LONG VIEW
THRIVE BY DESIGN

The New Physician Adviser

Part 1 of 2 | Resetting the Foundation

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From Being a Gatekeeper to Becoming a Capacity Catalyst

Key Learnings

- **The traditional physician adviser model is no longer fit for patient outcomes in an ever evolving, complex payer contract environment.** Part-time, rotational physician-advisor programs no longer match the real-time volume hospitals manage. Inadequate availability, limited fluency in evolving payer criteria, and poor integration with the care team leave health systems exposed to unnecessary delays in care, denials, and missed revenue.
- **A foundational reset of the Physician Adviser role (PA) is needed.** Health systems must reframe the PA role as a strategic function grounded in clinical excellence AND mastery of utilization management, data fluency, and team-based communication. This reset is essential to improving patient flow which protects both patients from unnecessary delays, extended stays, compromised care coordination and health system revenues in today's tight financial environment.
- **Fixing the foundation sets the stage for broader reform.** In an environment of rising demand, reimbursement pressure, and workforce constraints, health systems that build this new PA foundation today will be positioned to become more competitive. Part 2 of this article will outline how to scale the PA model to achieve better outcomes and flow with the same or fewer clinical FTE's.

Who Are Physician Advisers (PA)?

Health systems now face tighter reimbursement rules, stricter payer reviews, and growing pressure to free inpatient beds. Every admission, order set, and discharge decision is now scrutinized for both clinical necessity and financial impact, with denials, audits, and public quality scores at stake. Bed capacity adds another layer of urgency: emergency departments face crowding when the inpatient length of stay creeps up, while surgical schedules back up if post-acute placement stalls. In this climate, health system leaders need a trusted clinical voice that can navigate medical criteria, payer dynamics, and operational flow all at once. That voice is the PA.

The PA is typically a board-certified physician with additional training in utilization management, documentation, and payer dynamics. The PA bridges bedside care and administrative processes. By validating medical necessity, correcting level-of-care assignments in real time, and coordinating discharge planning, they ensure proper clinical care for the patient, protect appropriate revenue, shorten avoidable days, and free beds for patients who genuinely need them. As margins tighten and

regulatory scrutiny grows, this role has shifted from a nice-to-have consultant to an essential member of the care team and a frontline driver of patient care, patient flow and financial integrity.

The Problem that Physician Advisers Face Today

Today, the PA role is often seen as a short-term "tour of duty" assigned to respected physicians. This approach no longer keeps pace with demand and the changing landscape of payer dynamics leading to very tangible problems – emergency departments board admitted patients for hours because inpatient beds remain tied up, elective surgeries are delayed for lack of post-op capacity, and observed to expected length-of-stay ratios sit well above 1.0, signaling avoidable days that strain staff and erode margin. Most importantly, patients feel these pressures most acutely, facing longer waits for admission or surgery, higher exposure to health system-associated complications, and frustration when necessary care seems out of reach. These delays can compromise outcomes, particularly for those with time-sensitive needs.

Sadly, the root cause is neither singular nor simple. Payer processes have become more complex as payers are under stricter regulations (e.g., shorter turnaround times for prior auth). As a result, health systems are under greater pressure to adhere to nuanced and detailed documentation tasks while moving patients efficiently from admission to discharge. The burn out of clinicians continues to reduce the total supply of clinicians and increases the cost of temporary clinical workforce. Moreover, with looming Medicaid and possibly Medicare cuts, current and projected demand for inpatient services continues to outstrip supply of clinicians and clinical services. The myriads of problems become difficult to manage together, especially without alignment of all stakeholders such as hospitalists, ambulatory specialists, case management, social work etc.

Today, health systems need a PA who is not only a trusted clinician but also an expert across multiple areas such as medical review criteria, payer requirements, operational coordination across clinical teams and the financial impact of care decisions.

Our two-part article makes the case that physician advisership is no longer just a support function but a strategic orchestration role. This first part focuses on rebuilding the foundation by providing a revised basic set of qualifications for an effective PA. The second part will focus on an enhanced operating model of how multiple PA's across multiple teams can work effectively so that better outcomes can be achieved without increasing the total FTE count of the health system clinicians.

Where Current Qualifications Fall Short

Health systems often assume that a physician with board certification and a willingness to review charts part-time is all that is required of a good PA. In practice, this current operating model leaves critical gaps. The table below describes the limitations of today's PA roles.

