



The American Hospital Association's

**CENTER FOR
HEALTHCARE
GOVERNANCE™**

Five Core Strategies for Developing High-Impact Physician Leadership:

Common Ground for the Board
and the C-Suite

Monograph Series

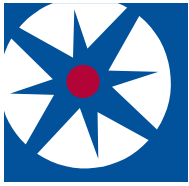
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About the AHA's Center for Healthcare Governance

The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information visit www.americangovernance.com.

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THE GAME HAS CHANGED DRAMATICALLY

Executive Summary

The emerging health care environment has changed the game for health care organizations and for physician leadership. The turbulence of that environment is going to require what could be called “agile organizations” adept at matching leadership and decision-making styles and setting and executing strategies appropriate to the nature and depth of environmental change. The challenges come in many forms, such as growth and the integration of physician practices, creating patient-centered medical homes or accountable care organizations, developing integrated delivery systems or aligning with value-based purchasing goals and requirements (see sidebar The Five Challenges for Trustees).

Agile organizations are going to rely on many more physicians in formal and informal leadership roles and in much more collaborative relationships with administrative leaders. Physician leadership is the missing piece for most health care organizations, whether they are systems, hospitals or large physician practices.

This publication presents an architecture or roadmap for developing the required web of physician leaders. It is designed to help executives and boards reach common ground. Developing physician leaders is a major challenge for health care executives and requires an investment of resources to realize the desired return.

The board can play a key role in encouraging executives to make wise investments in physician leadership and supporting them in “holding the course” to achieve this essential goal.

Sidebar

THE FIVE CHALLENGES FOR TRUSTEES

1. Understand the nature of the current and evolving health care environment and the implications for the organization—and the heightened chronic stress that the CEO and senior team will be under for the foreseeable future.
2. Understand the need to create an agile organization to deal with this scenario.
3. Understand the central role that a physician leadership web plays in an agile organization.
4. Support the CEO in executing the five core strategies (listed on page 6) for building such a web, making the investment to realize the essential benefits.
5. Hold the board accountable for its knowledge and its support of the CEO and hold the CEO accountable for the execution of the five core strategies.

Note: Holding the CEO accountable is not a matter of making one more demand for performance. It is the board’s way of saying, “This is important and we realize how easy it will be for it to be lost in the midst of all the demands on you. Don’t let it get lost.”

Fortunately, there are five clear strategies for building webs of aligned physician leaders that can effectively partner with executive leaders and boards.

1. **Design the leadership web**—matching three distinct types of leadership roles to the key work of the organization and matching physicians to those roles.
2. **Recruit the best talent to the roles and create flexible compensation plans**—recruiting internally and/or externally; building internal talent or buying external talent; and matching the roles and recruiting requirements to compensation plans while expending resources prudently (don't throw money at it).
3. **“Prepare the ground” for the physician leaders**—ensuring the networks of necessary work relationships are in place and required resources are available.
4. **Develop leadership capability following the 80/20 rule**—allocating 80 percent of attention and resources to carefully customized just-in-time, on-the-job-training and 20 percent to formal “pipeline” programs/ institutes.

5. **Deal with the phenomenon of “physician whiplash”**—effectively helping physicians deal with the impact of the often significant change that naturally occurs when they transition from clinical practice to the practice of leadership (or try to balance both). Clinical practice is 180 degrees different from the practice of leadership in many different ways and this will undermine physician leaders unless confronted directly.

AND—Be worthy of the Physicians Who Say “Yes” to Leading—execute the first five strategies with discipline and commitment with no wavering.

If these strategies are successfully executed then the answer to the question, “Are there enough physician leaders to make the difference in today’s health care environment?” is “Yes.”

THE FOUR GAME CHANGERS

The Challenge

The health care environment has certainly not been without change, but it has entered a period of change that will dwarf what we have seen previously. It is likely that the changes will come in waves and those waves will certainly require significant increases in the quantity and quality of physician leadership.

That means most health care organizations will see a rapidly expanding gap between the quantity and quality of available physician leadership that they have available and what will be required for sustained success, even in the near future.

There are currently many good physician leaders and a significant number are exceptional, but there simply aren't enough in place to meet the leadership needs of organizations in the emerging health care environment. Health care organizations need to get on a fast track in tapping what is an extraordinary pool of potential physician leaders.

This is not an indictment of today's health care systems or physician leaders. The environment is simply requiring a dramatic increase in leadership, particularly physician leadership. The game has changed and health care organizations need to respond to this gap with boldness, confidence and a sense of positive urgency.

Four Key Characteristics of the Changes in Health Care

The four game changers in the emerging health care environment are the following. They are not the only characteristics, but they are the ones that together provide a solid focus for leadership.

