Building the Physician Leadership Team of the Future

Market Observations and Discussion Guide
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# Table of Contents

**Physician Leadership Resources for Clinical Leaders** ................................................. 4

**Executive Summary** ........................................................................................................ 5

A Look at the Physician Leadership Performance Improvement Opportunity ....................... 6

**Four Observations on Physician Leader Evolution** ....................................................... 9

1. Governors and Change Agents: Leader Roles Taking One of Two Paths .......................... 10
2. Professionalizing Physician Leader Roles ....................................................................... 12
3. Early Steps into Performance-Based Physician Leader Compensation .......................... 14
4. Systems Leveraging Physician Management Redesign to Build Systemness .................... 16

**Discussion Guide** ........................................................................................................... 21
Physician Leadership Resources for Clinical Leaders
Research from the Physician Executive Council

Physician Executive Council Membership at a Glance

• Research membership focused on supporting the CMO and team with best demonstrated practices, insights, tools, expert consultations, and networking opportunities
• Provide expert guidance to members as they build an effective physician leadership team, engage the medical staff, and minimize variation.
• Webconferences, tools, and publications tailored for use by clinical leadership team (VPMA, CQO, CMIO) and emerging physician leaders
• For more information, please email Amanda Berra at berraa@advisory.com

Additional Resources on Improving Physician Leadership
Available on advisory.com

The Clinical Transformation Leader’s Toolkit
Provides tools and strategies for overcoming the top six barriers to effective clinical transformation leadership

Physician Leadership Effectiveness Compendium
Best practices for elevating physician leadership performance

The Future of the Medical Staff Organization
Strategies for reengineering governance and operations to advance clinical quality

The Evolving Role of the CMO
An analysis of survey data and strategies for rightsizing the role
Executive Summary

Health system executives nationwide are beginning to reimagine physician leaders’ roles to support changing organizational goals. This research briefing, with a companion discussion guide, is designed to facilitate conversations among health system stakeholders on the evolving role of the physician leader.

Systems Continue to Struggle to Effectively Leverage Physician Leaders

Seventy percent of chief medical officers see physician leadership development as a “top time-consuming priority” for the foreseeable future.1 In addition to time, physician executives are making a significant investment in physician leaders. The average institution spends upwards of $100,000 dollars per year on physician leadership development.2

Despite this investment, chief medical officers report that they are not achieving the desired return from their physician leaders. A large portion of the problem relates to conventional physician leadership structures, which have developed ad hoc over a century, as health systems have grown and care delivery models have changed. The result has been vague, duplicative, and unevenly scoped roles and reporting relationships for physician leaders.

We see four major trends reshaping how physician leaders are deployed in health systems today:

Four Observations from the Market on Physician Leader Evolution:

1. Governors and Change Agents: Leader Roles Taking One of Two Paths
2. Professionalizing Physician Leader Roles
3. Early Steps into Performance-Based Physician Leader Compensation
4. Systems Leveraging Physician Management Redesign to Build Systemness

Discussion Guide:

Using the research in this paper as a foundation, the discussion guide starting on page 21 supports stakeholders in evaluating the current state of physician leadership at their organizations and planning for future physician leadership redesign. The discussion should help set a clear trajectory of physician leadership, supported by explicit three-, six-, and twelve-month goals on which to base a physician leadership transformation plan. As you work toward your physician leadership goals, we invite you to call upon us to facilitate discussions with your team, offer further guidance, or provide any other needed support. As always, we appreciate the opportunity to serve you.

2) Ibid.
Widely Considered a Top Priority

Although physician leaders have always been important, hospital systems are now counting on them to leverage their clinical expertise and influence within the care team to drive change in an increasingly value-driven market.

Accordingly, physician executives report they will devote an increasing amount of time to developing other physician leaders across the next several years. Systems expect to recruit new physician leaders into brand-new roles, in addition to sharpening the skills of existing physician leaders.

