Wanting to “Be” in a Job Differs Significantly from Actually Wanting to “DO” the Job

Larry R. Kaiser, MD, FACS
The Lewis Katz Dean, Lewis Katz School of Medicine at Temple University
Sr. Executive VP for Health Affairs, Temple University
President and CEO, Temple University Health System
What I Hope to Accomplish

• Challenges that I face and a few of the challenges inherent in healthcare today
• Some thoughts about leadership and self-awareness
• Recognize the difference between wanting to “be” in a job and actually wanting to “do” that job
• Talk about leading yourself
• Not sure that it’s a valid assumption that any of you desire to do anything more than be a chair of surgery
My Own Path

• John Rhea Barton Professor and Chair, University of Pennsylvania School of Medicine, 2001-2008

• President, University of Texas Health Science Center at Houston and Alkek-Williams Chair, 2008-2011

• The Lewis Katz Dean, Lewis Katz School of Medicine at Temple University; Sr. Exec. VP for Health Affairs, President and CEO, Temple University Health System, 2011- present
Temple Health
Total Revenues of $2.0 Billion

Academic Health System + Fox Chase Cancer Center + Health Partners Plan (partial ownership)

- 1,000+ beds at four hospitals
- Lewis Katz School of Medicine
  - 961 students
- 700+ physicians
- Urgent Care, Ambulatory Care & Transport Team
- One of only 44 NCI designated comprehensive cancer centers in the country
- Founding member of the National Comprehensive Cancer Network (26 members)
- Not-for-profit HMO with over 40 hospitals, 6,400 physicians, 257,000 Medical Assistance & 15,000 Medicare members
- $1.5B in Premium

Total Revenues of $2.0 Billion
Philadelphia County

- 23% of adults smoke
- 31% are obese (BMI greater or equal to 30)
- 29% are inactive (adults with no exercise)
- 17% drink heavily or binge
- Chlamydia rate 1332/100,000 adults (3x national rate)
- Teen births 56/1000 females age 15-19 (2x national rate)
- Children living in single parent households 59%
- Housing issues (overcrowding, high cost, lack of kitchen or plumbing) 24%
- Average income: $37,000
- Persons below the poverty level: 26% (13% in PA)

www.countyhealthrankings.org – RWJF and UWPHI
Urban Healthcare Provider

- **Financial:**
  - $2.0B in revenues

- **Inpatient & Observation:**
  - 38,700 acute discharges
  - 9,900 observation cases

- 7,000 + Medicaid apps/yr.
- 170,000 ED Visits

- 3000 births, 95% MA

- **Payer Mix:**
  - Medicaid - 34% (46% at TUH)
  - Medicare - 43% (High Dually Eligible population)

- Largest volume of penetrating trauma
- Largest PA MA provider
- No public hospital in Philly
- No CON laws
Temple’s Medicaid days represent 45% of its total days, more than double comparable Pennsylvania academic medical centers, while it’s commercial payer mix of 13% is nearly half that of the next closest center.

Source: AAMC Databook 2016 (based on FY 2015 data)
The sickest 5% of the population spends *fifty times as much per person* as the healthy majority.
Transformation is Here

Hospitals and health care systems are in transition to a revised health care delivery model characterized by

• Value-based payment based on clinical outcomes
  • VOLUME TO VALUE

• Population health management
• Patient-centered care and consumerism

The Ultimate Goal is Volume to Value: Shifting the Curve

**Value-based second curve: The new reality**
- Payment rewards *value*: quality and cost efficiency
- 90% of traditional Medicare payments for hospitals linked to VPB by 2018
- 30% of Medicare FFS payments tied to quality or value through alternative payment models by 2016; 50% by 2018.
- Shared risk: Providers share in insurers savings or losses
- Increased inpatient severity (Alternatives to low risk admissions)
- IT utilization essential for population health management
- Increased importance of scale—networks, covered lives
- Aligned incentives to support transitions and coordinated care
- MACRA final rule changes payments to clinicians based on quality, accelerating the shift to value

**Volume-based first curve**
- FFS reimbursement
- Process recognized
- Outcomes not rewarded
- Acute inpatient focus – FFS and case rates
- Lack of IT investment incentives inpatient
- Stand-alone system thrive
- Regulation impedes alignment and collaboration between hospitals and physicians

