ADVENTURES IN MEDICINE

Career & Life Planning

Survival Guide

Market Trends & Trials

Discovery Resource
ST-02
Your Market Guides:

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**The Governance Institute**

The Governance Institute serves as the leading, independent source of governance information and education for healthcare organizations across the United States. Located in San Diego, The Governance Institute serves over 11,000 trustees and CEOs through its membership services.
In This Stage: Market Trends & Trials

As any good anthropologist will tell you, understanding the people, landscape, language and culture you’ll encounter on this adventure is a prerequisite for success.

You’ll want to know the location of **DANGERS** and **PITFALLS**. The peaks and valleys. The smooth, safe path and the treacherous, rough rock.

In this stage, you’ll learn how hospitals and medical groups are changing, about the roles and responsibilities of those you’ll be working with and the pressures and economics that drive hiring decisions. You’ll learn how to enter the changing world of healthcare and map your **PATH TO SUCCESS**.

So let’s dig in.

P.S. Oh, by the way, they’ve had some rough luck recently, with a major earthquake impacting the landscape of healthcare.

Be alert. It’s a jungle out there.

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Changing Landscape of Healthcare

Throughout medical school and residency, you may have been exposed to or even experienced for yourself the **POLITICAL TURMOIL** and **SILO MENTALITY** that have been beleaguering many physicians in the hospital setting for a long time.

With the onslaught of rapid-fire change occurring within the healthcare industry, let’s gain a basic understanding of hospital structures that exist today and briefly discuss the new structures of tomorrow.

**TODAY: SILOS**

For decades, healthcare organizations have been operating essentially as **INDEPENDENT UNITS WITHIN A LARGER WHOLE**. With a few exceptions, hospitals and physicians function in separate worlds. Hospitals provide practice privileges for physicians seeking access to practice in the hospital setting. Those physicians make up the “independent medical staff,” and largely function as a group of individuals. The medical executive committee (MEC) typically is the interface between hospital administration and the medical staff.

This independence has been encouraged over the years since the advent of managed care in the 1970s, with the traditional payment structure in which physicians and hospitals are reimbursed separately for services, based on a fee-for-service payment schedule. This encourages doctors (and hospitals) to provide more services in order to get paid more — volume, not value. It does not provide incentives for hospitals and doctors to coordinate care.

Though physician employment in hospitals has increased over the past five years, the healthcare system overall is still very fragmented today, with thousands of independent providers — many in the same market area — duplicating services.
TOMORROW: SYSTEMS

Going forward, the need to **WORK TOGETHER** will cause the physical makeup of the hospital and medical staff to go through many changes and transitions, some of which have already begun. New physicians will find themselves in organizations in the midst of forming a new direction, with existing physicians seeking to protect their autonomy, and administrations seeking to engage physicians in care coordination.

Recently, The Joint Commission published new leadership standards in its *2009 Comprehensive Accreditation Manual for Hospitals* that refocused the leadership structure of healthcare organizations from silos to a comprehensive system:

“For many years prior to 1994, the standards included chapters on ‘Management,’ ‘Governance,’ ‘Medical Staff,’ and ‘Nursing Services.’ In fact, each department in the organization had its ‘own’ chapter of standards, as if the good performance of each unit — governance, management, radiology, dietary, surgery, and so forth — would assure the success of the organization. The Joint Commission sought the advice of some of the nation’s leading healthcare management experts and clinical leaders from both practice and academia to redesign this unit-by-unit approach. They were unanimous in their advice: stop thinking of the healthcare organization as a conglomerate of units and think of it as a ‘system.’ A system is a combination of processes, people, and other resources that, working together, achieve an end.

“If we want a healthcare organization to succeed, it must be appreciated as a system, the components of which work together to create success. It is not possible to determine what each component should be and do unless it is examined in the light of the goals for the system and the rest of the system’s components. For a healthcare organization, the primary goal is to provide high-quality, safe care to those who seek its help, whether they are patients, residents, clients, or recipients of care. While there are other goals for a healthcare organization, including financial sustainability, community service, and ethical business behavior, The Joint Commission’s primary focus is on the organization’s goals of providing high-quality, safe care to patients.”

