FROM THE GUEST EDITOR

John M. Park, MD
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Don Berwick, the former president of the Institute for Healthcare Improvement, once likened the modern health care to building a car. In both cases, simply having great components is not enough. What if we tried to build the world’s greatest car by assembling the world’s greatest car parts? We would connect the engine of a Ferrari, the brakes of a Porsche, the suspension of a BMW and the body of a Volvo. What we get, of course, would be nothing close to a great car but a pile of very expensive junk. Similarly, if we want our patients to receive the best care possible, not only we as surgeons must do a great job, but also a collection of other components

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FROM THE EDITOR

Elizabeth B. Yerkes, MD

Leaders are both born and made, perhaps with a genetic predisposition to give off that “follow me” pheromone but also shaped by experiences and effort to achieve the organization’s goals. Many thanks to John Park for conceiving this Edition of Dialogues in Pediatric Urology, sharing his own path and experience, and for collecting and sharing the wisdom of Marty Koyle, Steve Docimo and Pat Cartwright!

Some of us, perhaps, should not or will not lead a large group during our professional lifetime, but there are still many people-pearls to appreciate in this Edition of Dialogues! Whether your next role will be as cub scout den leader, family reunion organizer, conference planner, Residency Program Director, Division Head, Surgeon in Chief, Chief Medical Officer or Chief Executive Officer, there is something to learn from our peers who have answered the call and responsibility of leadership.

Clearly the level of risk, frustration and satisfaction will vary amongst these roles, but all are laudable. The degree to which you may have to modify your clinical activity is a huge commitment to the greater good, particularly while still “in your prime” clinically.

Rather than our typical callout quotes from the text, I thought I would share a few of my favorites, in no particular order:

“Yet big ideas for change with individual stockholders separately first instead of at a big joint meeting.”

“...executive leadership at its best shuns the credit-taking ceremony”

“...surgeons may be a particularly good fit for [leadership] roles, as they tend to be decisive and less risk-averse than other physician types”

“[leadership] is an art that takes as much education and practice as innate talent”

“...acquiring knowledge and skills related to the business of medicine can be valuable for any practitioner and can provide gratifying experiences.”

“Never undermine others. No gossip. No blaming.”

“Leaders require a vision for what we can become...of equal importance is the transparency and ability to communicate such visions.”

“Get to know the PEOPLE FIRST, then the issues…”

Are YOU ready?
From the Guest Editor  (continued from page one)

– hospitals, clinics, operating rooms, administrators, other medical specialists, and nurses - has to somehow mesh and function effectively. In modern medicine, we depend increasingly on complex systems of people and technologies, and making them work together for the benefit of our patients remains one of the biggest challenges. In such systems, effective leadership that brings these parts together matters more than ever. Even as we discover new and innovative approaches in the care of our patients, these advances in knowledge must be applied by a collection of a vast team of people, working together under a great leadership.

During the last few years, I have had a privilege of learning and growing in leadership role as the Surgeon-in-Chief of the C. S. Mott Children’s Hospital at the University of Michigan. I discovered that beyond what I could control as a pediatric urologist – attempting the best hypospadias repair, orchidopexy and extrophy closure, etc. – I depended upon a complex system of components that are beyond my control working harmoniously, in order for my patients to receive the best outcome. I have come to appreciate the value of great leadership for an organization, whether it is a small division of handful of surgeons or a multibillion-dollar health system.

Leadership, in its simplest definition, is having a positive influence on a team of complex and diverse people with varying skills, experience, and backgrounds in such manner that they are aligned and move toward a common goal. I have come to learn that it is an art that takes as much education and practice as innate talent. There is a proverb that says, “If you think you are leading but no one is following, you are simply walking.” Leadership is not unique to pediatric urology, but for our field to continue to grow and thrive on the shoulders of our founders and predecessors, we should seriously value and invest in developing future leaders in our field who can align us as much as investing in developing new surgical skills and making scientific discoveries. In this unique, perhaps unusual, edition of Dialogues in Pediatric Urology, I invited some of the key leaders in pediatric urology who have mentored me to share their wisdom on leadership.

Why Leadership Matters To Pediatric Urology

Martin Koyle, MD
Professor of Surgery, University of Toronto, Chief, Paediatric Urology, The Hospital for Sick Children

We are all to some degree, products of our own environment(s). Having trained back in the 1970’s-80’s, it was an era, especially in urology, of primarily male surgical trainees, who followed orders dogmatically from those senior to us, ordered test after test without attention to costs, and where we lacked evidence for many of the common entities that we treated. It is now the era of evidence based medicine (EBM). In fact, the British Medical Journal has gone so far as to state that since its inception, EBM represents one of its 15 most significant milestones.1 However, surgical decision-making within the operating room is often based on “experience-based” medicine. It has been acknowledged that surgeons can be faulted for following a practice simply because that is the way they have been taught.2 It is safe to say that most of us surgeons are reluctant to change.