1. Finance is the Driver

Change is being driven by new and still forming financial requirements and

opportunities. Prior to 1980, finances were plentiful enough not to require much physician leadership in the corporate realm. Between 1980 and 2010 financial pressure increased significantly, affecting the balance between the business of health care and the care of patients, as the shift from volume- to value-based care delivery and payment accelerated. A comparable increase in the need for physician leadership to guide this transition also occurred, although efforts to develop more physician leaders were spotty.

Health care finances post-2010 are driving a dramatic increase in the need for physician leadership. That leadership is essential for enhancing access, controlling cost and utilization and increasing quality and patient satisfaction. It is essential in building the capability to accept and manage risk at increasingly challenging levels. The agility to do that simply will not be possible without significant increases in physician engagement and leadership.

The health care financial picture will continue to be fuzzy, with requirements for value-driven care delivery often out of alignment with organization design and capability, making agility essential. Physicians need to play a significant role in setting the strategies for meeting these challenges and for effectively and rapidly implementing the strategies at the operational level.

2. Clinical Transformation is at the Heart

Health care systems are faced with the challenge to essentially "rebuild the plane in flight." This will require transforming clinical practice from primarily vertical structures organized around hospitals to primarily horizontal structures organized

around care processes. It also must be accomplished without harming patients, burning out staff or putting the financial health of the institution at too high a risk.

The challenge is that the required integration of care crosses many boundaries, many complex systems and processes, and it involves a diverse group of stakeholders that often have competing interests.

Clinical transformation is the area where the greatest physician leadership is needed, at both the design and implementation stages. Agility is once again the critical characteristic as clinical transformation takes organizations into uncharted territory where they essentially “learn the way.” There are some proven models for parts of the challenge, but even those have to be crafted to fit the nature of each health care system.

The process of designing the best systems of care, implementing them effectively, monitoring success and making the needed alterations (repeatedly) requires physician leadership at every stage. This is not just participation, but true leadership; and it must be consistent, not sporadic.

Integrated and synergistic systems of care cannot be created and required performance sustained without levels of physician leadership beyond what is currently in place in many organizations.

3. Enhanced Information Systems are Essential

Clinical transformation and the ability to manage the enterprise must be enabled by enhanced information systems that provide a wide array of timely usable information—both clinical and administrative. Such an Information Systems (IS) function is essential for linking the efforts of various stakeholders, particularly physicians collaborating in a system of care. It is also essential for reporting, understanding and managing the organization.

Without effective IS there is no chance of achieving the quality improvement, population health management and cost management required, nor will payers be able to craft payment systems that reward integrated care.

Physician leadership is needed up front to design the IS support required, but it is even more important to effective implementation and sustained operations. For example, one of the key roles for physician leaders in this area is to challenge and support physicians in mastering the use of Electronic Health Records (EHRs) and using the information they can generate to manage care. The extra requirements that EHRs place on clinicians are widespread and well known. The benefits to clinicians and clinical care are not yet widespread, and they need attention in order to be identified/developed and spread across systems. That will require focused and committed physician leadership.

4. The Impact of the Changes is Complex and Enterprise-Wide.

“Rebuilding the plane in-flight” will involve multiple change initiatives with varying combinations of strategy, structure, roles, processes, technologies, relationships, required competencies, leadership styles and culture. Because health care delivery involves a high degree of interdependence among organizational units and staff, changes in one part of the organization will naturally ripple out into other parts of the organization or system.

As organizations continue to face changes, they must re-align themselves rapidly and repeatedly to maintain or regain performance. That kind of agility will not be possible without a web of physician leaders that extends well into the organization and that can influence performance widely and effectively.

AGILE ORGANIZATIONS

The Key to the New Health Care Game

Agile organizations that are adept at change will require all leaders, but especially physicians at the forefront of care and treatment, to make consistently good choices about strategies, effectively and efficiently implement them and continue to do that as the requirements of the environment continue to change (see Sidebar “Ten Characteristics of Agile Organizations”). Accomplishing this in a way that enhances—not diminishes—the organization and its people will become more important as health care systems move more deeply into the changes agility requires.

Physician leadership development in this scenario is really about taking health care organizations to the next level of performance and creating agile organizations that can sustain that performance in the face of continuously emerging challenges.

Central to effective physician leadership is creating a critical mass of highly competent physician leaders and the organizational architecture and culture within which they can effectively lead.

Sidebar

Ten Characteristics of Agile Organizations

1. Speed and quickness in establishing vision and strategy to match environmental demands.
2. Formal and informal, disciplined leadership that extends well into the organization—a web of leaders to implement strategy.
3. Collaboration across many boundaries and under intense pressure to perform.
4. High levels of trust across stakeholder groups and low levels of fear.
5. Teamwork with alignment across boundaries.
6. Flexibility and resilience—the ability to re-align quickly and re-energize.
7. Creativity and innovation and the ability to spread innovation rapidly.
8. Common ground on key issues, goals, approaches and style.
9. Effective accountability and rapid response.
10. The ability to become stronger with every change—even the toughest.

