Director's Forum

Physicians as Executives: Opportunities and Strategies for Health-System Pharmacy Leaders

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ABSTRACT

To deal with the pressures in health care that stress clinical excellence and profitability, health systems are increasingly recruiting physician executives or physicians in leadership and management positions. Physicians occupy less than 5% of all hospital leadership positions, but there is an apparent increase in the recruitment of physician executives. With the growth in the number of physician executives, pharmacy leaders must capitalize on their existing clinical relationship and apply it to health care leadership and management. By focusing on developing an executive presence, by clearly describing a patient-centered strategy and vision for pharmacy, and by nurturing the existing clinical relationships, the pharmacy director can work with physician executives to promote patient-centered pharmacy services.

Health care leaders in the United States are increasingly accountable for efficiency and effectiveness in the health care system. This focus requires a change in the skill mix in providers, an increased use of automation and information systems, and cost-saving initiatives in the face of shrinking reimbursements. Health care leaders need to be skilled in strategic planning, have visionary leadership, and exhibit leadership courage in making hard decisions about health care priorities. They also need to have a firm understanding of what is needed to provide patient care. This mix of leadership qualities has led to an increasing number of physicians being selected to assume executive leadership positions in hospitals and health systems.

The physician as executive has grown out of the changing relationships between physicians and hospitals. Twenty years ago, physicians began to change their relationship with hospitals from contractor to employee. In 2014, a survey conducted by the American Medical Association found that roughly 60% of family doctors and pediatricians, 50% of surgeons, and 25% of surgical subspecialists were employed by a hospital or health system.¹ This new relationship has created a new revenue stream for hospitals (physician

fees) while impacting health care outcomes. For example, an employed physician infectious disease medical director advocates on behalf of the hospital for appropriate antibiotic use, resulting in reduced drug costs and decreased antibiotic resistance.²

Other examples of physician alignment and its benefit include a Centers for Medicare and Medicaid Services (CMS) demonstration project at The Wenatchee Valley Medical Center (WVMC). The purpose of this project was to test the effectiveness of physician alignment on the management of chronic diseases and care coordination.³ At the onset of the study, an analysis found that 48% of Medicare costs at WVMC were due to emergency department (ED) visits and inpatient hospital charges. By partnering physician leaders with hospital administrators to create a new shared vision of health care delivery, WVMC secured the engagement of its providers to realize robust change. Providers' suggestions for the development of services were prioritized, physicians were entered into shared-savings agreements, and providers were recognized based on performance (readmission rates, patient testimonials, outcomes, etc) rather than volume. At the conclusion of the 36-month demonstration, WVMC saw a 17%

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decrease in inpatient admissions, length of stay, ED visits, skilled nursing facility days, and outpatient visits. There was also a decrease in the costs of providing care with an increase in CMS quality metrics realized at the end of the demonstration period.

The center of most health care reform initiatives is the patient-centered model of care, including accountable care organizations (ACOs) and patient-centered medical homes (PCHMs). A recent (October 2013) survey found that nearly 75% of providers who responded participated in at least one value-based payment model.⁴ Over 60% believed that these programs would be the majority model in future health care finance, whereas less than 30% agreed that the model incentivized the risks associated with this system appropriately. Now more than ever the fiscal strength of health care organizations will be tied directly to the clinical outcomes of the populations they serve. This focus on outcomes justifies institutions' desires to link clinical expertise with effective executive-level leadership.

Mergers and acquisitions have helped health systems and providers remain dominant in the marketplace by reducing overhead, increasing market share, and distributing financial risks among member groups. Industry experts predict that upwards of 20% of the national's hospitals and health systems will pursue at least one merger over the next 5 years. In fact, the Center for Healthcare Economics and

Policy found that 551 hospital mergers occurred from 2007 to 2012 involving 832 hospitals.⁵

To deal with the pressures in health care that stress clinical excellence and profitability, health systems are increasingly recruiting physician executives or physicians for leadership and management positions. The American College of Physician Executives (ACPE) hosts over 11,000 members and estimates that the number of physician executives is slated to grow dramatically in the next 5 to 10 years. Physicians generally do not have the training and skills of the traditional business executive in health care (eg, the master's of health service administration graduate [MHA]). The ACPE provides a network of graduate studies and certification programs in management and leadership tailored to physicians who are assuming executive roles in health systems. Physician executives need a distinct combination of credibility, knowledge, motivation, strategy, and managerial prowess. For the same reason, the number of combined MD/MBA programs have doubled in the past decade, illustrating the need for management skills in addition to clinical proficiencies.⁶ The Hanley Center for Healthcare Leadership cites 6 skills for the physician executive: systems awareness, strategic focus, key management/business skills, self-awareness, knowledge of trends, and strong interpersonal skills that foster teamwork and collaboration (Table 1).⁷