With escalating health costs in the Western world, the operating buzzword today is “value”. Simply, value represents an equation of quality/cost (V= Q/$). We are being measured more than ever before on accountability and outcomes. Realistically, however, the impacts of longevity and patient complexity and rapid advances in medical (e.g., Robotics) and non-medical (electronic medical records - EMR) technology have the greatest influence on costs. As doctors from my era, we have relished our independence, while functioning in random and relatively disorganized systems. Conflict resulted as external forces eroded our autonomy. Who hasn’t heard a colleague complain about the EMR, coding, billing, this “new system” or checklist, and other “non-medical” necessities, that now control a great part of our professional lives?

Leadership has been thought to be both an inherent and a learnable commodity. Suffice it to say, not all individuals can become (great) leaders and not all leaders are exemplary managers. Leaders require a vision for what we can become, rather than maintaining the status quo. Of equal importance is the transparency and ability to communicate such visions. This engenders the dissolution of barriers and silos, enabling trust and a concept of team over individuality. The necessity for leadership in medicine is certainly not unique to pediatric urology. However, without effective leadership, the likelihood of being “influential players” in the evolving landscape of healthcare is lost. Whether we like it or not, metrics (pay for performance, rather than volume) is a reality. Performance and outcomes, and hence benchmarks, are very difficult to quantify at a macrosystem level, but it would be to our benefit to establish baselines for Pediatric Urology. At macrosystem levels, PHIS and NSQIPS are tools that are already in place to address institutional data and outcomes. If we return to the concept of value, the more we work as a group and a “team” (yes, I recognize that we compete, have rivals, and not everyone is the other’s best friend!), the more we can provide representative global data on outcomes and positively affect dollars expended, the more likely we are as a specialty to improve and be recognized. This requires organization, and hence effective leaders who understand and embrace the new metrics, rather than resist external changes that are already becoming major driving forces. This is not as easy as it seems, given human nature that resists change. It is important to reflect sociologically, rather than medically, when analyzing the impact of diffusion of innovation and change. Rodgers described 5 characteristic stages related to Diffusion of Innovations that create an “S” curve, based on drivers and barriers to change. An innovator can almost always find someone to jump on his bandwagon, i.e., “early adopter”. The key, however, is then engaging the 2/3 of stakeholders who represent the early-late majority. Lastly, there will always be the naysayers or laggards or late adopters. (Figure 1).3 Don Berwick has focused on Rogers concepts of Diffusion of Innovations, as it relates to healthcare. He has aptly stated: “Health care is rich in evidence-based innovations, yet even when such innovations are implemented successfully in one location, they often disseminate slowly - if at all.” In his book “The Tipping Point”, Malcolm Gladwell simplifies this notion by identifying the 3 traits required to set a process into motion:, the “Maven” (the idea person who gathers he infor-
Why Leadership Matters

(continued from previous page)

I have been privileged to have been influenced positively by outstanding leaders and innovators in my 3 decades of pediatric urology practice (Retik, Duckett, Ehrlich, Bloom, Ransley) as well as my peers and trainees, but have also learned negatively by witnessing others who have been autocratic and self-serving. The history of Pediatric Urology as a defined specialty, and ultimately in the USA, the acceptance of Pediatric Urology by the ABU with a certificate of added qualification (CAQ), attests to such quality leadership within Pediatric Urology. With effective and genuine leadership, we can engage our colleagues and other stakeholders in positive changes that will improve health care quality. In order to sustain and catalyze further changes as the systems evolve, as Hayes has advocated, it will be our working “smarter, not harder!” that drive our successes. Codman, a century ago defied the status quo, leaving Harvard University and the Massachusetts General Hospital, and pioneered hospital reform while addressing the importance of outcomes. His advocacy for enhancing quality led to today’s Morbidity and Mortality rounds, the American College of Surgeons, and the Joint Commission. The young Pediatric Urologists of today are learning different skills than my peer group did 30 years ago. Their leadership skills must be cultivated and promoted intentionally with an investment mindset.