To train this new cohort of physician leaders and to continue to build a robust pipeline, the average institution is investing $100,000 per year.¹ The type of leader training varies widely, but respondents to the Physician Executive Council’s 2014 Physician Leadership Survey report a significant investment.

Investing Heavily to Build the Bench

Use of Physician Leader Training Program by Type

2014 Physician Leadership Survey
n=103

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-house training (&lt;10 hours per year per leader)</td>
<td>32%</td>
</tr>
<tr>
<td>In-house training (&gt;10 hours per year per leader)</td>
<td>26%</td>
</tr>
<tr>
<td>Leveraging External Experts</td>
<td>42%</td>
</tr>
</tbody>
</table>

$10K-$500K
Range of annual amount spent to train physician leaders¹

$100K
Average annual amount spent to train physician leaders¹


Reaching for a New Leadership Performance Bar

Despite the training invested in preparing bright and capable individuals, physician executives remain widely dissatisfied with the performance of their physician leadership team today. A major part of the problem is these leaders’ context: a leadership structure that is essentially outdated. The health system has grown and care delivery models have changed, but traditional leader roles and reporting relationships have often remained the same. At the same time, new entities and roles have been added without clarifying how they should relate to existing structures or one another.

Recognizing that the old system no longer works, executives are now looking to develop new roles and structures. Hospital and health system leaders often ask questions such as, “How do we change our physician leadership structure to promote ‘systemness’ across our multi-facility system?” These types of questions point to a common understanding of a new performance bar for the leadership team and structure as a whole. Presented here are the five key goals that health systems cite as desired capabilities of a future physician leadership team.

Diverse Leaders Not Adding Up to an Effective Team

Physician Leaders Across the System

<table>
<thead>
<tr>
<th>Department Leaders</th>
<th>Physician Executives</th>
<th>Clinically Integrated (CI) Network Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insufficient bandwidth for leadership duties</td>
<td>• May have out-of-date job descriptions</td>
<td>• Leaders disconnected from system</td>
</tr>
<tr>
<td>• Disconnected from organization initiatives</td>
<td>• Stuck in facility or entity silos</td>
<td>• Set goals independently</td>
</tr>
</tbody>
</table>

Inpatient Focus | Cross-Continuum Focus | Outpatient Focus

Medical Executive Committee
• Poorly aligned with system goals
• Leaders elected, not selected
• Usually siloed by acute care facility

Medical Directors
• Poorly aligned with system goals
• Inconsistent job descriptions
• Little accountability

Medical Group Leaders
• Leaders siloed from rest of system
• Roles may be duplicative with other physician leaders

Health Systems Solving for Many Problems at Once

Common Goals for Physician Leadership Redesign
• Raise the Standard of Care
• Build and Lead Service Lines
• Promote Systemness Across Acute Care Facilities
• Manage the Care Continuum
• Integrate Facilities, Medical Group, and CI Network

Source: Physician Executive Council interviews and analysis.
Four Observations on Physician Leader Evolution

Below are four trends we have seen in the market place as health systems begin to rework physician leader roles and structures.

1. Governors and Change Agents: Leader Roles Taking One of Two Paths

Some (but not all) health systems are splitting hospital-based physician leader roles into two evolutionary paths: governors and change agents.

- Change agents are primarily working on building toward the delivery system of the future
- Governors are primarily focusing on optimizing existing services and structures

2. Professionalizing Physician Leader Roles

Health systems are providing physician leaders with project management support and the skill training needed to excel in their roles, in addition to adding robust accountability measures.

3. Early Steps Into Performance-Based Physician Leader Compensation

Health systems are revisiting physician leader compensation, examining performance levers such as putting physician leaders’ incentives at risk for performance on leadership responsibilities.

4. Systems Leveraging Physician Management Redesign to Build Systemness

Systems are leveraging physician management redesign to as a way to restructure and better integrate the entire clinical delivery system.
Are There Two Evolutionary Paths for Physician Leaders?