As a result of this shift in thinking about the structure of leadership for healthcare organizations, The Joint Commission created a recommended leadership structure that not only included the governing body of the organization (Board of Directors or Board of Trustees) and an administrative staff (C-Suite), but also a team of physician leaders (licensed independent practitioners) who could speak uniquely to the clinical aspects of care that drive quality of patient care and safety. According to the white paper, “In a hospital, this third leadership group comprises the leaders of the organized medical staff. Only if these three leadership groups work together, **COLLABORATIVELY**, to exercise the organization’s leadership function, can the organization reliably achieve its goals.”

With the need for collaboration among the three leadership groups of a healthcare organization, the function and makeup of the medical staff will be very different. Hospitals will continue to be required to have a medical staff (of some form or another) to meet Joint Commission standards. The question will be how to comply with these regulations while making the transition to clinical integration and accountable care.
Medical Market Trends

There are many emerging trends impacting the business side of medicine. Whether you allow these market conditions to impact your relationships with your employer, patients, and/or your family will be determined how you react. Will you be a victim to the market conditions or be known to rise above by any market condition to fulfill your life and career goals?

<table>
<thead>
<tr>
<th>TREND</th>
<th>IMPACT ON:</th>
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<tbody>
<tr>
<td></td>
<td>Hospital Organization</td>
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<tr>
<td>Shortage of physicians</td>
<td>Access to care will be an acute issue as more uninsured and</td>
</tr>
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<td></td>
<td>underinsured patients are able to obtain health insurance and begin seeking care.</td>
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<tr>
<td></td>
<td>Recruitment efforts and integration models/incentives for physicians need to be a</td>
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<tr>
<td></td>
<td>top priority to attract needed physicians to the community.</td>
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<tr>
<td>Malpractice insurance</td>
<td>Hospitals have been implicated in malpractice suits for allowing the physician in question to have practice privileges. Hospitals are burdened to prove that they went through a rigorous credentialing process and show proof of documentation.</td>
</tr>
<tr>
<td></td>
<td>Hospitals and physicians must work together to educate patients about their care options and help them select appropriate care, rather than promoting overutilization of services simply to protect against malpractice.</td>
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</table>
**MARKET TRENDS & TRIALS**

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<tr>
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<tbody>
<tr>
<td></td>
<td>Hospital Organization</td>
</tr>
<tr>
<td><strong>Failed economy</strong></td>
<td>• Possibly tighter pressures on local hospitals to prove their tax-exempt status, especially if affiliated with a system corporation located in another region, as local governments may be seeking more revenues in places where they did not seek it before.</td>
</tr>
<tr>
<td></td>
<td>• For people who do have insurance, companies are increasing deductibles, so patients don’t go because they don’t want to pay deductibles, and when they do go, hospitals have a harder time collecting the money.</td>
</tr>
<tr>
<td></td>
<td>• Business closures, bankruptcies and foreclosures are all adding to the mix.</td>
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**REFLECTION:**

What impact might these trends have on your decision to practice medicine in your chosen specialty?

What’s your understanding of these trends? What have you heard or been exposed to?
The Big One: Healthcare Reform

There are three major shifts occurring related to healthcare reform: substantial increase in covered population, shifting Medicare and Medicaid financial risk to providers, and reduction in Medicare payment rates.

SUBSTANTIAL INCREASE IN COVERED POPULATION

About 16 million Americans will be added to the Medicaid program, and Medicaid reimbursements will be raised to Medicare levels for general internists, family physicians and pediatricians in 2013 and 2014.

Still, many doctors have no interest in this new pool of Medicaid patients. Throughout the country, some doctors are trying to lower their percentage of Medicare patients or even eliminate them entirely. Some doctors will also avoid the new Medicaid patients because they say that dealing with government insurance programs is a snarled tangle of frustrating paperwork.

Most physicians don’t have that choice. A lot of physicians operate on very short margins and are unable to cut their overhead. They get paid relatively little per patient visit and need to have volume. Yes, there are premier practices that won’t accept insurers offering less than Medicare rates, but they are the exception rather than the rule.

