. Now all incoming doctors to Sound Physicians participate in this leadership development program, and they are building strong leaders throughout the organization.

Developing Robust Relationship Management Skills

Several studies on physician leadership have noted the importance of social awareness, social skills, and the relationship aspects of leadership. Of course, practicing physicians interact with patients, but the interactions tend to be episodic and individually focused, with the doctor clearly in charge. Most physicians have been trained to keep emotion out of the job, and are not comfortable showing vulnerability in the workplace. So their work experience doesn't adequately prepare them for managing complicated workplace relationships and being seen as authentic leaders.

One way to address this gap is to give physician leaders better feedback at all levels. Yet we frequently see that health care organizations are reluctant to give performance reviews, especially to physicians. They are often viewed as professional class and not "staff." What's more, physician leaders tend to loath providing feedback to other physicians.

A great example of a physician who, through feedback, became a better leader is Dr. James (not his real name), who leads the emergency services department at a major academic medical center. After 20 years of individual clinical experience, he was appointed chair of the department (an MD leader role in our pipeline), where he was faced with a mandate to improve quality, efficiency, and morale in the department.

His new role required him to work in new ways with nursing leadership and other clinical departments that interacted with the emergency department. But he soon discovered a culture of silos and finger pointing that made this challenging.

Dr. James had already developed some business and leadership skills from taking on administrative and lower-level leadership roles in the five years before he was named department chair. But he needed to work on his influence skills, broaden his strategic perspective, and deepen his ability to lead change.

Through 360 degree feedback, he learned that certain elements of his leadership style that had previously been effective were no longer serving him well. In particular, his strong bias for action, when applied to a department chair role, came across as a tendency to move too quickly before sharing the big picture or rationale for key decisions.

After getting this feedback, he worked far more effectively with colleagues. He also developed a cross-functional leadership team that gave him input on his strategy and coordinated operational oversight. The end result was a more aligned and collaborative leadership team for the department.

Acquiring a Strategic Perspective

Many physician leaders who are promoted to lead an entire enterprise or a business segment (level four or five on our pipeline) lack the necessary experience for the job. They aren't skilled in managing and blending functional and business strategies, portfolio assessment, factoring in short- and long-

term tradeoffs, and taking a longer-term strategic approach to decisions. These shortfalls can render such leaders ineffective.

Faced with such challenges, Dr. Ronald DePinho resigned in March as CEO of MD Anderson Cancer Center in Houston. In his resignation, he said that the center "needs a new president who will inspire greater unity and a sharp focus on navigating the tectonic changes in healthcare delivery and economics." His lack of strategic perspective and inability to balance the institution's financial, business, and clinical demands revealed he wasn't right for the role.

In contrast, consider Dr. Kevin Tabb, CEO of Beth Israel Deaconness, who is known for his ability to think strategically. He was instrumental in forging a merger with Lahey Health, another large Northeastern system. Dr. Tabb has effectively moved through the different levels of leadership, gaining experience through a variety of roles with increasing responsibility and scope, first at GE's health care technology business and then at Stanford Hospital & Clinics, where he moved up the ranks to chief medical officer before becoming CEO at Beth Israel Deaconness. In following this development path, Dr. Tabb gained the experience and skills he needed to be successful in a broader, more integrated role.

A Tall Order

We believe every healthcare institution that wants highly effective physician leaders should start building a pipeline to develop physicians at key stages of their career. But we also realize this is no easy task.

One way to start is by focusing on the leadership level of greatest need. After diagnosing how current leaders at each level are faring, their organization can zero in on the weakest areas and build stronger skills development programs there.

For any program to work, it must gain physicians' trust. This means it must address issues that matter to them and be grounded in evidence. A good way to design the program is to get an influential group of physicians into a room to discuss the skills they're interested in developing and involve them in the program's design.

By beginning to build a sustainable program, healthcare institutions can bolster leadership competencies at all levels, in ways that physicians will welcome.

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Harvard Business Review

REPRINT H04KLJ
PUBLISHED ON HBR.ORG
OCTOBER 17, 2018

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LEADERSHIP DEVELOPMENT

Why Doctors Need Leadership Training

by Lisa S. Rotenstein, MD, Raffaella Sadun and Anupam B. Jena

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Medicine involves leadership. Nearly all physicians take on significant leadership responsibilities over the course of their career, but unlike any other occupation where management skills are important, physicians are neither taught how to lead nor are they typically rewarded for good leadership. Even though medical institutions have designated "leadership" as a core medical competency, leadership skills are rarely taught and reinforced across the continuum of medical training. As more evidence shows that leadership skills and management practices positively influence both patient and healthcare organization outcomes, it's becoming clear that leadership training should be formally integrated into medical and residency training curricula.

In most professions, the people who demonstrate strong leadership skills are the ones who take on greater leadership responsibilities at progressive stages of their careers. In medicine, physicians not only begin managing and directing teams early in their careers, but they rise through the ranks uniformly.

Within the first years of graduate medical training, or residency, resident physicians in all specialties lead teams of more junior residents, as well as other care personnel, without undergoing any formal training or experience in how to manage teams. It is rare for first-year resident physicians (interns) to not become second-year residents, for second-year residents to not become third-year residents, and for senior residents to not become fellows or attending physicians, although each step involves more management. And the span of leadership and responsibility grows once physicians enter independent practice.

