Speaking the Language of the C-Suite: From the CEO Perspective

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PACE Healthcare Consulting, LLC
Objectives

- Understand how and why C-suite and medical staff approach their work differently and why it leads to conflict
- Discuss the new skill sets needed for physicians to successfully take on administrative roles
- Highlight how the future may look for the Physician Advisor
Physicians View of CEOs?
How CEOs May See Physicians
Perceptions

I care about quality of patient care, he/she only cares about money.

Which one said this of the other? CEO or Physician?
Physicians and CEOs Have Ingrained Differences

Differences arise from:

- Education
- Career Paths
- Organizational Perspectives
- Fields Attract Different Personalities

Different Lenses

<table>
<thead>
<tr>
<th>Physician</th>
<th>CEO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doer</td>
<td>Planner/Designer</td>
</tr>
<tr>
<td>Solution-oriented</td>
<td>Process-oriented (Reduce Variation)</td>
</tr>
<tr>
<td>1:1 Interaction</td>
<td>1:Many Interaction</td>
</tr>
<tr>
<td>Always “on”</td>
<td>Some down-time (changing)</td>
</tr>
<tr>
<td>Decision-maker</td>
<td>Delegator</td>
</tr>
<tr>
<td>Autonomous</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Patient Advocate</td>
<td>Organization Advocate</td>
</tr>
<tr>
<td>Professional Identification</td>
<td>Organizational Identification</td>
</tr>
<tr>
<td>Immediate Gratification</td>
<td>Delayed Gratification</td>
</tr>
</tbody>
</table>

http://cph.uiowa.edu/ruralhealthvalue/insights/Presentations/MacKinney%20-%20Physician%20Allies
A. Clinton MacKinney, MD, MS Accessed March 3, 2014

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A. Clinton MacKinney, MD, MS Accessed March 3, 2014
Friction from Changing Environment Factors
Physician Environmental Pressures

Just to name a few:

- Declining Revenues for Hospitals and Physicians
- Physician – Hospital Competition for Same Services
- Keeping up with Technology
- More Rules to Follow that Require Cooperation
  - EMRs
  - Billing Audits
  - Meaningful Use
  - ICD 10
Physician Environmental Pressures

- Affordable Care Act
- Increasing Physician Employment
- Physician Shortage
- Power Shifting to Institutions
  - Physicians Threatened at Deep Emotional Level
  - Worried about the future of patient care
  - Will physicians just be shift workers dependent on the Electronic Medical Record to know patients?

Physician Environmental Pressures

Also Conflict Between Physicians

- Employed verses Independent
- Generational Differences
  - Baby Boomer Physicians value the relationship with patients and independent decision making
  - Younger physicians value balanced life and predictable work schedule
  - All physicians fear administrators in medical decisions . . . This probably includes physician advisors

http://www.modernhealthcare.com/article/20130713/MAGAZINE/307139995 Sean K. Murphy
Physician Environmental Pressures

- Traditionally physicians are very stable and stay in one location
  - New employment opportunities are changing the traditional model
- AMGA and Cejka Search report more than one-third (36%) of reporting groups expect the pace of retirements to increase in the coming year, compared with 27 percent with that expectation two years ago
  - Highest Turnover in Late and Early Years of Practice
- Up to 70% of physicians across all specialties change jobs within their first two years, and hospitalists are at the top end

CEO Environmental Pressures

- Population Health - manage the Entire Continuum Including Physicians
- Uncertain Reimbursement
- Keeping up with Technology
- Move from Volume Driven to Value Driven Reimbursement (but still paid on volume)
- Shift from Departmental Management to Matrix Management
- Manage Multi-generational workforce

Personal Observations

- Medical Staff Leadership Conflicts of Interest Difficult to Manage
- Miscommunication
  - CEO—it’s just business
  - Physician—it’s personal
- Smaller Medical Staffs to Perform the Work
- Full time employed physician leaders becoming more accepted
CEO Stability

Key statistics on CEO turnover and recruitment from a recent Black Book Rankings poll completed by 1,404 healthcare provider organizations' HR officers and board members

- Average hospital CEO tenure is under 3.5 years
- 56% of CEO turnovers are involuntary
- When a new CEO is hired, almost half of CFOs, COOs and CIOs are fired within nine months
- Within two months of a new CEO appointment, 87% of CMOs are replaced
- 94% of new CEOs without healthcare sector experience believe extensive healthcare knowledge is not necessary to replace senior management positions
- 89% of people involved in the hiring process believe a broad area of business expertise is beneficial in a hospital CEO position
- Most new hospital CEO candidates come from a venture capital/private equity industry background (42%), followed by finance and accounting (40%), banking (32%) and marketing and sales (19%).