Physician leaders rarely have the bandwidth to both govern the existing system and lead changes such as implementing a new care standard or preparing for population health management.

For this reason, some leaders are being asked primarily to lead change, and others to govern the existing system.

When this split occurs, CMOs, cross-continuum service line leaders, and in some cases, medical directors, tend to be the ones asked to lead change, while VPMAs, department leaders, and the Medical Executive Committee are asked to govern the existing system.

CMOs’ roles are clearly on the change agent path. This is important for two reasons:

1. CMOs traditionally were not hired to excel as “change agents”; this may explain the high degree of turnover in the CMO role today.
2. The CMO’s scope of responsibilities is too much for any one leader to manage. The multiplying spheres of responsibility roughly correspond to areas where CMOs will need to delegate to “governors” or add new change agents to help.

CMOs Clearly On The “Change Agent” Path

Percentage of CMOs Identifying Selected Responsibilities as One of Their Most Time Consuming

2012 Physician Executive Survey

n=75

Traditional Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Three Years Ago</th>
<th>Three Years From Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement</td>
<td>80%</td>
<td>45%</td>
</tr>
<tr>
<td>Medical Staff Affairs</td>
<td>67%</td>
<td>32%</td>
</tr>
<tr>
<td>Leadership Development</td>
<td>45%</td>
<td>36%</td>
</tr>
<tr>
<td>Health IT, Informatics</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>Care Standardization</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>Population Health</td>
<td>12%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Emerging Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Three Years Ago</th>
<th>Three Years From Now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Development</td>
<td>36%</td>
<td>27%</td>
</tr>
<tr>
<td>Health IT, Informatics</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>28%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: 2012 Physician Executive Survey; Physician Executive Council interviews and analysis.
Adding Qualifications, Definition, and Scope to Leader Roles

Catholic Health Initiatives (CHI) is a good example of an organization that has taken steps to reorient its CMO role around change agent competencies.

CHI developed a list of "next-era" competencies necessary to excel as a regional CMO. Now it uses behavioral interviewing, an online performance trait assessment, and non-clinical case interviews to assess whether candidates for the role have those competencies, which are prerequisites for the position.

Health systems are also establishing (or evolving) the role of cross-continuum service line leader as a change agent position. Virtua Health System has made this a system-wide (multi-facility) leadership position that is carefully and explicitly differentiated from the "governing" role of chairs and chiefs in the relevant departments of each service line. The table outlines the delineation that the system makes to scope responsibilities between physician leader roles.

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Update Executive Objectives, Skill Set for New Normal

**Case in Brief: Catholic Health Initiatives**

- 89-hospital health system based in Englewood, Colorado
- CHI corporate leadership realizes strategic importance of standardized regional CMO role and develops modernized job responsibilities for the position
- Partners with industrial psychology firm to determine "next-era competencies" necessary for success in the updated role
- Formally assesses current and potential regional CMOs using behavioral interviewing, case studies, and trait assessment to determine whether they possess "next-era competencies"

**Sample “Next-Era” Physician Executive Competencies**

- Communicates influentially
- Improves systems
- Has global strategic view
- Operates with financial/business savvy
- Demonstrates agility
- Maintains patient focus

---

Defining What Program Directors Do (and Don’t Do)

**Chairs Retain Explicit Authority Upon Introduction of Program Directors**

<table>
<thead>
<tr>
<th>Chair/Chief Responsibilities Existing Role</th>
<th>Program Director Responsibilities Existing Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make recommendations for clinical appointments</td>
<td>Promote and develop evidence-based practice protocols</td>
</tr>
<tr>
<td>Disseminate administrative and medical staff updates to department</td>
<td>Address all performance and administrative issues</td>
</tr>
<tr>
<td>Run department meetings</td>
<td>Monitor performance improvement data</td>
</tr>
</tbody>
</table>

**Defined Cross-Facility Oversight of Critical Care Program Director**

The creation of program directors has greatly improved our cross-continuum oversight, but clearly differentiating their role from those of existing leaders was the key ingredient.”