PHYSICIAN LEADERSHIP WEBS

Central to Agile Organizations

Leadership webs are designed to provide the leadership power, reach, credibility, flexibility and resilience required by today's health care environment. The analogy of a web (e.g., a spiderweb) is a good framework for thinking about and designing leadership architecture. A spider web covers a wide area with relatively few resources and is effective in accomplishing its purpose. It is also carefully designed, uses strong flexible resources, relies on many key connections and needs to be maintained—although it can still function even when parts are damaged or in disarray.

A web is a good analogy for leadership in general, but it is particularly important when designing physician leadership structures and integrating physician leadership fully. Ten characteristics of an effective physician leadership web include:

1. The requirements of leadership are spread across a web of physician leaders that extends well into the organization.
2. Leaders in the web are connected to each other and aligned on purpose, strategy and leadership style.
3. The leadership web includes many roles that vary by degree of formality, scope and longevity.
4. Large, formal, ongoing roles are limited, but very carefully designed and filled.
5. The variety of leadership roles and their definition closely match the key work of the organization.
6. The competencies of physicians in each specific role match the work required of that role.
7. Physician leadership development is customized to the role and physician, and it is delivered through multiple methods. It is most often “on-the-job” and “just-in-time” development.
8. Physician leaders are partnered with their appropriate administrative counterparts, and those roles and relationships are carefully defined. They also are connected to other physician leaders for challenge and support.
9. Compensation is flexible—a combination of salaries for large formal roles and flexible reimbursement for many roles. Compensation closely matches the work load required and is related to outcomes.
10. Leaders set high standards for their behaviors and outcomes and routinely hold themselves accountable. Accountability is simply built in as a natural part of how they do business.

Sidebar

FOR TRUSTEES

Trustees who appreciate the emerging health care environment and the need for agile organizations with physician leadership webs tightly integrated will be in a position to have the right conversations with CEOs and senior teams. Those conversations will lead to confidence within the board about the value it is adding and confidence within the executive ranks that the board will both challenge and support them appropriately. That confidence is essential for an organization to be agile and remain healthy. Boards need to decide how and where these conversations fit into the board structure and issue agenda.

BUILDING THE PHYSICIAN LEADERSHIP WEB

Five Core Strategies

Building a web of physician leaders is very straightforward. It involves five core strategies: design the web, recruit the right talent and design flexible compensation models, “prepare the ground”, build the required competencies, and deal with the impact of change on physicians as they assume new roles. And, do all of that in a way that is worthy of the physicians who make the commitment to answer the call to lead.

Strategy #1: Design the Web of Physician Leaders

This strategy can be broken down into a set of specific steps to be taken in concert.

1. Map and gain alignment on priorities and desired outcomes for the organization and design leadership roles to fit the work required. That work can range from growth to the ability to manage risk and from clinical integration to integrating new physician practices. The key is to map the work required and design roles to match that work.

Roles can be large and small, formal and informal, some that are ongoing and some that are time- and task- specific. Maintaining role flexibility ensures that roles can be matched to work as priorities change or as projects or initiatives are competed. Flexibility also opens opportunities for bringing new physicians into leadership roles without overwhelming them in the beginning. This is particularly important for physicians who will be maintaining some level of clinical practice.

2. Take advantage of the three main categories of physician leadership roles to achieve performance and flexibility.

Leadership roles can take many forms. Some will be traditional, such as Chief

Medical Officer and Vice President of Medical Affairs. Some will be new, such as Vice President of a Service Line, Chief Clinical Information Officer or President of a Clinically Integrated Network. The most flexible roles will be project or initiative specific, such as leading patient-centered medical home implementation, effective use of EHRs or mentoring new physician leaders. It’s a matter of taking advantage of the strengths of each type of role—traditional, new and flex—to match the priority work and achieve the desired outcomes.

3. Keep, start and stop (don’t just add roles and throw money at them).

Designing a physician leadership web is not a matter of just adding roles and throwing money at them. It’s about going through a thoughtful and disciplined process to determine three things: What roles do we want to keep (and why)? What roles do we want to add (to achieve what outcomes)? What roles do we want to eliminate or redesign? Not only does that process match work with leadership roles, but it also opens up possibilities for rethinking current roles and identifying new and exciting roles. Both talent and financial resources can be deployed or redeployed to conserve resources. Additional financial resources may be necessary, but redeploying funds already in the budget should be a complementary task.

4. Focus on capability, not representation.

Leadership roles should not be seen as “representative” roles. Talent is the key factor in selecting physician leaders, not representation for departments, organizations or demographic groups. There are no longer any “throw-away” roles, no longer room for mediocrity in physician

leadership. The current environment compels physician leaders to demonstrate a commitment to performance.