Although many primary care doctors are eager to start seeing these new patients, specialists may get the short end of the stick. The Medicaid reimbursement rate for them will not rise to Medicare levels.

SHIFTING MEDICARE AND MEDICAID FINANCIAL RISK TO PROVIDERS

The exploding interest in Accountable Care Organizations (ACOs) sparked by the health reform legislation represents a sea change in the way hospitals and physicians currently function. An accountable care organization is a clinically integrated healthcare provider (various models, including hospitals with an employed physician group, or a physician group that has contracted in some way with a hospital or health system) that assumes responsibility for the quality of patient care as well as the cost decisions behind that care, for a certain population.

The ACO will receive one “bundled” payment for an entire episode of care (from the initial doctor visits to the procedure in the hospital, to the follow-up visits, etc.). The ACO is then responsible for dividing that single payment across the various providers involved in the episode of care. In the short term, this will be played out as a pilot program for Medicare, and the bundled payments will vary depending on patient outcome (i.e., positive outcomes will receive higher payment; thus the ACO is accepting risk). In the long term, most experts assume that this will be the primary direction most payers will move towards, not just Medicare.
It will open up new **CHALLENGES** and **OPPORTUNITIES** for physicians in practice, and those in new leadership roles. Physician career paths will reflect calls to move into a new mix of clinical practice and leadership roles for such diverse positions as:

- Traditional medical staff leadership
- Health-system clinical care councils
- Care-management committees
- Clinical service-line management in hospital systems
- Health plan care management
- Medical directorships for many functions within integrated healthcare systems

**REDUCTION IN MEDICARE PAYMENT RATES**

Hospitals will receive lower reimbursements across payers. Immediate challenges are **MAXIMIZING EFFICIENCY** and **ELIMINATING WASTE** in care-delivery systems to maintain operating revenue and credit rating. They must position themselves to accept bundled payments and risk-based payments.

With regards to **INSURANCE**, changes in managed care, rising medical costs, and government regulations will no doubt impact insurance costs as well. In the short term, Medicare patients may find fewer doctors willing to accept them. In the longer term, payments will likely level out, and physicians will need as many patients as they can get, so fewer will be turned down based on insurance/payment levels.

Notably absent from healthcare reform was any mention of fixes to the **SUSTAINABLE GROWTH RATE (SGR)**, which determines physician reimbursement. Medicare reimbursements cuts — whether or not made at the full 21.2% as proposed — would be disastrous. Markets would lose long-term attraction of physicians into medical school, access to physicians could be constrained, and stand-alone physician practices would fall by the wayside as practices merge and join hospitals to gain economies of scale and to secure working capital for enhanced technologies, process improvements and staffing support.
OVERALL IMPACT ON PHYSICIANS

What do doctors stand to gain or lose in all of this? As people in a caring profession, many doctors are either truly or theoretically happy that about 32 MILLION more Americans will soon have health insurance. Yet physicians have every right to be concerned about their own livelihoods and medical practices. For some doctors, the healthcare bill will create burdens and opportunities. Others see no benefits, particularly specialists. And funding the reform — despite what politicians say — could portend an ominous future for physicians.

Although, physicians are likely to face the same pressures from the reform era as their colleagues, this guidebook provides you an opportunity to understand the landscape and take control of your mind and seek the solutions that align with your values.

- More public calls for improvements in CLINICAL QUALITY and better PATIENT SAFETY.
- More 24/7 PUBLIC REPORTING on the Internet of quality and cost-performance metrics.
- More REGULATORY OVERSIGHT from state and federal governments that constrains clinical decision making.
- SQUEEZE IN TAKE-HOME PAY as practice expenses rise and revenues are constrained.
- More MULTI-SPECIALTY GROUPS will be formed by and with hospitals in efforts to prepare for accountable care.
- Exploding demands to rely on ELECTRONIC MEDICAL RECORDS (EMRs) across care settings to better manage chronic disease.
- ACOs’ demand for clinical integration will move physicians into LEADERSHIP ROLES.
• Regulators and governing boards will demand more FORMAL ACCOUNTABILITY and development of physician leaders as a means to successful physician alignment.

