Succeeding in Health Care Reform: Developing Physician Leaders as Coaches

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Succeeding in Health Care Reform: Developing Physician Leaders as Coaches

Michael G. Cassatly and Anne Power

Even with the passage of the Affordable Care Act of 2010, a considerable amount of confusion still remains about the future landscape of health care in the US. One fact is certain though: financial risks and rewards will be shared among all parties involved in a patient’s care. This article discusses how physicians, a heterogeneous group of independent entrepreneurs, need to transform into a cohesive group to ensure not only their success but the success of all parties involved in patient care. We present a case study transitioning physicians from their current role as stakeholders to their new role as stakeholder partners in the reformed health care system. In this case, physicians learned and used the skills emphasized in Coach Principle Leadership™. Through this process they developed into physician leaders and applied coaching concepts to transition into the new health care landscape.

Historically, the medical reimbursement model in the US has been one of fee-for-service: the more services provided in the care of a patient, the more the reimbursement to health care providers and hospitals. The Affordable Care Act of 2010 mandates a transformation from this historical model to one based on the success of the patient’s medical outcome, called value-based purchasing. Additionally, all entities responsible in a patient’s care and outcome will share in the medical reimbursement. Thus, the success of one stakeholder in a patient’s care, such as a hospital, is dependent upon the success of the other stakeholder, such as a physician. While hospitals are well-organized entities, physicians are a heterogeneous group of independent entrepreneurs and tend not to function as a cohesive unit. In this article we present a case study where physicians successfully organize into a cohesive group with our process called Coach Principled Leadership™.

A NEW FRAMEWORK

While at first glance the change from a fee-for-service model to one of value-based purchasing appears to further usurp physician control of health care, a more detailed examination reveals it actually empowers them. Why? Because the Affordable Care Act encourages the current stakeholders in a patient’s care, physicians and hospitals, to form collective associations called Accountable Care Organizations (ACOs). The members of the ACO are not only responsible to coordinate overall patient care but share in a bundled payment for the success of that care. Thus, rather than pay hospitals and physicians individually, payment will be paid to the ACO. The rewards and risks are shared by all members of the ACO; physicians and hospitals are no longer independent.
The Affordable Care Act of 2010 mandates a transformation from this historical model to one based on the success of the patient’s medical outcome, called value-based purchasing.

THE HISTORY
In order to define a better future of health care system and the accompanying cultural changes for physicians to transition to stakeholder partners, one needs to look at three trends affecting the US health care system before legislated health care reform. First, physicians were the historical, central driving force in the US health care system prior to the late 1980s, both in terms of patient care and the economics of health care. They made the decisions affecting patient care, such as accepted therapeutic, pharmaceutical, and behavioral modalities which ultimately impacted the business of health care. They make business decisions, such as the number of hospital admissions or which hospital to admit patients, the brand of hip replacement or cardiac stent surgically placed, and even the next blockbuster drug. The physicians’ autonomy and care decisions seemed endless. The independent entrepreneurial spirit inherent to physicians, one so prized and encouraged, resulted in a plethora of treatment modalities for the same illness and was governed without the advantages of efficient business models.

Figure 1. Examples of media assault on physicians: Highway billboard & The Economist magazine

The second trend was when managed care, introduced in the late 1980s, began the erosion of the physician’s central role in patient treatment and their power as a driving economic force in health care. The increasing rise in medical costs due to an unfettered fee-for-service payment system caused the third trend, the assault on the US health care system. This constant condemning of the US health care system was multi-directional: from the government, the ubiquitous gamut of media sources, and businesses of all sizes (see Figure 1). This multidirectional assault had profound and
Physicians must transition from a group of independent practitioners with many solutions to the same problem to unified stakeholder partners willing to accept standardizations in procedures and care delivery.

**THE CHALLENGE**

Although physician and hospitals are stakeholder partners in the new landscape of health care reform, they have a significant structural difference. Physicians tend to be an independent heterogeneous group, whereas hospitals represent business entities that are cohesive. This contrast presents two major challenges to their future relationship as stakeholder partners in ACOs. The first challenge, poor communication, stems from the disparate nature of physicians. Any loosely organized group is much more prone to miscommunication and poor data exchange than one which is well organized. Effective communication is absolutely necessary to obtain the high levels of successful patient outcomes mandated in the value-based purchasing model to maximize reimbursement for the ACO. The second challenge is the capability of physicians to accept the standardized treatment modalities necessary to have system-wide cost efficiencies. Physicians must transition from a group of independent practitioners with many solutions to the same problem to unified stakeholder partners willing to accept standardizations in procedures and care delivery. Consequently, the formation of ACOs and the subsequent loss of physician autonomy require a new identity and skill set for physicians. Physicians must not only maintain competent clinical skills, but they must now add the competency of working well with benchmark treatment modalities.