5. **Expand roles as capability increases.**

There may be significant numbers of physicians new to leadership roles who will rapidly increase their capabilities. Their roles can then expand to take advantage of their increased skills. It is better to start new physician leaders in smaller roles that can be expanded to match developing capabilities. Flex roles in particular can be initiated with a relatively small scope and expanded as physician leader performance increases.

6. **Make room for new leaders, and don't burn out the veterans.**

Much of the opportunity for organizational agility will come from developing a variety of roles of smaller scale and scope to bring newer leaders into the game *and* keep those in larger roles from being overwhelmed. Some larger roles may be divided to allow greater focus, new energy, new players and less stress on physicians in these roles.

7. **Avoid the “Sink or Swim” Approach.**

It is important for health care organizations to avoid the classic trap of taking people who have proven themselves masters in a technical domain and throwing them into a leadership domain—along with magical thinking that says they will immediately be successful.

The key is to prepare the environment for each physician leader so that he or she is supported and able to achieve some quick wins. That includes identifying the key relationships physician leaders will rely on and preparing the way, ensuring that necessary information is available and that support processes and technologies are in place. It also means being clear on the outcomes to be achieved and, in most cases, providing basic guidance about how to achieve them. Upfront preparation

is an obvious complement to the fourth core strategy (customized development plans) discussed in more detail below.

Moving the Needle

There are many ways in which a web of high-performing physician leaders can “move the needle” for a health care system, hospital or physician practice. Priorities will vary from organization to organization, but the following examples are illustrative. Some are focused on major initiatives and some on the culture of leadership.

1. The ability to grow/attract/acquire and then integrate physician practices to capture or protect a market
2. The ability to effectively manage chronic disease populations that account for the majority of health costs—managing risk.
3. The ability to appropriately keep referrals within the health care system
4. The ability to effectively support CEOs in working with boards and external stakeholders—aligned leadership
5. The ability to create a sustainable organizational culture of alignment and high performance
6. The ability to design and implement patient-centered medical homes (particularly in systems where scale—the number of offices—is a significant factor)
7. The ability to design and implement an accountable care organization within a community—with true and sustainable integration of care
8. The ability to lead clinical transformation where required to meet quality and cost challenges
9. The implementation and effective use of electronic medical records to meet requirements *and* to improve clinical practice—for individual patients and patient populations
10. The ability to position the health care system as “the place where the best and brightest want to practice.”

As these examples illustrate, capable physician leadership performance can greatly benefit both patient care and health care business performance in a turbulent environment.

Strategy #2: Recruit the Right Talent—Internally and/or Externally and Design Flexible Compensation Models

Because each physician leadership role is such a critical piece of the leadership web, the question of “Where do we find the right talent?” becomes a critical one. Essentially, talent can either be “built” internally or “bought” in the market. In many cases, it will be a careful combination of both.

Guiding Questions

Although every case will have its own unique aspects, there are several questions that can guide the process.

- Do we have the talent inside for this role?
- If not, can the necessary capabilities be built quickly with the person/people we have?
- How fast do we need to have this role make a significant impact?
- How important is it for us to have a known entity in this role?
- How hard would it be for an “outsider” to step into this role and fit with our culture?
- How much of a positive impact might an “outsider” have on our culture?
- How long would it take to recruit someone from the outside?
- What are the political realities of build/buy for this role (yes, politics matter)?
- How big is the external pool for this leadership role?
- How competitive can we be in recruiting in the market?

A good “build or buy” decision often takes more time, discipline and discussion than anticipated, but it can be a make-or-break decision, so it’s worth the attention.

The build/buy question is also influenced by the type of role under consideration.

Sidebar

FOR TRUSTEES

Trustees can play a major role in this strategy by encouraging senior leadership to commit the time to do this well—making room on their agendas, getting the resources needed to support physician leaders, avoiding shortcuts. With all the competing demands that senior leadership faces, it is important for them to know that this strategy is highly valued by the board and worth their commitment. This can be assured by including physician leadership development as a frequent agenda item at committee and full board meetings.

1. **Traditional roles** will probably be filled from within (build), particularly if there is a strong developmental pipeline that has been readying people for those roles. If, however, the pipeline is not strong or if the requirements of the role have risen dramatically, then a senior traditional role might need to be filled through an external search.
2. **New roles**, such as Chief Medical Information Officer (CMIO), Vice President of a Service Line or President of a Clinically Integrated Network, can be filled internally if the talent and commitment to development from both the individual and the organization is there, but may also be filled from outside if specific skill sets and talent are required, but don’t currently exist internally.

The specific new role also will influence the decision. For example, the Chief Referral Officer role may best be filled by an internal choice because of the need for familiarity with the players, clinical service

arrays and organizational culture. On the other hand, with the increase in complexity and importance of clinical informatics, an external search might be required to find that rare skill set for the CMIO.

