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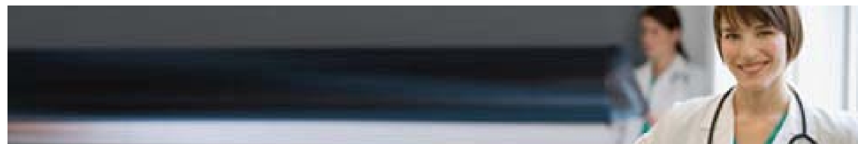

12 Tasks to Success: The Roles and Tasks of Physician Executive Consultants

By Aron S. Wolf MD, MMM, CPE

The physician executive who ventures out as a consultant brings a unique and varied expertise to the development and implementation of new health care projects whether they are of a stand alone nature or integrated into an existing system. The physician executive consultant brings his or her medical knowledge, business training and health care leadership and management experience to the project.

Here's a case study that demonstrates the use of these skills in the development of a newly created project and describes my specific roles and responsibilities as consultant in this project over a 3 1/2 year period. This project has been a partnership between the consultant, the founder of the project, the project board and CEO, governmental entities, funding entities, and the professional and consumer communities of Alaska. The success was partially through the role of the consultant as an independent professional knowledge holder who has been able to be the voice for what is economically viable and scientifically valid.

In early 2004 I was approached by the founder who is an attorney and is known nationally for his successful advocacy of the rights of people diagnosed with serious mental illness. Jim Gottstein had just finished reading and was extremely impressed by Robert Whitaker's *Mad in America* which refers in one section to a 1971-1983 NIMH project named Soteria House which demonstrated that many people suffering from acute psychiatric difficulties could be treated in an alternative manner that did not rely primarily on the use of antipsychotic medications.1

The residents of the Soteria project were those individuals who were having their first or second psychotic episode and had not been labeled as disabled from their illness. The program treated them in a home-like milieu with the treatment relying almost entirely on building trust and relationships with support and intervention by peer counselors by "being with" the residents rather than "doing to" them. The program had very positive outcomes but had remained only a research project and had never transitioned to a sustainable entity.

Gottstein's idea was to develop and reproduce the Soteria project treatment ideas as a sustainable part of the continuum of treatment in Alaska. He thus incorporated Soteria-Alaska as a 501©(3) non-profit corporation.

It was at this juncture that Gottstein contacted me through my consulting firm, Wolf Healthcare. He asked me to review the data from the original project. He requested that if I felt that the concept was worthwhile, to consider writing a business plan for initial funding to make Soteria-Alaska a reality.

My review of the NIH Soteria project showed me a very exciting treatment model. Indeed it is one that I had been familiar with in my training at Chestnut Lodge which was the venue described in *I Never Promised You a Rose Garden*.2 Those earlier treatments were very similar to those described in the Soteria project, with the exception that Soteria had more treatment done by "peer consumers."

The original Soteria as a research project had protocols where the use of antipsychotic medications was proscribed in many instances. Gottstein felt that people should have programs where the non-use of medications was allowed. My first challenge was to use my knowledge and skills as a possible physician consultant in this project to assert that in 2004 that there could not be a program that "banned" the use of all psychotropic medications.

This intervention and the agreement that resulted from it shaped a program that has become viable. It forged a very strong collaboration between Gottstein and me that has moved the program forward. The outcome of the intervention was that I would indeed agree to be a consultant for the program and that the program would have the milieu of the original program, but it would also have a medical director and that medications would be utilized as necessary but not as the first line of intervention.

1. Business plan development

With this agreement Gottstein and the new "consumer" board of Soteria-Alaska engaged me as my first task to write an initial business plan that was to be presented to the board of The Alaska Mental Health Trust Authority. The Trust is a quasi-independent state agency with assets of almost $400 million whose mission is to fund programs benefiting the mentally ill, those with substance abuse issues, the frail elderly and those with traumatic brain injuries.

The money for my initial consultation was funded personally by Gottstein as there were no external funding sources at that juncture. This initial business plan outlined the mission, vision and values of the project. It described the project, who it would serve, and the finances that would be involved in running such an enterprise.

Data for the business plan were gleaned from the writings of Dr. Loren Mosher, the NIH data on the program and personal communications with Ms. Alma Menn who had been the director for the original Soteria Project. This business plan, following the original Soteria-House configuration, envisioned a home-like setting for eight to 10 people with early acute psychotic episodes. The house would have two staff at all times. Some of these staff would be former consumers. The projected length of stay would be one to four months.

The program was to be built on providing an environment where the patients would feel safe. A variety of interventions would be used including traditional and alternative medicine. Antipsychotics would, however, sometimes be used voluntarily over a period of time when someone was "stuck." Once the project was operational it was projected that the annual budget would be about $450,000. This initial business plan accompanied a request to the Trust of $50,000 for an initial planning grant.