• Will need more primary care physicians to COORDINATE with hospitalists.

• Physicians must be able to NEGOTIATE for their fair share around the table of the new ACOs.

The nation may therefore face the challenging irony of offering more coverage for more people, but having fewer physicians ready, willing and able to respond to the new needs and demands for care under the new reforms.

**Hospital Organization Structure & Practice Options**

• The following provides an overview of the connection points between PATIENTS, HOSPITALS, and PHYSICIANS in regard to hospital organization structure and practice options. By understanding each of the roles of senior leadership teams, Board of Directors, community, and how each practice setting is connected to the hospital will give you an understanding how an organization operates as well as providing you insight on what type of setting is the best fit for you.

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**HOSPITAL ORGANIZATIONAL CHART**

- **Patient**
  - **Board of Directors**
    - **Chief Executive Officer (CEO)**
      - **Senior Leadership Team (COO, CFO, CMO/VPMA, CNO, CIO)**
        - **Physician/Hospital Employee**
          - **Patient**
    - **Medical Staff**
      - **Practice Options**
        - Multi-Specialty Group (MSG)
        - Single-Specialty Group (SSG)
        - Solo Practice
        - Independent Contractor
        - Locum Tenens (Substitute Physicians)
      - **Patient**
ROLE DEFINITIONS:

- **Board of Directors**: The Board of Directors is responsible for strategic and generative thinking about the organization and its mission, vision and goals, and oversight of the organization's functions, especially its financial sustainability. The governing body has an additional fiduciary obligation to continuously strive to provide safe and high-quality care to the patients who seek health services from the organization. If the Hospital is a 501(c)3 not-for-profit — as most hospitals are — the governing body has a responsibility to benefit the community, often called “community needs.”

- **Chief Executive Officer (CEO)**: Responsible for quality of care and fiscal responsibility, including:
  - Providing information and support systems
  - Providing recruitment and retention services
  - Providing physical and financial assets
  - Identifying a nurse leader at the executive level who participates in decision making
  - Representing the hospital in the community
  - Speaking for the hospital in matters of regulatory, legislative and accreditation issues

- **Chief Operating Officer (COO)**: Responsible for the day-to-day operations (staffing, resourcing, service, plant and clinical equipment) of the hospital.

- **Chief Finance Officer (CFO)**: Responsible for the registration and billing of patients, negotiations with third-party payers, and management of all issues related to the balance sheet of the hospital (debt structuring, investment management, accounts payable, etc.).

- **Chief Medical Officer (CMO)/Vice President Medical Affairs (VPMA)**: Responsible for the effective organization of the medical staff structure, including the medical executive committee; together with the CNO, assures the quality of care provided and patient safety.

- **Chief Nursing Officer (CNO)**: Responsible for the effective organization of the professional nursing structure; together with the CMO/VPMA, assures the quality of care provided and patient safety.

- **Chief Information Officer (CIO)**: Responsible for building and maintaining efficient and cost-effective clinical and business information technology networks to support the day-to-day and strategic needs of the hospital.

- **Medical Staff**: Oversees the quality of care, treatment and services provided by those individuals with clinical privileges; self-governing but accountable to the governing body, who approves the medical staff structure, which conforms to medical staff guiding principles. There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirement.
PRACTICE OPTIONS:

- **Multi-Specialty Group (MSG):** A physician-owned group with more than three physicians with a minimum of two different specialities.
  
  - Pros: Trial period before commitment; less risk up front; minimal administrative and management duties; focus on clinical vs. business
  
  - Cons: Less autonomy; multiple partners may have different philosophies and priorities; higher stress to drive revenue and perform; chance of not being voted in as a partner; dealing with staffing, administrative and business issues; less stable, more volatility with income

- **Single-Specialty Group (SSG):** Two or more physicians within the same discipline. Generally, physicians are employed for one to three years, with a track to partnership.
  