3. **Flex roles** will typically be built because they are usually of more limited scale, may change as the priority work changes, and are often designed to meet unique aspects of the organization as well as existing talent.

As with the build/buy question, the three types of leadership roles also will influence the nature of compensation design. Because compensation design is becoming a bigger challenge, it is worth investing time upfront to get it right.

1. **Traditional Roles:** Good data nationally and locally often exist and can be used to design a competitive package that meets the standard of “fair market value.” Total compensation packages will usually take the classic form of base salary and benefits, with possible variable compensation options (bonuses, incentives, etc.).
2. **New Roles:** Some roles are already supported by useful compensation data. Some (because they are new nationally) will have little or no comparative data. These will require careful thought about the value/outcomes of the role and their influence on compensation design.

New roles may have compensation designs similar to traditional roles, but some may have a much greater reliance on variable pay to match the scope of the job and the expected outcomes.

3. **Flex Roles:** Health care organizations typically will have little or no access to relevant comparative data nationally or locally when designing these roles. Their usually smaller scope as well as the flexible nature of the role—time and task specific—would argue for more of a stipend- or

performance-based approach. This type of role requires creativity to develop, but provides a lot of opportunity for high impact while conserving resources.

In many cases physicians taking on leadership roles also will be practicing medicine, and compensation will need to be designed to fit that reality. Time committed to leadership activities is time away from patient care and, therefore results in lost revenue. That loss must be balanced, although not necessarily on a dollar-for-dollar basis. Non-monetary rewards may be key in achieving the right balance.

For more on the three types of roles for physician leaders, see Addendum A on page 20.

Strategy #3: “Prepare the Ground” for Physician Leadership Success

This is one of the most overlooked aspects of physician leadership development, yet it can make the difference between rapid, significant success and mediocrity or failure. We are asking physicians to perform almost immediately in a domain that they have not yet mastered. We wouldn’t ask an elite athlete in one sport to perform at a high level in a very different sport, yet we often act as though physicians can magically do that going from the practice of medicine to the practice of leadership.

Although challenges vary significantly from one leadership scenario to another, there are a few core strategies that can be used to maximize the likelihood of physician success.

1. **Put a basic support network in place for the physician.** This is a network composed of key people with whom the physician leader must collaborate. It can range from administrative partners and other physician leaders to key people “who get things done in the system” as well as coaches or mentors. This network also can include selected board members who can work with physician leaders whose areas

Sidebar

FOR TRUSTEES

The opportunity for boards to make a difference is threefold. First, they can support the investment required to put the right physician leaders in the right roles to accomplish the priority work. Second, boards can exercise their duties in the wise use of resources and compliance with fair market value principles regarding compensation. Third, in the case of some key physician leadership recruitment efforts, trustees can play a carefully crafted role.

of responsibility or developmental needs are an appropriate fit. Part of building this network is preparing those in it to engage effectively with physician leaders.

- 2. Orient the physician to the likely experience he or she will encounter.** This orientation can focus on the leadership culture of the organization, the experiences leaders of change can expect, and the “whiplash” that physicians often experience going from the practice of medicine to the practice of leadership (discussed in more detail in Strategy #5 on page 17).
- 3. For physicians new to leadership or new to a role, ensure a draft plan is in place to help them begin to address the nature of the challenge.** Creating a draft plan is a good way to clarify the desired outcomes for the role, help physician leaders think through the best ways to go about their pursuit and also identify the likely barriers and pitfalls in assuming the role. It’s also a good way to reality-test expectations. Such a plan can also provide a good orientation to how things really get done, which is critical for physician leaders new to the organization. A draft plan can

achieve its ends by being very basic, which then allows the physician leader plenty of room to be the author of the full plan needed to take on the role.

- 4. Ensure that resources are in place to match the challenge.** A well-devised draft plan will help identify the resources (human, financial, informational, etc.) required to implement it. The organization must then have the discipline to allocate those resources. Frequently this is not done and can seriously undermine the physician leader.
- 5. Look for ways to create early wins to build momentum and confidence.** This is particularly important for leading large complex projects or initiatives. Few things add as much energy to efforts as achieving early wins. This is particularly true for new leaders or leaders new to specific challenges.
- 6. Put a process of “dynamic accountability” in place.** This approach to accountability stresses frequent and informal checks that focus on:
 - interim achievements and worthy efforts that can be celebrated;
 - what has been learned; and
 - what to keep doing, stop doing or start doing to move the effort ahead.This approach to accountability minimizes stress, raises energy and keeps people aligned.
- 7. Connect physicians in leadership roles with each other.** This is a critical, but often overlooked strategy designed to help physicians feel connected and get to know and appreciate one another. These relationships allow physician leaders to challenge and support one another, learn from each other and provide much richer guidance to the system.