Dr. Alka Kohli, VPMA, Virtua

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**Source:** Catholic Health Initiatives, Englewood, CO; Virtua, Marlton, NJ; Physician Executive Council interviews and analysis.
Observation 2: Professionalizing Physician Leader Roles

Not Fully Supporting Physicians in Their Leadership Roles

One of the major challenges for many physician leaders is balancing clinical and leadership responsibilities. Many physician leaders feel that this dual focus is critical for staying clinically up-to-date and maintaining credibility among peers.

For executives, the challenge of managing physician leaders is to ensure that, even though leadership may be only a part-time role, physicians are still well prepared and fully supported to execute on their leadership responsibilities—just as they are for their physician responsibilities.

Our research suggests that the "leader" role for physician leaders is not receiving sufficient support—especially compared to what is offered to high-performing leaders in general, outside the physician leader context.

Without basic supports such as a clearly scoped role, project management skill training, performance management, and a coherent reporting context, physician leaders are essentially being set up to fail. The consequences can include both low return on individual initiatives and high risk of eventual leader burnout.

All Physician Leaders Wear Two Hats

Full-Time and Part-Time Physician Leaders by Role

2014 Physician Leadership Survey

n=119

<table>
<thead>
<tr>
<th>Role</th>
<th>Full-Time</th>
<th>Part-Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMO—System</td>
<td>96%</td>
<td>4%</td>
</tr>
<tr>
<td>CMO—Facility</td>
<td>77%</td>
<td>23%</td>
</tr>
<tr>
<td>VPMA</td>
<td>73%</td>
<td>27%</td>
</tr>
<tr>
<td>CMO</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>COO</td>
<td>62%</td>
<td>38%</td>
</tr>
<tr>
<td>Service Line Leader</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>Department Chair</td>
<td>24%</td>
<td>76%</td>
</tr>
<tr>
<td>Medical Director</td>
<td>20%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Not Fully Supporting Physicians As Leaders

1. Role Scoping
   Clearly defined mandates, sized for that leader's bandwidth, along with matching authority, which allows leaders to focus their work on the areas where they can have the greatest impact

   Do physician leaders have this? | X

2. Project Management
   Necessary training, resources, management toolkits, and upper-level management support provided to leaders for execution on unit-level and organization-wide initiatives

   X

3. Performance Management
   Clear direction and substantial accountability against concrete goals linked to organization-wide priorities

   X

4. Coherent Leadership Structure
   Reporting lines and org structure road maps to help individuals, divisions, and entities relate productively to one another

   X

Source: Physician Executive Council interviews and analysis.
Exploring Performance Management for Physician Leaders

Performance management is widely considered a crucial type of support for helping leaders reach their potential. Yet in the case of physician leaders, nearly half of organizations report no performance tracking for physician leadership.

To provide physician leaders with performance management, organizations must solve two common problems: lack of clear leadership goals for physician leaders, and lack of formal assessment process for physician leadership.

One advanced approach to leadership performance assessment comes from Advocate Health Care, based in Chicago, Illinois. At Advocate, physician leaders are regularly assessed against concrete competencies, which are tailored to the type of leadership role, as well as a set of leader potentials that are shared in common across all leaders.

Often Not Measuring Physician Leader Performance

Physician Leadership Performance Tracking

2014 Physician Leadership Survey
n=98

Leadership Competency Scorecard and/or Qualitative Reviews

No Performance Tracking

60%

40%

Two Common Obstacles

1. Physician leaders do not have clear performance goals
2. No clear, standardized assessment process for physician leaders

Assessing Both Performance and Long-Term Potential

Case in Brief: Advocate Health Care

Performance-Based Assessment

- Key result areas and goals
- Example leadership competencies:
  - Builds collaborative relationships
  - Acts strategically
  - Accelerates performance
  - Builds talent for the future
- Example leadership competencies:
  - Interpersonal savvy
  - Learning agility
  - Drive for financial results
  - Integrity and trust