Table 1. Essential foundation skills for physician executive leadership

Essential skills	Description
Systems awareness	Aware that decisions made at any level will affect all other levels and knows how to influence these decisions. Founded in community concern, sustainable productivity, and systems thinking.
Strategic focus	Develops strategic plans that are both purposeful and visionary; remains goal oriented with a history of goal achievement, execution, and high performance.
Key management/business skills	Understands finance, marketing, organizational behavior, informatics, continuous quality improvement, productive conversations, and other key skills necessary to be a business leader in health care.
Self-awareness	Committed to ongoing professional and personal development expressed through high integrity leadership; able to take tough stands, approach unfavorable discussions, confront organizational issues, and share personal feelings/vulnerabilities about situations.
Health care trends	Understands the need for collaborative relationships among different disciplines to prepare for the evolving trends in health care delivery and payment.
Fosters teamwork and collaboration through strong interpersonal skills	Focuses on the development of high-performance teamwork among members across the organization; promotes collaboration to establish common ground, find mutual benefits, develop synergy, and create win-win situations.

According to ACPE, patient-centered care should be quality centered, safe for all, streamlined and efficient, measurement based, evidence based, value driven, innovative, fair and equitable, and physician led. The 2013 Physician Executive Summary conducted by ACPE reported that more physicians were filling roles such as chief operations officer, chief administration officer, chief strategy officer, and other administrative positions.⁸ The survey supported the observation that physician executives are pursuing and obtaining nontraditional positions within the hospital executive structure. The same survey identified nearly 1,200 executive physicians who were senior and/or C-suite level executives in their organizations.

The assumption is that there is a growing trend for physician leadership, but actually there is a paucity of physicians in executive positions. Of the nearly 6,500 hospitals in the United States, only 235 are physician led. This is in stark contrast to 1935 when physicians led nearly 35% of hospitals in the United States.⁹ In the debate between the MD and MBA/MHA as a chief executive officer (CEO), the answer may lie in organizational behavior rather than pure credentials. In short, are clinical leaders more effective at producing operational change compared to their nonclinical counterparts? Common traits of successful change agents include having a clear vision, patience, and persistence, being knowledgeable, and investing in relationships.¹⁰ Both MDs and MBA/MHAs can have these traits; however, physician leaders have the notable advantage of being knowledgeable in the delivery of health care. They can also lead by example and demonstrate the intended change through their own practice. It is this connection to the frontline delivery of health care that makes physician executives more effective change agents.

The traditional reporting structure for pharmacy departments is through an administrator (assistant or associate hospital director) or higher level executive position (chief operating officer) who is responsible for support services (radiology, laboratory, respiratory therapy, and pharmacy). Individuals with graduate degrees (MHA) and fellowship or residency experiences generally occupy these positions. Pharmacy directors often interact with the medical staff through relationships developed through the Pharmacy & Therapeutics Committee (P&T). In some instances, the chair of the P&T committee is involved in establishing and monitoring the performance measures for the pharmacy director. There are several examples of hospitals and health systems in which the pharmacy director reports directly to a physician, for example,

the Cleveland Clinic and MD Anderson Hospital. There may also be hospitals in which the pharmacy director has a matrix (dual reporting) relationship with physicians; for example, at The Ohio State University Wexner Medical Center (OSUWMC), the pharmacy director reports to a hospital director and to a physician health-system chief operating officer.

The goal of this article is to summarize the key strategies for engaging physician executives in supporting the pharmacy practice model initiative. This article will describe the movement to appoint physicians as chief executives in health systems, outline how physician executives may impact pharmacy practice models, and summarize key strategies of pharmacy leaders in influencing physician executives to support pharmacy practice model change. As pharmacy directors improve their effectiveness in engaging and positively influencing physician executives, health systems will make significant progress in developing patient-centered pharmacy services.

PHYSICIANS AS EXECUTIVES

With the adoption of the Patient Protection and Affordable Care Act of 2013 (ACA), health care organizations are tasked with improving quality and outcomes, increasing patient access to care, and reducing the associated costs of care provided to patients. When reviewing health care as an industry, it is easy to conclude that few leaders have kept up with the evolution of health care and even less are equipped with the change management competencies to lead their organizations through the massive upheaval in practice change that is the ACA.