Adopted from Ian Morrison, 2011; AHA, 2013; Department of Health and Human Services, January, 2015; MACRA 2016
The Temple Center for Population Health

Founded in 2014 to promote and support the population health efforts of Temple Health and North Philadelphia

Goal: Attain a sustainable, coordinated model of health care delivery through clinical and business integration, community engagement and a balance of medical and nonmedical interventions to promote high value care and healthy populations

Manage $26 Million in risk and pay for performance revenues.
~ 75,000 lives

Pay-for-Performance

- Medicare
  - Value Based Purchasing
  - Readmission Reduction
  - Hospital Acquired
    Conditions
  - Merit Based Incentive Payments
  - Advanced Payment
    • CPC + Track One
- Aetna
- Keystone First (Medicaid)
- Independence Blue Cross
- Health Partners (Medicaid and Medicare)
- Cigna Health Spring
  (Medicare)
- Law Enforcement Health Benefit Administrators.

Shared Savings

- Independence Blue Cross
  - Pay for Performance
  - Medicare & Commercial
- Cigna Health Spring
  - Medicare

Shared Risk

- Cigna Health Spring
  - Medicare

Full Risk

- Health Partners (Co-Founder & Partial Owner)
  - Medicare Advantage
  - Medical Assistance
  - CHIP

Key Program Elements

- Risk, Shared Risk and Pay for Performance contracting
- Data analytics, risk stratification and workflow management
- Care and quality management infrastructure
- NCQA Level 3 - PCMH Primary Care Platform
- Community Alliances
Payment Models Driving Transformation

**Medicare Goal: VALUE**
By 2018 - 50% of payments will be associated with an alternative payment model; 90% of payments will be tied to quality

- Quality Care and Cost Management Strategies
  - Comprehensive Primary Care +
  - Bundled Payments
  - Shared savings
  - Shared Risk
  - ACO’s
# The Field Guide to Medicare Payment Innovation

CMS is deploying an array of voluntary and mandatory payment innovation programs to accelerate the transition to accountable payment models. This field guide details the 12 highest profile programs as of November 2015, and is inspired by the convergence of the policy, payment, and population health movements to disrupt the traditional fee-for-service business model.

## HHS’s Payment Goals

<table>
<thead>
<tr>
<th>Program</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-Acquired Condition Reduction Program</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Merit-Based Incentive Payment System</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement Initiative</td>
<td>2K+</td>
<td>5K+</td>
<td>10K+</td>
</tr>
<tr>
<td>Comprehensive Care for Joint Replacement Model</td>
<td>78%</td>
<td>80%</td>
<td>85%</td>
</tr>
</tbody>
</table>

## Payment Program Key

- **Change Accelerator**: Provides funding, training, and peer networking to support local delivery system innovation; ultimately seeks to identify and disseminate best practices.
- **Pay-for-Performance**: Rewards or penalizes providers for performance against select quality and cost metrics; often focuses on safety, outcomes, and patient satisfaction measures.
- **Bundled Payment**: Establishes a single price for a comprehensive episode of care, often spanning the care continuum; minimizes the time and cost of care for patient populations over time; eliminates the volume-based incentives for fee-for-service economics.
- **Total Cost of Care**: Holds providers accountable for the overall quality and total cost of care for patient populations over time; eliminates the volume-based incentives for fee-for-service economics.

## Oncology Care Model

- **Program**: CMS program seeking to improve the quality and efficiency of care for oncology patients nearing chemotherapy across six month episodes of care.
- **Goal**: Reduce costs and improve outcomes.

## Medicare Shared Savings Program

- **Program**: A program for Accountable Care Organizations (ACOs) that serve Medicare fee-for-service beneficiaries.
- **Goals**: Improve the quality, safety, efficiency of care and reduce costs.
- **Outcomes**: Reduce Medicare expenditures and improve access to care.

## Pioneer ACO Model

- **Program**: A program offering an advanced model for accountable care organizations (ACOs) that serve Medicare fee-for-service beneficiaries.
- **Features**: Included financial arrangements such as shared savings and losses, and measures for quality, efficiency, and patient outcomes.

## Next Generation ACO Model

- **Program**: A program offering advanced models for accountable care organizations (ACOs) that serve Medicare fee-for-service beneficiaries.
- **Objectives**: Improved financial risk and reward, as well as more flexibility, through the Pioneer ACO Program.
- **Outcomes**: Better outcomes and lower costs, with greater financial risk and reward.