Potential-Based Assessment

- Example leadership abilities:
  - Adaptability
  - Intellectual curiosity
  - Drive to learn
  - Desire for more responsibility

Source: Advocate Health Care, Oak Brook, IL; Physician Executive Council 2014 Physician Leadership Survey, n=103; Physician Executive Council interviews and analysis.
Observation 3: Early Steps into Performance-Based Physician Leader Compensation

Incentives Underutilized in Driving Physician Leader Performance

For many hospitals and health systems, paying physician leaders for their time is a fact of life today. The rate of hospitals paying physicians to attend meetings rose from 37% in 2012 to 62% in 2014.

For hospitals and health systems looking to raise the effectiveness of physician leader teams, the question becomes whether there is an opportunity to raise expectations by moving from a pay-for-time model to instead (or in addition) putting compensation at risk for specific performance goals.

Paying for Physician Time a Fact of Life for Many

Percentage of Hospitals Reporting Paying Physicians to Attend Meetings

*MD Ranger Fifth Annual Physician Contract Benchmark Report (2014)*

![Bar chart showing the percentage of hospitals reporting paying physicians to attend meetings, with 37% in 2012 and 62% in 2014.]

For physician leaders outside of the C-suite, compensation is rarely at risk. Physician leaders in frontline roles are usually paid hourly or not at all, suggesting an opportunity to use incentives for better alignment at frontline leadership levels.

The core argument for performance-based compensation goals is that such goals have great signal value. Financial benefits aside, a targeted set of goal-linked incentives is an effective way to communicate organization priorities and indicate how leaders should be allocating their time.

Frontline Leaders’ Compensation Rarely At Risk

<table>
<thead>
<tr>
<th>Compensation for C-Suite Physician Leaders¹</th>
<th>Compensation for Non-C-Suite Physician Leaders¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At Risk</strong></td>
<td><strong>Fixed</strong></td>
</tr>
<tr>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>84%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Most Common Compensation Models by Leadership Role¹

<table>
<thead>
<tr>
<th>Physician Leader</th>
<th>Most Common Compensation Model in Use</th>
<th>Respondents Using Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Line Leader</td>
<td>Base earnings + hourly rate for leadership duties</td>
<td>37%</td>
</tr>
<tr>
<td>Department Chair</td>
<td>No additional compensation</td>
<td>36%</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Base earnings + hourly rate for leadership duties</td>
<td>41%</td>
</tr>
</tbody>
</table>

¹) 2014 Physician Leadership Survey, n=103.


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Pay Linked to Organizational Priorities

**Department Chair Compensation At-Risk**

**Components of Compensation**

- **Base**
  - Traditional department chair responsibilities, including:
    - Peer review
    - Credentialing
    - Attendance at MEC

- **Department Goals**
  - Department-specific clinical measures (e.g., 30-day admission rate for AMI, hospice length of stay for cancer patients)

- **Organizational Goals**
  - Patient satisfaction scores
  - Core measures performance

**Case in Brief: Kona Medical Center**

- 500-bed hospital located in the Midwest
- Developed at-risk compensation for department chairs to incent and hold chairs accountable for specific, strategic goals
- Chairs receive monthly reports illustrating performance against goals

Factors Motivating Physicians to Take Leadership Roles

2014 Physician Leadership Survey

<table>
<thead>
<tr>
<th>Rank</th>
<th>Ability to Influence System Strategy</th>
<th>Respondent Ranking (1=strongest to 6=weakest)</th>
<th>33%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ability to Improve Patient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Personal Growth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Career Advancement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Prestige</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
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<th>Respondent Ranking (1=strongest to 6=weakest)</th>
<th>27%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4</td>
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<tr>
<td>5</td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td></td>
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</tr>
</tbody>
</table>

Whether in the context of conversations about organization-level goals or not, physician leaders must see how their work is influencing system strategy and improving patient care—because those are the primary reasons why physicians take leader roles in the first place.