**THE SOLUTION**

Using our process, Coach Principled Leadership™ (CPL™), nurse practitioners and physicians were able to reframe their perspectives and successfully address their loss of control in health care as well as loss of career satisfaction due to the health care siege mentality. For instance, one physician noted patients were “more appreciative” when he “actively listened” to what they said, resulting in the physician feeling better about his career. What is more important, we have also used CPL™ to successfully address the challenges of the cultural shift by developing physicians into physician leaders practicing coaching principles among themselves and the health care team. As recently noted by Navigant Consulting (Bard & Nugent, 2011, p. 5)

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Today’s biggest challenge is not physician-hospital integration, but its precursor condition, physician-physician integration. Health care leaders eager to move forward are confronting a confusing, redundant, or underdeveloped physician leadership architecture that does not support the organization of an integrated patient-centered, outcome-focused, organized delivery system.

**Coach Principled Leadership™ Overview**

Coach Principled Leadership™ uses the powerful tools of coaching to help leaders effectively lead, and teams and individuals effectively perform, innovate, and adapt to ever-changing realities. Specifically, questioning and listening skills are developed and self-awareness increased in order to enhance the leader’s emotional and social intelligence. The outcome is an increased capacity to be present with the patient, curious about their perspective, and using a better-trained ear. An improved physician-patient relationship results in better overall patient care. Patients noted the hospital physicians “took the time to understand what I was saying” and “explained so I understood” my illness. The program emphasizes relationships between physicians, between physicians and patients and their families, and between physicians and other health care professionals (see Figure 2).

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**Figure 2. The alliance of relationships, resources, and results in Coach Principled Leadership™**

![Figure 2](image-url)
Coach principled leaders lead by

• providing support, challenge, and vision;
• demonstrating emotional and social intelligence, and cultural competency;
• effectively communicating through collaborative conversations;
• displaying mutual respect, mutual trust, and freedom of expression;
• showing curiosity by asking questions about other points of view; and
• listening intently for understanding and alignment.

THE IMPLEMENTATION

This case study describes a program to develop hospital-based physicians into physician-leaders at a large full-service hospital that is part of a $2 billion public and private health care system in the Midwest. There were ten participants in the three month program, all members of a larger 21-member hospitalist physician team. The ten members, who were representative of the larger group, were composed of seven physicians (hospitalists), a nurse practitioner, a clinic manager, and the hospital’s Chief Medical Officer.

Physician Leadership Development Program

The Physician Leadership Development Program (PLDP) was sponsored by the Chief Medical Officer and an external third party was contracted to deliver the three phases (see Table 1 below). Phase I, the Assessment Phase, had two parts. Part one was designed to define the program’s objectives by interviewing and coaching the Chief Medical Officer and the Chief of the Hospital Physician Program. There were two defined objectives. The first was to identify and resolve the issues preventing the hospital physicians from working effectively and communicating as a health care team, or to physician-physician integration. The second was to develop the hospital physicians as leaders serving as role models for the entire hospital’s medical staff, or to develop a physician leadership architecture. The second part of Phase I was an individual interview of the ten participants with the following four questions:

1. What does being a physician, nurse practitioner, or clinic manager leader mean to you?
2. What qualities must a physician, nurse practitioner, or clinic manager leader possess?
3. How does a physician, nurse practitioner, or clinic manager leader lead?
4. What are the opportunities and challenges for you as a physician, nurse practitioner, or clinic manager leader?

The second [objective] was to develop the hospital physicians as leaders serving as role models for the entire hospital’s medical staff, or to develop a physician leadership architecture.

1 A hospitalist is a physician who specializes in hospital medicine. They are by necessity hospital-based and treat inpatients.
Phase II, the Team Building Phase, occurred over a two-day weekend period held outside of the hospital work environment and consisted of four parts. The first part, the kickoff event, took place on Friday evening over an informal cocktail hour and dinner to introduce the agenda for the weekend program and to have the participants socialize outside the work environment. Frequently, due to the demanding work, health care practitioners rarely “know” their fellow workers. Additionally, and not infrequently, due to the necessity of working different shifts to provide 24 hour round the clock patient care, health care teammates rarely meet face-to-face. For these reasons, an initial social event seemed important to the group’s members.

The following morning began the second part of Phase II where team building, peer-to-peer collaboration exercises, and self-administered personality assessments in teams of two were performed. The concept of Coach Principled Leadership™ was introduced at the conclusion of part two, just before lunch. Again, it seemed important to allow the team to get to know each other outside of the work environment, thus the lunch was held in an intimate private setting to foster conviviality.

Part three began after lunch and focused on applying the collaboration and coaching skills acquired earlier to form an action plan to address the program’s objectives: effective communication of the Health Care Team and hospital physicians serving as physician leader role-models for medical staff. Part four began the following morning with a summary of the actions necessary to meet the agreed upon goals to fulfill the objectives and to assign participants’ specific roles to meet the program’s objectives.

