Key Habits of the Successful Physician Director

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Chairman, Department of Surgery
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"Winning (Good patient care) is not a sometime thing; it's an all the time thing. You don't win once in a while; you don't do things right once in a while; you do them right all of the time. Winning is a habit. Unfortunately, so is losing."
Physician Director Responsibilities (shared, incomplete, but in order of importance)

- **Ensure quality** – the buck stops here
- Explain benefit of transplantation to leadership
- Build community and teamwork
- Correctly size programs/set staffing goals
- Manage physicians
- Help set and implement the vision for the center
- Assist in choosing and developing personnel across the center
Key Habits

- Take ownership
- Listen and communicate
- Develop processes and procedures
- Keep emotions under control
- Get help when needed
- Act decisively
- Be data driven, ensure data is accurate
1. Ensure quality

Quality is Job 1.
**Ensure quality – why?**

1) It is the reason the center exists and why everyone comes to work every day
2) Creates pride
3) Increases volumes
4) Lowers cost and improves contracting
5) Gives leverage
6) Publically reported – reflects on the institution
7) Prevents CMS/UNOS/Insurance ‘issues’
Quality – Take Ownership

• Ultimately the center can not survive with poor outcomes

And neither can the physician director!
What is Quality?

• Actual Quality: Can your group achieve a successful outcome with a given patient population more often than what would be expected?

• Perceived Quality: What do others think about the quality of your program?

• Reported Quality: How do UNOS, CMS, and insurance companies view your program?
A 65 year old man, Harley rider (lives to ride), with end stage liver disease from Hepatitis C, MELD 39, recently resolved SBP, worsening confusion receives a DCD liver from a 50 year old with hepatitis C, 40% steatosis. Family and staff understand high risk nature of the procedure and wish to proceed. Patient does well and is discharged home, treated successfully for hepatitis C. 9 months later crashes his motorcycle and is DOA.

<table>
<thead>
<tr>
<th>Type of Quality</th>
<th>Rating</th>
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<tbody>
<tr>
<td>Actual Quality</td>
<td>High</td>
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<tr>
<td>Perceived Quality</td>
<td>High</td>
</tr>
<tr>
<td>Reported Quality</td>
<td>Low</td>
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</table>
A 35 year old man with PSC undergoes liver transplant with a 31 year old healthy donor liver. There is a large bile leak on POD 1 which is managed with a drain. The patient becomes septic and develops multiple intra-abdominal abscesses. He is hospitalized multiple times over the year and spends 6 months total in the hospital.

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<tr>
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<tr>
<td>Reported Quality</td>
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An 11 year old previously healthy girl presents with a 3 month history of an abdominal mass. CT scan shows replacement of the liver by tumor with extension into the heart. Biopsy shows rare tumor thought to be curable with resection. Team is curtly informed of the plan and undergoes liver transplant on full cardiopulmonary bypass. Liver does well but the patient dies on POD 3 of a massive pulmonary embolism.

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<tr>
<td>Perceived Quality</td>
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<tr>
<td>Reported Quality</td>
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</table>
Quality – Listen and Communicate
Houston, we’ve had a problem
How do you know if your program has a problem?

A) The surgical director comes to your office and says: “I’m worried about my technical skills and I’ve made some errors recently. To be honest, the booze isn’t helping. Perhaps someone junior to me and more up on current practice could watch me and critique my surgical skills.”

B) The medical director comes to your office and says: “You know I’m getting older, I’ve made some judgment errors recently and, to be honest, the booze isn’t helping.”

C) None of the above
Quality – Listen and Communicate

Speak with people to figure out what is going on

Develop rapport and trust
Develop Processes and Procedures

• QAPI – The backbone of the program
  • Review all programs on a quarterly basis
  • Mandate attendance of stakeholders with decision-making authority
  • Be comprehensive
    • Outcomes
    • Process
    • Communications with patients and referring physicians
    • Regulatory compliance
    • Identification of common patient care problems
    • Finance
Most problem identification:

- Should come out of QAPI
- Can and should be fixed through QAPI with appropriate leadership, discussion, and dissemination
- Should not be learning about problems via CUSUM (bad), SRTR reports (worse), or insurance company letter (you always wanted to be a high school teacher anyway….)
Tools to Assess Program

- Internal monitoring of outcomes through QAPI
- SRTR results
- CUSUM reports
- UHC and other reporting structures
- Published literature
- Financial performance
In my program when we have a problem it is because:

1) We operate on the sickest patients

2) We take risks to benefit the patient that no other program takes

3) We have programs that no other programs have and they are not adequately risk adjusted

4) We got unlucky
Don’t do this though you may want to
Lake Wobegon...

where all the women are strong, all the men are good looking, and all the children are above average
• When there is a problem there is a problem
PRBC Use Two Years – Total RBC Per Liver Transplant for a Six-Month Period
# Adult Liver Outcomes, 6-month Increments