Understanding these drivers of physician leader motivation should also help us understand leader disengagement. Leaders are more likely to be frustrated by inability to positively affect change through the role than by inadequate remuneration.

Observation 4: Systems Leveraging Physician Leader Redesign to Build Systemness

Improving System Integration by Reducing Leader Silos

Systems can optimize leadership roles, provide performance management training and support, and incentivize leaders, but still have little to show for it without solving the organizational design challenges that most health systems face today. A typically fragmented patient pathway is depicted here; it showcases the persistent disconnects in physician leadership structures. Nationwide, progressive systems are tackling this opportunity for redesign in two ways (or possibly two phases): optimizing existing leadership structures and building new ones.

The most straightforward way a system can optimize physician leadership structure is simply to ensure that all system entities are coordinating their efforts and are represented in key groups and meetings. For example, Indiana University Health includes both medical group and hospital leadership in all system planning meetings. This ensures that the entities' strategic investments and decisions are unified, and not in conflict, with one another.

“Single Clinical Enterprise” Remains Aspirational for Most

Fragmented Physician Leadership Over Typical Diabetic Pathway

<table>
<thead>
<tr>
<th>Hospital-Based Physician Leaders</th>
<th>Clinically Integrated Network Physician Leaders</th>
<th>Medical Group Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT system flags diabetic patients based on lab results</td>
<td>Diabetics without a PCP referred to NP-staffed Diabetes Care Center</td>
<td>Patient matched with PCP in two to three weeks</td>
</tr>
</tbody>
</table>

Patient Admission  Patient Discharge  Transition Home  Follow-Up with PCP

Inpatient Diabetes Team provides additional support, management

48 to 72 hours post-discharge, Diabetes Care Center team contacts patient to provide education, ongoing monitoring

Seat on Executive Team Bridges System, Medical Group Divide

Medical Group Leaders ➔ Health System Leadership ➔ Hospital-Based Leaders

Benefits to Medical Group

- Representation in key decisions impacting clinical, practice operations
- Consideration of physician practice concerns when setting high-level strategy
- Bidirectional line of communication to facilitate feedback, input between system and group

Benefits to Health System

- Physician perspective on decisions impacting system-wide care delivery
- Channel to communicate rationale for system-level strategy decisions, foster support
- Safeguard to ensure practice-level activities in sync with system strategy

Case in Brief: Indiana University Health Physicians

- 1,100-provider medical group employed by 3,326-bed, 16-hospital system based in Indianapolis, Indiana
- Medical group leaders present for all health system executive vice president meetings
- Medical group leadership influences health system strategy, contributing to a more comprehensive view of care delivery and organization-wide performance goals

Source: Indiana University Health, Indianapolis, IN; High Performance Medical Group, Health Care Advisory Board, 2011; Physician Executive Council interviews and analysis.
Clinical Consensus Groups Set System-Wide Care Standards

Banner Health is perhaps the nation’s best example of using the power of the shared forum to improve system integration. At Banner, Clinical Consensus Groups (CCGs) are the backbone for clinical standardization across all facilities in the system. The CCGs define clinical standards for the system and support the implementation of evidence-based practices system-wide. Each CCG contains representation from each facility within the system and is supported by program managers (administrative partners) and process engineers who ensure the clinicians in the CCG are able to participate at top of license.

Each CCG presents clinical recommendations to the Care Management Council, chaired by the system CMO, which ultimately makes system-wide decisions.