These elements for “preparing the ground” are basic and should not interfere with the physician leader’s ability to be the author of the experience and create what he or she needs for success. They do, however, provide an exceptional foundation on which the physician leader can build. They also demonstrate to physician leaders that a good deal of thought has gone into preparing them for success—that they are not alone and are, in fact, the focus of a great deal of support.

Strategy #4: Customize Physician Leadership Development

The 80/20 rule applies here. That rule says that, for most organizations, the best approach to developing physician leadership is to focus 80 percent of the attention and resources on just-in-time/on-the-job (JIT/OTJ) training closely tied to the role of each physician in the leadership web. The other 20 percent should be devoted to participation in the classic pipeline that trains physicians in more formal settings and over a longer period of time.

Most organizations need both approaches, but use them in the wrong balance. The 80/20 balance supports customization of a development plan that matches a physician’s specific and immediate needs—and achieves a significant impact sooner.

Several key actions support this strategy.

1. **Map the competencies needed for physicians in specific roles.** A few core competencies will need to be developed for all physician leaders—but only a few. Most physician leadership development needs to be customized to a physician in a particular role. Each leadership role will have capabilities required to achieve the desired outcomes. Each physician will come to that role with a set of capabilities. The questions are (1) “Where are the gaps?” and (2) “How do we close those gaps as rapidly as possible to enable early successes in the role?”

Sidebar

FOR TRUSTEES

The board contribution here can be very simple and straightforward. The board can simply say, “We realize that this strategy is critical and often overlooked. We will look forward with great interest to stories about how the organization has prepared the ground for our physician leaders and about some of their early wins.” If no stories are forthcoming, some probing may be in order, as this is a challenge easy to overlook in the press of other business. A light hand by the board can make a big difference.

2. **Employ multiple methods of development.** This is critical for both JIT/OTJ development and more formal approaches. There are many methods for leadership development, ranging from courses, seminars and conferences to online education, shadowing, carefully crafted job assignments, partnering and coaching. The greatest leverage occurs in creating the right combination of methods for the particular physician in the specific leadership role.
3. **Ensure that the appropriate relationships are in place**—with administrative partners, other physician leaders, coaches or mentors. This requires a good deal of discipline as the daily press of business pushes relationship building to the back burner. The problem, of course, is that most important work—particularly across boundaries—is accomplished through relationships.
4. **Create a sense of joint ownership with physicians.** Customizing development makes it much easier for an organization to create a sense of joint ownership with

each physician and, over time, in the culture as a whole. Shared ownership of leadership development continues to influence performance, so it is worth the investment to create it early in the process. Steps include involving physicians as early as possible in determining development needs and possible approaches to meeting them.

Reinforcing the importance of self-directed learning as well as frequent and informal accountability checks to ensure desired experience and outcomes are being achieved also create shared ownership of the leadership development process.

5. **Assign executive responsibility.**

Because customized leadership development is significantly different from the norm in health care, it is critical that senior executives take responsibility for it. Internal Human Resources, Organization Development or Training Departments should not be asked to take on this type of work without senior executive ownership, guidance and sustained support.

Internal departments will need to function as brokers of leadership development services and partner with executives and physician leaders in the customization process. However, if physician leadership development isn't owned at the top, it won't happen—certainly not in a sustained way.

Strategy #5: Deal Effectively with the Impact of Role Change on Physicians

There is an exceptionally challenging phenomenon that can naturally and powerfully undermine efforts to develop physician leadership. It is usually silent and unacknowledged, which is why it can be so destructive. It is the “whiplash” that physicians naturally experience when they go from having mastered the art of medicine to trying to master the art of leadership—usually under immediate pressure to perform.

Sidebar

FOR TRUSTEES

Leadership development often gets lost in the crush of operations and is particularly vulnerable under cost reduction pressure. It doesn't usually get completely lost, but it can get scaled back and de-emphasized. The board can ensure this doesn't happen with this core (and very high ROI) strategy simply by continuing to ask questions about progress, outcomes, and what barriers are being encountered that the board might help with. The board can also encourage the senior team to ensure that a senior executive, no more than one level below the CEO, has responsibility for this development and the resources it requires and is held accountable.

The preparation and approach traditionally used to develop practicing physicians is, in many ways, 180 degrees from that used to develop good leaders. Great medicine and great leadership have traditionally required different skills of their practitioners, although this is changing as care delivery becomes more of an integrated, team-based endeavor. It's not a matter of right and wrong—the practice of both disciplines is just different in many ways. The complicating factor is that it doesn't take more than a few of these differences at play to seriously interfere with a physician's ability to make the transition from clinical practice to leadership. The following examples of the differences make the point.