  - Pros: Trial period before commitment; less risk up front; minimal administrative and management duties; focus on clinical vs. business
  
  - Cons: Chance of not being voted in as a partner; dealing with staffing, administrative and business issues; less stable, more volatility with income

- **Solo Practice:** Private practitioner who is solely responsible for decisions. Physicians can be supported by the hospital through an income-guarantee arrangement, or they can set up their own practice if they are self-funded or if they choose to leverage through a bank.
  
  - Pros: Complete autonomy, high reward
  
  - Cons: High risk; little back-up; high overhead; less stable, more volatility with income

- **Independent Contractor:** Similar to solo practitioners except that the physician contracts with a hospital or group to provide a service for a specific amount of money per year.
  
  - Pros: Flexible hours; work when needed or desired; opportunity to write off business expenses
  
  - Cons: Inconsistent hours and schedule; less security

- **Locum Tenens (Substitute Physicians):** This arrangement allows physicians to choose their own hours and the number of days they would like to work. The locum tenens organization plans out their work schedule and sends them on assignments.
  
  - Pros: Opportunity to travel; great schedule time; able to experience many different types of practices
  
  - Cons: Long-term travel can be wearing; many have to travel to undesirable communities; uncertain schedule; unstable income
REFLECTION:

Given current market trends and pros and cons of each practice setting, which one(s) appeal to you right now? Why?

Must-Have Physician Leadership Competencies

The swirling array of pressures for change and calls for medical care that is more accountable, more transparent, of higher value and better quality cannot happen without physicians. But perhaps the physicians of tomorrow will be different than the ones of the past. Physicians entering practice are likely to experience these factors in their practice reality:

- More likely employed in multi-specialty groups within **INTEGRATED HEALTHCARE DELIVERY SYSTEMS**

- Have a new **BALANCE** between the calling of a medical career and the calling of family and eclectic lifestyle pursuits

- Influence the health and healthcare of thousands of people a year through practice, but also through **LEADERSHIP ROLES** in many physician leadership positions

- Rely more on **MULTI-DISCIPLINARY TEAMS** of physician extenders for people with chronic disease

- Need to master **SOCIAL NETWORKING TOOLS** and **EMRs** to manage more engaged and assertive patient populations

Most new graduates will have received little preparation in medical school or residency for these new challenges and opportunities. Life long learning will not only apply to keeping pace with an explosion of **CLINICAL KNOWLEDGE** for the practice of medicine, but also a dizzying selection of **NEW TECHNOLOGIES** and **CONSUMER EXPECTATIONS** to deliver health gain as well as healthcare, as well as provide better value for the money and a superior patient care experience.

There has never been a more important time for physicians to step forward into leadership roles. The healthcare system is transforming and it is critical that physicians shape its future.
When choosing the type of practice and/or position that comprises the right fit, it’s imperative that you evaluate where you are at with each of these **COMPETENCIES** and strategically interview at Employers who can provide you the structure to help you grow into these roles professionally. To self assess these competencies, set some time aside to walk through the exercises on page 48 and 49.

- **Patient Centric.** Leaders in healthcare will need to focus more on the patient than ever before, even with the “system perspective.” A good physician leader will **UNDERSTAND** and effectively **COMMUNICATE** the impact on the patient for every decision being made.

- **Business Acumen.** Physicians will need a working knowledge of the world of medicine from a business perspective. Cost drivers, financial implications and ability to make decisions that have a **POSITIVE IMPACT** on the organization and patient satisfaction represent key outcomes.

- **Team Focus.** Physicians are part of a team, and a good physician leader is a true **COLLABORATOR** and builds **COHESION** with aligned goals across physicians, administrators, patients, payers and other stakeholders. An important part of this competency is being able to communicate effectively to non-physician leaders the importance of physician input in a large organization such as a hospital or health system.

- **Facilitator of Change.** Like any leader in any type of organization, a physician leader must be able to facilitate change, seek out differing points of view, encourage active discourse, and **BRING OUT THE BEST** in his or her team.