Developing an Infrastructure to Deliver the Vision

Banner’s Care Management Structure

- Program managers are workflow and process engineers
- Care Management Council
- Clinical Consensus Group
- 24 Banner Facilities

Care Management Leadership

Clinical Consensus Groups:
- 17 CCGs¹ (e.g., critical care, orthopedics)
- Implement care protocols across the system

Care Management Council
- Led by system CMO
- Includes all CCG physician leads
- Sets care redesign strategy for system

Case in Brief: Banner Health

- 24-hospital system based in Phoenix, Arizona
- Care Management Council (CMC) serves as clinical leadership for system with lateral reporting lines to C-Suite and quality committee
- In 2009, Banner introduced facility CMO-led Clinical Consensus Groups (CCGs) focused on implementing care protocols across the system; currently 17 CCGs operating
- As of 2014, facility CMOs transferred CCG leadership to CCG physician leads
- CCG work supplemented by work of program managers, workflow and process engineers who design the workflows and systems required to execute on CCG-approved clinical practices

¹) Clinical Consensus Groups

Source: Banner Health, Phoenix, AZ; Physician Executive Council interviews and analysis.
Boosting Systemness by Elevating CMOs out of Facilities

Shifting now to examples of health systems redesigning formal leadership structures to improve integration, some health systems nationwide are pursuing this goal by taking the traditionally hospital-based CMO position and making it a system-wide role instead.

CHI Franciscan Health took this tack. To reduce entrenched clinical fiefdoms and provide added signal value to system-wide strategic issues, the system removed their acute care facility-based CMOs and elevated them to associate CMO roles with system-level oversight. Each associate CMO is responsible for a different system-level strategic imperative. Department medical directors are now the highest-level physician leader in each facility.

Physician Leadership No Longer Embedded at Facility Level

Executive Physician Leadership Structure at CHI Franciscan Health

New associate CMO roles created for system-wide functional oversight.

Associate CMO of Medical Affairs
Associate CMO of Quality
Associate CMO of Medical Informatics

Departmental medical directors are highest level of leadership at facilities.

This model has allowed us to move past a lot of the parochialism that can occur in a multi-hospital system.”

Mark Adams, CMO
CHI Franciscan Health

Case in Brief: CHI Franciscan Health

- Eight-hospital system based in Tacoma, Washington
- CHI Franciscan Health raised all executive physician leadership out of facilities for greater system oversight, to increase care standardization, and to reduce variation
- Four-person senior physician leadership team is comprised of system CMO and three associate CMOs of Medical Affairs, Quality, and Medical Informatics
- No executive physician leadership at the facility level; highest-level physician leaders in the facilities are medical directors
- In addition to system duties, each associate CMO has some facility support duties, such as medical staff management

Source: CHI Franciscan Health, Tacoma, WA; Physician Executive Council interviews and analysis.
Community Health Network (CHN) has created a matrixed network of service line physician leaders and regional physician leads to take the place of more traditional facility-level CMOs. The regional physician leaders oversee multiple facilities within a region and have oversight of the entire care continuum for their region’s facilities, including hospitals, urgent care clinics, and physician practices. Distinct accountabilities for broad cross-continuum leadership and deep clinical service line leadership, with all leaders reporting up to a single chief physician executive, promote an unprecedented level of system integration.

Regional Physician Leaders, Service Line Dyads Integrated

- Physician leaders given new regional oversight of care delivery across multiple facilities
- 6 CHN Region Physician Leaders
- Regional Physician Leaders and Service Line Physician Leaders

Case in Brief: Community Health Network

- Seven-hospital system based in Indianapolis, Indiana
- Due to historical misalignment within CHN, system restructured leadership to better align hospital and physician practices
- Six regions each have a physician lead with oversight of hospitals, urgent care clinics, on-site work clinics, and affiliated physician practices in the region
- Service lines have physician/administrator dyad leadership and operate across all regions
- Regional physician leadership and medical group physician leadership all report up to one system chief physician executive
- VPMA stationed at each facility for day-to-day operational oversight of care delivery

Source: Community Health Network, Indianapolis, IN; Physician Executive Council interviews and analysis.
One Final Leadership Success Factor: Look Beyond Leaders

Nationwide, health systems are working on many different fronts to improve the efficacy of physician leaders. Role clarification, goal identification, accountability, and improved infrastructure will all help systems maximize the return their physician leadership.