## Hospital Value-Based Purchasing Program

- **Program**: A program paying for performance with hospitals receiving 30-day core measures.
- **Goals**: Improve care for the most serious conditions, reduce costs, and improve outcomes.

## Hospital Readmissions Reduction Program

- **Program**: A program targeting hospitals with excess 30-day readmissions for six conditions.
- **Goals**: Reduce readmissions, improve outcomes, and reduce costs.

## Comprehensive Primary Care Initiative

- **Program**: A program designed to provide comprehensive primary care services to patients, particularly those with multiple chronic conditions.
- **Benefits**: Improved access to care, reduced costs, and enhanced health outcomes.

## Hospital-Acquired Condition Reduction Program

- **Program**: A program targeting hospitals with high rates of hospital-acquired conditions.
- **Benefits**: Reduced rates of hospital-acquired conditions, improved patient outcomes, and reduced costs.

## Merit-Based Incentive Payment System

- **Program**: A program paying providers for performance against quality and cost metrics.
- **Benefits**: Improved quality of care, reduced costs, and increased patient satisfaction.

## Bundled Payments for Care Improvement Initiative

- **Program**: A program paying providers for a comprehensive episode of care.
- **Benefits**: Reduced costs, improved quality, and increased patient satisfaction.

## Comprehensive Care for Joint Replacement Model

- **Program**: A program paying providers for comprehensive care for joint replacement.
- **Benefits**: Reduced costs, improved quality, and increased patient satisfaction.

## The Advisory Board Company

- **Program**: A program providing comprehensive care for joint replacement.
- **Benefits**: Reduced costs, improved quality, and increased patient satisfaction.

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**See our latest on payment transformation**

advisor.com/pay/transform
The Squeeze

Community Hospital
- Competes on cost and convenience
- Some tertiary where costs are easily covered
- Strong ambulatory programs

Major Teaching Hospital
- Has higher costs of high acute
- Can struggle to recruit skilled physicians
- Can struggle to leverage costs with volumes

Academic Medical Center
- Competes on technology/skills
- Heavy focus on tertiary
- Leverage high cost high acute services with volume

Patients Flow To Lower Cost & Convenience

Make $’s on Low Cost

Make $’s on High Acuity
A Few Facts about Leadership

• Not for everyone
• There is no formula or direct path to a leadership position
• There is a significant difference between wanting to BE and really wanting to DO
• Having a business degree does not guarantee a leadership position
• Not great jobs if you have an overwhelming desire to be loved
• Must be prepared to put your own interests secondary to the interests of the rest of the entity
• Are you willing to step out of your comfort zone?
Thoughts on Leadership

• “The key to being a good leader is keeping people who hate you away from those who are still undecided.” (Casey Stengel)
WHAT IS DIFFERENT ABOUT YOU THAT EQUIPS YOU TO LEAD?

Or alternatively:

WHAT IS SPECIAL ABOUT YOU THAT OTHERS SHOULD WANT TO FOLLOW YOU?
Chair as Middle Management

• Middle managers have a complicated relationship with power
• Power is activated and experienced in the context of interpersonal relationships.
• Interacting with superiors, one adopts a more deferential low-power behavioral style.
• Interacting with subordinates, on the other hand, we adopt a more assertive high-power behavioral style
Chair as Middle Managers

• Simultaneously are “victims and the carriers of change”
  • Receive strategy prescriptions from their bosses above (Dean, CEO)
  • Have to implement those strategies with people who work beneath them.
  • Find themselves stuck in between various stakeholder groups
  • Can produce “relentless and conflicting demands

• Norms and expectations associated with being a leader (e.g.,
  assertiveness) incompatible with the norms and expectations
  associated with being a subordinate (e.g., deference).
  • Problematic when one must play both roles because humans are notoriously
    inefficient when it comes to task switching
Chair, Then What?