Prior to the passing of the ACA, the last significant change to the health care industry came in 1965 with the creation of Medicare under the amendments to the Social Security Act. In the subsequent years, executives with traditional MBA training realized business opportunities in the health care leadership and were instrumental in the growth of the nonphysician executive position. During the 1970s and 1980s, as health care grew more complex and more expensive, the quality issues still remained. Physicians have rarely assumed leadership roles and habitually abdicated these roles in favor being experts in their prospective fields rather than managing the environment around them. In fact, a 1972 *Forbes* article noted that as health care continued to expand as a business, it had become "too important" to leave in the hands of physicians. This approach to management left health care in a precarious position as the focus on revenue generation and improving quality diverged over 30 years ago.

Institutions have begun to view physicians as integral members of their leadership teams. Their commitment to quality and their natural curiosity in solving clinical care issues makes physicians a natural choice to infuse innovation into health care management. Although physicians occupy less than 5% of all hospital leadership positions, there is an apparent increase in the desire for their leadership. We reviewed the CEOs/presidents of the top 20 health care organizations ranked by *U.S. News* for 2013 to 2014; half employed a physician as their CEO or president.¹¹ Furthermore, the top 5 hospitals in the rankings were all lead by physicians and all 5 organizations are consistent high performers in the metrics considered in the rankings. This would suggest that organizations and patients are mutual beneficiaries when physicians assume leadership roles.

The OSUWMC is seeking a physician leader to head their organization; our anecdotal experience tells us that more of our physician colleagues are interested in assuming chief executive roles. Educational programs focused on the development of physicians as leaders are now offered by health care executive associations such as the ACPE.

The question of whether physicians should serve as chief executives has resulted in some debate. It is generally agreed that physician executives can have a positive impact on the costs and quality measures for a health system. In a large, cross-sectional study to determine the association between hospital performance and leadership structure, data were collected from the top-ranked 100 US hospitals in 2009 and from 300 CEOs.¹² Several findings are worthy of discussion. Using Index of Hospital Quality (IHQ) scores, the study found that in the fields of cancer, digestive disorders, and heart and heart surgery, physician-led hospitals significantly outperformed nonphysician-led hospitals. Even when eliminating hospital size and number of beds as a confounding factor, the disparity between the 2 groups remained. The study found that in hospitals with physician executives, the scores on quality and profit were 25% higher than those run by nonphysicians. Is this due to the fact that better hospitals are physician led? Or are physician executives more attracted to higher performing hospitals?

The design of this study can only be suggestive of causality; it cannot inaugurate physicians as more effective leaders than their nonphysician counterparts. Physicians are highly trained and understand the importance of evidence-based decision making. Physicians also understand how to work in teams

and, in many cases, how to effectively run a team to meet a goal (eg, a patient care team or hospital patient unit). Physician executives for the most part can influence other physicians in changing practice patterns, complying with drug formulary changes, and participating in quality improvement activities. Unpublished research from the University of Pittsburgh showed that the most successful indicator of success in preventing medication errors was having a physician executive in charge of a medication safety project. Finally, OSUWMC's medication safety program, led by a physician and facilitated by the pharmacy, has resulted in a significant reduction in harmful medication errors.¹³

PHYSICIAN EXECUTIVES AND THE PHARMACY PRACTICE MODEL

The pharmacy department will be directly affected when physicians assume leadership roles. The American Society of Health-System Pharmacists (ASHP) has identified the need for significant advancement in pharmacy practice models as one of the most pressing issues facing pharmacy leaders.¹⁴ It is imperative that pharmacists recognize the opportunities given by health care reform to be recognized as clinical care providers who contribute to the delivery of quality care and safe medication use practices. There is a theme throughout the argument for physician-led hospitals regarding their positive impact on quality, safety, and costs. Mutual support between physician executives and pharmacy leaders will ideally lead to pharmacy practice model advancement that would satisfy the objectives of both leaders.