But many organizations are also looking at a factor beyond leader roles, management, or structure. In short, they are looking at culture. Leaders cannot accomplish ambitious performance and change goals by themselves. Health systems need an organizational culture that is supportive of the goals and efforts of physician leadership.

A long-standing example of cultural innovation comes from MemorialCare, in California, which developed a Physician Leadership Society that focuses on the adoption of evidence based-practice. Membership is open to any physician who signs a pledge agreeing to support the culture of evidence-based practice within the organization.

By creating this broad base of participation and support, MemorialCare ensures its leaders are never working alone in what should be an organization-wide mission to establish and uphold a high standard of clinical care.

We are working on building interdependence and breaking down fiefdoms between specialties and units of our organization, and it starts with being really intentional about your leadership culture. I am a big believer in culture. Culture trumps everything. Culture is something you have to be very thoughtful about. You have to visualize the culture you want to have, and physicians will respond."

Executive Medical Director, Chairman of the Board, Large Integrated Delivery System

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Executive Medical Director, Chairman of the Board, Large Integrated Delivery System

Physician Society Promotes Leadership Culture

**Physician Society Board**
- Physician Informatics Committee
- CME and Research Teams

**Best Practice Teams**

**Leadership Society Model**

**Physician Role in Leadership Society**
- Elected board members serve as face of Leadership Society at local medical center
- Members are a cross-section of physician leaders and frontline medical staff
- Physician leaders are de facto champions of clinical guidelines at each facility

**Two Keys to the Physician Leadership Society**

1. Physician decision-making infrastructure elevated to system level stature to allow for maximum influence
2. Society design and decision-making protocols are representative of all specialties and all physician constituencies

Source: Physician Executive Council interviews and analysis.
Discussion Guide
Discussion Guide

This discussion guide is designed to aid clinical strategy stakeholders in developing an approach to growing, integrating, and reimagining physician leaders’ roles in system transformation. Clinical stakeholders from entities across the system should leave the discussion with a clear vision of the trajectory of physician leadership at the organization in addition to explicit three-, six-, and twelve-month goals that will build toward the physician leadership transformation plan.

Assessing the Paths of Physician Leaders
Is it necessary to differentiate between physician leader roles that primarily lead change versus those of governance? Why or why not?
If physician leaders have varying levels of engagement and ability to achieve key organization goals, what should executives do?
If physician leader roles need restructuring, do executives have what they need to make those changes? If broad role restructuring is needed, what steps would executives need to take to make it happen across the next 12 months?

Professionalizing Physician Leader Roles
Where are the greatest gaps today in providing physician leaders with training and skill support?
Where are the greatest gaps today in goal-setting and assessment of physician leader performance against goals?
If there is consensus that all physician leaders should have clearer goals and regular performance assessments, do executives have the power to make that happen? What action steps would need to happen to complete the change in the next 12 months?

Exploring Performance-Based Physician Leader Compensation
Is your organization today under- or overpaying for physician leaders’ work?
Should physician leader compensation be put at risk? If so, what model do you think would be most effective and fair?
If physician leader compensation models should change, can executives make that happen in the next 12 months? What action steps would be needed?

Redesigning Physician Leadership Roles to Improve Systemness
Are all physicians across system entities well represented at the executive level at your organization? If not, which groups are missing?
In what ways does the current leadership structure at your organization work, and in what ways does it not work, in focusing leaders on common goals?
What do you think the physician leadership structure should look like to best succeed in the market of five years from now?

Beyond Leaders: Building a Supportive Culture
Does our clinician culture support leader efforts to raise performance and lead change? How can we create broad momentum for the work that physician leaders are charged to do?

Source: Physician Executive Council interviews and analysis.
Next Steps: Establishing Goals for Physician Leadership Redesign

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