• Dean– Responsibility vs Authority
  • Where does the physician practice reside
  • Dean’s role in the governance of the practice
  • Medical School– Cost center (with a few exceptions)
  • Revenue generated on the hospital side
  • Funds flow

• Health System “C-Suite”—CQO, CMO, CEO

• Position outside of Medicine
The Contrarian's Guide to Leadership

Steven B. Sample

President, University of Southern California

Foreword by Warren Bennis
• “many men want to be president, but very few want to do president”.
  • told to Steve Sample early in his career by a senior colleague
• “Some of the unhappiest people I know are those whose aspirations for a high-level leadership position were finally satisfied, and who only then found out that they didn’t really want to do what it is that the position required. They had spent years clawing and scraping their way up the side of the mountain, and upon reaching their goal discovered that the realities of life at the top were a far cry from what they had imagined them to be” Steve Sample, late President of USC
“When a person first attains a top leadership position, he’s often dazzled by the perquisites and deferential treatment which accompany high office; indeed these may well be the things that motivated him to seek the top job in the first place. But soon these ephemeral glories fad and he’s left with the realities of his job— the nitty gritty of day-to-day leadership. Does this person want simply to be the president, or does he really want to do president”?

Is This Really What you Want to Do?

Need to look within and ask yourself that question
Need to know yourself, strengths, weaknesses, “baggage” that you bring
## Summary of Income Statement

### Unaudited June 30, 2017*

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th></th>
<th>Variance</th>
<th>Prior Year</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unaudited</td>
<td>Budget</td>
<td>Variance</td>
<td>Prior Year</td>
<td>Variance</td>
</tr>
<tr>
<td>Total Revenues</td>
<td>$1,746,162</td>
<td>$1,691,969</td>
<td>$54,193</td>
<td>$1,636,450</td>
<td>$109,712</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$1,751,920</td>
<td>$1,676,137</td>
<td>(75,284)</td>
<td>$1,632,095</td>
<td>$119,825</td>
</tr>
<tr>
<td>Operating Income (Loss)</td>
<td>(5,758)</td>
<td>15,833</td>
<td>(21,591)</td>
<td>4,355</td>
<td>(10,113)</td>
</tr>
<tr>
<td>Non Operating Income</td>
<td>6,894</td>
<td>8,018</td>
<td>(1,124)</td>
<td>6,591</td>
<td>303</td>
</tr>
<tr>
<td>Net Income (Loss) as Reported</td>
<td>$1,135</td>
<td>$23,851</td>
<td>(22,715)</td>
<td>$10,946</td>
<td>$9,810</td>
</tr>
<tr>
<td>Liquidity</td>
<td>$356,717</td>
<td>$350,026</td>
<td>$6,691</td>
<td>$332,594</td>
<td>$24,123</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>77</td>
<td>79</td>
<td>(2)</td>
<td>77</td>
<td>-</td>
</tr>
</tbody>
</table>

* All figures presented exclude the portion of the University’s non-preferred appropriation which is received through Temple University Hospital.
• Our supply chain pipeline report keeps the health system focused on yielding value through physician lead supply chain strategies and programs.
Confidential and Privileged
MEMORANDUM

TO: Professional Liability Reserve Committee

FROM: John R. O'Donnell, Esquire
       Paul B. Wright, Esquire

DATE: 9/22/17

RE: Cases for Review – September, 2017

The following cases will be reviewed during the September 28, 2017 meeting:

<table>
<thead>
<tr>
<th>Cases in Suit:</th>
<th>Responsible Service(s)/ Institution(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. James, Ronald</td>
<td>Radiology/Pulmonology/Family Medicine (JH)</td>
</tr>
<tr>
<td>2. Johnson, Charmaine</td>
<td>Family Medicine/PA (TUH)</td>
</tr>
<tr>
<td>3. Jones, Nancy</td>
<td>CT Surgery/Surgery/Nursing (TUH)</td>
</tr>
<tr>
<td>4. Koppany, Cheryl</td>
<td>Anesthesia/(TUH)</td>
</tr>
<tr>
<td>5. Leach, Lakishia</td>
<td>EM/Radiology (TUH)</td>
</tr>
<tr>
<td>6. Mack, Kadijah</td>
<td>EM (TUH)</td>
</tr>
<tr>
<td>7. Snyder, Beth</td>
<td>GI/Surgery/(TUH)</td>
</tr>
<tr>
<td>8. Villafane, William</td>
<td>Nursing (TUH)</td>
</tr>
</tbody>
</table>

Observation/Claim Cases:

<table>
<thead>
<tr>
<th>Responsible Service(s)/ Institution(s)</th>
</tr>
</thead>
</table>


Cost Drivers and Focus

• Per Capita Cost:
  • All Part A (hospital) and B (outpatient) payments for an attributed beneficiary