Akanksha Jayanthi2.18.2013 Accessed 3.4.14
What does all this mean?

- More uncertainty than ever
- More change than we have ever encountered in our careers
- The need to work together-including strategic planning

OPPORTUNITY!
Build on Shared Values

• Altruism
• Service
• Enjoy Challenges

Opportunity

The Current Landscape Creates the Need for a Physician – CEO Middleman

- Chief Medical Officers
- Vice Presidents of Medical Affairs
- Vice Presidents of Resource Management/Physician Advisors
Communication

- First we need interpreters since we do not always speak the same language.
- Physician Leaders could bridge the communication gap between physicians and hospitals.
- For Example:
  - Physician documents plan of care and notes in patient chart.
  - CEO documents organizational plans and minutes of meetings to advance plan.
  - Physicians talk about UTI, PTCA, CBC.
  - CEOs talk EBITDA, FTEs, Cost per APD.
  - Physicians round on patients.
  - CEOs round on the organization.
What Will Make Physician Leaders Successful?

- Relationship with CEO and C-suite
  - Be proactive in meeting with CEO
  - Provide insight to CEO
  - Provide data driven information
  - Don’t take things personally
- Respect from medical staff
  - Viewed as Subject Matter Expert by Medical Staff
- Interpersonal Relationships
- Presence in clinical areas
What Will Make Physician Leaders Successful?

- New hybrid knowledge set - Medical training plus new skill set:
  - Expertise in resource management and quality
  - Understanding of how organizations function e.g. strategy and operational effectiveness
  - Getting things done through others (delegate to hospital staff)
  - Fundamental knowledge of finance
  - How to lead teams
How To Gain Knowledge

- Formal Education (MBA, Leadership Courses)
- Certifications and Associations
  - American College of Physician Advisors
  - American Board of Quality Assurance and Utilization Review Physicians (ABQAURP)
- Other Professional Groups
- Executive Groups
- EXPERIENCE!
Get Support

- Ensure you have the power and know-how to hold staff and physicians accountable
- Know where you reside on the Organization Chart and Committee Structure
- Use both formal and informal power

Did I Mention Patience?
Fundamental Organizational Systems
Must Understand Organizational Building Blocks
Pop Quiz!

- How do the next set of slides make you feel?
Building Blocks of all Organizational Systems

**Structure**
- Committee Structure as “Information Highway”
  - Board
  - Hospital
  - Medical Staff
- Organizational Structure (Organization Charts)
  - Hospital
  - Medical Staff
- Information Technology Infrastructure & EMR (WHAT)

**Process**
- Board & Hospital Plans (Compliance, Quality, UM)
- Committee Minutes
- IT Use & Access to Data
- Policies and Procedures
- Chart Review and Reporting
- Education and Training
- Rounding for Results
- Human Resources & Evaluations
- Peer Review (WHEN, WHERE, WHY)

**People**
- Staffing Levels
- Staff Knowledge
- Staff Training
- Accountability
- Culture (WHO)

Continual Measurement and Accountability
Committee Structure

- Governing Board
  - Compliance Officer
  - CEO
    - Executive Team
    - Finance
      - Compliance Committee
      - Chart Audit Committee
      - Revenue Cycle Team
  - Utilization Review Committee (KPIs)
  - Medical Executive Committee
    - Peer Review Committee (KPIs)
    - Performance Improvement Committee
  - RAC Committee
    - Hospital Departments (KPIs)
    - Performance Improvement Teams
    - Continuous Survey Readiness Team

Formal reporting structure
- Lines of team collaboration, e.g. information sharing, cross-functional teams, etc.