1. Prescribe and Comply vs. Influence and Collaborate
2. Immediate & Short Term vs. Short, Medium & Long Term Results
3. Procedure/Episode vs. Complex Processes with Lots of Stakeholders
4. Hard Science vs. Social Science
5. “The” Expert vs. One of Many Experts & Sole Responsibility vs. Shared Responsibility

6. Relating to Sick/Injured People vs. Healthy People
7. Focusing on a Patient's Interests vs. on Patients' Interests—Individuals vs. Populations
8. Well-Defined Problems vs. Ill-Defined & Often Messy problems.
9. Consistent Solutions/Protocols vs. Highly Variable Strategies Required by a Fluid Environment
10. Working Solo or in Small Teams vs. Many Teams and Large Complex Networks

Physician Strengths

Fortunately, physicians bring with them some common strengths that provide a very strong foundation on which to build leadership capability. For example, physicians:

1. Demand credibility—then commit
2. Are outcomes-focused
3. Are highly intelligent & multi-faceted
4. Are exceptional learners
5. Are fast
6. Are good under pressure
7. Have high expectations—of self & others
8. Have sense of purpose & significance

These strengths can provide a good foundation when matched to a specific challenge. The main pitfall to avoid is physicians relying too much on these skills without complementary leadership skills, which can turn these character assets into liabilities.

Physician leaders that have been appropriately prepared and supported in developing their leadership skills report a variety of benefits that have resulted from answering the call to lead. They fall into three main categories: power and meaning, connections, and growth. See Addendum B on page 21 for more details.

The Meta-Strategy: Be Worthy of the Physicians Who Answer the Call to Lead (A Challenge for the C-Suite)

Asking physicians to take on meaningful leadership roles and prepare themselves to do so carries a moral/ethical challenge for health care leaders. That challenge is to be worthy of the physicians who say “yes” to the call to lead.

Health care leaders must acknowledge that they are asking physicians to move away, to varying degrees, from their areas of passion and preparation and enter a world that is profoundly different. They are leaving a history of success for the unknown. This is a highly personal as well as professional challenge for physicians. See Addendum C on page 22 for more details.

This is a C-Suite challenge for two reasons. First, physicians will look to the C-Suite to judge whether the organization is really serious about physician leadership performance and development. A lack of commitment in the beginning or wavering on the path is a pretty clear message that the organization is not really serious about physician leadership. Physician commitment will rapidly erode, and it will be hard to recover.

Second, because the approach required now is so different from previous efforts, it is the C-Suite that must provide the vision and resources and then “hold the course.” The C-Suite cannot expect others to move away from traditional approaches to physician leadership role design, development and performance if they don't clearly lead the way.

It Comes Down to Courage, Vision, Commitment and Integrity

As with most complex challenges, there is an underlying pattern that provides the basis for dealing with the challenge. In the case of developing and deploying sufficient physician leadership, the factors that make the difference are:

Sidebar

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Trustees can appreciate and acknowledge the level of personal commitment, effort and risk that physicians must assume in stepping up to lead. They can also hold the board, CEO and senior team accountable for the level of execution of the five core strategies. And they can simply encourage physicians to say “yes” to leading. It also could be interesting and instructive for the board to periodically hear from physician leaders about their experiences leading in the system.

- The courage to see the scale and scope of change that the emerging health care environment is requiring.
- The vision to develop the agile organizations necessary to meet the fluid challenges of health care.
- The commitment to building the web of physician leaders that is the missing piece for many health care organizations—designing the leadership roles, recruiting the right people, “preparing the ground” for success, focusing on just-in-time and on-the-job development—and dealing with physician whiplash.
- The integrity and discipline to do all of the above in a way that is worthy of the physicians that take the risk and make the commitment to answer the call to lead.

ADDENDUM A—THE THREE TYPES OF ROLES FOR PHYSICIAN LEADERS

Overview & Comparison

Each type of leadership role has its own characteristics and each offers different benefits. Used together they offer the chance to customize an organization's physician leadership structure to very closely match priority work, take advantage of existing physician leadership resources and provide the flexibility in leadership necessary to match evolving environmental challenges.

For each of the three types of roles, a few examples and notes about how to think about or address them are included below. How to recruit physician leaders (build internally or buy externally), how to compensate them and how to develop them are also addressed.

Traditional Physician Leadership Roles

These roles have been common in health care for some time. Many of them will continue to be part of the physician leadership web. Some may be redesigned (perhaps split into more than one role to avoid overwhelming any one leader and to open up opportunities for others) or some may be deleted.

Common Examples

- CMO
- Chief Quality Officer
- VPMA
- Department Chair
- Trustee

How to Address Them

- Disciplined choice about whether to keep, redesign or delete
- Good to have, but are they now a priority?
- May keep, but change scope or scale

Watch Out

- Comfortable common roles—known world
- Tenacious—may be hard to let go of or redesign

Recruiting, Compensating and Developing

- Build or buy? Could be either
- Compensation? Probably traditional
- Development? Probably formal, traditional training

New Physician Leadership Roles

With all the changes in health care and the need for more physician leadership, a whole range of new roles is opening up to match priority work. A tremendous amount of leverage can be achieved from carefully designing new leadership roles.