Although medical trainees spend years learning about physiology, anatomy, and biochemistry, there are few formal avenues through which trainees learn fundamental leadership skills, such as how to lead a team, how to confront problem employees, how to coach and develop others, and how to resolve conflict. Some residency programs across the country are developing career tracks specifically for those interested in management and leadership careers, but these paths are often targeted towards individuals explicitly seeking management positions or healthcare management projects in their training, missing the fact that *to be a physician is to lead*. The set of individuals who would benefit from leadership skills in daily practice is much wider than those with specific career interests in management.

Despite this lack of focused attention toward development of leadership capabilities in trainees, evidence suggests that leadership quality affects patients, healthcare system outcomes, and finances alike. For example, hospitals with higher rated management practices and more highly rated boards of directors have been shown to deliver higher quality care and have better clinical outcomes, including lower mortality. Enhanced management practices have also been associated with higher patient satisfaction and better financial performance. Effective leadership additionally affects physician well-being, with stronger leadership associated with less physician burnout and higher satisfaction.

These benefits are crucial in a healthcare landscape that is increasingly focused on measuring and achieving high care quality, that is characterized by high rates of burnout across clinical personnel, and that is asking physicians to lead larger, multidisciplinary teams of nurses, social workers, physician assistants, and other health professionals.

Medical schools and residency programs should modify curricula to include leadership skill development at all levels of training — and this should be as rigorous as development of clinical reasoning or procedural skills. Leadership curricula should focus on two key sets of skills. First, interpersonal literacy is crucial for effective leadership in modern healthcare. This includes abilities related to effectively coordinating teams, coaching and giving feedback, interprofessional

communication, and displaying emotional intelligence. The centrality of these skills has been recognized by healthcare institutions globally, including the American Medical Association, the National Health Service, and the Canadian College of Health Leaders.

A second, separate set of necessary skills deals with systems literacy. In today's healthcare landscape, physicians need to understand the business of healthcare organization, including concepts such as insurance structure and costs that patients encounter. Physicians are also increasingly responsible for understanding and acting on quality and safety principles to correct and enhance the systems they work in. Finally, given the sensitive nature of their work, physicians must be comfortable with recognizing, disclosing, and addressing errors, and helping their teams do so as well.

Formal education on these topics could take the form of dedicated didactics during medical school and residency training, orientation sessions, and skill-building retreats, which are common in other occupations that require managerial development. At least some teaching should be delivered longitudinally over multiple years. This is important, because as trainees rise in the medical ranks and gain more responsibility (i.e. supervising medical students for the first time as interns, overseeing teams for the first time as junior residents), their ability to engage with leadership content changes.

Trainee performance evaluations should explicitly assess for adequate progression of leadership capabilities, with targeted remediation available for those not demonstrating competency. Residents should not be allowed to progress in training without achieving pre-specified proficiency in these areas. Assessment systems should also be developed to mitigate biases that downplay or disregard women's and minorities' leadership capabilities. And importantly, longitudinal studies will be needed to rigorously assess effectiveness of programs for teaching and measuring leadership skills. A 2015 systematic review of physician leadership development programs found that few reported negative outcomes or system level effects (i.e. impact of training on quality metrics) of their interventions.

While these changes may seem daunting given the vast amount of information trainees are already responsible for and the time-constrained nature of training, studies have found that trainees *want* to formally develop leadership skills. And several programs stand out as examples of how this can be done.

As first described in a 2013 *Harvard Business Review* article, Vanderbilt's Otolaryngology program developed a 4-year program for residents consisting of Naval ROTC topics, public speaking training, a micro-MBA course, and a capstone leadership project. This program, which is delivered over morning conferences or dinner sessions (when residents are excused from the operating room), exposes trainees to health care policy, finance, conflict resolution, checklist and debriefing programs, public speaking, and one-on-one communication simulation sessions. Trainees ultimately use the skills they gain for collaborating with Vanderbilt undergraduates, primary care physicians, and others on a population health project during one of their four training years. The program's founder and

Vanderbilt Otolaryngology's Chair, Dr. Roland Eavey notes that delivering similar content to faculty is key for gaining buy-in regarding the educational importance of leadership and to ensure appropriate modeling of effective leadership.

Meanwhile, at the Uniformed Services University, medical students undergo a 4-year curriculum focused on leadership attribute development. The Military Medical Practice and Leadership didactic curriculum is delivered in preclinical years and focuses on self-awareness, communication skills, and team dynamics. Subsequently, students take part in four multi-day "medical field practicum" experiences, during which they are introduced to their responsibilities as military officers and undergo both lecture and simulation modules focused on patient care, operations, and crisis management. Fourth-year medical students are ultimately evaluated on medical knowledge and leadership abilities in a simulated tactical field setting. Although centered in undergraduate medical education, this program is notable for its longitudinal mix of didactic and practical experiences and its evaluative nature, and could with reductions in time intensity be tailored to the graduate medical education setting.

Undoubtedly, enhancing leadership training in medicine will increase the costs of training and assessment. Yet, as we seek to optimize the therapeutics and procedures we perform to reduce mortality and enhance care quality, we should also seek to optimize the skills of the physicians leading all corners of healthcare system. For as the evidence shows, it can make an important difference for healthcare outcomes, experiences, and financial sustainability alike.

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