Developed by Elizabeth Lamkin, PACE
The Power of the Committee

Pearson's Law: "That which is measured improves. That which is measured and reported improves exponentially." - Karl Pearson
Physician Utilization Management Committee

Committees

- Utilization Management Committee
- Physician Advisor KPIs
- Case Management Department KPIs
- Physician Scorecard Reporting
- RAC/Billing Compliance Committee

Information Flow

Departments

- HIMMS Department
  - Inter-disciplinary Chart Reviews
    - Open
    - Closed
    - Special Studies

- Quality Department
  - Standard Chart Reviews
  - Peer Chart Reviews

- Business Intelligence & IT
  - Scorecards
  - Analytics
Your Team for Revenue Cycle Integrity

- Medical Staff
- Clinical Staff
- Clinical Documentation Improvement (CDI)
- HIMS
- IT
- Care Management
- Physician Advisor
- Nursing
- Ancillaries
- HIMS
- Finance (Correct Charge Master)

Physician Leader

- Claims Submission
- Third Party Follow-Up
- Rejection Processing
- Payment Posting
- Appeals
- Contract Management
- Financial Counseling
- Scheduling/Registration Certification
- Utilization Review
- Medical Record Documentation
- Encounter Charge Capture Coding

Finance

Finance Care Management

Finance Care Management

Physician Advisor Compliance

Patient Access

START
Your New Toolkit

For Herding Groups
Use Agendas to Provide Structure and a System of Accountability for Outcomes

**RAC Committee Meeting Agenda**

Date: ___________________________ Time/Location: ______
Facilitator: Care Management Director       Record Keeper: Administrative Assistant

Majority of Work is Completed Outside of Committee / Purpose: Committee has Oversight and Accountability of Structure, Process and People Related to RAC and Billing Compliance

<table>
<thead>
<tr>
<th>#</th>
<th>Topic/Action Items</th>
<th>Time Limit (minutes)</th>
<th>Tab</th>
<th>Responsible</th>
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<tbody>
<tr>
<td>1</td>
<td>Call to Order</td>
<td>1</td>
<td></td>
<td>Chair</td>
</tr>
<tr>
<td>2</td>
<td>Approve Minutes (distributed via email prior to meeting)</td>
<td>5</td>
<td>A</td>
<td>All</td>
</tr>
<tr>
<td>3</td>
<td>Standing Reports</td>
<td>10</td>
<td>B</td>
<td>As assigned</td>
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<tr>
<td></td>
<td>1) Update on RAC/OIG websites/Issues</td>
<td></td>
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<td></td>
<td>2) Results of Risk Assessment</td>
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<td>3) Actual Recoupment for Quarter</td>
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<td></td>
<td>4) Other External Billing Audits in Process</td>
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<td></td>
<td>5) Education: a) Staff b) Physicians</td>
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<td></td>
<td>6) Chart Review (Variances/Trends)</td>
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<td></td>
<td>7) Revenue Cycle (Denials/Bill Holds) Trends</td>
<td></td>
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<tr>
<td>4</td>
<td>Care Management/Physician Advisor Report (Variances)</td>
<td>10</td>
<td>C</td>
<td>Chair and PA</td>
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<tr>
<td></td>
<td>1) Concurrent Chart Review Findings</td>
<td></td>
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<tr>
<td></td>
<td>a) Medical Necessity</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>b) Continued Stay</td>
<td></td>
<td></td>
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<td></td>
<td>c) Other</td>
<td></td>
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<td></td>
<td>2) Physician Issues (Trending Report/No Names)</td>
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<td></td>
<td>3) Discharge Appropriateness</td>
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<td></td>
<td>4) Code 44 Usage</td>
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<td></td>
<td>5) Other issues</td>
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### Use Agendas (cont.)

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<tr>
<td>6</td>
<td>RAC Correspondence</td>
<td>10</td>
<td>E</td>
<td>Revenue Cycle RAC Coordinator</td>
</tr>
<tr>
<td></td>
<td>1) Pre-payment Audits</td>
<td></td>
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<td></td>
<td>2) Post Payment Review Results Letters</td>
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<tr>
<td></td>
<td>a) Automated Reviews</td>
<td></td>
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<tr>
<td></td>
<td>b) Complex Reviews</td>
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<td></td>
<td>c) Extrapolation</td>
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<td></td>
<td>3) Demand Letters</td>
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<td></td>
<td>4) Overpayment Amount</td>
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<td></td>
<td>5) Reserve Set Up</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6) Notification to Compliance/C-Suite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Appeals</td>
<td>5</td>
<td>F</td>
<td>Care Management RAC Coordinator</td>
</tr>
<tr>
<td></td>
<td>1) Number of Claims that Meet Criteria for Appeal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Number of Actual Appeals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) Percent Logged into Internal Appeal Tracking Database</td>
<td></td>
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<tr>
<td></td>
<td>4) Report on Active Appeals</td>
<td></td>
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<tr>
<td></td>
<td>5) Report on Appeal Status in Regional RAC Tracking</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>6) Appeals Requiring CEO Approval for Continuance (Cost/Benefit Analysis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>New or Old Business</td>
<td>5</td>
<td></td>
<td>All</td>
</tr>
<tr>
<td>9</td>
<td>Set time for next meeting</td>
<td>5</td>
<td></td>
<td>Chair</td>
</tr>
<tr>
<td>10</td>
<td>Adjourn</td>
<td>1</td>
<td></td>
<td>Chair</td>
</tr>
</tbody>
</table>
Utilization Management Committee (UMC)