Table 1. Gaps in the Legacy Physician-Advisor Model

Limitation	Description	Example
Adviser not available when care team needs input	Rotational PAs are on site only a few hours per week, so many status questions wait until the next review cycle.	A 250-bed health system discharges about 40 inpatients and manages 25 observation cases daily. A part-time PA who reviews 15–20 charts one afternoon a week leaves roughly 85% of real-time decisions to frontline staff with no second-level support. This problem worsens on the weekend.
Thin mastery of payer criteria	InterQual and MCG updates arrive quarterly, yet rotational advisers rarely train on every release.	An observation patient with chest pain meets new InterQual criteria for inpatient after serial troponins, but the adviser is unaware, so the stay remains "observation." When the claim is

Limitation	Description	Example
		denied, the health system loses roughly $1,200 in revenue for that single case.
No live data to spot hot cases	Without dashboards or AI scoring, advisers review charts in alphabetical order rather than by risk or timing.	A case flagged as "likely denial" is reviewed three days after discharge. By then the appeal window has closed, costing the health system the entire DRG payment (≈ $7,800).
Limited peer-to-peer bandwidth	Payers typically allow a 24- to 48-hour window for peer-to-peer calls, but a part-time adviser may be off-site when the call request arrives.	Six denial notices land on Thursday; the adviser returns Monday. The appeal deadline passes for three of them, forfeiting $18,000 in gross revenue.
Cannot escalate discharge barriers in real time	Rotational advisers rarely attend discharge huddles, so clinical or social obstacles linger.	A patient cleared for SNF transfer waits two extra days because a mandatory rehab order is unsigned. Those avoidable days cost $2,000 in staffing and bed occupancy while another ED patient boards six hours awaiting an inpatient bed.
Disconnected from command-center flow	Bed control often makes capacity decisions without clinical context from a PA.	ICU holds a step-down patient because the med-surg team questions acuity. Without a PA to mediate, the hold blocks an ICU admit, forcing a critical patient to remain in the ED for four hours longer than target boarding time.
Little influence on post-acute placement	Advisers unfamiliar with SNF and home-health criteria focus only on inpatient status.	A frail elder qualifies for "swing-bed" rehab but is kept two extra health system days while placement is sorted. At $650 per day in variable cost, the delay adds $1,300 in expense and ties up a med-surg bed needed for scheduled surgery.

Qualifications For a Foundational Reset

A highly effective PA brings a unique blend of clinical acumen, administrative understanding, and interpersonal skills to their role. To reset the foundation of this function, a revised set of foundational qualifications are needed as shown below.

Board Certification

Active certification in a core specialty such as internal medicine, family medicine, or surgery demonstrates clinical mastery and signals a commitment to ongoing professional development.

Clinical Experience

Several years of bedside care across mixed-acuity populations equip the adviser to assess medical necessity, interpret subtle changes in patient status, and speak credibly with attending physicians. While often not a specialist, the PA must understand and be able to communicate with other specialists and know when to engage another specialist to facilitate peer-to-peer conversations.

Knowledge of Utilization Management Principles

Working fluency in InterQual, MCG, and payer guidelines, including prospective, concurrent, and retrospective review processes, allows the adviser to align status decisions with evidence-based criteria in real time. Also, PA's must have basic familiarity with individual payer contracts.

Working Knowledge of Healthcare Regulations and Compliance

A strong grasp of CMS rules, state regulations, HIPAA, and quality-reporting requirements helps protect the health system from audit risk and reimbursement claw-backs. Understanding the new set of Artificial Intelligence (AI) regulations both at the national and state levels allows for workflow processes to be

compliant with the law and safe for patients. Regulation appropriate placement in hospice can assist the facility with reduction of mortality and readmission rates, while improving the patient experience.

Communication and Interpersonal Skills

Clear, concise and "action oriented" dialogue with clinicians, nurses, case managers, administrators, and payers is essential for resolving disagreements, guiding documentation, and accelerating care progression.

Leadership and Problem-Solving Abilities

The adviser should be comfortable leading multidisciplinary huddles, mediating peer-to-peer calls, and troubleshooting complex medical or social barriers to discharge. Knowing how to represent the ethics committee policies and engage the ethics committee as needed is crucial.

Familiarity with Clinical Documentation Improvement (CDI)

Understanding how precise documentation drives accuracy and appeal success ensures that the medical record fully reflects patient severity and resource use.

Data and Analytics Competence

The ability to interpret live dashboards, length-of-stay, denial trends, and AI-generated risk scores allows the adviser to prioritize high-impact cases and demonstrate measurable value.

The Long View

Health systems are under pressure from multiple sides – rising inpatient demand, persistent reimbursement constraints, and an overstretched clinical workforce. None of these forces are likely to ease. In fact, most are accelerating.

In this context, health systems that succeed will be those that manage to deliver better outcomes with fewer resources. A critical step in that direction is rethinking the physician adviser role, not as a temporary support function, but as a strategic capability. In the long view, winning health systems will be those that fix the foundation first.

Part 2 of this series will lay out an enhanced operating model to help health systems do exactly that: improve outcomes and reduce friction, with same or even fewer FTE's.

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