The Pharmacy Practice Model Initiative (PPMI) established by ASHP is a guideline intended to help pharmacy leaders engage key stakeholders at the highest levels in their hospitals or health systems to support practice model change in pharmacy. As pharmacists, our education and training has prepared us to assume roles in direct patient care. Collaborative care between physicians and pharmacists is not a new development. The benefits of collaborative practice have been well documented, and collaborative practice agreements and physician support for widening the scope of practice agreements are commonplace across the country. Physicians and pharmacists have enjoyed a fruitful history of mutual support that has lead to improved quality of care, enhanced safe medication use practices, and positive impact on economic outcomes.¹⁵

Physicians are aware of the advancing roles of pharmacists in hospitals and health systems and oftentimes are among their strongest supporters. One

of the more comprehensive case studies for physician-supported, pharmacy practice model advancement involved the Veterans Health Administration (VHA) health system. In the VHA system, clinical pharmacy specialists (CPSs) are credentialed (requiring residency, specialty board certification, or equivalent experience) and then undergo a privileging process called “scope of practice determination” that, if successful, grants significant increases in scope of practice compared to clinical pharmacists found outside of the VHA system. The first CPS was employed with the VHA in 1995 with further enhancements to their scope of practice occurring in 2003. As of 2013, there are over 2,500 CPSs nationwide; through utilization of their extensive knowledge involving medication therapy management, CPSs reduce physicians’ clinical and administrative burden.

Pharmacists must leverage the relationships they have with physicians to help advance clinical pharmacy practice. Participation in P&T Committees helps establish strong relationships and advance pharmacy practice. Antimicrobial stewardship programs (ASPs) often have representation from both physician and pharmacy clinical leaders. These are patient-centered activities. As with the PPMI objectives, pharmacy practice models have to place the patients in the center and focus all efforts and resources on improving their experience. When pharmacy’s goals align with those of our physician partners, advancement will occur organically rather than out of necessity.

STRATEGIES FOR DEALING WITH PHYSICIAN EXECUTIVES

Interacting with physician executives can be a rewarding experience if pharmacy leaders are adequately prepared. As discussed earlier, there are relatively few physicians who currently occupy the lead executive position in hospitals and health systems. Therefore there are a limited number of pharmacy leaders who have had the opportunity to work with this emerging group of executives. Some of the strategies employed by various leaders in pharmacy that resulted in positive advancement of the pharmacy practice model are detailed in the following discussion.

Demonstrate an Executive Presence

The department of pharmacy, through its impact on the medication use process, significantly impacts patient care in hospitals. Nearly 80% of orders in hospitals are related to medications; as a result, the pharmacy director must work with a variety of

hospital leaders to advocate for the efficiency and effectiveness of the medication use system. In their interactions with those leaders, pharmacy directors have to establish an executive presence; they have to demonstrate leadership behaviors that reflect the executive role. Credentials, training, experience, and results are important for establishing executive presence, but perception remains a hurdle. Even when occupying the title of administrator of pharmacy, director of pharmacy, or chief pharmacy officer, some pharmacy leaders may find it difficult to convince senior leaders of their executive presence.

In the article “Cracking the Code: Executive Presence and Multicultural Professionals,” author Sylvia Ann Hewlett affirmed that executive presence is comprised of 3 pillars: *gravitas*, communication, and appearance.¹⁶ Of these, *gravitas*, the act of exuding confidence, standing your ground, speaking truthfully, and maintaining emotional intelligence, is the most important pillar for pharmacy leaders to master. The ability to handle conflict and crisis with poise and confidence is the essence of confidence. Leaders in any profession are tasked daily with the responsibility of guiding their respective units to success or failure. Confidence should never be confused with arrogance; successful leaders handle conflict with grace and humility, not bravado and grandstanding. Leaders are often required to stand their ground or be firm when the situation requires.

Communicating Your Vision and Strategy

Although looking and acting the part of a pharmacy executive is important, the development of a vision for pharmacy practice and a viable strategy to implement those plans is vital to being effective with physician executives. Pharmacy directors need to have a clear vision of how pharmacy can contribute to organizational goals in patient care, medication safety, and finance. The most critical advice for pharmacy leaders is to be patient-centered when describing their department. Conversations should never focus on what is best for the pharmacy; instead all proposals should be presented based on how the department can positively impact the patients. The difference between interactions with physician and nonphysician executives is the degree to which their commitment to patient care is integrated with their vision of organizational success. As we seek to develop practice models, physicians will look to us for innovative approaches to patient care. Pharmacy can be a powerful complement for physician services if we consistently seek opportunities to reduce the clinical

burden that physicians have to manage. Pharmacists are now nearly universally accepted as competent providers of chronic anticoagulation services as proven over dozens of studies focused on clinical outcomes. Taking this example, pharmacy has freed up physicians' time, provided a critical service for patients, delivered more personalized care, and reduced costs by reducing readmissions and hospital stay length.¹⁵

A case example of physician alignment and collaboration was OSUWMC noting the growing gap between patients in their access to expensive oncology medications. Patients were being discharged with prescriptions for medications that were too expensive for them – leading to poor outcomes from nonadherence. Furthermore, physicians had very little understanding of the costs of medications and blamed patients for nonadherence. In response to this growing concern, OSUWMC developed a medication assistance program (MAP); the director of the program established relationships with physicians and communicated the vision and strategy for the MAP. The CEOs of both the cancer hospitals and university hospitals then realized the importance of this program and provided the necessary support for its operations.