Example Utilization Management Committee Meeting Agenda

Date: ___________________________ Time/Location: _______________

Chair: Physician

Facilitator: Care Management Director    Record Keeper: Administrative Assistant

Majority of Work is Completed Outside of Committee / Purpose: Committee has Oversight and Accountability of Structure, Process and People Related to RAC and Billing Compliance

<table>
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<td>Approve Minutes (distributed via email prior to meeting)</td>
<td>5</td>
<td>A</td>
<td>All</td>
</tr>
</tbody>
</table>
| 3  | Standard Reports/Scorecard:
  Admissions/Length of Stay/CMI
  Top Ten DRG’s
  Focus DRG’s
  Readmissions
  Avoidable Days
  Denials
  One Day Stays
  Compliance with Two-Midnight Rule
  Observation Bed Status and Hours
  Transfer Data for inpatient patient and ED
  Operative and Invasive Procedure Review
  PEPPER Report Summary | 20                   | B   | All as assigned     |
### UM Agenda (cont.)

<table>
<thead>
<tr>
<th>#</th>
<th>Topic</th>
<th>Time Limit (minutes)</th>
<th>Tab</th>
<th>Responsible</th>
</tr>
</thead>
</table>
| 4  | Clinical Protocols  
Policy Reviews  
UR PI initiatives  
RAC Activity and Updates  
Tracking and Trending of Physician UM Performance issues  
Referrals to Peer Review | 10                   | E   | All         |
| 5  | Customize to Facility Needs                                          | 5                    | F   | All         |
| 6  | New or Old Business                                                  | 5                    |     | All         |
| 7  | Set time for next meeting                                            | 1                    |     | Chair       |
| 8  | Adjourn                                                              | 1                    |     | Chair       |
### Section of UM Scorecard

<table>
<thead>
<tr>
<th>Observation Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation ALOS in hours</td>
<td></td>
</tr>
<tr>
<td>Unit Occupancy Rate</td>
<td></td>
</tr>
<tr>
<td>Percent Discharged Home</td>
<td></td>
</tr>
<tr>
<td>Observation OP Days</td>
<td></td>
</tr>
<tr>
<td>Observation OP Cases</td>
<td></td>
</tr>
<tr>
<td>Observation Cases Converted to IP</td>
<td></td>
</tr>
<tr>
<td>Observation IP conversion %</td>
<td></td>
</tr>
<tr>
<td>Observation Days % of Total Patient Days</td>
<td></td>
</tr>
<tr>
<td>Observation OP Cases % of Admissions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Times</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average DC Time of Day for Medicine</td>
<td></td>
</tr>
<tr>
<td>Average DC Time of Day for Surgery</td>
<td></td>
</tr>
<tr>
<td>DC after 11am %, Medicare</td>
<td></td>
</tr>
<tr>
<td>DC after 11am %, Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readmissions within 30 Days</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Readmissions (30 days, % of DC)</td>
<td></td>
</tr>
</tbody>
</table>

For full sample scorecard go to www.pacehcc.com
### Physician Scorecard Reporting