Common Examples

- CMIO
- EVP, Clinical Integration
- VP, Service Line
- Chief Referral Officer
- Chief Recruitment Officer
- VP, Physician Integration
- VP, Clinical Innovation
- CEO, Institute for..... (various opportunities)

How to Address Them

- Match the emerging priority work with desired outcomes
- Can vary in scope and scale
- May replace traditional roles or parts of those roles
- Need to be defined well because they are new
- Opportunity to bring “young guns” into the leadership structure

Recruiting, Compensating and Developing

- Build or Buy? Could be Either
- Compensation? Probably Traditional
- Development? Probably intensive OJT/JIT

Flex Roles for Physician Leadership

These are the roles that can add a great deal of flexibility to the leadership structure, open up opportunities for new physician leaders and ensure that priority work is matched with them. The possibilities are almost endless, so it's a matter of being disciplined and creative in designing them.

Common Examples

- Coach—Effective EMR Use
- Champion, Patient-Centered Medical Home
- Team Leader, Practice Integration
- Consultant, Leading Change
- Coach, Impaired Physicians
- Coach for Senior Administrator
- Project Leader (may be a dyad with an organization executive)

How to Address Them

- Can closely match the priority work
- Can be of any scale and scope
- Can change at any time to maintain the right match of priorities and people
- Can be crafted as entry level leadership roles
- Some roles will have multiple players
- Are usually task and time specific vs. general
- Ongoing roles

Recruiting, Compensating and Developing

- Build or buy? Probably build
- Compensation? Creative non-traditional
- Development? JIT/OJT

ADDENDUM B—WHY IT'S WORTH IT FOR PHYSICIANS TO SAY "YES" TO THE CALL TO LEAD

When asked why it's worth it to take on the challenges of leadership, step outside of a comfort zone and deal with the whiplash experience, physician leaders have consistently given the following answers (often within six to nine months of assuming a leadership role). These factors seem to fall into three categories.

Power and Meaning

- The ability to make a significant difference
- The ability to influence—to be potent—and not be a victim.
- The ability to play a major role in designing care processes and providing quality care in a changing environment.
- The chance to be the author of change vs. being a target.

Connections

- Meaningful connections with peers and administrators.
- Feeling “on the inside”—knowing what's going on.
- Realizing how much talent there is in the organization/system.

Growth

- Job enrichment and career opportunities.
- Developing one's self—the pleasure of learning and growth.
- Pride in mastery of a new, challenging domain.
- Intellectual stimulation and the ability to compete in a new domain.

ADDENDUM C—DRAMATICALLY INCREASING PHYSICIAN LEADERSHIP PERFORMANCE

System Leader Actions and Physician Actions

Health Care System Leader Actions <i>“Worthy of Physicians Making the Leap”</i>	Potential Physician Leader Actions <i>“Courage and Commitment to Make the Leap Into Leadership”</i>
<ol style="list-style-type: none"> 1. Vision. Create a vision of physician leadership in the organization, the outcomes expected and the plan for developing the leadership web. 2. Create the Architecture. Design the organizational elements required for that vision—physician leadership structure, three types of roles, relationships, processes, support systems, competencies, compensation, etc. 3. Recruit & Reward. Develop the ability to recruit internally and externally and design flexible models of compensation to match leadership roles. 4. Customize. Identify the range of competencies to be developed and a system for customizing the development methods for each physician leader. 5. “Prepare the ground” for physicians with the right relationships, information, processes etc. 6. Commit & Be Accountable. State the leadership commitment to making it all happen. Establish a system of accountability to ensure progress and model commitment and accountability. <p>These are the actions that show physicians that the organization is worthy of their commitment to lead and the risk and effort that will be required of them to be successful.</p>	<ol style="list-style-type: none"> 1. Get in the Game. Commit to playing a leadership role (large or small, formal or informal) with an understanding of the significance of each role. 2. Learn Fast. Commit to the required developmental experiences—just like the commitment to medicine. 3. Manage the Journey. Self-manage to navigate the journey to become an effective leader. Be a partner in the physician leadership development initiative, not just a recipient or participant—provide feedback, be part of the accountability process. 4. Partner. There are no “Lone Rangers” in leadership, so build and maintain the partnerships with key administrative leaders, other physicians and clinical staff that establish the network you will need for success. <p>Note: While the challenge for the system is to be very strategic in thought and design and then support implementation, the challenge for physician leaders is to fully commit to the journey required to become effective leaders and to “hold the course” to master the practice of leadership just as they have mastered clinical practice.</p> <p>This is unlikely to happen if the organization has not clearly done its part. On the other hand, it is very likely to happen if the organization’s commitment is evident and seen to be comparable to the challenge.</p>

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