“Leaders must encourage their organizations to dance to forms of music yet to be heard.” - Warren Bennis

Bibliography

Figure 1: Rodger’s Diffusion of Innovation. (From Wikipedia)

Why Physicians Should Lead The Healthcare Transformations

Steve G. Docimo, MD
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UPMC Physician Services Division, Professor of Urology, The University of Pittsburgh School of Medicine

The pediatric healthcare market is changing. These changes include regionalized health care resources, with consolidation of inpatient services to large tertiary and quaternary care centers, contrasting with ambulatory specialty services delivered over a wide geographic area. Primary care offices are adopting robust care coordination models to become patient centered medical homes, but at the same time, more care is being delivered in urgent care centers, retail outlets and online. Changes in the insurance marketplace, particularly a significant shift of the financial burden for healthcare services to the consumer, are resulting in price consciousness that is unprecedented in the United States. And most significantly, the government, which is rapidly becoming the payer for the majority of patients, has signaled that the transition to payment based on advancing population health rather than the volume of services rendered is rapidly approaching.

In response to these and other changes, both insurers and hospital systems are scrambling to consolidate to create economies of scale and market power. Most Children’s Hospitals and many pediatric physicians are now part of these larger health systems—like the Children’s Hospital of Pittsburgh of UPMC, a 600+ million-dollar enterprise that is part of a 12-billion-dollar integrated delivery and financing system (healthcare delivery and insurance vehicle all rolled into one). But children’s healthcare services and adult healthcare services are being pulled in very different directions in many markets, creating tension within these systems. Health care reform and the transition to risk based payment systems (bundled payments, pay-for-performance and continued on next page)
capitation, for example) leave traditional large healthcare organizations, particularly academic medical centers, feeling cumbersome and outdated. In the new world, these large adult healthcare centers compete fiercely for patients, particularly through cultivating networks of primary care physicians (something most Children’s Hospitals did long ago). The need for adult subspecialists seems to be waning, creating lower physician job security than at any time in our past, while children’s hospitals still face specialist shortages. Traditional academic departments and divisions are giving way to care delivery models organized around disease processes and service lines in order to provide the highest quality and most cost efficient care, but disease processes and service lines are quite different in the adult and pediatric worlds.

The overriding goal for both adult and pediatric health systems will no longer be to maximize services provided, particularly in the inpatient setting, but to advance the health of the entire served population through coordinated and optimized patient contact throughout the spectrum of care. While advancing the health of the population is clearly the right thing to do, we still live largely in the age of fee-for-service payments and therefore the financial viability of physician practices and health systems is negatively affected by increasing health and decreasing the need for acute services. The next decade will witness a careful dance between providers and payers, both trying to maximize revenues while shifting to a population health paradigm, and only the nimble will thrive through and beyond this transitional period.

Does all of this sound daunting, and a little pessimistic? Daunting, maybe, but the outlook for healthcare, particularly pediatric healthcare, has never been better. Let me give a few examples:

First, let’s look at patient safety. The likelihood of a child coming to harm as a result of seeking healthcare services is lower than it has ever been, and will certainly continue to decrease. The Children’s Hospitals’ Solutions for Patient Safety (SPS) Network is one example, consisting of more than 80 pediatric medical centers sharing data and best practices to reduce patient harm. To date, the consortium has significantly reduced the rate of ten hospital acquired conditions: examples include reducing adverse drug events causing harm by 42%, catheter-acquired UTI by 45%, ventilator associated pneumonia by 47% and Falls by 81%. Overall, from baseline rates, 4,746 children were saved from serious harm as of June, 2015, at an estimated savings in healthcare services of more than $92 million (http://www.solutionsforpatientsafety.org/our-results/).

Second, the availability and sharing of data generated through electronic health records and registries have begun to result in the rapid increase in quality of care and outcomes in a number of chronic disease states. One example is ImproveCareNow, a large pediatric program that started as a quality improvement registry for Crohn’s disease, and now is a true network-based Learning Health System with data automatically updated through template documentation in three major electronic health records. As of March, 2015, the network consisted of 73 centers, and data from more than 8200 children with Crohn’s disease were included. The power of such networks is tremendous, with evidence that they can obviate the need for expensive and difficult randomized control trials to answer many questions rapidly with improved outcomes for the participants (EGEMS (Wash DC). 2015; 3(1): 1168.; Pediatrics. 2014 Jul; 134(1): 37–44.).

Finally, the promise of population health is exciting, even if unproven in most pediatric settings. One example is asthma care, where there is evidence that the ratio of asthma-controller prescriptions filled to all asthma prescriptions filled correlates with asthma exacerbations (www.pediatrics.org/cgi/doi/10.1542/peds.2015-0809), suggesting that relatively straightforward care coordination and care pathways might significantly decrease the morbidity of chronic disease, and the need for acute care services.