The MAP improves patient outcomes by providing access to medications to the underinsured and uninsured thereby reducing charitable write-offs, avoidable hospital admissions, and ED visits. Each year the program assists over 2,000 patients while providing over \$12 million dollars in medication assistance from drug manufacturers. The success of this program has been recognized system wide and is often regarded as the blueprint for the successful design and implementation of a MAP and of physician engagement and outreach. The American Pharmacists Association (APhA) recognized the MAP with its 2011 Pinnacle Award, celebrating the MAP's significant contributions to improving medication access to vulnerable patient populations.

Developing Effective Relationships with Physicians

Developing relationships with key physicians, not necessarily those in executive positions, can help influence physician executives and grow the practice model. Scott Knoer, PharmD, MS, FASHP, the Chief Pharmacy Officer at the Cleveland Clinic, feels strongly that success in life and in our profession revolves around effective relationships. These ties are formed through committee involvement, patient care initiatives, or in less formal settings. The P&T Committees is the most consistent environment in which to establish collaborative and cooperative relationships

between physicians and pharmacists. Knoer advises that pharmacy leaders must be visible to the P&T Committee members, as well as a hardworking, important part of the committee's functioning. Knoer also advises leaders to take advantage of opportunities to be a part of physician-centered committees and groups. Sitting on these groups can be instrumental in influencing the way physicians view pharmacy administration as clinicians and leaders. Examples of this practice include having the director of pharmacy or chief pharmacy officer as required members of the physician onboarding team, helping to create effective pharmacy and physician relationships.

By engaging key physician leaders in oncology, neurology, and rheumatology, Knoer utilized their support to garner the capital investment needed to establish a specialty pharmacy. Not only has the specialty pharmacy been a tremendous financial success by creating a new revenue string for the health system, but the clinical and administrative benefits have also been recognized. With the health system–owned specialty pharmacy, physicians can ensure that their patients have access to specialty medications when necessary. Additionally, their administrative assistants spend less time having to work with a third-party specialty pharmacy to get medications for their patients, which frees them to focus on other aspects of patient care.

Establishing physician relationships to secure funding for a program such as specialty pharmacy was also successful at the University of Wisconsin, Oregon Health & Science University, University of Michigan, Johns Hopkins, and Houston Methodist. OSUWMC is the latest large academic medical center to establish a specialty pharmacy marketplace through physician engagement. OSUWMC is preparing for the opening of its first specialty pharmacy that will focus on oncology and neurology medications, entirely advocated for by hematology/oncology physician leaders in the medical system.

Relationships can start from committee or onboarding involvement but should evolve as appropriate. Several pharmacy heads have promoted the practice of having less formal meetings with their physician heads to build stronger relationships. These interactions can pay dividends when critical decisions regarding pharmacy need to be made in the future.

Finally, pharmacists must maintain their place as medication experts in the medical health system. Clinical pharmacists and pharmacy leaders alike must recognize the need to remain clinically relevant in the evolving health care culture. When viewing the rise of physicians as executives, we note that nearly

all of these leaders maintain their clinical relevance by continuing to practice medicine in addition to fulfilling their executive responsibilities. This provides a glaring divergence in pharmacy leadership where it would be exceptionally rare for pharmacists in these positions to also practice clinically. While some believe we should reevaluate our approach to the separation of clinical and leadership opportunities, others lament the need to display clinical expertise even as pharmacy heads. For future pharmacy practitioners and leaders, an emphasis on management and leadership will need to become commonplace in the pharmacy school curriculum. Increased interest in PGY-1/PYG-2 health system pharmacy administrative residencies will hopefully support the development of the pharmacy administrator as a clinical leader.

CONCLUSION

Health-system pharmacists work daily with physicians in patient care and are best suited to adapt to working with physicians as executives. This long-standing clinical relationship has been successful, because physicians regard pharmacists as medication experts. By focusing on developing an executive presence, by clearly describing a patient-centered strategy and a vision for pharmacy, and by nurturing the existing clinical relationships, the pharmacy director can make significant advances with physician executives in promoting patient-centered pharmacy services.

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