- **Systems / Strategic Thinking.** A physician leaders needs a “system” perspective — understanding the roles of the physicians and other care providers inside a complex system of processes, people, and care delivery. The physician should be able to develop a **STRATEGIC MINDSET** and **METHODOLOGY FOR LEADING COMPLEX ORGANIZATIONAL SYSTEMS**.
**SELF-ASSESSMENT: PHYSICIAN LEadership COMPETENCIES**

Complete the following assessment to determine areas of strength and areas of development. This does **NOT** mean that you need to or will be competent in all areas. The goal is to identify areas for **PROFESSIONAL DEVELOPMENT** and determine what type of Employer is most likely going to provide the support for you to grow as a physician. Add the individual items to get a total score for each competency.

### PATIENT CENTRIC

<table>
<thead>
<tr>
<th>Item</th>
<th>Weakness</th>
<th>Strength</th>
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<tbody>
<tr>
<td>I show empathy and match my feelings with those of another person in an interaction.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I am able to develop a high level of trust with my patients.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>Patients feel comfortable sharing their health concerns with me.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I can easily meet and initiate conversations with new people when necessary.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I am a strong communicator (listening, responding, explaining, etc.).</td>
<td>1 2 3 4</td>
<td>5</td>
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</table>

**Total score**

**Level of importance to master in the next one to three years**

<table>
<thead>
<tr>
<th>Level</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
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### TEAM FOCUS

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<tr>
<th>Item</th>
<th>Weakness</th>
<th>Strength</th>
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</thead>
<tbody>
<tr>
<td>I am able to effectively work in a team environment.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I don’t allow my ego to get in the way of making team decisions.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I am a strong collaborator with colleagues, staff, and hospital administration.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I speak up about the things that I would like others to be open about with me.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I feel comfortable addressing conflicts as soon as they arise.</td>
<td>1 2 3 4</td>
<td>5</td>
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**Total score**

**Level of importance to master in the next one to three years**

<table>
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<th>Level</th>
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<th>Low</th>
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### BUSINESS ACUMEN

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<tr>
<th>Item</th>
<th>Weakness</th>
<th>Strength</th>
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<tbody>
<tr>
<td>I am able to develop and implement strategies and goals.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I understand the healthcare industry and the basic structures/processes of a hospital or health system.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I understand how a physician private practice connects/aligns with the healthcare system as a whole.</td>
<td>1 2 3 4</td>
<td>5</td>
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**Total score**

**Level of importance to master in the next one to three years**

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<tr>
<th>Level</th>
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**SYSTEMS/STRATEGIC THINKING**

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<tr>
<th>Competency</th>
<th>Weakness</th>
<th>Strength</th>
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<tbody>
<tr>
<td>I am able to think and make strategic and tactical decisions.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I think of new ways to approach a problem from a process perspective.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I am able to work in a complex hospital/practice setting.</td>
<td>1 2 3 4</td>
<td>5</td>
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**Total score**

**Level of importance to master in the next one to three years**

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<th>High</th>
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**FACILITATOR OF CHANGE**

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<thead>
<tr>
<th>Competency</th>
<th>Weakness</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>I show patience with my staff when implementing a change, knowing that there is an adjustment period.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I am able to adapt to change in procedures, medical advances, healthcare requirements, etc.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
<tr>
<td>I am open to the ideas and perspectives of others.</td>
<td>1 2 3 4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Total score**

**Level of importance to master in the next one to three years**

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<tr>
<th>High</th>
<th>Medium</th>
<th>Low</th>
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Gaining knowledge and skill in these competencies will enhance your clinical/technical abilities over time. Choose one of the competencies you ranked high in importance to master, and respond to these prompts:

**COMPETENCY:**

<table>
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<tr>
<th>List concerns you might have with this competency overall:</th>
<th>What's at stake if you ignore items that reflect areas of weakness?</th>
<th>List growth opportunities:</th>
</tr>
</thead>
</table>

Identify one to two action items to work on over the next one to three years.
Stage 2 Action Checklist

Make sure you have completed these tasks by the end of this stage:

- Consider how market trends and healthcare reform might affect you in your practice.

- Identify which leadership competencies you need to develop further.

“The jack-of-all-trades seldom is good at any. Concentrate all of your efforts on one definite chief aim.”

— Napoleon Hill