So, how did I have the vision and wisdom to transition to a leadership career at such a momentous time? Unfortunately, no vision or wisdom was involved—I was asked to step in to fill a sudden vacancy for what I assumed was a temporary assignment. I think that many physician executives in the authors’ generation either migrated or were thrust into leadership roles on the basis of right time, right place and a willingness to get involved. Most of us have little formal training in business or leadership—I finished a Masters of Medical Management just two years ago and well into my executive career. Once given the opportunity to look up from a busy surgical practice and participate in the decision-making process—“having a seat at the table” (or being “in the room where it happens” for you Hamilton fans)—we can become as interested in the administrative challenges of medicine as we are in the clinical challenges. Whether or not one aspires to a physician executive role, acquiring knowledge and skills related to the business of medicine can be valuable for any practitioner, and can provide gratifying experiences.

There is a major difference between contributing as an executive leader and contributing as an academic physician. The latter requires claiming credit for accomplishment in order to advance one’s career, while executive leadership at its best shuns the credit-taking ceremony. Leading change, particularly in a complex and skill-based industry like healthcare, requires the willingness to be in the background, enabling others to do the right thing and making sure they get credit for it. Another difference is the need for communication. We are trained to be individual contributors, forging ahead to do what we believe is in the patient’s interest while informing only those who need to actively participate, often through direct orders. An executive needs to communicate continuously at all levels as there is no individual contribution. Most of us who transition from clinical medicine learn this lesson the hard way, often several times, before we get the hang of it. These skills are valuable whatever one’s role, so I would encourage everyone with any interest to seek leadership experiences, and identify strong mentors to guide along the way. I have found the opportunity to influence the care of thousands of children, as opposed to one at a time, to be equally fulfilling and endlessly challenging.

Clearly, the pediatric health care sector faces unprecedented challenges as business structures, payment models, consumerism and the demand for population health focus dramatically alter the landscape. At the same time, we are at what appears to be the greatest inflection point for the quality of health care since the Flexner report. The need has never been greater for physician leaders who commit to developing an understanding of business principles, but can combine that knowledge with what only they bring to the table: a comprehensive understanding of health and disease that is shared by no other discipline. There has never been a more exciting and important time to foster physician leadership.
Leadership Lessons Learned Within Complex and Integrated Health Care Entities

Patrick C. Cartwright, MD
Professor and Chief, Division of Urology, University of Utah Medical School
Surgeon-in-Chief, Primary Children’s Hospital

John and I have talked before about the challenges faced by those helping to lead complex health care entities (including departments, clinics, hospitals, health care systems, payors, etc.). Not only is it challenging to help lead an organization at baseline, given the current climate of health care changes, there is little doubt that we all—as members of these entities—must retool and work differently than ever before, both by restructuring internally and considering new external partnerships. Now there’s a challenge!

In terms of background, my own exposure in leadership has come mainly in my roles as a faculty member (Chief of Urology and Interim Chair of Surgery) at the University of Utah (U of U) and as the Surgeon-in-Chief of Primary Children’s Hospital, which is operated by Intermountain Healthcare. The U of U and Intermountain are serious competitors in the adult care market, while on the pediatric side, the U of U faculty account for 95% of admission to Intermountain Primary Children's Hospital. The University is a typical large academic institution, while the Intermountain Healthcare includes 23 hospitals with its own distinct corporate culture. This all makes for a truly complex integration of varying entities! As the Surgeon-in-Chief, I view my job(s) as helping our children’s hospital make decisions that will assure that children get the best possible and most cost-effective surgical care and that my colleagues who work at the Primary Children’s Hospital get the best of what both Intermountain and the U of U have to offer.

Since I am not sure how to best give you my thoughts, advice, and hard-earned lessons, maybe I will simply approach it as if you had come to me and said, “I have been asked to lead my large faculty group as it merges with another Department and seeks to partner with several hospitals. Any advice?”

The first thing I would recommend is try and be sure that there are good physician leaders involved on all fronts. We as physicians know the territory of health care in a unique way and are best positioned to help keep complex systems on track for giving the greatest care at a reasonable cost. And there is good bit of data out there that organizations with physician CEOs are the most successful by many measures. My own personal view is that surgeons may be a particularly good fit for such roles, as we tend to be decisive and less risk-averse than other physician types. And everybody knows that urologists are the happiest and most communicative of all surgeons! That’s why we have so many urologists in leadership (unproven personal theory).