The month following the weekend retreat consisted of Phase III, known as the Presentation Phase. During this time, the participants wrote the health care team’s documents to meet the program objectives, with us as coaches facilitating the process only when necessary. At the four week conclusion, the documents were presented to the remainder of the 21-member hospital physician team.

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<th>Table 1. The structure of the Physician Leadership Development Program</th>
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<td><strong>Phase</strong></td>
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Several problems areas were identified causing a lack of communication and cooperation between the hospital physician team. These were resolved with specific written policies generated by the coaching program’s participants.
IMPACT OF THE PROGRAM

Attesting to the impact of the PLDP on the hospital-based physician program and organization were two different groups of outcomes. The first cohort has completed their program and the second is still in the process of implementation. The immediate outcomes originated from the action plans developed during the PLDP.

Immediate outcomes

Objective I: Physician-physician integration. Several problems areas were identified causing a lack of communication and cooperation between the hospital physician team. These were resolved with specific written policies generated by the coaching program’s participants. Examples of written policies to improve communication between physicians that directly improved patient care are

- a Patient Hand-off Policy leading to improved patient continuity of care at daily and weekly shift changes;
- a Hospital Physician On-Call Scheduling Process that clearly defined on-call responsibilities leading to full staffing for all shifts; and
- a Patient Admission Process ensuring hospital physicians remained in the hospital throughout their entire 12-hour shift.

Additional proposals discussed to enhance physician-physician integration dealt with topics such as improving monthly hospital physician meeting attendance, raising patient satisfaction scores, and an enhanced new hospital physician orientation and re-orientation program. At the conclusion of this three month coaching program, the participants were writing policy to deal with these additional proposals.

Objective II: Develop physician leadership architecture. As a direct result of the coaching program, a policy was written to build a hospital and community awareness program of the hospital physician team, which served to focus attention on the hospital physician team members. Spotlighting the qualifications and accomplishments of the hospital physicians in the weekly hospital newsletter read by the staff, patients, and community is one example of calling attention to their leadership role in the medical center. Additionally, one can reasonably assume the written policies and proposals originating from the coaching program would exhibit the hospital physician team as an exemplary program in the hospital and thus, the members of the team as physician leader role models. Certainly the hospital physicians felt empowered due to the program as evidenced by comments such as “I am now proud to be a member of this team.” Physicians are quick adaptors at applying coaching skills and we have found
Coach Principled Leadership™ to serve as an excellent framework to develop physician leaders.

**Transformative outcomes**

During Phase III, program participants used newly acquired coaching skills such as providing challenge and vision, asking questions about other points of view, and listening for understanding and alignment. They began to question the fundamentals of the hospital-based physician program itself, posing questions like these:

1. Is the hospital-based physician program equitable to all participants? If not, how can we make it more equitable?
2. Who is the hospital-based physician program serving, us or our patients?
3. How can we make the program more patient-centered?

These questions, along with others, shook the foundation of the hospital-based physician program, resulting in an entirely new initiative to transform the program to better serve the hospital’s patients. At this time, almost nine months since the conclusion of the PLDP the framework of the redesigned hospital-based physician program is almost complete, and soon the implementation process will begin.

**CONCLUSION**

The Affordable Care Act of 2010 empowers physicians by encouraging the formation of Accountable Care Organizations and changing the physician’s role in the US health care landscape from that of a stakeholder to one of a stakeholder partner. The steps necessary in the successful transition to stakeholder partners for physicians is first, physician-physician integration into a cohesive group, followed by physician development to leadership roles. Our case study of a 10-member hospital physician leadership development program within a larger hospital-based physician group, illustrates the application of our coaching process, Coach Principled Leadership™, to facilitate both steps in the physicians’ transition. Two groups of outcomes resulted from this case report of our Physician Leadership Development Program. The immediately enacted group of outcomes clearly demonstrates physician-physician integration and the development of a physician leadership architecture. The second group of outcomes, redesigning the hospitalist program, illustrates the power of physician leadership architecture that can be based on and sustained by coaching principles.
REFERENCES


ABOUT THE AUTHORS

Michael Cassatly, D.M.D.

**Phone:** 561-747-8550  
**Email:** michael@medachieve.com

Dr. Michael G. Cassatly is a Board Certified Oral and Maxillofacial Surgeon, a graduate of the Columbia Coaching Program, and President of MedAchieve, a company providing business coaching solutions for the health care sector. His business acumen and 27 years as a practicing surgeon permit him to appreciate that coaching health care practitioners result in more successful patient outcomes and improved physician career satisfaction. Michael’s clients are physicians and health care organizations throughout the US.

Anne Power, Ed.D.

**Phone:** 513-600-2704  
**Email:** tuipower@aol.com

Anne Power holds a doctorate from the Department of Organization and Leadership at Columbia University. She has over 25 years of experience in coaching, organizational consulting, and leadership development. She currently is a faculty member at Columbia University’s Coach Certification program in New York.
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