• Medicare Spending per Beneficiary:
  • All costs associated with an episode of care 3 days before an admission and 30 days post discharge
Medicare Annual Quality and Resource Use

Rates physician practice compared to peers

= desired quadrant

High Quality Low Cost
Rating Action: Moody’s Upgrades to Ba1 Temple University Health System (PA); Outlook Stable

Global Credit Research - 20 Oct 2016

New York, October 20, 2016 -- Summary Rating Rationale

Moody's Investors Service upgrades to Ba1 from Ba2 Temple University Health System (TUHS), PA. The rating outlook is stable at the higher rating level. The rating action affects approximately $507 million of rated debt issued through the Hospitals and Higher Education Facilities Authority of Philadelphia.

The upgrade to Ba1 reflects durability of TUHS' financial turnaround with a second consecutive fiscal year of marginally profitable operating performance. The rating also acknowledges the health system's large size, clinical diversification, its role as a safety net provider for the City of Philadelphia, as substantiated by historically sizable funding from the Commonwealth, and close working relationship with Temple University (TU). The rating remains constrained by still modest margins, above average Medicaid exposure, heavy reliance on supplemental funding, a highly leveraged balance sheet relative to operations and cash, and an especially competitive market which continues to consolidate.
Health System Achieved Full Covenant Compliance

<table>
<thead>
<tr>
<th></th>
<th>Consolidated</th>
<th>Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income</td>
<td>1,135</td>
<td>1,722</td>
</tr>
<tr>
<td>Depreciation</td>
<td>51,131</td>
<td>50,605</td>
</tr>
<tr>
<td>Interest</td>
<td>28,595</td>
<td>28,497</td>
</tr>
<tr>
<td>Income Available for Debt Service</td>
<td>80,861</td>
<td>80,824</td>
</tr>
<tr>
<td>Annual Debt Service *</td>
<td>45,148</td>
<td>44,480</td>
</tr>
<tr>
<td>Annual Debt Service Coverage (Req'd 1.10)</td>
<td>1.79</td>
<td>1.82</td>
</tr>
</tbody>
</table>

**DEBT SERVICE COVERAGE RATIO**

<table>
<thead>
<tr>
<th></th>
<th>Consolidated</th>
<th>Obligated Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expenses</td>
<td>1,751,920</td>
<td>1,747,577</td>
</tr>
<tr>
<td>Depreciation</td>
<td>51,131</td>
<td>50,605</td>
</tr>
<tr>
<td>Adjusted Expenses</td>
<td>1,700,789</td>
<td>1,696,972</td>
</tr>
<tr>
<td>Expense Per Day</td>
<td>4,660</td>
<td>4,649</td>
</tr>
<tr>
<td>Liquidity</td>
<td>356,717</td>
<td>322,887</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>77</td>
<td>69</td>
</tr>
</tbody>
</table>

*Inclusive of approximately $5.5M of various capital leases and loans*
Health Partners Plans
TUHS Financial Results

• For the ten years ended June 30, 2017, the arrangement with HPP has returned to Temple:
  • $92,076,067 of Risk Contrasting income, and
  • An additional $41,099,000 from the gain on the sale of a Medicare Advantage Plan in Fiscal Year 2008.

• Below is TUHS’s performance from the HPP ownership as reflected on its financial statements.

<table>
<thead>
<tr>
<th></th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>Unaudited June 30, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>(4,855,916)</td>
<td>(7,582,680)</td>
<td>(8,773,314)</td>
</tr>
<tr>
<td>Medicaid &amp; CHIP</td>
<td>7,463,998</td>
<td>16,293,917</td>
<td>37,012,195</td>
</tr>
<tr>
<td>Total</td>
<td>$ 2,608,082</td>
<td>$ 8,711,237</td>
<td>$28,238,881</td>
</tr>
</tbody>
</table>
Distinguishing between wanting to “be” and actually wanting to “do”

• Must have the ability to look deep within
• Considerable self-awareness—really know yourself
• Be able to recognize your strengths and weaknesses
• Desire to get out of your comfort zone
How to do it?