Next thing, if you happen to be one of those physicians leading in a complex and integrated system, you must come to the point of being “all in.” You know how a resident working with you finally makes the transition from simply “being on the service” to acting like they “are the service?” That is the idea. You have to assume a genuine accountability and you can’t undermine or blame others for leadership decisions. This is difficult when you first start out, but it becomes important as the entity gets progressively more complex, since there are so many people out there that you could blame when the outcome becomes less than optimal. If you want to lead it, you must believe that the mission and vision of the organization are truly worthwhile and that you can be “all in” in a way that can bring others along. Such demonstration of integrity and transparency is what will also help you weather the tough times and stand for success.

Once you are all in, make effort to truly understand the culture that exists in all the different parts of your system. What do they value? How do they go about getting things done? Who do they work well or poorly with? How do they make decisions? Who are their thought leaders? What is their risk tolerance and willingness to change? You must know what all the constituent parts are, and that involves genuine listening and going around repeatedly to do it.

Here is a simple listing of some leadership ACTIONS that I have learned and still keep learning in dealing with a big system that has lots of moving parts and is ever changing:

1) Get to know the PEOPLE FIRST, then the issues, then the operations—it’s always the people first, because without them, you go nowhere. People buy in to the leader and then the vision.
2) Work to understand and build the common and shared mission and vision.
3) Be able to make a strong case for why your complex system has value and why people should get on board and support it.
4) Be transparent in everything possible.
5) Be inclusive whenever possible.
6) Vet big ideas for change with all stakeholders separately instead of at a big joint meeting.
7) Focus discussions on issues and opportunity instead of personal failures.
8) Always stand for the ability of the organization to succeed.
9) Talk in person about anything really important rather than emails.
10) Communicate frequently. (This is an area of continued personal failures.
11) Never undermine others. No gossip. No blaming.
12) Work to reframe conflicts and challenges into opportunity for better outcomes.

Finally, leadership can be summed up as “facing the brutal facts and still keeping the faith.”
“Inside C.S. Mott Children’s Hospital”: Getting to Know You

Is there an interesting story behind the name of your hospital?
Our Children’s Hospital is named to recognize the generous philanthropic gift given by late Charles Stewart Mott, a businessman, philanthropist and former Mayor of Flint, Michigan. The “Unofficial” story is that Mr. Stewart received an outstanding care for his BPH by the renowned urology chief at Michigan, Reed Nesbit, and out of his gratitude, he was inspired to make a gift to the University of Michigan pediatric care per Dr. Nesbit’s urging. The original hospital opened in 1969, and the new C. S Mott Children’s Hospital opened in December 2011.

How many beds in your hospital? 348 beds

Regarding your Program:

Parent Urology Institution:
University of Michigan Department of Urology

Is that a Department or Division of Urology?
Department

What is your relationship to the parent program?
(all one group in all regards; academic appointment but no financial relationship, clinical adjunct faculty, etc) We are all in one group as a department.

Pediatric Urology Division Head:
John Park

Fellowship Program Director:
John Park

How many years have you had a fellowship (include years that pre-date ACGME)?
We trained few fellows many years ago (such as Julian Wan and David Bomalaski in mid-80’s). We were recently recertified in 2013 by the ACGME. We recruit and train one fellow every 3 years (one year clinical and two years in health services research with an integrated Masters degree and funded fellowship by the NIDDK). Our program aspires to bring the outstanding HSR and clinical research aspect of our department to the field of pediatric urology, while seeking a right balance of our departmental resident-fellow education and the manpower issue of pediatric urology.

Who are the full-time (clinical) pediatric urologists in your group:
John Park, Julian Wan, Vesna Ivancic, Kate Kraft

Do you have any part-time pediatric urologists? (please name and indicate what they do with nonclinical time)
David Bloom (Department Chairman)

Briefly, what is your basic science research niche(s)?
None at this time

How many cases did your group do last year (all sites)?
1500

If physician extenders are part of your group, how many and briefly how they function in group:
We have two full time nurse practitioners. They see their independent clinics, focusing primarily on bladder and bowel dysfunction and other non-surgical UTI management issues.

Describe your practice structure/model: (choose any combination of these or others: academic, private, multispecialty, corporate/healthcare system):
Academic

Describe your pay structure: (choose salaried by hospital/organization/government, salaried by group, productivity-based):
Salaried faculty in a department

What are you best known for clinically? (one, please)
Medical and surgical management of complex neurogenic bladder and bowel dysfunction

What else do you think you should be/will be known for? (two only, please)
We are part of well-established multidisciplinary DSD (Disorders of Sex development) team

Describe the flavor of your group/program in four words or less:
Patient focused, compassionate, team-based, collaborative