2. Finance and funding

My second task as consultant was to present this initial plan to the staff and board of the Trust. The board was intrigued by the concept. My presence as a physician as well as a consultant was important in answering the medically related questions in the proposal. Although interested in the plan, the Trust felt that we had not "done enough homework" in accessing key stakeholder groups. They challenged us to meet with these groups and then possibly return at a later date with a revised proposal. We also made a presentation to the largest Alaska Foundation. Not unexpectedly, their response was identical to that of the Trust. They expressed interest but also

gave us direction to “go back and do more community homework.”

3. Data collection

My third task from May 2004 to April 2005 was to meet with and discuss the idea of the project with a broad range of provider and consumer mental health and medical groups within the state. It was also to access and accumulate outcome data from other similar programs throughout the country and internationally. Although The Trust denied our initial funding request, they were willing to allocate $35,000 to us in mid year as we were following all of their development suggestions.

4. Sustainability

My fourth task was to reformulate the business plan incorporating all that we had learned during the course of the year. This reformulation included funding for a director/CEO of the program. The Trust funded our revised proposal for $135,000. We also presented this version of the plan to the large Alaska Foundation that we had met with the prior year, both to keep them informed and to alert them that we might be coming to them for capital funds in the future.

5. Key personnel

My fifth task with the help of Gottstein and Alma Menn was to hire a director for the program. We instituted a national search and received a significant number of resumes from across the country. We were surprised and pleased at the quality of the candidates and their willingness to become involved with a program that did not have guaranteed sustainability. As a result of the interviews, we selected Susan Musante as the contract CEO as of April 2006. Musante was a provider who had worked in many similar venues in New York and New Mexico.

6. Long-range planning

My sixth task was to work with Musante in defining a full and formal five-year business plan for Soteria-Alaska with funding initially by the Trust and then by other long range funding sources. The timeline for the presentation of this comprehensive plan to the Trust was only six weeks. Thus, Musante as a new director and I had to spend a considerable amount of time during that period to formulate what the Trust was requiring. The plan was presented to the Trust board and was approved for funding at $160,000 for the fiscal year starting July 1st 2006 with a probable opening of the project in September of 2007.

7. Legislative and governmental interaction

The opening of the project in September of 2007 depended on embedding part of the funds within the general state mental health budget. This requirement then mandated my 7th task which was to meet with legislators, the department of mental health, and the governor's office to explain the project and to have them include funding for it in the state budget.

Although the request for funding in the state budget made its way through the department of behavioral health services all the way to the governor, she had decided to veto any and all new initiatives for the department, and it was not funded for that fiscal year. The Trust, however, was by this time committed to the project and out of their monies they funded the project for an additional $200,000 to continue planning and opening in the spring of 2008. This sum of money was to acquire the facility and then to pay for staff hiring, training and implementation in that fiscal year.

8. Licensing and zoning

The eighth task, which was also in this same time period, involved finding a property for the project and working with city and state officials to determine both the licensing and zoning categories for the project. At both the state and city levels this was complicated as the project did not fit any of the “usually” defined categories and the city and state had conflicting definitions of what we might be called. Ascertaining answers to where we “fit” required several meetings which included city and state officials. After we secured a designation we then found a venue and have finally negotiated a five-year lease/option to purchase agreement for that program site.

9. System development on a macro level

The ninth task was to meet with the local "single point of entry" mental health emergency room and the physicians of the state hospital to begin to work out mechanisms for referral to the program. We also met with the local mental health center and the local mental health providers to determine where the program would fit in the overall continuum of care. It was of great importance to have met physician-to-physician and administrator-to-administrator for the comfort level of those in the community.

10. Data and quality outcomes

The tenth task was to ensure that the program would be able to derive outcome data from the project. With this in mind, we met and contracted with academics from both California and Alaska to develop an outcome monitoring plan to ensure this aspect once the program became functional from the metrics that I was able to outline as necessary for the project.

11. Sustainability redux

The eleventh task will be to work once again to ensure that Soteria-Alaska becomes embedded in the state budget. We will meet with all of the political leadership that we did last year. The difference this time is that the program will have opened and have residents so it has been assured by the Trust that it will advocate to include the program in the state budget. The Trust has also assured Soteria-Alaska that it would fund the program out of their funds if the political process did not work again this year.

12. Staff development and operational protocols

The twelfth and final task will be to hire and train the staff as well as a medical director. The medical director will need to understand the program and feel positive about the treatment philosophy. This task will also include the development and writing of all the specific protocols for the program. All of these protocols, the hiring and the training will need to be accomplished between January and March 2008. Externally that time period will also be needed to "sell" the program once again to the provider and consumer communities as it becomes a reality within the total care delivery system. During this phase, potential stakeholders will include foundations to meet eventual capital needs

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