• Seek out new experiences and new contexts– get out of your comfort zone
• Get honest feedback
• Explore biography– seek to understand that context that made you what you are
• Return to roots
• Find a “third place”– work, family, and ?
Thoughts on Leadership

• “Being powerful is like being a lady; if you have to tell people you are, you aren’t.” (Margaret Thatcher)
Know and Show Yourself--Enough

• You must be sufficiently self-aware and also be prepared to self-declare
• Effective leaders know enough and show enough to maximize their leadership impact
• Effective leaders have a sense of what works for them with others
• Primarily a matter of self-awareness
A model describing what each of us is like, as we are known both by others and by ourselves. Divides personal awareness into four different types.
Self-Leadership: Pay Attention to Yourself (Dan Rockwell)

- Listen to yourself
  - Spend a day monitoring your words and tone. What message were you sending?
- Consider what it’s like to listen to you
  - Negative leaders believe they’re positive.
  - Word are rudders—life and leadership go in the direction of your speech
- Explore what it’s like to sit across the table from you
  - You aren’t as pretty as you think and others aren’t as ugly
  - Others see you better than you see you. See yourself through the eyes of others.
  - Monitor your wake
- Self Leadership: Expect more from yourself than you expect from others
Emotional Intelligence

• Key differentiator between good and great performers: strength in social and emotional competencies
• Emotional Intelligence: ability to perceive, understand and manage the emotions of oneself and those of others with whom we have interpersonal relations (Daniel Goleman)
Emotional Intelligence

• Understanding of what constitutes EI central to leadership
• People may be strong in some elements but seemingly lacking in others
• See Clinton, Bill
  • Remarkable disparity in EI: tremendous empathy but devoid of self-control
• Donald Trump
  • Devoid of empathy, devoid of self-control, delusions of grandeur, lack of any self-awareness
Authentic Leadership

• How can people become and remain authentic leaders? (George, et al. HBR, Feb. 2007)
• Interviewed 125 leaders to learn how they developed their leadership abilities
Authentic Leadership

• Interviews failed to identify any universal characteristics, traits, skills or styles that led to success
• Leadership emerged from their life stories
• Constantly testing themselves through real-world experiences and reframing life stories to understand who they were
Leading Yourself

• During the past 50 years >1000 studies done to determine definitive styles, characteristics, or personality traits of great leaders
• Still no clear profile of the ideal leader
• Most important capability for leaders to develop: self-awareness
• Knowing your authentic self requires courage and honesty to open up and examine one’s own experiences
Leading Yourself

• Denial– the greatest hurdle that leaders face in becoming self-aware
• Authentic leaders must be willing to listen to feedback
• Basis for authentic leadership– values derived from your beliefs and convictions
  • You won’t know your true values until they are tested under pressure
Authentic Leadership

• Begins with understanding the story of your life
• It’s the personal narrative, not the mere facts of your life that matter
• Motivation frequently came from a difficult experience in their lives
• Instead of seeing themselves as victims they used these experiences to give meaning to their lives
• Reframed events to rise above challenges and discover their passion to lead
Your Development as an Authentic Leader– Questions you need to ask yourself

• People and experiences in your early life that had the greatest impact on you
• What tools do you use to become self-aware?
• What are your most deeply held values? Where did they come from?
• What motivates you extrinsically? Intrinsic motivations?
• What kind of support team do you have?
Why Lead?

• Special rewards for authentic leaders
  • The pleasure of leading a group to achieve a worthy goal, ie, creating a financially and academically successful department where each individual can achieve to their full potential
  • The inner satisfaction that you have empowered others
Ten Behaviors of Strong Personal Leadership (Eblin)

• Self reflection-- Great leaders take the time to identify and articulate **how they are at their best**
• Self awareness–are aware and intentional. *What am I trying to do? How do I need to show up to make that happen?*
• Self care-- understand that they perform at their best when they take care of their health and well being
• Continuous learning– they never stop learning. challenge their own assumptions by asking why, seeking fresh sources of input, asking for feedback on their performance
• Listening-- ask open-ended questions and pay attention to the answers. They practice transformational listening, not just transactional
Why Should Anyone be Led by YOU?

Effective Leaders must answer this question every day in all they say and do.
Take Away Messages

• Surgeons possess many qualities that make them ideal change agents
  • Decision makers, risk takers, activists, leadership skills; healthy fear of failure, accountability
• In the current era we need to become surgeons and “something more” (Skinner).
  • Leaders in patient safety and quality; efficient use of resources
• If the opportunity arises, and after a period of frank self-assessment, become part of the decision-making process. Step up.