#### Physician Record Key Performance Indicators

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Physician A</th>
<th>All Other Physicians</th>
<th>Total Cases Hospital</th>
<th>Dept of Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td># Patient Accounts</td>
<td>419</td>
<td>14,102</td>
<td>14,521</td>
<td>4,364</td>
</tr>
<tr>
<td>Patient Days</td>
<td>1,576</td>
<td>58,283</td>
<td>59,859</td>
<td>18,782</td>
</tr>
<tr>
<td>Case Mix Index</td>
<td>1.0988</td>
<td>1.2908</td>
<td>1.2853</td>
<td>1.1993</td>
</tr>
<tr>
<td>Average Age</td>
<td>77.3</td>
<td>59.3</td>
<td>59.8</td>
<td>78.6</td>
</tr>
<tr>
<td>Denied Days</td>
<td>79</td>
<td>1,515</td>
<td>1,676</td>
<td>526</td>
</tr>
<tr>
<td>% Denied Days</td>
<td>5.0%</td>
<td>2.6%</td>
<td>2.8%</td>
<td>2.8%</td>
</tr>
<tr>
<td># Deaths</td>
<td>5.5488</td>
<td>205,3056</td>
<td>210,8544</td>
<td>100</td>
</tr>
<tr>
<td>% Mortality</td>
<td>1.3%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>2.3%</td>
</tr>
<tr>
<td>ALOS</td>
<td>5.3</td>
<td>5.9</td>
<td>5.8</td>
<td>6.1</td>
</tr>
<tr>
<td>%GMLOS</td>
<td>3.9</td>
<td>3.7</td>
<td>3.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Pot Excess Days</td>
<td>328</td>
<td>11,633</td>
<td>11,961</td>
<td>4,765</td>
</tr>
<tr>
<td>% Medicare Cases w/ALOS &gt; GMLOS</td>
<td>41%</td>
<td>38%</td>
<td>38%</td>
<td>43%</td>
</tr>
<tr>
<td>Pot Avoid $ (@$600d cost)</td>
<td>$196,998</td>
<td>$6,979,851</td>
<td>$7,176,848</td>
<td>2,859,058</td>
</tr>
<tr>
<td># One (1) Day Inpt Stay</td>
<td>57</td>
<td>2,800</td>
<td>2,857</td>
<td>690</td>
</tr>
<tr>
<td>% One (1) Day Inpt Stay</td>
<td>14%</td>
<td>20%</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td># Three (3) Day SNF DC (excludes pts from SNF)</td>
<td>7</td>
<td>183</td>
<td>190</td>
<td>84</td>
</tr>
<tr>
<td>% Three (3) Day SNF of all SNF Dispositions</td>
<td>9.5%</td>
<td>11.3%</td>
<td>11.2%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Total Charges</td>
<td>$10,942,721</td>
<td>$398,169,496</td>
<td>$409,112,217</td>
<td>127,182,738</td>
</tr>
<tr>
<td>Payor Actual PMT Net Rev</td>
<td>$2,512,886</td>
<td>$122,168,902</td>
<td>$124,681,788</td>
<td>32,964,979</td>
</tr>
<tr>
<td>PMT-DIR COST (CM)</td>
<td>$447,392</td>
<td>$27,181,592</td>
<td>$27,628,984</td>
<td>7,706,187</td>
</tr>
<tr>
<td># Cases w/Charges &gt;$50K</td>
<td>31</td>
<td>1,628</td>
<td>1,658</td>
<td>492</td>
</tr>
<tr>
<td>% Cases w/Charges &gt;$50K</td>
<td>7.3%</td>
<td>11.5%</td>
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**Needs Update for Two Midnight Rule**
Administrative “Charting” Minutes

Organization Name

Meeting Name: [Insert Meeting Name]
Date: [Date]
Time/Location: [Time/Location]
Facilitator: [Insert Name]
Recorder/Timekeeper: [Insert Name]

Purpose/Name:

*Insert names of all committee members. Use an “x” for attendees and leave the box blank for members not at the meeting*

<table>
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Guest: __________________  Guest: __________________  Guest: __________________

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<th>Discussion</th>
<th>Conclusions/Recommendations</th>
<th>Responsible</th>
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<td>Approval of Minutes</td>
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Pop Quiz Results

If you did not fall out of your seat in a catatonic state, there is hope to bring you over to the dark side . . . Hospital Administration!

or

You can create a new hybrid leadership style able to operate in both worlds
The Future for Physician Leaders

- Offer stability in an organization
- More leadership opportunities with greater influence
- Consider a new delineation of privileges for credentialing a Physician Advisor
- Continue to define the role and job title
- Internal and external needs will expand
- Needs at multiple levels
  - Both doers and leaders
Conclusion

- The future brings both challenges and opportunities
- We cannot survive without a coordinated effort so we need to take the time to understand each other
- Opportunity for new physician leadership role that may launch more Physician CEOs
The New Physician Leader

“The kid’s good.”
Thank you!

Elizabeth Lamkin
Info@pacehcc.com