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Number</th>
<th>1 yr Graft Survival</th>
<th>1 yr Patient Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2011-06/30/2011</td>
<td>46</td>
<td>80.43%</td>
<td>82.61%</td>
</tr>
<tr>
<td>07/01/2011-12/31/2011</td>
<td>63</td>
<td>85.71%</td>
<td>87.30%</td>
</tr>
<tr>
<td>01/01/2012-06/30/2012</td>
<td>44</td>
<td>84.09%</td>
<td>88.64%</td>
</tr>
<tr>
<td>07/01/2012-12/31/2012</td>
<td>54</td>
<td>88.89%</td>
<td>88.89%</td>
</tr>
<tr>
<td>01/01/2013-06/30/2013</td>
<td>65</td>
<td>96.92%</td>
<td>98.46%</td>
</tr>
</tbody>
</table>
## Take back rate

<table>
<thead>
<tr>
<th>TIME PERIOD</th>
<th>TAKEBACK INDEX HOSPITALIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/11 – 6/30/11</td>
<td>16/47 = 34%</td>
</tr>
<tr>
<td>7/1/11 – 12/31/11</td>
<td>13/63 = 57%</td>
</tr>
<tr>
<td>1/1/12 – 6/30/12</td>
<td>11/42 = 26%</td>
</tr>
<tr>
<td>7/1/12 – 12/31/12</td>
<td>8/54 = 15%</td>
</tr>
<tr>
<td>1/1/13 – 7/1/13</td>
<td>9/64 = 14%</td>
</tr>
</tbody>
</table>
The Physician Director Role in Fixing Problems
A. Achieve Buy-In

- Communicate that there is a problem in the program using data, then more data from independent sources whenever possible.
  - We used data from UHC, UNOS, SRTR and CMS.

- Establish a vision for where the program needs to be and how to get there
  - Everyone at the table wants to be the best program in the country.

- Communicate the advantages of this new model
  - Higher volumes, better outcomes, increased contribution to mission of the medical center
<table>
<thead>
<tr>
<th>Administration</th>
<th>Anesthesia</th>
<th>Nursing</th>
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<tbody>
<tr>
<td>Naji Abumrad</td>
<td>Mike Pilla</td>
<td>Jerita Payne</td>
</tr>
<tr>
<td>Dan Beauchamp</td>
<td>Rickey Anderson</td>
<td>Chris Webb</td>
</tr>
<tr>
<td>Nancy Brown</td>
<td>Jesse Ehrenfeld</td>
<td>Cynthia Wheeler</td>
</tr>
<tr>
<td>Laura Butler</td>
<td>Shannon Kilkelly</td>
<td>Beth Adame</td>
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<tr>
<td>Roger Dmochowski</td>
<td>Ram Pai</td>
<td>Robyn Begley</td>
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<tr>
<td>Bill Furman</td>
<td>Amy Robertson</td>
<td>Beth Cline</td>
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<tr>
<td>Allen Kaiser</td>
<td>Jeff Waldman</td>
<td>Jackie Fowler</td>
</tr>
<tr>
<td>Mike LaPosada</td>
<td>Ann Walia</td>
<td>Ashlee Goodson</td>
</tr>
<tr>
<td>Walter Merrill</td>
<td></td>
<td>Jessica Lock</td>
</tr>
<tr>
<td>Wright Pinson</td>
<td>Quentin Eichbaum</td>
<td>Karin Mayes</td>
</tr>
<tr>
<td>Shea Polancich</td>
<td>Anne Neff</td>
<td>Andie McRae</td>
</tr>
<tr>
<td>David Posch</td>
<td>Pampee Young</td>
<td>Angela Mitchell</td>
</tr>
<tr>
<td>David Raiford</td>
<td></td>
<td>Marisa Neely</td>
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<tr>
<td>Warren Sandberg</td>
<td>Roman Perri</td>
<td>Carmen Vazquez-Marin</td>
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<tr>
<td>Marcella Woods</td>
<td>Joe Awad</td>
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<td>Ed Zavala</td>
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<tr>
<td>Blood Bank/Hematology</td>
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<td>Hepatology</td>
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<td></td>
<td></td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Establish Oversight</td>
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<td>------------------------</td>
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<tr>
<td>• Assemble a team with decision-making authority</td>
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<tr>
<td>• Should represent leadership at each level and be a highly respected and credible group</td>
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<td></td>
</tr>
<tr>
<td>• No big egos and people who give not suck energy</td>
<td></td>
<td></td>
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<tr>
<td>• Establish common goals</td>
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</tbody>
</table>
C. Develop a Plan

• What do we need to accomplish – vision
• How are we going to do it – management
• Our unique advantage in leading change is that most of us do this to help patients and this can be a motivating common goal
D. Communicate Ideas

- Be visible and available
- Monitor behaviors
- Lead by example
E. Implement Change

- Honestly examine your processes
- To achieve change, something has to change
- Some people will be unhappy about this
- Spend time deciding – once a decision is made, expect everyone will comply
- The system exists for the patients, not the providers
F. Gain Momentum

- Grab low-hanging fruit to show progress
- Communicate
- Communicate
- Communicate
G. Lock in Long-Term Changes

- Develop a culture which is responsive and willing to change
- Establish systems which encourage this
2. Explain the benefit of transplantation to senior leadership

- Advanced services
- Media attention
- Financial performance
- Case mix index
- Medicare cost report funds
- Generates need for services
Key Habits

- Take ownership
- Listen and communicate
- Develop processes and procedures
- Keep emotions under control
- Get help when needed
- Act decisively
- Be data driven, ensure data is accurate
Interacting with Senior Leadership

• Partner with your administrator

• Need to establish trust and rapport

• These are the people who are invested in your success but who also control the resources you will need

• Present data whenever possible

• Data is available including benchmarks, outcomes, organ use, financials, etc.

• Make your case based on data and vision
Financial Issues

• Your program should be making money unless:
  • You have a very small program or
  • Are doing high volumes of innovative treatments that are not reimbursed – this is a programmatic decision and everyone should expect poor financials
3. **Build community and teamwork**

- This is not a normal job
- People will need at times to do extraordinary things to care for patients
- Employee satisfaction and patient outcomes are linked
- Allows you to make changes and improvements
Key Habits

• Take ownership
• Listen and communicate
• Develop processes and procedures
• Keep emotions under control
• Get help when needed
• Act decisively
• Be data driven, ensure data is accurate
• “The show doesn’t go on because it’s ready; it goes on because it’s 11:30.”
  • Lorne Michaels discussing Saturday Night Live
Big mistake made by physician leaders

- Not allowing everyone to vote at selection committee meetings
- This undermines community and teamwork
4. Correctly size programs/set staffing goals

• What is the right size for your program?
  • Appropriate for the market and the resources expended
  • Larger than 25
    • Staff commitment
    • Familiarity
    • Call schedule
    • Fixed costs
    • Regulatory burden
    • Outcome burden
Key Habits

- Develop processes and procedures
- Get help when needed
- Act decisively
- Be data driven, ensure data is accurate
Correctly size programs

- Liver transplant center risk tolerance.
- Johnson SR, Karp SJ, Curry MP, Barugel M, Rodrigue JR, Mandelbrot DA, Rogers CP, Hanto DW.
- Abstract

Recent changes in Center for Medicare & Medicaid Services (CMS) condition for participation, using benchmark volume/outcomes requirements for certification, have been implemented. Consequently, the ability of a transplant center to assess its risk tolerance is important in successful management. An analysis of SRTR data was performed to determine donor/recipient risk factors for graft loss or patient death in the first year. Each transplant performed was then assigned a prospective relative risk (RR) of failure. Using a Monte-Carlo simulation, transplants were selected at random that met the centers' acceptable risk tolerance. Transplant center volume was fixed and its risk tolerance was adjusted to determine the impact on outcomes. The model was run 1000 times on centers with varying volume. The modeling demonstrates that centers with smaller annual volumes must use a more risk taking strategy than larger volume centers to avoid being flagged for CMS volume requirements. The modeling also demonstrates optimal risk taking strategies for centers based upon volume to minimize the probability of being flagged for not meeting volume or outcomes benchmarks. Small volume centers must perform higher risk transplants to meet current CMS requirements and are at risk for adverse action secondary to chance alone.
Help set staffing goals

• People need to be working to their highest level of training
• Need to right size the group.

Amount of work that gets done

Number of people
Help set staffing goals

- Too few people leads to burn out, poor working environment, departures
- Too many people leads to inefficiency, drama, and loss of focus
- Goal is a stable, content work force who are working hard
- Goal is not to run super lean
5. Manage physicians

• Herding cats
Key Habits

• Take ownership
• Listen
• Develop processes and procedures
• Keep emotions under control
• Get help when needed
• Act decisively
• Be data driven, ensure data is accurate
Manage physicians

- Competence
- Desire for autonomy
- Treatment of/interactions with staff
Beware of the Dinosaurs
Beware of the Dinosaurs
6. Help set the vision for the center

- What are the goals of the institution?
- What are the goals of the people?
- What institutional support do you have?
- What is the market?
- Are the vision and resources aligned?
Key Habits

- Listen
- Get help when needed
- Be data driven, ensure data is accurate
Assist in choosing and developing personnel across the center

- In terms of individual decision, these are some of the most important ones that need to be made
- What is the culture?
- How does the culture need to change
- The no $%^&*% rule
- ‘Personnel is Policy’
Medicine is (always) changing

- Financial stress
- Regulatory stress
- Public information

- But: We can do more for patients then ever before
• Toto we’re not in Kansas anymore
ORGAN TRANSPLANTS ARE BEST LEFT TO THE PROFESSIONALS
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Thank you!

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